The Professional Guest: conceptualizing home visits in palliative care settings

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Abstract

Background: Home-based palliative care is a growing trend, necessitating a deeper understanding of the unique challenges faced by professional staff members in this setting. The shift to home-based care has been driven by advances in technology, changing demographics, and a move toward more patient-centered approaches. As a care setting, the home environment offers distinct characteristics, presenting both advantages and drawbacks for patients and healthcare providers.

Objectives: This study aims to explore the experiences and perceptions of professional staff members providing palliative care in patients' homes.

Design: A qualitative descriptive study.

Methods: Qualitative study with 36 home-based hospice professionals using questionnaires and interviews. Thematic analysis identified key themes in staff experiences and challenges.

Results: The central theme of "The Professional Guest" highlights the hybrid identity and boundary role professional staff members must navigate, being both medical professionals and guests in the patient's domain. Four sub-themes emerged: (1) Observing and Applying, emphasizing the conscious scanning of the home environment to build trust and tailor care plans; (2) Asking for Permission, respecting the patient's territory and adapting to their norms; (3) Expecting the Unexpected, maintaining flexibility and improvising in unfamiliar situations; and (4) Preparing the Ground for Your Absence, equipping patients and families with comprehensive self-care guidance during professional staff members' absences.

Conclusion: The "Professional Guest" phenomenon captures the complexities of providing care in patient's homes, necessitating a delicate balance between professionalism and personal vulnerability. Specialized training programs and policies should be developed to support professional staff members in navigating this hybrid identity and effectively negotiating the boundaries between professional and personal spheres.

Plain language summary

Home visits for end-of-life care: understanding healthcare workers' experiences

This study looks at how healthcare workers feel about providing end-of-life care in patients' homes. As more people choose to receive care at home rather than in hospitals, it's important to understand the challenges healthcare workers face in this setting. The researchers interviewed 36 healthcare workers from different backgrounds who work for a home-hospice service in Israel. They found that these workers often feel like "Professional Guests" in patients' homes—they need to be both medical experts and respectful visitors. This can be tricky to balance. The study identified four main ways healthcare workers handle this situation: They carefully observe the home environment to build trust and plan care. They ask permission before doing things, respecting that they're in the patient's space. They stay flexible and ready for unexpected situations. They teach patients and families how to manage when healthcare workers aren't there. The study concludes that providing care in patients' homes is complex and requires a delicate balance between

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> being professional and being personally involved. The researchers suggest that special training programs and policies should be created to help healthcare workers navigate these challenges and provide the best possible care for patients at home.

Introduction

Previously, home and end-of-life care were standard social practices, typically the only choice for meeting medical and social needs.[1] During the 20th century, advances in technology, science, and society led to the rise of institutionalized medical care, especially in Western nations, shifting these responsibilities from individual homes to state and technology-driven settings. Consequently, hospitals became viewed as the default and safest environments for complex, chronic, or terminal care.[2]

Recent years have witnessed a shift in the perception of health and well-being in the Organization for Economic Cooperation and Development (OECD) countries,[3] driven by the development of technology and modern medicine, coupled with changing demographics, including an aging population and an increase in the prevalence of chronic diseases. There has been a transition from a reactive approach to healthcare to a preventive and proactive one, based on home and team-based care transitioning between hospital settings.[4–6]

This trend is growing, as there is pressure on various population groups to avoid prolonged hospital stays,[7,8] particularly toward the end of life.[9,10] The rationale lies in the belief that home settings expose individuals to fewer infections, preserve the patient's sense of identity and comfort, promote independence, maintain symptom management, and cater to the essential needs of both the patient and their family.[11–13] The COVID-19 pandemic has accelerated this trend, with many severely ill patients preferring home-based care.[14–16]

Similar to those changes, home palliative care policies are also rising.[17–19] Palliative care aims to alleviate suffering and enhance the quality of life for patients with chronic or terminal illnesses and their families. It involves an interdisciplinary approach, addressing medical, emotional, social, and spiritual needs.[2,20] Palliative care provides symptom management and addresses physical, emotional, and spiritual issues while respecting patients' choices, beliefs, and values.[21] This approach can be initiated upon diagnosis and continue alongside curative treatment, including end-of-life care and bereavement support.[22] Home-based care involves the regular provision of home visits by clinicians (e.g., physicians, nurses, social workers, and other multidisciplinary professional staff members), and in Israel is a benefit covered by the HMO (Health Maintenance Organization, also known as Kupat Holim).[23,24] Around 3% of the population over 65 are cared for by home care services.[25]

