Ethical considerations in psychiatric inpatient care
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The ethical landscape in everyday practice as described by staff
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Abstract

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This thesis focuses mainly on the general ethical considerations of staff and not pre-defined specific ethical problems or dilemmas. The aims of this thesis were: first, to map ethical considerations as described by staff members in their everyday work in child and adolescent psychiatry as well as in adult psychiatry; second, from a normative ethical perspective, examine encounters between staff and patients; and third, to describe staff justification for decisions on coercive care in child and adolescent psychiatry. The material in the three first studies comprised ethical diaries written by staff in 13 inpatient clinics. The fourth study included all the medical records of patients who were admitted to coercive care during one year in child and adolescent psychiatry in Sweden.

In a final analysis, combining all the four studies, three staff ideals were identified: being a good carer, respecting the patient’s autonomy and integrity and having good relations with patients and relatives. Staff often felt that the only reasonable way in many situations was to act in a paternalistic way and take responsibility, but they considered it to be problematic.

Four main themes were identified as ethical considerations. These were the borders of coercion, the emphasis on order and clarity rather than a more reciprocal relationship with patients, a strong expectation of loyalty within the team, and feelings of powerlessness, mostly in relation to patients.

I have identified four challenges for inpatient psychiatry. First, formal and informal coercion in inpatient care raise ethical concerns that also can be emotionally difficult for staff. Second, the professional role and care needs to be redeveloped from providing routinised care to providing more individualised care. Third, staff often worry about how patients manage their life after discharge, indicating that patients need better support. Fourth, staff also need support; they often experience feelings of being alone with their thoughts about ethical difficulties at work. Future research could contribute in the mapping of ethical considerations, in helping to develop, implement and evaluate methods for managing these issues in psychiatric settings, and to develop the normative ethical language so that it is more relevant to the clinic reality.

Keywords: Staff, psychiatric care, diary method, qualitative content analysis, ethical issues, decision making, coercive care, adolescent.

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List of papers

This thesis is based on four original papers, which will be referred to in the text by their Roman numerals.


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1. BACKGROUND

Psychiatry is a value-laden activity. Research on ethical issues in psychiatry has thus far mainly focused on normative ethics, on how staff should handle ethical issues. However, the interest in empirical ethics is growing and new studies are being published more frequently. Empirical ethics gives an opportunity to identify ethical issues that arise in psychiatry. It can provide a basis for creating a relevant ethical language to discuss and resolve ethical challenges present in psychiatry.

This thesis includes both an empirical and a normative ethical approach. I have chosen to use the concepts of consideration and justification. As psychiatry is a value-laden activity, staff should reflect on and consider ethical issues at work. When a situation is so serious that coercive interventions are considered, the action also needs to be justified both legally and ethically. The focus of this thesis is on the general ethical considerations of the staff, rather than focusing on pre-defined specific ethical problems or dilemmas, and on their justification for coercive care. It is not only the content of mental health services that is value-laden, even the way that mental health services has been organised, and is organised today, is also a value-laden question. Due to this fact, but also in order to understand the considerations of staff, it is necessary to have some historical and organisational background about the psychiatric inpatient care. I choose to present this overview short since the focus of this thesis is the staff’s views on ethical issues, not the history or organisational problems of psychiatry.

The introduction starts with an overview of the role of values in psychiatry from ethical and legal perspectives. A chapter about normative ethical perspectives in encounters with patients follows. The introduction concludes with a presentation of empirical research on ethics in psychiatric settings.

1.1. Values in psychiatry

I have chosen the concept of values as the point of departure in this thesis because values are always actualised in encounters with patients. In the process of examination, treatment and care of the patient, issues or considerations may appear that contain ethical aspects. It is these aspects in every day work that are the main interest of this thesis.
1.1.1. Psychiatric context and values

Many value issues become apparent in psychiatry. There are aspects within psychiatry that makes it more value-laden than most other medical fields\textsuperscript{1}. First, the diagnosis is usually based upon an assessment of the patient’s and other people’s narratives about symptoms, life situation and functional disability, rather than irrefutable medical facts\textsuperscript{1-4}. Second, the psychiatric treatment process is concerned with areas of human life where concepts such as normality, identity, and value preferences come to the fore in a more distinct manner\textsuperscript{5}. Third, mental health care professionals often have to manage conflicting values. A common dilemma is to balance between respecting the patients autonomy, which can often be reduced by the disorder, and doing what they perceive to be in the best interest of the patient\textsuperscript{5, 6}. Under certain circumstances, weighing up conflicting values may lead to a decision for coercive care. Four, a psychiatric ward is a multi-professional work place where psychiatric team members’ personal values about diagnosis, treatment and management may be highly diverse in comparison to many other fields of medicine\textsuperscript{1, 7, 8}. There are also reasons outside psychiatry that make value issues important for consideration. Psychiatric services have been questioned scientifically and politically to a greater extent than other areas of health care\textsuperscript{1}. As well as this criticism aimed at psychiatry, psychiatric patients are still stigmatised in our society. This can lead to impoverishment, social marginalisation and lower quality of life\textsuperscript{5}; consequences that are contrary to the values of legislation in democratic societies. Many patients and their families wish that mental healthcare staff would help them to reduce the feeling of shame and enable them to be treated as ordinary persons\textsuperscript{10-12}. In order to meet these wishes, staff members have to show a high awareness of their own values as well as what the ward and the organisation as a whole stand for in relation to patients.

To handle this value-laden reality of psychiatric practice, Fulford\textsuperscript{1, 13, 14} proposed that psychiatry should see itself as a values-based practice. The concept of values-based practice should also be seen as a complement to evidence-based practice, rather than replacing it. Striving for a values-based practice implies that staff should recognise that both facts and legitimately different value perspectives are present in every meeting with patients and stakeholders. At first, staff should find out the values of the patients and work according to a patient perspective. To solve problems, values-based practice emphasises the importance of staff communication skills. Staff should be able to reason and balance different legitimate value perspectives.
1.1.2. Historical overview

The modern era of public psychiatric hospitals started in the 19th century. Several reformers advocated the idea of mental hospitals, asylums for the mentally ill, instead of prisons and almshouses. This would provide a sheltered place where patients could live and heal, rather than being placed in prison or other institution not designed for this group of people. Norvoll describes these early hospitals as staff-centred institutions where the care staff had an unclear role in the treatment. The patients seldom met professionals and many patients were seen as incurable. The role of the care staff was to maintain the daily routines and to ensure that patients were calm and adapted to the rules of the ward. This tension regarding psychiatric institutions whereby there is a dichotomy in psychiatric institutions between treatment of patients and social control of people with abnormal behaviour has interested researchers in social sciences. The idea of asylums, namely that patients should be isolated from society and placed in an institution, was already being criticised in the beginning of the 1900s and the trend of deinstitutionalisation started in the 1950s. However, it wasn’t until the 1960s and 1970s that deinstitutionalisation really took off when psychiatric institutionalisation of patients received strong criticism from various interest groups and there was a growing interest in the media for reporting on abuses in psychiatry.

In recent decades, there has been a continuing deinstitutionalisation in psychiatry in the Western world and outpatient care has become more common. Many patients have reported positive changes since leaving the old inpatient settings but also difficulties in coping with life in the community. This development has, however, created new ethical issues. If a patient does not want to participate in outpatient rehabilitation programs or activities and is left alone, is this a way of respecting the patient’s autonomy, or is it just neglect of a patient in need of care? Another issue is that the problems of institutionalisation did not disappear with the old psychiatric hospitals since they can also be found in new alternative forms of community-based institutional settings. In the last decades, several countries have implemented coercive psychiatric care in outpatient settings. This measure is problematic from an ethical point of view and the effectiveness of this kind of treatment has also been questioned. One study from a county in Sweden...
reported that coercive outpatient care increased the total use of coercion of patients23.

The reduction in the number of hospital beds has brought about a situation where patients are a hospitalised for shorter periods18. This has resulted in a higher proportion of inpatients with acute mental illness and, in Sweden, around half of them are receiving coercive care24. This development has had a negative impact on the care environment24 and has led to new ethical issues for psychiatric inpatient care. At the same time, some of the ethical problems of asylums are still present in today’s inpatient care with staff centred care and patients who have to be calm and adapt to the rules16, 25. Fewer hospital beds in psychiatric inpatient care has also led to transinstitutionalisation whereby those who are mentally ill are being placed in prisons and other institutions instead of mental hospitals15. Some ethicist15 therefore argues that society should go back to the idea that some patients who do not cope with their lives in society, despite extensive outpatient care, need the asylum that an inpatient care unit can provide.

1.1.3. Values and legislation in child and adolescent psychiatry

There are ethical problems that are specific to child and adolescent psychiatric care, and not found in the adult situation26, 27. Ethical principles and practices in the treatment must be modified because it is necessary to consider the age and degree of maturity of the young person27. More attention has recently been focused on the rights of the child within medical care, especially in view of the Convention on the Rights of the Child28. All children in Sweden, regardless of age, have the right to participate in care planning and decisions about their care. The child’s right to decide for his or herself is related to the child’s maturity in relation to how difficult the decision is, and what significance it has for the child’s continued health29. Children also have, under most circumstances, the right of confidentiality in relation to their parents from the age of 1529. At the same time as the rights of the young patient must be respected, the parents need both information and support to be able to assume their parental responsibility28. In cases where the child has serious psychiatric problems, a decision of coercive care can be made by a physician irrespective the parents’ wishes29.

There are several active stakeholders, parents, schools and social services, in relation to child and adolescent psychiatric care in comparison with adult patients in psychiatry. This collaboration may give rise to conflicts of interest such as, for instance, unintended disclosure to stakeholders; a problem staff have to balance in an ethically reasonable way28. Staff need to handle
the collaboration with stakeholders and the information in such way that the primary concern is about the protection of the rights of the child\textsuperscript{27}.

1.1.4. Legislation and values in psychiatric health care

The aim in the Swedish health legislation is to provide good health care on equal terms for the entire population and the care should be based on respect for the autonomy and integrity of the patient\textsuperscript{30}. Sometimes, mental health care can be provided as coercive care. According to the Swedish Compulsory Mental Care Act\textsuperscript{30}, coercive care may only be given if the patient i) is suffering from a serious mental disturbance, ii) due to his/her mental state and general personal circumstances has an absolute need of inpatient psychiatric care, and iii) objects to such care. When the care need is assessed, it should also be taken into consideration whether the patient, due to his/her mental disturbance, is dangerous to others. This is, however, not a compulsory prerequisite for coercive care in Sweden. A licensed physician in public health care is, after an examination of the patient, entitled to issue a care certificate if it is discovered that the prerequisite for coercive care are fulfilled. When the certificate is issued, the patient should be taken to a public psychiatric hospital as soon as possible. The care certificate is valid for 4 days. After the patient has arrived at the hospital, the decision of coercive care should be settled within 24 hours by a psychiatrist after a new examination of the patient.

This Compulsory Mental Care Act, like the legislation in most countries expresses several values that may overlap as well as be conflicting. When analysing the legislation in the five Nordic countries, Syse\textsuperscript{31} identified values such as respect for autonomy, integrity, beneficence, justice and the sanctity of life. In comparison with former legislation, the Swedish Compulsory Mental Care Act\textsuperscript{30} has a strong emphasis on the patient’s right to integrity and to participate in treatment. The aim in coercive care should always be to get the patient to participate voluntarily in the necessary treatment and receive the help that she/he is considered to be in need of. Coercive measures should only be applied if they are proportionate to the objective of the measures and if less restrictive measures are considered to be insufficient. Coercive care should only be used if the patient, after receiving customised information, is not participating voluntarily.

Psychiatric coercive legislation differs between countries in Europe and changes over time. There are at least four specific characteristics in the current Swedish legislation that are worth mentioning in comparison with the corresponding laws in Europe. First, the Swedish Compulsory Mental Care
Act\textsuperscript{30} does not distinguish between children and adults; it only mentions that patients over the age of 15 have the right to plead their own cause. This differs from some other countries such as the Finnish Act where the criteria for coercive care are different for children in order to secure the child’s health and development\textsuperscript{32}. Second, the Swedish Act allows patients to be in coercive care for up to four weeks without legal trial, which is quite long compared to most other countries where the judicial authorities must be contacted immediately, often within 24 (i.e. Czech republic and Spain) or 48 hours (i.e. Italy or Poland) following the decision for coercive care\textsuperscript{33}. Third, in most countries in Europe such as Germany and the United Kingdom, for example, the danger towards other people or the public is a main criterion when assessing the need for coercive care\textsuperscript{33}. In Sweden, this is a only a supplementary criteria whereby the problem should be “taken into account” in the assessment of the patient. Fourth, the Swedish legislation, like the Irish legislation\textsuperscript{34}, allows patients in voluntary treatment, if certain conditions are fulfilled, to be converted to coercive involuntary care during their hospitalisation, which is highly controversial and not allowed in all countries.

1.2. Normative ethics in staff members’ encounters with patients

In this thesis I have chosen to use three normative ethical perspectives found in international declarations for health care and psychiatry as a point of departure when it comes to staff’s encounters with patients. The relation between the patient and the caregiver is asymmetric. It is the staff members who, within the organisational and spatial limits, set the frame for encounters between staff and patients. Intentional as well as unintentional framing by the organisation or staff can have a crucial impact on patients’ opportunities to be heard and participate in the process\textsuperscript{35, 36}.

Psychiatric services should be based on ethical guidelines concerning professional ethics in medicine in general such as the Hippocratic Oath\textsuperscript{37} and the International Code of Medical Ethics.\textsuperscript{38}, and in psychiatry, in particular the Hawaii\textsuperscript{39}, Madrid\textsuperscript{40}, and Kobe declarations\textsuperscript{41}. Engström\textsuperscript{36} found three ethical perspectives in these ethical guidelines that form the basis for the encounters between staff and patients: paternalism, autonomy and reciprocity (Table 1).
Table 1. An overview of the three ethical perspectives 37, 38, 40-43

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Core normative document(s)</th>
<th>Core values highlighted</th>
<th>Decision made by (decision-model)</th>
</tr>
</thead>
</table>

These perspectives may be understood in relation to the historical development of normative medical ethics with a considerable overlapping between the three perspectives. On one hand, it is possible to see these perspectives as conflicting, but on the other hand they can be seen as complementary, representing three different and useful contributions to the ethics of psychiatry. The four principles of bioethics presented by Beauchamp and Childress 42 are highlighted in the ethical guidelines, but they emphasise different aspects of these core values. An important difference between the three perspectives is the ideal about who should have the right to plan and make decisions about care and treatment 43. Traditionally, in the paternalistic decision model, the physician makes the decisions. In the decision model of autonomy, it is the well-informed patient who has the right to decide. In the model of reciprocity, the physician and the patient take a joint decision. These three decision models are the most commonly discussed in the literature 43.

