COACTION

EMPIRICAL STUDIES

Corroborating indicates nurses' ethical values in a geriatric ward

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Abstract
The aim of the study was to identify nurses' ethical values, which become apparent through their behaviour in the interactions with older patients in caring encounters at a geriatric clinic.
Descriptions of ethics in a caring practice are a problem since they are vague compared with the four principles of autonomy, beneficence, non-maleficence, and justice.
A Grounded Theory methodology was used. In total, 65 observations and follow-up interviews with 20 nurses were conducted, and data were analysed by constant comparative analysis.
Three categories were identified: showing consideration, connecting, and caring for. These categories formed the basis of the core category: "Corroborating." In corroborating, the focus is on the person in need of integrity and self-determination; that is, the autonomy principle. A similar concept was earlier described in regard to confirming. Corroborating deals more with support and interaction. It is not enough to be kind and show consideration (i.e., to benefit someone); nurses must also connect and care for the older person (i.e., demonstrate non-maleficence) in order to corroborate that person.
The findings of this study can improve the ethics of nursing care. There is a need for research on development of a high standard of nursing care to corroborate the older patients in order to maintain their autonomy, beneficence, and non-maleficence. The principal of justice was not specifically identified as a visible nursing action. However, all older patients received treatment, care, and reception in an equivalent manner.

Key words: *Ethical values, geriatric wards, grounded theory, nursing ethics, nurses behaviour*

In a study about satisfaction (Kahn, Hassan, Anwar, Babar, & Babar, 2007), patients felt that nurses were good at providing privacy and there were regular vital sign check-ups. However, the patients were dissatisfied with the nurses' behaviour. In other studies satisfaction depends on the patient's ability to participate and being involved concerning their own care (Ford, Schofield, & Hope, 2003; Larsson, Sahlsten, Segesten, & Plos, 2011). Different demands on nurses by patients affected them in their work situation and make them feel powerless in caring (Berg, Berntsson, & Danielsson, 2006).

Nurses are dependent on collaborative interaction (Bischop & Scudder, 1985, 1996), and they should meet patients and relate to the older patients' situation. This collaborative interaction (i.e., a caring relationship) is expressed by Gaut (1983) as "caring for" and "caring about." "Caring for" is a one-way relationship in which the nurse is responsible. "Caring about" is a quality found in the relationship between nurse, older patient, and next of kin; that is, treating them with respect and dignity. A caring relationship is characterised by promise and involvement (Hjelm, Hartwig, & Berterö, 2007). In

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1

a caring relationship, the nurse must have an ethical responsibility. Ethical responsibility depends on personal responsibility and this responsibility cannot be avoided, ignored, or transferred (Clancy & Svensson, 2007).

Individual responsibility is connected with nurses' behaviour, ethical values, and morals and these are important aspects that influence their actions, which in turn influence the quality of care (Schluter, Winch, Holzhauser, & Hendersson, 2008). Values represent the basis of ethics as they form the backbone of how we act, behave, and address different moral situations (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2003). Care is both thought and action—which are interrelated (Tronto, 1993). Care ethics aim to increase ethical reflection, focusing on values such as engagement, solidarity, and moral sensitivity (Vanlaere & Gastmans, 2005). As explained by Cronqvist, Burns, and Lützén (2004), caring about someone rests on moral grounds because moral obligation is inherent in the notion of caring and assumes personal ability to know what is morally right in the caring encounter. The nurse's attitude, values, self-respect, and so on influence the choice of a care plan (Gustafsson & Parfitt, 2002), and choices are made apparent in communication with the older patient and care plan documentation (Gunhardsson, Svensson, & Berterö, 2008).

Nurses' behaviour may have revealed ethical values that were interpreted by patients, hence the dissatisfaction (Castledine, 1996). Older patients are sometimes vulnerable and do not have much to decide about in caring. It is important to monitor the nurses' performance because it affects the older patient. A nurse's performance is made apparent in verbal and non-verbal ways of communicating (Noddings, 1984; Orlando, 1961, 1972). Important aspects when caring for older patients are security, trust, integrity, and personal decision-making (SFS, 1982; National Board of Health and Welfare, 2005), in order to carry out good health care (SFS, 1982; ANA, 2001; ICN, 2002). There is also a connection between the patient's experience of value, the nurse's work, and the ethical environment (McDaniel, Veledar, LeConte, Peltier, & Maciuba, 2006).

There are different versions of ethics in care, which complicates the picture of ethical theories in nursing. Descriptions of ethics in a caring practice are another problem, since they are vague compared with the four principles of autonomy, beneficence, non-maleficence, and justice (Edwards, 2009). These four principles are central components of nursing and health care ethics (Beauchamp & Childress, 2001). Again, nurses' individual ethics depend upon each person's upbringing and the atmosphere of the caring situation (Edwards, 2002; McDaniel, Veledar, LeConte, Peltier, & Maciuba, 2006).