However, community preparedness to deliver home-hospice services is lacking, leading to most patients being referred to hospital treatment or receiving palliative care only in the advanced stages of their illness.[26] As a care setting, home-based care offers distinct characteristics, presenting both advantages and drawbacks. One primary advantage is the comfort and familiarity it provides, contributing to patients' emotional well-being, and allowing for personalized care plans tailored to individual needs and preferences.[27] In contrast to the hospital setting, home-based care fosters a less formal relationship between professional staff members and patients, governed by fewer norms and rules.[28] Professional staff members in home settings do not have a clear and predefined status, unlike in hospitals. The physical environment of hospitals shapes the staff's image in the patients' perception, influencing relationship dynamics, expectations, and the role assigned to them by the patients.[29] In home-based care, there is a shift in power dynamics: ownership of treatment and the treatment environment are not solely in the hands of the professional staff member. This situation creates a process of negotiation on various aspects of care, which does not occur during treatment in the hospital setting.[30]

The asymmetry in the relationship system between professional staff members and patients in home-based care is described in various contexts but is not necessarily fixed and can change throughout treatment and changing circumstances.[28] Often, patients receiving home-based care expect maximum adaptation to their needs by professional staff members, as well as much greater openness in terms of personal exposure and the quality of the relationships formed.[28,31]

For professional staff members, there is a heightened awareness that they are operating in the patient's "territory," and this influences their conduct. Home-based care allows for an understanding of the patient's natural environment, family dynamics, and the development of broader relationships while providing comprehensive care. Professional staff members consider their steps carefully, maintaining a neutral demeanor (i.e., not standing out and avoiding influencing family relationship dynamics), with considerable awareness and sensitivity to the home environment and their impact on the patient and their family.[32] Moreover, professional staff members devote significant thought to preserving the patient's privacy in a space that is not their own, such as knocking before entering, requesting privacy when sharing medical information, and more.[33] There is also a significant influence by professional staff members on the primary caregiver's sense of competence, reducing anxiety, and even enhancing the family members' connection to the meaning of therapy.[34]

The relationship formed between the professional staff member and the patient at home is seen as central, impacting the patient's condition and how they cope with the challenges of the disease.[35] This relationship is built gradually and involves establishing trust as a therapeutic goal,[35,36] as well as highlighting that the patient primarily values interpersonal relationships with their professional staff members. They emphasize the quality of communication and the sense of respect, security, and trust they feel, rating these elements above all other aspects of the professional staff members-patient relationship and the overall quality of care.[28,34]

Home-based care and its complexities may leave professional staff members feeling uncertain in navigating their roles as team members, as compared to care settings outside the home.[37] Adapting to each patient's unique home environment is described as a major challenge, requiring open-mindedness, non-judgmental perspectives, and flexibility. This adjustment is essential in terms of respecting family dynamics and values, as well as providing quality care in unconventional living conditions.[38] Close contact with patients' families is frequently cited as demanding for home care professional staff members.[32]

Building a caring yet professional relationship with patients in their homes is regarded as a more critical responsibility for professional staff members than in institutional care, demanding enhanced interpersonal abilities and attentiveness,[34] and sometimes described as isolating[32] and vulnerable.[39] Fostering mutual trust and collaboration with patients and families, while maintaining clear roles and boundaries, is paramount.[38] Furthermore, professional staff members may be exposed to the emotional challenges faced by patients' loved ones, such as grief, separation, anger, frustration, and anxiety.[40]

The study aims to explore the experiences and perceptions of professional staff members in home-based palliative care, focusing on understanding their roles and challenges in providing end-of-life care at home. Additionally, it seeks to refine the conceptualization and articulation of the complexities inherent in home-based hospice care. By gaining insights into these staff members' unique challenges and needs, the research seeks to inform training programs, shape policies, and enhance care strategies for terminally ill patients in home settings.

Method

Design
The study employed a qualitative content analysis approach using two data collection methods: written questionnaires with open-ended responses and semi-structured in-depth interviews. This design was chosen to explore and understand the complex experiences of healthcare professionals in home-hospice care.[28,34,42] The reporting of this study conforms to the Consolidated criteria for reporting qualitative research (COREQ) statements (Supplemental Material).[41]

Study setting and recruitment

The study was conducted in Israel between March 2022 and November 2023, focusing on employees of Sabar Medical Services, one of the largest organizations in Israel providing home-based care, primarily home-hospice services. Sabar operates nationwide, serving both central and peripheral regions of Israel, and provides services to all HMOs in the country.

The inclusion criteria included staff members working in the home-hospice unit for over a year, including physicians, nurses, social workers, psychologists, and others. All participants had palliative care training either through academic programs or organizational training. Exclusion criteria were less than 1 year of experience, working in the organization but not directly treating home-hospice patients, and staff working exclusively with children rather than adults and elderly patients.