1.2.1. Paternalism

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. (Hippocratic Oath)

Medical ethics has a long history. It was already included in the first known documentation of knowledge in medicine. These documents are called “Hippocratic Corpus” and consist of seventy papers from 400 BC, which include professional ethical guidelines called the Hippocratic Oath 36, 37 (Table 1). This perspective is often called paternalism. Staff should only use
their knowledge and skills for the benefit of the patient, never do harm (the “primum non nocere” principle) and always act only in the patient’s best interest. The Hippocratic Oath also states that health care professionals are bound by confidentiality but no other patient rights are specified. In contrast, there is a long description of the importance of being loyal to colleagues. These principles are still at the heart of contemporary medical ethics, where beneficence and nonmaleficence are core values but the loyalty to colleagues has now been modified in the International Code of Medical Ethics:

A PHYSICIAN SHALL deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

In the paternalistic decision model, the physician plans and decides about the treatment of the patient (Table 1). The rationale for this view is that it is only the physician who has the knowledge about medical disorders and whose suggestions the patients are expected to comply. The concept of compliance does not, in itself, imply a paternalistic decision model but has typically been used to describe a situation where the professional is consulting biomedical research to find out the best treatment for the patient group to which the patient belongs and decide according to what seems to be in the patient’s best interest.

The paternalistic unilateral decision model ignores the patient’s perspective and can lead to decisions that may be perceived as abusive by patients. This power imbalance is problematic both from a political and ethical perspective and it can also prove to be ineffective. The patient may not comply with the treatment plan if the specific needs and preferences of the patient are not fully taken into account, and the treatment effort spent on the patient may not give the expected effect.

1.2.2. Autonomy

A PHYSICIAN SHALL respect a competent patient’s right to accept or refuse treatment. (The International Code of Medical Ethics)

The discussion on medical ethics after the Second World War aimed to strengthen the patient’s rights in relation to the health care system since some physicians in Nazi Germany used their position to take measures that clearly violated the patient’s dignity and human rights. However, even in normal circumstances, there is a risk that the defence of professional values.
turns into a defence of the professional organisation, which is especially problematic in an environment such as psychiatry where patients often do not have a voice in society. A central document supporting this perspective is the World Medical Association’s International Code of Medical Ethics. This code corresponds well with the Hippocratic Oath but emphasises the patient’s right to autonomous decisions regarding medical care. The code states that the physician is obliged to respect a competent and well-informed patient’s right to accept or refuse treatment.

A key idea in this perspective is that the patient has the right to make a decision about treatment, even if this decision is contrary to the patient’s best interest from a professional perspective (Table 1). However, according to the psychiatric ethical codes, it is possible to make a decision about coercive care if a person lacks decision-competence and has a serious mental illness, but only if serious impairment to the patient or others is likely to occur without treatment.

Autonomy as a core value of medical ethics has become increasingly dominant; some, especially in the Western world, would even see it as a trump value. Many philosophers and psychiatrists are critical of the fact that autonomy often overrides other values in health care. First, the autonomy perspective presents a negative view of the possibility for communication between human beings; a person is like “a black box” that someone else cannot understand unless the person clearly expresses what they want. Second, the concept of autonomy is based on a single individual without context. There is reason to question the view that “each man is an island”, especially in working with people from cultural backgrounds where the family rather than the individual is often seen as the basic unit. Third, the autonomy of patients in need of psychiatric care is often diminished by the mental disorder. If medical professionals place too much emphasis on the psychiatric patient’s autonomy and respect the patient’s decision to refuse care it may result in severe consequences.

1.2.3 Reciprocity

The patient should be accepted as a partner by right in the therapeutic process. (Madrid Declaration)

The third perspective is reciprocity; highlighted in The Hawaii, Madrid and Kobe Declarations issued by the World Psychiatric Association. The Hawaii and Madrid declarations emphasise mutual respect and co-opera-
tion, which means that staff should always work in partnership with patients, their families and other collaboration partners, and give them a real opportunity to participate in mental health care planning and treatment. The Kobe declaration focuses even more on the family and the civil rights of the patient than the other declarations.

RESOLVED to support people with mental illnesses and their families and promote equity, non-discrimination in health policy, and special provisions in health care, education, employment, and housing. (Kobe declaration)

Patients and their families are expected to participate as full partners in the delivery of mental health care. The notion of being a full partner indicates that participation is a core value (Table 1). The declarations also state that psychiatric professionals should act at community level to support patients in obtaining the health care, education, employment and housing that they need. This can be seen as a plea for justice, which is considered to be a core value in medical ethics. This great emphasis on the importance of the patient’s rights and relationships distinguish psychiatric ethics from the common medical ethics which traditionally have had a more individualistic approach. However, many of the ideals for psychiatric clinical ethics have begun to spread to the rest of health care such as, for example, the theory of value-based practice.

This perspective views the ideal as shared decision-making (Table 1) whereby the process should be characterised by deliberation and not negotiation, since the patient has a weak position in relation to the professional staff. The fundamental principle is that staff should identify, acknowledge and respect the values of the patient in question. Thereafter, the professional should plan and decide together with the patient, and possibly with other stakeholders. Decisions should never be handed over to ethical, or other, experts since the professionals in psychiatry have the psychiatric competence and the patients are those who know what it is to live with their illness or disability.

Shared decision-making is complicated because it assumes that two people mutually shape the decision while, at the same time, the balance of power is asymmetric and the autonomy of patient can be diminished. This implies that staff members during the same patient visit may need to change their approach in order to reach a successful and reasonable decision. Sandman and Munthe have carried out an analysis of the different models of decision making in health care. They argue that shared decision making is the best model. In cases where a patient is not able to participate, they
propose a more paternalistic approach, but they emphasise that the focus should be on the best interest of the patient and the goal is to find a compromise that the patient can accept.

1.3. Empirical research on ethical issues in psychiatry

This thesis focuses on staff views on ethical issues. Before presenting the research about these issues, I would like to give a brief overview of some aspects that are important for the understanding of the organisational context in psychiatry. Thereafter, I will present research about staff views on ethical issues in psychiatric inpatient care, and also how patients perceive inpatient care. The main focus of this presentation is on coercive care and measures since issues in this area have been ethically problematic in psychiatry, and researchers have mainly concentrated on coercion. There are not as many studies about the staffs’ own perceptions of ethical issues in psychiatry; therefore, parts of the research presented are studies where ethical issues are treated in an implicit way.

Two studies published in Swedish are presented in more detail since these data were collected by the same research group simultaneously with the data used in this thesis. They provide additional information about the settings of these studies and they influenced my pre-understanding of the settings, issues of coercive care and staff ethics in psychiatry.

1.3.1. The organisational context

In this section, I will first present some findings about how organisational values can interact with staff values. Second, psychiatric practice consists of multi-professional teams. Such teams are necessary since psychiatric practice needs medical, psychological and social competence, but having professionals with different perspectives in the same team can also be problematic. Third, moral stress is a theory developed to explain the vulnerability of health care staff when it comes to dealing with ethically difficult situations; some of these studies have been carried out in psychiatric inpatient care. This theory has been used in earlier research and our research group has used it when interpreting results. Four, I will present some research findings about the patient possibilities to participate in their care.

1.3.1.1. Staff values and the organisation

The set of values that are held by members of staff can make a difference in patient encounters. In general, there are signs that values have a significant impact on behaviour in the workplace and that these staff values interact.
with the values of the organisation. Most people nowadays have low acceptance of formally expressed values. Thus, a person-to-person relationship is more effective when it comes to implementation of organisational values than a person-to-organisation relationship. This means that staff members are mainly influenced by the feelings of obligation toward the manager and these feelings exert a strong influence on staff behaviour; stronger than the influence of official organisational policies. Research indicates that people who are aware of their own values and have an understanding of the organisation’s values, also have the highest level of commitment to the organisation. Employees who are committed to the organisation are more motivated, productive and satisfied than those who are less committed. The common values of a workplace are not always obvious in everyday work since we tend to notice them when they conflict with, or are different from, our own. In such situations, values will become apparent and standard ways of acting may be challenged.

1.3.1.2. The psychiatric team
Psychiatric practice is a hierarchical system where employees with different occupations and views on mental disorder are expected to work together in teams. This can be problematic. In child and adolescent psychiatry, in particular, there are several different ideologies with substantial differences on how to view the child, family, and psychiatric treatment. In a study of multi-professional working practices in outpatient psychiatry it was found that all professions focused mainly on the social aspects in the descriptions of the patients. At the stage when the decision was going to be taken, the focus moved to physiological and psychological aspects and those taking part in the discussions and decisions were mainly physicians and psychologists. The conclusion was that the relational aspects of team work, as well as a hierarchical relationship between the professions, can limit the opportunities for psychiatric teams to highlight patient issues in a comprehensive manner, and make full use of the team’s collective expertise.

1.3.1.3. Moral stress
Research indicates that the heavy workload can create feelings of inadequacy, fear and anxiety among staff. The concept of “moral stress” has been suggested to describe the conflict that arises because:

1. nurses are morally sensitive to the patient’s vulnerability;
2. nurses experience external factors preventing them from doing what is best for the
Support from, and alliance with, the team is one strategy used by nurses (or other staff members) to reduce moral stress, but it does not necessarily solve the ethical issues. Despite the fact that moral stress arises from an organisational level, it is often considered as a problem to be handled by staff members on an individual level. Staff members often have a need to talk about feelings of inadequacy and powerlessness, but this is most often done in an informal context with colleagues or other persons. Lützen et al. found that it was important for the well-being of the nurses to find solutions to the ethical issues and, when it was not possible, they expressed feelings of guilt, frustration and powerlessness. Another study revealed that 52% of nurses and social workers in health care were frustrated by the fact that they could not find solutions for their ethical issues.

1.3.1.4. The patient perspective on participation

Since 1992, the health care legislation and the legislation about coercive care in Sweden has emphasized the participation of patients and relatives in the treatment but, in a study from a single county in Sweden, no difference in participation could be detected between 1991 and 1997. Many of the patients did not know if they had been admitted voluntarily or not, nor if they had a care plan. In another study, patients reported that they did not feel that they participated in the treatment, nor did they feel that they were involved in the care planning. Lützen et al. found that it was important for the well-being of the nurses to find solutions to the ethical issues and, when it was not possible, they expressed feelings of guilt, frustration and powerlessness. Another study revealed that 52% of nurses and social workers in health care were frustrated by the fact that they could not find solutions for their ethical issues.

According to Swedish legislation, young people have the right to participate in the care and decisions concerning the content of care. In an ideal situation, participation in treatment decisions can be therapeutic and have positive effects on adolescents in terms of self-confidence, self-esteem and in giving an understanding of the meaning of care.
in child and adolescent psychiatry\textsuperscript{36}, most patients reported that they rarely experienced that they were involved in their care. They had very little knowledge of the legal conditions and about their rights. Some of them were not even aware of whether they were voluntarily or involuntarily admitted patients.

\subsection*{1.3.2. Ethical issues in inpatient care}

Nurses in psychiatric care often have a heavy workload, including situations where they sometimes have to respond to violence from patients and have to administer coercive measures\textsuperscript{25}. In order to cope with working in this environment, staff tend to adopt a professional role: diagnosing the patients’ behaviour, avoiding ordinary everyday conversations with them and adhering to formal and informal rules\textsuperscript{25, 70, 76}, which can be perceived by patients as not being cared for\textsuperscript{36} or as rejection\textsuperscript{77}. The fact that staff in psychiatry have the right to use coercion affects the everyday relationships between staff and patients at the ward. Coercion is not just a matter of coercive care and measures, wards often have coercive routines\textsuperscript{2} and the possibility of using coercion enables staff to invoke a "coercion context" if patients do not comply\textsuperscript{78}. Furthermore, some research indicates that loyalty within the team is strong and may prevent independent decisions\textsuperscript{25, 76}.

\subsubsection*{1.3.2.1. Coercive care}

A challenging ethical situation that has been reported by staff in out-patient settings, may be to observe how a patient’s health deteriorates while the patient refuses treatment. They reported that they had tried to build a trusting relationship with the patient until coercive care was needed\textsuperscript{2}. The decision on coercive care is not easy to make. A recent study from Norway shows that many physicians, 45 \%, found it difficult to use the two medico-legal criteria: need for treatment and dangerousness to self or others\textsuperscript{79}. In interviews with physicians, Feiring and Ugstad\textsuperscript{80} found that the paternalistic perspective was dominant when justifying involuntary admission, despite the fact that the clinicians often had deliberative-oriented ideals. As for the decisions, they were described as being in the patients’ best interest and patients were described as suffering from serious mental disorders and lacking decision-making capacity. Five studies\textsuperscript{2, 79-82} in adult psychiatry indicate that psychiatrists not only consider the severity of, and risks associated with, the patient’s disorder in connection with decisions about coercive care. Alexius et al\textsuperscript{81} found that they assessed the ethical benefits of coercive care for a
patient compared to ethical costs due to the violation of the patient’s autonomy. The four other studies found that psychiatrists also took into consideration how other people would be affected by the decision and could sometimes find themselves to be influenced by pressure from healthcare workers, family or the police2, 79, 80, 82.

With regard to adolescents, a Finnish study83 found that psychiatrists consider that the criteria for coercive care of minors should be broader than for adults and that coercive care should also be used as a preventive measure. Two studies of medical records indicate that coercive care was associated with psychotic symptoms, mental retardation, temper tantrums, substance abuse, violent behaviour, and suicide risk32, 84. Another study reported that only a few patients were admitted to coercive care with the motivation that they were a potential harm to others and this was virtually never a sole argument85.

1.3.2.2. Coercive measures
Some studies have reported that staff found coercive measures as ethically problematic, especially, forced medication in adult psychiatry86-88 and tube-feeding in adolescent psychiatry2. One study found that staff view coercion as ethically problematic; they thought it was wrong but sometimes the only possible alternative3. In another study, participants reported that it was important to them that coercion was done with a caring attitude, respecting the dignity of the patient2. The dramatic positive change that medication can have on the patients may justify coercion. In order to legally justify coercive measures against a patient, participants reported that they continually documented the patient’s status and refusal to take the medicine3. In another study, staff reported that the use of restraints on patients was seen as a task for nurses, and there was an expectation that male nurses would be more active than females. Participants reported that some staff members had more need of feeling in control and used restraint quicker than others. They reported feelings of conflict if they could not justify the use of coercion on a patient according to their own judgment. These problems around coercion were issues they could not discuss with anyone else other than co-workers, since they would not understand89. Staff have reported being sensitive about how coercion is applied and some of them have chosen to resign from previous workplaces because the ward culture allowed the staff to use coercion in such a way that they could not accept3.

Some studies report that staff members often have difficulties recognising ethical issues associated with coercive measures. A study by Lind80 reported
that only 18% found implementation of forced medication as ethically problematic, while other measures were perceived as being even less problematic. Hem et al² proposes that this can be interpreted as staff recognising these challenges to be professional and clinical since there is a lack of an ethical language that makes these ethical challenges explicit. In studies where participants reported a higher awareness of problems with coercive measures, they did not perceive the use of restraint or seclusion as resulting in immediate negative consequences for the patient. Seclusion could even be perceived as therapeutic; it may help patients to calm down and feel better⁹¹. Patients, on the other hand, have reported that seclusion is sometimes used, even when a patient has just been a little disturbing, in order to punish patients and they did not believe that seclusion had any positive therapeutic value⁹². If patients morally evaluated the coercion as being good, they could agree that it was right and accept it⁹³.

Research implies that the care environment created by management and staff has a crucial influence on the use of coercive measures. The wide variation in the use of coercive measures in different psychiatric services in Europe cannot be explained by patient diagnoses or other patient variables alone⁹⁴. Instead, it would appear that some institutions are more successful than others in creating a safe environment, minimising the frequency of coercive measures. An unsafe environment seems to create more conflicts and situations where staff members need to restrict patients’ freedom or deny patients something that they want⁹⁴.