Authors explain nurses' actions in different ways, for example, the caring interaction must be permeated by a belief in the older patients and their capacity, and nurses ought to support the patients in realising their own vitality ambitions (Nordenfelt, 2000). The nurse's openness and sensitivity can affect older patients so that they open up and share difficulties with the nurse (Eriksson & Nåden, 2002). This support could consist of the professional's presence, touch, and listening; the creation of a base for a caring relationship (Fredriksson, 1999) and strive to understand patients perspective (Covington, 2005). The ideal nurse is an eager, loving, sympathetic, and supportive person; the care ability depends on how helpful the nurse is (Bischop & Scudder, 1985; Tarlier, 2004). These descriptions of the nurse's characteristics lead up to supporting the patient's identity by strengthening the patient's involvement and participation in their own health, i.e., confirmation (Gustafsson & Parfitt, 2002).

Study findings indicate the importance of supporting the patients in their own situation to achieve their own goals. Nurses need to change roles to make a patient active even if the patient is in palliative care (Hjelm et al., 2007). The nurse has to develop an approach of humility and carefulness when trying to help patients so that they preserve their activity and dignity. Nurses must also demonstrate knowledge as it influences their action in practice (Purkis & Bjornsdottir, 2006). Concrete caring actions only have an ethical value in the light of the quality of the caring attitude of which they are the expression (Gastman, 1999). Studies of this sort are important as ethical studies are almost always examined indirectly, i.e., how nurses' act are unclear and know the complex reality of ethical practice (Goethals, Gastmans, & de Casterlé, 2010).

The study

Aim

The aim of the study was to identify nurses' ethical values that become apparent through their behaviour in the interaction with older patients in caring encounters at a geriatric clinic.

Design

In order to understand human behaviour a qualitative approach was used, influenced by symbolic interactionism. Gestures, attitudes, and the control of attitudes between people are important components in symbolic interactionism (Blumer, 1962, 1969, 1986). As this study is based on symbolic

interactionism through which researchers identify the ethical values visible in nurses' actions and behaviour, the methodological approach was Grounded Theory (GT), using observations and follow-up interviews (Glaser & Strauss, 1967). The intention of such a method is to achieve a deeper understanding of concerns, actions, and behaviours of groups of individuals through the nurse's own words and actions. It is an inductive general method in which theory is generated (Glaser, 1978; Glaser & Strauss, 1967).

Setting

The setting for this study was a geriatric clinic in a medium-sized Swedish city. The geriatric clinic is a stroke and rehabilitation ward with 22 beds. Geriatrics is a branch of medicine devoted to prevention, diagnosis, and treatment of disorders affecting old people (Geriatric Medicine in Sweden, 2009). The average caring time for older patients is approximately 18 days and, after discharge, they go home or to another caring facility. The words "older patient," as used in this context, define people aged 65 years or above with varying needs of care (WHO, 2008).

Participants and ethical considerations

Approval was obtained from the clinic manager, the department director, the personnel department, and the unions involved. While conducting the study, consideration was given to The Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2008), law of research ethics (SFS, 2003:460), which concerns the ethical cornerstones of empirical research (SFS, 2003:460). Approval for the study was obtained from the Regional Research Ethics Committee at Linköping University Hospital, "Dnr".170-06. All older patients were asked if they agreed to the observations of caring encounters between themselves and the nurses. All patients agreed verbally.

The sample population were staff nurses at the geriatric clinic. Before data collection commenced, a meeting was held in which the nurses were given verbal and written information. Written and verbal informed consent was obtained from all nurses.

A total of 20 nurses participated in the study, i.e., all invited nurses. The nurses comprised 19 females and 1 male ranging in age from 25 to 62 years, with a median age of 45 years. Twelve of the nurses were registered nurses and eight were enrolled nurses. Their experience ranged from 1 year to 40 years, with a median of 19 years. The nurses had different backgrounds; some had engaged in other occupations before working as nurses and some were foreign born.

In the investigated clinic, the competence mainly concentrated on medical investigations, medical treatments, and rehabilitation of patients with stroke, dementia, osteoporoses, and fractures. Older patients should receive care and rehabilitation suitable for their needs and they should also have an individual caring plan. Health care professionals in geriatric clinics have a holistic view and the interactions with the patient should appear as teamwork (National Board of Health and Welfare, 2011).

Observations and follow-up interviews

Empirical data collection took place between February and May 2008. The researcher was non-participant; that is, was dressed as a health care professional but did not work as one, although at times the researcher assisted the health care professionals. The researcher listened, watched, and had conversations with the participants in the study (Morse & Field, 1996). The researcher accompanied the nurses on the ward, and 65 different caring encounters were observed. A follow-up interview was conducted directly after the observations (Berg, 1995). In the follow-up interviews the nurses were asked "Can you tell me what happened in this caring encounter?" The follow-up interviews (2–10 min) were conducted in private and away from the other person involved in the encounter. These follow-up interviews were tape-recorded and transcribed verbatim. Transfers, events, information, social intercourse, and so on were recorded on a pocket-tape recorder as well as in a notebook as field notes. This was done immediately after every observation, verbatim, and as scrupulously as possible (Patton, 2002). Approximately 85 h of observation were included, divided into 4-h shifts.

