Counteracting Abuse in Health Care from a Staff Perspective

Ethical Aspects and Practical Implications

Anke Zbikowski

Linköping University

Division of Gender and Medicine
Department of Clinical and Experimental Medicine
Faculty of Health Sciences, Linköping University
SE-581 83 Linköping, Sweden

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Cover design: Ralf Hintz, Per Lagman

To Marianne Zbikowski

Abstract

Background: Abuse of patients by health care staff (AHC) is a cause of unnecessary suffering, which is inconsonant with the premise in medicine of not doing harm to the patient. The understanding of AHC in this thesis is considered two-dimensional: as a patient's subjective experience and as violation of a patient's dignity. Patients' experiences of these events are rather well studied and are characterized by feelings of neglect and a loss of their human value. However, little is known about staff's perspectives on AHC and what they can do to counteract it.

Aim: The overall aim of this thesis is to approach AHC from the perspective of health care staff in order to develop and test a model for enabling health care staff to recognize and take action in situations where AHC is about to happen and to handle it professionally once it has happened.

Methods: To explore professionals' formal perspectives on AHC, five sets of ethical guidelines for staff working within gynecology and obstetrics were examined in study I, using an analytical framework based on empirical studies regarding issues related to AHC. Data for studies II and III were collected at a women's clinic that had chosen to host an intervention model based on Forum Play (FP) as a method for counteracting AHC. In FP, an improvisational theater method, based on Boal's Forum Theater, staff together stage problematic situations from their own experience and test different ways of acting. In study II, qualitative interviews with 21 staff members from the target clinic were conducted, to capture the staff's perception of AHC before the intervention. Study III evaluated the impact of 16 FP workshops by means of questionnaires focusing on the occurrences of AHC and the perceived effects of FP, sent to all staff (n=137) before, during, and after the intervention. In study IV, ten participants of an FP course, consisting of a mixed group of employees working within health care, were interviewed about their experiences of the FP course.

Results: In study I, it was shown that all guidelines failed to address issues related to AHC, mainly structural issues such as power imbalances between professionals. In study II, the staff's described perception of AHC was best categorized as *ethical lapses,* integrating theoretical descriptions of AHC with a defensive staff-centered position that rejected responsibility for AHC. In study III, no indication of an increased awareness of AHC was found, but an increase in the staff's ability to act in situations with a moral dilemma was confirmed, even one year after the intervention. The findings of study IV suggest that FP has the potential to develop a *response ability*, enabling staff to become active in AHC situations. The power to intervene when witnessing AHC was emphasized.

Conclusions: Assuming that clinical practice is a moral activity with the good of the patient as its end, it is important for staff to be able to understand AHC from the patient's perspective. To accomplish this, even structural aspects such as power imbalances between professionals have to be considered. By failing to address these important aspects, ethical guidelines appear to be a limited resource for helping to counteract AHC. FP enables staff participants to adopt a patient's perspective and to develop an understanding of their power and responsibility to act when in a situation involving AHC. Furthermore FP seems to provide a useful tool for staff learning to display and overcome structural obstacles in order to intervene when witnessing AHC. If counteracting AHC is understood as a matter of acting professionally, practical training such as FP needs to be prioritized.

Swedish abstract / Svensk sammanfattning

Bakgrund: Kränkningar av patienter i vården (KV) orsakar onödigt lidande. Detta är oförenligt med vårdens grundläggande premiss att inte skada patienter. I denna avhandling förstås KV på två sätt, dels som en subjektiv erfarenhet hos patienten och dels som något som inkräktar på patientens integritet och värdighet. Patienters erfarenheter av KV är relativt väl utforskat. Konceptet KV har beskrivits som att det kännetecknas av känslan att bli åsidosatt och förlora sin värdighet som människa. Personalens syn på KV och vad personal kan göra för att motverka KV är betydligt mindre utforskat än patientperspektivet.

Syfte: Denna avhandling närmar sig KV från vårdpersonalens perspektiv med syftet att utveckla och testa en modell som främjar både personalens förmåga att känna igen och agera i situationer med risk för KV och deras förmåga att hantera situationer professionellt när en patient har upplevt KV.

Metod: I studie I undersöks KV från ett yrkesetiskt perspektiv. Med hjälp av ett analytiskt ramverk baserat på tidigare empiriska studier relaterade till KV analyseras fem etiska koder för vårdpersonal inom obstetrik och gynekologi. Data till studie II och III samlades in på en svensk kvinnoklinik, där man valt att genomföra en intervention mot KV med hjälp av forumspel (FS). Denna metod använder improviserat rollspel: personalen spelar upp scener som visar situationer med moraliska dilemman från det dagliga arbetet och tillsammans testar man olika möjligheter att hantera situationen. För studie II intervjuades 21 medarbetare angående sin uppfattning om KV innan interventionen genomfördes. För studie III konstruerades en enkät som skickades till all personal (n=137) före, under och efter interventionen. Utfallsmått i studie III var hur många gånger personal hört talas om eller varit i en situation där en patient kränkts, och hur deltagandet i workshops med FS hade påverkat deras förmåga att handla så som de upplevde moraliskt rätt. I studie IV intervjuades tio informanter från olika yrkeskategorier om sina erfarenheter av att delta i en FS kurs.

Resultat: Studie I visar att det saknas aspekter relaterade till KV i alla etiska koder, och framför allt strukturella aspekter såsom t.ex. maktobalans mellan personal av olika yrkeskategorier. I studie II beskrivs vårdpersonalens uppfattning om KV som *etiska lapsusar*. Resultatet länkar samman hur personal beskriver KV på ett teoretiskt plan med deras defensiva och personal-orienterade hållning och pekar på ett tillbakavisande av det egna ansvaret för att KV sker. Studie III ger inga hållpunkter för en större medvetenhet om KV på kliniknivå efter interventionen. Bland deltagare i FS finns en förbättrad förmåga att agera så som man uppfattat som rätt i situationer med moraliska dilemman, även ett år efter interventionen. Studie IV visar att en FS kurs kan bidra till att utveckla en förmåga att reagera och agera situationer av KV, framför allt då man är vittne till KV.

Slutsatser: Om man utgår från att vården har ett moraliskt ansvar att eftersträva vad som är av godo för patienten, är det viktigt att vårdpersonal kan anamma patientens perspektiv i situationer av KV. Detta innebär att man beaktar även strukturella faktorer såsom t.ex. maktobalans i samspelet mellan personalgrupper eller mellan personal. I de granskade yrkesetiska koderna saknas dessa aspekter. En intervention mot KV förutsätter därför att metoden får personal att inte bara se patientens perspektiv, utan också synliggör vad som hindrar personal från att agera i en situation där en patient kränks. Avhandlingen visar att FS ger personal möjlighet att ändra perspektiv, att utveckla insikt om sitt ansvar och sin makt och att förbättra sin förmåga att agera i KV situationer. Om man anser att det hör till personalens professionalitet att kunna motverka att patienter kränks borde därför praktisk träning som FP prioriteras i vidareutbildning av personal.

List of original papers

This thesis is based on the following four original papers, which are referred to in the text with Roman numerals (I-IV).

I. **Zbikowski A**, Brüggemann AJ, Wijma B, Zeiler K, Swahnberg K. Ethical guidelines and the prevention of abuse in healthcare. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 2012**.** 165 (1): p. 18-28.

II. Swahnberg K, **Zbikowski A**, Wijma B. Ethical lapses: staff's perception of abuse in health care. *Journal of Psychosomatic Obstetrics and Gynaecology*, 2010. 31 (3): p. 123-9.

III. **Zbikowski A**, Brüggemann AJ, Wijma B, Swahnberg K. Counteracting abuse in health care: a quantitative evaluation of an intervention with Forum Play for staff. In manuscript.

IV. **Zbikowski A**, Zeiler K, Swahnberg K. Forum Play as a method for ethical learning: a qualitative study among Swedish health care staff. In manuscript.

Contents

1 Preface

Towards the end of my resident training in obstetrics and gynecology in 2006, my supervising resident asked me if I was interested in participating in a research project that was to be conducted at a women's clinic. For some reason, I had a reputation for having an interest in "soft" issues like psychosomatic medicine. The project was about abuse in health care. I was thrilled and terrified at the same time. This was an opportunity to learn more about abuse and violence, about ethics and behavior. However, it was also about me being a professional and me being a patient. Now, it would even be about me being a researcher.

2 Acronyms

AHC	Abuse in health care
TO	Theater of the Oppressed
FP	Forum Play
CCA	Constant comparative analysis
WMA	World Medical Association
SMA	The Swedish Medical Association
FIGO	The International Federation of Gynecology and Obstetrics
ICN	International Council of Nurses
ICM	International Confederation of Midwives

3 Introduction

The departure point for this thesis is the realization of a seemingly non-medical problem, situated within the health care system and caused or facilitated by members of the health care staff, which can have far-reaching consequences for patients. This thesis is about the journey of approaching abuse in health care (AHC) from a practitioner's view. It covers the examination of aspects of ethical guidelines for health care professionals, the exploration of health care professionals' understanding of AHC, and the study of a concrete method for staff to learn ways to counteract AHC. The question that initiated this research activity was as follows: How is it possible for health care professionals to do something to patients that harms them, when health care is there to heal patients or at least to alleviate their suffering? The dimensions of AHC, both quantitative in terms of its prevalence and qualitative in terms of patients' experiences, had been explored, but the phenomenon had not yet been approached from a practitioner's perspective. Therefore, starting out from this question and an idea for testing out an educational model at a clinic, the project has expanded. Beginning with the theoretical ideas that are fundamental for the choices that have been made during this journey, this thesis now comprises the following: 1) an exploration of how ethical guidelines for health care professionals address factors that are related to AHC, 2) how health care staff working within obstetrics/gynecology perceive AHC, 3) an exploration of an educational model as it was conducted in workshops with staff at a women's clinic on the one hand, and 4) a similar exploration in the form of a course for county council employees working within health care on the other hand. The first sections provide an overview of the theoretical considerations and foundations of the thesis, ending with a description of the method that was used in the intervention at a women's clinic and in the course for county council employees working within health care. Then, there are sections on the methods/materials and results, reporting on the particular studies. Finally, the insights from the studies are integrated in the discussion and related back to the initial considerations.

3.1 Theoretical background

3.1.1 What is AHC?

The term "abuse in health care" was introduced in the first studies that attempted to capture the prevalence of this phenomenon in Scandinavia (1, 2). It is a translation of what the

researchers described in Swedish as *övergrepp i vården,* a term that embraces a range of offences from abuse to assault. Owing to its potential to provoke controversy and to be rejected, the denotation of the research was changed to *kränkningar i vården,* which contains a similar range of meanings as *övergrepp i vården,* but can be used more broadly. At the same time, in Sweden, the term *kränkning* became used widely and was at risk of no longer being considered so serious. Lexically, the term *abuse* as an action between individuals means treating a person in a harsh or harmful way (3), implying a wide range of behaviors from humiliation to causing serious psychological and/or physical damage. From patient narratives, cases, and reports, it was known that the entire spectrum of abuse can be found even in health care, inflicted on patients by staff (4-8). To assess its prevalence, AHC was operationalized by Swahnberg et al. in the NorVold Abuse Questionnaire (NorAQ) (1). Among female patients seeking gynecological care at a Swedish university hospital, the lifetime prevalence for AHC was 20% (n=842) (9). By the time the prevalence study was conducted, two-thirds of the patients with an experience of AHC reported that they were still suffering from the experience. That AHC indeed implied considerable distress for patients was pointed out by qualitative studies among informants selected by means of the AHC definitions in NorAQ (1). The experiences of female informants were captured in the core category[1] "nullified" (10) and those of male informants in the core category[1] "mentally pinioned" (11). According to the analysis of Brüggemann et al., the concept of AHC is defined "by patients' subjective experiences of encounters with the health care system, characterized by devoid of care, where patients suffer and feel they lose their value as human beings" (12, page 123). It is assumed that AHC is most often unintended (ibd.). In spite of the theoretical and empirical efforts to grasp AHC, it is still not a consistent and established term. To clarify the considerations that have shaped my perception of AHC used in this thesis, I will take Brüggemann et al.'s concept analysis as a departure point to outline AHC from an ethical perspective.

3.1.2 AHC as a patient experience

The reasons for seeking help from health care services are manifold. An association with suffering can be assumed in most cases, be it suffering from illness or trauma, the fear of suffering, or the prevention of suffering. The experience of suffering is one that is profoundly individual and not necessarily related to the seriousness of the disease or trauma. Some but

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[1] Core category is a term that is used in qualitative research that follows the methods of Grounded Theory. It integrates all categories of the analyzed data and constitutes a process or theory (75).

not all patients perceive the deterioration and functional limitation caused by a disease as Kottow views it, namely, as an existential crisis (13). AHC and suffering can be related in different ways: suffering can be caused by health care staff in a patient who was not suffering before. Health care staff may fail to identify a patient as someone who is suffering, or they may cause more suffering in a patient who is already suffering. However, does AHC refer to anything that causes additional suffering? Many procedures in health care can cause unease, discomfort, or even pain. Without the provision of information and obtaining consent, they can be perceived as abuse. However, in health care, even seemingly normal and "harmless" routines can cause suffering when the patient does not understand what is going on.

A determinant of AHC is the conceptual issue of being "devoid of care" (12). While this expression can be understood as the absence of any care, it rather implies the absence of the care that is needed for a patient in a specific situation. Different Scandinavian authors have explored and described its consequences as "suffering related to health care" (14), "suffering caused by care" (15) and "suffering from care" (Swedish: *vårdlidande*) (16-18). Suffering from care may add to the suffering from illness, to the experience of "losing grip" (19), and it may in this situation even override the suffering from the illness (14). In her investigation of the concept of care in medical practice and medical ethics, Martinsen emphasizes care as a crucial point in all encounters in medicine (20). According to her understanding, care as implicit in the concepts of beneficence or non-maleficence[2] (21) fails to acknowledge care as a central feature of the encounter, as both concepts are primarily understood in terms of doing what has to be done to cure the disease without causing additional physical harm. Her investigation of the concept of care in medicine is particularly useful in the context of AHC, as she emphasizes the risk of exposing the patient to harm, when care is lacking in the clinical encounter (20).

3.1.3 Problems of the subjectivity of AHC

Not every patient experiences her condition as suffering when seeking help from health care and not every patient suffers when experiencing certain situations in health care. The vast spectrum of how patients perceive, interpret, and integrate experiences in their lives makes it difficult for the caregiver to distinguish suffering from dissatisfaction, resentfulness, and ill

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[2] According to Beauchamp and Childress the principle of beneficence includes all forms of action intended to benefit other persons and the principle of non-maleficence imposes an obligation not to inflict harm on others (21).

feeling. This in turn seems to blur the boundaries of the definition of AHC. Consider a case in which a patient is denied free transportation because a physician judges that the patient is healthy enough to take the bus home. Can the patient in this case feel abused? Opposing answers are possible. *No*, because the situation can be understood by the patient as an offence, and the patient may be dissatisfied, but the patient has not been harmed. *Yes,* because the refusal of such transportation was made in a disdainful manner, the patient may perceive the situation as AHC. But what is the definition of "disdainful"? How we communicate with each other, and how we interpret another's words and gestures depends heavily on the context, our own mental state, and the prevailing norms. Therefore, a patient's asserted perception of AHC may seem inappropriate or inflated from the outside view, but as a perception it can hardly be refuted. On the other hand, the caregiver may have experienced the situation the other way around, with the patient being aggressive and demanding, and feeling offended even when addressed in a normal manner. While this problem cannot be resolved when understanding AHC as a subjective experience of the patient, an "objectively"[3] defined delimitation of the appropriateness of the perception of AHC is not necessarily a helpful approach in considerations on how to counteract AHC. Assuming that the vulnerability in a clinical encounter is greater on the side of the patient, and the caregiver has the greater possibility to act, it is irrelevant for the success of the encounter whether the perception of the patient is "right" or "wrong" in the eyes of the caregiver. Considering how to resolve conflicts between physicians and "difficult" patients, Fiester points out that the question of culpability on either side misses the point, as it is a question of perception (22). Owing to the power asymmetry of the physician-patient encounter, the physician as a part of an organization probably has more potential to improve or handle well difficult encounters with patients. Fiester's argumentation that those who belong to one of the conflicting parties in a conflict cannot also be mediators of that conflict can also be applied to failed encounters in AHC: it should be acknowledged that the caregiver needs help to resolve the problem. This is highly relevant for considerations on how to counteract AHC.