1.3.2.3. Informal coercion and perceived coercion

Informal coercion refers to different forms of pressure being put on the patient in order to get the patient to be compliant with regard to treatment and the rules of the ward. Informal coercion is used when formal coercive measures are considered to be inappropriate. Szmulker⁹⁵ identified four different manipulative techniques that staff might use to get patients to comply with treatment before resorting to the use of physical coercion.

- **Persuasion** - with the aim of getting the patient compliant by providing realistic information about the benefits and risks associated with the proposed treatment.
- **Interpersonal leverage** - using the personal relationship and emotional dependency to get the patient to comply.
- **Inducement** - offering something to the patient if he/she complies with the treatment.
• **Threats** - making it clear to the patients that if they do not comply with the treatment, there will be negative consequences.

There is, however, a lack of studies from the perspective of staff regarding how members of staff reason about the use of informal coercion. In a study from 10 countries, staff reported that they often use informal coercion. They think it is effective but many staff members also perceive its use as problematic. Several studies imply that staff in psychiatry also routinely restrict voluntary patients their freedom and quite often these patients also perceive themselves as being admitted and treated by coercion. Patients reported that this perceived coercion was not directly related to whether or not the care was voluntary in legal terms. In a study from Ireland, 22% of patients in voluntary care reported as high levels of perceived coercion as involuntary patients. Involuntary patients have reported that they consider staff members to have a paternalistic attitude and sometimes perceive them as being disrespectful and abusive. They would like to be more involved in the decisions. Some reasons patients gave for these negative perceptions were that they did not perceive their treatment as appropriate, nor did they consider that they had participated sufficiently themselves regarding admission and treatment, and they did not feel that they were being respected and cared for by staff.

### 1.3.3. Research context of this thesis

This thesis is a part of two large research projects. The first was entitled *Forced to help: a multi-disciplinary study of coercive treatment in Swedish child and adolescent psychiatry* and the aim was to examine the phenomena of coercion from many different perspectives. The project, therefore, had co-workers from the fields of philosophy, ethics, psychiatry, sociology and pedagogy. The project was started because the research on coercion in psychiatry has been focused on adults, and although coercion is also used in the care of children and adolescents, there were only a few studies in this field. Two of the studies in this project were of special importance to this thesis. The chapter on normative ethics was based on Engström’s review of the literature and this chapter was used as the basis for paper III. The other was a study of justifications in coercive care by Thorsén et al and this was used as the basis for paper IV. The second project was entitled *Compulsory treatment in Swedish psychiatry - a development project on ethical dilemmas*. The purpose of this project was to utilise the knowledge and experience from previous projects, including the abovementioned, in order to
create a basis for clinical improvement work around coercion in psychiatry. The aim was to improve the ethical awareness and create a dialogue with patient and user organisations, collaboration partners, and society at large. The presentation below gives good additional information about the settings.

1.3.3.1. Arguments for coercive care in child and adolescent psychiatry

In an analysis of interviews with psychiatric staff in child and adolescent psychiatry, Thorsén et al.\textsuperscript{53} identified six arguments which were commonly used to justify coercive care. The argument most used was named as the \textit{protection argument}. People lacking the ability to take responsibility for themselves, or being possibly dangerous to others, must be protected from themselves by society through coercive care. This concept is often referred to as weak paternalism and is seen as ethically justified when the situation is obvious, such as suicide attempt or overt violence. When central values for the patient and others are threatened and the patient has lost the ability to take responsibility, this is seen as reason enough to violate the patient’s autonomy. The second most frequently used argument was the \textit{solidarity argument}. Some staff argued that the welfare society has a wider obligation to its citizens, justifying the use of coercion against people who have the ability to take responsibility but nevertheless making unreasonable choices that may jeopardise their health; this is often referred to as strong paternalism. A third argument was the \textit{treatment requirement argument}; the patient may have a great need of care, and coercion is the only way to create the necessary prerequisites for providing this care. In this argument, coercion is not necessary for the security of the patient or others but it is seen rather as the only possible option for controlling the illness in certain cases. The intention is to restore the patient’s mental function, and in some cases physical function, with the aim of increasing the patient’s capacity to take autonomous decisions and accept voluntary treatment. In the fourth argument, the \textit{clarification argument}, staff members argue that a decision of coercive care makes the situation and the care prerequisites clearer. The advantage of a decision about coercive care is that it seems to reassure staff that they are entitled to use coercive measures when needed. The fifth argument is the \textit{parent support argument} whereby staff members argue that coercive care is sometimes necessary in order to strengthen or complement parental authority towards the young patient and make it clear who decides about treatment. It can also be justified if a parent exhibits weak parental authority, is
not participating in the care and if this is viewed as detrimental for the health of the child. The last found argument was the everyday care argument that states that coercive care makes it easier to provide adequate care, making hassles and troubles in everyday care more easily avoidable.

1.3.3.2. Coercive care, ethical problems and ethical support
In a study, Kjellin et al.54 administered a questionnaire to seven clinics in adult psychiatry. Staff and the clinic directors were asked if they perceived that coercive measures were followed up. About half (51 %) of the staff and most (83 %) of the clinical directors responded that follow-up was always or frequently done. Around a quarter (23 %) of the staff reported that they discussed problems around coercive care and treatment at workplace meetings, treatment conferences or in other more formal settings, and more than a third (35 %) reported that they discussed these problems in informal settings. Clinical directors responded that problems around coercive care and treatment were discussed frequently at formal meetings (56 %) and more seldom in informal settings (39 %).

According to the survey, nearly three out of four (73 %) reported about general rules that restricted the freedom of all patients to act, and not just those in coercive care. General rules mentioned were, for example, meals, phones, computers, smoking, television viewing and use of alcohol. Staff members described conflict of loyalties in which they have to choose to stand up for their opinion on the patient's needs or adapt to other staff views; this was perceived as being stressful and difficult. The ethical problems reported by staff were often issues around coercive measures or informal coercion, such as patients who did not get permission to go outdoors and other routines that limited the rights of patients.

About a quarter (26 %) of the staff stated that ethical issues were discussed at regular rounds. Less than a third of these staff members (30 %) reported that they participated in specific forums for ethical reflection within the clinic, and fewer than half of these stated that they had discussions at least once a week. A majority of the clinical directors (68 %) reported that ethical reflection in some kind of form takes place at least once a week.

This result is similar to the findings of a study done 20 years earlier. It seems that staff have as little possibility for conversation and reflection on ethics and coercion nowadays as they did 20 years ago502.

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2. RATIONALE AND AIMS

2.1. Rationale of the thesis

Researchers have shown considerable interest in normative ethics in psychiatry and about the concept of coercion as well as considerations about how and when coercive care can be justified from a philosophical or legal perspective. However, there are relatively few empirical studies in psychiatry and even fewer in child and adolescent psychiatry. Normally, studies on ethics in psychiatric inpatient care have focused on ethical issues, predefined by the researcher. Earlier studies in psychiatry have often focused on coercive care and measures or on the concept of moral stress. There are few studies to be found about staffs’ perceptions of ethical issues in psychiatric inpatient care and how they perceive ethical issues in a broader sense. In addition, results of empirical research on ethical issues in psychiatry have sometimes been contradictory. Some studies have shown that staff members worry about ethical issues and they are at risk of being harmed by stress, whereas other studies have shown that staff members have difficulties recognising ethical issues associated with coercive measures. Subsequently, there is a need to study ethical issues facing psychiatric staff in their everyday work – without predefined questions or definitions – thereby contributing to a picture of the ethical landscape involved. Such results may contribute to the creation of an ethical language that makes these ethical issues explicit.

In addition to providing a good description of the ethical landscape of psychiatric inpatient care, there were a further two specific areas that attracted my interest. The first one concerned some research and literature that implies that staff members often reduce the patients’ autonomy and they do not communicate in a normal way with patients. While there is a great deal of normative literature about ethical perspectives in encounters with patients, empirical studies are lacking with regard to these ethical perspectives. I, therefore, wanted to examine if, and in what way, these ethical perspectives manifested themselves in our empirical material. The other interesting issue concerned arguments for decisions about coercive care. Previous research indicated that staff had many arguments for supporting decisions about coercive care of young patients. These arguments were expressed in general ways in interviews or diaries and not in situations where a decision had to be taken. Since coercion in psychiatric
care is ethically problematic, it is important to be aware of the kind of arguments that are used in these assessments of young patients. Thus, I was interested in examining if and how these arguments were used in a situation where a decision had to be taken about coercive care of a young person.

2.2. Aims of the thesis
The aims of this thesis are: first, to describe the ethical considerations as staff members perceive them in child and adolescent psychiatry and in adult psychiatry in their everyday work; second, from a normative ethical perspective examine encounters between staff and patients; and third, to describe staffs’ justification for decisions on coercive care in child and adolescent psychiatry.

The specific aims of the four studies in this thesis were:

1. The aim of this study was to provide a qualitative description of situations and experiences that gave rise to ethical problems and considerations as reported by staff members on child and adolescent psychiatric wards, although they were not provided with a definition of the concept.
2. The aim of this study was to provide a qualitative description of situations and experiences that staff members perceive as giving rise to ethical issues at work.
3. The aim of this study was to describe and analyse statements describing real work situations and ethical reflections made by staff members in relation to three central perspectives in medical ethics; paternalism, autonomy and reciprocity.
4. The aim of this study was to examine and describe how professionals document their value arguments when considering the need for coercive psychiatric care of young people.
3. MATERIAL

This thesis contains four papers. The first three studies are based on ethical diaries written by staff members in adult psychiatry and in child and adolescent psychiatry. In the fourth study, we had access to medical records from child and adolescent psychiatric clinics.

3.1. Settings

The first study was carried out at six child and adolescent psychiatric wards in central Sweden. The second study was carried out at seven adult clinics in central Sweden; four of which provided general psychiatric care, two forensic psychiatric care and one integrated psychiatric addiction care (Figure 1).

All of these clinics provided both voluntary and coercive care, apart from forensic psychiatry that only had coercive care. The clinics served all children and adolescents under 18 years (I) and all adults (II) in need of psychiatric inpatient care in their respective catchment areas.

The clinics were chosen in order to get enough variation. Had the sample been smaller, the results might reflect a specific ward culture as opposed to Swedish psychiatry in general. In adult psychiatry, many clinics specialise in certain fields and within child and adolescent psychiatry, there are many different types of clinical ideologies. There were also quantitative reasons for including a large number of clinics. Asking the staff to keep a diary also carried the risk of a low response rate, so the studies needed to have a relatively large number of participants.

Figure 1: The settings of the studies included in this thesis.
The third study involved all the above-mentioned psychiatric wards (Figure 1).

The fourth study included all 21 child and adolescent clinics in Sweden (Figure 1) that provided coercive care according to the Compulsory Mental Care Act30.

3.2. Participants

The inclusion criterion in the first three studies was all staff members on the wards, irrespective of occupational status, who worked directly with the patients (Table 2). They were asked to keep an ethical diary over the course of one week.

Table 2. Overview of the four studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>Data collection</th>
<th>Clinics</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ethical diaries</td>
<td>6</td>
<td>68</td>
</tr>
<tr>
<td>2</td>
<td>Ethical diaries</td>
<td>7</td>
<td>105</td>
</tr>
<tr>
<td>3*</td>
<td>Ethical diaries</td>
<td>13</td>
<td>173</td>
</tr>
<tr>
<td>4</td>
<td>Medical records</td>
<td>21**</td>
<td>143</td>
</tr>
</tbody>
</table>

* The third study includes the same data as the first and second study.

** The six clinics in study 1 are included in these 21 (See Figure 1).

The first study was carried out in 2003 when 68 participants handed in their diaries anonymously. At this time the normal staffing of a child and adolescent clinic was as follows: approximately half were mental health care assistants; of the other half, the majority comprised registered nurses; the others were physicians, psychologists, social workers and teachers. Approximately 20-30 persons were employed on each ward. The response frequency varied greatly between wards, ranging from 3 to 18 persons, and the total response rate was just under 50 %.

In the second study, the diaries were included in a questionnaire on ethics and coercive care. In 2008, a total of 415 questionnaires were distributed. The number of responses was 213. Of these participants, 105 kept a diary. This yielded a response rate of 25 %. Half of the participants were mental health care assistants (50 %), 39 % were registered nurses and 11 % were other professionals such as psychiatrists, psychologists and social workers. Most of them, 85 %, had worked in psychiatric care for more than 3 years. Their average age was 44 years and 74 % were women.

The third study involved all participants mentioned in the first two studies.
In the fourth study, I had access to the complete medical records of all 143 patients who were involuntarily admitted in child and adolescent psychiatry in Sweden (1 July 2002 – 30 June 2003). They were admitted 156 times during the year of investigation. One patient with one admission was excluded since the patient was enrolled in forensic psychiatric care.

The 142 patients in this study were almost exclusively adolescents and the length of stay in inpatient care was in average 43 days. There were about twice as many girls as boys. The adolescents’ problems varied considerably, but the most frequent diagnoses were eating disorders, psychoses, depression with or without suicide attempts and neuropsychiatric disorders (Table 3). Twenty-one per cent had concurrent substance abuse and nine per cent were asylum seekers.
Table 3: Background data of the study population, categorised according diagnostic groups used in ICD 10.

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Frequency (% of total)</th>
<th>Girls (% of the group)</th>
<th>Age Min/M/Max</th>
<th>Days Min/M/Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and behavioural disorders due to psychoactive substance use. F10-F19</td>
<td>6 (4)</td>
<td>17</td>
<td>16/17/17</td>
<td>1/7/29</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders. F20-F29</td>
<td>12 (8)</td>
<td>42</td>
<td>14/16/17</td>
<td>7/32/173</td>
</tr>
<tr>
<td>Mood (affective) disorders. F30-F39</td>
<td>34 (24)</td>
<td>74</td>
<td>10/16/18</td>
<td>0/12,5/300</td>
</tr>
<tr>
<td>Behavioural syndromes associated with physiological disturbances and physical factors. F50-F59</td>
<td>19 (13)</td>
<td>79</td>
<td>11/15/17</td>
<td>1/28/304</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour. F60-F69</td>
<td>4 (3)</td>
<td>75</td>
<td>14/16,5/17</td>
<td>2/46/50</td>
</tr>
<tr>
<td>Disorders of psychological development F80-F89</td>
<td>7 (5)</td>
<td>57</td>
<td>13/16/17</td>
<td>1/13/126</td>
</tr>
<tr>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence. F90-F98</td>
<td>15 (11)</td>
<td>67</td>
<td>11/15/17</td>
<td>1/31/679</td>
</tr>
<tr>
<td>Z: Observation</td>
<td>5 (4)</td>
<td>60</td>
<td>13/15/16</td>
<td>1/4/43</td>
</tr>
<tr>
<td>X: Intentional self-harm</td>
<td>4 (3)</td>
<td>75</td>
<td>13/15/17</td>
<td>1/9,5/52</td>
</tr>
<tr>
<td>Missing diagnoses, uncertainty in assessment or an unspecified mental disorder F99</td>
<td>9 (6)</td>
<td>50</td>
<td>13/16/17</td>
<td>1/7/92</td>
</tr>
<tr>
<td>The study population</td>
<td>142</td>
<td>64</td>
<td>10/16/18</td>
<td>0/14/679</td>
</tr>
</tbody>
</table>
4. METHODS

4.1. Design and procedure

4.1.1. Ethical diaries
One of the research methods available to gain access to people’s stories about their everyday lives is to use the diary method. Alaszewski\textsuperscript{109} defines a diary as a document kept on a regular basis. It is personal. It deals with recollections and a reflection of events close in time and contains something that the person finds relevant to record. Thus, the diary gives a subjective view of the person’s reality. Researchers who take a sociological approach have used the diary method most widely\textsuperscript{109}. It is also used in medical research but is not common within psychiatric research. A search on Pubmed (jan -15) for psychiatry with “diary” in the title, yielded a result with a total of 62 references, nine of which were from 2013-2014 and all dealing with patients rating negative symptoms. These diaries were not diaries in accordance with Alaszewski’s definition; the questions in them were specific and not diaries where the participants themselves can determine what they consider relevant to record.

