Healthcare personnel’s experiences of situations in municipal elderly care that generate troubled conscience

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Healthcare personnel may perceive troubled conscience when feeling inadequate and powerless. It is important to further explore healthcare personnel’s descriptions of situations in daily work, which generate troubled conscience to increase the awareness of such situations. This study aimed to describe healthcare personnel’s experiences of situations in municipal elderly care that generate troubled conscience. In this qualitative study, interviews were conducted with Registered and Enrolled nurses and nursing assistants (n = 20) working in municipal elderly care. The interviews were tape-recorded, transcribed verbatim and analysed with content analysis. Situations that generated troubled conscience was (i) Being caught between different demands, comprising being forced to prioritize between different residents’ needs, being torn between residents’-/relatives’-/and co-workers’ needs and expectations’ and between work and private life, (ii) Being torn away from residents to other ‘must do’s’, comprising stealing time from residents’ to do housekeeping chore’ and to ‘obey’ rules and recommendations, (iii) Feeling unable to relieve suffering, comprising falling short when striving to help, lacking knowledge, advice and support and time to ease residents’ suffering and finally, (iv) Being part of providing care that is or feels wrong, comprising providing poor care and/or witnessing co-workers providing poor care, and being forced to give care that feels wrong. These findings identify important factors that generate stress of conscience (stress caused by troubled conscience), including difficulties with balancing priorities and following rules and recommendations that seem contrary to best care, and the need for interdisciplinary teamwork. Findings point to that sharing what conscience tells in the work team opens up possibilities for healthcare personnel to constructively deal with troubled conscience. Intervention studies are needed to explore whether such measures contribute to relieve the burden of troubled conscience and increase possibilities to provide high quality care.

Keywords: troubled conscience, municipal elderly care, content analysis, stress of conscience.

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Introduction

Working in elderly care has been described as a sensitive and demanding task (1, 2). It is demanding to perceive lack of resources to enhance residents’ quality of life (3) and this can generate troubled conscience among personnel, sometimes to the extent that they have to deaden their conscience in order to stay on working (4). Demanding issues and strain in elderly care include time shortages (5–7), lack of support (e.g. 1), feelings of inadequacy and powerlessness (8), difficulties in managing behavioural and psychological symptoms in people with dementia disease (9) and, for nurses, feelings of boundlessness and invisibility (7). In units where staff report high job strain, residents have significantly low capabilities for performing activities of daily life (10). It is apparent that working in elderly care places high demands on personnel’s skills, and it is a challenge to keep providing good care (11).

Acting against one’s own values can be compared with acting against one’s conscience. Several studies have revealed that healthcare personnel may experience troubled conscience for not providing the quality of care they expect of themselves (12–15). Quantitative studies have shown that conscience can be perceived as an asset that can help personnel to provide good care (4, 16). In interviews, Swedish nurses describe conscience as a driving force, a source of sensitivity and an important factor in decision-making (17). Healthcare personnel have reported that they perceive conscience as an authority, a warning

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signal, an asset or a burden, as demanding sensitivity and as depending on culture (16). Not being able to follow one’s conscience to provide the care one wants can generate stress of conscience, that is, stress caused by troubled conscience (18). A study showed that about one-third of the personnel in elderly care perceived their conscience as too strict and one-fifth reported that they needed to deaden their conscience in order to keep working (4), which has been shown to be associated with stress of conscience (19).

Having to deaden one’s conscience in order to keep working in healthcare and experiencing stress of conscience from perceiving lack of time to give the care needed is found to be associated with ‘emotional exhaustion’ (often regarded as the core dimension of burnout). Experiencing stress of conscience from perceiving one’s work so demanding that it influences home life and from perceiving oneself not being able to live up to others’ expectations at work is also found to be associated with ‘emotional exhaustion’ (18, 20, 21).

Research on stress of conscience and burnout indicates that experiences of shortcomings and being exposed to contradictory demands strongly relate to burnout. High burnout scores concerning emotional exhaustion were found in 22.1% of the personnel participating in a study in elderly care (4).