3.1.4   AHC as the loss of dignity

The experience of the loss of value as a human being has been identified as one determinant of the concept of abuse in health care from a patient's perspective (12). This part of Brüggemann et al.'s concept analysis is among others grounded in the results of a study by

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[3] Objective in this context: based on facts or standards that allow a definite categorization.

Swahnberg et al. that explored female patients' experience of AHC (10). The main finding of "being nullified" implies "a state of lost dignity, frustration, and anxiety, which creates personal suffering" (ibid., page 165). As a choice from the multitude of different conceptions and theories, the following elaborations are meant to clarify the understanding of the loss of dignity as used for outlining AHC. Jacobson, who has among others explored dignity violations in health care, considers two forms of dignity. *Social* dignity, which is displayed in the process of acknowledging the individual's value and reflecting it back to the individual in the interaction, and which can be violated or lost, is distinguished from *human* dignity belonging to every human being, which is an inherent and inalienable value (23). Nordenfeld uses the German word *Menschenwürde* when he talks about that form of dignity that implies the idea of an equal human value, which is bound to basic human rights and therefore cannot be lost (24). Besides *Menschenwürde*, he distinguishes three forms of dignity, namely, the dignity of merit, the dignity of moral stature, and the dignity of identity. In contrast to *Menschenwürde*, the other three forms of dignity can vary in degree: they can be diminished or lost. In Brüggemann et al.'s concept analysis, losing one's value as a human being is an expression of a subjective experience. While the value as a human being can be understood in many ways, Nordenfeld's concept of the dignity of identity appears to be particularly useful for outlining AHC. According to Nordenfeld, the dignity of identity is violated when the subject's private sphere is transgressed, and her integrity and autonomy, including her social relations, are abridged: "Hurting a person is not only a violation of integrity; it also entails a change in the person's identity. The person is after this a person with a trauma; he or she has in a salient sense a new physical identity." (24, page 76). However, the violation of the dignity of identity does not need an agent. Even illness and trauma can violate the dignity of identity (ibd.). Thus, when a patient seeks help, she may already have experienced this form of dignity violation. Whereas in Brüggemann et al.'s concept analysis, the loss of value as a human being is named among the subjective experiences, Nordenfeld argues for an objective dignity of identity that is not bound to a conscious experience. Thus, while an unconscious person does not suffer when she is naked and exposed to others' views, her dignity is still violated as her privacy and integrity were disregarded (24). Concerning AHC, the implied loss of the dignity of identity allows health care professionals who are involved in such a situation to identify AHC regardless of the patient's ability to consciously experience AHC or to express this experience.

Thus, the delimitation of AHC, as outlined above, takes into consideration both the patient's experience, which implies suffering related to the experience of AHC, and the loss of the patient's dignity of identity. One of these two aspects is sufficient, but not necessary, for delimitating AHC. AHC can take place when patients have subjective experiences of encounters with the health care system that are characterized by lack of care or by loss of their dignity of identity. It can also happen when patients lose their dignity of identity without being aware of it. While the health care professional in certain situations may have difficulties relating to the patient's experience, staff can recognize the violation of a patient's dignity of identity.

3.1.5 What can be assumed to facilitate AHC?

The considerations about how AHC can be delimitated do not allow conclusions to be drawn about the reasons *why* AHC happens. Assuming that health care staff who have chosen a profession that aims at the alleviation of suffering, and who even might regard their profession as a vocation, it seems unlikely that heath care staff would intend to abuse patients and that health care professionals are particularly malicious. Hence, invoking only individual faults to explain the high prevalence of AHC must be considered insufficient. To tackle AHC practically, for the research team, it was necessary to widen the perspective and to learn about mechanisms that are described to influence individuals' behavior. Thus, the theoretical foundation for the development of the project's intervention and studies three and four is built on insights from peace research, social psychology, and moral philosophy.

3.1.6 Structural aspects

Talking about violence in the context of AHC may seem to be overstating the problem, and turning to disciplines like peace research or philosophy is not the first thing one is expected to do when trying to find out why health care professionals act in a way that is experienced as AHC by patients. However, there are reasons for doing so. Firstly, AHC came into focus as a research area when it surfaced in psychotherapeutic contexts as devastating experiences. Thus, subsequently, it was assessed as one form of violence with harmful effects similar to those of other forms of violence (25). As violence does not occur in a vacuum, it is meaningful to explore the mechanisms and conditions of violence in order to understand its occurrence. Secondly, as AHC is located in the sphere of health care, this specific context needed to be explored and peace research seemed to offer interesting analytical tools.

To refer to mechanisms of violence in the context of AHC implies the assumption of a broader understanding of violence in accordance with the work of Kleinman. Considering the violence of everyday life, Kleinman points out the inadequacy of common classifications of violence as they fail to explain the dynamics and effects of social violence, that is, the oppressive forces of social order, as an interworking of social powers on different levels (26). The peace researcher Galtung also defined violence broadly as "avoidable insults of basic human needs" such as survival, wellbeing, identity, and freedom (27, page 292), which could fit into the concept of AHC. He developed a model that integrates events of direct violence, such as interpersonal violence, with processes of structural violence, which manifest through built-in repression and exploitation, and cultural violence, which legitimizes direct and structural violence by making it "feel right" (27) or one could also say making it "feel normal." In the context of AHC, the value of Galtung's model can also be seen in its analysis of the complexity of violence, uncoupling direct violence from the isolated act of an individual and contextualizing it as a result of cultural and structural conditions. In medicine and health care, Galtung's concept has been applied, for example, by Farmer, to set the causation of certain diseases in the context of the perpetuation of social conditions and distributions of power (28), but also by Banerjee et al., who explored structural violence in long-term residential care for older people in Canada and Scandinavia (29). In the latter example, the authors show how care workers were exposed to structural violence through high workloads, rigid work routines, low autonomy, and low status, which made it difficult, if not impossible, to fulfill the residents' needs, who in turn behaved violently towards the care workers (29). The authors of the latter study suggest that, in care facilities, the experiences of those who care and who are cared for are strongly informed by structural conditions.

In social psychology, the significant impact of structural conditions on human behavior was shown by Zimbardo in the Stanford Prison Experiment in 1971, and his analysis of the human rights violations and abuses in Abu Ghraib[4] Prison in 2004 (30). According to Zimbardo dehumanizing others, anonymity, diffusion of personal responsibility, blind obedience to authority, uncritical conformity to group norms, and passive tolerance of evil through inaction or indifference are processes at work when ordinary people abuse or harm others. Zimbardo emphasizes that behavior is always subject to situational forces, which are embedded in a particular power system. However, he makes it clear that he does not deny the responsibility

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[4]In the Stanford Prison Experiment, social psychologists explored how assigned roles shape behavior. The experiment had to be terminated prematurely because the situation got out of control (30)

of the individual, who in his view is not a slave to the power of situational forces. In health care, high workloads, long working hours, and stress can be considered as situational forces that have an impact on staff behavior. Reduced attention, empathy, concern, and sensitivity as well as increased irritability and a tendency to objectify patients can be a result of such working conditions. As Passalacqua and Segrin could show, physicians (residents) experienced a significant decline in empathy from the start to the end of a single long-call shift and reported lower levels of patient-centered communication during the latter half of a long-call shift. (31).

3.1.7 Aspects of medical practice

Colaianni looks more specifically at particularities in the practice of medicine (32). She explicates a number of aspects inherent to medical practice that she describes as moral vulnerabilities. Besides structural aspects such as rigid hierarchies and requirements for career advancement, she includes the performance of invasive actions on the human body and the infliction of transient pain and discomfort on patients as acts that are unthinkable outside the medical context. Doing such things as well as overcoming being repulsed in certain situations requires willpower by the health care professional as well as some amount of detachment to be able to do what is necessary in a given situation. In addition, she points out that the need to use a specific language in medicine, implying an impersonal and technical diction, may facilitate dehumanization, equivocation, or euphemism. Following Colaianni's observations, these particularities in medicine can be considered to constitute the gray zone where AHC is likely to occur. Balancing individual resources and capabilities with requirements inherent in medical practice and structural requirements, forms of dehumanization can be assumed to be part of health care staff's strategies to perform according to the external expectations. Consistently, Haque and Waytz consider dehumanization as a consequence of social practices and requirements in hospitals and are – similarly to Brüggemann et al. (12) – not inclined to suggest that health care staff's methods of dehumanization have a malicious intent (33). Scrutinizing different forms of dehumanization, they differentiate between a number of possible nonfunctional and functional causes of dehumanization in medicine. According to their categorization, mechanization, empathy reduction, and temporary moral disengagement (34) are forms of dehumanization that allow the physician to be able to resolve medical problems and to justify carrying out painful or discomforting procedures. In contrast, deindividuating practices, impaired patient agency, and dissimilarity were pointed out as non-

functional causes of dehumanization. In the latter two causes, the otherness of the patient is crucial. Examples of these practices are labeling a patient as an illness or using a patient to demonstrate one's own competence. Deindividuating practices however refer to both the staff member and the patient. According to Haque and Waytz, this means that, by becoming a part of a group, being dressed in the same clothes as the rest of the group, both patients and staff become less identifiable, implying to the patient that their identity as a person is not recognized, while staff members perceive that their personal level of responsibility is diminished (33).

3.1.8 What aspects of ethics in clinical medicine are considered in this thesis?

Since the first recorded administration of the Hippocratic Oath in a medical school setting in 1508 (35), the persistence of oaths as well as the emergence of a multitude of ethical guidelines for health care personnel seems to prove that there has been an ongoing need to articulate moral standards for health care professionals. In Sweden, the obligations of health care staff are stipulated in the Swedish health care law (36). Furthermore, there are a number of documents on ethics for different health care professionals and different workplaces. In contrast to the law, the various ethical guidelines are not legally binding and, if these documents on ethics would be considered to contain obligatory rules, it is unclear how compliance with these rules would be ensured. Giving ethical guidelines legal validity or replacing them with laws for judging ethical aspects of medical practice has been rejected on the grounds that this would cause problems rather than solve them, as contextual aspects of different situations and the individuals involved could not be addressed adequately (37, 38). The practical use of ethical guidelines has been questioned, as the oversimplification of ethical issues, which is implied in the procedure of codification, results in a loss of specificity, allowing different interpretations to be deduced (38). A study on physicians from culturally distinct countries showed that there was an overall sense that ethical codes were ineffective, but above all, there was a lack of awareness of the content of documents on ethics pertaining to their practice (39). However, other functions that have been ascribed to ethical guidelines may reflect their role in health care. By determining and clarifying an aspiration, they may emphasize the commitment to and justification of a certain way of acting. Ethical guidelines may be part of the education of health care professionals. According to a focus group study on nurses, delineating the nursing domain and clarifying nurses' responsibilities were among the most important functions that the informants expected of a code of ethics (40). Thus, when

ethical guidelines are part of the professional norms that elucidate a profession's fundamental alignment (41), they can be considered as one of the criteria that characterize a profession (37). Silfverberg denotes that professional ethics can be considered as an application of generally accepted norms to requirements that are specific for the profession (41), as certain situations do not arise outside the professional context. They also emphasize what can be expected from staff, which is important for staff members themselves, but also for patients and the public. Professional ethics may give a framework that delimits the radius of ethical acting[5] and may provide cornerstones for discussion or consideration in difficult situations. In this way, basic assumptions on health care ethics are made explicit. As such, they also indicate what issues are to be addressed as ethically relevant for health care. However, Silfverberg also points to an important aspect of the relationship between ethical guidelines and moral agency in health care: Before acting, one has to recognize that a situation demands action and the moral dimensions of a specific situation have to be understood (41). This recognition evolves from the interpretation of circumstances and these interpretations guide the agent's considerations. Whereas the agent's consideration may also include rules, rules cannot be used in the previous step. Rules cannot capture the unique situations that arise in medical practice.

Among the different perceptions and theories about ethics in medicine, Pellegrino provides an understanding of medical practice that integrates the patient's perspective and aspects that transcend the patient's perspective (42). According to Pellegrino, medicine can be seen as a moral activity in the sense that it is oriented towards the patient's benefit. Its end, as he sees it, is the good of the patient, which encompasses four components: 1) the medical good, aiming at restoring the body's functioning and alleviating suffering by applying medical skills and knowledge; 2) the patient's perception of the good, which is unique to every patient according to what life the patient wants to live; 3) the good for humans, being grounded in the value of being human, and respect and dignity that follow from that; and 4) the spiritual good or the good of the patient as a spiritual being, referring to the ultimate meaning of life beyond material wellbeing (42). According to Pellegrino, the clinician has to assess all four levels of the patient's good as far as possible, but without giving the patient's preferences priority over all other goods. To integrate what is technically right with what is morally good, certain virtues are required in the professional: fidelity to trust (healing relationship), suppression of self-interest (vulnerable patient, dependent on the power of the professional), intellectual

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[5] Here: acting that is guided by the commitment not to cause unnecessary harm or suffering to the patient.

honesty (knowing one's own limits), compassion, courage (to stand up for what is good), and prudence (42). Pellegrino's approach is in harmony with the ethical rationale of this thesis, in the sense that the clinical encounter is understood as a moral activity. While it is debatable which virtues are needed to serve the good of the patient, in this thesis, the focus on the good of the patient can be considered as a premise.

3.1.9   What has to be considered concerning methods to counteract AHC?

In clinical encounters, health care staff work in an area of tension between the endeavor to act according to the health care institution's ethical requirements on the one hand and the structural and situational forces that can impede acting according to these requirements on the other. Following the previous consideration of AHC, its occurrence cannot be addressed as an individual problem, even if it might be perceived as such. A nurse who witnesses how a physician humiliates a patient might have the attitude that she or he cannot enjoin the physician how to act, and a midwife who lost her composure in a chaotic delivery situation might be perceived as unprofessional and blameworthy by her colleagues. In clinical health care, much of the daily work is done by teams. The patient often meets several professionals in her contact with the health care system, sometimes one-to-one and sometimes with a number of professionals at a time. Encounters where professionals act in a way that can be experienced as abuse by a patient may be perceived by witnesses as unprofessional or disruptive behavior, but not necessarily understood as abuse. For someone who is witnessing what is happening in such a situation, it might be difficult to integrate ethical, social, and personal factors of the situation, in order to decide how to act appropriately. When being one of a group witnessing abuse, the passivity of the rest of the group supports the sense of not having the responsibility to act. The increased fragmentation and subspecialization in health care constitutes a risk for responsibility remaining unclear, leaving the patient in a vacuum, which can be experienced as abuse by the patient. Stavert and Lott discuss the problem of fragmented responsibility in a case story of a seriously ill patient suffering from an unknown disease, where all physicians involved were literally waiting for those working in another specialty to become active (43). However, even without an entire group being involved, the fragmentation of responsibility constitutes a risk for letting abuse happen (30, 44).

Glover understands the fragmentation of responsibility as one of a number of mechanisms that can neutralize an individual's moral identity (45). In Glover's understanding, this accounts for the sort of person somebody wants to be. According to Glover, moral identity is

only a reliable moral resource if rooted in human responses, such as respect and sympathy. In his book "Humanity," he describes moral identity and human responses as key concepts for a humanized ethics. Following Glover's analysis of the history of the 20th century, human responses are eroded by degradation of others, fear, pressure to conform or obey threats, a monopolizing belief system, distance from the victims, narrowing the aim of the response to a certain group of people, remoteness and unreality, and a deficit of moral imagination. Beside the fragmentation of responsibility that was addressed earlier, mechanisms that may neutralize moral identity are: passivity, the "habit of participation," narrowing of attention to only bureaucratic matters, moral slide, and weakened or silenced criticism. Glover points out that people with different characters respond very differently to moral crises, but that differences of character are not just innate. His insights are relevant for the development of approaches to counteract AHC insofar as strengthening staff's moral resources by nurturing human responses, awareness, and moral imagination can help to improve their resistance to environmental or situational forces (45).

