Closeness and distance: a way of handling difficult situations in daily care

Karin Blomberg BSc, RN
Research Assistant, Nurse Tutor, Department of Health Sciences, Örebro University, Örebro, Sweden

Eva Sahlberg-Blom PhD, RN
Senior Lecturer, Department of Health Sciences, Örebro University, Örebro, Sweden

Aims and objectives. The aim of this study was to describe how care team members caring for patients with advanced cancer describe how they handle difficult situations in daily care. In this paper ‘difficult situations’ refers to those situations team members themselves describe as difficult.

Background. Serious illness and impending death involve great changes in a person’s life. The care of patients with advanced cancer is complex and many different factors influence each care situation. This places demands on the way care team members handle problems and difficulties in daily care.

Design. Qualitative descriptive study.

Methods. The study is based on 16 focus group discussions with care team members who were caring for patients with advanced cancer at three different care units in two Swedish cities. The focus group discussions included 77 participants. The procedure for data analysis was inspired by the phenomenological method.

Findings. The results show that care team members handled difficult situations by balancing between being close and distancing themselves. In most situations their choice of strategy seemed spontaneous rather than being a conscious decision, although it was sometimes described as a more conscious approach. Variations of closeness and distance that were identified were Identity, Meaning, Limit-setting and touching, Prioritization, the Team and the Organization. These could also be seen as tools that could facilitate or impede the use of closeness and distance.

Conclusions. The results show that care team members have a need to reflect over daily care and to become aware of what governs different care actions.

Relevance to clinical practice. If the experienced difficult situation is not handled in a way that is beneficial to the care team member, patient and relatives, it is assumed that this can result in stress, burnout and, above all, non-optimal care.

Key words: care team, coping, focus groups, oncological nursing, palliative care, professional–patient relations
Introduction

The care of seriously ill and dying persons is demanding work in which care staff encounter many dimensions of suffering that can sometimes not be totally alleviated (Öhleń 2002). Interviews with hospice nurses showed that they experienced both personal and professional difficulties when a ‘good death’ could not be attained (Rasmussen et al. 1997, Rasmussen 1999, Kristjanson et al. 2001). However, palliative care is not only described as demanding it is also described as a work which could mean both professional and personal growth and developing (Molander & Parviainen 1996, Rasmussen et al. 1997, Rasmussen 1999). According to Molander and Parviainen (1996), the greatest challenge in palliative care is confronting the feelings of relatives and their relatives. This places demands on the way care staff manage problems and difficulties in daily care so that the work itself does not result in stress, burnout and poorer quality of care for patients and their relatives.

At the same time, changes in care such as organizational changes and financial restraints can affect the care team’s daily work with patients and relatives. Requirements for effectiveness and productivity are thought to have led to increased stress in the area of health care (Pettersson & Arnetz 1997). Tishelman et al. (2004) described the care of patients with advanced cancer as complex, where the organization, relations between care team members, patients and relatives and theoretical and experience-based knowledge were significant factors influencing every concrete care situation. The most prominent was the tension between the ideal and the reality, i.e. between what the care staff wanted to give and the care that was actually given. This tension can lead to moral stress where organizational factors can make it difficult, or totally impossible, to meet the needs of patients and families (Corley 2002, Lützen et al. 2003). Taylor et al. (2002) call attention to the importance of having an ideal but also that unrealistic goals or difficulties in reaching the goals can lead to stress, a loss of ideals and a dehumanization of care.

