A comprehensive picture of ethical values in caring encounters, based on experiences of those involved. Analysis of concepts developed from empirical studies.

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…“whatever you wish that others would do to you, do also to them”… Matthew 7:12
ABSTRACT

Older people should have a life with a sense of value and should feel confident. These ethical values, which are expressed in normative ethics, are expected to prevail in empirical ethics. Central components of nursing are the ethical issues of autonomy, beneficence, non-maleficence and the principles of justice. The general aim of this thesis is to identify and describe the ethical values that are apparent in the caring encounter and their influence on the people involved. This is done from the perspective of the older person in study (I), next of kin in study (II) and nurses in study (III). In study (IV) the aim was to synthesize the concepts from empirical studies (I-III) and analyze, compare and interrelate them with normative ethics. Studies (I, III) were empirical observational studies including follow-up interviews. Twenty-two older people participated voluntarily in study (I), and in study (III) 20 nurses participated voluntarily. In study (II) fourteen next of kin were interviewed. In studies (I-III) constant comparative analysis, the core foundation of grounded theory, was used. Five concepts were used in the analysis in study (IV); three from the grounded theory studies (I-III) and two from the theoretical framework on normative ethics i.e. the ICN code and SFS law. Five categories; being addressed, receiving respect, desiring to participate, increasing self-determination and gaining self-confidence formed the basis for the core category “Approaching” in study (I). ‘Approaching’ indicates the ethical values that guide nurses in their caring encounters with older people. These ethical values are noted by the older people and are greatly appreciated by them, and also lead to improved quality of care. Four categories were identified in study (II): Receiving, showing respect, facilitating participation and showing professionalism. These categories formed the basis of the core category “Being amenable”, a concept identified in the next of kin’s description of the ethical values that they and the older patients perceive in the caring encounter. In study (III), three categories were identified: showing consideration, connecting, and caring for. These categories formed the basis of the core category “Corroborating”. Corroborating deals with support and interaction. Empirical ethics and normative ethics are intertwined, according to the findings of this study (IV). Normative ethics influence the nurse’s practical performance and could have a greater influence in supporting nurses as professionals. Criteria of good ethical care according to this thesis are: showing respect, invitation to participation, allowing self-determination, and providing safe and secure care. These criteria are elements of the concept of being professional. Professionalism of nurses is shown by: the approach nurses adapt to the performance of their duties, and their competence and knowledge, but also how they apply laws and professional codes.

Keywords: Ethical values, grounded theory, older patient, next of kin, nursing care, qualitative methods, empirical ethics, normative ethics
LIST OF PAPERS

This thesis for a doctoral degree is based on the following four papers, referred to in the text by their respective Roman numerals:


IV  Jonasson L-L, Liss P-E, Westerlind B, Berterö C. Empirical and normative ethics: a synthesis relating to the care of older patients. *Nursing Ethics*. 2011 Accepted

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INTRODUCTION

The public are interested in how older people are cared for by nurses in nursing homes and in hospital. There are often reports in the media about ill-treated older patients. These signals greatly affect the readers. Why is that? Possible answers could be that the public expect older persons to be well-treated, and today ethical values are discussed in many organizations. What values does the individual person have and how are they expressed? Ethical values may cause everybody to feel valued and respected and give a feeling of “being someone”. These values are important especially when one person depends on another person, which occurs in different caring situations. Why does it not function well enough? It could be because professionals experience they are weary and have restricted possibilities to make decisions. It could also be demands on an organizational level, such as stress and economic factors. Health care organizations even face demands from patients, next of kin, colleagues and politicians. Every patient has the right to feel valued, respected and “to be someone”, but this right is not always granted. Older patients are an especially vulnerable group in health care organizations, and therefore it is more important than ever to focus on the older patients. The way the older patient is treated provides an indication of the quality in caring encounters. Maintaining the welfare of the older population is one of the most important goals of the public health services (Hanzade & Mebrure, 2004; WHO, 2011). Older people are an expanding group in several welfare systems, and their needs for care are ever-increasing (Flesner, 2004; Hansson et.al., 2006), and the current view is that older people should be able to influence their own everyday life and grow old in safety and with their self-determination.
preserved (UN, 2002; WHO, 2005; OPD, 2006). The care of older people is also related to financial limitations (Klevmarken, 2008; Thomson et al., 2009), and such limitations represent a special challenge for every health care organization and for nurses in terms of offering care of good ethical quality (SFS, 1982:763; ICN, 2010). Next of kin observe the actions of nurses to make sure that they are well-prepared (Wright, 1999; Li, 2005). Nurses also have responsibilities in caring that correspond to laws and codes (SFS 1982:762; ICN, 2010). Values described in law and codes may influence nurses and can be seen as a kind of public guarantee of qualitative good and safe care for older patients (Fletcher et al., 2001). These values increase demands on nurses to act as professionals, and to give good quality care (Tschudin, 2003). There are some problems; the expressed wishes of the public regarding older patients’ rights and how health care professionals should act are not always satisfactorily met in practice (WHO, 2011). These facts increase the need for studies regarding caring ethics in practice i.e. studies on empirical ethics and how normative ethics interrelate with empirical ethics.
BACKGROUND

Ethical values in caring

Caring is a universal phenomenon and has been defined by Heidegger (1962) as the way people think, feel and behave towards others; caring is an aspect of humanity. These aspects become apparent in caring encounters through nurses’ practice. The people involved have different experiences of caring depending on how they think and feel. In accordance with that, Edwards (2002) states that ethical values are the backbone of the way we act, behave and deal with different moral situations.

Ethical values are defined as the fundamental values that form individual norms and actions and that become visible in empirical ethics. In their actions, nurses ought to treat older patients with respect, which entails supporting their integrity and making it possible for them to maintain self-esteem, individuality and participation. Nurses should also have a good attitude towards older patients and their next of kin (Edwards, 2002; SOU, 2008). What is a good attitude? Atree (2008) answers the question from the patients’ and next of kin’s perspective by saying it is individualized, patient-focused and related to need. The nurses provide care humanistically, through establishing a caring relationship.

The care of older patients is humanistic if all patients are treated equally, and have equal worth. Every person’s life, self-determination and integrity should be respected, and every person has physical, mental, social, cultural and
spiritual needs to be met. To meet the older patients’ needs there are three levels of ethics in caring, i.e. the personal ethic, group ethics and the philosophical aspect of ethics (Edwards, 2002). The personal ethic is also related to personal responsibility i.e. ethical responsibility. This responsibility cannot be avoided, ignored, or transferred (Clancy & Svensson, 2007). From a professional, theoretical perspective, a value is a symbol that signifies the meaning of the interest in caring, the human-universe-health process (Parse, 1998). The nurse’s own self-respect and dignity are ethics on a personal level. Personal ethics concern how the individual reacts and performs in different settings and encounters, and this depends upon the person’s upbringing and the atmosphere at work e.g. in the caring situation. The group ethics are dependent on the environmental atmosphere synonymous with caring culture. This caring culture embodies the system of meaning, beliefs, knowledge, and actions (Romanucci-Ross et al, 1997, Cortis et.al., 2003). The philosophical level explains the ethical questions on an academic level (Edwards, 2002).

Health and human rights are closely interrelated with the ethical value in caring (WHO, 2005). Ensuring health and human rights means the older patient should be treated according to their own situation and importance (Lindh et.al, 2007). They want to be involved and can participate in their treatment decisions, but the trend is a complex one (WHO, 2005). Why is it complex? It depends from what perspective the trend is seen. If the perspective is from nurses, it could be said that some people base their ethical decisions on principles of justice, equality, impartiality, and rights. Others base their decisions on a care perspective, where the need to establish caring relationships and reduce hurt takes priority over the consideration of justice and rights. The moral order is not to act unjustly towards others, and not to turn away from someone in need in caring encounters (Gilligan, 1982;
Respecting the patient’s autonomy may be at odds with the professional desire to do well or prevent harm (Mueller et al., 2004). An appropriate attitude and ethical sensitivity and thus the autonomy of older patients and their next of kin and their experience of beneficence develop through relationships between nurses, older patients and next of kin. This support assists the older patients and protects their autonomy and integrity (Beauchamp & Childress, 2001; Edwards, 2002). Beneficence is a duty to help others, and involves the obligation of fitting in with others. Non-maleficence means that the health care professional should not do the older patient any harm. The principles of justice state that all patients should be treated equally and respected in a fair way in caring encounters (SFS 1982:762; Beauchamp & Childress, 2001). In accordance with that, treatment is given after nurses communicate and participate and reach an agreement with the patient. In this process, the nurses feel satisfaction, and the patients will notice that satisfaction (Söderberg, 1999). Does this always happen? It ought to depend on whether nurses feel satisfaction or not. The above occurs in benign health processes, but the nurses could feel satisfaction even with mistreatment, which in turn would lead to the dissatisfaction of the older patient. However, the National Board of Health and Welfare (2007) state that the older patient’s need for integrity requires openness and respect for the patient’s beliefs and values. The behaviour and focus should be on the older patient’s and the next of kin’s whole situation; in other words a humanistic view should be taken.
Older persons and next of kin

The definition of an older person in most developed countries is accepted as a person of the age of 65 or older. There is no universal agreement on the age at which a person becomes older. The common use of calendar age to mark the beginning of old age assumes a similarity with biological age (WHO, 2009). As there is no accepted and acceptable definition, the age at which a person finishes employment has in many instances been used to define old age (Roebuck, 1979; Thane, 1989; WHO, 2009). The ageing process is a biological reality. It is also subject to the ways each society makes sense of old age. In the developed world, age in time plays a central role. The age of 60 or 65, approximately equal to retirement age in most developed countries, is said to be the beginning of old age (Ryu, 2009).