In this context, the following aspects can be considered as important issues for developing ways to counteract AHC: the recognition of situations of AHC, the understanding of one's own responsibility towards the patient, and the development of courage and capability to become active in supporting the patient. This implies that an educational method for counteracting AHC needs to increase the staff's ability to recognize AHC, strengthen their moral resources, evoke their commitment to act, and enable them to take action.

Ethical learning

How health care professionals should interact with patients and their relatives, but also with colleagues and other professionals, is partly conveyed during the professional's education. Values, attitudes, and ethical obligations are addressed in the curricula of medical schools and in nursing education. Ethical education in medicine can imply the imparting of knowledge on theoretical aspects of ethics, namely, ethical principles, the ethical aspects of new technology, or changed societal conditions, as well as critical thinking and ethical reasoning. According to Eckles et al., in the literature, two general goals of ethical education in medicine can be identified: 1) creating virtuous physicians and 2) providing physicians with a skill set for analyzing and resolving ethical dilemmas (46). However, referring to the juxtaposing of the two goals as a virtue/skill dichotomy, this seems to be grounded in a perception of the two terms that is not shared by all ethicists. Understanding virtues as skills, Zeiler brings together

virtue ethics with the philosophical perspective of phenomenology of the body, and discusses the role of embodiment and habituation in the development of virtues, as one dimension of learning ethics in medical education (47).

The view of considering ethical expertise as the attainment of theoretical knowledge has been criticized as it leads to the expectation that, if ethical theory is known and applied, the right solution to ethical issues can be found (48-50). Moreover, this view may mislead practitioners to under- or overestimate their own capacity to handle questions of everyday ethics (49). However, viewing the aim of learning ethics as the development of certain habits of mind and character, including that of critically asking oneself, "*Why do I do this?*" has implications in the way in which ethics can be taught. While learning from role models and learning in practice (49, 51, 52) are considered crucial for the development of virtuousness, it has also been pointed out that it may be necessary to compensate for the lack of appropriate experiences through practice by means of vicarious experience, as provided by fiction, for example (51).

Considering the importance of role models, it has been shown that 1) the ideal role model may not be the person who is assigned to convey ethical knowledge (49) and 2) practitioners are not always aware of their function as role models, which may have negative consequences. A study on Swedish medical students conducted by Lynoe et al. indicates that there is also an interaction between the perceived quality of the role model and the general attitude and interest in medical ethics (53). The lack of good role models during practical clinical education was related to a lower level of interest in ethics. Moreover, the number of students with a lower level of interest was higher at the end than at the beginning of the education If there are reasons to assume that practitioners' behavior is unconsciously passed on to younger colleagues and that a completed education does not result in virtuousness, it can be concluded that even experienced practitioners need to reflect and work on their approach to interacting with staff and patients.

Teaching or learning?

Freire rejected the idea of education as a process where knowledge is possessed by a teacher who imparts it actively to passive students, who are filled with it like empty containers (54). In his view, this idea distorts education and knowledge, which are attained and characterized by a process of true inquiry. Moreover, he considers this form of education as a manifestation

of oppression as the teacher is in a position of power of one who not only possesses knowledge, but also determines what knowledge is and completely controls its impartment. This kind of education maintains oppressive structures as it does not facilitate students' development of a critical consciousness. Instead, it cultivates students' credulity and fosters their ability to adapt to prevailing oppressive structures. The implied constellation with the teacher as the subject and the students as objects opposes the students' ontological vocation to be fully human (54). In his alternative model of education, which Freire calls problem-posing education, the dichotomy between teachers and students is abolished. Instead, students and teachers develop knowledge together in a critical dialogue. This form of learning is contextual as it relates to the students' own reality, their own experiences. According to DasGupta et al., Freire's concept can be used in health care to create a non-hierarchical learning environment that also has an impact on patients, as it facilitates the creation of a similar clinical environment, where patients are encouraged to raise questions and speak with their doctors about their concerns (55).

Following Freire's argumentation, it seems inappropriate *to teach* strategies to prevent AHC by imparting the accumulated insights on AHC to staff and giving them advice about what they should do and what they should not do in interactions. Firstly, this form of teaching would reproduce and fortify the prevailing forms of inequality. Secondly, by isolating AHC from its context, it would negate the complexity of AHC and give health care staff the illusion that there is a right solution out there for every case of AHC. Instead, it could be advantageous when learning how to approach and respond to AHC to start from the staff's experience, which can become a driving force to develop their own ways of tackling the difficulties of counteracting AHC.

Learning with Forum Play

Österlind provides a foundation for applying Boal's techniques of the Theater of the Oppressed (TO) as an educational method that is both contextual and transformative (56, 57). In TO, Boal, who was inspired by Freire's pedagogy, translates the ideas of learning in interaction, as a form of overcoming oppressive structures, into various forms of interactive theater. His intention was to make oppressive structures visible and to activate those witnessing a depicted situation to recognize their own situation. By stepping onto the stage and taking action, they could start to redress the oppression. The interchangeability and thus the involvement of actors and non-actors produce a shared experience, and oppression that

might have been experienced as an individual problem is understood as a shared one (57). While Boal's methods were initially aimed at counteracting political oppression, eventually they were extended, refined, and adapted to all forms of oppression, from the oppression of minorities to the internalized oppression of individuals. Boal acknowledged the importance of questioning and changing his techniques according to the requirements of those who should benefit from them (58). However, he was clear about the principles of the TO: to transform the spectator into the protagonist of the scene and, by thus having activated the spectator, to achieve a change in society. In Sweden, Boal's methods have become known and applied in educational contexts, especially in the form of Forum Play (Swedish: *Forumspel).* Originally working with socio-analytical role-play, Byréus, a Swedish theater pedagogue, developed Forum Play (FP) by integrating Boal's TO method of Forum Theate improvised role-play, and value clarification (59, 60). The improvised role-play in FP takes up problems related to the participants experience and the group explores together different possibilities of how the depicted situation can be changed. FP combines role-play with value exercises that give the participants the possibility to reflect on the motives and attitudes that are linked to their actions (60). In Sweden, FP has been used in schools, social work, and workplaces to counteract discrimination and bullying and to give the participants the possibility to train their handling of conflict situations (59). Features that have been associated with FP by Falk-Lundqvist and which underline its dialogical way of learning are as follows (61):

- Starting a discussion rather than trying to determine the truth;

- Abandonment of thinking in categories of right or wrong;

- Maximizing the number of perspectives on a problem;

- Primarily allowing all solutions;

- Leaving it to the participants to decide which solution is best;

- Allowing the expression of things that might not be expressed in normal life because of fear of confrontation;

- Giving the participants a better chance to get a different perspective and to find a constructive way of dealing with a problem in reality.

According to Boal, it is not necessary to find a solution during the play; it is the debate that activates, inspires, and stimulates the spectators, not the solution (58). The course of the play

is supported and facilitated by a so-called joker, who must not manipulate or influence spectators and who does not decide anything her/himself, but lets the spectators take positions in unresolved situations.

Concerning health care, experiences with Boal's methods have been reported from health care education addressing questions of professionalism (62), problems related to hierarchical structures (63-65), the gap between theoretical and practical knowledge concerning caring relationships (66), and communication (67, 68).

The contexts of FP in this thesis

In this thesis, the application of FP in two different contexts is explored: 1) FP as conducted in the form of 16 workshops for all employees at a women's clinic and 2) FP as a course consisting of five workshops for employees of a county council, most of them health care professionals, who had a working relationship with the county council's ethical advice board. Both FP applications shared the following characteristics:

- The participation was voluntary and free of charge for the participants;

- The participants were exempted from their ordinary work during the workshops;

- The participants received information about FP and the workshops;

- During the workshops, all participants were asked to recollect episodes of abuse in health care, which they had heard of or been involved in;

- The episodes were narrated to the rest of the group;

- The group chose two to three episodes to work with;

- Short role-plays were created by subgroups;

- Role-plays were shown to the rest of the group with the aim of clearly demonstrating the problem of the situation;

- The spectators were encouraged to interfere as soon as they had an idea about an alternative way of acting and then to try that out in the role-play;

- In these trials to find alternatives, body language was a particular focus;

- The actors in the role-play and then the spectators gave feedback on the effects of the new alternative;

- The procedure was repeated to try out as many variations to handle the situation as possible, so that ideally the group could agree upon at least one alternative that they could have chosen had they been in the situation that was illustrated in real life;

- After role-playing, participants reflected on and discussed their experiences during the workshop.

3.2 Gender aspects

Structural violence as conceptualized by Galtung (69) originates from power inequalities within social structures, such as power inequalities between women and men and between individuals with high and low educational backgrounds. Similar power inequalities also exist between professions and between caregivers and care recipients. In the present project, three different structures of subordination can be identified: between female and male staff, between staff having the power to help and the help-seeking patient, being subordinate to the staff, and between the different categories of staff in the health care system. It has been acknowledged by feminists and conceptualized as intersectionality that individuals are defined by multiple dimensions such as gender, class, race, and (dis)ability, which have an impact on status and power within social structures (70). While the concept of oppression has been explored and applied to the gendered status of nurses (71, 72), power relations within nursing have also been examined using intersectionality as a theoretical lens, which allows integration of aspects of both oppression and privileges within and between groups that shape encounters between nurses and patients (73). In this thesis, intersectionality has been used as an inspiration to consider the different constellations of power imbalances in the health care system, which vary according to the situation. A professional may have more power in a situation with another professional who is lower in the hierarchy, but less power in a situation with a colleague who may be at the same level in the hierarchy, but who is more privileged for reasons of social inequality, such as in terms of race or gender. In this sense, it is important to widen the perspective of the oppressor and the oppressed and not get trapped in stereotyped assumptions. In an example from her experience with FP, Byréus illustrates how

schoolchildren working with the problem of bullying could identify with both the perpetrator and the victim of bullying depicted in a scene (59). Thus, FP could serve as a platform to explore power inequalities and to understand oppression as a matter of context.

3.3 Methodological considerations

In this thesis, both qualitative and quantitative methods are applied. Traditionally, qualitative and quantitative methods have been attributed to different paradigms, which have fundamentally different premises. Thus, in positivism it is assumed that only one truth or reality exists, which can be measured and studied (74). In contrast interpretative research is based on the assumption that reality is constructed and exists within a context. Accordingly an ultimate truth cannot be determined. Instead multiple interpretations of reality exist (74, 75). Polit and Beck point out that in spite of different understandings of reality and attainment of knowledge, both paradigms have a number of features in common. In both paradigms the aim of research is to gain understanding about phenomena and to generate knowledge through empirically gathered information (75). Furthermore the assessment of quantifiable data and the use of statistical methods is not necessarily the same as applying a positivistic methodology (76). This thesis is embedded in a specific context, which has influenced the choice of procedures, the samples, and the interpretation of the results. Both ontologically and epistemologically it is closer to the naturalistic paradigm than the positivistic. The research is therefore inevitably influenced by the researcher and the research process (77). Hence, the appraisal of the findings refers to questions of coherence and compatibility with other accounts in the research area, and to the probability that the results apply in similar contexts (75, 78).

4 Aims of the thesis

The overall aim of this thesis is to approach AHC from the perspective of the health care professional in order to develop and test a model for enabling health care staff to recognize AHC, to handle it professionally once it happens, and eventually to prevent AHC from happening. The thesis can be subdivided into two parts, an exploratory part and an evaluative part, including the following aims:

Exploration of ethical guidelines for staff and staff's perceptions:

- to map out the explicit ethical framework in health care in the form of ethical guidelines and exploring their informativeness in relation to AHC (paper I);
- to study the implicit understanding of AHC as reflected by health care staff (paper II).

Investigation of the applied intervention method:

- to evaluate the application of FP workshops in a women's clinic in Sweden as an interventional project to improve staff's ability to counteract AHC (paper III);
- to explore the experiences of participants of a FP course for employees of the target clinic's county council, most of them health care professionals who were ethical appointees or being involved in the ethical advice board's educational activities, and to understand the implications of their experiences for ethical learning (paper IV).

5 Materials and methods for all studies

5.1 Design

The project has a traditional design for intervention projects, being divided in explorative, interventional, and evaluative phases. In Table 1, the design of the separate studies is shown.

**Table 1**. Design of the studies of the thesis

General aim	Study	Research question	Design	Material/ Participants	Method
Exploration of the pre-suppositions	I	AHC: (how) do ethical guidelines deal with it?	Qualitative study	11 articles with results from empirical studies related to AHC; 5 ethical guidelines for health care staff within obstetrics and gynecology	Content analysis of ethical guidelines using a framework developed according to empirical findings
	II	What is AHC according to staff's perceptions?	Qualitative study	Employees at a women's clinic, selected by purposive sampling (n=21)	Constant comparative analysis
Investigation/ Evaluation of the applied method	III	What impact does FP have on hospital staff regarding their awareness of AHC and their ability to counteract AHC?	Quantitative study Prospective, pretest-posttest	All staff employed at a women's clinic in Sweden (n=137) during the study period	Statistical analysis of self-administered postal questionnaires
	IV	How is the participation in FP with focus on AHC experienced and what can be learned about FP as a method to counteract AHC?	Qualitative study	All participants (n=10) of an FP course (currently or previously employed at a county council in Sweden)	Constant comparative analysis

5.1.1 Study I: Content analysis

The aim of this study was to analyze the content of ethical guidelines to understand how such guidelines address factors related to AHC. Different forms of analysis have been used to analyze ethical guidelines, for example, concerning their applicability as practical guidance (38) or concerning their ethical orientation and functional linguistics (79). The form of content analysis that was developed for this study was inspired by the idea to search for

exclusively empirical evidence about AHC and to apply this evidence consistently in the analysis of ethical guidelines (Figure 1).

Figure 1. Development of the analytical framework for study I
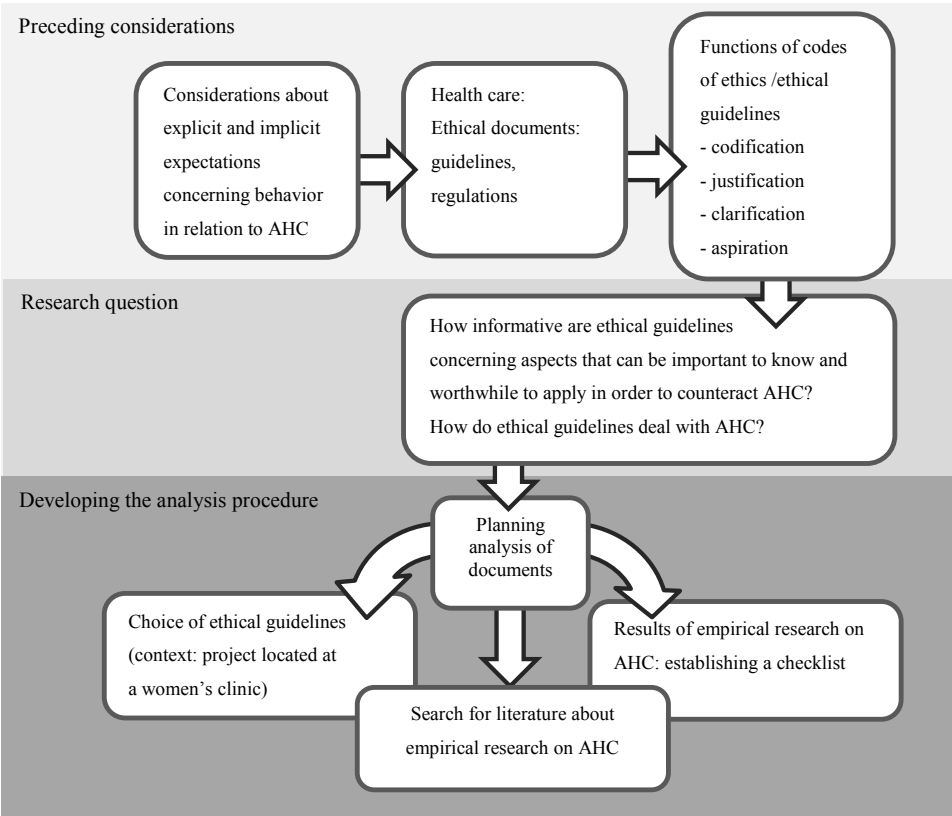
The method applied was a procedure performed in four documented steps: conducting a literature search with a focus on empirical evidence about factors related to AHC, selecting ethical guidelines for the analysis, generating an analytical framework, and analyzing the selected ethical guidelines.

