# Ethical values in caring encounters from elderly patients' and next of kin´s perspective

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# ORIGINAL PAPERS

This licentiate thesis is based on the following papers, which will be referred to in text by Roman numerals, **I - II:**

**I**    Jonasson L-L, Berterö C, Ethical values in caring encounters in a ward for older

people: View from the older person. (resubmitted)

**II**    Jonasson L-L, Liss P-E, Westerlind B, Berterö C. Ethical values in caring

encounters on a geriatric ward from the next of kin´s perspective:  An interview

study. (accepted 2009 for publication in the International Journal of Nursing

Practice)

# Abstract

The welfare of the elderly population is one of the most important goals of the public health services.  At macro level the Swedish National Board of Health and Welfare state that the premier goal is for elderly people to have dignified and comfortable lives. They should have a life with a sense of value and feel confident. These ethical values which are expressed on macro level or as normative ethics are expected to prevail at micro level. In our study the micro level is the caring encounter between the elderly patient, next of kin and nurses. Ethical values and morals are important aspects that influence the quality of care, videlicet in empiric ethics.

The aim of study (**I**) was to identify and describe the ethical values experienced by the older person in the daily interaction with nurses in a ward for older people during caring encounters. In study (**II**) the aim was to identify and describe the governing ethical values that next of kin experience in interaction with nurses who care for elderly patients at a geriatric clinic. Study (**I**) which was an empirical observational study included follow-up interviews. Twenty-two older people participated voluntarily. In study (**II**) interviews with fourteen next of kin were conducted. In both studies Constant comparative analysis, the core foundation of grounded theory was used.

Five categories; Being addressed, receiving respect, desiring to participate, increasing self-determination and gaining self-confidence formed the basis for the core category in study (**I**): Approaching. Approaching concerns the way people become closer to each other in a physical space .It also includes how people become closer to each other in a dialogue, which involves verbal or bodily communication. Approaching indicates the ethical values that guide nurses in their caring encounters with older people. This ethical value is noted by the older person and has an individual value, as well as leading to improved quality of their care. The older person will be confident and satisfied with the caring encounter if the desired components in the nurse's approaching are exhibited.

Four categories were identified in study (**II**): Receiving, showing respect, facilitating participation and showing professionalism. These categories formed the basis of the core category: "Being amenable", a concept identified in the next of kin's description of the ethical values that they and the elderly patients perceive in the caring encounter.  Being amenable means that the nurses are guided by ethical values; taking into account the elderly patient and next of kin. Nurses who focus on elderly patients' well-being as a final principle will affect next of kin and their experience of this fundamental situation.

## Keywords:

# Sammanfattning

## Bakgrund

Hälso- och sjukvårdslagen framhåller betydelsen av trygghet, integritet och respekt för patienten. Vården ska bedrivas på ett sådant sätt att patienten är delaktig i sin egen vård och behandling. En gemensam värdegrund, en vårdfilosofi, är en nödvändighet för att bedriva god omvårdnad till patienter. Ett väl genomtänkt etiskt förhållningssätt är en förutsättning för vårdandet. Det är upplevelserna som utgör en grund för patienternas och de närståendes bedömning av omvårdnadens värdegrund. Olika patienter/närstående har olika behov och önskemål. Personalens förhållningssätt, etiska värdegrund och moral är viktiga aspekter som påverkar vårdkvaliteten. Sjuksköterskan skall ge omvårdnad som respekterar mänskliga rättigheter och visar hänsyn till människors värderingar, vanor och tro. För att patienten skall få en positiv upplevelse, behöver alla sjuksköterskor göra rätt, visa deltagande, lyssna uppmärksamt, arbeta för förbättring och svara patienten med känslighet. För att öka självaktningen och hopp hos patienten så behövs ett understödjande arbetssätt av vårdpersonalen. Sjuksköterskor är mer än andra hälsoarbetare beroende av en samverkande interaktion med patienten. Det är viktigt hur sjuksköterskan förhåller sig till den äldre och de närstående, bra förhållningssätt ger upplevelse av trygghet. Det är också viktigt att vårdpersonalen kan integrera sociala behov hos patienten tillsammans med medicinska behov. Socialiseringsprocessen är viktig och påverkar beteendet hos både patient, närstående som vårdpersonal. Är sjuksköterskan öppen för att vad den äldre patienten och dennes närstående har att säga, formas en bas av partnerskap mellan dem. Det finns väldigt få studier som identifierar den etiska värdegrunden och speciellt inte några studier där det etiska värdegrunden har identifierats ute i verksamheten, såsom den synliggörs för patienter, närstående etc. Det är därför av vikt att identifiera denna etiska värdegrund och utifrån denna kunskap kunna omsätta teori/kunskap till praktisk handling.

Två delstudier ingår i avhandlingen

## Övergripande syfte:

Den äldre patienten och närståendes identifiering och beskrivning av den etiska värdegrund som erfars i interaktionen i omvårdnadsmötet med vårdpersonal på en geriatrisk klinik
De specifika syftena är:
Delstudie (**I**)
 att identifiera och beskriva den etiska värdegrund som erfars av den äldre patienten i den dagliga interaktionen med vårdpersonal på vårdavdelning för äldre
Delstudie (**II**)
 att identifiera och beskriva de närståendes erfarenhet av den etiska värdegrund de möter i interaktionen med vårdpersonal som vårdar den äldre patienten på en geriatrisk klinik

## Metod

I studie 1-2 används metoden enligt Grounded theory, då den fokuserar på sociala processer och interaktion och avsikten är att generera en avgränsad teori, som förklarar skeendet. I delstudie (**I**) sker datainsamlingen med hjälp av observationer och uppföljande intervjuer med den äldre patienten. De uppföljande intervjuerna förtydligar observationerna och vidimerar eller förkastar de intuitiva tolkningarna. Grounded Theory är en högt strukturerad forskningsmetod för att insamla kvalitativa data och bearbeta dessa data. Datainsamling och

analysarbetet sker parallellt. Analysarbetet sker med hjälp av Constant Comparative Analysis. Datainsamling fortgår tills "mättnad" har uppnåtts i materialet dvs. nytt framkommer i analysen för att kunna identifiera och skapa nya koder eller kategorier. Den sista nivån är att nå en teoretisk nivå, identifiera en teoretisk konstruktion dvs. en Core kategori, som besvarar frågeställningen och förklarar fenomenet som studeras

I Delstudie **(II)** som är en kvalitativ intervjustudie, där de närståendes erfarenhet på den etiska värdegrund de möter i vården identifieras. Det är upplevelserna som utgör en grund för de närståendes bedömning av omvårdnadens värdegrund. Olika erfarenheter, olika behov och önskemål styr bedömningen av vilken värdegrund de som närstående möts av. Grounded Theory och Constant Comparative Analysis används som metod för att bearbeta fakta.

**Resultat**

Resultatet i delstudie (**I**) visar på att den etiska värdegrund och vårdpersonalens moraliska handlingar är viktiga aspekter som påverkar upplevelsen av omvårdnadskvaliteten hos den äldre. Vilken etisk värdegrund som sjuksköterskan har synliggörs när hon/han närmar sig den äldre. Det är viktigt att sjuksköterskan som möter den äldre personen är uppmärksam att närmandet är av stor betydelse för hur den äldre senare deltar i omvårdnadsprocessen. Närmandet påverkar den äldre och den äldre bestämmer om sjuksköterskan kan komma närmare eller inte. Den äldre personen blir trygg och nöjd med omvårdnadsmötet om alla delar av närmandet är så bra som möjligt. Interaktionen mellan sjuksköterskan och den äldre som beror på hur närmandet sker påverkar den äldres upplevelser och reaktioner. Hur sjuksköterskan talar till den äldre, hur den äldre blir visad respekt, upplevelse av delaktighet, får bestämma själv och upplevelsen av trygghet beror på närmandet.