Data analysis

All data, observations, and follow-up interviews were transcribed and used as a unit. The transcribed text was analysed using Constant Comparative Analysis, an inductive analysis method (Glaser, 1978, 1992). The analysis began by openly encoding the first observation/follow-up interview. The next step was to capture the substance in the data, to break it down into identifiable substantive codes that illustrated the influence of caring situations. The different codes and interviews were compared to each other to strengthen their identification. The codes were labelled with origin words from the data (Glaser 1978; Glaser & Strauss, 1967). The second observation/

follow-up interview was analysed and compared with the first one. All data were processed the same way.

Thereafter, the analysis continued with the aim of reaching a higher level of abstraction of the material, thereby allowing identification of categories. The codes were analysed and similar meanings in the codes were identified and clustered together into categories. The categories were labelled with more abstract concepts. These categories were also compared with the codes and the other categories. The gathering of data and analysis continued until a "saturation point" was reached after 65 observations/follow-up interviews. Nothing new emerged in the analysis that enabled identification or creation of new codes or categories. The number of concepts/behaviour created saturation, not the number of nurses. The final level reached involved identifying a theoretical construction—a core category—that answered possible questions and explained the phenomenon under study (Glaser, 1978; Glaser & Strauss, 1967). Categories were related to each other and scrutinised to verify their relevance. A core category was the major category found in all data (Glaser, 1978, 1992).

Validity

The findings of GT do not take the form of the reporting of facts but are a set of probability statements about the relationship between concepts, or an integrated set of conceptual hypotheses developed from empirical data. Validity in GT should be judged by fit, relevance, workability, and modifiability (Glaser 1978, 1992; Glaser & Strauss, 1967). This study is fit as data are linked to their sources (Berg, 1995; Glaser, 1992).

Conducting observations with follow-up interviews as confirmation is a triangulation technique imbedded in GT. This method strengthens the relevance of the findings in the study (Glaser, 1978, 1992; Glaser & Strauss, 1967). Relevance is when the findings are recognisable for people. Since data are derived from empirical data, the findings could be useful and fulfil requirements for workability (Berg, 1995; Glaser, 1992; Glaser & Strauss, 1967).

Findings

Three categories were identified during the analysis: showing consideration, connecting, and caring for. These categories formed the basis of the core category: "Corroborating" (see Figure 1). The core category "corroborating" explains how nurses' ethical values are made apparent through their behaviour in the interaction with the older patient in caring encounters at a geriatric clinic. All three categories
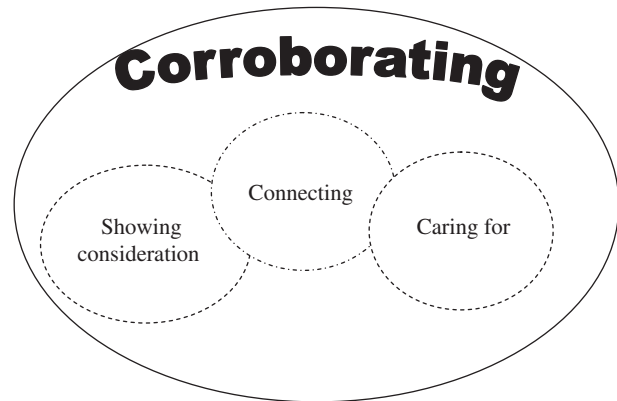

Figure 1. The three categories: showing consideration, connecting, and caring for are related to and affect each other. These categories generate the core category "Corroborating."

are related and thus influence each other, but are separate, aiming to generate the core category. The core category and categories identified and described are abstracted to a theoretical level. Some sequences from observations and quotations from the follow-up interviews are provided from the empirical data.

Corroborating

Corroborating means that one person has a responsibility to promote a relationship, confirming a person, and making the person feel more secure. This relationship is based on support and giving strength; that is, nurses have an obligation to do good from the account of patient's own values and necessity. Consideration and thoughtfulness must be shown towards the other party. This also involves having good manners towards someone else. The nurse is responsible for the other person and care and treatment must, as far as possible, be designed and given in consultation with that person.

Corroborating indicates nurses' ethical values that are apparent through their behaviour in the interaction in caring encounters. In corroborating, the focus is on the person who needs integrity and self-determination; that is, it involves application of the autonomy principle. Corroboration places a responsibility on the nurse to promote another person's well-being (beneficence) and health through support and giving strength. As with caring encounters, the foundation is based on a corroborative relationship. The actions in caring encounters are both verbal and physical. Corroborating means being sensitive to another person's gestures, listening to the person, and trying to understand his/her thoughts. It also means giving priority to the person's needs in the situation, a form of benefit. Corroborating means to act in such a way that time is given to the older person, aiming to maintain the person's self-control

and strength. This is done to benefit the person. This means paying attention to the other person's condition and encouraging them in order to motivate them. Encouragement is central to corroborating. Encouragement can be expressed verbally through words or physically through a pleasant demeanour. Corroboration is based on experience and knowledge about the patient as a person, and on paying attention to reactions in different caring situations (beneficence, non-maleficence). It is also about having good intentions and creating something good.