5.1.2 Studies II and IV: Qualitative interview studies

The aim of study II was to explore health care staff's perceptions of AHC. While AHC had earlier been explored from a patient perspective, it had not been studied from a staff perspective. Being interested in the experiences of staff, a qualitative research design was

chosen. In areas where existing knowledge is still insufficient, qualitative methods are appropriate to use when the research implies the search for an understanding, rather than an explanation (77). Polit and Beck explain qualitative research as "the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design" (75, page 763). The method chosen for both study II and study IV was a constant comparative analysis (CCA) (80, 81), which applies the principal procedures of Grounded Theory (82), such as purposive and theoretical[6] sampling, and the process of coding and developing categories through constant comparison. Grounded Theory originates from sociology and is used to explore social processes in the environment where they take place and to develop theories about them (82). This method was thus considered appropriate for study II. CCA was also used for study IV because the point of interest was the participants' experiences of an FP course and the way FP worked as a learning method.

5.1.3 Study III: Quantitative study, pretest-posttest design

Study III focused on the exploration of the impact that FP might have had on the staff at a women's clinic in Sweden. Between January 2008 and January 2009, 16 FP workshops addressing the issue of AHC were conducted at the target clinic. Each workshop lasted 3–3.5 hours. All workshops were held by a professional FP leader. An English-speaking ethicist conducted the first 14 workshops, whereas the last two were held by a Swedish-speaking drama pedagogue. The timing of the workshops during the study period in relation to the distribution of the questionnaires is shown in Table 2. The questionnaires were distributed before (QI, t_0) during (QII, $t_0 + 5$ months), and after the workshop series (QIII, $t_0 + 14$ months, and QIV, $t_0 + 26$ months).

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[6] Purposive and theoretical sampling: the participants are selected by the researcher in order to obtain as rich and varied data as possible in regard to the research question and emerging findings (75, 82).

Table 2. Distribution of questionnaires in relation to the workshops

Year	2007	2008												2009			2010	
Month	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March-December	January	February
Number of FP workshops		4	3	3	3						1	1		1				
Distributed Q	QI					QII									QIII			QIV

Note: Q=questionnaire

The staff of the clinic had been informed about the workshops via three information meetings and the clinic's intranet. All staff members (n=136)[7] employed at the women's clinic during the period when the workshops were conducted were given the possibility to participate in least one FP workshop. The participation was voluntary. All staff members had the possibility to register for the workshops on the intranet. Of 136 staff members, 76 participated (56%) in at least one workshop and of the FP participants 26 (34%) staff members participated in two or more workshops. The number of participants varied between 4 and 15 per workshop session, including members of the research group.

In order to assess changes in relation to the intervention, the study followed a pre-test/post-test design (75). The lack of established methods for measuring the effects of this particular form of intervention was the reason for the development of questionnaires with specific questions concerning AHC and FP. The use of self-administered questionnaires made it possible to include the entire staff of the clinic in the sample and to follow them over a long period of time.

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[7] The number of employees was varying during the time of the study. Here n refers to the number of employees who had the possibility to participate in FP during the workshop period.

Hypotheses

1) More openness and increased awareness of AHC at the clinic

Everyday conversations between those who participated in FP (FP participants) and those who did not (non-participants) were expected to lead to greater openness about AHC and to make it a subject of discussion at the clinic, thus increasing awareness of instances of AHC. Accordingly,

   a) the number of instances of AHC reported by all respondents would be expected to increase during and after the workshop series and would remain unchanged or decrease (wearing-off effect) after one year;

   b) the effect was expected to be more explicit among FP participants than in the total sample.

This hypothesis is based 1) on the (at that time preliminary) results of two qualitative studies, which indicated that health care staff do not recognize AHC as such, so prior to FP it did not receive their attention (83); and 2) on the fact that staff's awareness varies according to context and possibilities to act; hence, the FP participants' awareness should show a more marked increase after FP than the awareness among the total staff (84).

2) Ability to counteract AHC

FP participants were expected to become able to recognize more possibilities to act in abusive or potentially abusive situations, and to act more according to their own beliefs than before the intervention.

This hypothesis is based on Glover's theoretical elaboration on the development of violence, which becomes possible through a gradual erosion of moral resources (45). Strengthening these resources is expected to be an important factor in enabling staff to counteract AHC. Moreover, the hypothesis is based on the work of Boal and his methods of interactive theater, in particularly its potential to activate spectators or observers to get involved in acting (56, 58).

5.2 Materials and participants

5.2.1 Study I

In health care institutions, there are a variety of documents outlining the prevailing values and ethical considerations related to the service that is being offered and the work that is being done. It is a common expectation that the members of a profession are committed to their ethical guidelines or their code of ethics. In many cases, national ethical guidelines have been developed or have simply been translated from international guidelines. As the study was part of a research project located at a women's clinic in Sweden, professional ethical guidelines for staff working within gynecology and obstetrics became the natural source for study I, and one national and four international sets of guidelines could be included in the analysis.

The Swedish Association of Health Professionals (Swedish: *Vårdförbundet*) relies on international guidelines and has published a Swedish translation of *The International Code of Ethics for Nurses* (85) and of *The International Code of Ethics for Midwives* (86). Both codes were included in the study. For physicians working within obstetrics and gynecology, *The International Code of Medical Ethics* published by the World Medical Association (87) and *The Swedish Medical Association's Ethical Rules* (Swedish: *Läkarförbundets Etiska Regler*) were included (88). The Swedish Society for Obstetrics and Gynecology (Swedish: *Svensk Förening för Obstetriks and Gynekologi; SFOG*) has not developed ethical guidelines specifically for Swedish gynecologists and obstetricians, but refers to the ethical guidelines published by The International Federation of Gynecology and Obstetrics' (FIGO) Committee for Ethical Aspects of Human Reproduction and Women's Health (89). The included guidelines are displayed in Table 3.

Table 3. Selection of ethical guidelines

Profession	Ethical guideline	Year of latest revision[*]	Organization/author
Physician	International Code of Medical Ethics	2006	World Medical Association (WMA)
	Swedish Medical Association's Ethical Rules (Swedish: *Läkarförbundets Etiska Regler*)	2009	Swedish Medical Association (SMA) (Swedish: *Läkarförbundet*)
Obstetrician/ gynecologist	Ethical Issues in Obstetrics and Gynecology: The role of the obstetrician/gynecologist as advocate for women's health	1999	The International Federation of Gynecology and Obstetrics' (FIGO) Committee for Ethical Aspects of Human Reproduction and Women's Health
	Violence against women	2007	
	Ethical framework for gynecologic and obstetric care	2007	
	Ethical guidelines in regard to terminally ill women	1999	
	Guidelines regarding informed consent	2007	
	The ethical aspects of sexual and reproductive rights	1997	
	Some ethical issues in the doctor/patient relationship	1997	
	Confidentiality, privacy and security of patient's health care information	2005	
	Professional obligations to fellow obstetrician/gynecologist	2006	
	Ethical guidelines on conscientious objection	2005	
Nurse	The International Code of Ethics for Nurses	2006	International Council of Nurses (ICN)
Midwife	The International Code of Ethics for Midwives	2008	International Confederation of Midwives (ICM)

Note: *at the time of the study

5.2.2 Study II

From a total of 131 staff members (at the time of the study 2007) employed at the target clinic, 21 staff members were recruited as informants. The selection followed the procedure of purposive and theoretical sampling. The sample included all professional groups as well as both sexes, as shown in Table 4. The informants were recruited at their workplace in the women's clinic with the help of a member of the research group, who was working as a midwife at the clinic. Her local knowledge was indispensable to conduct purposive sampling as she facilitated contact with informants who could assumedly provide new perspectives and enrich the data.

Table 4. Background characteristics of the informants in study II

Occupation	Female	Male
Administrators/secretaries	3	0
Auxiliary nurses	5	0
Midwives	6	0
Physicians/gynecologists	2	5

5.2.3 Study III

All staff that were employed at the target clinic on a regular basis between December 2007 and February 2010 were eligible for the study. The number of employees varied during the study period, accordingly the number of eligible study participants was divergent for the four measuring points. The mean number of employees during the entire study period was 133 per year. During the entire workshop period 136 staff members had the possibility to participate in FP workshops. The questionnaires were sent to a total of 137 employees. The demographic data of the employees, FP participants and non-participants are displayed in Table 5.

Table 5. Background characteristics of the clinic's staff, FP participants and non-participants

	Employees at the women's clinic who had the possibility to participate in FP (n)[1]		FP participants[2]		Non-participants[3]	
Total	136		76	56%	60	44%
Female	126	91%	71	56%	55	44%
Male	10	9%	5	50%	5	50%
Physicians	20	16%	13	65%	7	35%
Midwives	76	54%	47	64%	29	36%
Aux. nurses	29	21%	11	41%	18	59%
Secretaries	11	9%	5	45%	6	55%
Age (years)[4] [5]						
median	49,9		50			
range	20->65		28-63			

Note:
[1] data from the clinic's personnel department
[2] data from the workshop registration
[3] data estimated from clinic-data and the data from the workshop registration
[4] age of FP participants based on data from FP participants' completed questionnaires (n=61)
[5] age in 2008

5.2.4 Study IV

All ten participants of an FP course that was conducted between November 2010 and September 2011 were recruited for this study. As the participants of the course are the same as the informants in the study, the sample will henceforth be referred to as participants. The course consisted of five separate full-day workshops. All participants had attended at least three workshops. Purposive and theoretical sampling was not considered useful given that there was the opportunity to include the entire group in the study. The sample of participants was heterogeneous concerning profession, work experience, and involvement in ethical working groups. Most of them had experience of being an ethical appointee (Swedish: *etikombud*) and were part of a network of employees with an interest in ethical issues and training. The course was organized by the county council's ethical advisory board, which also recruited the participants for the course, with the aim of learning FP as a method to approach difficult situations in health care such as AHC. By the time of the interviews, one of the participants had officially retired but continued to do temporary work, and another had changed workplace (but not profession) and was no longer employed by the county council. All participants had some experience with role-play, mostly during previous education. None

of them had experience with the methods developed by Boal or derived models of interactive theater, such as FP. The sample is described in Table 6.

Table 6. Background characteristics of the FP course participants

Age (years)*	range	35-67
	median	55,5
Sex	female	8
	male	2
Profession	psychologist	2
	physician	2
	therapist	2
	nurse	2
	midwife	1
	spiritual caregiver	1
Work experience in health care (years)*	range	13-44
	median	25,5

Note:
*at the time of the interview

5.3 Data collection

5.3.1 Study I

The databases PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and Psych INFO were searched for reports on empirical studies that had been published between January 1996 and March 2011 and explored AHC or aspects of it. A total of 24 search-term combinations allocated to the three databases yielded 541 results. Eleven articles, seven on studies with a qualitative and four with a quantitative design, were included in the study (2, 5, 6, 10, 11, 83, 84, 90-93).

5.3.2 Study II

The interviews were conducted in a quiet room at the informants' workplace, lasting 60 minutes on average. The informants received oral information about the study as well as written information when written informed consent was obtained from them. To maintain the focus on issues related to AHC while giving the informants the possibility to speak freely, the interviews were conducted in a semi-structured fashion using an interview guide on the main

themes for the interview. Following the CCA, the analysis procedure was started directly after the first interview. This allowed the interviewer to adjust the interview guide, displayed in Table 7, after considering the results of the first two interviews.

Table 7. Interview guide study II

Questions
1. *How do you like your workplace?*
2. *Are patients being abused in health care?*
3. *When I say abuse in health care, what is the first thing that comes to mind?*
4. *Who is the agent when abuse in health care occurs?*
5. *How does abuse in health care occur?*
6. *How can health care staff intervene against abuse in health care?*

The interviews were tape-recorded and transcribed verbatim by a secretary, who had no relationship to the clinic. Memos were written during and after interviews as well as during reading of the interview as an integral part of the analysis procedure.

5.3.3 Study III

A questionnaire (Q) was developed in four versions for evaluating the intervention. The questions that are included in study III and their respective scales are displayed in Table 8. In addition, all versions contained questions about background characteristics such as age, gender, and profession.

Table 8. Questions from questionnaires QI–QIV that were included in the study

Question	Measurements/ answer alternatives	Questionnaire
1. *Have you heard any stories about abuse of patients in health care[1]?*	No Yes, once. Yes, several times	QI, QII, QIII, QIV
2. *How many times [have you heard about AHC[2]]?*	Count	
3. *Have you been involved in a situation where a patient has been abused in health care[1]?*	No Yes, once. Yes, several times	
4. *How many times have you been involved [in a situation where a patient has been abused in health care[1]]?*	Count	
5. *Do you think that FP has affected your ability to act in a way that feels right to you in situations with moral dilemmas[3] in health care? Your ability has increased*	VAS scale 0 (lowest score) to 10 (highest score)	QII, QIII,QIV
6. *Do you think that FP has affected your ability to act in a way that feels right to you in situations with moral dilemma[3] in health care? Your ability has decreased*		
7. *After your participation in FP, did your way of handling a health care situation involving a moral dilemma[3] correspond more to what you felt was the right thing to do?*	No No, I have not experienced such situations Yes, once. Yes, several times	QII, QIII,
8. *After your participation in FP, **to what degree** did your way of handling a health care situation involving a moral dilemma[3] correspond to what you felt was the right thing to do?*	VAS scale 0 (lowest score) to 10 (highest score)	QII, QIII, QIV

Note:
[1]Definition given in all questionnaires: *"In this context, abuse in health care (AHC) refers to a failed encounter in health care, implying that a patient or staff member feels hurt or humiliated by the experience."*
[2]Variations: In QI, the question relates to the last 12 months, in QII–QIV, the question relates to the time since the last questionnaire.
[3]'Moral dilemma' as understood here, refers to a situation where staff A is confronted with something that she perceives as abusive, where she has an impulse to take action to change the situation or for example stop the abusive action, while at the same time she feels obliged to defer to the tacit rules of the setting, according to which she is to refrain from interfering.

One version of a complete questionnaire (QIII) is shown in the appendix (in Swedish).

The anonymized and encoded questionnaires were sent home to all staff members with a stamped and self-addressed envelope. Two reminders were sent to non-respondents. During the study, only the clinic's administrative secretary, who was responsible for the distribution and registration of returned questionnaires, had access to the key for decoding to be able to send reminders.

5.3.4 Study IV

The participants of the FP course were first informed verbally about the interview study. Later, they were contacted individually by e-mail or phone and invited to participate in the study. The data were collected in the form of semi-structured interviews, which were conducted between April 2012 and May 2013. The interview guide as shown in Table 9 was modified after the first two interviews by removing two questions that proved to be confusing. The interview focus was on the experiences of the participants during the FP course and how they related to these experiences. All interviews took place at a quiet location chosen by the respective participants. The interviews lasted between 40 and 60 minutes, and were tape-recorded and transcribed verbatim by the interviewer and by a secretary. The transcripts were checked for their correctness by the interviewer.