In summary, earlier studies have found that healthcare personnel perceive conscience as an asset in their work. However, conscience may also be perceived as a burden, and not being able to follow one’s conscience may generate stress of conscience, which is shown to be associated with burnout. Healthcare personnel who experience troubled conscience feel powerless and inadequate and struggle to be ‘good enough’ in their work. It is therefore important to explore healthcare personnel’s descriptions of situations in daily work that generate troubled conscience in order to increase our awareness of the specific content in such situations. Hopefully, such knowledge will increase our possibilities to take measures aiming to decrease healthcare personnel’s stress of conscience and, at the same time, increase the quality of care. Measures to prevent stress of conscience and burnout must be founded on an understanding of the problems and their origins.

Aim

The aim of the study is to describe healthcare personnel’s narrated experiences of situations in municipal elderly care that generate troubled conscience.

Method

A qualitative, descriptive design, suitable in research into healthcare personnel’s experiences in care situations, was selected for the study.

Participants

From 21 municipal housing facilities for the elderly in a medium town in northern Sweden, one was randomly chosen to participate. All healthcare personnel (n = 28) in two units of the chosen facility were asked by mail to participate in interviews. Six Registered Nurses (RNs), six enrolled nurses (ENs) and eight nurse assistants (NAs) agreed to participate (n = 20). Two of the RNs had positions as first line managers. All participants but one were women. They ranged in age from 35 to 63 years (md = 51), and mean time working in healthcare was 26.3 years (md = 26). Employment at the present workplace ranged 1–15 years (md = 10), 16 participants worked part-time (68–90% of full-time) and four worked full-time. The term ‘nurses’ refers to RNs and ‘care providers’ refers to ENs and NAs in the study. The concept ‘healthcare personnel’ includes RNs, ENs and NAs.

Context/Setting

The study took place in a special municipal housing unit for older people with dementia diseases, multiple diseases and extensive disabilities. The staffing varied according to the estimated needs of the residents, 0.74, respectively, 0.85 staff member per resident. Continuous shift ran weekdays and weekends: 4–6 care providers were on duty during the day (7:00–16:00), 2 in evenings (16:00–21:00) and 1 at night, responsible for two units (23 residents). At the weekends, staffing was lower. Nurses were available daytime during weekdays, and in the evenings, at night and at weekends, they served several housing units on a consultative basis. General practitioners were consulted once a week for medical questions.

Data collection

The interviews were carried out by four interviewers between September and November 2009 and were conducted in a secluded room in connection with the housing units. The four interviewers used an interview guide that was developed within the research group and which they had agreed on. The participants were encouraged to
narrate freely about their experiences. The initial questions used were: ‘Please, tell me about your experience of troubled conscience?’ and ‘Please, tell me about a specific situation when your conscience was troubled?’ Probing questions were posed to encourage progression in interviews, for example, ‘So what then?’ The interviews were recorded and transcribed verbatim (except names and places), with laughter, sighs and silences marked. The interviews lasted 22–101 minutes (md = 60), for a total length of 20 hours and 46 minutes.

Data analysis
To interpret the interviews, a thematic content analysis was performed, inspired by the framework of Burnard (23, 24). The analysis involves open coding of data, searching for and identifying a set of topics or common themes by grouping coded data by meaning (23, 24). The interviews were first transcribed verbatim, then read and verified against the audio files. Then all texts were read and re-read to gain an overall impression. Single words or phrases, that is, meaning units in line with the aim of the study were condensed and coded. The coded phrases were extracted and sorted into groups on the basis of similar content and abstracted into sub-themes that were sorted and abstracted into themes that are threads of meaning, linking substantial portions of the text together (25). An example of the analysis is presented (Table 1). To ensure trustworthiness, all steps in the analysis and the emerging sub-themes and themes were discussed in an open and critical dialogue within the research group and in research seminars. After revisions, consensus was reached about the most credible interpretation of the text. The findings were also presented to the participants, who said they recognized and found them trustworthy. To allow the reader to judge the trustworthiness of our interpretations, quotations are used in presenting the findings. Some minor revisions have been made in the presentation of the findings to ensure confidentiality.