Corroborating includes the categories of showing consideration, connecting, and caring for. To be considerate is to be present in the caring situation, show respect, and involve another person in a trusting relationship. In connecting there is communication between two individuals to create participation. The connecting function is related to someone else and it deals with information, instructions, guidance, or small talk. Caring for means to carry out a task in a caring encounter using competence and knowledge regarding the issue to be solved, and also to make the task safe and secure for the person who is being cared for—demonstrating non-maleficence.

Corroborating verbalised by one nurse:

You must have focus and get through ... consider gestures..., what the patient says, what is most important for the patient, and help the patient with that. Give time to the patient and listen and encourage.

Showing consideration

Showing consideration concerns opening up the situation, through suitable actions such as showing respect and infusing confidence in another person in a caring encounter. Showing consideration, which could be done both verbally and physically, invites both parties to participate. Verbal invitation takes place through words and questions. Physical invitation happens through eye contact and nearness as well as by showing trust in the older patient and his/her capacity. These actions promote the well-being (beneficence) of the person, and if the nurse considers this person in a holistic way, makes contact and shows concern for the person throughout the caring process, mutual respect will be fostered. There is a desire to do well for (benefit) as well as perform acts of kindness. Showing consideration means having an open mind and being helpful, being "here and now," having a sense of caring about another person. Time is an important element in this caring encounter, as the amount of time dedicated to

the patient gives an indication of that person's value. These actions, which are connected with showing consideration, are made apparent when caring about older patients in caring encounters. On the other hand, showing a lack of consideration includes having an arrogant attitude that manifests itself in nurses not talking directly to the patient but to each other over the patient's head or talking about ward-related tasks, displaying irritation, or laughing at the patient. Sometimes nurses find themselves in a dilemma of whether to follow ward routines or act according to the older patients' wishes, i.e., respecting the older patients' autonomy. A sequence to illustrate data from an observation:

[T]he patient answers very quietly, I will not get out of bed, I am tired, I will stay I [in] bed. The nurse responds, "It will be nice to get out of bed, and you will go home to your man today"—in a way to relieve the atmosphere. Another nurse joins the effort to convince the patient. The patient still refuses, but the nurses are determined.

Nurses use different strategies such as negotiation, verbal explanation/argument, or ignoring the older person's protests. This was expressed in a follow-up interview:

She ... the patient didn't want to get out of bed, uhm ... and I knew that she had a clear intellect, uhm ... it was a little bit unpleasant to get her up against her will ... get her up so early ... uhm ... if I had this caring encounter in her own home so of course she had to decide by herself ... I will stay in bed for 1 hour more ... Now we had the routines of the ward to take into consideration ... and certain other things so we took no notice of her ... and that was not a good feeling.

Connecting

To connect means to relate together; to be relating to someone. Connecting is a relationship created through the caring situation. Connecting is central to the interaction in caring encounters as the associated actions open up collaboration. These actions serve to benefit someone. Connecting serves as a link between the people involved in the encounter. Questions are asked and actions are performed in order to assess the situation in the caring encounter. The older patient is at the centre of attention and has autonomy. Connecting could also entail small talk or questions, aiming to create a good atmosphere where both individuals meet in a dialogue.

Connecting is often the starting point of a special task. Information provided by the nurse prepares the older patient who receives notice before any actions are carried out.

Connecting could also mean a flow of information from one person to another. In connecting, one person invites another person. This person is free to choose options that often concern small decisions. Connecting could also be about guidance, where one person is in need of advice to solve a problem. These actions benefit the patient. Connecting also appears in a physical sense in approaching and contacting. Communication is richer in longer caring encounters. Connecting could be associated with caring for and task orientation and is common in short caring encounters where mostly just one person talks. There is less connecting when several nurses are involved in the caring situation and in acute situations. Ethical values become apparent in connecting as described from the observation and follow-up in the next interview:

> Do you wash your face yourself? [Nurse gives the older patient washcloth and soap and towel.] Yes ... now you will wash yourself calmly and peacefully. Call me with this bell ... [The older patient does not see. The nurse repeats her last remark, then the patient sees the button she should push to get help.] You have a dress and socks behind you. Call us then we'll come.

Nurses use different strategies as stated in the follow-up interview:

> This information is important, well very important, so you don't just do it: for us it is natural ... tell them that now I am doing this because ... especially patients who have had a stroke, it is different due to a stopper or a bleeding or ... naturally, often when you have had a stroke you have difficulties putting things together and the memory is affected, you need to talk about the same thing all over again and they do not remember. All the time repeat and repeat.