Vachon (1999) found that a high level of stress was a problem when palliative care was evolving but that today there is no difference in this regard compared with other care forms. Vachon (1995, 1999) points to support on both the individual and organizational levels as a reason why stress in palliative care is not at a higher level today. However, greater stress is apparent where social support, participation in decisions and a realistic workload are lacking (Vachon 1999). The importance of identifying the psychological needs of care staff and how these can be met is described by many authors (Byrne & McMurray 1997, Boyle & Carter 1998, McDonell et al. 2002). Boyle and Carter (1998) demonstrated the need for both professional and emotional support. If the nurse lacks this support, the coping strategies he or she uses when experiencing stress and death anxiety can be directly inappropriate in the professional role. Farrington (1997) points out that research has called more attention to causes and consequences than to strategies the nurse uses for handling stressful situations. The aim of the present study is to describe how care team members caring for patients with advanced cancer describe how they handle difficult situations in daily care. In this study ‘difficult situations’ refers to situations care team members themselves define as difficult.

Method

Materials and methods

The study is a part of a multi-centre research project, the ‘ÖS’ project (Tishelman et al. 2004). Sixteen focus group discussions (FGD) comprising care team members caring for patients with advanced cancer were conducted in 2000 and 2001. The FGDs included care team members at three different care units in two Swedish cities. The care units comprised a palliative unit with a ward and home-based care, a palliative unit with wards, home-based care and day care, and a pulmonary medicine ward at an acute care hospital. A total of 77 persons took part and each focus group comprised two to eight participants. All team members were women and they varied in terms of age and work life experience. Each focus group was composed of persons from the same care unit and comprised a mix of professions that included nurses, assistant nurses, psychologists, occupational therapists, occupational therapist aids and physiotherapists.

Each FGD lasted between one and two hours and took place at the participants’ workplace. Work-related disturbances were not permitted during the course of the FGD. The discussion was led by a moderator whose aim was to pose introductory, open-ended questions and stimulate the whole group to involve themselves in continued discussion and activity. Examples of introductory questions posed by the moderator were: What do you experience as difficult in your daily work? How do you handle these difficulties? During the course of the discussion the moderator posed follow-up questions to group participants such as: Can you describe that in more detail? Can you give an example? An observer took part with the aim of observing the participants’ activity and supporting the moderator in activating the whole group. These observations were discussed and documented by the
moderator and observer after the FGD had ended. Six different moderators conducted the 16 FGDs. All of the moderators were nurses. Their experiences differed and they were currently working as clinical nurses, lecturers and/or researchers. All except one of the moderators had taken a course on methodology in FGDs led by Barbour (Barbour & Kitzinger 1999) and continuing methodology discussions took place among the different moderators.

Each FGD was tape-recorded, transcribed word-for-word by a professional transcriber and then read and corrected by the moderator and the observer.

Ethical issues

Care team members were informed verbally and in writing concerning participation in a FGD. Their right to discontinue participating was stressed. They were assured the greatest possible confidentiality and the importance of their responsibility to make sure that what was said remained within the group was also emphasized. They were also told that they could contact the moderator after completion of the FGD if that was felt to be necessary. Permission for the study was obtained from the respective unit managers. The study was approved by the research ethics committee.

Analysis

Analysis of the 16 FGDs was begun when all FGDs had been transcribed and was carried out in a number of steps inspired by the phenomenological method (Giorgi 1985, Giorgi & Giorgi 2003) and applied by Sahlberg-Blom et al. (2000). The aim of the phenomenological method is to get a description of a phenomenon on everyday experience, as it is described by a person, before any theories being devised to explain the experience. The meaning of the original text was condensed in several steps so that variations and the essence of the studied phenomenon emerged (Giorgi 1985, Giorgi & Giorgi 2003).

Step 1

- The order in which the FGDs were analysed was random.
- The text was read through to get an overall picture.
- The text was divided into meaning units.
- Each meaning unit was transformed in two steps, where the meaning of the text was increasingly condensed in each step and transformed at the same time into more theoretical language with a nursing scientific perspective.
- The meaning units in the transformed text were then grouped together into a third transformation based on common characteristics.
- Different variations and the essence of the phenomenon emerged (for an example, see Table 1).