Ethical considerations
Information about the study was provided verbally and in writing, and participants gave written informed consent. Participants were informed that participation was voluntary and that they could choose to end the interview at any point without giving any reason. Confidentiality was guaranteed, that is, no names or contact details were written on the transcriptions, and no unauthorized person had access to them. The study was approved by the ethics committee of the university (reference number 09-099).

Findings
Analysis of the interviews resulted in four themes and eleven sub-themes (Table 2).

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensation</th>
<th>Sub-themes</th>
<th>Theme</th>
</tr>
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<tbody>
<tr>
<td>If a resident asks me to help as I walk by, but I am on my way to some other residents, and I have to say ‘you have to wait’, that evokes troubled conscience. I can feel I really want to help immediately but that is not possible</td>
<td>Need to prioritize between residents with similar needs</td>
<td>Being forced to prioritize between different residents’ needs and expectations</td>
<td>Being caught between people’s different demands</td>
</tr>
<tr>
<td>Relatives want to have medication prescribed, but I think that at some point there must be a natural end. The residents may be in bad shape, but still relatives want them to be admitted to hospital and given medication. It does not feel worthy</td>
<td>Torn between relatives and residents</td>
<td>Being torn between residents’-/relatives’-/and co-workers’ needs and expectations</td>
<td></td>
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<tr>
<td>I went to work despite own sickness (because if I stay home, the crew is reduced in the workplace and this evokes troubled conscience) but I did not manage to do my job. But you have the right to be home when you are sick, even if there are no substitutes</td>
<td>Torn between work and private life</td>
<td>Being torn between work and private life</td>
<td></td>
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</tbody>
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Table 1 Examples of structural analysis in the first theme, ‘Being caught between people’s different demands’

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or more residents in need at the same time, having to prioritize among them even when their needs seem equally important and having to make at least one resident wait, for example, for toileting. At night, with fewer personnel, prioritization may be even more difficult. Knowing that having to wait can have negative consequences for residents, such as increased suffering, anxiousness and a bad mood the day after a bad night, increases care providers' troubled conscience. It is difficult to prioritize, and being aware of that certain strong-minded residents may demand and receive care to the cost of others leads to further remorse in care providers.

The alarm is raised constantly, especially in nights. I am alone in the unit and I hear residents are up on their feet, someone yells, someone is anxious. That's when I feel inadequate...

...it feels like we are slop buckets. We are expected to drop our tasks and be available for pedicurist, occupational therapist and nurse... We must be available at once...

Being torn between work and private life is a dilemma faced by care providers when illness requires them to stay at home. If they do stay home, they know that staff is reduced in the workplace and this troubles their conscience. If, on the other hand, they go in to work ill, their conscience is troubled by knowing that not being healthy, they may not be able to fulfil their duties at work.

