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EMPIRICAL STUDY

Care of the old—A matter of ethics, organization and relationships

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Abstract
The world stands on the threshold of a demographic revolution called global ageing. According to the World Health Organization (WHO), the population aged 60 and over is expected to increase from today's 650 million to an estimated 2 billion by 2050. Alongside demographic changes, dramatic changes can also be observed in older people's services. The shift has resulted in reduced government spending on caring for ill and frail older people in health care. Today, many governments have developed strategies to keep older people living well in their private home for as long as possible and have replaced long-term care institutions with residential homes. The aim of this study was to illuminate the meaning of caring for older people as experienced by health care students and professionals working in this field. Interviews were carried out with 17 women and one man, aged 21–65 years; six were Registered Nurses (RN), six were Enrolled Nurses (EN) and six were nursing students. The interviews were analyzed with a phenomenological hermeneutical approach and provided three themes and eight sub-themes: *Ethical moral self* with sub-themes "meeting the needs of the old", "pliability towards the old", and "difficulties in meeting aggressiveness"; *Organizational and co-workers ethical moral actions* with sub-themes, "co-workers who are offensive", and "supportive and non-supportive leaders": *The relation with the old persons and their relatives* with sub-themes "fellowship and closeness in the relation", "uncertainty and fear in the relation", and, "demands from the older persons' close relatives".

Key words: *Care of the old, phenomenological hermeneutics, ethics, organization, care relation, nurses, students*

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The world stands on the threshold of a demographic revolution called global ageing. According to WHO, the population aged 60 and over is expected to increase from today's 600 million to an estimated 2 billion by 2050 (WHO, 2012a). More than half of those aged 60 and over live in Asia, with Europe being the continent with the second largest number of older people (United Nations, 2010). In almost every country, the population aged 60 years and over is growing faster than any other age group, resulting in an increase in older peoples' care needs (WHO, 2012b), while there is a shortage at the same time of health care professionals with an undergraduate, graduate and postgraduate education in nursing (Cowin & Jacobsson 2003). In this light, with an insufficient increase in numbers of health care professionals and in health care resources, there is an urgent need for a well-educated health care work force committed to their profession and attracted to working with older people.

Alongside demographic changes, dramatic changes can also be observed in older people's services. The shift has resulted in reduced government spending on caring for ill and frail older people in health care. Today, many governments have developed strategies to keep older people living well in their private home for as long as possible and have replaced long-term care institutions with residential homes. These have similar access to services and the same skilled professionals and care workers as in traditional nursing homes (Rostgaard, 2002). Currently, with long-term care in hospitals no longer an option in many developed countries, older people with multi-faceted and complex care needs are discharged from hospitals to residential or private homes, placing an extraordinary burden on those

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who care for them (Fortin et al. 2004; Summer Meranius, 2010). Caregivers are currently facing more demanding tasks with recurrent caring situations that raise ethical issues, moral dilemmas and emotional stress, despite the growing awareness of patients' rights and a strengthening of regulatory systems (Commission of the European Communities, 2008). Emotional stress and conflict of interest occur when one's professional judgment is in conflict with organizational demands. Dwyer, Andershed, Nordenfeldt, and Ternestedt (2009) found when interviewing 21 employees at different nursing homes that they regarded their job as meaningful and were proud of their work. They exhibited, however, a moral ambivalence between the care they were able to provide and what they would like to provide. The gap between their ideals and reality resulted in frustrations which they described as a hinder to providing dignified care. Furthermore, mixed feelings towards work have also been noticed by Häggström, Mamhidir, and Kihlgren (2010). They found that caregivers experienced a committed relationship to older people living in nursing homes but felt guilty when organizational structures forced them to rush their daily care and did not allow enough time for each person. The caregivers expressed their love and affection in their everyday encounters, but also expressed a fear of doing something wrong even when acting in the older persons' best interests (Häggström et al. 2010).

While care for older people seems complex, with a relationship between the caregiver and the older person that could be vulnerable, health care professionals need to make well-considered decision in terms of what is best for the older person and his/her future needs. For caregivers balance all these demands successfully, key aspects are ethical discussions (Suhonen, Stolt, Virtanen & Leino-Kilpi, 2011), the ability to work independently and influence over decisions. Good organizational structures, based on a well-coordinated team with good co-workers and a fair and understanding manager, are important for maintaining good care (Josefsson, Åling & Östin, 2011). This underlines the important role of a well-educated work force with the right skills to carry out comprehensive decisions and treatments. Given the growing awareness of the importance of multiple perspective understanding of caring for older people, further research is needed in order to understand the complexity of providing care and to develop strategies for enhancing its quality.

The aim of this study was to illuminate the meaning of caring for older people as experienced by health care students and professionals working in this field.

Methods

In order to reach the meaning of caring for older people a qualitative approach and a lifeworld perspective emanating from health care students' and professionals' lived experiences were chosen (Dahlberg K, Dahlberg H & Nyström, 2008). Interview data has been analysed using a phenomenological hermeneutic method inspired by the French philosopher Paul Ricoeur (1976). The phenomenological hermeneutic method discloses the essential meaning in human beings' lived experiences through interpretation (Lindseth & Norberg, 2004). It is not the lived experience itself that is to be understood—but the meaning emerging in front of the text (Ricoeur, 1976). To disclose the meaning, narrative interviews are useful. When a narrative is written down it becomes an autonomous text expressing its own meaning and the text then needs further interpretation to disclose its essential meaning.