Resultatet i delstudie **(II)** visar på corekategorien " Att vara tillgänglig" . Fyra kategorier identifieras i delstudie **(II);** dessa är det förhållningssätt som sjuksköterskan har, hur visar sjuksköterskan respekt i sina handlingar, erbjudandet av delaktighet och hur visas sjuksköterskans professionalism. Dessa fyra kategorier utgör basen för corekategorien :att vara tillgänglig. Att vara tillgänglig är ett koncept som de närstående beskriver som svar på den etiska värdegrund de möter i omvårdnadsmötet. Att vara tillgänglig menas att sjuksköterskan vägleds av de etiska värderingarna så att de närstående och den äldre bjuds in i omvårdnadsmötet. När sjuksköterskan är tillgänglig påverkas de närstående, därefter blir det en interaktion mellan sjuksköterskan, närstående och den äldre. Denna etiska värdegrund är synlig och har ett individuellt värde för de närstående. Den förnimmelse som följer av när sjuksköterskan är tillgänglig, leder till en upplevelse av god kvalitet på omvårdnaden till den äldre.

**Diskussion**
Den etiska värdegrund som vägleder sjuksköterskan i omvårdnadsmötet synliggörs när sjuksköterskan närmar sig den äldre patienten i enlighet med delstudie (**I**). Dessa värden är viktiga för den äldre och har både ett individuellt värde samt leder till en utveckling av vårdkvaliteten. Det är viktigt att alla sjuksköterskor som arbetar med äldre personer förstår att beroende på hur närmandet sker så har det ett stort värde för den äldre personen. Detta påverkar också hur den äldre senare tar del av omvårdnadsprocessen. "Närmandet" påverkar den äldre att bestämma om de accepterar sjuksköterskans närmande eller inte. Den äldre personen är trygg och tillfredsställd med omvårdnadsmötet om de önskade delarna i sjuksköterskans "närmande" uppvisas. Interaktionen under närmandet påverkar den äldres

upplevelser och reaktioner på hur den äldre upplever hur tilltalet sker, blir visad respekt, detta leder till en önskan att delta, ger ett ökat självbestämmande, som ger en upplevelse av trygghet hos den äldre. Detta sätt att närma sig på gör det möjligt för den äldre personen att uppleva att det var en " varm hand som hjälpte mig". Det finns behov av att realisera dessa etiska värderingar och handlingar i empirin, i sjuksköterskeutbildningar och i all Hälso- och sjukvård.

Vårdpersonalen förväntas vara tillgängliga och analysen av denna delstudie **(II)** bygger upp konceptet utifrån de närståendes beskrivning av den etiska värdegrunden som de möter i omvårdnadsmötet. "Att vara tillgänglig" som har identifierats och beskrivits i denna studie är unik gällande kopplingen till det etiska perspektivet . Tillgänglighet sammanbinds ofta till tidsbegrepp. "Att vara tillgänglig" förenas ur ett vidare perspektiv till kompetens, stöd, förhållningssätt eller interaktion med vårdpersonalen. Ingen av funna artiklar berättar om sambandet mellan: det förhållningssätt som vårdpersonalen har, hur respekt visas i vårdpersonalens handlingar, erbjudandet av delaktighet och upptäckande av vårdpersonalens professionalism. Dessa kategorier har ett samband och har en relation till "att vara tillgänglig" Att vara tillgänglig talar om att vårdpersonalen skall bjuda in de närstående och de äldre. Görs detta så kan de närstående ta en aktiv del i omvårdnaden av den äldre. De känner sig inte utanför beslutsfattandet rörande den äldre. De närstående är sensibla för vårdpersonals distanserade förhållningssätt, och de närståendes upplevelser är att vårdpersonalen ignorerar dem. Detta motverkas om vårdpersonalen är tillgänglig. God kvalitet på omvårdnad är när närstående kan komma till avdelningen på olika tider när det passar dem. Det måste finnas en atmosfär av respekt och öppenhet bland vårdpersonalen, som beror på den etiska värdegrund som finns i personalgruppen. Att vara tillgänglig bekräftar också vårdpersonalens kompetens. Att vara tillgänglig är att vara lyhörd för vad närstående och den äldre har att säga, öppna upp för delaktighet i omvårdnadsmötet. Detta öppnar upp för ett partnerskap mellan de närstående, den äldre och vårdpersonalen. Dessa fynd pekar ut vikten av vårdpersonalens närmande enligt delstudie (**I**) och att de är tillgängliga enligt delstudie (**II**) med målet att skapa delaktighet och god omvårdnadskvalitet.

# CONTENTS

# Introduction

The welfare of the elderly population is one of the most important goals of the public health services (1, 2). Sweden has an ageing population, out of a total of more than nine million inhabitants in 2006, 17.3% were aged 65 or more and 5,4% had reached the age of 80 or more (3). Elderly people are an increasing group in several welfare systems, and their needs of care are ever- increasing (4, 5). Elderly people should be able to influence their own everyday life and grow old in safety and with their self-determination preserved (6-10).

In Sweden discussions about ethical values in care are pressing issues. At macro level the Swedish National Board of Health and Welfare state that the premier goal is for elderly people to have dignified and comfortable lives. They should have a life with a sense of value and feel confident (11). The Swedish Health and Medical act states that all people have the same value and the patient with the greatest need for care will have first priority. Hence, patients and their next of kin should be perceived with respect, be able to maintain their integrity and possibility to participate (12). Many elderly people and their next of kin are affected by these goals and intentions.

These ethical values which are expressed at macro level are expected to prevail at micro level. In our study the micro level is the caring encounter between the elderly patient, next of kin and nurses.  The caring encounter takes place between the elderly patients, their next of kin and health care professional such as nurses. There are some problems, the public intentions expressed at macro level regarding elderly patients' rights and how the health care professional should act do not function satisfactory in practice.  Furthermore training for health care professionals includes limited instruction about care for elderly patients (2). Therefore more studies from the perspective of elderly patients and next of kin are needed (2, 11-14).  In this study, the term "health-care professionals" mostly refers to nurses.

# Background

## Elderly patients

The elderly patients are experts on their own health and life experiences, and their experiences form the basis for a judgement of caring encounters. Elderly people in need of care expect to be respected in the caring encounter and they want to be more involved in decisions surrounding their own treatment, but there is an unbalance between the patient's participation and the nurse's options (10).

The most developed countries have accepted the age of 65 as the definition of an elderly or older person. There is no universal agreement on the age at which a person becomes older. The common use of calendar age to mark the beginning of old age assumes similarity with biological age (15). As there is a lack of an accepted and acceptable definition, the age at which a person is revealed of employment has in many instances been used to define old age (15-18).

The ageing process is a biological reality. It is also subject to the ways each society makes sense of old age. In the developed world age in time plays a central role. The age of 60 or 65, approximately equal to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, age in time has little or no importance in the meaning of old age (19).

## Next of kin

The elderly patients and their next of kin are primarily seen as informants and recipients of information in caring encounters. Next of kin is a person who has a close relation to the elderly patients (20). In this study next of kin is a brother, sister, husband, wife, son or

daughter of the elderly patient; a person in the close family environment (21), they have a blood-relationship.

The health care professional's ability to recognize the importance of next of kin for successful patient care is quite adequate. However, insufficient attention is paid to next of kin and their need for support (22). Next of kin and health care professionals may have different values and objectives for the elderly patient, and next of kin may feel excluded from the decision-making process. Next of kin notice signs of misery and if their elderly relation does not receive a clear diagnosis, this adds to their frustration as well. The experience of being involved and being taken seriously may possibly relieve next of kin if they experience the health care professional to be supportive (23).