Older persons are a heterogeneous group of people and their need for care increases when they become older. How older patients are received by the health care professionals, such as nurses, in the health care system shows the ethical standards of the caring system (Flesner, 2004). Good ethical standards are revealed when older patients are seen as experts on their own health and life experiences, and their experiences form the basis for an assessment of caring encounters. Older people in need of care expect to be respected in the caring encounter and they want to be more involved in decisions about their own treatment (WHO, 2005). It is important to be involved, but a study by Werntoft et.al. (2007) states that being old means being in a low priority category, and that prioritization causes worry which could increase discomfort.
and uncertainty. The older patients and their next of kin are primarily seen as informants and recipients of information in caring encounters. The next of kin is a person who has a close relation to the older patients (National Board of Health and Welfare, 2009). In this thesis next of kin means a brother, sister, husband, wife, son or daughter of the older patient, i.e. a person in the close family environment.

The nurse’s ability to recognize the importance of the next of kin for successful patient care is quite well-known. However, insufficient attention is paid to the next of kin and their need for support (Åstedt-Kurki et.al, 2001). Next of kin and nurses may have different values and objectives for the older patient, and the next of kin may feel excluded from the decision-making process. The next of kin may become aware of signs of misery and if next of kin do not receive a clear diagnosis, this adds to their frustration as well. The experience of being involved and being taken seriously may possibly relieve the next of kin if they experience nurses to be supportive and respected (Li, 2005). The experiences of the next of kin and the older patient are dependent on the caring relationship with nurses. Patient satisfaction depends on several things i.e. caring, quality of care, communication and information from nurses, professional technical skills and competence, and organizational and environmental factors (Chawani, 2009). All these factors influence how the older patient experiences autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2001), but there also needs to be a will to act according to these factors.

Considering the older patient’s position, it is especially important to have laws and ethical codes that guide health care professionals such as nurses (WHO, 2008). There is also a need for health care professionals to be aware of these codes and laws and understand how to incorporate them into their caring actions.
CONCEPTUAL FRAMEWORK

Normative ethics

Questions may arise about what the laws and codes, i.e. normative ethics mention, and how normative ethics influence nurses in terms of empirical ethics. Normative ethics concern the way a person should or ought to act in different situations (Edwards, 2002). The words or expression used in normative ethics should be clearly defined in normative ethics because this form of ethics can be described as a set of moral values or principles that should guide every person in their actions and decision-making in daily life. Ethics become preserved in law, and this law in turn is applied in practice through codes of conduct and organizational policy, i.e. sets of rules that govern the person’s behaviour in relation to others in the workplace. Every profession needs specific rules, including the nursing profession in the health care system (Fortuna, 2005).

However, no code can provide complete rules for moral reasoning and actions for all situations (Beauchamp & Childress, 2001). Values refer to one’s evaluative judgments about what makes something good or what makes something desirable (Pense, 2000). Different laws and codes should have some meaning for the patient (Castledine, 1996), and should be understandable for nurses. There seems to be a limited and subjective understanding of ethics among nurses, as well as how to use codes in caring practice (Pattison & Wainwright, 2010). The normative guiding principles described in laws and
codes are both critical and normative. They should help in choosing the right action and in evaluating that action (Van der Scheer & Widdershoven, 2004). For the nursing profession the ethical codes concern normative ethics. Butts and Rich (2005) stated that the International Council of Nurses (ICN) illustrates the values of the nursing profession and serves as a guideline for ethical behaviour as well as the beliefs and values that should be accepted. The normative ethic (SFS 1982: 762; ICN, 2010) should have an effect on the empirical ethic, but this is not always the case. Nurses in a study by Tadd et.al. (2006) were unfamiliar with the content in the ICN code and believed that the code had little practical value. Ethical values and morals are important aspects that influence the quality of care and should affect empirical ethics. On the other hand, quality of care depends on the nurse’s behaviour, ethical values and actions (Schluter, 2008).

Examples of values in The Health and Medical Service Act (SFS 1982:762) are autonomy, integrity, dignity, and justice that are found in official texts or in other governing documents formulated, for example, by professional organizations. It is the nurse’s responsibility to uphold these values through caring performance, irrespective of the personal views nurses have. The values are legislative ways to guarantee a certain quality and security for those affected by society’s responsibility to give care. The patients have a legal right be treated in a way that allows them to maintain their integrity and dignity (Tschudin, 2003). However, it is not only important to focus on the patient’s dignity i.e. how one regards others; it is also important to focus on self-regard, i.e. nurses’ own self-respect and dignity (Gallagher, 2004).

However, Holland (2010) expressed doubt about the virtue ethics approach to nursing ethics, i.e. how professional ethics related to normative ethics. Thus it
is important to understand values and moral attitudes in nursing care (Nåden & Eriksson, 2004). However, there are problems in descriptions of caring ethics. Ethics are complex, and sometimes it is difficult to see them in empirical terms or to see the consequences of normative ethics (Edwards, 2009). Nurses have a responsibility to maintain their level of competence, plan and deliver quality care, delegate tasks safely, and evaluate the services provided, in terms of empirical ethics. Contrary to Doel (2010), nurses ought to use ethical standards of practice described in the nurses’ code in areas of practice and not just use the code as an insurance policy when something goes wrong.

**Empirical ethics**

Empirical ethics concern the study of how a person really acts in different caring situations (Edwards, 2002). The ethical values in caring are values based on professional ethics. The information in professional ethics describes the ideal of good caring; how it should be and how it should be supplied in accordance with normative ethics. But individual requirements for good care arise in the encounter with the patient. Nurses have their own personal responsibility but are also regulated to ensure they give the best care (Tschudin, 2003).

The focus on care has not taken into consideration understanding the true nature of the relationship between caring and the base of ethical knowledge that underpins nursing and that must support nursing for it to be a viable profession in practice (Tarlier, 2004). Responsive older patient -next of kin-
nurse relationships reflect both on personal moral knowledge and disciplinary ethical knowledge (Carmi & Wax, 2002). Thus, ethical conflicts arise as a result of poor patient/next of kin and professional communication; therefore there is a need for effective communication. Nevertheless, ethical questions occur (Mueller, 2004), and therefore it is important to evaluate empirical ethics in caring (Carmi & Wax, 2002).

The ideal view of a nurse is a supportive person. A nurse’s care ability depends on how cooperative the nurse is (Bishop & Scudder, 1985; Bishop & Scudder, 1996). This depends on the choice of care plan as well as the nurse’s attitude, values and self-respect (Gustafsson & Parfitt, 2002). The caring interaction must be permeated by a belief in the older patients and their capacity (Eriksson et al., 2003), and the nurses ought to support the patients in realizing their own ambitions for vitality (Nordenfelt, 2000).

The ethical practice of nurses is a complex process that combines both ethical reasoning and ethical behaviour. Personal ethics are concerned with how the individual reacts and performs in different settings and encounters, and this depends upon the person’s upbringing and the atmosphere at work, e.g. in a caring situation (Edwards, 2002; Goethals & Gastman, 2010). Therefore it is very important to develop the nurses’ codes, with the aim of strengthening the nursing profession (Verpeet et al., 2006). The existence of the codes is important and their applicability is usually appropriate, despite new challenges posed by modern health care (Numminen, 2009).

The previously mentioned principles of autonomy, beneficence, non-maleficence and justice are embodied in normative statements that guide how
things ought to be; what actions are, in theory, right or wrong (Beauchamp & Childress, 2001). These ethical principles are distinct but hard to observe as common values in caring actions, i.e. through the nurses’ morality, and the manner, character and behaviour they have. A nurse could perform as an eager, loving, sympathetic and supportive person, and the care ability depends on how helpful the nurse is; however it is not enough (Tarlier, 2004; Bishop & Scudder, 1985; Edwards, 2009). How nurses manage their time whilst on duty is a decision in resource allocation. Nurses should allocate time and skills in such a way that the older patients benefit (Edwards, 2003). In order to create a caring relationship in the encounter with the patient, nurses should give older patients the benefits of mutuality, equality, acceptance and acknowledgment (Bishop & Scudder, 1996).

Today, the tasks of nurses are varied, and range from health-promotion and preventive activities to nursing the sick and dying as well as contact and care for all patients and next of kin (Gunhardsson et.al.2008). This means there are challenges for nurses, and this could generate moral distress (Pauly, 2009; Ulrich et.al. 2010). Also the findings in a study by Jacobsen and Sørlie (2010) showed that care providers experience ethical challenges in their everyday work. Ethical challenges faced by nurses could include providing autonomy and dignity for older patients.

Often the knowledge about the older patient in caring encounters is subjective, intuitive empathy with the other person’s living situation. Caring knowledge is of a subjective nature (Tschudin, 2003), but there are also some aspects of caring knowledge related to theory building. Skår (2009) found in a study that nurses’ descriptions of their experiences of autonomy in work situations
contained different themes: the nurses ought to have a holistic view and know the patient i.e. understand the physical, emotional/mental and spiritual aspects of the individual older patient. It is also important to have confidence in one’s own knowledge i.e. the nurses are secure and they act positively. To be knowledgeable and confident was found to be the main meaning of autonomy in nursing practice. The findings of Skår (2009) were that a nurse’s openness and sensitivity are fundamental to caring, and this attitude can affect older patients so that they open up and share difficulties with them (Eriksson & Nåden, 2002).