Caring for

Caring for is a well-defined responsibility for nurses. It concerns competence, skill, and knowledge regarding different tasks. It includes medical-technical tasks, physical caring, taking into care, and specific caring; it is about non-maleficence. Often these are routine tasks in divided caring situations where there is a larger focus on tasks; divided situations could be interrupted by a telephone ringing, other

caring staff entering the situation, and so on. Even when several nurses work together with the same older patient in a caring encounter, focus is on the task in the encounter, as the nurses interact with their colleagues rather than the patient. Caring tasks are focused upon both by experienced and inexperienced nurses. Focusing on caring tasks is a sort of corroboration. It deals with carrying out tasks safely and creates confidence between the different people in the caring encounter, i.e., it demonstrates non-maleficence. Focus is still on the older patient's state of health. These actions often start with connecting and then involve performance of caring, conducting a test, control, and so on. Focusing on caring tasks entails less verbal activity. There is a clear focus on caring tasks, particularly in acute situations or when there are communication difficulties. In these situations of care for the older patients, focus is on carrying out the task correctly so as not to harm the person and perhaps save a life. An example from an observation:

> Nurse goes to a lonely man and says hello and the older man's name. The man does not answer. You will change your drip now ... The nurse disconnects the old drip and hangs up the new one, then unscrews the peg and puts a new peg on the drip and flushes with sodium-chloride, and then "increases the flow" ...The nurse says the infusion is going in well ... The nurse says nothing to the patient, there is no reaction from the patient ... The nurse leaves.

Nurse's explanation on acting with a focus on duty:

> Well it became more one-sided and more focused ... on the task we were performing ... not so much talk. Yes, it was a more serious caring encounter ... in this case it was about an infusion with great amount of additives and so ... I was very focused on what to do ... so it was not a personal meeting ... with the patient ... the patient was so tired and exhausted that he was not easy to communicate with ... I was there to take action.

Discussion

Corroborating could seem similar to the concept of confirming (Gustafsson & Parfitt, 2002; Randers, Olson, & Mattiasson, 2002). However, corroborating involves more than confirmation, it is support by means of strengthening evidence in caring, and this explanation related to ethical values in caring encounters has not been mentioned before in the

literature. Nurses motivate older patients through encouragement. Unlike the obstacles encountered by Stabell and Nåden (2006), nurses can take action, verbally and physically, in order to encourage. All depends on the nurses' decision-making (SFS, 1982:763) and ability to notice the older patients' need of rehabilitation so that they maintain their integrity and self-determination; that is, corroborating is to benefit the older patient. Nurses promote the relationship with the older person, and caring is based on respect for self-determination and privacy. There is also mutuality in the relationship, and the different persons involved exchange information, creating participation. This supportive attitude guarantees security in the caring relationship for the older person.

The concept corroborating includes showing consideration, connecting, and caring for are findings in our study. Compare these findings with Nåden and Eriksson (2004), who discussed invitation and confirmation. There are similarities between these two mentioned studies, but there are also some differences. In this study caring for is one aspect of a nurse's practical performance. Thus it is related to carrying out a task in a caring encounter using competence and knowledge regarding the issue to be solved, and also to making the task safe and secure for the person who is being cared for. Caring for is a one-way relationship in which the nurse is responsible for the older patient. This becomes apparent when the older patient has communication difficulties. Caring for entails a reduced amount of verbal activity. Carrying out the duty safely and securely for the older patient is one aspect of ethical values. Caring for is about non-maleficence, it is a central component of nursing and health care ethics (McDaniel et al., 2006; SFS, 1982:763). The ethical values in caring encounters are more than showing consideration and connecting. The concept of corroborating includes caring for, which is one aspect of ethical values (The National Board of Health and Welfare, 2005). The nurse must reflect on how to corroborate the older patient as a unique person with unique needs. Focusing on caring tasks is associated with years in the occupation and developing skills—from a novice to an expert (Benner, 1984).

Time is an important element that characterises respect for the older patients, as it makes them feel that they have value. In our study it is corroborating because time given to the patients supports their strength and autonomy. Corroborating includes more than the findings in the study by McDaniel et al. (2006), stating that more time helps in developing a caring relationship. Corroborating is a foundation for creating a caring relationship, as

suggested in a study by Hjelm et al. (2007). Nurses can corroborate older patients by paying attention to their reactions, being sensitive in different caring situations, and showing interest in actions beneficial to the older patient.

The nurse shows consideration through action by being "here and now." They are present in the caring encounter—socially, physically. and psychologically. Older patients should feel that they are at the centre of attention (Cortis & Kendrick, 2003; Orlando, 1961; Teeri, Leino-Kilpi, &Välimäki, 2006). To be considerate of someone in need of caring could be compared with the concepts of "caring about" (Berterö, 1999) and "being." The latter includes the subcategories "being there" and "being with" (Kapborg & Berterö, 2003). In the present study, showing consideration includes being present in the caring situation, showing respect, involving another person, and creating a trusting relationship. Nurses' ethical responsibility is to be considerate (Clancy & Svensson, 2007). When the actions mentioned above become apparent, the older patient will trust the nurse and consideration is demonstrated.