## Caring encounter

In a caring encounter elderly patients and next of kin meet health care professionals in an area of growing relationship.  In this encounter a caring relationship develops, and this relationship is the centre in the process of the caring encounter. The relationship is built on giving and receiving (24). Health care professionals such as nurses are dependent on collaborative interaction with the patient (25, 26), and they should meet the patients and relate to the elderly patient´s situation. The health care professional's openness and sensitivity can affect elderly patients so that they open up and share difficulties with them (27).
 In a caring relationship, also termed caring agreement the aim is to coach the patients to develop health.  This professional caring relationship is based on knowledge of the requirements of ethics and can have a variation of intensity in the actual caring encounter.  By using knowledge of ethics the patient is guided through a gentle caring process by the health care professional (24).

From the patient's perspective there are four different caring relationships.  First, caring relationships could be understood as friendly relationships. In this interaction the patients feel that the health care professional is attentive and that he/she values the elderly patient's experience. Second, there are caring relationships where the professional is active and gives care from his/her heart. The caring relation is well nurtured, and a direct contact begins. Third, there could be a distant caring relationship. In distance caring interactions elderly patients feel loneliness, fear, worry and pain. The health care professional appears as a sort of health worker. In non- caring relationships or the final relationship, the elderly patient feels that the professional does not see them. The patients' experience is that they are treated as an object and the professional attitude is unkind and heartless (28). Kasèn (28) says that the first meeting with the patient acts as a guideline in the ensuing caring relationship. Committed health care professionals with an open attitude influence the patient to be more open (28).

The health care professional as well as the patient needs security in a caring relationship. This security enables a foundation for preserving dignity for both parts. The knowledge and understanding of these findings could be used in caring encounters to guide professionals to a careful and reciprocal approach and as Berg (29) states; this will reduce the patient's sense of vulnerability and lead to the patient becoming more confident (29).

The ideal view of a health care professional such as a nurse is an eager, loving, sympathetic and supportive person. The health care professional's care ability depends on how helpful he/she is (25, 30). The professional's choice of care plan depends on his/her attitude, values and self-respect (31).

The caring interaction must be permeated by belief in the elderly patients and their capacity (32), and the health care professionals ought to support the patients in realizing their own vitality ambitions (33). This support could consist of the professional´s presence, touch and listening; the creation of a base for a caring relationship between the elderly patient, next of kin and professionals (34). Health care professionals such as nurses should provide care completely and without any form of discrimination. Today the tasks of professionals such as nurses are varied and range from health-promotion and preventive activities to nursing the sick and dying as well as contact and care for all patients and next of kin (35).

## Conceptual framework

### Ethics

Ethics is grouped into normative ethics and empiric ethics. Normative ethics concerns the way a person should or ought to act in different situations and empiric ethics concerns the study of how a person really acts. Principal ethics and codes express normative ethics. On the basis of empiric studies one can make the conclusion regarding the principal ethics and codes we should comply with (36).

Normative ethics can be described as a set of moral values or principles that should guide every person in their actions and decision- making in daily life. Ethics becomes preserved in law, which in turn is applied in practice trough codes of conduct and organizational policy. The codes of conduct and organizational policy are sets of rules that govern the person's behaviour in relation to others in the workplace. Every profession needs specific rules e.g. the nursing profession in the health care system (37).

The law which is normative declares that the healthcare system should be developed so that it functions for everyone. (11, 36, 38). In Sweden the Swedish National Board of Health and Welfare (39) states that health-care professionals such as nurses should meet the patient and their next of kin with values like respect, integrity, and dignity. The professional should display openness and respect for the patient's beliefs and values. The behaviour and focus should be on the patient's and next of kin's whole situation, in other words a humanistic view (39). This leads to the growth of ethics in society and helps the public to focus on the elderly patients' growing self-determination and autonomy (38, 40).

The principal ethics within the National Health Care System is a general broad and normative outline, aimed at actions and conducts. Assessments and visions taken from the foundation of these principles serve as guidelines for how health-care professionals should act towards patients and their next of kin when they are confronted with ethical discussions (36, 41).

There are some central components of nursing and health care ethics. The ethical issues of nursing are autonomy, beneficence, non-maleficence and the principles of justice. Stating that an elderly patient has autonomy is to say that he/she has the capacity for self-government; making his/her own decisions concerning the future. (42, 43). Beneficence is a duty to help others, and involves the obligation of fitting in with others. Non-maleficence means that the health care professional should not do the elderly patient any harm. The principles of justice state that all patients should be treated and respected in a fair way in caring encounters (42). Respecting the patient's autonomy may be at odds with the professional desire to do well or prevent harm (44). Ethical values are defined as the fundamental values, which form individual norms and actions and become visible in the study of empirical ethics. A dignified life for patients entails respecting their integrity and making it possible for them to maintain

self-esteem, individuality and participation.  The elderly patient and their next of kin should also be met by nurses with a good attitude (11, 36).

## Nursing ethics

For the nursing profession the ethical codes concern normative ethics. The International Council of Nurses (ICN) illuminates the values of the nursing profession and serves as a guideline for ethical behavior as well as beliefs and values that should be accepted. (36,45). One guideline example states that: *The nurse shall provide care that respects human rights and is sensitive to the values, customs and beliefs of people* (46, p.5). Another guideline is that of the Danish Nursing Council that states that the nurses' attitude and relationship in caring encounters should focus on the patient's best and that ethical tools should be used in the care (47).

The American Nursing Association (ANA) is a similar normative guideline, which includes statements regarding comprehensiveness of quality, acknowledging the values of the nursing profession (36, 48). The ANA code of ethics also states that *"the nurse´s primary commitment is to patient, whether an individual, family, group or community"* (48, p. 9).  The American Nurses' Association Code of ethic states that nurses should delegate equal duties to others and also to themselves, including the liability to protect security and integrity (48).

No code can provide complete rules for moral reasoning and actions for all situations (43). Values refer to one´s evaluative judgments about what makes something good or what makes something desirable (49). Nurses have a responsibility to maintain their level of competence, plan and deliver quality care, delegate tasks safely, and evaluate the services provided,

videlicet in empiric ethics.  The increasing number of reports on abuse of elderly people in health care settings must be brought to attention by nurses. Raising awareness of causes and consequences as well as developing/enforcing ethical standards of practice are crucial in caring encounters (50).

Ethical standard could be illustrated by an example of how elderly patients are received by the health care professional. Professional relationships are built on that the professional being a nurse, a professional actor, but also that there is a meeting with activities (51). This meeting could be seen as similar to social interaction, including analysis of social reality in caring situations (52).

Human beings use their experience and knowledge in relation to the situation they find themselves in. They are always active in various ways which means that they are different. Consequently, people define a situation in caring encounters in different ways. Common traditions and beliefs are easy to define but many small or big movements from a person could be hard to predict (52, 53).


Values signify meaning of what is important to a person, families, groups and communities (54). From a professional, theoretical perspective a value is a symbol that signifies meaning of the interest in caring, the human -universe-health process (55). Ethical values are the backbone of the way we act, behave and deal with different moral situations (42).  According to Gilligan (56) some people base their ethical decisions on principles of justice, equality, impartiality, and rights. This is a justice perspective. Others base their decision on a care perspective, where the need to care for relationships and reduce hurt takes priority over the consideration of justice and rights. The moral order is not to act unjustly towards others, and not to turn away from someone in need in caring encounters (36, 56). When health care

professionals communicate and collaborate and reach an agreement with the patient, they feel satisfaction and the patients will notice that satisfaction as well (57).