The nurse as well as the patient needs security in a caring relationship. This security provides a foundation for preserving the dignity for both parties. This knowledge and understanding could be used in caring encounters to guide professionals to a careful and reciprocal approach (Eriksson, 2002). Berg (2006) states; this (knowledge and understanding) will reduce the patient’s sense of vulnerability and lead to the patient becoming more confident in the interaction.

**Interactions**

Interaction is about actions or influences of people, groups or things on one another. In a caring encounter there is an interaction between nurses, older patients and the next of kin. If the individuals recognize a situation as real, the consequences are real as well. The professionals, such as nurses, patients and next of kin not only recognize the reality in the caring encounter; it also guides their behaviour (Milton, 2007). The individuals are “here and now”; they define the present situation and interact with current symbols (Blumer, 1962;
Blumer, 1969; Blumer, 1986; Orlando, 1961; Orlando, 1972). Current symbols in the interaction occur via symbols in the form of sound, vision and actions. By using symbols humans create, and recreate the situation in which they are active. Symbolic interactions involve people creating meaning and developing their reality (Blumer, 1986). Every person is socialized by symbols, and culture is symbolic. All people learn the behaviour of their society through symbols, and all people are units of society. Values, ideas, rules and aims are symbols, and they make it possible for people to interact (Blumer, 1962).

The theory of Orlando describes a perception of the nurse’s special function and response in the care situation. This theory is a holistic one that views every human being as unique, and the patient is active and responsive in the caring encounter. The theory deals with the way the nurse understands the patient’s situation. Nurses and the older patient should make a decision about the patient’s care needs together. The patient’s needs are connected with the patient’s vulnerability in different caring encounters. The goal of this situation/interaction is designed for the patient’s benefit (Orlando, 1961; Orlando, 1972). The patient will be confirmed and respected if the interaction between verbal and non-verbal communication functions. The nurse creates a trusting atmosphere and good contact with the older patient by listening actively and showing empathy (Panjkihar, 2009). Interaction is a feedback process between the older patient and the nurse. The older patient is in need of confirmation; a positive response (Hummelvoll, 2000). In an ethical context, the caring conversation is one in which nurses make room for suffering persons to regain their self-esteem through the culture of caring, and this makes a good life possible (Nåden & Sæteren, 2006).
Symbolic interactions (gestures, attitudes etc.) help researchers to identify the community of values and ethical values that guide the activities of professionals such as nurses in the caring encounter. The older patients, next of kin, and nurses as well as researchers, interpret and evaluate the encounter. It is important to describe, identify and interrelate these values as various reports have said that the care of older patients in the health-care system, as well as in society, does not always fulfil the intention of valuing older persons (WHO, 2005; SOU 2008:51).
AIMS

The general aim of this thesis is to identify and describe the ethical values that are apparent in the caring encounter, and the influence of these values on the people involved (empirical ethics). The aim is also to synthesize concepts from the empirical studies identified and clarify their meaning and applicability by analyzing them with normative ethics.

The specific aims are:

Study I To identify and describe the ethical values that are experienced by the older person in daily interaction with nurses in a ward for older people during caring encounters.

Study II To identify and describe the governing ethical values that next of kin experience in interaction with nurses who care for elderly patients at a geriatric clinic.

Study III To identify nurses’ ethical values that become apparent through their behaviour in their interaction with older patients in caring encounters at a geriatric clinic

Study IV To synthesize concepts from empirical studies (I-III) and analyze, compare and interrelate them with normative ethics.
METHODS

Grounded Theory

In order to understand and describe the experience of the older patients, next of kin and nurses in caring encounters, a qualitative approach was used (Berg, 1995; Glaser & Strauss, 1967). A qualitative approach is suitable when there is a wish to understand human behaviour. Symbolic interactions are an ensemble between people and the social aspects of real life (Glaser & Strauss, 1967). Thus, Grounded Theory (GT) methodology was used, which is an approach based on Symbolic Interactionism. GT consists of the discovery and development of theories, and it starts with obtaining and analyzing data in a constant, systematic and comparative way (Glaser, 1992). The purpose of such a method is to achieve a deeper understanding of concerns, actions and behaviours of groups of individuals through the older patients’, next of kin’s and nurses’ own words and actions. It is an inductive general method in which theory is generated (Glaser & Strauss, 1967; Glaser, 1978).

The Grounded Theory method is a highly systematic research approach for the collection and analysis of qualitative data. Data are systematically gathered and analyzed, and there is a continuous interplay between analysis and data collection. Data collection is continued until so-called “theoretical saturation” is achieved, i.e. nothing new that changes the categories is found in the data (Glaser & Strauss, 1967). The goal of grounded theory is to achieve the third level of the concept i.e. the core category. The first level is collecting the empirical data, the second is generating categories, and thirdly comes
Discovering the core category, which organizes the categories that correspond to the participant’s experiences and actions (Glaser, 2002).

Qualitative content analysis

A qualitative content analysis (QCA) (Mayring, 2000) was conducted of the ethical values in normative ethics outlined in the Code for Ethics for Nurses (ICN, 2010) and the Health and Medical Service act (SFS, 1982:763). In ICN the concept is a code: a set of rules and conventions. In the Health and Medical Service act (SFS 1982: 763) the concept is a framework: a basic structure. The qualitative content analysis is performed to find the components of the respective concepts; code and framework.

The aim of qualitative content analysis is to reduce the data to its smallest parts, textual units. The rules of analysis are that the data must be analyzed bit by bit and should be organised into content analytical units. The research question decides the aspects of the text interpretation. The specific method, structuring content analysis, used in this thesis analyses the answer to a previously stated research question and the purpose is that the exact formulation of definitions will structure the duty very precisely (Mayring, 2000).

Simultaneous concept analysis

The approach of simultaneous concept analysis (SCA) uses consensus group discussions and develops matrices with interrelated concepts simultaneously. Simultaneous concept analysis is an addition to the process of explaining. The individual concepts are analyzed and followed by a critical assessment of interrelated antecedents defining characteristics and outcomes, and giving
insight into existing relationships. The interrelations between the concepts are as important as the concepts themselves (Haase et al. 2000).

A simultaneous concept analysis (Haase et al., 2000, Mårtensson et al., 2009) was chosen because it could answer the research questions and develop a process model, presenting the interrelated empirical and normative ethics. In SCA, individual concepts are analyzed and accompanied by a critical examination of interrelated antecedents, defining characteristics and outcomes, and this gives insights into existing relationships between the concepts. The method in study (IV) involves nine steps, which are described below. The steps are intertwined with one another. The simultaneous concept analysis strategy makes clear that concepts in care are complex and interrelated. Because these interrelationships exist, these concepts cannot be analyzed in isolation.

**Describing the setting**

The data were collected in a geriatric clinic at a county hospital in a medium-sized city in Sweden. Patients in a geriatric clinic have various care needs. Geriatrics is a branch of medicine devoted to prevention, diagnosis, and treatment of disorders affecting old people (Geriatric Medicine in Sweden, 2009). Professional competence in a geriatric clinic generally involves having profound knowledge about older patients’ ill-health and diseases. In the investigated clinic the competence was mainly concentrated on medical investigations, medical treatments and rehabilitation of patients with stroke, dementia, osteoporoses and fractures. Older patients should receive care and rehabilitation suitable for their needs and they should also have an individual caring plan. Health-care professionals in geriatric clinics have a holistic view
The studies included in this thesis were performed at inpatient wards. The geriatric clinic consisted of three wards and a reception. The data were collected in a stroke and rehabilitation ward with 22 beds. There were six single rooms, two double rooms, and three rooms each having four beds. The working organization at this ward consisted of a team of physicians, registered nurses, enrolled nurses, physiotherapists and occupational therapists. The nursing team consisted of either one enrolled nurse and two registered nurses, or two enrolled nurses and one registered nurse. The nursing teams were responsible for caring for the older patients; there were approximately six patients in every nursing team. Health-care professionals such as nurses and physicians worked irregular hours. The physiotherapists and occupational therapists worked regular hours. There were also consultant physicians on the ward specialising in areas such as orthopaedics, rheumatology, infection and so on. The average care time for the older patients was approximately 18 days, and following discharge they returned home or went to another care facility.

**Describing the participants in studies I-III**

The participants in study (I) were selected on the basis of being older patients aged 65 or older. All patients who understood and spoke Swedish were asked about participation. Twenty-two out of 24 patients accepted. Before their hospital stay at the inpatient ward, they lived in different home settings, such as their own apartment or house or in a nursing home. They lived alone or
with a next of kin. The older patients differed regarding caring needs (see table 1).

The participants in study (II) were selected on the basis of being a next of kin to inpatient geriatric patients. Fourteen next of kin (husbands, wives, sons, daughters, brothers or sisters) agreed to participate. They lived at varying distances from the older patients. They had different occupations (see table 1).

The participants in study (III) were staff nurses at the geriatric clinic. A total of 20 nurses participated in the study. The nurses had different backgrounds; some had engaged in other occupations before working as nurses, see table 1.