In our studies, staff members were asked to keep an ethical diary over the course of one week. The diary had eight pages. The first page contained instructions and the following pages were blank, except for the name of the day. This method was selected in order to obtain statements freely provided by staff members, thus facilitating the discovery of experiences of the phenomenon in question that would otherwise have remained concealed if employing more structured methods. We were of the opinion that asking a broad question in a non-restrictive format would possibly uncover other considerations of an ethical nature. The concept “ethical consideration” was chosen because in the Swedish context of the word “consideration”, some kind of cognitive reflection is implied in situations where there are choices between different ways of acting.

The instruction that participants received was as follows:

Using this ethical diary, we want to try to capture the situations and experiences that you perceived in some way as ethical considerations at work. This can apply to principal issues with an ethical dimension, as well as real-life situations in everyday care.

You are free to express yourself as you wish. Describe the situations you have experienced that included ethical considerations and your thoughts about
them. Please be detailed in your description of the situation, as well as about your thoughts.

The diary should be kept over the course of one working week (week xx). The best way to do this is to write down your experiences and thoughts each day at the end of the day. Write on the attached papers and submit the diary in the drawer that will be available in the ward. The diary should be handed in as soon as possible after the end of the week.

4.1.2. Medical records
We asked all 21 child and adolescent clinics in Sweden to provide us with copies of the complete medical records of all patients involuntarily treated during one year (2002-07-01 - 2003-06-30). Of these 21 clinics, 16 provided coercive care during this year and all of them delivered medical records to us. The other five clinics did not treat involuntary patients during the specified period.

4.2. Qualitative content analysis
Qualitative content analysis was used to analyse the diaries and medical records; a method considered adequate for providing a good qualitative description of a field. Content analysis can be used quantitatively or qualitatively to analyse texts or observations; both approaches can be used in the same study. Qualitative content analysis is quite commonly used in health research to analyse, for example, patient or staff perceptions and experiences of care situations. The researcher can interpret the text to find themes that are consistent in the material.

Qualitative content analysis is, in itself, atheoretical, allowing the researcher to choose a theory or rely on their professional knowledge and experience. The starting point of an analysis can be done either with an inductive or deductive approach. An analysis starting with an inductive approach begins with looking for recurring themes in the material. The deductive approach begins with predetermined categories that are derived from a theory or from empirical research. In this thesis, the first two studies are analysed with an inductive approach and the last two studies with a deductive approach. Whether using an inductive or deductive approach in a study, the process in content analysis is about abductive reasoning, which means that the researchers switch between using inductive and deductive reasoning. In our studies, we used abduction as follows. In the inductive studies (I, II), a first set of themes was created inductively which was then tested deductively. In the deductive studies, predefined values (III)
or arguments (IV) were tested deductively against the material. When this was done, we discovered phenomena in the material (1-IV) that did not fit into our proposed interpretation. These findings were then interpreted inductively, which gave us a new proposal for interpretation. Thereafter, we checked if these new ideas could be fruitful in the interpretation of the whole material. The whole material was available during the analysis since the process was not linear but it involved a back and forth movement between the whole and parts of the text. We strived for ecological validity which means that the results should not distance itself from what the staff wrote, however, my interpretation does not necessarily need to match the staff’s views of their reality.

In qualitative content analysis, the researcher(s) are doing an interpretation of a text and there is often more than one possible interpretation that can be relevant. That’s why the concept of trustworthiness is used when talking about reliability and validity in qualitative content analysis. More about trustworthiness in these four studies will be discussed in the Discussion chapter.

4.2.1. My pre-understanding
When I started working in healthcare in the 1980s, it was in an institution for the mentally retarded. They had lived in institutions all their life and were then living in houses with around 6 people in each house. The institution was run according to the old school of thought. The important work in this setting was to clean the house and maintain routines and rules. This work got me interested in questions of ethics and how staff’s encounters with service users in health care can, and should be, framed. Later on in life, I studied to be a social worker and my interest in ethics and encounters with service users resulted in my choice of this subject for my doctoral studies. I view value-based practice as an ideal for thinking how encounters with patients can be framed.

A central element in my pre-understanding, derived from my review of the literature and our professional education and experience, was that psychiatric work contains numerous ethical considerations. I had also noticed that staff members sometimes demonstrate difficulties in identifying ethical issues at work, at least with regard to coercive care and measures and that the research literature available supports this view.
4.2.2. Content analysis with inductive approach, study I & II

Qualitative content analysis, inspired by Graneheim and Lundman\textsuperscript{113}, was used to analyse the diaries in the first and second studies. Three persons conducted the analysis of these studies: Veikko Pelto-Piri (VP); Karin Engström (KE), a pedagogue; Ingemar Engström (IE), a child and adolescent psychiatrist. We started to analyse the diaries from child and adolescent psychiatry (I) and, thereafter, from adult psychiatry (II). Since many of the statements were considered to be descriptions of problems rather than considerations, we chose to analyse all statements containing a problem or a consideration.

The first step of the analysis was to read through the diaries several times in order to gain an impression of the material as a whole. To start with, each day’s diary notes was treated as a meaning unit\textsuperscript{113} (Table 4) in which we searched for considerations or problems. VP and KE summarised all meaning units into preliminary condensed meaning units and coded them individually (Table 4). These codes were often in form of key words or a short sentence and were a first attempt at interpreting the meaning unit.

Table 4. An example of the thematisation of a statement.

| A meaning unit | A 12-year-old boy came to us when the mother was admitted to adult psychiatry. The police arrested the boy for shoplifting food. It appeared that the family left the refugee camp after the expulsion decision. We became a “terminus” for societal responsibility without being aware of the reason. Our opinion is irrelevant. We shall just detain him pending other services taking over. Great frustration within the staff group where some lose all their knowledge and experience, and begin complaining about collaboration partners |
| Preliminary condensed meaning unit | We must take care of a refugee boy who shoplifted, without questioning the decision. We became a “terminus”. |
| Code | Asylum - patient who does not need care |
| Condensed meaning unit | A boy admitted when the mother is in adult psychiatry. Deviated from the refugee camp. Shoplifting. Great frustration! |
| Sub-theme | A terminus for the patient |
| Theme | Powerlessness |
We went through the whole material together and took decisions about the final condensed meaning unit and how to continue to create interpretations individually. When we compared our interpretations, we sometimes chose to keep two alternative interpretations, as shown in Table 4. All interpretations were discussed with IE in order to reach a consensus agreement. In this initial interpretation, it was important for us to stay close to the text. Similar underlying meanings formed sub-themes, the number of which was gradually reduced. At this stage we began to formulate themes and translate themes and sub-themes into English. From these results, a final interpretation was done of the whole material; themes and sub-themes were chosen that provided a basis for a thick description that best described the material as a whole. It was important to have a back and forth movement between the whole and parts of the text during all stages of the analysis since the process was not linear, as demonstrated by Table 4. The word “terminus” was used by a participant and in the preliminary condensed meaning unit, but not in the condensed meaning unit or interpretation, and then it appeared as a sub-theme in the final interpretation. In order to verify our final interpretation, the material was re-thematised on the basis of the sub-themes that had emerged and some adjustments were made to the final result.

4.2.3. Content analysis with deductive approach, study III & IV

Qualitative content analysis with deductive approach was used to analyse the texts in the third and fourth studies. This method is relevant when there is existing theory or research finding, but still a need for further research. The starting point of the third and fourth studies was findings in the project Forced to help: a multi-disciplinary study of coercive treatment in Swedish child and adolescent psychiatry. In the third study, the initial themes were taken from a review of the literature that identified three perspectives in medical ethics: paternalism, autonomy and reciprocity. These three perspectives were used as categories. In the fourth study, research findings about arguments to justify coercive care in child and adolescent psychiatry were used as initial categories.

In the third study, we used all the diaries to capture a description of staff encounters with patients and to consider the way in which these encounters were consistent with, or contrary to, the perspectives of paternalism, autonomy and reciprocity. I used NVivo8 to identify all the values in the three perspectives in the review. Based on this analysis, I obtained an initial list.
of 28 values, which were used as categories\textsuperscript{11}. Some of these categories reflected the same kind of values so the value categories were merged and reduced to 15 values that focused on the central values in psychiatric ethics in terms of staff encounters with patients (Table 5).

Table 5. 15 of the 28 initial values in the code list prior to the analysis of the empirical data.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Initial values (codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalism</td>
<td>In the best interest of the patient</td>
</tr>
<tr>
<td></td>
<td>Promoting and restoring health</td>
</tr>
<tr>
<td></td>
<td>Providing relief and comfort</td>
</tr>
<tr>
<td></td>
<td>Delivering good care</td>
</tr>
<tr>
<td></td>
<td>Professional competence and integrity</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Informing the patient</td>
</tr>
<tr>
<td></td>
<td>Accepting the decisions of competent patients</td>
</tr>
<tr>
<td></td>
<td>Respecting autonomy</td>
</tr>
<tr>
<td></td>
<td>Respecting integrity</td>
</tr>
<tr>
<td></td>
<td>Protecting human rights</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Participation</td>
</tr>
<tr>
<td></td>
<td>Confidence</td>
</tr>
<tr>
<td></td>
<td>Cooperation</td>
</tr>
<tr>
<td></td>
<td>Consensus</td>
</tr>
<tr>
<td></td>
<td>Involvement</td>
</tr>
</tbody>
</table>

I used NVivo 8 to categorise the statements that were placed in one of the three perspectives on the basis of the balance of power that was described between staff and patients and thereafter into a value category that the statement referred to. However, statements that had no reference to encounters with the patient were omitted. These omitted statements often referred to organisational problems. To obtain a manageable amount of categories, I suggested how to merge categories that had many statements in common and that seemed to relate to similar value issues. The final value categories were labelled in a way that yielded a “thick description” of the content they represented\textsuperscript{116} (Table 6 & 10).
Table 6. An example of the coding of a statement.

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Initial value (code)</th>
<th>Statement</th>
<th>Final Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalism</td>
<td>Professional competence and integrity</td>
<td>At work tonight a patient was catastrophising about all the terrible things that happened to her relatives + agitated and verbally threatening towards staff. It’s difficult to approach her without offending her. How should I encounter the patient in her suffering?</td>
<td>To take responsibility</td>
</tr>
</tbody>
</table>

This analysis (to create value categories, code the statements and merging categories) was done in close cooperation with KE, who went through data and the analysis several times and gave comments and ideas for further analysis. IE participated in these discussions. Consensus solutions were sought, so that all participating researchers could account for the results.

A summary was made of all the medical records in the fourth study. This summary consisted of the patient’s background, current situation, the psychiatric assessment and justification for coercion (Table 7), in order to get information about the patient’s mental condition and personal circumstances and to be able to interpret the justification of coercion. The main focus was on the day when the care certificate was written and the week prior to that day. This summary was made by Christina Lindvall (CL), a social work student who served her internship in psychiatry, along with VP and supported by IE.

We were searching for the different forms of justification of coercive care that formed the basis for the decision. For categories in this analysis, we used the six arguments as identified by Thorsén\(^5\); the protection argument, the solidarity argument, the treatment requirement argument, the clarification argument, the parent support argument and the everyday care argument. We also noted arguments that did not fit properly in the pre-defined arguments.

CL made an initial coding, VP went through this coding with more stringent criteria. Lars Kjellin (LK), a mental health service researcher, conducted an inter-rater assessment by randomly selecting 36 cases, reading and commenting them. In most cases, LK agreed with the coding of VP. Problematic coding occurred, in particular, regarding over-categorisation to the parent support argument, but also to the treatment requirement argument. Problematic cases were discussed with LK and IE until consensus was
reached, and VP did a new categorisation of all cases in question to achieve a consistent interpretation throughout.

In the analysis of the protection argument, VP searched cases for documented dangerousness, which was divided into three categories: 2 = mortal danger, 1 = risk of harm, 0 = absence of documentation on risk.

- An assessment of risk of self-harm (1) or suicide (2) and/or that the patient had recently injured themselves (1) or attempted suicide (including suicide threats) (2).
- An assessment of risk of harm (1) or mortal danger to another person (2), and/or that the patient had recently harmed (1) or made an assassination attempt (including given explicit death threats) (2) or committed a serious assault on another person (2).

This analysis was done in cooperation with LK and IE.
Table 7. An example of summary of data from one case with coding: (1) the protection argument, (2) the solidarity argument, (3) the treatment requirement argument, (4) the clarification argument, (5) the parent support argument and (6) the everyday care argument; and a preliminary interpretation*.

<table>
<thead>
<tr>
<th>Background.</th>
<th>Current situation.</th>
<th>The psychiatric assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care certificate</td>
<td>The parents have been trying to control the patient's eating habits, but have not been successful (5). She has had previous contact with psychiatric services, but the eating behaviour is unchanged. Has previously been admitted voluntarily (BMI 14). The patient's older sister has anorexia.</td>
<td>Severe anorexia nervosa. The patient acts by screaming, crying and locked herself in the bathroom. The patient refuses treatment and tube feeding (3). She has anorexic thoughts and delusions about body image (1).</td>
</tr>
<tr>
<td>Other documentation</td>
<td>Lives with her two parents and an older sister. She has two older siblings, who moved away from home.</td>
<td>The parents sought acute with the patient, she was on the waiting list for treatment in Anorexia-Bulimia Clinic. The patient refuses tube feeding and totally refuses to eat (3). Care certificate written due to the severe self-starvation (1).</td>
</tr>
</tbody>
</table>

4.3. Research ethics

Participants in the ethical diary studies received a letter with information about the background and purpose of the study, instructions, and an ethical diary. A specially appointed staff member at each clinic handed out the diaries, provided information about the study and reinforced the principle of voluntary participation in the study. Informed consent was given by returning the diary, as is customary in medical research in Sweden and requested by the Ethical Review Board. A decision was taken to use anonymous diaries in child and adolescent psychiatry since the clinics were small and had several professional groups with few individuals, which meant that people could be easily identified. We thought that the participants would dislike the idea of giving us personal background information.

Participants in the fourth study were not informed about the study. To contact each individual and ask for consent to use medical records regarding his or her involuntary psychiatric care was regarded as ethically problematic since reminders of past negative events may cause distress. It would also be practically difficult and probably result in a large number of dropouts.