The focus on care has not taken into consideration understanding the true nature of the relationship between caring and the base of ethical knowledge that underpins nursing and that must support nursing for it to be a viable profession in practice (30,36). Responsive elderly patient -next of kin- nurse relationships reflect both on personal moral knowledge and disciplinary ethical knowledge (40). Ethical conflicts arise as a result of poor patient/next of kin and professional communication; therefore there is a need for effective communication. Nevertheless ethical questions occur (44). Thus it is important to evaluate empiric ethics in caring. Information must come from the elderly patients, next of kin and the nurses (40).

## Interactions

The patient will be confirmed and respected if the interaction between verbal and nonverbal communication functions. The nurse creates a good contact with the elderly patient and a trusting atmosphere by listening actively and showing empathy (58). Interaction is a feedback process between the elderly patient and nurse. The elderly patient is in need of confirmation (59). In an ethical context, the caring conversation is one in which the health care professional makes room for a suffering person to regain his/her self-esteem through the culture of caritas and makes a good life possible (60).

In a caring encounter there is an interaction between health care professionals, elderly patients and next of kin. Their definition of the caring encounter forms the base of the situation they are involved in. If the individuals recognize a situation as real, the consequences are real as well. The professionals, such as nurses, patients and next of kin not only recognize the reality in the caring encounter, it also guides their behaviour. The situation is to be viewed as a

whole, not only as interacting people (54). The individuals are "here and now" they define the present situation and interact with current symbols (53, 61-62). For the nursing discipline it is important that the individual nurses create importance moment-to-moment in caring encounters trough valuable frameworks that guide life, practice and actions (54)

Symbols could manifest themselves as human signals through sound, vision and actions. By using symbols humans create, and recreate the situation they are active in. Symbolic interactions involve people creating meaning and developing their reality (52-53, 62). Every person is socialized by symbols and culture is symbolic. All people learn the behaviour in their society through symbols, and all people are a unit of society. Values, ideas, rules and aim are symbols, and they make it possible for people to interact (52, 62).

A social object could be a human being, a symbol, or anything else. A social object is defined by the person in the situation (52). A symbol is a sign and carries a special meaning for everybody who is in the same situation. Gestures and facial expressions are symbols; even words are illustrated by symbols. The meaning of a symbol depends on the way the situation is defined. Both the person who sends a message and the receiver must agree on the meaning of the sign, which then becomes a symbol (52). Symbolic interactions rest on three primary premises. First, individuals act on things based on the meaning they attribute to them. Second, such meanings arise from the interaction between individuals. Third, an interpretive process is used by the person every time he/she must deal with things in his environment (53).

## The theory of Orlando

The theory of Orlando is similar to that of symbolic interactions. This theory aims to help nurses or other health-care professionals to achieve good care in practice (63). The theory focuses on the interaction between a professional and a patient and has the purpose to facilitate the nurse to understand ongoing events. The theory of Orlando emphasises that the patient is always at the centre and the procedures are alike. The process consists of; the elderly patient's behaviour, the nurse's or professional's reaction and the care per se (64).

The theory of Orlando makes a perception of the nurse's or healthcare professional's special function and response in the care situation. The Orlando theory is a holistic theory that views every human being as unique; the patient is active and responsive in the caring encounter and it deals with the way the nurse understands the patient's situation. Health-care professionals such as nurses and the patient should make a decision about the patient's care needs together. The patient's need is connected with the patient's vulnerability in different caring encounters. The goal of this situation/interaction is designed for the patient's benefit (65).

Symbolic interactions help researchers to identify the community of values and ethical values that guide the activities of professionals such as nurses, as gestures, attitudes etc. are shown in the caring encounter. The elderly patients, next of kin as well as researchers, interpret and evaluate the encounter. It is important to describe and indentify these values as reports actually describe that the care of elderly patients in the health-care system as well as in society do not always fulfill the intentions (10, 11).

# Aims

The general aim of this study was to identify and describe the ethical values elderly patients and next of kin experience in their interaction with health-care professionals such as nurses in caring encounters at a geriatric clinic.

The specific aims were:

Study I

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

Study II

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

# Methods

In order to understand and describe the experience of the elderly patients and next of kin in caring encounters a qualitative approach was used (66). A qualitative approach is suitable, when there is a wish to understand human behaviour. Symbolic interactions are an ensemble between people and the social aspects of real life (67). Thus, Grounded Theory methodology was used, an approach based on Symbolic Interactionism (68). Grounded Theory (GT) consists of the discovery and development of theories starting from obtaining and analyzing data in a constant, systematic and comparative way (68). The purpose of such a method is to

achieve a deeper understanding of concerns, actions and behaviours of groups of individuals through the elderly patients' and next of kin's own words (67,69).

Grounded theory method is a highly systematic research approach for the collection and analysis of qualitative data. Data are systematically gathered and analyzed, and there is a continuous interplay between analysis and data collection (67). Data collection is continued until so-called "theoretical saturation" is achieved, i.e. nothing new in data is found, that changes the categories (67).

## Describing the setting

The data were collected in a geriatric clinic at a county hospital in a medium-sized city in Sweden. Focus was on the elderly patients, older than 65 years old and their next of kin.

Patients in a geriatric clinic have various care needs. Geriatrics is branch of medicine devoted to prevention, diagnosis, and treatment of disorders affecting old people (70). The professional competence in a geriatric clinic in general holds profound knowledge about the older patients' ill-health and diseases.  In the investigated clinic the competence is mainly concentrated to medical investigations, medical treatments and rehabilitation of patients with stroke, dementia, osteoporoses and fractures. The elderly patients receive care and rehabilitation suitable for their need and they should also have an individual caring plan. Health-care professionals in geriatric clinics have a holistic view and interactions with the patient appear as teamwork (71).

The studies included in this thesis were performed at inpatient wards. The geriatric clinic consisted of three wards and a reception. The data were collected in a stroke and rehabilitation ward with 22 beds. There were six single rooms, two double rooms and three four-bed rooms.

The working organization at this ward consisted of a team of physicians, registered nurses, enrolled nurses, physiotherapists and occupational therapists. The nursing team consisted of i.e. one enrolled nurse and two registered nurses or two enrolled nurses and one registered nurse. The nursing teams were responsible for caring for the elderly patients; there were approximately six patients in every nursing team. Health-care professionals such as nurses and physicians worked irregular hours. The physiotherapists and occupational therapists worked regular hours. There were also consultant physicians on the ward such as orthopedic-, rheumatologic-, infection- doctors and so on. The average caring time for the elderly patients was approximately 18 days and following discharge they returned home or to another care facility.

## Describing the participants

The participants in study I were selected on the basis of being an elderly patient older than 65. All patients who understood and spoke Swedish were asked about participation. 22 out of 24 patients accepted. The elderly patients varied in age between 65-90.Before their hospital stay at the inpatient ward, they lived in different home settings such as their own apartment, house or in a nursing home. They lived alone or with a next of kin. The elderly patients differed regarding caring needs, age, and two were foreign born, figure 1.

The participants in study **II** were selected on the basis of being a next of kin to inpatient geriatric patients. Fourteen next of kin (husbands, wives, sons, daughters, brothers or sisters) agreed to participate. They lived near the elderly patients or far from them. They had different occupations, and were of different ages. One next of kin was foreign born and two were living abroad. Next of kin were aged between 30- 80 years, figure1.