Table 9. Interview guide study IV

Questions
1. *Why did you participate in the FP course?*
2. *How are you affected by the issue "abuse in health care"?*
3. *Can you talk about your experiences during the FP course?*
a. *Concrete situations*
b. *Experiencing oneself, experiencing others*
c. *Interactions*
4. *In what way have you been confronted with abuse in health care since the course?*
a. *Experiences*
b. *Importance of the experiences from the course in everyday life*
c. *New insights from the course*

5.4   Data analysis

5.4.1   Study I

After scrutinizing the selected articles and identifying issues that were related to AHC, 14 questions addressing these issues were developed to form the analytical framework. For the sake of clarity, the issues were divided into four content-related groups, named *patient aspects*, *relationship aspects/responsibility*, *power aspects*, and *staff aspects*. The analysis of the codes was performed by applying the questions of the analytical framework to each of the included codes of ethics separately. The codes of ethics were examined one question at a time. Initially, the analysis was performed by two researchers independently. The results were then compared and discussed until consensus was reached in cases where the results did not initially match.

5.4.2   Study II and study IV

The collected data in the form of interviews was analyzed according to the procedures of constant comparative analysis (CCA) (82), which implies that data is compared within an interview and also that all data from one interview is compared with new data from the next interview (80). The process of analysis is linked to the process of interviewing as the analysis of the interviews is started before the next interview is conducted. The primary units of comparison are substantive codes, which consist of relevant data; that is words or expressions of the informants that are related to the research question. These are singled out by analyzing the transcribed interviews line-by-line in the first step, and in the next step, they are compared within the interview and with the substantive codes of the next interviews. On a more abstract level, categories are established from the substantive codes. Finally, the relationship between the categories is examined, which is then captured in the core category, answering the research question. In study II, no new codes came up after the 11th interview (saturation). Ten more interviews were analyzed to fill up and stabilize the categories and to confirm that no new features could be found in the material. In study IV, saturation was reached after eight interviews.

5.4.3 Study III

To reject or confirm hypotheses 1 and 2, changes between the questionnaires QI (t_0), QIII (t_0 + 14 months), and QIV (t_0 + 26 months) were assessed by applying non-parametric statistical tests. Dichotomous or dichotomized variables were tested by McNemar's test, using the IBM Statistical Package of Social Sciences version 22. For ordinal variables, Svensson's test was applied (94). This statistical method allowed assessment of the pattern of change of ordered categorical data in the study. The size of an effect of the intervention attributed to the group is expressed by the measure of systematic change in position, RP (relative position), ranging from -1 to 1. A systematic change towards higher scores after the intervention results in a positive RP value, which is considered significant when the 95% confidence intervals (CI) does not include zero. The measures and the 95% (CI) of the measures were calculated by using freeware provided by Örebro University, Sweden (95). The systematic change in position can be visualized by a receiver operating characteristic (ROC) curve. An ROC curve deviating below the main diagonal shows a systematic change towards higher scores.

Regarding hypothesis 1, an increased awareness of AHC was expected to be displayed on an increasing number of occasions where AHC would be recognized (questions 1–4, Table 8). In order to assess the counts for a one-year follow-up, the counts of QII were added to QIII for questions 2 and 4, which ask about the number of occasions on which AHC was recognized. Svensson's test for ordinal data was applied for questions 1 to 4. In addition, McNemar's test was applied to the dichotomized versions of questions 1 and 3.

In testing hypothesis 2, a positive effect of FP was expected to be displayed as an increase in FP participants' perception of their capacity to act according to their inherent moral beliefs, and an increase in the number of reported occasions on which FP participants had acted more according to their beliefs (questions 5, 7, and 8; Table 8). Those tested for a change were the respondents who reported participation in at least one FP workshop (FP participants), and who had completed two of the questionnaires among QII–IV. Possible changes were assessed by Svensson's test.

5.5 Ethical aspects of the research

According to the Swedish Research Council, ethically acceptable research demands information, consent, confidentiality, and confinement of the assessed data for use within research. Whereas study I is only based on existing published guidelines, these demands

apply to studies II to IV. Studies II and III were embedded in a larger research project at the same target clinic. Three information meetings were held to give all staff members the chance to obtain information and to ask questions. Moreover, written information was published on the clinic's website in the hospital's intranet system. Thus, the staff members were informed about the overall plan and the purpose of the research. They could familiarize themselves with the responsible research team and were provided with their contact details. Additional information, including the method of the study, was for study II provided in an information sheet, on which the informants also gave their written informed consent to participate in the study. For study III, additional information was given on the questionnaires that were distributed to the staff members. Consent to participate in the study was assumed when one filled in and returned a questionnaire. For study IV, the participants received information about the planned study at the end of the course and finally received written information on the sheet on which they provided written informed consent. It was emphasized that participation in the studies was entirely voluntary and that the participants had the possibility to withdraw their consent from the study at any time. The research project was approved by the regional ethical review board in Linköping, Sweden (reg. no. 194-06).

Both AHC and FP are sensitive issues, which have the potential to evoke emotional reactions and to raise controversy. Health care professionals themselves might have experienced any conceivable kind of abuse, as a child or as an adult, in a private or in a professional context, as a professional and/or as a patient. Confrontation with the issue of abuse in the form of written questions, during an interview, or during interactive theater can evoke memories associated with painful feelings of discomfort, guilt, or shame. Theater methods can have a powerful impact on individuals' emotional state and their way of dealing with personal experiences, as is known from psychodrama[8]. At the beginning of the workshops and also in the context of the FP course, it was made clear that the techniques that are used in FP do not have a therapeutic orientation and are clearly distinct from techniques such as psychodrama. However, in case the FP would evoke serious distress, the participants had the possibility of contacting the research team, who could make contact with a therapist. The questionnaires were sent to the homes of staff of the women's clinic. In that way, it was ensured that the staff members could fill in the questionnaires in privacy.

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[8] Psychodrama has been developed by the psychiatrist Jacob Moreno. The enactments of real-life situations are used to gain insights about them and to work with them in a psychotherapeutic sense (96).

Given these precautions, it can be assumed that the potential benefit from the studies in this thesis outweighs the possible temporary discomfort that they might have caused to some of those who were addressed or became involved. The research team concluded that the studies could benefit both staff and patients, as they address AHC from the perspective of those who work in health care and have a focus on finding ways to improve staff's ability to handle AHC.

6 Results

6.1 Study I

According to the literature search, there are a limited number of articles that provide empirical research on abusive behavior of staff against patients, and also that understand this behavior as abuse. Nonetheless, 14 reports addressing features related to patients, relationships and responsibilities, power, and staff could be identified and were subsequently used as an analytical framework for the analysis of ethical guidelines. The analysis revealed that sets of ethical guidelines for the different professional groups working within obstetrics and gynecology differ distinctively regarding their content on issues that are related to AHC. Issues that were mostly disregarded were:

- considering the patient as a person with his or her own perspective;

- considering the possibility of a patient being a victim of abuse or violence;

- considering power imbalances among health care professionals;

- addressing sexual misconduct;

- addressing ethical misconduct of co-workers.

We found that the ethical guidelines of the FIGO (89) and of the ICM (86) were those that contained most of the issues that have been empirically shown to be important in regard to AHC. These were the only sets of guidelines that referred to the issues of sharing/redressing power imbalances between professionals (only in the ICM's guidelines) and the patient's personal experience of violence (only in the FIGO's guidelines).

6.2 Study II

The analysis of the interviews with CCA resulted in two categories: "ethical failure towards a patient" and "staff members avoid responsibility," which are linked to each other in the core category of "ethical lapses." The first category is characterized by the informants' accounting for ethical violations and resembles knowledge from ethical guidelines or formal education as it lacks reference to personal experience. In contrast, the second category displays a

dissociation from AHC. Here, the informants emphasize the randomness of AHC, by pointing out that the staff had probably been thoughtless and not recognized AHC and that certain patients were more vulnerable. The results show that, in spite of the ability to perceive AHC theoretically, no connection to their own experiences was expressed in the interviews. Instead, their own experiences were dissociated from the theoretical account of AHC and a defensive staff-centered position was taken.

6.3 Study III

The total number of staff members who received a questionnaire was 137. One or more questionnaires were completed by 84% (115/137). The response rates of the particular questionnaires were:

- 70% for QI (92/131)
- 63% for QII (85/134)
- 59% for QIII (79/133)
- 59% for QIV (78/132)

6.3.1 Hypothesis 1

The numbers of respondents in terms of the different combinations of questionnaires that they completed and subsamples available for the testing of hypothesis 1 are shown in Table 10, and the yielded numbers of paired assessments per questionnaire combination are shown in Table 11.

Table 10. Numbers of respondents in terms of the combinations of completed questionnaires and subsamples available for the testing of hypothesis 1

Number completed questionnaires per respondent	4	3				2						1		
Completed questionnaires	I	•		•	•	•	•	•				•	•		
	II	•	•	•	•		•		•		•				
	III	•	•		•	•		•	•	•					•
	IV	•	•	•		•				•	•	•		•	
Respondents who answered this combination of questionnaires (n = 115)		53 (46%)	7 (6%)	6 (5%)	4 (4%)	1 (1%)	10 (9%)	5 (4%)	3 (3%)	3 (3%)	2 (2%)	1 (1%)	12 (10%)	5 (4%)	3 (3%)
Eligible for testing of hypothesis 1		53	18				24						Not eligible for testing: 20		
Eligible for testing of hypothesis 1 (in total)			95												

Note:

• = completed questionnaire

Table 11. Paired assessments per questionnaire combination eligible for the testing of hypothesis 1

Combination of questionnaires	Paired assessments (n)
QI + QIII	63
QIII + QIV	64
QI + QIV	61

Hypothesis 1 could not be supported. The pattern of change in the total sample was expected to show an initial increase of the number of reported AHC incidents that would remain unchanged or decrease. This pattern was expected to be salient among FP participants. The frequencies of questions 1 are shown in Figure 2 for the entire sample and in Figure 3 for the FP participants and the frequencies of questions 3 are shown in Figure 4 for the entire sample and in Figure 5 for the FP participants.

Figures 2–3. Results for questions 1:

"Have you heard any stories about abuse of patients in health care"?

	QI	QIII	QIV
No	54	55	42
Yes, once	21	11	22
Yes, several times	16	12	12

	QI	QIII	QIV
No	20	30	20
Yes, once	15	9	19
Yes, several times	13	10	10
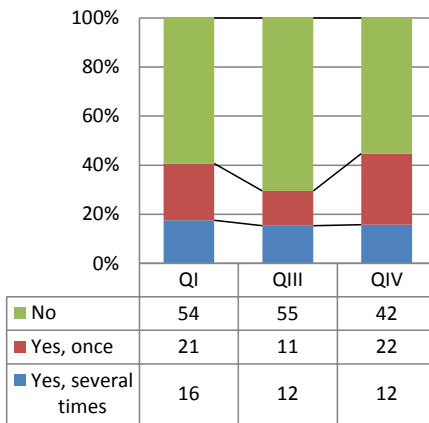
Figure 2. Question 1: All respondents   **Figure 3.** Question 1: FP participants
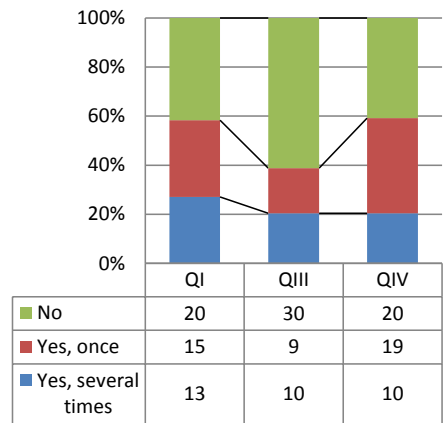
Note:
QI=questionnaire I (t_0)   QIII=questionnaire III (t_0+14 months)
QII=questionnaire II (t_0+5 months)   QIV=questionnaire IV (t_0+26 months)

42

Figures 4–5. Results for questions 3:

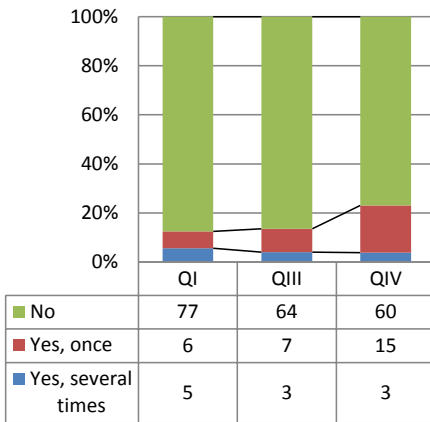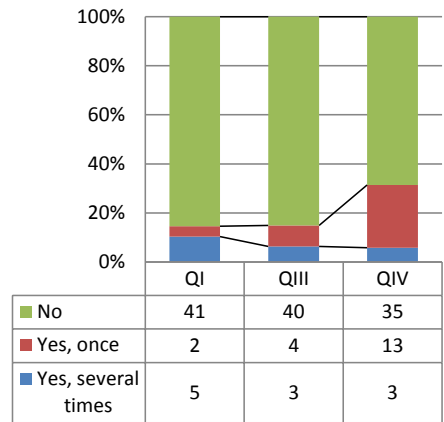**"*Have you been involved in a situation where a patient has been abused in health care?*"**

	QI	QIII	QIV
🟩 No	77	64	60
🟥 Yes, once	6	7	15
🟦 Yes, several times	5	3	3

Figure 4. Question 3: All respondents

	QI	QIII	QIV
🟩 No	41	40	35
🟥 Yes, once	2	4	13
🟦 Yes, several times	5	3	3

Figure 5. Question 3: FP participants

Note:
QI=questionnaire I (t_0)   QIII=questionnaire III (t_0+14 months)
QII=questionnaire II (t_0+5 months)   QIV=questionnaire IV (t_0+26 months)

Between the first measurement after the end of the workshop series (QIII) and the follow-up one year later (QIV), an increase of the number of occasions when staff had heard stories about AHC could be shown in the paired assessments in the group of *all* respondents. This change was only found in the dichotomized version of the question 1 (McNemar's test, p=0,041). However no difference was found between baseline (QI) and the long-term follow-up (QIV).

Concerning the number of occasions when staff had been involved in AHC, no changes could be found in the paired assessments between any questionnaire combination.

6.3.2 Hypothesis 2

Hypothesis 2 could be supported. FP participants were expected to report an increase in their ability to act in situations involving a moral dilemma, and their handling of such situations was expected to correspond more often to what they felt was the right thing to do. For the testing of hypothesis 2, it was necessary that participation in FP was reported in at least two

completed questionnaires. The numbers of FP participants who were included in this hypothesis testing are shown in Table 12 and the yielded numbers of paired assessments per questionnaire combination eligible for testing of hypothesis 2 are shown in Table 13.

Table 12. Numbers of FP participants who were included in the testing of hypothesis 2

Number of questionnaires completed per respondent		4				3				2				
Completed questionnaires	I	🔴						🔴						
	II	🔴	●		●	🔴	●		🔴	●	🔴	●		🔴 ●
	III	🔴	●	●	●	🔴	●	●		🔴	●	🔴	●		
	IV	🔴	●	●		🔴	●	●	🔴 ●			🔴	●	🔴	●
Respondents reporting participation in FP in ≥2 questionnaires		31	4	1		3	1		3		2		2		1
Eligible for testing of hypothesis 2		36				4			3		2		2		1
Eligible for testing of hypothesis 2 (total)		**48**												

Note:
● = Completed questionnaire
🔴 = Reported participation in FP

Table 13. Paired assessments per questionnaire combination eligible for testing of hypothesis 2

Combination of questionnaires	Paired assessments (n)
QII + QIII	37
QIII + QIV	41
QII + QIV	38

In all three questionnaires, an increase of the perceived ability to act was reported. The estimated increase was higher in QIII, that is, after the workshop series, than in QII, that is, during the workshop series. Thereafter, the increase remained stable throughout QIV. The number of reported occasions involving a moral dilemma when the FP participants' way of acting corresponded more to their own moral beliefs than before the intervention, was higher after the workshop series (QIII) than during the workshop series (QII).