The staff members' palliative care training came through courses from the Ministry of Health or the home hospice. Professional staff members provide care across central and peripheral areas to culturally and religiously diverse populations. In end-of-life home-hospice care, nurses visit at least weekly, and physicians and social workers at least bi-weekly or more, depending on the patient's needs. Multidisciplinary team (including physicians, nurses, and social workers) visits are common at the beginning of care and during crises, but most visits are conducted independently, with team consultations as needed.[6]

The recruitment process was conducted by two external female researchers (a Doctor of Nursing and a Doctor of Medical Ethics, both with PhDs). These researchers are experienced in conducting qualitative research, from the planning stages through interview execution, analysis, and discussion of findings. They had no prior relationship with the interviewees and introduced themselves as external researchers collaborating with the organization's leadership to explore staff working in the palliative program's needs. Both researchers have previous experience in end-of-life and home care studies, with one having extensive nursing experience and knowledge.

The sampling recruitment process occurred in two stages: The first stage: A convenience sample[42] was conducted. An email with an open-ended questionnaire was sent to all eligible professional staff members (N = 103). Twenty-seven participants responded to this questionnaire, providing written responses. In the second stage: A criterion sample[42] was employed. Nine additional participants, primarily key managers, were recruited for in-depth, semi-structured interviews (see Appendix 1). These interviews, lasting approximately 60 min each, were conducted and recorded online via Zoom. During the interview, the participants were in the clinic or their homes, for their convenience. Reflective journals were written after each interview by the interviewer to record thoughts, patterns, biases, challenges, and emotions for later discussion and analysis.[43,44]

Interviews continued until thematic saturation was achieved. This was defined as the point at which no new themes or significant insights emerged from additional interviews. We also ensured that we obtained rich, multilayered data that provided comprehensive insights into our research questions.[45]

Participants

To protect participant anonymity, detailed demographic information has been aggregated. The study comprised 36 multidisciplinary participants (from the two research stages; 64% women). Regarding religious affiliation, approximately 80% were Jewish. Ages ranged from 28 to 65 years. Professional experience varied from 1 to over 20 years in their respective fields. For detailed participant characteristics, please refer to Table 1.

Data collection

The initial stage involved an email with an open-ended questionnaire, aimed at understanding participants' experiences in homecare, sent to all eligible professional staff members. Twenty-seven participants responded to this initial email.

In the second stage, nine additional participants (mainly key managers) were recruited for semi-structured interviews. These interviews were conducted by the two main researchers (GY and IHH), lasting approximately 60 min each, and were conducted online via Zoom for convenience.[46] The interviews began with an explanation of the research objectives, followed by closed-ended socio-demographic questions and open-ended research topics. These topics were designed to explore concepts from previous studies that

Table 1. Participants' characteristics (*N* = 36).

Demographic variables	*N* = 36
Religion	
Jews	30
Other (including Muslims and Christians)	6
Place of birth	
Israel	26
Other	10
Religiosity	
Secular	27
Traditional	4
Religious/ultra-Orthodox	5
Profession	
Physicians	7
Nurses	20
Social workers	7
Psychologist and thanatologist	2
Tenure in the organization	
0–3 years	3
4–7 years	22
More than 8 years	11
Professional experience:	
0–3 years	1
4–6 years	7
7+ years	28

examined the coping strategies and challenges faced by staff working in end-of-life home care settings with patients and their families.[47–49] Additionally, the questions addressed the unique characteristics of professionals working in these environments, including their ability to adapt to diverse home situations, manage complex family dynamics, and provide compassionate care in less controlled settings.[50–53]

Example prompts included: "What are the key characteristics of working in an organization that provides hospice home care?" "What challenges do you face in your work with the home hospice?" "What aspects of hospice home care make it unique compared to care in an institutional setting?" and "Describe the training for palliative care specialists, particularly the aspects specific to providing care in the patient's home." Additional questions emerged through dialogue between the interviewer and interviewee.[54]

Analysis

The data analysis process was conducted in two stages, aligning with the data collection methods. In the first stage, a thematic analysis was performed on the written responses to the questionnaires sent via email. The second stage incorporated the transcribed in-depth interviews, completing the full data analysis process across all phases.

For both stages, we manually employed thematic content analysis by two researchers, following Braun and Clarke's method.[55] First, the researchers familiarized themselves with the data by thoroughly reading the questionnaire responses and interview transcripts to gain an in-depth understanding. Next, initial codes were generated, systematically categorizing relevant segments of the data. These codes were then grouped into broader themes that reflected key patterns. The themes were reviewed and refined to ensure they accurately represented the data. Once defined and named, the themes were articulated, capturing the core ideas emerging from the analysis. Finally, the findings were compiled into a report, supported by illustrative quotations that highlighted the participants' experiences.