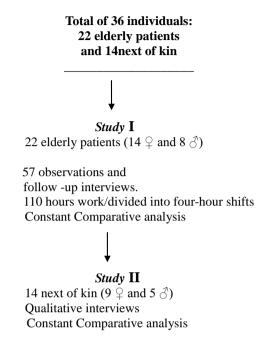**Several types of data were collected and analysed.**

**Total of 36 individuals:**
**22 elderly patients**
**and 14next of kin**

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↓

*Study* **I**
22 elderly patients (14 ♀ and 8 ♂)

57 observations and
follow -up interviews.
110 hours work/divided into four-hour shifts
Constant Comparative analysis

↓

*Study* **II**
14 next of kin (9 ♀ and 5 ♂)
Qualitative interviews
Constant Comparative analysis

**Figure 1. Study design.**

## Data collection – Observation and follow- up interviews study I

A "gate-keeper" i.e. a nurse at the ward, was the communication link between the researcher

and conceivable participants for the study. The nurse identified patients according to the

inclusion critera; understand and speak Swedish and being older than 65.  The researcher (L-

LJ) contacted the patients for permission to observe the caring encounter (72).  All

observations were carried out as non-participant observations (73). The researcher listened to,

watched and had conversations with the participants in the study. The researcher was a non-

participant in that she was dressed as a healthcare professional but did not work as one,

although at times the health-care professionals needed some assistance (74).

The data collection in study I, took place between October 2004 and January 2005. It included approximately110 hours of work, divided into various four-hour shifts such as morning, forenoon, noon, afternoon, evening and night shifts. The researcher followed the nurses at the ward for approximately 1.5 months with the purpose of gaining knowledge of the local care-culture, observing different situations and interactions (66). The remaining time, approximately 2.5 months, was used for data collection, which was gathered by observing 57 different caring encounters and follow-up interviews with the elderly patients directly afterwards where they could tell of their experiences of the encounter. In the follow-up interviews the elderly patients were asked "Can you describe how you experienced this caring encounter? It was important to create an open relationship between the elderly patients and the researcher who was a non-participant observer (i.e. present on the ward but not taking part in the care), in order to reach as complete a picture as possible of the elderly person's situation. The follow-up interviews were conducted in private and away from the nurses involved in the encounter. These follow-up interviews were tape-recorded and verbatim transcribed. Transfers, events, information, social intercourse etc. were recorded on a pocket-tape recorder as well as a note-book as field-notes, immediately after every observation, as verbatim and scrupulous as possible (73).

## Data collection – Interviews Study II

In study II data was collected from November 2006 to September 2007.
One nurse at the geriatric clinic gave nineteen elderly patients and their next of kin verbal and written information about the study and that participation was voluntary. The next of kin were asked about participation in an interview by the nurse. Five next of kin refrained from participating. Next of kin chose the place and time for their interviews: Three next of kin were interviewed at the hospital and 11 in their own homes.

An interview guide was used which gave the interviewer freedom to have a conversation with the interviewee on a specific topic (73). The interviewer was free to explore and ask questions that would explain the aim of the study (66). Examples of questions are: What are your experiences of the caring encounter? How do the nurses take care of you as next of kin? Are you, as next of kin, involved/participating in the care given?

The informants expressed, in their own words, their experiences and contributed their perspectives regarding the caring encounter.  The interviews lasted between 30 and 90 minutes, were tape-recorded and transcribed verbatim.  All interviews were conducted by the same interviewer (L-L J), who also made the transcripts. After 13 interviews saturation was reached. One more interview was performed for the purpose of confirmation, in order to secure saturation (67).

## Data analysis

All the data from recorded observations and transcribed follow-up interviews in study I and the transcribed interviews in study **II** were analysed by Constant Comparative Analysis (67-68).  Grounded Theory- and Constant Comparative Analysis is an inductive and iterative, process of generating, examining and constant comparing of concepts and categories. The process moves back and forward trough varying stages of complexity and interrelationships leading to new discoveries about the experiences under study (66), figure 2.
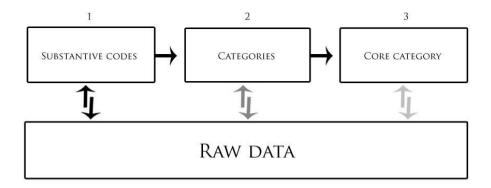
**Figure 2.** Diagram of Analytic process of Grounded Theory- Approach towards data on ethical values in caring encounters.

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

The second stage was to capture the substance in the data, to break it down into identifiable concepts and substantive codes that illustrated the experiences. The different codes and the different interviews were compared to each other to strengthen their identification. The codes were labeled with origin words from data (66, 68). Thereafter, the analysis continued with the aim of reaching a higher level of abstraction of the material, thereby allowing identification of categories. The codes were analysed and similar meanings in the codes were identified and clustered together into categories. The categories were labeled with more abstract concepts. These categories were also compared with the codes, and the categories (67-68). A category is more abstract than codes and the name of such a category should be more informed, general and sophisticated than the codes it stands for (68). The gathering of data and analysis continued until a "saturation point" was reached; nothing new emerged in the analysis that

enabled identification or creation of new codes or categories. In these studies saturation was reached after 52 observations and follow-up interviews (study I) and 13 interviews (study II).

The third stage involved developing theoretical constructs― core categories from a combination of theoretical and empirical knowledge, and contribute theoretical meaning and scope to the theory (68) This final stage to be reached involved identifying a theoretical construction – a core category- that answered possible questions and explained the experience, the ethical values that was under study (66,68). Categories are related to each other and scrutinized to verify their relevance. A core category is the major category that is found in all data (67-68) and was developed by identifying the relations between the different categories, i.e. linking them together. This construct adds theoretical meaning and scope to the substantive theory and could be implicitly found in all data (68).

## Validity

Using a qualitative method, validity is relevant to the population in these studies. When generating a theory there is also an intrinsic factor in verifying interpretations (75).

The findings of GT are not a reporting of facts but a set of probability statements about the relationship between concepts, or an integrated set of conceptual hypotheses developed from empirical data (76). Validity in GT should be judged by fit, relevance, workability, and modifiability. The theory is an integrated set of hypotheses, not of individuals (67-69).

A GT has codes that fit the data and realty from which it is derived. Fit has to do with how closely concepts fit with the incidents they are representing, and this is related to how thoroughly the constant comparison of incidents to concepts was done. A theory should work and will be able to explain the major processes of behaviour of the substance area. The theory has workability when it explains how the problem is being solved with much variation. It

must be relevant to the core category and its ability to explain what is going on in a caring encounter. If the participants, the elderly patients and next of kin recognize the construct, there will be relevance (66-68).

A modifiable theory can be altered when new relevant data is compared to existing data, which is to say that the theory has modifiability. Data from observations and follow-up interviews (study **I**) and interviews (study **II**) were compared with each other at all time. It could be tested whether a theory was modifiable, when new and further studies were performed on daily caring encounters, presenting similar or different findings (68).

Even if the samples were small, they could be generalized to other similar caring areas (67). The criteria fit, work, relevance and modifiability are argued to support the fitness of a theory, and support a broader evaluation of the quality of grounded theories (77-78).

## Ethical considerations

These studies were approved by the Regional Ethical Review Board. Approval for study I and II was also given by the manager of the clinic, the director of the department, the personnel department, and the union organisations involved. While conducting the study, consideration was given to The Declaration of Helsinki (World Medical Association Declaration of Helsinki 2004) and other ethical aspects of the Swedish law (79-80).

All data were treated with confidentiality. There was no dependent relationship between the researcher and the patients or the next of kin. No individual answers could be identified, as data were abstracted (74)

The observation focused on human behaviour. Therefore the researcher could not give exact information about the research aim but tried to be as clear as possible (66).