Step 2

- After five interviews no new variations occurred and the following 11 FGDs were therefore analysed deductively based on what emerged in step 1. No new variations occurred during the deductive analysis.
- To validate the results, all 16 FGDs were read again against the background of variations and the essence of the studied phenomenon. Quotations were identified to illustrate the results.

Results

The phenomenon’s essence, Closeness and Distance, emerged. This can be seen as a scale where care team members described their strategy as a balance between being close and distancing themselves. In most situations their choice of strategy seemed spontaneous rather than being a conscious decision, although it was sometimes described as a more conscious approach. An example in which this occurred was in a discussion about increasing the staffing to have more time for the patients. It was found that such a measure could also involve negative consequences for care team members:

Carola: I think you should have more time to maybe sit with the patient, because they’re often really anxious and all that, and then it can often have a calming effect just to sit there and have time to talk, then they calm down, but you rarely have time.

Maria: …I wouldn’t want it like that because I think there’d be a little too little to do, or you’d have too much time and go in to each patient too much…

Different variations of the essence emerged that could be divided into seven groups: Identity, Meaning, Limit-setting and touching, Prioritization, the Team and the Organization. These could also be described as tools which in themselves facilitated or impeded the use of closeness and distance (Fig. 1). The variations could be dependent on one another and were, in some cases, overlapping in character.

Identity

Care team members consistently described themselves as an instrument for handling difficult situations. The self was seen as a tool that could be used in daily work, where it was a matter of give and take both personally and professionally. The starting point for a caring role was described as human love where there is respect for all kinds of people. A strong sense of personal
Table 1 The analytical procedure

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Transformation 1</th>
<th>Transformation 2</th>
<th>Transformation 3</th>
<th>Variations and essence</th>
</tr>
</thead>
<tbody>
<tr>
<td>62. A: But I think E should remember that when you work in the area of care like we do it's a team, teamwork as it's called in English. And we work as a team and no one should stand alone and feel alone in doing this, since there's always someone here, even those who work nights, they have ward 4 or someone they can call and ask</td>
<td>62. A thinks that E should remember that when you work in the area of care you work as a team. A describes that in a team no one stands alone since there's always someone to ask, even if you work nights</td>
<td>62. A thinks teamwork means that no one is alone, and that 24 hours a day there is always someone to ask</td>
<td>62–66 + 208. Teamwork means that none of the care team members is alone and there is always someone else to ask. Care team members need to ask what colleagues would have done in a similar situation and get support, even if they have worked for a long time and are very experienced. This does not concern only practical situations but can also involve how a person should be treated. It is important to have an open atmosphere in the ward where questions are allowed</td>
<td>The team CLOSINESS</td>
</tr>
<tr>
<td>63. E: Yes well that's what feels so good, that there's been such a good atmosphere so that you've been able to ask questions</td>
<td>63. E describes that it feels good that the atmosphere is such that questions can be asked</td>
<td>63 + 66. E and B think that the atmosphere in the ward is such that questions can be asked and that the staff discuss things with one another</td>
<td>63 + 66. E and B think that the atmosphere in the ward is such that questions can be asked and that the staff discuss things with one another</td>
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<tr>
<td>64. A: You should ask. E: And I've done that. I've like asked about everything. Even when I've felt almost certain, if it's only almost certain, then I've like always checked with someone (laughs)</td>
<td>64. A thinks that you should ask and E describes that she has done that, even when she has felt almost certain, in order to check with someone else</td>
<td>64 + 65. Even if you have experience you need to ask or talk with a colleague in order to find out what the colleague would have done in the situation and get support. Sometimes this does not simply concern practical situations, it can also involve how a person should be treated</td>
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<tr>
<td>65. Or often you can, even when you have experience, maybe you end up in situations where you need to talk with someone, then you figure something out together, what you should do. Or like I asked someone, what would you do in this situation? It doesn't have to be about something...something really...practical, it can be about how you should treat a person or something like that</td>
<td>65. E describes that even when you're experienced you can end up in situations you need to talk with someone about in order to figure out together what should be done. Sometimes you need to ask what someone else would have done in the situation. E describes that this does not have to be about practical aspects, it can concern how a person should be treated</td>
<td>65 + 66. Even if you have experience you need to ask or talk with a colleague in order to find out what the colleague would have done in the situation and get support. Sometimes this does not simply concern practical situations, it can also involve how a person should be treated</td>
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<td>66. B: But we often discuss this. E: Yes, we do. And it feels good that you can do that</td>
<td>66. B and E think this is often discussed and that it feels good that this is possible</td>
<td>66 + 67. B and E think that this is often discussed and that it feels good that this is possible</td>
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The balance between