To show respect is an important aspect, as mentioned by both the older patients and their next of kin in another study (Jonasson, Liss, Westerlind, & Berterö, 2010). As nurses must find a structure in the ward, there are discussions about ways to show respect (Cameron, 2004). Nurses sometimes show disrespect both verbally and physically. These actions could create moral distress; therefore it is necessary to find support from the team around the older patient and their next of kin (Ulrich, Hamric, & Grady, 2010). In the present study some of the nurses found themselves in a dilemma of having to choose between routines in the ward and acting according to the older patients' wishes. Different strategies were used, for instance, verbal explanation and ignoring the patient. Similar findings were found by Slettebo and Haugen Bunch (2004), which raises some questions. What is more important, following the patient's wishes or the ward routines? Are actions different when the patient is in his/her own home compared to a hospital? An answer could be that it ought to be the nurses' main goal to benefit patients and focus on the best for them. As stated in the study by Lindh, Severinsson, and Berg (2009), attention must be given to the institutional and professional processes that influence morals in caring situations.

It is important that nurses work in a supportive culture (Jakobsen & Sörlie, 2010), so that they can give corroborating care. This supporting culture should influence all nurses and other professionals to have a similar corroborating approach in caring encounters with older patients.

Connecting with someone means to create a relationship between the nurse and the older patient. A nurse must be considerate; that is, display both verbal and physical actions before connecting. In a study by Cortis and Kendrick (2003), the nurses invited the patient to interact by asking questions; but in our study, invitation came from consideration. Being considerate makes ethical values apparent through actions that are not only verbal. Connecting serves as a link between the individuals involved in the encounter. A relationship is created between the nurse and the older patient in the caring encounter. The nurse's outlook is revealed in connecting. Special situations ought to focus on connecting; that is, in caring encounters including several nurses or in acute situations. In these situations ethical values become apparent. The focus is still on the older patient's well-being (beneficial). It is then important that the nurse is corroborative, uses experience from previous encounters, and interacts with the patient. If the nurse is trustworthy, the patient will trust him/her. The patient interprets the nurse's verbal and physical actions. For instance, a nurse creates trustworthiness if she says "I am coming back" and then does exactly that as found by Sellman (2006).

Hopefully, the findings of this study can improve the ethics of nursing care, which are unclear according to Edwards (2009). The study by Suhonen, Stolt, Launis, and Leino-Kilpi (2010) mentions that there is a need for research on development of a high standard of nursing care to corroborate the older patients in order to maintain their autonomy, beneficence, and non-maleficence. According to ethical values, nurses have a responsibility to maintain their level of competence, to plan and deliver quality care, perform tasks safely, and evaluate the services they provide (ICN, 2002). Perhaps this study could give some guidance in right direction. The principal of justice is not specifically identified as a visible nursing action in this study. However, it was noticed that patients were received and cared for in an equivalent manner.

Conclusion

Corroborating indicates nurses' ethical values that are apparent through their behaviour in the interaction with the older patient in caring encounters. In corroborating, the focus is on the patients so that they can maintain their autonomy. Corroboration places a special responsibility on the nurse to benefit the older patient through support and giving strength. This study presents the ethical values apparent as a corroborative relationship. Corroborating means being sensitive to the older patient's gestures, dedicating time, listening, and trying to

understand thought. These actions serve to benefit the patient. In corroborating, giving encouragement in order to motivate is central. This can be expressed verbally but also physically through a pleasant demeanour. Further, corroboration is based on beneficence and non-maleficence facilitated through the nurse's experience and knowledge about the older patient as a unique person. Corroborating includes the elements of showing consideration, connecting, and caring for; that is, creating a trusting relationship and using competence and knowledge in caring for the older person. Nurses with corroborating behaviour in the caring encounter with the older patient guarantee good, safe, and secure care, which is in accordance with laws and professional codes.

Study limitations and strengths

One limitation could be that making direct observations could be affected subjectively by the researcher/observer making "private" interpretations. Using follow-up interviews is a way to triangulate data/interpretations. There was no time delay between the observations and follow-up interviews, which may strengthen the validity of the observations in the study. The nurses recalled the caring situation immediately and clarified what had happened from their point of view. Thus the risk of incorrect under- or over-interpretation was reduced (Berg, 1995). Another limitation is that the researcher/observer has limited experiences doing observations and follow-up interviews. This limitation rectified with reflections and supervision is one technique to assure quality (Berg, 1995) that has been used by the researchers in this study.

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References

American Nurses' Association (ANA). (2001). *Codes of ethics*. Washington, DC: ANA.

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). Oxford: Oxford University Press.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley, 13–34.

Berg, L. (1995). *Qualitative research methods for the social science*. Boston, MA: Allyn and Bacon.

Berg, L., Berntsson, L., & Danielsson, E. (2006). Caring relationship in an out-patient clinic: Balancing between vulnerability and dignity. *International Journal for Human Caring*, *10*(4), 23–30.

Berterö, C. (1999). Caring for and about cancer patients: Identifying the meaning of the phenomenon "caring" through narratives. *Cancer Nursing*, *22*(6), 414–420.