**Table 1. Describing the participants in study I-III**

<table>
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<tr>
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<th>Study II</th>
<th>Study III</th>
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<td>2</td>
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<td>Nurses</td>
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<td>12</td>
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<td>Enrolled nurses</td>
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<td>8</td>
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<td>Experience range</td>
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<td>1-40</td>
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Several types of data were collected and analysed

**Study I**
- Grounded Theory
- 57 observations and 48 follow-up interviews
- 110 hours work divided in four hours shifts
- Constant Comparative Analysis

**Study II**
- Grounded Theory
- 14 qualitative interviews
- Constant Comparative Analysis

**Study III**
- Grounded Theory
- 65 observations and 65 follow-up interviews
- 85 hours work divided in four hours shifts
- Constant Comparative Analysis

**Study IV**
- Qualitative content analysis of (ICN, 2002) and (SFS, 1982:763)
- Simultaneous concept analysis of components in study I, II and III and (ICN, 2002), (SFS, 1982:763)

Figure 1. Study design.
Observation and follow-up interviews studies I, III

A “gate-keeper” i.e. a nurse at the ward, was the communication link between the researcher and potential participants for study (I). The nurse identified patients according to the inclusion criteria; able to understand and speak Swedish and being aged 65 or older. The researcher (L-LJ) contacted the patients for permission to observe the caring encounter (Hudson et al., 2005). All observations were carried out as non-participant observations (Patton, 2002). The researcher listened to, watched and had conversations with the participants in the study. The researcher was a non-participant in that she was dressed as a healthcare professional but did not work as one, although at times the health-care professionals needed some assistance (Morse & Field, 1996).

The data collection in study (I) took place between October 2004 and January 2005. The researcher followed the nurses on the ward for approximately 1.5 months to gain knowledge about the local care culture, and to observe different situations and interactions (Berg, 1995). The remaining time, approximately 2.5 months, was used for data collection. Data was gathered by observing different caring encounters and the follow-up interviews with the older patients directly afterwards when the patients could talk about their experiences during the encounter (see figure 1). Observations included work divided into various four-hour shifts such as morning, forenoon, noon, afternoon, evening and night shifts. The researcher followed the nurses on the ward for approximately 1.5 months in order to gain knowledge of the local care culture, observing different situations and interactions (Berg, 1995). The remaining time, approximately 2.5 months, was used for data collection. Data was gathered by observing different caring encounters and the follow-up interviews with the older patients directly afterwards, when the patients could talk about their experiences during the encounter (see figure 1). In the follow-
up interviews the older patients were asked “Can you describe how you experienced this caring encounter?” It was important to create an open relationship between the older patients and the researcher, who was a non-participant observer (i.e. present on the ward but not taking part in the care), in order to obtain as complete a picture as possible of the older person’s situation. The follow-up interviews were conducted in private and away from the nurses involved in the encounter. These follow-up interviews were audio-recorded and transcribed verbatim. Transfers, events, information, social intercourse etc. i.e. observations, were recorded immediately after every observation on a pocket tape recorder as well as in a note-book as field notes. The information was recorded verbatim and as scrupulously as possible. These data were also transcribed verbatim and scrupulously into text (Patton, 2002).

Empirical data collection in study (III) took place between February 2008 and May 2008. The researcher was non-participant, i.e. was dressed as a health care professional but did not work as one, although at times the researcher assisted the health care professionals. The researcher listened, watched and had conversations with the participants in the study (Morse and Field, 1996). The researcher accompanied the nurses on the ward, and different caring encounters were observed (see figure 1). A follow-up interview was conducted directly after the observations (Berg, 1995). In the follow-up interviews the nurses were asked, “Can you tell me what happened in this caring encounter?” The follow-up interviews were conducted in private and away from the other person involved in the encounter. All data from the observation as well as the follow-up interviews were handled in exactly the same way as the data in study (I).
Interviews Study II

In study (II), data was collected from November 2006 to September 2007. One nurse at the geriatric clinic gave nineteen older patients and their next of kin verbal and written information about the study and told them that participation was voluntary. The next of kin were asked about participation in an interview by the nurse. Five next of kin refrained from participating. The next of kin chose the place and time for their interviews. Three next of kin were interviewed at the hospital and 11 in their own homes. An interview guide was used which gave the interviewer freedom to have a conversation with the interviewee on a specific topic (Patton, 2002). The interviewer was free to explore and ask questions that would explain the aim of the study (Berg, 1995). Examples of questions are: What are your experiences of the caring encounter? How do the nurses take care of you as next of kin? Are you, as next of kin, involved/participating in the care given? The informants expressed, in their own words, their experiences and contributed their perspectives regarding the caring encounter. The interviews lasted between 30 and 90 minutes, and were tape-recorded and transcribed verbatim. All interviews were conducted by the same interviewer (L-L J), who also made the verbal transcripts. After 13 interviews, saturation was reached. One more interview was performed for the purpose of confirmation, in order to secure saturation (Glaser & Strauss, 1967).
Ethical considerations

When starting a research project it is important to reflect on its different aspects. What different ethical issues are we going to meet, how should we handle technical recording, confidentiality and informed consent in observations follow-up interviews and interviews? How should documentation be handled? As a researcher one must always think and act in ways that respect the dignity, rights and views of others. One must also understand the change of role from nurse to researcher (IES, 2004; SSH REB, 2005).

There are some central ethical principles in health care and also in research ethics. The ethical issues are autonomy, beneficence, non-maleficence and the principles of justice (Beauchamp & Childress, 2001, Hermeren, 1999). Autonomy in this research study was demonstrated by the fact that the informants always had the right to refuse participation in the study and they could withdraw at any time if they wished. The observation focused on human behaviour. Therefore the researcher could not give exact information about the research aim but tried to be as clear as possible (Berg, 1995).

In these studies two older patients and five next of kin refused to participate. None of the nurses declined. Verbal and written information was given to the older patients, next of kin and nurses. If any questions arose, the researcher answered them. Informed consent was obtained. Beneficence in this study should be taken to mean increased knowledge about experience from different perspectives about ethical values and how these values are demonstrated. This research is about the close encounter between the older patient, next of kin and nurses. Knowledge could increase the quality of caring. This research highlighted the older persons’, next of kin’s and also nurses’ experiences in order to increase security in the caring encounter (SFS, 2010:659).
Non-maleficence in this research was demonstrated in that all data were treated with confidentiality. There was no dependent relationship between the researcher and the patients, the next of kin or nurses. No individual answers could be identified as data were abstracted (Morse & Field, 1996; IES, 2004). The older person, next of kin or nurses might have felt pressure from the researcher to participate in the study (Berg, 1995). It is important that the behaviour of researchers is sensitive in all qualitative research (Morse & Field, 1996). Observation, follow-up interviews and interviews could imply ethical problems. If the older patients seemed embarrassed or self-conscious about the researcher’s presence, the researcher went away and did not observe the situation. It was important that the researcher considered the well-being of the older patients and next of kin. Observations and interviews should not harm or cause any worry for the older patients or their next of kin. In follow-up interviews and interviews, the older person, next of kin and nurses answered the follow-up questions of the researcher in their own words. It is important to be sensitive to reactions of older patients, next of kin or nurses (Ford & Reuter, 1990; Gustafsson et al., 2004). Justice in this study was demonstrated in that all participants were given the same opportunity to take part in the study. These studies were approved by the Committee on Research Ethics in Linköping, “Record no” 170-06. Approval for studies (I, II) and (III) was also given by the manager of the clinic, the director of the department, the personnel department, and the union organisations involved. While conducting the study, consideration was given to The Declaration of Helsinki (World Medical Association Declaration of Helsinki 2004) and other ethical aspects of the ethics of research act (SFS, 2003:460).
Data analysis

Constant Comparative analysis

All the data from the recorded observations and transcribed follow-up interviews in studies (I) and (III) and the transcribed interviews in study (II) were analysed by Constant Comparative Analysis (Glaser & Strauss, 1967; Glaser, 1992). Grounded Theory- and Constant Comparative Analysis is an inductive and iterative process of generating, examining and constant comparing of concepts and categories. The process moves back and forward through varying stages of complexity and interrelationships, leading to new discoveries about the experiences under study (Berg, 1995), figure 2.

![Diagram of Analytic process of Grounded Theory- Approach towards data on ethical values in caring encounters.]

Every word and sentence was analyzed. This first stage includes in vivo or substantive codes that describe experiences or behaviour in the exact wording
in raw data. The analysis began by openly encoding the first observation/follow-up interview or interview. The second observation/follow-up interview or interview was compared with the first one. The process continued in the same way for the following observations/follow-up interviews or interview.

The second stage was to capture the substance in the data, and then to break it down into identifiable concepts and substantive codes that illustrated the experiences/behaviour. The different codes and the different interviews were compared to each other to strengthen their identification. The codes were labelled with origin words from data (Berg, 1995; Glaser, 1992). Thereafter, the analysis continued with the aim of reaching a higher level of abstraction of the material, thereby allowing identification of categories. The codes were analysed and similar meanings in the codes were identified and clustered together into categories. The categories were labelled with more abstract concepts. These categories were also compared with the codes, and the categories (Glaser & Strauss, 1967; Glaser, 1992). A category is more abstract than a code and the name of such a category should be more informed, general and sophisticated than the codes it stands for (Glaser, 1992). The gathering of data and analysis continued until a "saturation point" was reached; nothing new emerged in the analysis that enabled identification or creation of new codes or categories. In these studies, saturation was reached after 52 observations and follow-up interviews (study I), 13 interviews (study II) and 60 observations and follow-up interviews (study III).

The third stage involved developing theoretical constructs - core categories - from a combination of theoretical and empirical knowledge, and contributing theoretical meaning and scope to the theory (Glaser, 1992). This final stage
involved identifying a theoretical construction - a core category- that answered possible questions and explained the experience and the ethical values that were under study (Berg, 1995; Glaser, 1992). Categories were related to each other and scrutinized to verify their relevance. A core category is the major category that is found in all data (Glaser & Strauss, 1967; Glaser, 1992), and was developed by identifying the relations between the different categories, i.e. linking them together. This construct adds theoretical meaning and scope to the substantive theory and could be implicitly found in all data (Glaser, 1992).