Table 2 Sub-themes and themes in the thematic analysis

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Being forced to prioritize between different residents’ needs and expectations</td>
<td>Being caught between people’s different demands</td>
</tr>
<tr>
<td>Being torn between residents’-/relatives’-/and co-workers’ needs and expectations</td>
<td>Being caught between people’s different demands</td>
</tr>
<tr>
<td>Being torn between work and private life</td>
<td>Being torn away from residents to other ‘must do’s’</td>
</tr>
<tr>
<td>Stealing time from residents to do housekeeping chores</td>
<td>Being torn away from residents to other ‘must do’s’</td>
</tr>
<tr>
<td>Stealing time from residents to ‘obey’ rules and recommendations</td>
<td>Feeling unable to relieve suffering</td>
</tr>
<tr>
<td>Falling short when striving to help/ease residents’ suffering</td>
<td>Feeling unable to relieve suffering</td>
</tr>
<tr>
<td>Lacking knowledge, advice and support to ease residents’ suffering</td>
<td>Feeling unable to relieve suffering</td>
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<tr>
<td>Lacking time to provide sufficient care for the residents’</td>
<td>Feeling unable to relieve suffering</td>
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<tr>
<td>Providing poor care</td>
<td>Being part of providing care that is or feels wrong</td>
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<tr>
<td>Witnessing co-workers providing poor care</td>
<td>Being part of providing care that is or feels wrong</td>
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<tr>
<td>Being forced to give care that feels wrong</td>
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‘Being torn between work and private life’ is a dilemma faced by care providers when illness requires them to stay at home. If they do stay home, they know that staff is reduced in the workplace and this troubles their conscience. If, on the other hand, they go in to work ill, their conscience is troubled by knowing that not being healthy, they may not be able to fulfil their duties at work.

I felt a troubled conscience when I went to work sick.../ One resident wanted me to stay with her, but I had a throbbing headache and could not manage the situation...I promised myself to never go to work sick again...I felt that I did not do my work

Being torn away from residents to other ‘must do’s’

This theme consists of two sub-themes: ‘stealing time from residents to do housekeeping chores’ and ‘stealing time from residents to ‘obey’ rules and recommendations’.

‘Stealing time from residents to do housekeeping chores’ describes care providers experiences of being pulled away from residents to attend to other mandatory duties. Duties expected to be performed daily, include cleaning, laundry, fixing leaky pipes and changing light bulbs. Care providers say that some of their co-workers see performing such duties as more important than taking care of residents. Troubled conscience generates when one does not have time with residents. We are caretakers, cleaners, washerwomen...we actually should have high salary...Instead of mandatory duties, we should take care of the residents, which we are here for...
Stealing time from residents to ‘obey’ rules and recommendations describes being forced to follow general recommendations and routines to the letter, even when they do not seem to contribute to good care for the resident. Documentation, requiring too many software programs, quality controls and care-planning all steal time from residents according to nurses. Care providers also have many examples of such regulatory time thieves, such as routine weight controls conducted whether or not they are needed, measuring food temperature before serving and cleaning the refrigerator and pantry several times a week. Such rules and recommendations are described as preventing care providers from devoting time and providing person-centred care, thus generating troubled conscience. Fridge and pantry must be cleaned and disinfected several times a week, we (care providers) must wear aprons/we must measure food temperature before serving/cooking is not allowed here, there’s a risk of contagion. There is no rhyme or reason...this is not longer homelike, it is an institution/the last time in their life...

Feeling unable to relieve suffering

This theme consists of three sub-themes: ‘falling short when striving to help/ease residents’ suffering’; ‘lacking knowledge, advice and support to ease residents’ suffering’ and ‘lacking time to provide sufficient care for the residents’.

‘Falling short when striving to help/ease residents’ suffering’ describes both a failing struggle to help or to activate residents and problems with organizational limits. Care providers strive to help/calming residents who are anxious, restless, unruly or aggressive every way they can, for example, through activities and closeness, but sometimes they feel that whatever they do, nothing seems to help. Residents with behavioural symptoms such as spitting, beating and pinching are described as difficult or impossible to help. Care providers suffer over both the residents with behavioural symptoms and the co-residents who become victims of the behaviour. Care providers also describe troubled conscience when they see residents, bored and insufficiently stimulated, leaning forward half-asleep over the tables. They strive to stimulate them by taking them outdoors, playing music and initiating daily activities, but nothing they do seems to please some residents.

It is difficult when someone is very restless//It is frustrating when nothing seems to help, no medication...//What should I do?//We try, but it is not always possible to activate them, sometimes it gets worse//We have tried physical restraints, but it looks terrible...

Nurses describe difficulties in helping/ease residents’ suffering because of the organizational structure, especially their extended area of responsibility during weekends and nights. For example, nurses often have to, on a consultative basis, assess residents’ state by phone through secondary information from care providers, which they find difficult and risky. Even though they strive to do everything they can to help ease residents’ suffering, nurses consciences are troubled when they ponder whether they have made the right decision or given the right support.