Closeness         Distance

Identity        Meaning        Limit-setting and touching
Prioritization   The team     The organization

Figure 1 Care team members’ handling of difficult situations is illustrated as a balance between closeness and distance. The tools used were Identity, Meaning, Limit-setting and touching, Prioritization, The Team and The Organization. These could both facilitate and impede the use of closeness and distance.

Identity and self-knowledge was described as important in the encounter with patients and their relatives, where care team members could sense their own limitations. Security within oneself and maturity were required. Life experience, closeness to other people and professional experience were described as important in being able to trust in one’s own feelings and intuition to meet, and sometimes harbour, the suffering of others. This was considered of importance to be able to be close to serious ill and dying persons and their relatives:

Anni: ...Well, some experience, I think so. You can’t come here directly from school...and without life experience.

Lena: I’ve worked with people and have some knowledge of human nature and it’s actually in your own interest to cultivate this, maybe read about people in different ways and think about how others think.

Anni: Well I believe you have to be secure in yourself to have the strength for this category of patients. I think that’s important.

In addition, the importance of knowledge was stressed, both in the form of common sense as well as knowledge specific to one’s profession, where education and courses were described as a possibility for keeping up-to-date and strengthening one’s professional role. A strong professional identity was considered important to be close:

Victoria: ...We took courses and talked about death and ethics and morals and everything about how you should conduct yourself. So I think I’ve got it, that it’s part of me.

Courage was considered an important quality in working with serious ill and dying patients. This could be courage to be challenged and to develop as well as to be close to people in difficult situations:

Anna: When you’re going in to a patient who’s dying, doing that and handling it...It can be a little sweaty when everyone’s sitting in there and all the relatives are watching you...

Carita: Then you want to infuse a sense of security too.

Sara: Sometimes it’s really hard to feel courageous, it’s hard to take that step in. Anyway I know there are patients where I’ve felt like I’ve stood outside and charged myself. Now I have to go in here. Maybe it’s someone who’s really touched you and you feel upset in general, then it can be really hard, especially with children.

Anna: Yes, those who are your own age or younger.

Meaning

In their daily encounters with seriously ill and dying persons and their relatives, care team members described the importance of seeing their work as meaningful in order to be close. They made comparisons with the work of midwives, where the same closeness to life and appreciation of live were described. Work with dying persons was described as ‘the circle of life is completed’. Team members felt they had attained a different approach to life through their work that influenced both their private life and their work life:

Carola: ...being born is just as natural as dying. It’s like a part of life and the circle is completed. You go around in a ring, hand in hand.

Vera: ...and I’m just as humble and just as thankful that I can be there when this person leaves life.

Maria: Yes it’s the same. We have the same thoughts and we have the same feelings about our jobs even though we are on two sides of the scale of life [care at the beginning of life and at the end of life].

There were also descriptions of when care team members felt it was difficult to see any meaning and when the experience had to do with distancing themselves from people’s suffering:

Gun: I want to say that life is nothing but suffering that has its ups and downs...and in addition if you know you’re going to die...that must be awful, you can’t see your children...

Susanne: There’s suffering you can’t reach, where you just have to stand there and look at it.