Bischop, A. H., & Scudder, J. R. (1985). *Caring, curing, coping.* Tuscaloosa, AL: University of Alabama Press.

Bischop, A. H., & Scudder, J. R. (1996). *Nursing ethics, therapeutic caring presence.* London: Jones and Bartlett Publishers International.

Blumer, H. (1962). A systematic summary of symbolic interaction theory. In A. M. Rose (Ed.), *Human behavior and social processes. An interactionist approach* (pp. 3–19). London: Routledge & Kegan Paul.

Blumer, H. (1969). *Symbolisk interactionism perspective and method.* Berkeley: University of California Press.

Blumer, H. (1986). *Symbolic interactionism perspective and method.* Berkeley: University of California Press.

Cameron, B. (2004). Ethical moments in practice: The nursing "How are you?" revisited. *Nursing Ethics*, *11*(1), 53–62.

Castledine, G. (1996). Nursing older people with dignity. *British Journal of Nursing*, *5*(3), 191.

Clancy, A., & Svensson, T. (2007). Faced with responsibility: Levinasian ethics and the challenges of responsibility in Norwegian public health nursing. *Nursing Philosophy, 8*(3), 158–166. doi: 10.1111/j.1466-769X.2007.00311.x

Cortis, J. D., & Kendrick, K. (2003). Nursing ethics, caring and culture. *Nursing Ethics*, *10*(1), 77–88.

Covington, H. (2005). Caring presence: Protecting a safe space for patients. *Holistic Nursing Practice*, *19*(4), 169–172.

Cronqvist, A., Burns, T., & Lützén, K. (2004). Caring about—Caring for: Moral obligations and work responsibilities in intensive care nursing. *Nursing Ethics*, *11*(1), 63–76.

Edwards, S. D. (2002). *Nursing ethics, a principle-based approach.* London: Macmillan.

Edwards, S. D. (2009). Three versions of an ethics of care. *Nursing Philosophy*, *10*(4), 231–240.

Eriksson, K., & Nåden, F. (2002). Encounter: A fundamental category of nursing as an art. *International Journal of Human Caring*, *6*(1), 34–40.

Ford, S., Schofield, T., & Hope, T. (2003). What are the ingredients for a successful evidence-based patient choice consultation?: A qualitative study. *Social Science & Medicine*, *56*(3), 589–602. doi: 10.1016/S0277-9536(02)00056-4

Fredriksson, L. (1999). Modes of relating in caring conversation: A research synthesis on presence, touch and listening. *Journal of Advanced Nursing*, *30*(5), 1167–1175.

Gastman, C. (1999). Care as a moral attitude in nursing. *Nursing Ethics*, *6*(3), 214–223.

Gaut, D. A. (1983). Development of a theoretically adequate description of caring. *West Journal Nursing Research*, *5*, 313–324.

Geriatric Medicine in Sweden. (2009). Retrieved March 11, 2011, from http://www.slf.se/templates/AssociationPage.aspx?id=21784

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine De Gruyter.

Goethals, S., Gastmans, C., & de Casterlé, B. D. (2010). Nurses' ethical reasoning and behaviour: A literature review. *International Journal of Nursing Studies*, *47*(5), 635–650. doi:10.1016/j.ijnurstu.2009.12.010

Gunhardsson, I., Svensson, A., & Berterö, C. (2008). Documentation in palliative care: Nursing documentation in a palliative care unit—A pilot study. *American Journal of Hospice and Palliative Medicine*, *25*(1), 45–51.

Gustafson, B., & Parfitt, B. (2002). Views of humanity and nursing practice. An analysis of nursing: A Christian/diaconal, a historical/medical and a humanistic/SAUC model. *Ethics & Medicine*, *18*, 159–170.

Hjelm, E., Hartwig, K., & Berterö, C. (2007). An inevitable journey by train: Nurses' narratives about palliative care. *Journal of Hospice & Palliative Nursing*, *9*(4), 206–211.

ICN. (2002). *ICN:s etiska koder för sjuksköterskor.* Stockholm: Svensk sjuksköterskeförening [The ICN code for ethics for nurses. International Council of Nursing]. Retrieved January 15, 2006, from http://www.icn.ch/1953rev.2000

Jakobsen, R., & Sörlie, V. (2010). Dignity of older people in a nursing home: Narratives of care providers. *Nursing Ethics*, *17*(3), 289–300.

Jonasson, L-L., Liss, P-E., Westerlind, B., & Berterö, C. (2010). Ethical values in caring encounters on a geriatric ward from the next of kin's perspective: An interview study. *International Journal of Nursing Practice*, *16*, 20–26.

Kahn, M. H., Hassan, R., Anwar, S., Babar, T. S., & Babar, K. S. (2007). Patient satisfaction with nursing care. *Rawal Medical Journal*, *32*(1), 27–29.

Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P., & Arnetz, B. (2003). Living with conflicts—Ethical dilemmas and moral distress in the health care system. *Social Science & Medicine*, *58*, 1075–1084.