The child and adolescent project Forced to help: a multidisciplinary study of coercive treatment in Swedish child and adolescent psychiatry was reviewed, according to previous regulations for research ethics review, by all of Sweden’s seven research ethics committees for medical research and was approved as a multi-centre study by the committee in Örebro (reg. 411–02). The study in adult psychiatry was part of the project Coercive care in Swedish psychiatry – a development project on ethical considerations, which was approved by the Regional Ethical Review Board in Uppsala (dnr 2008/017).
5. RESULTS

In this thesis, I have made an attempt to integrate and interpret the results from the four studies as a whole on the basis of what could be seen as scientifically valuable and clinically relevant. It is not a new analysis, the existing subthemes (I, II), values (III) and arguments (IV) are used in this interpretation of the material in its entirety. This integrated interpretation differs mainly in three ways from the papers. Firstly, in the diaries, staff members express their ideals as caregivers. Staff ideals are interesting because they should affect the staff’s view of what is worthwhile to have ethical reflections about. I have, therefore, chosen to identify and present these ideals explicitly. Secondly, this presentation includes a comparison of child and adolescent psychiatry (I) and adult psychiatry (II) since there are interesting differences that are worth discussing. Thirdly, I used some material from the analyses and data that does not appear in the papers; this applies particularly to quotes. In order to give the reader an opportunity to see as much of the data as possible, I have provided other quotes in the Results section than those used in the four papers.

The results begin with a presentation of the main findings as a summary of the four papers and then the integrated interpretation is presented in two sections: the first section concerns the ethical ideals of the staff and the second section concerns the staff’s ethical considerations in general and justifications of coercive care.

5.1. Main findings

5.1.1. Study I

Three themes emerged in the analysis of diaries from child and adolescent psychiatry; 1) good care 2) loyalty and 3) powerlessness (Table 8). These results contain statements describing situations in which participants express a wish to be respect and to listen to patients, as well as more statements that express a desire for relatively strict, routine-based care.

The theme good care contains statements about the ideal of commitment but also about problems living up to the ideals. Staff members emphasised the importance of involving patients and parents in the care, but also the need for professional distance. Participants seldom perceived decisions about coercive measures as problematic. Instead, it was the process towards
the decision of coercive measures that was an ethical issue. The use of informal coercion was seen as problematic, especially in relation to voluntarily admitted patients.

Table 8. The themes and sub-themes that emerged in the interpretation of the data in child and adolescent psychiatry.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good care</td>
<td>An ideal of commitment</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Building alliances for good care</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>The borders of coercion</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>A professional distance to patients</td>
<td>25</td>
</tr>
<tr>
<td>Loyalty</td>
<td>The patient comes first</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Belonging to the team</td>
<td>14</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>Inadequacy in relation to patients</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>A terminus for the patient</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Feelings of helplessness</td>
<td>47</td>
</tr>
<tr>
<td>Not thematised</td>
<td></td>
<td>17</td>
</tr>
</tbody>
</table>

The statements that were not thematised were plain descriptions of work without a consideration or problem associated with psychiatric care or treatment.

The theme *loyalty* contains statements in which staff members perceived an obligation to be loyal to their colleagues as well as formal and informal decisions and routines. They also felt contradictory expectations from different stakeholders; mainly parents but also doctors, colleagues, managers and the social services.

The theme *powerlessness* contains statements about situations that create frustration whereby freedom of action was perceived as being limited and mainly concerns inadequacy in relation to patients. Participants wrote about violations against patients that they have witnessed or have been informed about by the patient. Participants perceived it as being problematic that they felt unable to react to offensive behaviour of colleagues in their team.

5.1.2. Study II

Four dominant themes emerged in the analysis of diaries from adult psychiatry: 1) good care, 2) order and clarity, 3) loyalty, and 4) inadequacy (Table 9).

The theme *good care* included statements concerning the importance to have respect for patients and the need for staff members to demonstrate commitment in their work. In contrast to child and adolescent psychiatry
they did not emphasise the need for keeping a distance to patients since they did not express the same problems of keeping a distance.

The theme *order and clarity* contained statements relating to how staff members established and maintained ward rules and routines. These rules and routines were found to create a distance between staff and patients. This happened also in child and adolescent psychiatry but was much more obvious in adult psychiatry.

Table 9. Themes and sub-themes that emerged in the interpretation of the results in adult psychiatry.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-theme</th>
<th>Number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good care</td>
<td>To respect and be kind to all patients.</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>The staff should demonstrate commitment and concern.</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>The borders of coercion</td>
<td>31</td>
</tr>
<tr>
<td>Order and clarity</td>
<td>The importance of consistent rules and routines.</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Staff members maintained order and were consistent.</td>
<td>27</td>
</tr>
<tr>
<td>Loyalty</td>
<td>The importance of loyalty within the team.</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>To be on the patient’s side and establish trust.</td>
<td>22</td>
</tr>
<tr>
<td>Inadequacy</td>
<td>Staff members felt unable to help the patients.</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Not daring or being unable to respond to offensive behaviour.</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Difficulties dealing with troublesome patients.</td>
<td>16</td>
</tr>
<tr>
<td>Not thematised</td>
<td></td>
<td>22</td>
</tr>
</tbody>
</table>

The statements that were not thematised were plain descriptions of work without a consideration or problem associated with psychiatric care or treatment.

The theme *loyalty* comprised statements relating to loyalty as well as conflicts between staff members and also in relation to patients and social services. Participants in adult psychiatry described fewer contacts and conflicts of loyalty with stakeholders in comparison to participants in child and adolescent psychiatry.

The theme *inadequacy* included statements relating to frustration of not being able to help patients or relate to troublesome patients. They were most often not as emotional about these problems as the staff in child and adolescent psychiatry, thus the theme was called inadequacy and not powerlessness as in child and adolescent psychiatry.
5.1.3. Study III
In the analysis of all the diaries, eight values emerged in the three pre-defined perspectives: Paternalism, Autonomy and Reciprocity (Table 10). The majority of the statements could be attributed to the perspective of paternalism and several to autonomy. Only a few statements could be attributed to reciprocity, most of which concerned staff members acting contrary to the values in the perspective.

Table 10. The result comprising three perspectives and eight values.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalism</td>
<td>Promoting and restoring the health of the patient. Providing good care. Assuming responsibility</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Involving patients in the planning and implementation of their care. Building trust between staff members and patients.</td>
</tr>
</tbody>
</table>

The conclusion of the study was that despite a normative trend towards reciprocity in psychiatry throughout the Western world, identifying descriptions of situations in the diaries where staff applied reciprocity in the relationships with patients proved to be difficult.

5.1.4. Study IV
In the analysis of medical records we found two main arguments used to justify coercive care in child and adolescent psychiatry. These were the need to protect the patient and coercion as a necessary requirement to be able to give treatment to the patient (Table 11).

Table 11 Arguments used in decisions of coercive care.

<table>
<thead>
<tr>
<th>Arguments</th>
<th>Psychiatric care certificate n=143</th>
<th>Other Documentation n=155</th>
<th>All Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The protection argument</td>
<td>96 %</td>
<td>86 %</td>
<td>99 %</td>
</tr>
<tr>
<td>The treatment requirement</td>
<td>56 %</td>
<td>45 %</td>
<td>69 %</td>
</tr>
<tr>
<td>argument</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The solidarity argument</td>
<td>1 %</td>
<td>3 %</td>
<td>4 %</td>
</tr>
<tr>
<td>The clarification argument</td>
<td>13 %</td>
<td>12 %</td>
<td>21 %</td>
</tr>
<tr>
<td>The caregiver support argu-</td>
<td>24 %</td>
<td>37 %</td>
<td>48 %</td>
</tr>
<tr>
<td>ment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The everyday care argument</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
</tr>
</tbody>
</table>
Other arguments were mainly used to support these two main arguments and were mostly used when describing the current situation, not in the final argumentation for coercive care.

Few value arguments were used in the decision of coercive care. The need of treatment was often implicitly clarified since the physician described a serious mental, and sometimes physical, condition.

### 5.2. Staff members’ ethical ideals

In this integrated interpretation I have identified three themes that reflect staff members’ ethical ideals. The fact that some of the themes in this integrated interpretation are selected to represent the staff’s ideals does not mean that the situations in them, according to participants are unproblematic. However, there are often very clearly expressed ethical ideals in these statements. These themes are: to be a good carer, to respect the patient’s autonomy and integrity and to have good relations with patients and their families. The themes in this integrated interpretation are described by sub-themes and values developed in papers I-III (Table 12).

Table 12. The three themes in staff ideals with subthemes that emerged in the analysis of papers I-III.

<table>
<thead>
<tr>
<th>Paper</th>
<th>To be a good carer.</th>
<th>To respect the patient’s autonomy and integrity.</th>
<th>To have good relations with patients and their families.</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>The staff should demonstrate commitment and concern.</td>
<td>To respect and be kind to all patients.</td>
<td>To be on the patients side and establish.</td>
</tr>
</tbody>
</table>

#### 5.2.1. To be a good carer

There were quite a number of statements about how staff should be and the way in which they should approach the patients.

Today I have put all my focus on trying to understand despondency among our patients. For me it is important that we professionals remember the fact that we go home, the patients don’t. Thinking of that as a professional also creates a greater understanding of the fact that it is not always easy to keep
your spirit and your energy levels up. But discussing such matters with the patients has helped in showing understanding; but the most important thing is maybe concern and commitment. (Adult psychiatry)

This statement from adult psychiatry led a sub-theme being titled: the staff should demonstrate commitment and concern (II). We found statements about commitment in the diaries from child and adolescent psychiatry too and choose to call the sub-theme: an ideal of commitment (I). Participants could become disappointed with themselves and colleagues if they were unable to live up to this ideal of commitment, such as when they did not have time to speak with patients. Commitment from staff led to confirmation from patients and other stakeholders, which endowed the work with meaning.

When the diaries were analysed with the predefined perspectives of paternalism, autonomy and reciprocity (III), paternalism was the most common one. Participants expressed the importance of working in the best interest of patients, which is fundamental in the perspective of paternalism. The participants aimed to provide good care but, at the same time, dare to make priorities against the will of patients and other stakeholders; if necessary, participants accepted they had to assume responsibility (II) and make decisions on the patient’s behalf. Some participants, especially in child and adolescent psychiatry, went beyond their professional role by taking more responsibility for patients than expected of them. In some cases, a physician wrote a care certificate for a young patient although serious mental illness was not clearly documented. It seemed to be a necessary intervention in a life threatening situation for the patient due to lack of other alternatives. Participants sometimes chose to prioritise a patient instead of acting in accordance with organisational directives or loyalty to colleagues, at times even keeping contact with patients who were discharged.

The only ethical consideration today was that a pupil got hot chocolate and fruit from the staff room. I only told this to my colleague. The others would just have opinions about having to give up their fruit. Humanity has to be done in secret. (Child and adolescent psychiatry)

5.2.2. To respect the patient’s autonomy and integrity

Autonomy (III) was clearly an ideal of the participants and the sub-theme to respect and be kind to all patients (II) captures the importance that participants stressed with regard to respecting patient integrity. These ideals
were not always easy to live up to. Fairly often the participants wrote critically of how other staff handled various situations and how they did not take into account the patient’s right to autonomy and integrity. Participants tried, as in the quote below, to find ways of showing patients respect in situations when carrying out a body search or continuous observation.

A third patient has extra observation (i.e. door open) but it is difficult to see into the room at night. I’m reluctant to go into the room at night when there is a girl in there (I’m a man), who has been sexually abused. I stay at the doorway and listen until I hear her breathing. (Child and adolescent psychiatry)

Respecting the patient’s right to self-determination and information (III) was an ideal of participants. Participants wrote that they accepted the decisions or opinions of patients who were capable of making decisions, even if they disagreed. If a patient was not considered capable of making decisions, the participants were of the opinion that staff members should decide but would continue to make efforts to involve the patient in the care.

Several threats to patient autonomy were reported. One was lack of resources, such as not being able to go outdoors since staff members lacked the time to assist.

A patient being treated in coercive care and has permission to go out with the staff and we are not able to do so because we don’t have enough staff. It is difficult to plan ahead because we are an emergency department. This often gives a feeling of not being ethically correct. (Adult psychiatry)

Relatives could request information about the patient, which was problematic if the patient did not wish to inform them. Occasionally the staff decided to withhold information from patients in order not to create anxiety on the ward, but they perceived it as problematic and against their ideals.

Some statements in the perspective of autonomy (III) pertained explicitly to protecting human rights, such as criticism of the slow handling of asylum cases in Sweden (child and adolescent psychiatry) and lack of respect for the patients right to their own opinions and religious beliefs (adult psychiatry).

### 5.2.3. To have good relations with patients and their families

Staff members tried to establish a trusting relationship with the patient and included the courage to take calculated risks in relation to leave of absence and discharge in adult psychiatry. In the theme loyalty a subtheme, the patient comes first (I), emerged in child and adolescent psychiatry and to be on the patient’s side and establish trust (II) in adult psychiatry. Within child
and adolescent psychiatry, especially, staff members reported a need to clearly communicate with stakeholders that they had focus on patients’ needs and not the needs of parents or other stakeholders, such as schools. It was evident in the diaries and medical documentation that parents often had their own problems, which meant that they could not always participate in the planning of care or be supportive parents to their children (I & IV). There were not as many active stakeholders to relate to in adult psychiatry as in child and adolescent psychiatry, which created less loyalty problems but also meant less commitment from other stakeholders towards patients.

Staff members, especially in child and adolescent psychiatry, reported expectations of being flexible and remaining calm as well as showing respect in meetings with angry or critical parents and collaboration partners since it was important to have a good communication with them. This concern led to a subtheme in child and adolescent psychiatry called building alliances for good care (I). It was not an easy task to cooperate with some of the parents since many of them had their own problems to handle. There was also medical documentation about many parents who were completely exhausted after taking care of their sick child, but also those who found it difficult to cope with parenting in general due to substance abuse, mental illness or social problems. At times the team became very frustrated due to failure to create an alliance.

The young person has refused medication so far // A staff member calls the mother asking her to come, but she has not got the strength to do so. When we insist she hands over the phone to her 20-year-old son who also says that his mother doesn’t have the strength to come. According to the care planning for the young person, only a few people within the staff should be in the care team and try to establish some kind of alliance with the young person. Apparently this hasn’t succeeded at all. He hasn’t responded to their efforts to communicate and it’s difficult to know if he understands what we mean. He doesn’t think he needs to be here. (Child and adolescent psychiatry)

5.3. Ethical considerations in psychiatric inpatient care

In this integrated interpretation, the themes of ethical considerations in psychiatric inpatient care are described by subthemes, values and arguments developed in papers I-IV, (Table 13).

The major change is that the subtheme the border of coercion in papers I and II is a theme in this presentation and the theme of loyalty (I, II) solely focus on loyalty to the team and other professionals, not towards the patients. Thus, the themes are: the borders of coercion; the emphasis on order
and clarity rather than a more reciprocal relationship with patients; a strong expectation of loyalty within the team; and feelings of powerlessness mainly in relation to patients.

Table 13. The four themes of ethical considerations in psychiatric inpatient care with subthemes and arguments from the analyses of papers I-IV.