Limit-setting and touching

Care team members described handling difficult situations by learning to set limits so as not to get too personal or too involved in the encounter with patients and their relatives.
This was considered to come with experience. They felt it was important not to be too close to the patient in order to 'save themselves':

Kim: No, I don’t think it’s hard to live the part as long as you don’t carry it too far.

Annelie: No, you have to set your own limits. Like this far and no farther. —

Sara: Well and you can’t be too personal, you have to keep a little of yourself for yourself. —

Kim: You don’t take it in, this is me and they’ll never get through this wall. It’s like saving yourself.

Sara: You have experience because you’ve had your blows and then you learn that now it’s enough and then you set up.

In meeting the family’s grief, care team members thought they should look neither happy nor sad. They thought they had no choice and that they were forced to close up and be firm and clear towards patients and relatives so that they would not come too close to them:

Helen: Well I met one today and what I’m thinking is not to enter into this suffering, it’s really important to set limits —

Tea: …sometimes you have to be quite firm or whatever you call it, hard and firm and clear over and over again.

Set limits could also concern not allowing themselves to be touched by the patient and distancing themselves instead. They were not honest with the patient but were playing a role:

Elina: …But I think I’ve learned something here that maybe I wish I hadn’t learned, I notice that I’ve become more skilled at talking around it.

Pia: Being a little vague and the like.

Maria: You come out with something so that you sound very confident without giving a clear answer. —

Elina: But it’s just the idea of seeming assured regardless of what I say, just that my voice sounds confident and straight-forward, then the patient can accept whatever I say. And that gives me a chance to find out so that the next time I go in I can give a more correct solution or whatever it’s about.

They also described handling difficult situation by touching the patient, stopping and being close both physically and spiritually. Spiritual touching was described as ‘being a part of the patient’, where care team members saw the relationship between them, the patient and relatives as a reciprocal relationship in which they also allowed themselves to be touched. By taking time and sitting down with the patient, things were described as happening within the team members themselves:

Barbro: She was literally lying in my lap and her lungs were bubbling unbelievably and nothing helped…and then I held on to her and then I held her with my head against hers and we sat like that…but it was nice.

Care team members could imagine what it would be like to be a patient or relative and could see themselves not only as professionals but also as fellow human beings who shared the exposed position and the vulnerability of being human. They described allowing themselves to be touched by looking at their own anxiety and by recognizing their own life crises or similar life situations.

Prioritization

In care team members’ encounters with difficult situations, different prioritizations were described as a way of handling these situations. They described how they sometimes did not give priority to difficult situations and instead concentrated on practical duties of a routine nature as a way of distancing themselves:

Ingrid: You can’t do that much, not much more than being there and letting them talk, I just listen. If you have the strength to do that. Some can’t do it, be there and listen, so they choose to do something else instead because it’s too hard. —

Kia: It’s hard sometimes. Sometimes you actually avoid going in to a certain room.

Care team members’ descriptions of a lack of time, where conversations with patients and relatives, for example, are not engaged in, could also be seen as a type of prioritization.

Patients’ symptom alleviation was prioritized differently by different team members in that symptoms considered easy to do something about, and where the effect of the measures used could be easily assessed, were given higher priority than symptoms team members experienced as difficult to do anything about:

Carola: …symptoms you can see, totally pain like oh, oh, oh, and nausea are not that easy to avoid seeing. These are given priority irrespective of what it’s like in the ward. Worry and anxiety are nothing you give priority to because you really don’t have time to see them. —

Maria: It’s like you say, you do something about what you can do something about, you run in with a shot because their breathing is wheezy and then after a while you see it coming out through the
catheter and their breathing is a little quieter, well then you’ve decreased your stress a little...you do something where you can see some kind of result.

Care team members also set priorities based on ‘personal chemistry’ in that they expressed a preference to care for patients they liked:

Malin: ...you actually like some people, you really like them. Nice people and you feel that well you feel sorry for them and so many feelings are stirred up. Then maybe you want to help that person more than someone else you’re caring for but where there isn’t that chemistry.