44

6.3.3 Reliability

Estimating the internal consistency by testing the two questions included in the testing of hypothesis 1 (questions 1 and 3, Table 8) was not considered useful, as they assess different experiences. According to the evaluation of the internal consistency of the variables capturing staff's perceived ability to act according to their own beliefs in situations with a moral dilemma (hypothesis 2), assessing an increase in the ability to act (question 5, Table 8), and the question, assessing the degree of acting more according to staff's own beliefs (question 8, Table 8), a good internal consistency can be assumed (Crohnbach's α ranging from 0.81 to 0.94).

6.4 Study IV

Analysis of the interviews with CCA resulted in four categories:

- Challenging taking-for-grantedness in a safe environment;

- Activating sensorial perceptions and emotional reactions;

- Recognizing the complexity of interactions and acting non-habitually;

- Realizing and balancing one's power to act.

These are linked together in the core category of "developing response ability." This core category connects processes and conditions related to acquiring the ability to respond adequately in situations where AHC occurs, with the understanding of the third person's potential to act in a situation that implies a power imbalance in favor of the abusive person. FP was experienced as a possibility to combine theory and practice and to try to act differently to the way one was used to. It also allowed the participants to express themselves both verbally and bodily in interactions and to reflect on their own and others' verbal and body language. Moreover, during FP, they had time to think about and try out forms of interaction that support the patient. The simulated reality of FP offers a platform in which ethical learning is realized by providing a safe space, suspending constricting structural conditions such as hierarchies and lack of time, fostering moral imagination allowing creativity in developing and trying out a variety of acting alternatives, and reflecting upon the observed and experienced situation.

7 Discussion

This thesis evolved from the disturbing insight that a considerable number of patients experience AHC during their lifetime. Suffering from AHC may lead to a loss of confidence in health care, with the risk of aggravating certain conditions when patients delay or avoid contact with the health care system (97). Not to do harm to patients has been described as the first principle of medicine (42), which can be traced back to Hippocratic writings and has influenced ethical guidelines for health care professionals (35, 98). The assumption that AHC is irreconcilable with the principle of non-maleficence motivated two efforts: 1) to explore how ethical guidelines relate to AHC and how health care staff perceive and relate to AHC, and 2) to explore a possible way to counteract AHC. While the results of every study presented in this thesis must be placed in their specific context, which is discussed in the respective papers, the studies are also related to each other. To illuminate the coherence in this discussion, I will first discuss studies I and II, which explore the professions' and professionals' positions towards AHC and related factors, and will then discuss studies III and IV, which focus on exploration of the applied method, FP. Finally, I will integrate the results of the four studies in discussing what can be learned from them and how this knowledge can contribute to staff's recognition of and action against AHC.

7.1 How do the studies contribute to the understanding of AHC? The exploratory studies

It can be assumed that staff's motivation to act and their way of acting when involved in (potentially) abusive situations are influenced by the way they understand and appraise what is happening. In study II, in which staff were interviewed about their perception of AHC, the character of the results was twofold. On the one hand, the results give a picture of staff knowing about AHC as an occurrence that does not correspond with what is understood as appropriate behavior in health care. On the other, the results suggest that staff members are reluctant to define AHC as being the staff's responsibility. The informants' way of reflecting on AHC at a more general level, with few accounts of personal experience, gave a detached impression, as if AHC were something that was known to happen somewhere else. Before the study was conducted, the research team assumed that the experience of AHC would imply an inner conflict as health care staff might feel distressed by not knowing how to act in

situations when it occurs. Therefore, it was unexpected that the informants did not express that they had experienced an inner conflict in this context. At the same time, the staff displayed a defensive position, relating AHC back to the side of the patient, in other words, highlighting patients with higher vulnerability and shifting the focus to the abuse of staff. There are a number of conceivable explanations for the results that were classified into the categories of "ethical failure" and "staff members avoid responsibility," which formed the core category of "ethical lapses". Not recognizing AHC, not wanting to recognize AHC, or recognizing AHC as collateral damage of medical procedures can be considered. Moreover, questions of social desirability or loyalty towards the clinic[9] are possible reasons for this finding, and a culture of keeping quiet about things like AHC could also have contributed. If staff had experienced distress in situations of AHC, the reasons for not expressing it in the interviews clearly dominated over all other considerations.

The substantive codes grouped into the category "staff members avoid responsibility" point at a problem related to the difficulty of delimiting AHC from a staff perspective, that is, the aspect of thoughtlessness. Causing a patient to suffer AHC by being thoughtless can be understood in different ways. It can be understood as the failure to recognize AHC, which may be a matter of not being aware of the patient's reactions or expressions, or it can be an inability to understand when the patient's dignity, in the sense of the dignity of identity (24), is violated. It can be assumed that both the awareness of AHC and the understanding of the patient's dignity can be learned by individual staff members or acquired through different forms of training. In contrast, thoughtlessness in the sense of distraction or inattentiveness gives rise to the question of whether it is realistic to demand a continuously high degree of attentiveness and awareness from an individual health care professional in any health care situation in order to avoid the emergence of situations that can be experienced as abusive by the patient.

The second study is linked to the first study that examined ethical guidelines for health care professionals, as two aspects from the results discussed above were included in the analytical framework, namely, the need to adopt the patient's perspective and the rejection of responsibility for AHC. Ethical guidelines combine many functions and, even though they may not have a direct impact on health care professionals' actions, they can be considered as documents that give an outline of how professionals are expected to relate to their patients,

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[9] Prior to participation in the project for this thesis, the clinic had been awarded a national prize for its efforts in improving the quality of care. As such, staff members may not have wanted to discredit the clinic.

their co-workers, and to the interests of the general public (99). While the issues in the analytical framework that was used in the first study to explore ethical guidelines in relation to AHC can be understood as issues that may be important for a number of other questions besides AHC, not one of the sets of guidelines analyzed took a position on all the aspects included in the analytical framework. Whereas the ethical guidelines differed concerning the gaps that could be identified, two issues in particular were lacking from all but two sets of guidelines. The issues only addressed in one specific set of guidelines each are *the possibility of a patient's experience of violence*[10], an issue that could only be found in one of the sets of guidelines of The FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health (89), and the issue of *considering power imbalances within health care* (between health care professionals), which is only addressed by the International Confederation of Midwives (ICM) (86). Interestingly, these two issues that are most often missing are related to social questions and structural inequalities. Empirical research indicates that a patient's earlier experience of violence is related to their experience of AHC (93). However, does this mean that this issue should be addressed in ethical guidelines? Is it maybe self-evident that all staff know that the experience of violence is a major risk factor in public health (100, 101), and thus automatically consider it as a factor that can influence the clinical encounter, so that the possibility of a patient's earlier exposure to violence does not need to be addressed in ethical guidelines? Seen through the lens of the study's findings, ethical guidelines give an impression of a kind of tunnel vision, making the social context of patient as well as physician appear marginal. Even the more obvious aspect of power imbalances between professionals is not addressed in ethical guidelines. Power imbalances between professionals influence staff's interactions and thus professionals' ways and possibilities of acting. Hierarchical structures can limit the health care staff's scope of action, which has an impact on staff's awareness of AHC (84). They may also provide staff members with the possibility of absolving themselves of responsibility for certain actions (102). While ethical guidelines are not all-embracing concerning ethics in medicine, they have been described as a compass that may give professionals direction for their actions (99, 103). In terms of AHC, the question is how health care staff find their direction if the compass does not function.

Therefore, for approaching AHC, an important aspect that is revealed by the results of the interviews with staff in the second study, and that is missing in most of the ethical guidelines, is the understanding of a shared responsibility, which acknowledges that not everybody can

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[10]Here as victims of abuse or violence.

be aware and alert all the time in every situation, but that a situation does not need to become a painful experience for patients when co-workers respond and act. According to the view of medical practice as a striving for the good of the patient, this implies that everybody involved in the situation acts towards this goal. Displacement, fragmentation, and rejection of responsibility have been pointed out as mechanisms that can facilitate harmful or abusive behavior (30, 44, 45). In health care, this is especially relevant as health care professionals' activities have an effect on the wellbeing of others.

Summing up the results of the two first studies of this thesis, it is suggested that, with regard to AHC, there are blind spots in ethical guidelines for health care professionals, as well as in health care professionals' perceptions. Addressing structural issues might not be understood as an obvious task for types of documents like ethical guidelines, but given the role that has been ascribed to ethical guidelines for the education and socialization of health care professionals (99, 103, 104), it might be worthwhile reconsidering this. In neither of the studies was the understanding of a way to relate to each other that emphasizes shared responsibility for the patient and for one another in health care salient.

7.2   How does FP address aspects that are relevant to AHC?
The evaluative studies

The aim of the last two studies of this thesis was to obtain deeper knowledge about the application of FP as a possible method to approach AHC. The qualitative exploration of participants' descriptions and reflections of FP allowed discussion of FP as a process that can affect participants differently and of what FP effectuated according to the participants. It also provided insights about the conditions under which these processes take place. Together with the knowledge from the quantitative study, these insights can be used for appraisal of the future applicability of FP.

7.2.1   Exploring situations where AHC occurs

In the participants' descriptions, FP appears to be operating on different levels. One level concerns the body and the senses, one level is where emotions, memories, and intuitions are involved, and one level is where experiences are processed intellectually, reflected upon, and

understood. Interviewees described the vicarious experience of FP as a powerful one in the sense that a patient's vulnerability and the consequences of different ways of interacting became tangible. As one participant put it:

> *"… just to illustrate ah abuse or emotions and such… just… this, well, this is so **physical**, so **powerful**, that… if you **do so** or **place yourself there** or **lay your arm** on mine, well so ah… [refers to a scene that was played out]. It was not only me, but we were many of us in that room who said, yeah, this was **very uncomfortable** the way you held me…"*
> (participant 3, participant's emphasis in bold style).

By providing the participants with opportunities to recognize and reflect upon their emotional reactions and remembered experiences, the participants could make use of them as a means for understanding. Moreover, they could be a motivational force to become active and try out new ways of interacting. In the sense of Glover's understanding of moral resources (45), FP seemed to facilitate responses such as empathy. As FP highlighted the problem's intensity and volatility, AHC could be approached without the obstacles of the "real" world, such as a lack of time, hierarchical structures, and patterns of routine. In this context, it might be important to mention that the course's participants had no working relationship with each other that implied dependence or a hierarchical relationship. Giving the participants the possibility to change perspective continuously, the problem became accessible to all participants, from the inside (as actors) as well as from the outside (as spectators). This simultaneously ensured that a new artificial reality was created with new situational forces that the participants could get trapped in[11]. Thus, the participants could preserve and develop their capacity to act, without having to take a position of detached objectivity. At the same time, the freedom to change perspective and position allowed the participants to question the inalterability of their usual ways of being and acting. According to the results, FP can be understood as a method with transformative potential, which can effect a change of patterns of acting. The participants described increased attentiveness, by which FP may facilitate a deepened understanding of the particular situation from the patient's perspective and motivate the participants to act according to that understanding and not according to routine or convenience.

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[11] Cf. Zimbardo's description of his own transformation during the Stanford Prison Experiment, where he himself did not notice how he slid from the role of the researcher into the role of the director of the "prison." In spite of the obvious artificiality of the entire setting, the situational forces had an unabated impact on all who were involved (30).

FP provides an important opportunity to grapple with AHC, which is so difficult to delimitate, not by asking, *what is AHC?* or *who committed AHC?*, but *how did we get there?* and *what can we do about it?* Boal emphasizes that depicting a situation in the moment when it cannot be changed anymore is of no use in Forum Theater (58). However, Forum Theater, and probably FP that is derived from it, provides the possibility to explore what could have been done before the situation escalated. In a way, FP is not a method that is goal-oriented, but focuses on the process of *how did we get there?* Thus, in spite of the attractiveness that can be seen in the possibility of finding a solution to a dilemma together, it is according to Boal more important to evoke a debate, not to find solutions (58). The focus is also not on finding the one who is "guilty." Therefore, the objection of "we are being abused, too," can be approached by asking *what can we do about it without becoming abusive ourselves?,* instead of approaching AHC as a question of guilt over a failed interaction.

7.2.2 Focus on the patient

The complexity of the situation and the ambiguity of acting "correctly" are revealed in FP. At the same time, FP enables the participants to work out ways to respond that may prevent or decrease the patient's suffering from AHC. The results of the qualitative study of FP may give rise to a discussion of whether the vicarious experience that is provided by FP can approximate reality closer than other forms of learning, such as narratives or other forms of theater, as it involves not only the imagination but also the body, evoking bodily sensations and reactions as well as emotions and memories. The professional's own experience may have an important role for creating an interaction with the patient that is not perceived as abusive by him or her. For example, a study by Roberts et al. indicates that resident physicians' own experience of illness was related to their compassion towards their patients (105). Obtaining an impression of a patient's situation by experiencing it in FP might thus also contribute to the health care staff's experiential knowledge in this sense. Indirectly, by taking the experienced interactions and the reactions of the patients into FP, staff can learn from the patients themselves. At the same time, FP reveals power relations and can enable participants to understand why certain forms of action should be avoided, why they are not effective, or why they cause or alleviate suffering.

7.2.3 Making disempowerment visible

In the results of study IV, the participants' exploration and understanding of power aspects appeared to be at the interface between FP and the real world. It implied the experience of being powerless, understanding verbal and non-verbal expressions of power, and recognizing the power to act as a bystander or witness. The variability and changeability of power distributions in situations were expressed by participants as being an important insight. In this context, the words of Boal and Freire, *oppression*, *oppressor*, and *oppressed* (54, 56), do not appear to be ideal. While it is important to identify the power distributions in a staged or real situation, the denotation of an oppressor could be counterproductive if it is understood as the character of a person. Using this connotation in a static and inflexible way may lead to a relapse to addressing AHC as a question of individual fault and guilt.

An unequal distribution of power is inherent in health care. In encounters between professionals and patients, the most obvious reasons for this are the differences in medical knowledge and in resources to free the patient from her suffering caused by disease or trauma, as well as the position of the patient as the one who is seeking help from the health care professional, who can potentially provide or withhold it. It has been pointed out that, while an asymmetry in the doctor-patient relationship can be considered as inevitable, this does not mean that this relationship is dysfunctional (106) or imbalanced (107). Among others, Goodrich and Wang have emphasized that simply replacing the model of a paternalistic relationship between doctor and patient with a contract model does not automatically imply that the patient has become empowered (108). By considering that the redressing of power imbalances is synonymous with shared decision-making, other aspects that add to the physician's power are neglected, such as class, gender, race, age, and language (108). Besides becoming aware of these aspects as a caregiver, the patient's perspective should be actively pursued to redress the power imbalance in the clinical encounter. Taking a critical stance to the popular phrases of autonomy and empowerment, Scott argues that true empowerment of the patient is not possible when retaining a practitioner's perspective in a way that prevents the practitioner from perceiving the patient's perspective and her vulnerability (109). Moreover, Scott points at the disempowering effect of the structures of care delivery that is added to the disempowering effect of illness itself. Exploring the question of why women give their consent to surgery that they actually do not want to undergo, Dixon-Woods et al. point to the reduction of women's capability to act in the structural actualities of the hospital. There, their decisions and actions become influenced, if

not dominated, by tacit rules of expected conduct, while at the same time, autonomy and shared decision-making give the appearance of being preserved (110). In the context of AHC, Brüggemann and Swahnberg have identified structural conditions as factors contributing to AHC, pointing out that the way health care is organized can be experienced as abusive by making patients feel completely powerless (111). Failing to understand the disabling effect that coming to an unfamiliar, controlled environment can have on an otherwise competent person and not actively giving the patient the opportunity to raise their concerns and their hopes are given as examples of disempowerment in Scott's article (109). These processes of disempowerment are invisible as they are built into routines and procedures in health, but were made visible in FP. A participant of the FP course reflected:

> *"And again… this… that we do not insist on this power as staff… that this is our arena, but that we are humble before this encounter with the patient [low voice]. And this is a matter of principle".* (participant 2)

Therefore, while power asymmetry is inherent to the clinical encounter, this does not imply that the encounter must lead to a power imbalance (112). Trying to redress power imbalances requires that the invisible mechanisms of disempowerment become visible.