Qualitative content analysis

Qualitative content analysis was used to answer the research question, “what is the content of ethical value” in the ICN code (ICN, 2010) and the Health and Medical Service act (SFS, 1982:763). The documents were read through thoroughly and key examples were extracted and used to formulate exact definitions (Mayring, 2000). The findings were intended to be used in the simultaneous concept analysis (Haase et.al. 2000). The findings were two concepts, “Ethical codes” and “HSL framework law” table 2.

The ethical codes of the ICN (ICN, 2010) set out rules governing nurses’ responsibility for human rights and ensuring respect for everyone’s dignity and values. It is a fair division when resources are divided in accordance with need. Nurses have an obligation to do well, to benefit the patient. The nurses should respect patients, the next of kin and colleagues in different situations. The patient should be treated as well as his/her condition, and ethical consideration should include ensuring that the patient receives sufficient
information. The nurse holds personal information in confidence and uses judgment in sharing this information. The nurse carries personal responsibility and accountability for nursing practice and for maintaining competence by continual learning. Judgment is used regarding individual competence when accepting and delegating responsibility. A nurse at all times maintains standards of personal conduct and ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people. Nurses act to protect individual human beings (ICN, 2010) (see table 2).

Health and Medical services, shown in table 2 should benefit and work for the prevention of all ill health. Health and medical services are aimed at assuring the entire population of good health and care on equal terms. Care should be provided with respect for the equal dignity of all human beings. Safety means providing care of good quality and catering for the patient’s need for security in care and treatment. The health care professional is responsible for the patient and should be willingly available to patients with needs. Participation means that care and treatment should, as far as possible, be designed and conducted in consultation with the patient and their next of kin. Care and treatment should be based on respect for the self-determination and privacy of the patient.
Simultaneous concept analysis

A simultaneous concept analysis (Haase et.al. 2000) was chosen because it could answer the research questions and could be used to develop a process model, presenting the interrelated empirical and normative ethics. The uniqueness of simultaneous concept analysis stems from each concept being developed simultaneously with all other concepts being taken into consideration, and this method explains the individual concepts and the relations between the concepts. Simultaneous concept analysis follows a nine-step model, and each step is described below:

Next, a simultaneous concept analysis (SCA) (Haase et.al., 2000; Mårtenson et.al., 2009) was conducted with the aim of answering the research questions and developing a process model. Individual concepts were analyzed, and this analysis was accompanied by a critical examination of interrelated antecedents, defining characteristics and outcomes.

**Step 1:** Development of the consensus group: Each individual brings a certain expertise to the group. The consensus group consisted of four researchers, namely the authors, who were skilled in nursing care, geriatric care, qualitative research methods and ethical issues.

**Step 2:** Selection of concepts to be analyzed: A total of five concepts were selected: three core categories from the earlier studies, and two from the analysis of normative ethics in the outline of the ICN (ICN, 2010) and the Health and Medical Service act (SFS, 1982:763). These five concepts were: approaching, being amenable, corroborating, codes, and framework.

**Step 3.** Refinement of the concept clarification approach: The approach involved using the constant comparative analysis method (Glaser, 1978) and the QCA (Haase et.al., 2000; Mårtenson et.al., 2009). Five concepts, along with their identified components, were used in the analysis (see table 2).
Step 4
Clarification of individual concepts: Each researcher in the consensus group made a critical and independent examination of the five concepts. In study (I), the older persons’ experiences of ethical values in the daily interaction with nurses in caring encounters were identified. In study (II), the next of kin’s experiences of the interaction with nurses who care for older patients was identified. Lastly, in study (III), the nurses’ ethical values, which become apparent through their behaviour in the interaction with the older patient in caring encounters, were identified. These three empirical studies established the importance of three concepts: approaching, being amenable and corroborating. The findings from this qualitative content analysis of ethical values in the normative ethics of the ICN code (ICN, 2010) and Health and Medical Service act (SFS, 1982:763) are shown in table 2. These five concepts were discussed in the consensus group, where each person argued based on their own knowledge and experiences about the concepts and components. The discussions lasted until the consensus group was in agreement about the antecedents, the critical attributes and the outcomes of all the concepts.
Step 5: Development of validity matrices: This specific validity matrix consisted of the five concepts from step 2, and of the 25 components from step 3. The validity matrix consisted in total of 125 concepts and components. All individual concepts and components were compared and contrasted with all other concepts and components. This helped to refine definitions and clarify antecedents, critical attributes and outcomes. The unique aspect of SCA (Haase et.al., 2000; Martinson et.al., 2009) is that each concept is developed simultaneously and all other concepts and components are taken into consideration.

Step 6: Revision of individual concept clarification: The consensus group re-examined all the concepts, and necessary revisions were made.

Step 7: Re-examination of validity matrices: Here the consensus group took semantics into consideration. The consensus group employed dictionaries to verify the terms. Only the terminology that really needed to be changed was changed.

Step 8: Development of a process model: The process model is an overview of the components and processes of the concepts. It should be seen as an analytic tool.

Step 9: Submission of the SCA results to peers for critique: This was the final step in the SCA process. When presenting the results informally to colleagues in a seminar the concepts were reworked again. This step was important, as was the possibility for the SCA and the process model to become complete. The process model was modified to some extent after discussion with colleagues in the seminar.
Validity and trustworthiness

Using a qualitative method is relevant to the population and study design in these studies. When generating a theory there is also an intrinsic factor of verifying interpretations (Jeanne, 1996).

The findings of GT do not take the form of a reporting of facts but are a set of probability statements about the relationship between concepts, or an integrated set of conceptual hypotheses developed from empirical data (Glaser, 1994). Validity in GT should be judged by fit, relevance, workability, and modifiability. The theory is an integrated set of hypotheses, not of individuals (Glaser & Strauss, 1967; Glaser, 1978; Glaser, 1992). It is about induction, and expresses what is happening in the empirical situation, such as how the participants act and express experience in these observations/interviews (Glaser, 1978).

A GT has codes that fit the data and reality from which it is derived. Fit has to do with how closely concepts fit the incidents they are representing, and this is related to how thoroughly the constant comparison of incidents to concepts was done. A theory should work and should be able to explain the major processes of behaviour of the subject area. The theory has workability when it explains how the problem is being solved. The theory must be relevant to the core category and its ability to explain what is going on in a caring encounter. If the participants, the older patients, next of kin and nurses recognize the construct, there will be relevance (Glaser & Strauss, 1967; Glaser, 1992; Berg, 1995). Relevance has been tested and acknowledged.
A modifiable theory can be altered when new relevant data is compared to existing data, which is to say that the theory has modifiability. Data from observations and follow-up interviews (studies I, III) and interviews (study II) were compared with each other at all times (Glaser, 1992). Tests on whether a theory is modifiable can be carried out when new and further studies were performed on daily caring encounters, presenting similar or different findings, as in the simultaneous concept analysis. Trustworthiness is guaranteed as the data is systematically collected (Glaser, 1978). In order to convey credibility, the researcher can present quotes directly from interviews (Glaser & Strauss, 1967). Even if the samples are small, they can be generalized to other similar caring areas (Glaser & Strauss, 1967). The criteria fit, work, relevance and modifiability are argued to support the fitness of a theory, and support a broader evaluation of the quality of grounded theories (Glaser, 1998; Lomborg & Kirkevold, 2003).

Several methods were used, such as observations, follow-up interviews and interviews. There were two researchers who discussed and analyzed data, and finally literature was used as data. This could be seen as a triangulation that is built into the method of grounded theory. Triangulation of data is important to improve the probability that the findings will be found credible (Lincoln & Guba, 1985). Trustworthiness can be strengthened by using several data sources, such as filed notes, observations, follow-up interviews and interviews.

Lincoln and Guba (1985) used trustworthiness instead of validity in qualitative research and to formulate credibility, transferability, conformability and dependability. In qualitative content analysis of ethical values the normative ethics of the ICN code (ICN, 2010) and the Health and Medical Service act.
credibility is about the concepts being strictly described and relating to each other without overlapping. Transferability means that the result can be applied in other contexts, and in this thesis it is examined in the simultaneous concept analysis where the findings from the qualitative content analysis and the categories from studies (I, II) and (III) were used. Dependability is about the close relationship and conformability means that the reader can understand that the components are extracted from data, i.e. ICN code (ICN, 2010) and Health and Medical Service act (SFS, 1982:763).

In the simultaneous concept analysis (Haase et.al. 2000), there is a process of constant validation of the concepts during the analysis. Validity is methodically built into the method and it is confirmed through the use of a validity matrix, and discussions in the consensus group and in the seminar with colleagues. Transferability means that the advanced outcome of interconnectedness, interdependence, corroboratedness, completeness and good care may be applicable in other caring encounters in which the patient, next of kin and nurses interact.
FINDINGS

The descriptions of the ethical values that are apparent in the caring encounter were that nurse’s ethical values are indicated by how the older patient is approached, by being amenable to the next of kin, and by corroborating. Normative and empirical ethics are interrelated and could be applicable in caring practice.