The coding process resulted in a thematic structure centered around the unique demands of hospice home care and the significance of home as a care setting, with various sub-themes such as Observing and Applying, Asking for Permission, Expecting the Unexpected, and Preparing the Ground for Absence. These themes were validated through a careful review of their prevalence across both the questionnaire responses and interview transcripts, ensuring the analysis was both rigorous and nuanced.[55]

To maintain rigor, we applied Guba and Lincoln's[56] evaluative criteria. Credibility was established through member checking and peer debriefing, while transferability was ensured by
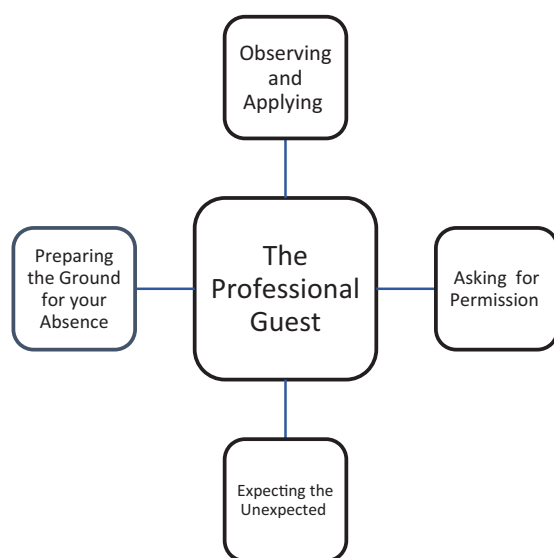
Figure 1. Thematic map of The Professional Guest in home-hospice care.

providing thick descriptions or research context and findings. Dependability was maintained via an audit trail of the research process, and confirmability was achieved through reflective journals and triangulation.

We implemented triangulation by cross-referencing the written questionnaire responses, in-depth interviews, and existing literature. For instance, we aligned our findings on "The Professional Guest" with studies on home-based care,[50,51,57] and professional boundaries in palliative care.[58–61] This approach not only validated our results but also ensured their consistency with broader research in the field, enhancing the overall robustness of our analysis across both stages of the research process.

Results
Analysis of data revealed a main theme: The Professional Guest. This theme encompasses the unique dynamics of providing palliative care in a home setting. The interviewees emphasized the complexity of hospice home care as compared to hospital settings, informed by their experiences in both environments. They noted that home-hospice care involves diverse populations needing rehabilitation, acute care, and/or palliative care. Additionally, there are differences in the psychosocial aspects of the patient and the constant presence of family members or other significant others in the home, not just their illness.

This end-of-life home care setting demands professionalism and autonomy but also recognizes patients' homes as their most important place. It is noted that the home is a significant place that influences the care and relationships among staff members, patients, and family members. The sub-themes of unique skills are: (1) Observing and Applying, (2) Asking for Permission, (3) Expecting the Unexpected, and (4) Preparing the Ground for Your Absence. These sub-themes are illustrated with quotes from the words of professional staff members, highlighting the complex and unique nature of home-hospice care (see Figure 1).

Observing and applying
According to the interviewees, upon entering patients' homes, professional staff members systematically scan for cues such as family photos, home esthetics, and personal items that can spark conversation and create intimacy. One interviewee described this process:

> If I see oil paintings and they all have the same name on them: A. Cohen and the person's name is Abraham, then I can say, "Wow, did you paint all of these?" This makes Abraham feel that I care about him, that I'm aware of where I am, that I know I'm not in my territory, but in his. . . (Participant No. 2)

Additionally, information gathered during home visits enables staff members to tailor care plans to patients' specific lifestyles, needs, and abilities. Critical insights, such as neglect or violence, which may not be apparent in clinical settings, can be identified, allowing for the creation of more personalized and effective treatment plans, as this quote illustrates:

> You enter such a place, and you immediately feel nauseous, but what do you do? You're not here to judge them or why they're in that situation. You're here to try to see if you can help them. I think we should not look down on them, thinking that I know better than them what's good for the case. (Participant No. 6)

The interviewees emphasized that in the home setting the patient and their family members are considered one therapeutic unit. They stated that the family is very present and significant, so part of the data collection process is reviewing and addressing the functioning of family members. Sometimes information emerges about

dysfunctional or harmful behavior, which becomes an integral part of the treatment plan. As one interviewee mentioned:

> Sometimes we are exposed to complex family dynamics not necessarily related to the patient. The family existed before the illness, with their struggles, style, way of life, customs, abilities, and resources. At the clinic, you see the patient and maybe their companion. But when you get home, you see more, the family, the community—even if you're entering for the patient, you're entering their family. (Participant No. 1)

The home environment also reveals differences in patients' organizational abilities, which informs how guidance and treatment programs should be adopted:

> We all know that guidance programs do not suit everyone. I entered a patient's home and got stuck in a pile of newspapers, old utensils, laundry, hoarders. . . This is their home, their safe space. If you give them a paper with a guidance program, they'll probably just throw it on the pile. Such a person needs daily guidance and verbal reminders. . . (Participant No. 16).