7.2.4 Empowering the bystander

Findings in the literature support the results of study IV, namely, that FP is applicable in the context of health care (64-68, 113-116), and also with the specific aim of approaching interactions that imply forms of abuse In fact, techniques based on Boal's methods have also been applied to approach the problem of bullying and interpersonal violence, where the focus was on the empowerment of bystanders (117-119). Integration of what can be found in the literature with the results of the studies on FP that have been discussed so far indicates that FP is an appropriate way to address AHC. The results of study III also suggest that participation in FP based on an educational workshop program increases the self-reported ability to act more according to what staff perceive to be morally adequate in a particular situation. One year after the end of the workshop series, staff members who had participated in FP still reported an increase in their ability to act in situations that they experienced as moral dilemmas, even if the increase was not as high as directly after the intervention. Additionally, the participants in FP workshops reported having experienced more situations involving moral dilemmas when they acted more according to their own moral beliefs. The

picture suggested by the results of study IV, namely, that FP facilitates a shift towards a patient perspective, is supported by Swahnberg and Wijma's study, which was based on interviews with staff from the target clinic before and after a workshop series (120). It showed that FP participants expressed an increased awareness of AHC and a greater willingness to acknowledge AHC and to take on responsibility to act in order to stop AHC. However, in study III, an increased awareness, expressed as a greater number of cases of AHC reported in the questionnaires, could be shown neither for the FP participants nor for the entire staff, for which there may be several reasons, as discussed below.

Therefore, while it can be helpful for health care staff to be able to resort to ethical guidelines or other forms of ethical expertise so as not to lose a focus on the goal of medical practice, which is in my view the good of the patient, as described earlier, it is also necessary for staff to acquire the ability to pursue this goal. Among a number of conceivable strategies to train these abilities, FP may be considered as one that takes into account structural aspects, such as power imbalances, and situational factors, such as lack of time, stress, and distraction. These can impede the ability to act according to what is perceived to be appropriate in the clinical encounter. Thus, FP integrates a factor that does not seem to receive much attention in ethical guidelines, namely, the shared responsibility for the patient, and the necessity to create an environment in health care that facilitates that health care staff's activities being directed to the good of the patient.

7.2.5 Difficulties and practical aspects

While study III as well the findings by Swahnberg and Wijma (120) support the application of FP in the context of AHC, the results of the quantitative study are not as supportive. Instead, the study reveals some problems that are relevant for the use of FP clinically. Firstly, the intervention probably did not reach those who do not recognize AHC or do not consider AHC as a problem that should be addressed in a time-consuming workshop. Secondly, the involvement of half of the staff members in FP did not yield a clear change in the entire clinic that was measurable using the applied methods. Thirdly, the intervention did not succeed in involving those who are at the lower end of the hierarchy in health care, such as auxiliary nurses and secretaries. While the secretaries' contacts with patients are limited, auxiliary nurses are, owing to their tasks, most likely to be in positions where they witness AHC.

Juxtaposing the qualitatively assessed benefits from FP to the disadvantages that may be ascribed to the implementation of FP as an educational option, can the conclusion be drawn that conducting FP as mandatory in-service training and reassessing it would be more promising? In addition, would this be justifiable? Comparable to the frequent application of practical training in the form of simulations and repetitions, providing health care staff with the ability to sustain their technical skills, it might be similarly worthwhile for health care staff to develop and maintain their skill at interacting with patients, basically for the same reason: not to cause harm by acting unprofessionally.

Interactive theater methods imply becoming active and exposed on a stage. Moreover, theater involves producing a way of being that is different from what one usually chooses to express. In "The Rainbow of Desire," Boal illustrates how an actor adopts the traits of the character she will play, an idea that may cause unease:

> *"Their 'personalities' [what a person appears to be], a picture of health and sanity, go looking in their 'person' [the potential for being that somebody has inside] for sick people and demons – the dramatis personae or 'personnages' (French) – in the hope that, once the curtain has fallen, they will be able to get them back into their cages."* (121, page 37).

That unease about role-playing could be found even among those who participated was mentioned in a report by Nilsson (one of the hospital's development managers) commissioned by the head of the department of the women's clinic (122). In this report, it is also underlined that FP participants experienced the workshops with an English-speaking leader as difficult because of the language. If this aspect was more of an impediment for those participants, who refrained from participating in FP, especially auxiliary nurses and secretaries, remains unclear. Nilsson's report, however, does not suggest that role-playing was a major problem for staff, in spite of the described challenges implied. Another reason why proportionally fewer auxiliary nurses were among the participants of FP can be the fact that the workshop groups were mixed groups, namely, in a workshop group, all professions could be represented. Auxiliary nurses may thus have chosen to refrain from participating because they wanted to avoid confrontations with superordinate staff during FP or assumed that difficulties or conflicts may arise after FP. With regard to the participants in Forum Theater, Boal states that it is important that the groups are homogeneous, namely, that they

share the same experience of oppression (58). This might be important for FP as well and is worthwhile considering when applying FP in a health care context.

Integration of the results of the studies on FP for this thesis with Swahnberg and Wijma's findings (120) and Nilsson's report (122) supports the assumption that FP is a safe method when the workshop sessions are accompanied by a skilful facilitator (joker). However, it is debatable whether conducting FP as mandatory training is an appropriate way to introduce it as a method in health care. As the implicit aim of FP is to counteract power imbalances, this aim could be undermined and thus distort Boal's concept of using theater to develop bottom-up strategies to counteract structural enforcements (56). FP would run the risk of being ineffective or counter-productive. Then again if FP is understood as a tool to develop ways to respond and to become active in situations that can be perceived as AHC by patients, FP can be useful for staff. A presupposition for the use of this tool seems to be the understanding that AHC exists as a problem that is not an individual problem but a problem that is shared by all staff. Moreover, motivation and openness are needed to accept a method that demands actively becoming involved physically, emotionally, and intellectually. While nobody should be forced to participate in FP, it can be considered as an obligatory issue of professionalism to implement educational measurements that improve the awareness of AHC, the motivation to counteract it, and to provide alternative tools to FP. This would also make it possible to improve measurements for evaluation and to compare the different educational methods.

However, being professional in interactions with patients can be difficult without an environment that allows and sustains it (123). Power imbalances, tacit norms, and rules have to become transparent in order to allow professionals to acquire the ability to overcome these obstacles, to act in a way that favors the patient's perspective, and to facilitate efforts to counteract AHC. By giving health care staff a choice, it is possible to manage the balancing act between implementing ethical learning methods and avoiding the perpetuation of oppressive structures that are probably counterproductive for ethical learning. Situational factors and the need to integrate these factors into ethical learning seem to be important in order to enable health care staff to find ways to prevent or counteract AHC.

Moreover, as health care professionals inevitably serve as role models for students and trainees, implementing a method to help staff to counteract AHC is absolutely indispensable if attitudes and behaviors that facilitate AHC are not to be perpetuated. Looking at AHC through the lens of ethical learning might raise the question of why ethical learning does not

receive more attention in the everyday work of health care professionals. It has been pointed out that practitioners become role models concerning ethics in health care whether they are aware of it or not (53). Concerning everyday ethical issues such as professional-patient interactions, the everyday work of the practitioner is an important opportunity for teaching and learning (124). Thus, a virtuous professional can play a more important role for a student's development of virtuousness than a formally assigned teacher (49). However, while the importance of the professional as a role model has been repeatedly emphasized, it is not as obvious how all staff from all professions can be enabled to live up to this important task. In FP, watching others' acting can also provide inspiration to adopt this way of acting in a similar situation in real life. In this way, FP can provide a number of role models, which may be an advantage of a heterogeneous group of FP participants, and foster an attitude of learning from each other, irrespective of people's positions at work or levels of experience.

In this context, the following aspects can be considered to be important for developing ways to counteract AHC that have been addressed by FP: 1) enabling staff to adopt the patient's perspective, facilitating the motivation to become active in favor of the patient when being in the position of an observer or bystander, 2) stimulating imagination and creativity to find new forms of acting and to be enabled to overcome structural obstacles that may impede staff from acting in support of the patient, 3) providing role models, and 4) involving everybody who observes a situation and fostering a sense of shared responsibility among health care staff.

7.3 Limitations

7.3.1 General limitations

Conceptual clarity

In this thesis and the studies on which it is based, a number of concepts are integrated that can be understood in different ways depending on the context and user. In this way, the term "moral dilemma," for example, has been used in the questionnaires to describe staff's experience of distress when not knowing how to act in a situation in which AHC occurs. The term had been introduced in the information meetings and during the FP workshops. Still it is

possible that staff can have understood the term in a different way. During the period when the studies of this thesis were conducted, it became more and more obvious that many terms related to AHC that were used during the project were multifaceted. In addition to that, different terms were used for FP, i.e. Forum Theater, Moral Agency Theater and FP, implying a risk of confusion among staff and compromising the respectability of the intervention. To make issues like AHC communicable, it is important to create a range of terminology that can be understood by practitioners without having to abandon subtlety. Future research on AHC must consider the equivocation of terms that are used ubiquitously.

Attrition

In spite of the efforts to ensure confidentiality of the questionnaires by mail distribution and coding, the sizes of all professional groups except the group of midwives were so small that employees could assume that they would be identifiable by the research team using the combination of profession, sex, and age. This applies especially to the group that is most inhomogeneous concerning age and sex, namely, the physicians.

The length of the questionnaires is also a factor that might have contributed to the non-response rates. However, the reduction of questions in the last questionnaire (QIV), did not have an impact on its response rate. The different response patterns during the study period combined with different patterns of participation in FP resulted also in a reduced number of paired assessments that could be used to analyze possible changes.

Selection

The sample in the quantitative study was neither randomized nor controlled. Randomization was not an option as it would have resulted in an even smaller subsample of FP participants. The use of non-participants as controls was deemed inappropriate because of the risk for erroneous inference due to the self-selection of the sample of FP participants. The average age of the sample was 50 years, the FP participants were predominantly female, and, of the professional groups, the midwives proved to be largest. An additional risk for selection is the non-response to questionnaires. The need for paired assessments in order to find possible changes made it necessary to create a number of subsamples for the questionnaire combination to be tested, which explains why the number of respondents that were actually tested per questionnaire combination was considerably decreased. This means that only about half of the entire group of respondents could be tested for hypothesis 1, and of the FP

participants, who had completed at least one questionnaire, about two-thirds could be tested for hypothesis 2. Thus, the results should be considered with caution.

7.3.2 Qualitative studies

The first study combines both a literature search and the development and application of an analytical framework. Disclosure of the researchers' decision-making process and description of all steps in the study procedure make it possible to judge this procedure critically and to repeat the study. That the application of the framework was initially carried out by two researchers independently made it possible to assess the degree of agreement and thus to confirm the congruence between the researchers. The analytical framework is based on empirical studies that were accessible when the study was conducted. Using the results from a very limited number of researchers and from our own research can be seen as problematic as it implies a risk for bias. Being aware of this risk, it was a deliberate choice only to include literature that was empirically grounded. The use of other search terms might have provided the study with more data for the analytical framework and it is more likely that the framework would have become enhanced rather than diminished. Certainly, more data from different researchers would also have enhanced the study's trustworthiness. Thus, it can be expected that studies aiming at analyzing ethical guidelines according to an analytical framework based on studies that are accessible today will look different due to the changing of the body of knowledge on AHC in the literature.

Owing to the variety of philosophical underpinnings, concepts, and procedures, the criteria for ensuring the quality of qualitative research are different from the criteria in quantitative research. According to the framework of Whittemore et al., which is based on different systems of criteria to evaluate qualitative research, the primary criteria for validity[12] include credibility, authenticity, criticality, and integrity (125). To ensure credibility, the adherence to structured coding procedures was emphasized and the findings discussed in regard to their context. By referring to the participants' own descriptions, the aspect of authenticity implying a reflection of the participants' perspective was regarded. Criticality was ensured by the procedures of reflection, which included writing down ideas and feelings after the interview,

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[12] Whittemore et al. use the term "validity" even within qualitative research. As validity is associated with research within a positivistic paradigm, the use of this term is not uncontroversial within qualitative research, where it is not unusual to use the term "trustworthiness" instead (125).

as well as discussing and clarifying emotional aspects and difficulties with other peer researchers. This ongoing process of reflection could help to identify unclear thoughts, feelings, or impressions that might have led to bias. The reflective work was also a source of ideas and understandings for theory development during memo-writing. The constant comparisons of data during the analytical process ensured the grounding of the interpretation in the data, enhancing the studies' integrity. Secondary criteria of the framework provided by Whittemore et al., providing supplementary aspects of validity, include among others thoroughness and congruence (125). As a technique from Grounded Theory, the method of constant comparative analysis as used in studies II and IV implies the principle of purposive sampling and the assessment of saturation (82). While this procedure was followed in study II, ensuring heterogeneity in the sample, purposive sampling was not considered useful in study IV because of the limited number of participants in the FP course. In study IV, the participants were highly motivated, had extensive work experience, were interested in ethical issues, and had a mean age of 55,5 years. More important is their own engagement in ethical discussions and training activities, which may imply a greater interest and enthusiasm for the applied method. While their experiences correspond with findings in studies that have applied interactive role-play in health care, ideally, participants of FP projects from different health care institutions should be studied in order to probe the understanding obtained from study IV. The studies are coherent insofar as they provide information on their context and conditions. As denoted in the methodological considerations, the appraisal of the findings should be based on the probability that the results could also be found in similar contexts, and not on universal generalizability. In spite of the fact that the samples in both qualitative studies are highly selected groups, the findings seem not to be so exceptional that they must be assumed to be exclusive to the context of the study.

7.3.3   Quantitative study

When study III was planned, the lack of validated measurement procedures to assess the impact of FP on staff called for the development of new measures. Concerning the validity of the operationalization of staff's awareness and staff's ability to act in situations of AHC, face validity was assessed. Moreover the development of the questionnaires was based on interviews at the target clinic, earlier research on AHC (4, 7, 8, 10, 92), literature from other research fields on factors that can be assumed to facilitate AHC (27, 45), and first-hand knowledge of Boal's interactive theater methods (56, 58, 121). However the design of the

study makes it susceptible to threats to internal validity. Being conducted in an open system, other influences on FP participants and non-participants cannot be controlled. Also the questionnaire could have had an influence on staff's awareness of AHC. Thus the number of occasions where staff had heard stories about AHC or had recognized AHC could have been even lower before the study. Many questions in the questionnaires required answers based on concrete experiences. Even if there is risk for recall bias, it can be assumed that staff would remember *if* they had heard stories about AHC or experienced occurrences of AHC or not. To avoid misunderstandings, a description of what was meant by AHC was given together with all questions that were related to this concept. Questions asking about the perceived ability to act according to the staff's own beliefs when involved in a moral dilemma were not complemented with an additional explanation. Owing to the novelty character of the project and the unique opportunity for a long-term follow-up, the development of the questionnaires was influenced by the attempt to capture several aspects of AHC and FP. At the same time, the complexity and length of both the particular questions and the questionnaires had to be reduced in order to avoid increases in non-responses to particular items and to the whole questionnaire. Thus, the number of questions relevant to study III is limited.

In spite of the attempt to quantify the effects of FP, it can be discussed whether the results of study III can be used to make a proposition about the effectiveness of the intervention regarding the actual impact on individual FP participants. The weaknesses of the study design are based partly on conceptual difficulties. According to the outline given in the introduction, AHC can be both an experience that is generated by the patient, which a caregiver may or may not understand, and a violation of the patient's dignity of identity, which the patient may or may not perceive (and this applies even to the caregiver). If AHC is a subjective experience, would other alternatives of evaluating the effect of the intervention, such as the assessment of change in the number of complaints by patients to the head of the department or a patient representative, be a more reliable measure of the effectiveness of FP? In a study on female patients, Brüggemann et al. have shown that many of the patients who had experienced a transgression of ethical principles in health care as wrong or abusive did not talk about these experiences with health care staff (126). Thus, a low number of complaints concerning AHC would not be a reliable measurement to assess the impact of FP on health care staff.