Lisa: ...if there is a special chemistry between you and this patient and you feel that things are working there, but you give a little more without thinking about it.

There were also descriptions where care team members prioritized being close to patients:

Karin: It’s also the case that you feel you have time to sit in peace and quiet and be with them [the patients] and go in to some room...

Helena: But in any case I think I have time or that I take time for that.

The team

The team was described as a support for facilitating closeness in daily work. Many thought there were opportunities for talking about what was experienced as difficult, showing their tears and anger and getting confirmation that they were doing a good job. A permissive environment in the team was considered essential if it was to be a support. Because the different personalities and experiences in the care team complemented and strengthened one another, team members were able to help each other when necessary, such as by making changes regarding patient responsibility. The possibility of contacting colleagues in difficult situations and for two staff members to make a home visit together was also seen as a support:

Ingrid: ...I think you have the strength to work if you can come out to the office and ventilate to those you work with after you’ve experienced some aggression...that turns things around, that’s what I feel. —

Carina: ...just to come out with it and say what you think without being judged, because then maybe you can go in and be professional again.

The team was also considered as support and security in that it was composed of different categories of professionals, as there was a need in daily care for different competencies in caring for patients and their relatives. Collaboration and teamwork among the different members of the team were considered important. The staff could share their knowledge, they could have discussions, and questions could be raised. Prerequisites for the team to be seen as a support and source of security were open communication and a common strategy that everyone followed. These gave the feeling of being a united team.

Care team members described their possibilities of feeling like team participants as important. Through the delegation of tasks, for example, they felt trusted and a part of the team. The opposite situation was also described, where team members did not feel they were participating in the care. Examples of this were situations where the doctor informed patients and relatives without involvement of the rest of the team, which could make it harder to handle difficult situations:

Beatrice: It would make things much easier if you could be there when the doctor informs the patient. That's what I think is most lacking...it’s not knowing exactly what the doctor has said, that’s what I think is the greatest obstacle. —

Lena: ...and for our own anxiety too, so that we know how the patient has perceived the situation.

The team could also be considered a source of distance when there was rivalry between different categories of professionals and between different colleagues. The hierarchy in health care was described as a distancing factor between team members where, for example, it was experienced as difficult to pose questions to the doctor. The team could also constitute protection in difficult situations, where vulnerability could be concealed and the individuals on the team disappeared. There was a feeling of ‘one for all and all for one’. By referring to other categories of professionals on the team, a team member could avoid answering questions from patients and relatives, which was a way of distancing oneself:

Eva: No, no, and if they should ask I can refer them to...then I refer them to the doctor. But then I don’t have to take these difficult questions and can work more with the physical side.

The organization

In some cases the organization could function as a support in handling difficult situations. Measures that could decrease the number of beds when there was a heavy workload and the possibility of working part-time were described as important to care team members. The possibility for reflection and clinical supervision and support were considered positive and signified help in handling stressful situations:
Lisa: ... We had clinical supervision last time when we had quite a few demanding patients so that we were quite tired of some of them and wondered if we were acting right toward the patient. And we talked about this, how we felt and what we did, with the supervisor...

Cecilia: I think it’s great because it gives you a chance to reflect over your job, and you don’t otherwise have time to sit down with your colleagues and do that.

Negative experiences of clinical supervision and support were also reported where the care team members did not think the supervisor did a good job. They also described the possibility of getting help and support from their manager and from others around them such as social workers and psychologists.

The care culture in the organization was described as meaningful with respect to being able to handle difficult situations. The palliative care philosophy was considered soothing and it facilitated greater closeness than more traditional care. In care units where both palliative and curative care was given, the culture of curative care could make closeness more difficult. Collisions arose between these two cultures, both between team members as well as within individual team members.