According to the interviewees, entering patients' home environments during care visits can lead to judgmentalism toward the patients, their values, and choices. Patients are exposed within their home environments, unable to control what aspects of themselves and their lives are presented. The interviewees acknowledged the danger of judging patients, which could harm the treatment process and their ability to express empathy. In their training, they work against this natural tendency to maintain empathy, which is viewed as an essential therapeutic tool in hospice home care:

> We enter luxurious homes, and we also enter homes where we struggle to find a place to sit because it's so dirty. So non-judgmentalism! You enter a situation, and in both cases—I must not assume. . . I must not have biases, and the same applies to poverty. (Participant No. 11)

The home environment provides professional staff members with valuable insights into patients' experiences and struggles, which cannot be obtained through questioning in clinical settings. Staff members can identify and empathize with the unique challenges patients face, fostering a sense of truly seeing and understanding the patient's reality, as illustrated by this quote:

> I can say—"you're on the fourth floor without an elevator, in your condition, that must be extremely difficult." In other words, I've noticed something unique about her, her struggle, and in doing so, I reflect that I see her, I see her struggles. (Participant No. 2)

The interviewees noted that compassion is consistently emphasized as a core aspect of professionalism and a central therapeutic tool in the organization. Some noted that compassion is more easily achieved in the hospice home care context:

> We need people who know how to be kind. . . who truly want to help another human being, and you don't know the patient at all, and now you're entering their home without judgment, and you need to watch their environment so you can care for them with compassion. (Participant No. 1)

Overall, the interviewees consistently emphasized the value of the hospice home care environment in providing invaluable insights, fostering empathy and compassion, building trust and open communication, and developing tailored care plans that better address patients' individual needs and circumstances.

Asking for permission

Hospice home care takes place in the patient's private and intimate space, requiring the treatment team to adapt to an environment that belongs to the patient, not themselves. This setting demands greater adaptation, beyond dealing with an unfamiliar environment; it involves entering the patient's domain. As one interviewee described:

> Can I sit? Can I use the restroom? Can I ask a question? There's no paternalism. Even if you want something, if you don't have it, you don't get to decide—at least not until trust is established. (Participant No. 22)

Interviewees highlighted the differences in coordinating visits between the home and the hospital, emphasizing that the home is the patient's sphere, not the professional staff members. This

can sometimes lead to conflicts, as staff members must balance their schedules with the patient's preferences:

> In the hospital, team visits are scheduled at the team's convenience. But at home, you need to consider the patient's and their family's needs. Coordinating visits in the home requires more sensitivity and respect for their space and schedule. (Participant No. 6)

> Families complain in some situations if I call two minutes before a visit or in other families if I call two days in advance. It's different from hospital rounds where patients adapt to the team's schedule. At home, they can say, "Dad's sleeping, come back later." (Participant No. 24)

Some interviewees suggest that when entering a patient's home, exaggerated politeness and gestures are necessary for building trust and ensuring that the patient feels comfortable in their own territory. The professional staff members should identify and acknowledge the patient's domain. As one interviewee stated:

> Ask exaggeratedly: "May I sit? May I wash my hands? May I plug in my computer?" It sounds simple, but it helps the patient feel at ease and in control of their territory. I'm making it clear that this is their space, and I'm the guest here. (Participant No. 9)

By overtly seeking permission for basic actions, the staff members reinforce the boundaries between the patient's territory and their own. This exaggerated courtesy allows the patient to maintain a sense of control and comfort in their home environment, fostering trust in the staff-patient relationship. This approach underscores the importance of respect and permission in home-hospice care, fostering a therapeutic relationship based on trust and comfort in the patient's environment.