Summary of articles I, II, III and IV

The importance of “Approaching” the older patient (I)

“Approaching” indicates the ethical values that guide nurses in their caring encounters with older patients (see figure 3). Approaching was visualized in interaction or participation by verbal and non-verbal communication. This sort of communication brings nurses closer, emotionally, to the other person, and this could lead to a more intimate, trusting relationship. Such a relationship needs to “be earned” by the approaching nurse and often starts with the way the nurse addresses the older person. If the object of addressing older patients is to pass on information and if this information is given in a polite manner, backed up by appropriate body language, then there will be an interaction. Approaching includes physical, psychological and social aspects, and it is important that these aspects are presented with respect, while taking the integrity of the older patient into consideration. The older patient will be confident and satisfied with the caring encounter if the desired components in the nurse’s approach are exhibited. The older patient reacts in one of three ways: positively, negatively or passively. These types of reactions also
describe the way older patients show their self-determination. The interaction
during the approach influences older patients’ experiences and reactions to
being addressed, receiving respect, desiring to participate, increasing self-
determination and gaining self-confidence. Thus approaching is about
maintaining the older patient’s autonomy and benefits, and ensuring non-
maleficence towards the older patient.

Being amenable, next of kin’s perspective (II)
Receiving and showing respect, facilitating participation and discovering
professionalism, formed the basis of the core category “Being amenable” (see
figure 3). Being amenable means that the nurses are guided by ethical values;
inviting the older patients as well as their next of kin into the caring encounter.
Being amenable influences the older patient and next of kin, as there is an
interaction between the older patient/next of kin, and the nurses.
Being amenable is about the nurse being there for the older patient and the
patient’s next of kin. The nurses meet the older patient/next of kin through
receiving them warmly; they encourage invite the next of kin through their
attitude and the way they approach them. This provides the basis for respect
between the people in the caring encounter. Being valued and acknowledged
opens up the possibility of participating and taking an active part in the caring
encounter. The nurses had authority in the caring encounter and could show
their professionalism, i.e. they were competent and guided by the ethical
principle that all people have equal value. The nurses focused on the older
patient’s well-being as a final criterion of good ethical care. This influenced the
next of kin, and their experiences of this fundamental condition for high
quality care seemed to be fulfilling. Thus being amenable demonstrates the
ethical principles of autonomy, beneficence and non-maleficence towards the older patient and next of kin.

**Corroborating indicates nurse’s ethical values (III)**

Corroboration places a responsibility on the nurse to promote another person’s well-being (beneficence) and health through support and through giving strength (see figure 3). The actions in caring encounters are both verbal and physical. Corroborating means being sensitive to another person’s gestures, listening to the person, and trying to understand his/her thoughts. It also means giving priority to the person’s needs in the situation, which is a form of benefit. Corroborating means to act in such a way that time is given to the older person, aiming to maintain the person’s self-control, strength and give autonomy. This is done to benefit the person. This means paying attention to the other person’s condition and encouraging them in order to motivate them. Encouragement is central to corroborating. Corroborating includes the categories of showing consideration, connecting and caring for. To be considerate is to be present in the caring situation, show respect, and involve another person in a trusting relationship. In connecting there is communication between two individuals to create participation. The connecting function is related to someone else and it deals with information, instructions, guidance or small talk. Caring for, means to carry out a task in a caring encounter using competence and knowledge regarding the issue to be solved, and also to make the task safe and secure for the person who is being cared for, i.e. following the principle of non-maleficence. The patients were received and cared for in an equivalent manner in accordance with the principal of justice.
Five-concept process model advancing to five outcomes; comprising empirical and normative ethics (IV)

According to these findings, empirical ethics and normative ethics are intertwined. The outcome interconnectedness, interdependence, corroboratedness, completeness and good care are all related to the nurse’s interaction with the older patient and next of kin, and the findings i.e. those found in the ICN code and The Health and Medical Service act (figure 4. The ICN code and the Health and Medical Service act) influence the nurse’s practical performance. Interconnectedness concerns the way people approach...
and connect with one another in the caring encounter. In interconnectedness, connecting is central to the interaction in caring encounters as the associated actions open up the caring relationship. The outcome of interdependence influences our mutuality in relations, how we need to rely on one another and how our attitude towards each other influences the other person.

In corroboratedness, a nurse has the responsibility of promoting a relationship; confirming the other person and making that person feel more certain. This relationship is based on support and giving strength, i.e. nurses have an obligation to do their best according to the patient’s own values and needs. Consideration and thoughtfulness should be shown towards the other person. Completeness is about preserving the totality of the person; it is about caring for and caring about the entire person in a caring encounter. The older person should experience being treated with professionalism and responsibility. Responsibility involves different aspects of the duty as a nurse. Good care means safe care provided with respect and a focus on the patient. It should be accessible, equal and professional. The nurse has a responsibility in caring for and caring about the other person in a caring encounter. Good care is performed with respect and consideration for individuals’ specific needs, conditions, expectations and values. Good care includes competency.
Findings of a generic nature

Being professional in caring encounter

Professional performance i.e. the nurse having competency, is a complementary finding in studies (I, II) and (III) and is judged from different perspectives in the caring encounter: the older patients’ perspective as “approaching” (I), “being amenable” from next of kin’s perspective (II) and “corroborating” from nurses’ perspective (III). These three studies are related to each other and they have a similar foundation. Studies (I, II) and (III) all have showing respect, invitation to participate, allowing self-determination and providing safe and secure care as criteria of good ethical care. These
ethical values are apparent in the interaction between the different persons in the caring encounter. In this interaction, nurses have responsibility. This involves competence, being professional. Competence is the ability and will to perform a task by applying knowledge and skills. Ability includes experiences, understanding and judgement to transform knowledge and skills. Will means an attitude, a commitment, courage and responsibility. Nurses have a responsibility to ensure an appropriate attitude, i.e. they have a responsibility to practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual. This also involves respect for patient autonomy. Knowledge means that the nurse knows; that she has necessary facts and methods at her disposal. A skill means that the nurse should be able to perform the task in practice. What and how nurses ought to perform in caring, i.e. the competence nurses have, is apparent in empirical ethics. It is also a motivation to ensure the well-being of the older patient. In studies (I, II) and (III) the normative ethics are noticeable in nurses’ practical performance. Findings in empirical ethics are interrelated with normative ethics in study (IV). The ethical values in empirical and normative ethics have a similar foundation. Thus normative ethics ought to provide support for nurses as professionals and influence the nurses’ practical performance. These studies make clear that normative ethics are closely related to caring practice (see figure 4). The goal in caring practice is promoting good, confident and secure care. This means all patients have equal value, care is provided with respect, and good quality is guaranteed in the caring encounter. Nurses perform caring according to the ethical principles of autonomy, beneficence, non-maleficence and justice. All these aspects demand competency; being a professional in the caring encounter.
Discussion of methods

In this thesis, four ethical principles of Beauchamp and Childress (2001), i.e. the principles of autonomy, beneficence, non-maleficence and justice are described. These principles can be interpreted in several ways and can be given different emphasis (Hermeren, 1999), as shown in this thesis. The principles are also useful both in research discussions and in interpretation of caring practice. This discussion of methods is about using a qualitative empirical approach (GT) in studies (I, II) and (III), and using qualitative content analysis and simultaneous concept analysis in study (IV).

The focus of the study was on behaviour, interaction and experiences, and therefore a qualitative empirical approach (GT) was appropriate. In studies (I) and (III), data were collected through observations and follow-up interviews. In study (II) data were collected through interviews. These seemed to be suitable methods, as the focus was on gestures, attitudes and the act of controlling attitudes in interaction between people. The approach also enhanced an understanding; the older patients, next of kin, nurses and the researcher could interpret and evaluate the encounter, i.e. establish the degree of beneficence' (Morse and Field, 1996; Jeanne, 1996).

Other methods could be discussed, i.e. questionnaires. These are connected with a larger sample, but the issues in these studies were interaction and experiences in the close meeting in caring encounters. It might be difficult to
use a quantitative approach to investigate the aims of these studies; the focus was on social structures/behaviour, close to the data perspective. The perspective of quantitative methods is remote from this perspective.

Answering a questionnaire demands great compliance from the researcher and the respondent regarding the meaning of the questions (Morse and Field, 1996).

In studies (I) and (II) a “Gate-keeper” identified possible participants. “The Gate-keeper’s” role was to facilitate access for the researcher. However, Hudson (2005) has found that the gate-keeper can obstruct data collection. In these studies, the gate-keeper provided invaluable help for the researcher, not interfering with or obstructing the research process.

During the observations the researcher’s presence in the caring encounter only had a small influence on the nurses’ and patients’ behaviour. The researcher then spent a long time on the ward to become familiar with the context and the ward routines. The nurses seemed to forget that the researcher was an observer and not a colleague. As mentioned by Berg, it is well-known that health-care professionals cannot control their behaviour for more than 14 days. After that period their awareness decreases and they forget about the researcher’s presence (Berg, 1995).

There was no time delay between the observations and follow-up interviews, and this may strengthen the validity of the observations in studies (I) and (III). The older patients and nurses recalled the caring situation immediately and clarified what had happened from their point of view. Thus the risk of wrong, under- or over-interpretation was reduced (Berg, 1995).
In studies (I) and (III), limitations can be discussed. It should be noticed that it is the number of observations/follow-up interviews that is of interest, not the number of participants (Glaser, 1994). In both studies (I) and (III), five more observations were conducted to secure the saturation judgement.