Informants in a research study always have the right to refuse participation in the study and they can withdraw if they wish. In these studies two elderly patients and five next of kin refused to participate. Verbal and written information was given to the elderly patients and next of kin. If any questions arose, the researcher consequently answered them.Informed consent was obtained. Observation, follow-up interviews and interviews could imply ethical problems. If the elderly patients seemed knowledgeable of the researcher's existence, the researcher went away and did not observe the situation. It was important that the researcher's attention was on the well-being of the elderly patients and next of kin. The observations and interviews should not harm or cause any worry for the elderly patients or their next of kin. The researcher should be sensitive to such reactions by the elderly patients or next of kin (81-83).

# Findings

## Summaries of the articles

### Study I

The ethical values were identified and described by the older patients in their daily interaction with nurses in a ward for older people during caring encounters according to the description below.

The core category was identified as "Approaching", and approaching was interpreted and identified in empirical data. This indicates the ethical values that guide nurses in their caring encounters with older patients. This ethical value was noted by the older person and it had both an individual value and lead to improvement in the quality of their care.

Approaching was visualized in interaction or participation by verbal and non-verbal communication, such as talking, mimicking, gestures, facial expressions and physical

movement. Approaching involves becoming emotionally closer to the other person, leading to a more intimate, trusting relationship. Such a relationship needs to "be earned" by the approaching nurse and often starts with the way the nurse addresses another person such as the older patients during the first contact. If the object of addressing older patients is to pass on information and if this information is given in a polite manner, backed up by appropriate, pleasant body language, then there will be an interaction. The initial approach may well develop into a positive caring relationship between the nurse and the older patients. Approaching includes physical, psychological and social aspects and it is important that these aspects are presented with respect, while taking the integrity of the older patient into consideration.

The older patient reacts in one of three ways:  Positively, negatively or passively. These types of reactions also describe the way older patients show their self-determination and even if they are able to state their self-determination during the ongoing caring encounter they can react differently. If all components in approaching are exhibited the older patient will feel confidence in and satisfaction with the caring encounter.

However, if they do not there can be negative reactions. A strategically considered approach will help bring about a good interaction, thus influencing the older patients' reactions, which are often based on how they have been addressed and the respect they have been shown.  A well considered approach can influence their desire to participate and foster their self-determination and self confidence.

To sum up the findings, the following five categories form the core category- approaching. The categories are; being addressed, receiving respect, desiring to participate, increasing self-

determination and gaining self-confidence. These categories are identified and described by the older patients, figure 3.
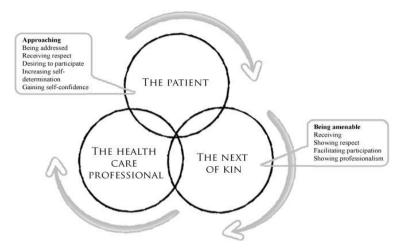


**Figure 3.** Interaction in the caring encounters between elderly patient, next of kin and health care professional as nurses. The figure illustrates that the nurse's ethical values are identified and described by elderly patients as "Approaching" and by next of kin as "Being amenable".

**Study II**

The ethical values that next of kin identified and described in the interaction with nurses caring for elderly patients at a geriatric clinic were labelled with the core-category "Being amenable".

Four categories were identified: Receiving, showing respect, facilitating participation and discovering professionalism, which formed the basis of the core category (figure 3). All the categories were related and affected each other; thereby the categories could sometimes seem interrelated and repetitive in generating the core category. Being amenable means that he nurses are guided by ethical values to invite the elderly patients as well as their next of kin

into the caring encounter. Being amenable influences the elderly patient and next of kin, as there is an interaction between the elderly patient/ next of kin and the nurses.

Being amenable is about the nurse being there for the elderly patient and their next of kin. The nurses met the elderly patient / next of kin through receiving them with nearness; they invited the next of kin through their attitude and the way they approached them. This provides the basis for respect between the people in the caring encounter. Being valued and acknowledged opens up the possibility of participating and being an active part in the caring encounter. The nurses had authority in the caring encounter and could show their professionalism, i.e. they were competent and guided by the ethical principle that all people have equal value. The nurses focused on the elderly patient's well-being as a final criterion of good ethical care, this influenced the next of kin and their experiences of this fundamental condition for high quality care seemed to be fulfilled.

Being amenable shows the ethical values in the nurse's behaviour and how the nurses act in caring encounters. The next of kin were satisfied when the nurses were sensitive regarding the elderly patients well-being, and that the nurses "were there", both physically and mentally through their behaviour and actions.

## Complementary findings

In study **I** and **II**, there is a varying extent of nurses' influence on the elderly patients. In both studies the nurses influence the elderly patients and their next of kin; it is the first step in creating contact so that an interaction can develop between them in the caring encounter. For the elderly patients it is about the way they are addressed by the nurses and for next of kin it is about the way they are received. The health-care professionals' "approaching", in study **I** and

"being amenable", in study **II** influence the elderly patients and the next of kin in the caring encounter so that an interaction can be made possible.

In both studies respect was identified. It was described in a similar fashion both from the patients' and next of kin's perspective. Respect for the elderly patients is about showing consideration, and for the next of kin it is about the professionals being attentive especially to the elderly patients but also to them. Influences include physical, psychological and social aspects.

Participation was identified in both studies. The elderly patients and their next of kin wished to participate. First the nurses influenced the elderly patients and their next of kin by giving them respect, which then facilitated participation for the elderly patients and next of kin. Respect and participation are connected in both studies. The studies also show how nurses invite the elderly patients and their next of kin to participate; it often concerns small everyday activities, such as questions "Would you like to go to bed? Or "Is everything okay".

When the elderly patients are shown respect and are invited to participate by the nurses, they achieve increased self-determination. The elderly patients respond in a positive manner. On the contrary, if the elderly patients do not experience respect or participation they have a negative or passive reaction depending on the extent of the nurses' influence. The elderly patients describe a feeling of confidence when nurses approach them well. The next of kin describe the nurses' professionalism when they are being amenable.

These studies focus on how the elderly patients and the next of kin identified and described the ethical values in caring encounters. It is important that the nurses notice the extent of their

influence on elderly patients and next of kin. Their success depends on their attitude and actions. If the elderly patient and next of kin experience that the nurse's attitude and actions are appropriate they will feel that they are important; they are valuable and the interaction takes place on equal terms.

# General discussion

## Methodological aspects

Both studies had a qualitative empirical approach (GT) as constant comparative analysis. Focus was on behaviour, interaction and experiences. In study I data were collected through observations/follow-up interviews. In study **II** data were collected through interviews. They seemed to be suitable methods, as focus was on gestures, attitudes and the act of controlling attitudes in interaction between people. It was also a positive understanding; the elderly patients, next of kin and the researcher could interpret and evaluate the encounter (74). Grounded Theory is an increasingly used research method that enables health-care professionals such as nurses to interpret practice and environmental situations (75).

Other methods could be discussed, i.e. questionnaires. They are connected with a larger sample, but the issues in these studies were interaction and experiences in the near meeting in caring encounters. It might be difficult using a quantitative approach to investigate the aims of these studies; focus was on social structures/behaviour, close to data perspective. The perspective of quantitative methods is far from data. Answering a questionnaire demands great compliance by the researcher and the respondent regarding the meaning of the questions (74).

In these studies a "Gate-keeper" identified conceivable participants. "The Gate-keeper's" role was to facilitate the entry for the researcher. However, Hudson (72) has experienced that the gate- keeper can obstruct or retard data collection. In these studies the gate-keeper was invaluable help for the researcher.

There was no time delay between the observations and follow-up interviews; this may strengthen the validity of the observations in study I. The elderly patients recalled the caring situation immediately and clarified what had happened from their point of view. Thus the risk for, wrong, under- or over-interpretation was reduced (66).