‘Lacking knowledge, advice, and support to ease residents’ suffering’ is about lacking knowledge on matters involving dying residents or assessments of, for example, anxiety, pain and drug issues among residents, where care providers seek advice and support from nurses but often fail to get the help they need. Care providers describe that they sometimes are met with a wait-and-see policy from the nurses. To see someone suffer and not getting help raises remorse.

...one resident who had had a thrombosis and seemed to have pain...the relative said to me: “he is in a pain”’; I called the nurse and told her that the resident was in need of painkiller, but it is tough to get help.

Although one knows it is the end of life, they should get help faster...

Nurses describe troubled conscience when they perceive lack of advice and support from management on matters where inappropriate personnel affect the work environment in a negative way, and residents ‘pay the price’.

‘Lacking time to provide sufficient care for the residents’ describes care providers having almost daily to compromise on residents’ care needs. Although they can provide basic care, care providers would like to have time to do more pleasant things with residents, to play games, go outdoors and give them a ‘grain of gold’, not just wash clothes, assist with hygiene and keep saying ‘I am coming soon’.

Almost daily one does not manage to provide the care a resident needs//One would like to do more, like potter around with them, take care of them and talk with them//One does not think of that [troubled conscience] daily, but when you do think, you get troubled conscience

Being part of providing care that is or feels wrong

This theme consists of three sub-themes: ‘providing poor care’, ‘witnessing co-workers providing poor care’ and ‘being forced to give care that feels wrong’.

‘Providing poor care’ describes healthcare personnel’s experiences of treating residents badly, avoiding residents and relatives and being accused of neglect. Treating residents badly is described as behaving inappropriately towards a resident, for example, care providers sometimes speak impetuously to residents or do not behave kindly. For example, when raising up the bed daytime to make it inaccessible for a resident who sleeps at day and are awake at night, care providers describe feelings of that this can be wrong, which in turn generates troubled conscience.

Avoiding residents and relatives is described in situations care providers and nurses currently cannot cope with. This
is about situations when they cannot meet residents' or relatives' needs in a way that they feel they should, instead they turn their back to them. Awareness of avoiding residents and relatives may linger and generate troubled conscience.

We have a resident who has many problems//We hoist up the bed in order to make it inaccessible in daytime, because he often does not sleep at nights// We know that we should not...

‘Witnessing co-workers providing poor care’ includes witnessing co-workers responding inappropriately to residents, insulting them or ignoring them. Poor care is also described when negligent co-workers are seen to make no effort to take care of basic nursing tasks for residents, such as grooming their hair, nails and clothes, and other tasks of importance for human dignity.

You cannot argue with or confront a person with dementia disease, but the short-tempered co-worker is still arguing about different issues, such as whether it is Thursday or not,… they also consider themselves as knowledgeable and they do not see that they behave insulting… it’s very difficult.

‘Being forced to give care that feels wrong’ occurs most often in the care of the dying, when care providers feel forced, for example, to give dying residents nutritional drinks, unjustified active treatment or help into a wheelchair. Nurses’ difficulties in the care of dying residents often centre on disagreements with the physician about pain assessment. Nurses describe requesting adequate pain relief for residents, but being denied and seeing severely ill or dying residents sent to hospital, where they die almost immediately instead of being cared for at the unit where they are known and know the personnel.

It is about pain relief at the end of life//I failed to persuade the doctor to give the large amounts of pain relief that the resident needed//It is our job. At the end of life they should not have to sit in bed and scream out of pain, fear, and anxiety. We are obliged to provide relief. It is the law.

Being forced to give care that feels wrong also includes having to act against residents’ will, even when these actions are in residents’ best interest. This occurs, for example, when care providers are forced to rouse stubborn residents, who are no longer able to make healthy decisions out of their beds or exclude residents from the kitchen area because of spitting behaviour. Facing these very difficult situations without finding better solutions generates troubled conscience in care providers.