In study (II), 14 next of kin were interviewed on one occasion. Perhaps some more information could be obtained by continuing interviews with the same next of kin, but 13 interviews gave saturation, and the 14 interviews confirmed the findings. Saturation was reached in the studies (Glaser, 1992; Morse and Field, 1996)

Observing nurses and older patients in caring encounters requires great energy and focus. The researcher listened with all senses, i.e. paid total attention to the phenomena in the caring encounter, so four hours of observation was enough (Berg, 1995). Observation and follow-up interviews can imply ethical problems. Data collection could lead to patients or nurses feeling that their integrity is threatened. It is important that the researcher’s attitude is respectful and sensitive i.e. that non-maleficence is demonstrated (Ford & Reuter, 1990; Patton, 2002; Gustafsson et.al., 2004).

Student nurses’ and colleagues’ reflections confirmed that there was a connection between the concepts, i.e. the findings and data fitted. In verbal presentations the audience recognized the core-categories and the categories as concepts in caring. This recognition shows that the studies are valid. As the findings were recognized and understood, the theory has workability and can be used in caring encounters (Glaser, 1998; Lomborg& Kirkevold, 2003).

Whether the theory is modifiable could be tested if new and further studies are performed on daily caring encounters, presenting similar or different findings.
Even if the samples were small, they could be generalized to other, similar caring areas (Glaser, 1992). The criteria fit, work, relevance and modifiability are argued to support the fitness of a theory, and to support a broader evaluation of the quality of grounded theories (Lomborg & Kirkevold, 2003).

The organization of the research process has been previously described; the data were sampled from raw data (see figure 2). These studies have fit because data are linked to their sources, as the Grounded Theory method requires (Glaser, 1967; Glaser, 1992; Berg, 1995). It is difficult to exactly replicate the same study, as time, context and persons change. Caring situations change depending on the people involved.

Observation with a follow-up interview as confirmation is a triangulation technique embedded in Grounded Theory. This method strengthens the relevance of the findings in the studies. These findings could be valuable for health-care professionals such as nurses and students in caring professions. The results derive from empirical data, so nurses and students can use these findings at work (Glaser, 1967; Glaser, 1978; Glaser, 1992).

Sometimes the researcher identifies special situations containing strong emotions that affect him/her (Hudson, 2005). For that reason it was important that the researcher could distance herself, for example, in observation studies. Reflections and “debriefing” is one technique that has been used by the researcher in these studies (Berg, 1995; Hermeren, 1996).

In study (IV), qualitative content analysis was carried out. There was a risk of incorrect interpretation. This was rectified by dialogue between researchers.
The SCA strategy highlights concepts in ethical values in caring encounters as complex and interrelated. Because this interrelationship exists, these concepts cannot be analyzed in isolation. The findings of this SCA have revealed how the normative ethics of the ICN and the Health and Medical Service act are conceptualized. An additional strength is that the concept process model is grounded in empirical data from observational GT studies (I, II) and (III). The strength of SCA is the consensus group process, where varied perspectives of the concepts are discussed and the discussion is ended when consensus is reached. This consensus was obtained during a number of discussions between the authors. One difficulty was that the authors were all Swedish native-speakers, which led to difficulties reaching consensus in English. This could be seen as a limitation of the study. To handle that issue in a good way English dictionaries, and native English speakers were used to find the correct nuances.

**Discussions of findings**

In this discussion, the focus is on the nurse’s part in the interaction with the older patient and next of kin. The reason for focusing on nurses was that nurses characterize the caring encounter, depending on how professional he or she is (see figure 4).

**Being professional in the caring encounter**

Being professional in care as a nurse, is an art (Nightingale, 1868; Nåden & Eriksson, 2004). Of central importance to nursing as an art are the values nurse’s displays in their attitude (Nåden & Eriksson, 2004). Goethals &
Gastman (2010) comment on this complex phenomenon and perhaps this thesis can provide further clarity. This phenomenon is associated partly with nurses’ practical performance but also their attitudes to professional codes and law (SFS, 1982: 762; ICN, 2010). It is essential for a nurse to “be professional”. The clarification of what it means to be professional in this thesis highlights the importance of treating other persons with appropriate behaviour and attitude. Nurses also ought to have a responsibility to maintain their level of competence and even develop their competence both theoretically and practically (SFS, 1982: 762; ICN, 2010). Central to nurse’s responsibilities is also knowledge about various issues in caring encounters. Nurse’s actions, competence and knowledge must focus on the value of the older patient’s autonomy and beneficence (Edwards, 2002; Beauchamp & Childress, 2001), and in that, nurses are influenced by laws and professional codes (SFS, 1982: 762; ICN, 2010). Normative ethics interrelate with nurse’s practical performance, as highlighted in study (IV). This thesis finding is partly similar to Kapborg & Berterö (2003), which pointed out that caring is both being and doing but there is no care quality without professionalism. A nurse, as described in this thesis, should be professional, and this professionalism is shown by: the approach nurses adopt in performing their duties, their competence and knowledge, but also how they follow laws and professional codes (SFS, 1982: 762; ICN, 2010). The professional nurse is not a nurse who knows all the answer. A nurse is professional when she / he know how to go on (Luntley, 2011).

Being professional is concerned with the nurse’s practical performance. This was shown in all empirical studies, but more clearly in study (III) identifying the concept corroborating includes showing consideration, connecting, and
caring for. Compare these findings with Nåden and Eriksson (2004), who discussed invitation and confirmation. This thesis linked invitation to participate and corroborating. Also, nurses’ respect and responsibility were found in both Nåden and Eriksson (2004), and in this thesis. There are similarities between these two studies, but there are also some differences. In study (III), caring for is one aspect of a nurse’s practical performance. Thus it is related to carrying out a task in a caring encounter using competence and knowledge regarding the issue to be solved, and also to making the task safe and secure for the person who is being cared for; thereby demonstrating non-maleficence. This part of a nurse’s practical performance is also an aspect of how nursing becomes an art. There is also another aspect to discuss. This thesis shows that nurses can be assisted in following professional codes and laws in practice (SFS, 1982: 762; ICN, 2010; Verpeet et.al., 2006). Accordingly, there is a need for a change of attitude by nurses, as Heikkinen et.al. (2006) stated, so they can see the possible advantages of using codes and law (SFS, 1982: 762; ICN, 2010). How could nurses change attitudes towards using codes and laws, perhaps with reflection tools? These tools could be used to reflect on actions but also to reflect on caring performance, according to Berterö (2010). It is also important to have some self-reflection, both individual and group reflection. These reflections ought to be connected with what codes and laws say. Using these tools ought to be a daily routine.

The nurses have responsibilities, but how far do these responsibilities extend? The normative ethics describe the responsibilities for nurses. Nurses take personal responsibility and accountability for nursing practice and should protect the older patient’s integrity. In this thesis, nurses’ practical performance is mentioned in approaching (study I), but also being amenable
Responsibility is connected with ethical competence. It is about seeing, reflecting, knowing, doing and being, according to Gallagher (2004). Being professional includes ethical competence consisting of both being, i.e. virtues, and doing, i.e. rules and principles, and of knowing, i.e. critical reflection (Eriksson et al., 2007). Nurses have ethical competence when they have the ability to focus on others, i.e. they respect the dignity of the older patient. There is also important nurse’s focus on themselves so they find self-respect. There is a need of self-inter pretation in dialogue with themselves but also with colleagues in the working environment, i.e. they must create a caring culture compatible with the four ethical principles (Romanucci-Ross et al., 1997; Beauchamp & Childress, 2001). This culture must be confident, and this confidence depends on rules of practice, and if the nurses are comfortable with reflection so they are enlightened, open-minded and empowered (Sumner, 2010). The findings in study (I-III) ought to benefit the older patients, next of kin and even nurses. The aim for every professional nurse is to create a culture of being professional.

According to this thesis, the criteria of good ethical care are: showing respect, invitation to participation, allowing self-determination for the patient, and providing safe and secure care. These criteria are part of the concept of being professional. In this thesis, in study (IV) the relationship between normative ethics (SFS, 1982: 762; ICN, 2010), and empirical ethics (study I-III) is clarified. The findings make clear there are common foundations i.e. interconnectedness, interdependence, corroboratedness, completeness and good care, but there is a need for progress in knowledge about law and professional codes, so nurses are familiar with their content. Normative ethics
have practical value, as an answer to Tadd et. al. (2006). Safe and secure care demands that nurses know rules and regulations (Kapborg & Berterö, 2003). This knowledge may benefit nurses when they meet ethical distress in practical performance. It is very important to support nurses in different ways so ethical distress and moral dilemmas can be avoided (Kälvemark et. a., 2003; Ulrich et. al., 2010).

Respect is one criterion of good ethical care that permeates all studies I – IV. In all these studies the category of respect is found in regard to the older patient (study I), next of kin (study II) and nurses (study III). Even professional codes and law (study IV) have respect as a strong incentive in formulation of caring performance and attitude, which is also shown in a study by Nåden and Eriksson (2004). In this thesis, the different perspectives on the interaction are interesting (Blumer, 1962; Blumer, 1969; Blumer, 1986; Orlando, 1961; Orlando, 1972). The ethical value of “being professional” is shown in appropriate approaching in study (I), being amenable, i.e. receiving and showing respect in study (II) , and showing consideration in study (III). All these findings may give nurses some ideas and practical tools to use when caring for older people. Respect has been discussed by many authors (Nåden et. al. 2004; Edwards, 2009; Ulrich et. al., 2010; Holland, 2010; Hussey, 2011) etc. None of these studies discussed respect according to nurses caring performance. Yet questions remain, for example: how far does nurses’ respect extend? What are the differences from different perspectives in experiences of respect? These questions could be interesting to study with the aim of furthering professionalism.
Another criterion of good ethical care is inviting to participate in study (I- II) and showing consideration in association with connecting in study (III). The invitation to participate, demands a special behaviour from nurses, namely showing consideration, which is a similar finding as in Eldh (2006). Law and professional codes (SFS, 1982: 762; ICN, 2010) mention the importance for nurses of creating an equal relationship in which the older patient and next of kin experience participation, possibly by participation in a “corroborating” relationship.