Expect the unexpected
In the interviews, the staff members describe that hospice home care work presents a unique and constant challenge—the need to deal with the unexpected and uncertain reality that lies beyond each patient's door. Unlike the familiar hospital environment, staff must adapt to changing and unforeseen circumstances. Every home visit reality requires flexibility, quick thinking, and an open mind:

> We are not in our safe area. We must adapt to the environment. Beyond the door, there are surprises. (Participant No. 7)

> What does surprise mean? In my eyes, it's really to be open-hearted to every possibility. To every statement, every style of choice, every thought, and every fear. (Participant No. 22)

The range of surprises can vary greatly, from physical condition difficulties and cultural constraints to family conflicts and even violent behavior. Staff must often improvise and create a professional visit on the spot:

> We had a nurse who was locked in the house and not allowed to leave. I have a nurse who was almost beaten up. I have a nurse who had an IV bag thrown at her. We need to improvise and create a professional visit, even though there are 80 people there. (Participant No. 6)

Entering the patient's private space challenges the typical sense of control found in hospitals, exposing staff to discomfort and dependence on the homeowner's hospitality:

> In the hospital, I was the homeowner. Here, he is the homeowner, and I'm entering as a guest. (Participant No. 16)

> Maybe it's a nice house where I can use the bathroom or maybe not? And maybe they'll welcome me nicely or maybe not? (Participant No. 8).

To meet this challenge, staff need to develop strong professional skills that provide confidence and certainty, allowing them to anchor themselves and project professionalism and control, but also to be sensitive and empathic:

> You need to be very good in your professional field, to feel very confident because you're solo. And I need to decide how to be, on the one hand, vulnerable and very modest and humble, and on the other hand, to project, you know, good eyes and professional confidence. (Participant No. 4)

Simultaneously, the organization needs to support staff through communication and collaboration mechanisms that can alleviate the sense

of loneliness and help cope with complex situations:

> We have a very structured methodological process in the organization called "raising a flag." So, if we encounter any challenge in the field, there is someone to share it with. (Participant No. 3)

Ultimately, hospice home care work requires professional staff members to have an open and flexible approach to accommodating the unexpected, while balancing vulnerability and humanity with professionalism and control. It offers a complex experience of exposure, challenges, and constant adaptation to a changing reality, but also opportunities.

Preparing the ground for your absence

Unlike hospitals with constant staff presence, end-of-life home care involves extended staff absence. Preparing the ground for this absence is a central role, as one interviewee explained:

> Most of the time, we are not present. In the hospital, they know there is staff around. . .But at home, you need to provide a sense of security that there is someone who will answer the phone, and what to do if there is a deterioration. (Participant No. 16)

Comprehensive guidance must be provided to patients and families on coping with symptoms, identifying emergencies, and initial treatment for deteriorating conditions:

> I explain to them in advance to give Dad the first dose of pain medication. . .and after two doses, if he is still in pain, you call me no matter what time it is. The same goes for shortness of breath—call me at any time if this is the situation. In other cases—please wait for the morning. (Participant No. 9)

However, the absence of a capable primary family caregiver in complex cases poses a major challenge, leaving staff uncomfortable with the family's ability to implement guidance optimally:

> We call it a non-functional primary caregiver, or the absence of a primary caregiver. . .We need to deal with patients in very advanced medical conditions where there is no real stable primary caregiver present who can receive the guidance and carry it out optimally.

At home, it's the patient's family at the center. It's impossible without the family. . .but we depend on them. (Participant No. 5)

To create a sense of security despite their absence, the team must develop 24/7 communication and support mechanisms, so families feel there is a "call button" even without staff physically present:

> How do you create that experience of the call button on the wall for calling for help, even when there is no call button on the wall? There has to be a system that can respond in real-time 24/7 so that if they need to come, they know how to come. (Participant No. 2)

The goal is to provide comprehensive preparation, guidance, knowledge, tools, and accessible professional support to help families feel secure during the staff's absence from the home environment.

Discussion

As society ages, the homebound population will grow.[52] Homebound and seriously ill adults benefit from the provision of medical care in the home,[50] including end-of-life care.[9,62] Working as part of a home-hospice care team presents significant professional and personal challenges, requiring unique communication skills with patients and families regarding complex issues.[6,63]

Sabar[64] introduced the term "Professional Guest" to describe the dual role of professional staff members in home-based care, where they must navigate the roles of both "guest" and "expert." This unique setting necessitates adjusting to the patients' home space governed by their rules, while simultaneously maintaining professional authority as in institutional settings. This dual identity requires heightened sensitivity and awareness, as professional staff members engage in overt and covert negotiations with patients and families, shaping professional relationship dynamics and the fulfillment of therapeutic duties.

The central Professional Guest theme highlights the unique challenges professional staff members face in providing end-of-life home care versus hospital/clinic settings. The findings elucidate the intricate hybrid identity and boundary role they must navigate, being both medical professionals

and guests in the patient's domain. This duality resonates with existing literature, emphasizing the complexities and training needs of individuals with multiple workplace identities.[65–67] Notably, we could not find references specifically addressing these challenges for professional staff members.