**Discussion**

The aim of the study was to describe healthcare personnel’s experiences of situations in daily work that generate troubled conscience in municipal elderly care. The findings show that healthcare personnel are feeling troubled conscience when being caught between people’s different demands and when they are torn away from the residents to others ‘must do’s’. It is difficult to prioritize between residents who need help at the same time and also between the residents’ needs and other duties. Healthcare personnel are daily confronted with and forced to make such difficult choices and they are often alone in their decision-making, which puts a heavy burden on their shoulders. It is easy to understand that having to make such priorities in daily work can breed feelings of powerlessness and inadequacy, earlier found to be meanings of troubled conscience (8) among healthcare personnel. Priority setting in daily elderly care is seldom studied. In a report about prioritizing in collaborations between Swedish municipalities and counties, the authors conclude that knowledge about priorities in Swedish healthcare is not distributed well enough, especially in social care (including elderly care) (26). In a study performed in elderly care, it was found that nurses felt that they were forced to prioritize residents’ physiological needs over their psychosocial needs. The authors conclude that nurses and physicians seldom or never seemed to discuss how to deal with dilemmas in setting priorities and factors of importance in such decisions; it seemed the responsibility rested on the individual professionals’ shoulders (27). A study performed in an emergency department shows that nurses, owing to lack of time, are forced to prioritize medical care or practical tasks and routines, a situation which according to the authors may lead to that their ideals of good care are unattainable (28). A reflection is that guidelines are supposed to help healthcare personnel to prioritize, but our findings do not show that they always do so. On the contrary, healthcare personnel describe that having to follow the guidelines can tear them away from caring for residents. However, because we asked participants to narrate their experience of troubled conscience, they reasonably did not mention any guidelines that they found helpful. Evidence-based knowledge is often used to create clinical guidelines in healthcare. These are necessary for developing and maintaining high quality healthcare, but as shown in our result, they can also generate troubled conscience in healthcare personnel who find that many guidelines, some of which they believe are questionable, steal their time from residents, making it difficult to attain the overall healthcare recommendation to provide person-centred care. In intensive care, one study shows that the majority of the personnel (n = 1359) are positive of guidelines and perceive them practical to use, one-third perceive that there are so many guidelines that it is difficult to keep up with them, one-fifth perceive guidelines too prescriptive and that the costs exceed the benefits, one-quarter perceive that they do not have time to keep up with guidelines and one-fifth regard guidelines as unpractical and unwieldy (29). No studies have been found regarding healthcare personnel’s attitudes towards guidelines in elderly care. Our findings supported by the studies mentioned earlier show that knowledge about attitudes and use of prioritizing and guidelines in el-
Findings show that feeling unable to relieve suffering and being part of providing care that is or feels wrong is another source of troubled conscience. Healthcare personnel described shortcomings in care and the lack of knowledge, advice, support and time to relieve suffering. These findings reveal difficult situations in the daily work, wherein healthcare personnel sometimes do not know the right thing to do and have no one to turn to for advice. Incorporating teamwork into the work place seems an obvious method for sharing, and perhaps ameliorating, these difficult situations. The need for interdisciplinary teamwork in elderly care is emphasized by researchers (30–32). Interdisciplinary teamwork aims to provide continuity in the care of the elderly, to facilitate judgements that demand several perspectives or competencies, to identify problems, find solutions and satisfy the person in need of care from a wholeness perspective (11). Teamwork makes it possible for personnel to support and be supported by each other and consequently relieve the burden of a troubled conscience generated from not knowing what to do and having no one to turn to. With the gathered knowledge and united efforts of all involved healthcare personnel, residents and their relatives, the opportunity to attain high quality care logically increases.