<table>
<thead>
<tr>
<th>Paper</th>
<th>The borders of coercion.</th>
<th>Order and clarity.</th>
<th>Loyalty within the team.</th>
<th>Feelings of powerlessness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>The borders of coercion.</td>
<td>The importance of consistent rules and routines.</td>
<td>The importance of loyalty within the team.</td>
<td>Staff members felt unable to help the patients. Not daring or being unable to respond to offensive behaviour. Difficulties dealing with troublesome patients.</td>
</tr>
<tr>
<td>III</td>
<td>To promote and restore the health of the patient.</td>
<td>Involve patients in the planning and implementation of their care. Building trust between staff members and patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>The six arguments for coercive care.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3.1. The borders of coercion

5.3.1.1. Arguments for coercive care

I have been working in this practice for quite a while. Maybe you become blind to ethical issues? I think coercive care works well... In practice there is, of course, a large grey area where we (in consultation with the parents) restrict the degree of freedom of voluntary care patients just as much as patients in coercive care. (Child and adolescent psychiatry)

Decisions about coercive care are often described as unproblematic in the diaries. However, when it comes to coercive care of children and adolescents, the distinction between coercive and voluntary care is somewhat diffuse and problematic. Parents might have approved care that the young person was hesitant about but was too weak to resist the actions of the staff. There are also participants who problematise decisions about coercive care since it gives staff the right to use coercive measures; such as the use of physical force in order to medicate the patient. Participants found it hard to explain to patients why the physician opted for coercive care when voluntarily treatment had been sought. The use of long periods of care in forensic psychiatry could sometimes cause difficulties when considering discharge.

Care planning: The current patient is being pushed out after 18 years of care. This means that it may go slowly so the patient can feel safe outside the ward. We must realise that the patient has become hospitalised and has a great fear of freedom and we need to help the patient based on his ability. He has to be able to control the pace himself. Ethical reflection: Coercive care versus voluntary. To appear before the county court to maintain that the patient has serious psychiatric thus avoiding the risk of him getting discharged prematurely. To "slip" on the criteria for the patient’s best interest? Difficult! (Adult psychiatry)

The main arguments used to justify coercive care in child and adolescent psychiatry, according to medical records, were the need to protect the patient and that coercion was a necessary requirement to be able to give treatment to the patient (Table 11). These arguments were often found in the final argumentation for coercive care, and were more common in care certificates than in other documentation. The other arguments were mainly used to support these two arguments and were mostly used when describing the current situation, mostly in other documentation than in the care certificates.
The most common of the main arguments was the protection argument (IV). It was used in almost all cases (Table 11). In a majority of cases, there was a documented risk of suicide or a recent attempt, or other life threatening states like dehydration due to an eating disorder (Table 14). Some patients had symptoms such as hallucinations or compulsive behaviour that could result in serious injury to themselves or to others. Consequently, it was sometimes necessary to use restraints or other coercive measures. The majority of cases were not considered to be dangerous to others. There were only 12 cases with documentation about i) a risk assessment of mortal danger to another person and/or ii) documentation of other serious acts which the patient had recently directed towards another person, such as a recent assassination attempt, serious assault or expressed death threats.

Table 14. Assessments of 155 cases of patients' dangerousness towards themselves and others in medical documentation.

<table>
<thead>
<tr>
<th>Mortal danger to others.</th>
<th>Risk of harm to others.</th>
<th>Not dangerous to other.*</th>
<th>SUM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of suicide.</td>
<td>7</td>
<td>31</td>
<td>117</td>
</tr>
<tr>
<td>Risk of self-harm.</td>
<td>4</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>Not dangerous to themselves.*</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>SUM.</td>
<td>12</td>
<td>54</td>
<td>89</td>
</tr>
</tbody>
</table>

*= absence of documentation

The second main argument; the treatment requirement argument (IV) was not used in an explicit way like the protection argument. In a vast majority of cases, the need for coercive care was expressed implicitly by descriptions of the patient's severe mental condition, but there were seldom any descriptions of what kind of care the patient needed.

The most usual of the supportive arguments was the caregiver support argument (IV). It was often used as an explanation as to why the youth was taken to psychiatric services. As a result of our analysis, we changed the name of this argument from the parent support argument to the caregiver support argument. Besides 59 families, there were also 16 special residential homes for adolescents, which had great difficulties handling the adolescent and needed the support an admission to inpatient care could give. The everyday care argument (IV) was not used in the documentation in a clear manner. However, it was mentioned that parents or the staff at residential
homes could not give the everyday care the adolescent needed in a satisfactory manner.

A supportive argument that was used fairly often was the clarification argument; it could indicate that the staff had plans to use coercive measures. In a few cases, a decision was documented that the patient was going to be subjected to coercive treatment, irrespective of the patient’s or the parents’ wishes and they were clearly informed of this. The solidarity argument was seldom used in medical records and only once in the care certificate.

5.3.1.2. Coercive measures and informal coercion
Many ethical considerations were raised regarding the borders of coercion (I, II), especially when there was no legal foundation for coercion, but decisions or routines that required patient compliance. Examples of such ethical considerations were raised when staff reported using informal coercion when patients refused to take their medication, get up in the mornings or take care of their personal hygiene.

The participants seldom perceived that prescribed coercive measures were ethically problematic, more often they were described as hard emotionally. Coercive measures were sometimes described as dramatic and extremely violating for the patient but were justified since the participants wanted to promote and restore the health of the patient (III).

Today, the psychiatrist decided that the patient needed to be injected with Cisordinol-Acutard. The patient who is here involuntary didn’t get any other alternative. The patient was upset and cried but didn’t put up any resistance. He just found himself with this decision having been made. It never feels good to give a patient medicine that he doesn’t really want to have but I know that it is necessary, I would like to get help myself, if I, one day became so sick. (Adult psychiatry)

In child and adolescent psychiatry, parents may oppose coercive medication or tube-feeding (I-IV). In a case where both the patient and the parents were against the use of tube-feeding, staff made it clear to the patient and the parents that this action would be taken regardless of their will. This was justified since it was the only way to save the patient’s life.

Participants described how decisions about coercive medication could be problematic if the staff members did not agree among themselves or with the doctor. A decision on coercive medication initiated a process with infor-
mal coercion that started with attempts to make the patient take the medicine voluntarily, followed by persuasion, threats of coercion and sometimes even deception.

Working nightshift. All is calm. However, I gave a very upset and confused patient medicine orally that had been crushed and mixed in yogurt. The woman is here under a coercive care order - but it still I didn’t feel quite right doing this. (Adult psychiatry)

If the patient resists all attempts, coercive measures are used and the medication is administrated, most often by male staff, using physical strength. Some participants worried during this long process because a patient who needs medication may experience deterioration in health or become violent.

5.3.2. Order and clarity

When we analysed the diaries of child and adolescent psychiatry, we found three themes: *good care*, *loyalty* and *powerlessness*. In the analysis of the diaries from adult psychiatry, similar themes emerged. A fourth theme also emerged that we called *order and clarity*. Participants stressed the *importance of consistent rules and routines* (II). They reported a desire to treat patients in an equal and routinised manner. There were similar statements in child and adolescent psychiatry. One example is that wards seldom had resources for social activities and some patients had no planned activities. Despite this, the staff insisted on patients getting up in the morning and having breakfast at a fixed time.

I nag at the patient to get up in the morning. Some don’t care about getting up for breakfast. Screams that I should get out of the room. Argues about showering, doesn’t want to do it, I feel that I’m nagging a lot of the time. (Child and adolescent psychiatry)

One reason why we did not identify the theme of *order and clarity* (II) in child and adolescent psychiatry might be that the staff expressed a greater emotional commitment and showed some more flexibility than those in adult psychiatry. Some participants were also aware of the conflict between the patients having individually adapted care versus the great emphasis on rules and routines. They argued against this emphasis on rules, which they believed created a too rigid attitude towards patients.

It’s very important to me not to have a lot of rules and limitations but rather think of why. Are they there for the good of the patients or for the staff? Of
course we have to be clear and straightforward and apply limits where necessary in relation to the needs of the patient’s illness, but we must then be also able to explain why, if the patient asks. (Adult psychiatry)

The expectations of the staff were that staff members maintained order and were consistent (II) and if patients did not comply with ward rules and routines, the staff was expected to react. According to some participants, patients who break the rules need to be made aware of the consequences in order to understand that their behaviour was not acceptable. Rule breaking patients in adult psychiatry may have their right to leave withdrawn or be restricted and told to stay in their room.

Consequential actions for some patients who violate the department’s eight golden rules. Should we acquit or convict? Fingertip feeling. (Adult psychiatry)

On occasion, patients were discharged from adult psychiatry as a consequence of their behaviour despite a serious mental condition. Participants had a firm conviction that conflicts could be avoided if staff members were consistent but at times they could also understand that complying with routines could be difficult for the patient.

It can sometimes feel hard to nag a patient to get up in the morning when I know it’s hard for him to get up, given the diagnosis he has. (Adult psychiatry)

Staff members felt a pressure from management and colleagues to maintain a professional distance to patients (I). Staff members who were too involved with patients were criticised by participants. One staff-member was, for instance, called a self-appointed extra mum. Some participants, especially in child and adolescent psychiatry, chose to have a closer relationship with patients but they did not always tell their colleagues about their commitment in order to avoid criticism. We found some statements where participants chose to be more personal in their relation to patients, but were aware of the ideal of having a certain distance to the patient.

Where do you draw the line for being too close to a patient who has been with us for a long time in the emergency unit? // We had a farewell coffee break together and gave her a gift, something we don’t often do but, on the other hand, she was no ordinary emergency patient. Some of us thought it was important to have a good ending of the relationship and wanted to say goodbye to her, whereas others did not think that was so important. I was among those who gave her a big hug and I was on the verge of tears, // It felt
very personal, but that feeling was OK in that there were other staff members who took a different approach, thus balancing the situation. (Child and adolescent psychiatry)

One possible interpretation is that the emphasis on rules and routines, and an approach that involves a distancing from the patients, makes it difficult to adapt an attitude of reciprocity (III). There were quite few statements of reciprocity. In these cases, the participants described striving to involve patients in the planning and implementation of their care (III). They also expressed a need for building trust between staff members and patients (III). One way of doing this was to listen to the patients and ask about their needs and wishes. However, some participants found it very difficult to control their negative feelings about certain seriously ill patients. They did not want any kind of reciprocity; instead they sought to distance themselves from these patients. Other participants had a more a reciprocal way in their encounters with patients and clearly shared the joy of patients when they were happy or the treatment outcome was positive.

Talked with colleagues about a patient with "anorexia nervosa". I feel happy because we are seeing progress in this patient’s case. The patient was able to talk about her problems when it comes to food. She wants to have more support when it comes to portion size. // Accepting extra nutritional supplements to gain weight. She thinks that it’s nice with night leave at home. // When it’s going well for the patient, I feel that my colleague and I have done good job. It feels rewarding. I hope it gets even more rewarding and I think we can achieve this with this patient. (Child and adolescent psychiatry)

5.3.3. Loyalty within the team
Participants, especially nursing staff, stressed the importance of loyalty within the team (II). Belonging to the team (I) was important and loyalty was described as necessary and positive because they believed that the team had to be united to avoid ‘splintering’ on the ward. The team continually made informal decisions concerning attitudes towards patients. Conflicts of loyalty rose when a participant did not agree with decisions made by other colleagues but was expected to execute them anyway or if the participant discovered that a colleague was mismanaging their work. When a colleague ignored the safety of a patient, one participant felt uneasy when considering writing a report about it.

It has come to my attention that a wheelchair-bound patient who has been prescribed supervision every 30 minutes was found sitting in their wheelchair by the night staff last night at midnight, which means that the staff didn’t
maintain the supervision as instructed. What should I do now? Write a report? Who’ll take this further? It’s hard when you have to report workmates. (Adult psychiatry)

Nursing staff could criticise other nursing colleagues in the diaries, but none of them reported that they had expressed this criticism openly during working hours. There was also a problem if other colleagues were criticised by parents or other stakeholders.

The mother stated that she had great confidence in me as opposed to my colleague. Since we work in teams around the patient (in this case 3 people), the situation became uneasy for me. I try discreetly to discover why my workmate and the patient have clashed, without losing the confidence I have received. I offer the mother the possibility of discussing the whole thing at the next meeting in order to sort things out. She will think it over. (Child and adolescent psychiatry)

Problems of loyalty also occurred in relation to collaboration partners, especially social services, which in many cases are responsible for supporting some of the patients after discharge. Staff members were expected not to criticise colleagues or collaboration partners if a patient or parents were present. In a few cases, professionals, who were not nursing staff, were openly critical.

I’m involved in a case where the relational problems are likely to worsen unless adequate help isn’t shortly offered. I have in this case a very strong focus on the children. This is a situation that touches me deeply and focuses on ethical issues. I’m prepared to take the consequences of that and to tread on a few toes to bring about the help that the family needs. Who would listen to the children otherwise? Who speaks on behalf of the children? Social services could have done so much more than they have done and I have not received a good explanation of why things turned out as they have. I’ve been working on getting the family on board, explained what kind of help they can get and got their permission to make the necessary contacts. The family is well outside my area of responsibility but it is impossible for ethical reasons to dismiss their needs because of it. I made a choice that feels good to me. (Adult psychiatry)

5.3.4. Feelings of powerlessness

The participants experienced inadequacy in relation to patients (I) because staff members felt unable to help the patients (II). Sometimes participants referred to concrete problems such as the ward, for example, not always having the resources to treatment for the patient and when a patient was to
be discharged, it was not self-evident that an outpatient clinic was going to take responsibility for the patient. Patients leaving the ward were not always getting the support they needed from social services. Staff members could feel inadequate with regard to patients if they did not have time to talk with them.

I have not got time to talk to the patients! There is one man in particular who tries to attract my attention, but I have not got time to sit down for a chat. I know that a talk would help him. My frustration probably shows. My job is to listen, to help – but all the paper work is eating me up. (Adult psychiatry)

The lack of beds in adult psychiatry gave the participants the impression that some patients were discharged too soon to a harsh life situation, often without the support they needed. Several factors in child and adolescent psychiatry such as an increased number of patients, new working tasks, cutbacks or reorganisations caused stress. Patients could also suffer from problems such as loneliness, which staff members cannot solve.

Loneliness: A patient without a social network. Social services don’t consider the patient’s addiction to be serious enough for them to have to work with the patient. Discharged! The patient is too healthy for continued help/support from us. No psychiatric problems. No abuse etc, etc... Discharged! Who/what is left?? The patient wants contact, conversation, support. The problem is loneliness... Who/what remains and how can loneliness be mediated away?... Ethical dilemma.... How do I work on myself after signing out a man who is "screaming" for help, discharging him to total solitude...? Who cures loneliness?? How/to whom can we refer the patient? (Adult psychiatry)

Some patients, both in adult psychiatry and in child and adolescent psychiatry, needed accommodation and/or treatment that could not be provided within the organisation and for whom no one wanted to pay. In child and adolescent psychiatry in particular, participants worried about seriously ill patients who did not receive the treatment they needed or were just waiting to be placed in another institution. Thus the ward became a terminus for the patient (I).