Discussion

Care team members handled difficult situations by balancing between being close and distancing themselves. In most situations their choice of strategy seemed spontaneous rather than being a conscious decision, while it was sometimes described as a more conscious approach. Closeness and distance has been described earlier in the literature by Glaser and Strauss (1965) as types of awareness context, in interactions between dying persons and hospital personnel. In this study, balancing between being close and distancing themselves was not described only in situations by patients and relatives but also in situations in the daily care between care team members, in interaction with the organizations and into themselves as both a professional and a human being.

Care team members showed great closeness in difficult situations when they allowed themselves to touch and be touched both physically and spiritually. However, it was difficult to distinguish between physical and spiritual touching when they described it as ‘being a part of the patient’. This seems to be in accord with Rasmussen’s (1999) description of the hospice nurse, which had more to do with ‘being’ than ‘doing’ and where it was difficult to distinguish between the nurse as a person and as a professional. Staff and patient in a caring situation were described there as ‘we’ through ‘shared lived experiences’. In the present study care team members’ possibility to be close and to share in the suffering seemed to be dependent not only on experience and education but also on aspects of personal identity such as self-knowledge, maturity and security. Care team members consistently described themselves as an instrument, which can indicate the need to direct attention to personal identity in the professional role. The question is what opportunities are provided in education and working life for actively working on oneself to strengthen one’s personal identity?

The results also showed that care team members handled difficult situations by distancing themselves in different ways. In other studies, distancing and evasive behaviour have been observed in different situations. Distancing was shown to be the most common strategy for protecting oneself among nurses at burn units (Nagy 1999). In palliative care and cancer care distancing has been described as a way for staff to protect themselves from painful feelings (Wilkinson 1991, Booth et al. 1996, Byrne & McMurray 1997). In the present study, care team members described prioritization as a strategy where, for example, symptoms considered easy to alleviate and where the measure gave immediate results were given higher priority than symptoms considered more difficult to do something about such as worry and anxiety. Team members could, in this way, feel some kind of satisfaction regarding efforts by which patients’ suffering could be alleviated. The results can also indicate a lack of knowledge and of effective interventions for symptoms such as worry and anxiety (Del Giudice et al. 1997). At times, care team members also chose to be more task-oriented than person-oriented. Prioritizations sometimes seemed to be more involuntary, such as when there was insufficient time or a lack of staff. Despite that, the question could be asked as to whether the needs of care team members or of patients and relatives govern the content of daily care. Attention should be directed to these issues and staff be given the possibility to reflect over them.

In the present study care team members described handling difficult situations both by being close and by distancing themselves. It may be that what is necessary is just this balance between closeness and distance. If care team members handle difficult situations by means of evasive behaviour, of if they develop too close a relationship with the patient, neither of these approaches is favourable for the patient, the relatives, or team members. Coping strategies of care staff in demanding situations in palliative care have been identified by means of different instruments (Dean 1998, Myles Evans et al. 2001, Payne 2001). As care is complex, team members probably do not handle difficult situations with just one or the other. The choice of closeness and distance seems to depend on the situation as well as on a number of other
factors, described in the present study as variations of closeness and distance. These could also be seen as tools that in themselves seemed both to impede and to facilitate the use of closeness and distance.

The results can be said to concern the health and ability to experience well-being of care team members as well as of the patient and relatives. If a difficult situation is handled in an inappropriate way, this can probably lead to stress, burnout and non-optimal care. The ability of care team members to create a caring relationship with the patient and relatives is probably of decisive importance regarding how the quality of the care will be experienced. Andershed and Ternestedt (2001) showed that the approach of care team members was of great importance regarding relatives’ experience of involvement. The lack of a humanistic approach, with evasive and disregarding behaviour, meant that relatives did not get the support they needed. Dahlberg (2002) described suffering from care as suffering arising from the relation between patient and staff where the focus of care was shifted from the patient’s suffering to the staff themselves and their needs. For the patient, suffering from care meant being disavowed as a suffering person. This can be compared with Halldörsdóttir’s (1997) conclusions, where people’s suffering was made worse by the inadequate way in which they were treated by the staff, which is termed ‘uncaring’.