Kapborg, I., & Berterö, C. (2003). The phenomenon of caring from novice student nurse's perspective: A qualitative content analysis. *International Nursing Review*, *50*, 183–192.

Larsson, I. E., Sahlsten, M., Segesten, K., & Plos, K. (2011). Patients' perceptions of nurses' behaviour that influence patient participation in nursing care: A critical incident study. *Nursing Research and Practice, 534060.* doi: 10.1155/2011/534060

Lindh, I-B., Severinsson, E., & Berg, A. (2009). Nurses' moral strength: A hermeneutic inquiry in nursing practice. *Journal of Advanced Nursing*, *65*(9), 1882–1890.

McDaniel, C., Veledar, E., LeConte, S., Peltier, S., & Maciuba, A. (2006). Ethical environment, health care work, and patients outcome. *The American Journal of Bioethics*, *6*(5), W17–W29.

Morse, J. M., & Field, P. A. (1996). *Nursing research. The application of qualitative approaches* (2nd ed.). London: Chapman & Hall.

Nåden, D., & Eriksson, K. (2004). Understanding the importance of values and moral attitudes in nursing care in preserving human dignity. *Nursing Science Quarterly*, *17*, 86.

National Board of Health and Welfare. (2011). *Geriatrik.* Stockholm: Socialstyrelsen. Retrieved March 10, 2011, from http://www.socialstyrelsen.se/ansokaomlegitimationoch intyg/bevisspecialistkompetens/omlakarnasnyast/Documents/stmal-geriatrik.pdf

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education.* Berkeley: University of California Press.

Nordenfelt, L. (2000). *Action, ability and health, essays in the philosophy of action and welfare.* Dordrecht: Kluwer Academic.

Orlando, I. J. (1961). *The dynamic nurse-patient relationship, function, process and principles.* New York: G.P. Putnam.

Orlando, I. J. (1972). *The discipline and teaching of nursing process: An evaluative study.* New York: G.P. Putnam.

Patton, M. (2002). *Qualitative research & evaluation methods.* London: Sage.

Purkis, M., & Bjornsdottir, K. (2006). Intelligent nursing: Accounting for knowledge as action in practice. *Nursing Philosophy, 7*(4), 247–256. doi: 10.1111/j.1466-769X.2006.00283.x

Randers, I., Olson, T. H., & Mattiasson, A. C. (2002). Confirming older adult patients' views of who they are and would like to be. *Nursing Ethics, 9*(4), 416–431.

Schluter, J., Winch, S., Holzhauser, K., & Hendersson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics, 15*(3), 304–321.

Sellman, D. (2006). The importance of being trustworthy. *Nursing Ethics, 13*(2), 105–115.

SFS. (1982:763). Hälso- och sjukvårdslag. Svensk författningssamling [The Health and Medical Service Act. Stockholm: Ministry of Health and Social Affairs]. Retrieved April 19, 2010, from http://www.sweden.gov.se/sb/d/574/a/23125

SFS. (2003:460). Codex rules and guidelines for research. The humanities and social sciences. Retrieved March 10, 2011, from http://www.codex.vr.se/en/forskninghumsam.shtml

Slettebo, Å., & Haugen Bunch, E. (2004). Solving ethically difficult care situations in nursing homes. *Nursing Ethics, 11*(6), 543–552.

Stabell, A., & Nåden, D. (2006). Patients' dignity in a rehabilitation ward: Ethical challenges for nursing staff. *Nursing Ethics, 13*(3), 236–248.

Suhonen, R., Stolt, M., Launis, V., & Leino-Kilpi, H. (2010). Research on ethics in nursing care for older people: A literature review. *Nursing Ethics, 17*(3), 337–352.

Tarlier, D. S. (2004). Beyond caring: The moral and ethical bases of responsive nurse–patient relationships. *Nursing Philosophy, 5*(3), 230–241.

Teeri, S., Leino-Kilpi, H., & Välimäki, M. (2006). Long-term nursing care of older people: Identifying ethically problematic experiences among patients, next of kin's and nurses in Finland. *Nursing Ethics, 13*(2), 116–129.

The National Board of Health and Welfare [Socialstyrelsen]. (2005). Kompetensbeskrivning för legitimerad sjuksköterska. Retrieved April 16, 2010, from http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/9879/2005-105-1_20051052.pdf

Tronto, J. (1993). *Moral boundaries, a political argument for an ethic in care*. New York: Routledge.

Ulrich, C. M., Hamric, A. B., & Grady, C. (2010). Moral distress: A growing problem in the health professions? *Hastings Center Report, 40*(1), 20–22.

Vanlaere, L., & Gastmans, C. (2005). The ethical and philosophical foundations of care ethics. *Nursing Ethics, 12*(2), 200–220.

WHO. (2008). *Definition of an older or elderly person*. Retrieved July 22, 2008, from http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html

World Medical Association Declaration of Helsinki (2008). *Ethical Principles for Medical Research Involving Human Subjects*. Retrieved October 22, 2008, from http://www.wma.net/en/30publications/10policies/b3/index.html