During the observations the researcher's presence in the caring encounter only had a small influence on the nurses' and patients' behaviour. The researcher then spent a lot of time at the ward to become familiar with the context and the ward routines. The health-care professional seemed to forget that the researcher was an observer and not a colleague. In agreement with Berg it is well-known that for instance health-care professionals cannot control their behaviour for more than 14 days. After that period their awareness decreases and they forget about the researcher's presence (66).

In study **I** limitations to the studies can be discussed. The researcher used a sample of 57 observations of 22 elderly patients; some of them were observed and followed up through interviews several times. It should be noticed that it is the number of observations/follow-up interviews that is of interest, not the number of participants (76). Saturation was reached after 52 observations of different caring encounters and follow-up interviews; videlicet nothing new appeared from data. The findings of study I were recognized by nurses during verbal

presentations (66-68). Five more observations were conducted to secure the saturation judgement.

In study **II**, 14 next of kin were interviewed on one occasion. Perhaps some more interviews of the same next of kin could bring more data, but 13 interviews gave saturation, and the 14 interviews confirmed the findings. Saturation was reached in the studies, i.e. no more categories and related aspects appeared in data (68, 74)

Observing nurses and elderly patients in caring encounters requires much energy and focus. The researcher listened with all senses i.e. paid total attention to the phenomena in the caring encounter; so four hours of observation was enough (66). Observation and follow-up interviews can imply ethical problems. Data collection could lead to patients feeling that their integrity is threatened. It is important that the researcher's attitude is respectful and sensitive (73).

The participants in study I had diverse caring needs, age, and ethnicity. In study II the next of kin varied in occupation, age and ethnicity. Informants described a wide spectrum of experiences, which made the phenomenon more nuanced (77).


Student nurses' and colleagues' reflections confirmed that there is a connection between the concepts, i.e. the findings and data fits. Data from observations and follow-up interviews (study **I**) and interviews (study **II**) were at all time compared with each other. In verbal presentations the audience recognized the core-categories and the categories as concepts in caring. This recognition shows that the studies are valid. As the findings were recognized and understood the theory has workability and can be used in caring encounters.

Whether the theory is modifiable could be tested, when new and further studies are performed on daily caring encounters, presenting similar or different findings. Even if the samples were

small, they could be generalized to other similar caring areas (68). The criteria fit, work, relevance and modifiability are argued to support the fitness of a theory, and support a broader evaluation of the quality of grounded theories (78).

The organization of the research process has been previously described; the data were sampled from raw data, figure 2. These studies have fit as data are linked to their sources; as Grounded Theory (66-68). It is difficult to replicate exactly the same study, as time, context and person change. Caring situations change depending on the people involved.

Observations with follow-up interviews as confirmation is a triangulation technique imbedded in Grounded Theory. This method strengthens relevance of the findings in the studies (67-69).These findings could be valuable for health-care professionals such as nurses and students in caring professions. Results derive from empiric data, so that nurses and students can use these findings at work (67-69).

Sometimes the researcher identifies special situations containing strong emotions which affect him/her (73). For that reason it was important that the researchers could distance themselves in e.g. observation studies. Reflections and "debriefing" is one technique that has been used among the researchers (14, 66).

## Discussions of the findings

In caring encounters there is an interaction between nurses, elderly patients and next of kin (52, 58-59). It is important to study caring encounters so that the elderly patients and next of kin can describe their interaction with nurses with satisfaction (2, 11, 13-14, 84). Their descriptions provide some knowledge that nurses can use in caring encounters, videlicet from

empiric ethics some conclusions about what principal ethics and codes the nurses should comply with (36).   Studies (**I, II**) explain how a nurse should act and behave in caring encounters to make elderly patients and next of kin experience that they are valuable

Through"approaching" the elderly patients noticed the nurses and interpreted what kind of nurse was coming closer to them. The elderly patients interpreted physical, psychological and social aspects as signals that the nurses were sending when "moving closer" to them. The ethical values and principals autonomy, beneficence, non-maleficence and the principles of justice that guide the nurses in the caring encounter are made visible in the "approaching" and this ethical value should be experienced by  the elderly patient (42-43). Approaching indicates the ethical values that guide the professional in the caring encounter with the elderly patients. It is important that all nurses understand that approaching has great significance for how the elderly patient will subsequently take part in the care process. Approaching represents the different phases of both verbal and non-verbal communication to establish a good relationship with the patient. Another study states that non-verbal behaviour is important to create a relation with a patient (85).

The approaching phase is very important for the entire care encounter and its outcome. The concept approaching connected to ethical values is not previously mentioned in literature as, hence adjoining concepts could be found. Approaching in study (**I**) is important for the elderly patients and their feeling of being valued. The strategy of this core category and categories; Being addressed, Receiving respect, Desiring to participate, Increasing self-determination, Gaining self-confidence is to make the elderly patient more involved in the caring encounter (86).  The nurses are responsible for their behaviour. In study (**I**) the process was identified and presented, pointing out the importance of the professionals' approaching. Approaching

can symbolize the interaction when health-care professionals come close to the elderly patients (52). This description is a person-centred process during a series of activities in caring which is a sign of good nursing practice (87- 88).

"Approaching" has an influence on the elderly patient while "Being amenable" is the core-category from the next of kin descriptions of their interaction with nurses in caring encounters at a geriatric clinic (**II**). Being amenable shows the ethical values in the nurse's behaviour and how the nurses act in caring encounters (42-43). The nurses focused on the elderly patient's well-being as a final criterion of good ethical care, this influenced the next of kin and their experiences of this fundamental condition for high quality care seemed to be fulfilled. As found by Atree, the professionals have the authority in the caring encounter and they show whether they are present both physically and mentally (89). It is important to emphasise that the ethical values and thus the ethical principals autonomy, beneficence, non-maleficence and the principles of justice that the professional displays in the caring encounter influences the next of kin in the interaction (42-43). Focus on how the interaction occurs between elderly patients, next of kin and professionals helps other people to understand what happens in the caring encounter (61, 64).

It is important that the elderly patients feel nearness. Nurses must have the perspective of the elderly patients as individuals as a starting point (64). This creates an interaction, which is in agreement with Orlando's theory (65) that emphasises that the patient is always in the centre. Other studies declare that the first meeting with the patient acts as a guideline regarding the continued caring relationship. Knowledge and understanding could be used in caring encounters to promote a careful and reciprocal approach by the professional (28-29). Eriksson (24) says that interaction is more of procedural nature. A relationship between a health –care professional and an elderly patient can also be unbalanced (5). In the present study the

significance of a good quality caring encounter depends on approaching. Several pieces of literature affirm how health-care professionals should interact with the elderly patients (23-26, 33).

The core category "being amenable" is based on four categories, identified as; receiving, showing respect, facilitating participation and showing professionalism. The concept of being amenable is not mentioned before in studies of ethical values in caring encounters. Being amenable is often described as accessibility (90).

The category receiving refers to the next of kin's description of nurses when they personify ethical values or the ethical principal non-maleficence (42-43) in caring encounters. The nurses are amenable, which is to say they invite next of kin with their attitude and thus influence them. The next of kin in this study felt either nearness or distance. Next of kin were satisfied when the nurses were being amenable in caring encounters (84). This data is the same as that found by Söderberg, i.e. receiving means welcoming participation which opens up for a relationship between patient, next of kin and nurses (57). Distance influences next of kin. When nurses distanced themselves the next of kin described it as a not so good a quality in caring, the same is found in a study by Attree (89).

The elderly patients' descriptions of nurses' addressing depend on approaching, and how it occurs. If the nurses are attentive to the way they approach and address elderly patients it makes it easier to create a relationship with them. Professionals should" be present" in the caring encounter, socially, physically and psychologically so that the elderly patients experience they are in the centre of attention (91-92). In other words the nurses are present and should not do the elderly patients any harm (42-43). Presence mediates hope, availability, communion, i.e. an experience of at-home-ness (57).