The hybrid identity model describes situations where individuals blend distinct identities and role expectations that may appear contradictory.[67] In end-of-life home care, professional staff members balance their professional medical identity with being a guest in the patient's private home sphere—a dual hybrid identity as clinical experts yet also subject to norms and rules in the patient's home.[64] Framing this dynamic through a hybrid/boundary identity lens provides insights into reconciling the seemingly conflicting professional staff members and respectful guest roles within the same context.

Unlike a clinical environment, which is the professional staff member's domain, home visits expose them to the patient's intimate personal space,[50,57] necessitating the process of observing and applying details such as sights, smells, and the overall home environment. This process, identified as a key sub-theme in our findings, involves the professional team developing unique skills for understanding and functioning within the home setting.[51,57] In a hospital, roles, rules, and power dynamics are clearly defined—the professional staff members occupy their professional territory, while the patient adheres to the clinical environment norms.[12,68] However, when entering a patient's home, the professional staff members blend their professional medical identity with that of a "guest" who seeks permission, respects personal boundaries, and adapts to the unique circumstances and norms governing that private sphere. Our findings revealed that healthcare professionals must develop acute observational skills to gather relevant information about the patient's living conditions, family dynamics, and potential health hazards or support systems within the home environment. This information is then applied to tailor care plans, make appropriate interventions, and provide personalized support that aligns with the patient's specific home context.

The interviewees noted that asking for permission was perceived as defining boundaries and creating a contract between them and the patients and families, delineating what belongs to their professional duties as guests and what belongs to the patient and family in their territory. Requesting permission reflects the process of negotiation between the professional staff members and the patient/family in an effort to define boundaries. Negotiation is a characteristic of and an integral part of hospice home care treatment. Asking for permission essentially expresses recognition of the home setting's significance for the power dynamics between the professional staff members and the patient. Without "asking for permission," the professional staff member may be perceived as insensitive, unprofessional, unsupportive, and essentially a poor professional. This has significance beyond nurturing the relationship; it impacts the potential for end-of-life home care to exist and how the staff member is perceived by the patient and family, coloring their professionalism and ability to establish a trusting relationship.

The hybrid "Professional Guest" positioning could impact the care experience. Exposure to the patient's environment may enable closer rapport and sensitive, compassionate care delivery.[69] Conversely, the dual positionality and inherent uncertainties may create identity conflicts that challenge care quality and professional staff members' mental well-being.[65] In this study, the team members saw the need to ask for permission during home visits as a professional source for creating more intimate connections with patients and families, despite the confusion.

They noted that sometimes it took time to build trust to enhance the "professional" part and minimize the "guest" part, but one of the advantages of hospice home care is prolonged treatment, with at least a weekly visit from the same staff member. In this way, the achieved intimacy is an advantage. We also found that the fact that they are guests allows them to see the home and tailor the treatment to the unique needs of that patient. So, in their view, the combination of being Professional Guests is an advantage from this perspective.

The Expecting the Unexpected sub-theme captures the unpredictability inherent to the healthcare professionals' hybrid role in hospice home care settings. These professionals must improvise and display flexibility in responding to unforeseen physical hazards, lack of necessary equipment, environmental conditions unsuitable for

providing optimal care,[58,70–72] cultural constraints, family dynamics, and other surprises disrupting established care protocols. Professional staff members often encounter home structures, clutter, or uncleanliness that may hinder care provision.[58,73] Additionally, they sometimes face violent situations from patients or family members, requiring adaptability and quick decision-making to ensure safety and maintain quality of care, despite challenging circumstances.[74–76] This unpredictability necessitates quick, effective adaptation by professional staff members. Differing cultural backgrounds likely influence guest versus host perceptions, further complicating uncertainties faced by professional staff members.[73,77] This duality of being a professional while adapting to a guest role in a patient's home requires specialized training and a nuanced understanding of interpersonal and cultural factors.[65] Organizations supporting the teams must develop clear policies to maintain the teams' sense of security, as they are in a more exposed and vulnerable setting as compared to teams operating in hospitals.[74]

The Preparing the Ground for Your Absence sub-theme reflects the unique challenge of equipping patients and families with comprehensive self-care guidance despite limited visitation hours. It underscores opportunities for technologies, such as telemedicine and remote monitoring, to bridge this gap during professionals' extended absences.[78] This study found that professional staff members understand the magnitude of responsibility in homecare and believe part of their professionalism is preparing the environment for the times when they are not present in the patient's home. This preparation requires open communication, appropriate and easy-to-use equipment for the patient and family, available communication lines with a consistent family caregiver, and, critically, the presence of an available and capable family member functioning while the professional is absent.