Our findings show that situations which also generated troubled conscience concern when healthcare personnel provided poor care themselves, witnessed co-workers provide poor care and when they were forced to provide care they felt was wrong. A questionnaire study in elderly care ($n = 146$) shows that perceiving that one sometimes is forced to provide care that feels wrong and seeing patients being insulted and/or injured are related to having to deaden one’s conscience in order to keep working in healthcare (19). In a study performed in Sweden, Australia and the United Kingdom, witnessing staff’s problematic behaviour and attitudes towards residents with dementia diseases was found stressful. When staff behaved badly, nurses felt powerless and frustrated as they did not know how to handle the situation (3). Having the courage to raise one’s voice in a culture of silence is not an act without costs for the individual; in fact, the costs can be very high and can come in the form of reprisals. The motive behind raising one’s voice is moral responsibility (33: 11, 18, 112–131), and hence, it is an act of conscience. A reflection is that the inner voice of conscience (34) may then be expressed outwardly when healthcare personnel take a position in defence of the person in need, that is, the resident. It seems reasonable that adopting this position would be less dangerous if it could be done together in the team, relieving the burden on the individual and increasing the opportunities to provide high quality care. When having none to turn to and witnessing co-workers provide poor care, it may be fruitful to share knowledge about what conscience is telling us together in a team, that is, enlighten conscience.

Our findings highlight the need for healthcare personnel to pay attention to their conscience and to express and interpret it’s message both individually and with others in order to make conscience an asset that is possible to follow in the daily work. The Latin word conscientia may be interpreted as ‘know together’ and ‘share knowledge’ (35). Conscience refers to something fundamentally social that involves concerns and principles that are sharable (36), need to be respected (37) and are too important to ignore (38). Conscience is an authority, when followed may help healthcare personnel to reflect on and learn from their shortcomings. Transforming one’s own and others’ shortcomings into new knowledge may create meaning, pride and a feeling of positive power to be used in doing one’s best for the elderly, and thus developing as a human being (21: 47, 51). Our conscience needs to be informed and educated with help from our fellow beings, and thus conscience may be understood as ‘co-knowledge’ (39: 27, 51, 62).

Methodological considerations

Our intention has been to comply with the standards for establishing trustworthiness stated by Lincoln and Guba (40), that is, credibility, dependability, transferability and confirmability. To accomplish this, an effort has been made to describe the process of analysis carefully (e.g. by illustrating the findings with quotes). The findings have regularly been discussed together in the research group to ensure consistency of findings. Content analysis, used in this study, is a method which was considered appropriate to the type of data collected. The interviews were voluminous, rich, varied and highly descriptive. To maintain the integrity of the entire text and not break it into pieces that could alter the overall meaning, it was important to read the whole text repeatedly and to keep it in mind during the analysis (24). There were no problems for any of the participants to answer the entry question, they could all narrate severe situations where troubled conscience was generated. A limit of the study may be that four people performed the interviews. Although the interviewers used an interview guide, there is a risk that they may have focused on what was said slightly differently, making trustworthiness hard to achieve. At the same time, this limit may be seen as an advantage in producing more nuanced and rich interviews.

Conclusion

The findings in this study show many situations that generate troubled conscience in the daily work of elderly care. Such detailed findings about what generates troubled conscience have, to our knowledge, never been
highlighted. The findings have identified important areas, for example, the difficulties with prioritizing and following guidelines in daily work and the need for interdisciplinary teamwork. Sharing what conscience tells and thus knowing together in a working team would open up opportunities for healthcare personnel to provide a high quality of care and to stay healthy themselves. It is very important to perform intervention studies in the future to explore whether it is possible, through ‘knowing together’, to constructively deal with a troubled conscience in the daily work of elderly care. The designs of these interventions should be based on healthcare personnel’s perception of situations that generate troubled conscience.

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Author contributions

Gunilla Strandberg was responsible for the study design. Eva Ericson-Lidman, Birgitta Persson and Gunilla Strandberg performed the interviews and analysis and Eva Ericson-Lidman and Gunilla Strandberg drafted the manuscript; Astrid Norberg contributed with valuable viewpoints.

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