Responsibility lies not only with the individual caregiver, but with the team, the organization, the care culture, education and political decisions. Education should be designed to provide the possibility for systematic reflection to become a natural part of continued professional life to create better prerequisites for being able to care for others. In discussions concerning stress and burnout there may be a danger of choosing distance to avoid the risk of burnout. ‘Shutting off’ work without engaging in reflection can be a poor strategy for care team members and, in the long run, for care. Professional clinical supervision and support has been seen as a way to stimulate reflection concerning daily care that contributes to professional as well as personal growth (Arvidsson 2000, Cutcliffe & McFeely 2001, Jones 2001, Teasdale et al. 2001). Further research is needed, however, regarding how clinical supervision and support affects the way care team members handle difficult situations.

There are few studies on care team members’ own descriptions of how they handle difficult situations. Through FGDs staff members stimulated one another to engage in reflection and careful consideration. This is in line with what Kitzinger (1995) thinks is the idea behind focus groups, which is that group processes can help people develop and clarify their ideas. Many researchers emphasize the importance of directing attention to methodological issues in the use of FGDs such as the composition of the focus group, the role of the moderator, and the interaction among group members (Sim 1998, Kitzinger & Barbour 1999, Webb & Kevern 2001). In the present study, group interaction was in focus during the course of the analysis in the search for consensus in the FGDs. Despite varying numbers of persons and activities in the groups there was a consensus. It is possible that some individual ideas may not have been expressed the group. Power relationships between professional groups and/or the relations of persons with one another may have had an influence. An unwillingness to share negative experiences or actions with others was not seen in these interview situations.

The moderator has a decisive role in a focus group, where the moderator’s personality, social identity and behaviour can affect participants (Sim 1998, Kitzinger & Barbour 1999, Webb & Kevern 2001). A difficulty pointed out by Sim (1998) involves the effort to reach an optimal balance between an active and a passive role as moderator. In the present study attention was directed towards these issues through continued methodology discussions between different moderators and observers. However, this does not preclude that the moderator may have influenced both the group activity and what was said/not said in the focus groups.

The analysis in the present study was inspired by the phenomenological method described by Giorgi (Giorgi 1985, Giorgi & Giorgi 2003). Opinion is divided concerning the choice of analytic method for FGDs. Carey (1995) points out that there are deficiencies in many studies regarding description of the analysis of FGDs. Many researchers think that analysis of FGDs is the same as for other qualitative data (Kitzinger 1995, Kitzinger & Barbour 1999, Sim 1998) and Webb and Kevern (2001) point to the need for greater discussion of the different methodological points of departure in the choice of methods of analysis, where phenomenology and focus groups are seen as incompatible. Webb and Kevern (2001) pointed out that focus groups involving group interaction and are not compatible with requires in a phenomenological approach that the individual described their experiences in a more uncontaminated way. This cannot be verified in the present study, nor was the study’s point of departure a phenomenological perspective; only the procedure of analysis itself was inspired by the method. The method of analysis and the rigorous way in which the text was analysed contributed to the emergence of the studied phenomenon and its variations.

Conclusions and relevance to clinical practice

The study can stimulate reflection over daily care and a discussion of how difficult situations are handled and what
support care team members need. It is also important for this knowledge to influence the design of education in the areas of care. In addition, the results of the present study can be seen as a basis for further research. Examples of research issues include how care team members handle difficult situations in other care contexts and how they can be given support and stimulation in order to attain professional and personal growth.

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Contributions

Study design: KB, ESB; data collection: KB; analysis: KB, ESB and manuscript preparation: KB, ESB.

References