Care occurs in the patient's home rather than in the hospital, requiring hospice home care providers to use physicians, nurses, technicians, social workers, and caregivers differently from traditional hospital settings, such as through telehealth or house visits.[12] Home care services offer substantial economic and health benefits, reduced risk of infection, increased patient mobility and well-being, cost savings, and improved clinical outcomes.[13,77,79] However, there is significant dependence on family caregivers.[80] Over the years, digital telehealth services have emerged to support home and hospice care, showing high satisfaction levels, especially during the COVID-19 pandemic, for engaging families and collecting patient-specific information to guide end-of-life care.[78]

While offering intimate, personalized care, this hybrid professional guest identity imposes psychological challenges. Professional staff members must adapt to unfamiliar spaces, balance professionalism and personal vulnerability, and manage uncertainty, factors warranting further study. This duality challenges traditional hierarchies and requires unique skills in negotiating roles, seeking permission, and establishing new norms in each home.

Strengths and limitations

We recruited professional staff members from one of the largest home-hospital services in Israel, ensuring a diverse range of participants in terms of status, profession, cultural background, and residential area. The credibility of the findings was strengthened through the triangulation of closed-ended email questionnaires, in-depth interviews, and a review of the literature. The findings were discussed with field experts. While the sample size was sufficient for a qualitative study, the results cannot be generalized to other professional teams, either within Israel or internationally. Our interviews primarily included nurses, with fewer physicians and social workers, reflecting the actual composition of the teams. Additionally, the lack of data regarding participants' cultural and socioeconomic backgrounds likely influences the guest/host dynamics. Including patients' and families' perspectives in future research could provide a more comprehensive understanding.

Recommendations for future research

Future research should explore the distinct roles and challenges faced by different professionals in hospice home care, such as nurses, physicians, and social workers. While this study highlighted the skills of "Professional Guests" in patients' homes, further investigation is needed to understand how these roles vary in practice and whether different professionals focus on various aspects of care. Additionally, studies should examine patient

and family perspectives, with particular emphasis on how cultural and socioeconomic factors shape the hospice home care experience and influence the dynamics between healthcare providers and recipients. Evaluating the role of technology in enhancing care and its impact on professionals' hybrid identities will also be crucial for improving home care practices.

Implications for policy and practice

To effectively address the complexities of providing hospice home-based care, it is essential to implement specialized training programs that equip healthcare professionals with the skills to navigate their dual roles as medical experts and "guests" in patients' homes. These programs should emphasize the importance of open patient-provider dialogue to tailor care that respects the unique dynamics of the home environment, including privacy, dignity, and preparedness. Furthermore, hospice home care protocols must be designed to accommodate individual preferences, ensuring a respectful and efficient care environment.

Support systems, such as consultation services, are crucial for reducing the professional isolation that staff may experience in home settings, thereby enhancing their sense of security and effectiveness. Additionally, developing technological and digital tools to assist families and patients during the absence of professional staff is vital. These tools can bridge gaps in care and provide continuous support, ensuring that patients and their families are better prepared to manage care independently when needed.

Conclusion

This study highlights the unique challenges faced by healthcare professionals providing end-of-life care in home settings, particularly the delicate balance they must strike as "The Professional Guest." Professionals must navigate a hybrid identity that blends clinical expertise with personal vulnerability, requiring a nuanced approach that respects both professional boundaries and the intimate nature of the home.

The findings emphasize the need for targeted training and supportive policies to help professionals integrate their dual roles and deliver high-quality care in these complex environments. By addressing these challenges, the healthcare system can better support compassionate, patient-centered care in the home, ultimately improving outcomes for patients and families.

Declarations

Author contributions
Ron Sabar: Conceptualization; Investigation; Methodology; Project administration; Resources; Supervision; Validation.

Inbal Halevi Hochwald: Formal analysis; Investigation; Methodology; Validation; Writing – original draft.

Moran Weiss: Conceptualization; Data curation; Investigation; Methodology; Resources; Validation.

Gila Yakov: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Supervision; Validation.

Competing interests
The authors declare that there is no conflict of interest.

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Supplemental material

Supplemental material for this article is available online.

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Appendix 1: Semi-structured interview guide—open-ended questionnaire

1. Can you describe your role within the home hospice?
2. What are the key characteristics of working in an organization that provides hospice home care?
3. What essential knowledge, skills, and characteristics are important for those working in home hospice care?
4. Please tell me about the training for palliative care specialists, particularly the aspects specific to providing care in the patient's home.
5. What challenges do you face in your work with the home hospice? How do these challenges affect you, the patient, and their family?
6. Could you share an incident that illustrates one of these challenges?
7. Can you describe common scenarios that present challenges in home-hospice care?
8. What aspects of home care make it unique compared to care in an institutional setting?
9. What are the advantages of working in home-hospice care for you, the patient, and their family?