When nurses promote an equal relationship with the older patient and next of kin by showing respect and inviting them to participate, forms a base for a corroborating relationship (study III). Maybe self-determination could be accomplished when nurses have a corroborating form of caring. This benefits the older patient. Nurses promote the relationship with the older person, and caring is based on respect for self-determination and privacy. There is also mutuality in the relationship, and the different persons involved exchange information, creating participation. This supportive attitude guarantees security in the caring relationship for the older person (SFS, 1982: 762; ICN, 2010; SFS, 2010:659). These findings are confirmed by Nyden (2003), whose conclusion was that the standards of care must be developed to make older patients feel safer and more secure. Nursing care for older patients needs to be defined in order to encourage the patients to take an active part in their own health process. Maybe a corroborating relationship could help the older patients to take more decisions and participate in their own health process.

Being professional is illuminated in this thesis through nurses corroborating (study III) and nurses showing corroboratedness (study IV). These new concepts could be said to be present in the caring situation, in showing
respect, and in involving another person in a trusting relationship, i.e. in accordance with principles of autonomy and beneficence. In connecting there is communication between two individuals to create participation, i.e. this is in accordance with the principles of autonomy, beneficence and non-maleficence. The connecting function is related to someone else and it deals with information, instructions, guidance or small talk. Corroboratedness is about being professional, which also includes knowledgeable performing. Nurses give care, i.e. carry out a task in a caring encounter using competence and knowledge regarding the issue to be solved, and they also make the task safe and secure for the person who is being cared for; thereby demonstrating non-maleficence. The nurse’s corroborating strategy gives confidence for the older patient, and the next of kin discover the nurse’s professionalism. This practice also presumably leads to the nurse being considered as someone special when it comes to caring for older patients (Lindh et.al. 2009). Thus “corroboratedness” could be seen more as a form of caring synonymous with being professional. Nurses with corroborating performance guarantee good, safe and secure care, which is in accordance with laws and professional code (SFS, 1982: 762; ICN, 2010; SFS, 2010:659). Corroboratedness and the nurse’s performance, using a corroborating strategy, could solve the complex issue of how to be professional in nursing.

A nurse being professional means understanding the importance of knowledge and competence and corroborating caring. This means nurses must have ethical values, i.e. showing respect, increasing the older patients’ co-determination, and thus strengthening the older patients’ integrity. It is not enough to be an eager, loving, sympathetic and supportive person (Bishop & Scudder, 1985; Tarlier, 2004; Edwards, 2009), if the nurse causes harm due to a lack of competency. All practical performance must be permeated with
autonomy, beneficence, non-maleficence and the principles of justice (Beauchamp & Childress, 2001; Edwards, 2002). Perhaps the findings of this thesis may assist in providing support for the development of person-centred care, and the evidence presented may be incorporated into practice (Hunter, 2010). There is a need for strategies to develop these elements of practice. Hence corroboratedness, i.e. being professional, which is about performing good, secure and safe care (SFS, 1982: 762; ICN, 2010; SFS, 2010:659) could be an answer.
CONCLUSIONS

The central components of nursing are the ethical issues of autonomy, beneficence, non-maleficence and the principles of justice (Edwards, 2002; Beauchamp & Childress, 2001). These principles ought to permeate nursing practice and should be apparent in the empirical ethics demonstrated in a nurse’s performance towards older patients and next of kin. This thesis makes clear that normative ethics, i.e. law and professional codes (SFS, 1982: 762; ICN, 2010) are intertwined with empirical ethics. Normative ethics and empirical ethics have the same foundation, but their expressions are different. The main criteria of good ethical care are, according to this thesis: showing respect, inviting participation, allowing self-determination, and providing safe and secure care. These criteria are part of the concept of being professional. Professionalism of nurses is shown by the approach nurses adopt to the performance of their duties; by their competence and knowledge, but also by how they apply laws and professional codes (SFS, 1982: 762; ICN, 2010). Practical performance is noticeable in approaching (I), being amenable (II) and corroborating (III). Corroboratedness could be seen as a synonymous with being professional. Nurses with corroborating performance in the caring encounter with the older patient and next of kin guarantee good, safe and secure care, which is in accordance with laws and professional codes (SFS, 1982: 762; ICN, 2010, SFS, 2010:659).
IMPLICATIONS

The findings in this thesis contribute knowledge that could be used in practice, enabling promotion of older patients’ autonomy and self-determination, and helping to boost their confidence in the relationship with nurses in the caring encounters. It is important that nurses have knowledge and competence; corroboratedness, i.e. that they are professional. Being professional means developing a relationship with the older patient. This relationship is based on support and on giving strength. Nurses should be considerate and thoughtful and have a good attitude, both verbal and physical. Care and treatment must, as far as possible, be designed and given in consultation with the older patients. The focus should be on knowledge about the patient as a person, and on paying attention to reactions in different caring situations. Corroboratedness is also about making tasks safe and secure for the person who is being cared for, but also about the attitude nurses have towards performance. Being professional, leads to the older patients experiencing confidence and security. It also leads to satisfaction both for the older patient and the next of kin. Nurses are dependent on and influenced by the experiences of the older patient. If the older patient is pleased with the caring encounter, the nurse is also pleased. The findings in this thesis suggest some ideas and practical tools to use when caring for older people. It is also vital that nurses know that they could be assisted on professional codes and laws, but there is a need to change the attitude of nurses so they can see the possible benefits of using professional codes and laws. This changing of attitude by using reflection tools to transform knowledge into practice could be encouraged in nurse training but also through the learning nurse’s gain in
practice as health care professionals. It is a special challenge for nurses to use evidence-based knowledge to transform knowledge into practical performance. There are many complex aspects to the caring encounter, but if nurses could be more aware of their own role and use the practical tools suggested by this thesis, perhaps the older patients would experience autonomy, self-determination and confidence; in other words they would experience good and safe care.
SVENSK SAMMANFATTNING


Övergripande syfte:
Det övergripande syftet i denna avhandling är att identifiera den etiska värdegrund som är synlig i omvårdnadsmötet och dess påverkan på människorna som är involverade (empirisk etik). Syftet är också att syntetisera dessa koncept från de empiriska studierna och identifiera och klargöra innebörd och användbarheten genom att analysera dem med normativ etik.

De specifika syftena är:
Delstudie (I)
- att identifiera och beskriva den etiska värdegrund som erfars av den äldre patienten i den dagliga interaktionen med sjuksköterska på vårdavdelning för äldre
Delstudie (II)
- att identifiera och beskriva de närståendes erfarenhet av den etiska värdegrund de möter i interaktionen med sjuksköterska som vårdar den äldre patienten på en geriatrisk klinik
Delstudie (III)
- att identifiera sjuksköterskors etiska värdegrund vilken synliggörs genom deras beteende i omvårdnadsmötet, genom interaktion med den äldre patienten på en geriatrisk klinik.
Delstudie (IV)
- att syntetisera koncepten från de empiriska studierna (I- III) och analysera, jämföra och relatera dem med normativ etik.
Metod


Resultat

Resultatet i delstudie (I) visar på kärn- kategorin ”att närma sig” som är den etiska värdegrund som sjuksköterskan visar. De fyra kategorierna: hur sjuksköterskan talar till den äldre, hur den äldre blir visad respekt, upplevelse av delaktighet, får bestämma själv och upplevelsen av trygghet beror på ”att närma sig”. Resultatet i delstudie (II) visar på kärn- kategorin ”Att vara tillgänglig”. Fyra kategorier identifieras, dessa är det förhållningssätt som sjuksköterskan har, på vilket sätt visar sjuksköterskan respekt, erbjudandet av delaktighet och hur visas sjuksköterskans professionalism. Att vara tillgänglig menas att sjuksköterskan vågleds av de etiska värderingarna så att de närstående och den äldre bjuds in i omvårdnadsmötet. I delstudie (III) identifierades tre kategorier: Visa hänsyn och omtanke genom att vara närvarande, skapa en tillitsfull relation och utföra uppgifter på ett säkert sätt. Dessa tre kategorier formar basen för ”Corroborating” som betyder att bekräfta, styrka och uppmuntra den äldre patienten. Delstudie (IV) visar att empirisk etik och normativ etik är sammanflätade och att begreppen skapa en relation, en ömsesidig relation, sjuksköterskans ansvar att skapa en bekräftande relation, sjuksköterskans ansvar och professionalitet att se hela
patientens förhållande och god vård menas säker, professionell, tillgänglig och lika vård som ges med respekt och fokus på patienten.

**Diskussion**

Denna avhandling gör klart att normativ etik beskriven i Hälso- och sjukvårdslagen och ICNs kod har samma grund men olika uttryckssätt jämfört med den empiriska etiken. Denna kunskap visar att normativ etik är sammanflätad med den empiriska etiken, och att den normativa etiken kan vara ett stöd för sjuksköterskor i handling i omvårdnadsmötet med den äldre patienten och de närstående. Vidare diskuteras att begreppet Corroboratedness kan ses som liktydigt med att vara professionell. Sjuksköterskor med en kompetens att vara professionell garanterar kunskap som leder till god och säker vård.
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