The category "respect" is found in both of studies (**I, II**). The elderly patients identify respect as receiving respect and next of kin describe nurses showing the elderly patient respect. Approaching influenced the elderly patients and it is connected with their interpretation of receiving respect. Showing respect involves the outlook of autonomy, beneficence, non-maleficence and justice for the elderly patients' experience and that of next of kin (30, 42-44). The professionals' actions should support the well-being (beneficence) and good health of the elderly patients (33). If there is a suitable approach and if the elderly patients are addressed appropriately, there are possibilities for them to feel respected. The nurses, the elderly patients and their next of kin experience dignity (93).

Showing respect is judged by the next of kin on the way nurses are being amenable and how they receive the elderly patients. In the interaction the next of kin notice the health care professional and how they act; verbally and non-verbally. This constitutes a basis upon which the next of kin can build their trust in the professionals in a caring encounter. Finfgeld-Connett (94) means that interpersonal sensitivity and intimate relationships precede the recipient's need for and openness to caring (94). Disrespect is revealed when the nurses are not attentive to the next of kin's need for information; this finding is similar to the findings of other studies (89, 91). The nurses' behaviour can be described as disrespectful when information passes from one professional to another, but by-passes the elderly patients or the next of kin. This behaviour shows the next of kin that the professional is not being amenable.

The category "participation" is found in both studies (**I, II**). Elderly patients wish to be invited to participate. The way this wish is fulfilled depends on the approaching process and theway

nurses address and show the elderly patients respect. Facilitating participation depends on whether the elderly patient is invited by the professional or not. Often the health care professional starts with asking questions in order to invite them to interact, this is in agreement with Cortis' (92) findings.

In study (**I**) we found three reactions to nurses approaching and the invitation to participate i.e. the patients expressed a positive, negative or passive reaction. Reactions have been mentioned before in a study by Randers et.al. (95), where the elderly patients played the role of an 'old cognitively impaired man'. This is a reaction to surviving a lack of ethical care (95). However in our study the elderly patients experienced that the approaching went well, that they received respect and were invited to participate by the professional. The elderly patients responded positively. In other words caring for the elderly patients is patient- centered (96). On the contrary, if the elderly patients did not experience approaching, respect or participation, they reacted negatively or passively depending on the level of influence from the nurses. The elderly patients were not satisfied when they could not influence the care (84, 97). Elderly patients reacting negatively or passively, signals to the nurses that they need to change their behaviour and be more attentive (2, 11-12, 14, 46). Participation is the foundation for meaningful partnerships between nurses and elderly patients (98). Next of kin wanted to participate but needed to be invited through respectful receiving by the professional who relied on them for a successful outcome in the caring encounter (60).The professional must facilitate this participation with sensitivity and openness. There is a need for ethical sensitivity in nurses because the caring encounter is a meeting between elderly patients in need of care and their next of kin who are worried (99). Some next of kin live in existential and practical uncertainty when caring for the elderly patients (100). A suitable attitude and ethical sensitivity and thus the autonomy of elderly patient and next of kin and their

experience of beneficence develop through relationships between nurses, elderly patients and next of kin (42-43).

Maintained or increased self-determination is promoted by the nurses' work towards the good of the elderly patients by approaching them in a correct manner: addressing, receiving, showing respect and facilitating participation. Nurses support the elderly patients through their attitude. This support brings the elderly patients o protect their autonomy and integrity (42-43).      This leads to an upheld dignity and consequently a worthy life for the elderly patients (11, 101 -102). When professionals experience themselves as personally responsible for the elderly patients as human beings, the elderly patients' dignity should be upheld (56).

The next of kin are sensitive to the health- care professional being amenable. The nurse's knowledge, empathy, and attitude provide an assurance in the caring encounter.  When professionals show this competence, by giving each and every elderly patient respect it indicates an ethical care which forms the base of good quality in the caring encounter (101) and such an attitude helps avoid possible misunderstandings (102). The next of kin form their judgement on these experiences and actions; professionalism leading to being amenable. According to Weaver et al. (99), professionalism is characterized by receptivity, responsiveness and courage.  Through the nurse's professionalism autonomy, beneficence, non-maleficence and the principles of justice are made visible (42-43)

The elderly patients describe a worthy life by gaining self-confidence. This feeling of confidence is possible if approaching and the five categories are used. This feeling is an emotion of security in the caring situation. Confidence in a caring situation is characterised by the professionals being confident and transferring this atmosphere to

the caring situation (11, 103). They should embody the ethical principals; autonomy, beneficence, non-maleficence and the principles of justice (42-43).

The actions and attitudes of the health-care professional reflect on his/her own ethical values. (42-43). Another study indicated that elderly patients' basic needs for ethical care were not met. The health-care professional did not see the elderly patients as unique individuals with their own preferences, resources and abilities (101). The caring encounter seemed to depend on the health-care professional and his/her attitude, values and self-respect (31). Healthcare professionals such as nurses are not always aware the of patient's perspective (97). It is still important to pay attention to the elderly patients' view in empiric studies about practical knowledge. So far there is little evidence to support presented declaration of caring and how to apply it to elderly patients (30). These studies (**I, II**) in empiric ethics can give some explanations of what is important for health-care professionals and the ethical values that appear in their interaction with elderly patients and next of kin.

Approaching and being amenable influence the elderly patients and their next of kin (**I, II**). This process is an activity (24), which forms the basis for a caring relationship, a relationship between elderly patients, next of kin and nurses. The knowledge of ethics in the caring process is important (24, 104). The findings in study (**I**) and study (**II**) form the basis for a reciprocal caring process/relationship where the elderly patients and next of kin have equal value (11, 29, 105).

# Conclusion

**I, II** Approaching and being amenable influence the elderly patients and their next of kin. These processes are activities and a basis for a caring relationship between elderly patients- next of kin- nurses.

**I** From the elderly patients' perspective Being addressed- receiving respect- facilitating participation- gaining self-determination make them feel confident These five categories describe a connection that influences the elderly patients to experience "Approaching"

**II** From the next of kin's perspective Receiving – showing respect – facilitating participation – showing professionalism, are the four categories that describe the connections that influence them to experience nurses as "Being amenable".

**I** The ethical values that guide nurses in the caring encounter are made visible in "approaching" and this ethical value is experienced by the elderly person. It is significant to the elderly patient as it has both an individual value and leads to improvement in the quality of their care.

**I, II** The core categories from these studies; approaching" and "being amenable", embracing the different categories presented ought to be used in the caring encounter on micro level; the elderly patient, next of kin and nurses. Using these findings and applying them in the encounters on a micro level, may even affect the macro level of the health care system. These grounded ideas about ethical values ought to permeate the whole health care system.

# Clinical implications

- All nurses who work with elderly patients understand that approaching has great significance for how the elderly patients will subsequently take part in the caring process.

- The approaching influences the elderly patients to decide as to whether or not they will accept the nurse's advances.

- The elderly patients should be confident and satisfied with the caring encounter if the desired components in the nurses' approaching are correctly fulfilled.

- It is necessary that all nurses are attentive to the observation that being amenable is of great significance for how the next of kin will experience the caring encounter; at present as well as in the future.

- Being amenable influences the next of kin as it results in interaction. The next of kin feel they are important; they are of value and interact on equal terms.

- The nurses' behaviour and actions make the ethical values visible for the next of kin. When the nurses are focused on the elderly patients' well-being as a final criterion of good ethical care, they are "Being amenable".

- Transforming ethical values and ethics to empirical actions, videlicet "approaching" and "being amenable" is needed in health-care professional education programmes and in in-service health-care.

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