A 12-year old boy is admitted here when his mum is admitted to adult psychiatry. The police had arrested the boy for shoplifting food. It would appear that the family absconded from a refugee camp after receiving a deportation order. We become a “terminus” for societal responsibility without knowing the causes and reasons. We are not to get involved! We are just to detain him while waiting for another institution to take over. There’s great frustration
within the staff where some members drop all their training and experience and start complaining about our collaboration partners. (Child and adolescent psychiatry)

The participants experienced *difficulties dealing with troublesome patients* (II). They sometimes became very frustrated with patients who were provocative, used offensive language or who refused to take a shower despite “smelling awful”. Sometimes the staff could experience difficulties in knowing how to handle their own feelings when encountering with these patients.

I'm the contact person for a guy who committed a crime. He has no empathy for his victim. I have dismal thoughts about him, but of course I don’t let that show. I find it very hard to deal with disturbed people. (Child and adolescent psychiatry)

The feeling of *not daring or being unable to respond to offensive behaviour* (II) was a heavy burden in adult psychiatry and the participants in child and adolescent psychiatry were even more emotional so the subtheme here was *feelings of helplessness* (I). Participants described situations where colleagues or collaborative partners behaved in an offensive way or made racist and abusive comments towards the participant, patients or colleagues. Patients could also inform participants about previous offences caused by staff, relatives, collaborative partners or others. It was difficult because the participants had no idea how to handle these situations. It appeared that these events and feelings were seldom communicated to the ward manager or others at work, but dealt with privately. One person spoke to a family member, while others wrote that they had experienced difficulty sleeping or had to take sick leave.

The participants in child and adolescent psychiatry sensed the feeling of hopelessness experienced by refugee families. Despite having ‘done everything’, they could see no improvement. It seemed pointless to treat the children of asylum seeker families as, according to participants, they needed a residence permit more than anything else.
6. DISCUSSION

In this thesis, I have identified four themes that can give rise to ethical considerations for members of staff in their everyday work. These themes are; the borders of coercion, order and clarity, loyalty within the team and feelings of powerlessness. Coercion in psychiatry is, from an ethical perspective, an important area of concern. The theme the borders of coercion revealed that informal coercion and the process leading to coercive measures was often perceived as being more problematic ethically than the actual administering of coercive measures. In the theme order and clarity, the emphasis on rules and routines gave the impression of the purpose being to give routine-based, and not individualised, care. Staff took informal decisions on rules and attitudes towards patients that limited patients’ autonomy. The demand for order and clarity also applied to staff. They were expected to be loyal and to follow the rules and routines. Staff members perceived that loyalty was expected towards colleagues, even if they thought that colleagues behaved badly towards patients. The witnessing of violations against patients or staff together with the perception that patients were not getting adequate help or were being discharged to a tough environment, gave rise to the theme feelings of powerlessness.

The discussion begins below with some thoughts being given on what the staff members seem to think that ethics is, and what kind of ethical ideals they stand for. A more detailed discussion then ensues with regard to the ethical challenges in psychiatry that the themes mentioned above imply and, thereafter, a section on methodological problems in these studies. The discussion concludes with some reflections about clinical implications and the need for future research.

6.1. Ethics and staff members

6.1.1. What does “ethics” mean to staff?

Some participants expressed a narrow understanding of ethics in the diaries and wrote that they had not experienced any ethical considerations during the week. Other participants only wrote once or twice in their diary during the week. There were also participants with a broad view of what ethical considerations might involve, including organisational and societal problems. Thus, it can be concluded that staff can interpret the concept of ethical considerations in a variety of ways.
We did expect that staff members would write about problematic issues around encounters with patients, but a great number of considerations were about conflicts of interest with others rather than with the patient. Conflicts of loyalties were common both within professions and between psychiatric staff and other stakeholders. These conflicts were sometimes a threat towards the quality and safety in work with patients since staff members could choose to be loyal to others, neglecting the perceived needs of the patient. Another area of conflict was raised by the hierarchal health care system; organisational problems were frequently raised in the diaries. Care staff could not always give the treatment, care and support they perceived that the patient needed. Sometimes, these organisational problems were concretely described. In other cases, participants criticised their own organisation in a generalised manner that gave the impression that they chose to attribute failures and other problems to the organisation.

In the study of medical records, we did not expect to find any extensive ethical analysis, at least not in the care certificates since these acute situations often require a quick handling and the certificate does not require any ethical analysis of the situation. Despite this fact, we did not anticipate that it would be so hard to find value arguments; especially in cases where the documentation revealed that the decision was, in the first place, an emergency measure in order to save the patient’s life, and not that the patient required psychiatric inpatient care.

Since we asked participants to write in the diaries about their ethical considerations and reflections about them, we had anticipated a greater number of considerations or dilemmas; statements containing reflections on alternative actions that could be taken in care situations, but these were quite rare. Even in cases with a dilemma, such as a quote about tube-feeding a starving patient, the participant stated that it was not an ethical dilemma since the patients was in a life threatening situation. Very often the statements only had a description of a problem and a direct response to it in the form of a solution, opinion or expressed feeling. This is consistent with some other studies; that staff often view the problems as being clinical and they do not pay attention to the ethical dimension of the situation\textsuperscript{2,64}. Likewise, it seems that the participants in the studies of medical records as well as the diaries lacked a language to express their ethical considerations at work. Descriptions of stressful situations that were attributed to organisational concerns and a lack of reflection make it reasonable to interpret many statements in the diaries as expressions of “moral stress” rather than ethical reflections.
6.1.2. Staff members’ ethical ideals

When analysing the diaries with the three predefined concepts of paternalism, autonomy and reciprocity, the staff ideal was predominantly a desire to respect the patients’ autonomy and integrity. In quantitative terms, the perspective that occurred most frequently was paternalism. However, the participants often described paternalistic behaviour as problematic. A reasonable interpretation of the diaries is that staff members are aware of the importance of autonomy and consider it problematic to act in a paternalistic fashion, although in certain situations it would appear to them to be the only appropriate way. Not surprisingly, the care certificates gave a more unambiguous correlation to the use of coercion since they were written to justify coercive care for the patient.

There were many normative statements that revealed an awareness of patients’ right to autonomy and integrity. Participants described how encounters between staff members and patients should appear in order to show respect to patients. However, when describing encounters with patients, the participants also stated that living up to these ideals were difficult. Previous research\textsuperscript{97, 107} provides examples of staff members who did not see any problem with routinely restricting the patient’s right to autonomy. In our studies, staff reported about restrictions of patient autonomy and were critical about some of these restrictions.

As mentioned earlier, the most frequent perspective was paternalism. A reason for the great number of paternalistic statements could be the ongoing reduction in the number of psychiatric beds resulting in shorter periods of admissions. The inpatients are, therefore, often in an acute phase of their illness and the proportion cared for by coercion has increased\textsuperscript{15, 24}. Thus, a larger proportion of patients are probably in need of support and substitute decision-making than earlier.

6.2. Four ethical challenges in psychiatry

In this thesis, I have identified a number of areas that provide challenges for inpatient psychiatry. First, formal and informal coercion in inpatient care raises ethical issues and can be emotionally difficult for staff. Second, the professional role needs to be developed from the frequent provision of routinised care to more individualised care. Third, patients seem to need better support, as staff often worry about how patients will manage their lives after discharge. Fourth, staff members also need support to do a good job
since working with patients with severe psychiatric problems may be stressful, staff often feel pressurised to be loyal to the team and they have feelings of being alone with their thoughts about difficulties at work.

### 6.2.1. Coercion

One of the challenges in psychiatry is to deal with coercion in a reasonable way. The main finding in the study of medical records was that, in the assessment of the need for coercive care, professionals most often used arguments about the need to protect the patient and to give necessary treatment, which was particularly emphasised in the care certificates. Descriptions were rare concerning the type of treatment that was considered necessary, which gave the impression that the decision for coercive care is simple; the patient lacked decision-competence and was in great need of coercive care. The way in which physicians argued was paternalistic, in a similar way to that discovered in a recent qualitative study about how clinicians reason when they are admitting patients to coercive care\(^9\). It was hard to find any arguments maintaining that other forms of treatment had been exhausted and that coercive care was the only available option. Instead, physicians often used their authority to make a claim about the need of coercive care.

The care certificate has a question about the patient’s mental condition and personal circumstances. The care certificates in this study give the impression that physicians had reduced this legal requirement to one single question about whether the patient’s behaviour was a danger to self or to others.

When reading the care certificates, they give the impression that the decision for coercive care was easy. This contrasts with an interview study where 45% of the physicians reported that they found it difficult to use the two medicolegal criteria\(^7\). There were also large differences in the arguments between care certificate and other documentation, where aspects other than lack of decision-competence and a great need of coercive care were documented. These differences and the lack of uncertainty indicate that physicians primarily adapted care certificates to fulfil the legal requirements. There is an even greater difference between these results, based on the medical records, in comparison with a study of how the staff were reasoning in general terms. In general terms, it was common for staff to argue for strong paternalism (the solidarity argument); that coercion should also be used for preventive purposes\(^5\). This kind of arguments is not in line with legislation and was not used explicitly in the medical documentation.
The problem of coercion in the diaries involved formal decisions both of coercive care and of coercive measures. However, staff perceived informal coercion as being even more problematic than formal coercion; especially concerning voluntary cared patients. The results of the diaries are in line with the four types of informal coercion that, according to Szmulker95, is used to get patients to comply with treatment. These four types of informal coercion are persuasion, leverage, inducement and threats. In our studies, informal coercion was used to get the patients compliant with both treatment and ward routines. We also discovered two other manipulative techniques: namely, deceiving patients to take their medicine and withholding information that could make the patient anxious.

The result of the studies of the diaries also partly confirms previous research findings whereby staff members sometimes find it difficult to identify ethical issues in relation to coercive care and measures90, 91. There are also quite a lot of statements in the diaries that reveal that staff can perceive coercive measures as dramatic as patients might do36 92, despite the fact that they do not always recognise these measures as ethical issues2.

Our studies and other research indicate that there is a need to increase awareness among staff and managers of the ethical aspects related to coercive measures1, 36, 54, 90, 94. When carrying out coercive measures, it is important to communicate with the patient, not because it necessarily changes the situation, but it can make the patient feel respected as a human being12, 72, 74. One study concluded that a therapeutic relationship creating a sense of trust is important in providing a safe treatment environment that prevents the need for using coercive measures as well as preventing violence on the ward117. Other aspects highlighted in this study are reasonable and understandable rules in the ward, the ability of the staff to be calm when approaching patients in aggressive situations, the willingness of the staff to try to understand why a patient is aggressive and that agitated patients require attention at an early stage. In the diaries, staff reported that they often did not have time to engage with patients. This prevents staff from observing early signs of patients getting scared, becoming violent or conflicts arising between patients.

6.2.2. The professional role

The second identified challenge is the professional role in psychiatric inpatient care. Some statements contained ideals and working methods that respect patients and their values, which correspond to a great extent with the concept of value-based practice1. Alongside a commitment to patients, there
was an expectation that participants should maintain a relatively strict routine-based care. This was most obvious in the diaries from adult psychiatry where traditions from the asylum culture seem to be strongest, with a staff centred practice and an emphasis on routine-based care. A possible interpretation is that reciprocal relationships with patients were not desirable. Instead of reciprocity to the patients, many participants stressed the importance of loyalty to the team and the maintenance of rules and routines in their work with patients, which is consistent with previous research. Staff members in child and adolescent psychiatry more often expressed a desire for a reciprocal relationship with patients, even if they could be criticised by other staff members for this approach. There were also statements in the diaries where participants themselves, or others in the team, used objectifying and dehumanising language about patients.

In some statements, participants questioned the attitude of distancing themselves from patients and dared to be more personal in their contact with the patient, which can be of great importance for the latter’s recovery. Some participants, especially in child and adolescent psychiatry, were striving for a reciprocal relationship but they did not often talk with colleagues about their commitment, due to the risk of being criticised by them. Statements indicating that the staff members openly criticised existing working practices, decisions or the conduct of their colleagues were rare. This is in line with other studies in health care; there seems to be silence surrounding abuse of patients and staff without managerial function have reported substantial discomfort when it comes to speaking out about their safety concerns. Apart from the nursing staff, other professionals wrote a few statements about how they openly criticised colleagues or social services. It is, thus, possible to interpret the results as if there are institutional norms that prevent staff from openly questioning the existence routine-based practice or from reporting cases, where it was evident that colleagues had failed in their responsibility to the patient.

There seems to be a pervasive tension that staff members have to deal with. On one hand, they should comply with the institutional norms whereby formal and informal decisions foster routine-based care while, on the other hand, there are demands for more individualised care. This could be interpreted as an indication that the tension between routine-based care and individualised care is more visible in the psychiatric discourse than it has been earlier, especially in child and adolescent psychiatry. We did not find any examples in the diaries explaining how this tension could be dealt with in a successful way. Staff members who were inclined to execute a
more individualised approach to care reported that they received criticism from colleagues and problems regarding loyalty were increased with them.

6.2.3. To support the patient

The third challenge I have identified is how to work with patients during their time as inpatients and assist them at discharge so that they get the support they need from psychiatric outpatient services, social services and other authorities. In some statements, these organisations were seen as inadequate for delivering good care and providing the patients with possibilities for having a good life. One interpretation is that staff found it stressful when they perceived that patients were not getting the care, treatment and support they needed. Moreover, it was not only patients who needed support, according to staff; many parents and other relatives of young patients often had their own problems and needed support. The staffs’ observations on how patients are mistreated or harmed by inadequate, or lack of, healthcare interventions and social support could be better utilised in the development of treatment, care and support for patients.

The Swedish refugee policy, with its long timeframe for handling cases, received much criticism from participants in child and adolescent psychiatry. It seems that current procedures, with long waiting times for residency permits, contributes to psychiatric problems in already traumatised refugee families120. The diaries contained no statements about staff members receiving support from the management when trying to handle these stressful situations with patients, which brings us to the next challenge, the support to staff.

6.2.4. Organisational support to staff

The fourth challenge for psychiatric inpatient care is the support for staff in their work. The result of the diaries and previous research2, 25, 65 show that staff often feel inadequate and sometimes helpless in their dealings with patients. In some of the statements, dehumanising language was used to describe patients, which may also indicate high levels of stress. Some of the statements in the diaries can be interpreted as moral stress, but some of the statements do not fit that theory. The moral stress theory assumes that it is mainly the way in which care is organised that prevents staff from doing their best for the patient62. Our results indicate that it is often the staff members themselves who recreate this routine-based care by deciding informally about rules and approaches towards patients. Some of these decisions cause stress among those staff members who strive for more individualised care.
One way to reduce these informal decisions and give support to staff would be a more active management involved in the daily decisions on how to handle difficult ethical situations and also ensuring that the workplace has a common base of know-how. Follow-up and reflection on coercive measures and informal coercion from an ethical perspective is also needed. Staff and managers should also discuss the possible negative consequences of coercive measures in order to choose the least restrictive alternative and to discover other methods that could be applied in encounter with distressed or aggressive patients. It is a challenge to create a difference in the relationships between staff and patients and involves a process that normally requires several kinds of intervention, such as staff education, changes in leadership and the therapeutic environment. To create changes in organisations, ethical reflection can be used, but more is required beyond reflection and this can be achieved with methods such as moral case deliberation. If the manager participates in these reflections, it becomes easier to find reasonable solutions and the ward manager gains better insight into the daily issues faced by the staff.