The consideration that staff would perceive AHC either in the form of realizing what the patient was experiencing or in the form of understanding an occurrence as a violation of a patient's dignity of identity was the premise for hypothesis 1 in study III. It was assumed that the effectiveness would be seen in an initial rise of reported cases due to an increased awareness, and in the long run, the number of reported occurrences of AHC would decrease. This presupposes that AHC occurs at the target clinic, which is likely according to a study of its prevalence by Swahnberg et al. (9). Implicit in this reasoning is also that everybody in the clinic participates in the intervention, which is irreconcilable with the ethical requirement of voluntariness that applies to research on humans. This voluntariness instead implies that the group of FP participants has been self-selected. The results indicate that there are differences between the groups of FP participants and non-participants concerning the proportion of groups of professionals. Moreover, in the first questionnaire – before the beginning of the workshop series – the group of FP participants reported more often that they had heard of cases of AHC. Even though these results must be considered carefully, they may indicate a difference in the perception of AHC. The motivation to participate may be related to this.

8 Conclusion

The question of how it is possible for health care professionals to cause unnecessary suffering when it is actually their task to alleviate patients' suffering was the starting point for this thesis. This work ranged from giving AHC an outline associated with ethical considerations, to suggesting and testing a practical approach to counteract AHC. The analysis of ethical guidelines for health care professionals showed that most of them fail to address several issues related to AHC; in particular, they do not emphasize the influence of structural and power-related aspects on health care encounters. Are staff aware of these aspects? In interviews before the workshop series had started, staff chose to distance themselves from AHC, placing it rather outside their experience, and rejecting responsibility for such incidents. FP was found to be a method to bring AHC closer to the FP participants by placing them in such situations. By experiencing AHC situations from different perspectives, involving the body, the senses, and the mind, FP participants came to understand their power and responsibility to act when in a situation involving AHC, and they could develop and train their ability to act. In this thesis, it has also been shown that the perception of an improved ability to act emerges during FP and persists over time. Concerning AHC, FP seems to be an effective method to counteract AHC for health care staff who are willing to work with this approach.

On the basis of an understanding of medicine as a moral activity with the good of the patient as its end, for counteracting AHC, it is not only important for staff to know the goal that should guide their actions, but also to become enabled to act. However, training of the ability to act in difficult situations is a matter of being in such situations, which can to a certain degree be simulated in FP, and to reflect and reprocess these situations afterwards. This makes it clear that the support of others, namely, colleagues and co-workers, and cooperation in this learning process are needed. Understanding AHC as a shared problem can motivate joint learning.

The provision of an ethical education in the context of AHC, as an integral part of staff's continuous learning during their working life, could contribute to an increased understanding of the patients' perspective. When the consequences of AHC for patients are being acknowledged and counteracting AHC is seen as a matter of acting professionally, practical training such as FP may become a high priority.

9 Implications for clinical practice

Several factors are important to consider when staff are learning to handle AHC via FP. For example, it is crucial to have a trained facilitator (joker) and an environment where staff can feel safe to act freely. Considerations about how to ensure accessibility must focus on the way that the work of health care professionals is organized, so as to avoid structural obstacles preventing staff from participating in FP. Thus, organizational efforts may contribute to FP becoming an effective and powerful tool for helping staff members to reflect on and learn from difficult situations. Given the power of situational forces, it is however important also to create a work environment that supports attitudes and actions that counteract AHC. According to Boal Forum Theater is intended to transform social structures (58). When applying Forum Theater or FP to health care, it can be assumed that this transformation is more likely to occur when FP is not limited to a small selected group of FP participants. Even if the results of study III suggest that the effects of FP do not wear off after one year, the continuous emergence of new and difficult moral situations for staff demands a method that is applied regularly.

10 Future research

In order to make use of the findings of this thesis in the daily work of a health care professional, it could be useful to find out about some aspects that remained obscure in the studies on which this thesis is based.

Above all, it seems important to develop and refine methods to assess the effects of FP, which could be helpful to improve its impact on staff. For example, the hetero- or homogeneity of the groups in FP workshops might be important in overcoming implicit power imbalances, which could hinder staff members from acting freely in the workshop and from taking full advantage of it. In this sense, it would be interesting to go further and find out how other intersecting factors such as age and gender influence the individuals' possibilities of participating in and making use of FP. To explore these aspects, it might be important to cooperate with researchers in other disciplines, such as sociology, psychology, and pedagogy, and to benefit from their different ways of generating new knowledge that can support patients and health care professionals.

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Appendix

Instruktion

Innan du svarar på en fråga ber vi att du läser hela frågan och alla svarsalternativ. Vissa frågor svarar du på genom att sätta ett kryss för det svar som passar bäst. Ibland ber vi att du själv skall skriva svaret, antingen genom att sätta en ring runt en siffra eller använda egna ord. Skriv tydligt inom markeringen med **kulspetspenna**.
Om du skulle skriva fel kan du stryka över det!
Om det finns för lite utrymme för dina svar kan du använda ett separat papper.
Använd gärna utrymmet på sista sidan för extra kommentarer.

I ALLMÄNT

1. Födelseår ☐1 ☐9 ☐ ☐

2. Kön
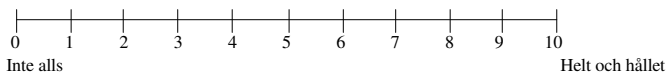☐ Kvinna
☐ Man

3. Yrke
☐ Barnmorska
☐ BUSK
☐ Gynekolog
☐ Läkare
☐ Sekreterare/administratör
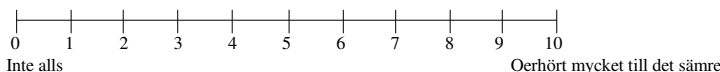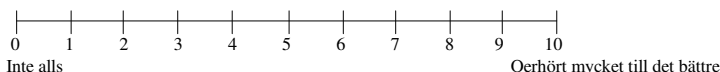
4. Har du blivit intervjuad av någon i forskargruppen?

☐ Nej
☐ Ja, en gång, av: ☐ Katarina Swahnberg ☐ Barbro Wijma ☐ Anke Zbikowski ☐ Anette Nilsson
☐ Ja, två gånger, av: ☐ Katarina Swahnberg ☐ Barbro Wijma ☐ Anke Zbikowski ☐ Anette Nilsson
☐ Ja, tre gånger, av: ☐ Katarina Swahnberg ☐ Barbro Wijma ☐ Anke Zbikowski ☐ Anette Nilsson
☐ Ja, fyra gånger, av: ☐ Katarina Swahnberg ☐ Barbro Wijma ☐ Anke Zbikowski ☐ Anette Nilsson

5. Projektet hade som mål att höja personalens medvetenhet om etiska/moraliska konflikter i möten med patienter.

(a) I vilken utsträckning har projektet uppnått detta mål?

```
  |----|----|----|----|----|----|----|----|----|----|
  0    1    2    3    4    5    6    7    8    9    10
Inte alls                                      Helt och hållet
```

(b) Hur har din psykiska hälsa påverkats av att delta i att försöka nå detta mål? (svara gärna på båda skalorna)

```
  |----|----|----|----|----|----|----|----|----|----|
  0    1    2    3    4    5    6    7    8    9    10
Inte alls                              Oerhört mycket till det bättre
```

```
  |----|----|----|----|----|----|----|----|----|----|
  0    1    2    3    4    5    6    7    8    9    10
Inte alls                              Oerhört mycket till det sämre
```

6. Projektet syftade också till att ge personalen möjlighet att lära sig alternativa sätt att hantera etiska/moraliska konflikter.

(a) I vilken utsträckning har projektet uppnått detta mål?

```
  |----|----|----|----|----|----|----|----|----|----|
  0    1    2    3    4    5    6    7    8    9    10
Inte alls                                      Helt och hållet
```
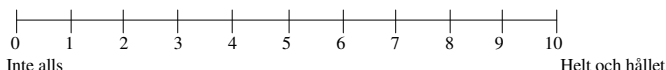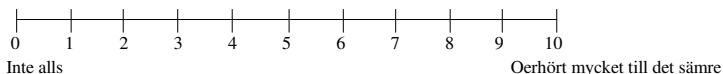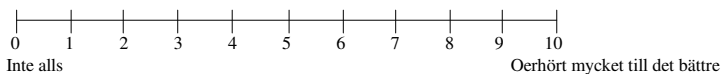
(b) Hur har din psykiska hälsa påverkats av att delta i att försöka nå detta mål? (svara gärna på båda skalorna)

```
 |---|---|---|---|---|---|---|---|---|---|
 0   1   2   3   4   5   6   7   8   9   10
Inte alls                          Oerhört mycket till det bättre
```

```
 |---|---|---|---|---|---|---|---|---|---|
 0   1   2   3   4   5   6   7   8   9   10
Inte alls                          Oerhört mycket till det sämre
```

II MORAL AGENCY THEATRE OCH FORUMTEATER

Med **moraliska dilemman** avser vi i detta formulär vårdsituationer där du upplevt en moralisk konflikt

7. Har du varit med på Moral Agency Theatre (med Susan) på kliniken mellan JAN - JUN 2008?

☐ Nej   ☐ Ja, tre gånger
☐ Ja, en gång ☐ Ja, fyra gånger
☐ Ja, två gånger

8. Har du varit med på Moral Agency Theatre (med Susan) på kliniken mellan SEP 2008 - JAN 2009?

☐ Nej   ☐ Ja, tre gånger
☐ Ja, en gång ☐ Ja, fyra gånger
☐ Ja, två gånger

9. Har du varit med på Forumteater (med Agneta) på kliniken mellan SEP 2008 - JAN 2009?

☐ Nej   ☐ Ja, tre gånger
☐ Ja, en gång ☐ Ja, fyra gånger
☐ Ja, två gånger

Om du svarat "ja" på fråga 7, 8 eller 9 ber vi dig att fylla i fråga 10-15. Om du svarat "nej" ber vi dig att fortsätta med fråga 16.

10. Har du tagit upp ett eget moraliskt dilemma på Moral Agency Theatre eller Forumteater?

☐ Nej
☐ Ja

11. Har du i efterhand tänkt på de moraliska dilemman vi arbetade med?

☐ Nej
☐ Ja, sällan
☐ Ja, ibland
☐ Ja, ofta

12. Beskriv vilka tankar du har haft.

....

....

....

13. Hur tycker du att Moral Agency Theatre och/eller Forumteater påverkat din förmåga att handla så som du tycker är rätt i vårdsituationer med moraliska dilemman? (svara gärna på båda skalorna)

Förmågan har ökat:

```
    0   1   2   3   4   5   6   7   8   9   10
  Inte alls                            I hög grad
```

Förmågan har minskat:

```
    0   1   2   3   4   5   6   7   8   9   10
  Inte alls                            I hög grad
```

14. Har du handlat mer så som du tycker är rätt i vårdsituationer med moraliska dilemman efter det att du deltagit i Moral Agency Theatre och/eller Forumteater?

☐ Nej
☐ Nej, jag har inte upplevt sådana situationer
☐ Ja, en gång
☐ Ja, flera gånger:_____ (ange antal)

15. I vilken grad har du handlat mer så som du tycker är rätt? (Obs: om det hänt mer än en gång: välj det tillfälle du är mest nöjd med)

```
    0   1   2   3   4   5   6   7   8   9   10
  Inte alls                            I hög grad
```
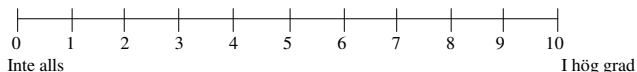
III KRÄNKNINGAR I VÅRDEN

Med **kränkningar i vården** avser vi i detta formulär ett **misslyckat möte** i vården, där patienten eller personalen känner sig **sårad eller förnedrad** av upplevelsen.

Har du upplevt dig kränkt i vården sedan vi skickade ut enkät nr. 2 i maj 2008?

16. Som patient?

☐ Nej
☐ Ja, en gång
☐ Ja, flera gånger:_____ (ange antal)

17. Som personal?

☐ Nej
☐ Ja, en gång
☐ Ja, flera gånger:_____ (ange antal)

18. Har du hört talas om att en patient blivit kränkt i vården sedan vi skickade ut enkät nr. 2 i maj 2008?
(Obs: vi menar inte det som bearbetades under Moral Agency Theatre eller Forumteater)

☐ Nej
☐ Ja, en gång
☐ Ja, flera gånger:_____ (ange antal)

Om du svarat "ja" på fråga 18 ber vi dig att fylla i fråga 19. Tänker du på flera olika händelser ber vi dig att välja den händelse som du tyckte var allvarligast. Om du svarat "nej" ber vi dig att fortsätta med fråga 20.

19. Kan du kort beskriva episoden?

20. Har du varit med om att en patient blivit kränkt i vården sedan vi skickade ut enkät nr. 2 i maj 2008?
(Obs: vi menar inte det som bearbetades under Moral Agency Theatre eller Forumteater)

☐ Nej
☐ Ja, en gång
☐ Ja, flera gånger:_____ (ange antal)

Om du svarat "ja" på fråga 20 ber vi dig att fylla i frågorna 21-32. Tänker du på flera olika händelser ber vi dig välja den händelse som du tyckte var allvarligast. Om du svarat "nej" ber vi dig att fortsätta med fråga 33.
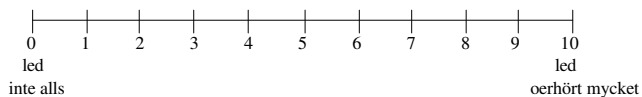
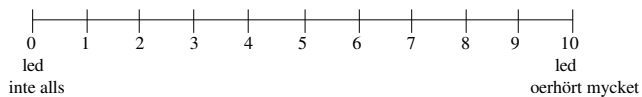**21. Kan du kort beskriva episoden?**

22. Hur skattar du patientens lidande?

```
  0    1    2    3    4    5    6    7    8    9    10
 led                                             led
inte alls                                  oerhört mycket
```

23. Hur kände du igen lidandet?

24. Vad gjorde patienten efteråt?

25. Hur skattar du ditt eget lidande?

```
  0    1    2    3    4    5    6    7    8    9    10
 led                                             led
inte alls                                  oerhört mycket
```

26. Vad gjorde du…
(a) före episoden?

(b) under episoden?

(c) efter episoden?

27. Upplevde du en moralisk konflikt?

☐ Nej
☐ Ja

Om du svarat "ja" på fråga 27 ber vi dig att fylla i fråga 28. Om du svarat "nej" ber vi dig att fortsätta med fråga 29.

28. Vad för konflikt var det? Mellan vilka moraliska krav?

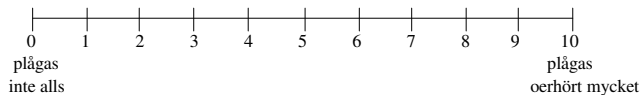**29. Vad tror du var orsaken till att patienten kände sig kränkt?**

30. Tycker du att du gjorde något fel? (Obs: vi menar inte medicinska misstag)

☐ Nej
☐ Ja

31. Tycker du att du bröt mot relevanta etiska koder?

☐ Nej
☐ Ja

32. Hur mycket plågas du nu av episoden?

```
|----|----|----|----|----|----|----|----|----|----|
0    1    2    3    4    5    6    7    8    9    10
```
plågas   plågas
inte alls   oerhört mycket

33. Hur tycker du att din hälsa, allmänt sett, har varit sedan vi skickade ut enkät nr. 2 i maj 2008?

☐ Mycket dålig
☐ Ganska dålig
☐ Ganska god
☐ Mycket god

TILL SIST!
Har du synpunkter på de frågor vi ställt, är vi intresserade av att ta del av dessa. Skriv gärna ned dem nedanför.

Om du har frågor angående studien eller vill diskutera något i anslutning till studien kan du vända dig till
Katarina Swahnberg 013 - 22 31 91, katsw@imk.liu.se

Tack för din medverkan!

EXTRA KOMMENTARER OCH EGNA SYNPUNKTER

14 Papers

Papers

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