Participants wrote about difficult situations that they perceived as stressful but they did not write about getting support from their managers, which may increase the symptoms of stress. It was difficult for some of the staff to let go of thoughts about these situations at work when they came home. A review in forensic psychiatry identified some factors that could reduce stress among staff. The recommendations were that the organisation should have an easily accessible support system including clinical supervision. Managers should also foster an open culture to enable staff members to express their feelings of guilt and frustration openly. Although the need for managerial support and ethical reflection for staff has been identified, the ward manager seldom has time to engage in the daily issues encountered by staff at the ward and staff seldom have a forum for ethical reflection or time for it in other formal meetings.

6.3. Methodological considerations
When carrying out a qualitative study, analysed with content analysis, it is necessary to consider several methodological issues to achieve trustworthiness. It is common to use the concepts of credibility, dependability and transferability when assessing trustworthiness.

To increase credibility, the collection of data and the analysis process have to be consistent with the focus of the study. A good selection of context and participants in data collection can contribute to credibility and to the
research question being answered in a broad and rich manner\textsuperscript{113}. The diaries (I-III) were collected in many different kinds of psychiatric inpatient services and in the study of medical records (IV), the complete annual population of patients in Sweden were included. This should provide opportunities to answer the research questions in a satisfactory manner and data should give a good picture of the ethical issues in Swedish psychiatry. Another aspect of credibility is that the researcher should seek consensus about the results with others, such as co-researchers and participants. During the research process all authors of the articles discussed the analysis and results until consensus was reached. In order to increase the credibility of the studies, the results have been presented and discussed with other researchers, management and staff in psychiatry and other healthcare services, and with representatives of patient organisations.

The researcher has to be aware of dependability, including any kind of inconsistency during data collection, and to take it into account in the analysis\textsuperscript{113}. The diaries in adult psychiatry and child and adolescent psychiatry were constructed in the same way and the data collection was done in the same manner in order to get consistency during data collection. There was only one difference. In adult psychiatry the diary was included in a survey with questions about coercion and ethics, whereas in child and adolescent psychiatry, the diary was handed out by itself. The medical records were only written for clinical purpose. Staff did not know that these records would be used in research. Therefore, they had not adapted what they were writing to be part of a research project. Data collection was done in the same manner in all of the clinics.

In order to help the reader to understand the transferability of results, it is important to have a good description of context, the participants and the procedure of collecting data and analysing them\textsuperscript{113}. Since the studies were carried out in Sweden, the introduction provides a description of Swedish psychiatry in order to enable the reader to determine the extent to which the thesis results may be transferable to other settings. As well as the description of the settings and the participants, I have also presented three important studies that are relatively detailed\textsuperscript{36, 53, 54} since these data were collected simultaneously from the same settings. This should also give a better understanding for the settings included in this thesis.

Ecological validity and social relevance can also be added as criteria for good content analysis\textsuperscript{110}. To obtain ecological validity\textsuperscript{128}, staff members could describe ethical considerations in the diaries in their own words. This method proved to be interesting. To the best of our knowledge, it has not
been tested previously in a scientific way by others. In the results, we strive to use the staff’s own words, but the participants do not have to accept all of my interpretations, nor share my opinions about psychiatric care. In this thesis, social relevance means that the results should be clinically relevant. The results of the analysis were communicated to, and discussed with, staff in psychiatric services, including the participating clinics. These discussions were not part of the study design but they influenced the analysis insofar as they revealed which statements and interpretations could be perceived as reasonable and a reflection of important experiences with clinical relevance in psychiatric inpatient care. On these occasions, all quotes used in the articles and most of them in this thesis have been discussed with staff before publication.

The data in child and adolescent psychiatry were collected in 2003 and the data in adult psychiatry were collected in 2008. Psychiatry develops over time and it is therefore reasonable to ask whether these data are clinically relevant today. When I have presented and discussed quotes from the diaries with staff in psychiatry, they have shown great interest in these discussions and found them to be clinically relevant. The results of the study of medical records correspond well with a newly published interview study by Feiring and Ugstad. They reported that clinicians had a paternalistic perspective when deciding about coercive care, despite the fact that the clinicians often had deliberative-oriented ideals. This result and other studies have had difficulties in detecting differences over time in psychiatry regarding patient participation and support to staff. This lends support to the idea that the organisation of psychiatric work is changing quite slowly. The studies in this thesis are also worthwhile for presentation since they rely on a relatively large qualitative data material and there are no similar studies published.

A major limitation of this thesis is that it only gives the ethical considerations of staff in the psychiatric wards, not the patients or other stakeholders’ perspectives. Another limitation was that most of the statements in the diaries were brief and often highlighted a critical event, but it was seldom possible to follow processes. The medical records had the same limitation. We could not ask questions to the participants about their practical and ethical reasoning, which probably was not documented fully. In further research, there is a need to complement the diary method and analysis of documentation with interviews or observations in order to obtain a more complete understanding of the ethical considerations made by staff in everyday psychiatric practice.
6.4. Clinical implications

6.4.1. Ethical reflections and the use of ethical diaries in the clinic
Quotes in the ethical diaries have been used in ethical reflection in clinics. In my experience, these have given a good start to ethical reflection for staff members and managers as they proved to stimulate the discussions about ethical issues. The quotes from the diaries were perceived as adequate descriptions of their reality. Such reflection provides a good opportunity for staff members to discuss alternative ways of acting. The ward managers were also happy with these discussions and found the diaries an excellent way of obtaining a picture of the current ethical issues. Taking time to reflect on practice can generate new ideas among staff about how encounters with patients should be and bring the ward manager closer to the clinical practice.

Normative ethics is often based on the premises that a single clinician takes decisions together with a patient. The work in a psychiatric clinic is based on teamwork; sometimes together with stakeholders. The results presented in this thesis indicate that there is a need for methods that can create an open atmosphere where the team and other stakeholders could resolve both ethical conflicts and conflicts of interest.

6.4.2. Challenges in psychiatric inpatient care
The ethical considerations presented earlier imply some ethical challenges for psychiatry that need to be managed. One such challenge suggested by these results is the development and clarification of the ethical reasoning regarding situations involving coercion of patients since earlier research suggests that coercive measures are viewed primarily as a clinical, rather than an ethical, problem. Besides formal coercion, staff often uses informal coercion. This practice is problematic and raises ethical considerations for staff members. Another challenge is to change the professional role from giving mainly routine-based care to more personalised care; a development that is likely to require significant effort from management.

The ward managers were neither mentioned in the diaries when staff members were concerned about patients, nor when staff did not know how to deal with informal decisions or violations against patients or other staff. There were no statements of active efforts to combat racism and the violation of patients and staff in the wards. If a staff member needed to talk to someone about problems at work, they seemed to do so in informal contexts and not with their ward manager. Ward managers could be more involved...
in the care and account for the decisions and values that the psychiatric organisation stands for\textsuperscript{56, 58}. This would increase the support to staff and help them to resolve the tension between routine-based care and individualised care.

Staff were concerned that patients did not always receive good treatment during their time as inpatients and were not always getting support after they were discharged from inpatient care. This knowledge that the staff have about deficiencies in treatment, care and support to patients could be used to improve the health care system and social services.

6.5. Future research

Psychiatric staff are expected to motivate patients to receive care and to cope with life in society. There is an indistinct boundary between motivating patients and using informal coercion. This raises the question: when do patients perceive the actions of the staff as being supportive and when do they perceive the actions as being coercive? A task for future research is to map out this border area and also problematise it from the legal and normative ethical perspective. There is also a need for research from an ethical perspective with regard to relatives and other stakeholder’s perceptions of encounters with professionals. An area of future research could also be the ward manager’s role in psychiatry, since there is a lack of studies about ward managers and the ways in which they can support staff and influence the care given to patients.

Normative ethics usually deals with encounters with patients, and contextual factors are more seldom in focus. The International Code of Medical Ethics\textsuperscript{38} mentions that staff members should report unethical practices. Problems relating to collegiality have been discussed in the ethical debate\textsuperscript{47}. The results of this thesis can be interpreted as conflicts of interest that raise many ethical considerations. One study pointed out that even clinical directors in Swedish healthcare had great difficulty in dealing with conflicts of interest since they lacked the tools to manage them\textsuperscript{129}. It is, therefore, important that education and training in ethics for management and staff do not only focus on encounters with patients. There is a need for methods that can provide management and staff with the tools and the ability to manage conflicts of interest. Future research could contribute both in the mapping of ethical considerations that arise in patient encounters and conflicts of interest and in also helping to develop, implement and evaluate methods for managing these issues in psychiatric settings. In addition to working with
these empirical questions, future research should also develop the normative ethical language so that it is more relevant to the clinic reality.
SVENSK SAMMANFATTNING (Swedish summary)

Etiska överväganden i psykiatrisk slutenvård - Det etiska landskapet i vardagsarbetet beskrivet av personal

Inledning
Utörgången för denna avhandling är att många värdefrågor aktualliseras i psykiatrisk slutenvård i vardagliga möten med patienter. Forskning pekar på att personal ofta uppfattar situationer och problem i patientarbetet utifrån kliniska och juridiska aspekter, men mer sällan utifrån etiska aspekter. Därför behöver forskningen kartlägga det etiska landskapet i psykiatri för att tydliggöra de etiska aspekterna i arbetet. En sådan kartläggning kan vara ett stöd för att skapa ett etiskt språk för att samtala om och hantera situationer med viktiga etiska aspekter. Denna avhandlings huvudsakliga mål var att kartlägga och tydliggöra de etiska överväganden som personalen gör i det vardagliga arbetet inom psykiatrisk slutenvård, inte att fokusera på några specifika etiska problemställningar eller dilemma.

Syftet med avhandlingsarbetet var att kartlägga de etiska överväganden som personalen gjorde i den psykiatriska slutenvården. I de två första delstudierna beskrevs de etiska överväganden som anställda uppfattade i sitt dagliga arbete i barn- och ungdomspsykiatri (delstudie I) respektive vuxenpsykiatri (delstudie II). I delstudie III analyserades möten mellan personal och patienter ur ett normativt etiskt perspektiv. I delstudie IV undersöktes vilka argument som läkare använde för att rättfärdiga beslut om tvångsvård enligt Lagen om psykiatriskt tvångsvård (LPT).

Metod
Materialet i de första tre studierna bestod av etiska dagböcker som personal skrivit under en vecka. Sammantaget lämnade 173 personal i dagböcker från 6 barn- och ungdomspsykiatriska samt 7 vuxenpsykiatriska kliniker. I den fjärde studien ingick samtliga fall av patienter i barn- och ungdomspsykiatri, som tvångsvårdades enligt LPT i Sverige under ett år, det var 142 patienter som skrevs in för tvångsvård 155 gånger.

Analyserna gjordes med kvalitativ innehållsanalys. I delstudierna I och II användes induktiv innehållsanalys eftersom syftet var att kartlägga det etiska landskapet i psykiatrisk slutenvård och ge en så fullständig bild som möjligt av innehållet i dagböckerna. I delstudierna III och IV användes de-

**Resultat**

En integrerad tolkning gjordes av samtliga delstudier, då identifierades tre ideal som personal hade och fyra om råden som skapade etiska överväganden. Personalens ideal var; 1) att vara en god vårdgivare, 2) att respektera patientens autonomi och integritet samt 3) att ha goda relationer till föräldrar och närstående. Trots att personalen lyfte fram respekten för patientens autonomi och integritet som ett ideal beskrevs många situationer där de valde ett mer paternalistiskt förhållningssätt. Detta uppfattades problematiskt, men personalen ansåg att det enda rimliga alternativet utifrån situationen var att ta över ansvaret från patienten. Fyra teman identifierades som etiska överväganden, 1) det (o)problematiska tvången, 2) ordning och reda, 3) lojalitet med arbetslaget och 4) känslor av maktlöshet.

kunde handla om när patienter vägrade att ta medicin, gå upp på morgonen eller ta hand om sin personliga hygien.

Temat *ordning och reda* uppkom eftersom det fanns en stark betoning på regler och rutiner, speciellt i vuxenpsychiatrin. Det var viktigt att patienter och personal följde de regler och rutiner som fanns. Personal uppfattade en stark förväntan att upprätthålla dessa regler och rutiner, även om vissa ansåg att det fanns personal som var för rigida med regelverket. Förutom regler och rutiner tog personalen löpande beslut om förhållningssätt till patienter som begränsade patienternas autonomi. Det var troligt att patienter ibland kunde uppfatta dessa begränsningar som tvång.

Särskilt omvårdnadspersonal betonade vikten av *lojalitet med arbetsläget*. Loyalitet ansågs nödvändigt och positivt eftersom det var viktigt att patienter uppfattade att personalen var överens. Om en omvårdnadspersonal ansåg att ett beslutat förhållningssätt mot en enskild patient var felaktigt så följde personalen den utförares arbetsuppgiften ändå. De valde att följa besluten som togs i teamet, även om de i dagboken kritiserade beslutet. Däremot kunde personalen vara öppet kritiska mot beslut som togs av andra yrkesgrupper. Andra professionella beskrev hur de kunde ta konflikter med sina kollegor, omvårdnadsteamet eller andra professionella för att driva ett patientärende.


**Diskussion**

Några deltagare hade svårt att överhuvudtaget identifiera någon händelse som hade gett upphov till ett etiskt övervägande. Andra deltagare hade där emot en bred syn på vad ett etiskt övervägande kunde handla om, där även organisations- och samhällsfrågor ingick. Förutom problematiska situationer med patienter handlade många etiska överväganden om intressekonflikter med kollegor eller andra intressenter. Dessa konflikter var ett hot mot patientsäkerheten, eftersom personalen ibland valde att vara lojal med kollegor eller andra intressenter istället för att möta patientbehovet som de
hade identifierat. Resultatet i denna avhandling överensstämmer med annan forskning som visar på att vårdpersonal inom psykiatrin ofta inte uppmärksammar den etiska dimensionen i möten med patienter utan ser dem som kliniska problem.


Enhetschefer nämndes inte i dagböckerna som ett stöd i arbetet, varken när anställda var oroliga för patienter eller när de inte visste hur de skulle hantera informella beslut eller kränkningar mot patienter eller personal. Om psykiatrin ska utvecklas mot en vårdbaserad praktik, bör det finnas enhetschefer som är aktiva i vården och som kan föra fram de värderingar som deras psykiatriska organisation vill stå för. Det finns en brist på studier om enhetschefers roll inom psykiatrin och på vilket sätt de kan stödja personal och påverka den vård som ges.

Citat från dagböcker har använts i etisk reflektion på kliniker med personal och chefer. Dessa gav en bra start för reflektion eftersom citaten uppfattades som adekvata beskrivningar av verkligheten. Sådan reflektion gav en bra möjlighet för att diskutera alternativa sätt att agera. Denna typ av diskussioner kan initiera ett utvecklingsarbete för att finna nya strategier i mötet med patienter samt i förlängningen också åstadkomma organisatoriska förändringar.
Framtida forskning skulle kunna bidra till utvecklingsarbetet med att utveckla, implementera och utvärdera metoder för att hantera etiska överväganden och intressekonflikter i psykiatrin. Det normativa etiska språket behöver också utvecklas för att vara mer relevant i förhållande till det psykiatriska vardagsarbetet.
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