Participants and setting

This study is part of a larger study from two counties in Sweden and the quantitative data has been reported elsewhere (Engström & Fagerberg, 2011). In October–December 2009 two questionnaires concerning attitudes towards older people and towards working with them were distributed to different settings for the care of older people and to colleges and universities offering education in the health care sectors. An inquiry was included about participation in an interview study on experiences of caring for older persons. A reply form was provided for participants to indicate interest and supply contact information, to be returned in a separate box in order to preserve confidentiality of the respondents to the questionnaires. Nine-hundred and fifty persons responded to the questionnaires and 100 indicated their interest in participating in the interview study. Every fifth was selected and 20 were contacted for interviews. One person declined since she had a baby just before contact. Nineteen taped interviews were conducted between February and April 2010, but one interview could not be used in the analysis due to the narratives merely yielding poor descriptions.

The participants are 17 women and one man, aged 21–65 years; six were Registered Nurses (RN), six were Enrolled Nurses (EN) and six were nursing students. Among the six RNs at the time of the interviews, one was studying to specialize in the care of older people, one to specialize in the psychiatric care and one towards a Master's Degree in Health Care Sciences. The interviews were conducted at the participants' work place,

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at the first author's office or by telephone, in accordance with the participants' wishes.

Data analysis

The interviews were transcribed verbatim and analyzed with a phenomenological hermeneutic method (Lindseth & Norberg, 2004) inspired by the philosophy of Paul Ricoeur (1976). The interpretation of the text consists of a dialectic movement between understanding and explanation as well as between parts of and the whole. It is a movement between what the text says and what it talks about, including three phases: naïve reading, structural analysis and critical interpretation. The analysis commenced with reading all interviews several times in order to formulate a first naïve understanding of the phenomenon. Thereafter, the text was divided into meaning units which were condensed and abstracted into subthemes and themes, a structural analysis. Examples of the structural analyses are provided in Tables I and II. Finally, the authors' understanding, the naive reading, structural analyses were brought together and reflected upon into a comprehensive understanding.

Ethical considerations

All participants were informed about the aim of the study, procedure for data collection and dissemination of findings, and that it was voluntary to participate and possible to terminate participation on any occasion without stating reason. The study was approved by the respective regional ethics committees (2009/229, 2009/1484-31/5) and carried out as described above. In the findings presented, all caregivers are referred to as "carers" irrespective of their status as students or professionals, in order to preserve their confidentiality.

Findings

The naive understanding of caring for the old is a deeper feeling of helping someone who needs help. The carers have an ethical foundation in their care of the old which provides great joy in being able to identify and meet each person's individual needs. There is a strong sense of community with the old and preserving their value as human beings. Confirmation by the old is joyful since they are vulnerable and exposed. It is difficult to care for the old if an ethical foundation for caring is absent amongst co-workers, managers, leaders, and in the organization itself. This is also apparent when the carers cannot meet the needs of the old due to their own fears or feelings of helplessness. The carers are exposed when providing care to the dying, exposed to the relatives, co-workers or to their own demands and expectations which they fail to fulfil. The caring situations can be so difficult that they want others to make care decisions for them.

The structural analyses provided three themes and eight sub-themes: *Ethical moral self* with sub-themes "meeting the needs of the old", "pliability towards the old", and "difficulties in meeting aggressiveness"; *Organizational and co-workers ethical moral actions* with sub-themes, "co-workers who are offensive", and "supportive and non-supportive leaders"; *The relation with the old persons and their relatives* with sub-themes "fellowship and closeness in the relation", "uncertainty and fear in the relation", and, "demands from the older persons' close relatives".

Ethical moral self

The carers narrated situations in which their own moral thinking had guided them in their caring. They took great pains to meet the need of the old persons no matter how things turned out, and were confirmed by the old person in hindsight that this had been good for them, even if it had meant that the carers were obliged to oppose their wishes. For the carers this implied that they had interpreted the situation correctly. The moral thinking meant emerging from medical and caring knowledge in order to regard the old person in need of care and to act accordingly.

> An old lady aged almost 90 was acutely admitted to us. She did not feel well at all, wanted to have her blood pressure checked and said she felt as though shadows were falling over her. We sat and talked for quite some time and I took my time with her. She said that I was the first person she had

Table I. Themes and sub-themes.

Ethical moral self	Organizational and co-workers' ethical moral actions	The relation with the old persons and their relatives
Meeting the needs of the old	Co-workers who are offensive	Fellowship and closeness in the relation
Pliability towards the old	Supportive and non-supportive leaders	Uncertainty and fear in the relation
Difficulties in meeting aggressiveness		Demands from the old persons' close relatives

Table II. Example of theme and sub-themes.

Ethical moral self		
	Condensation	Sub-theme
An old lady aged almost 90 was acutely admitted to us. She did not feel well at all, wanted to have her blood pressure checked and said she felt as though shadows were falling over her. We sat and talked for quite some time and I took my time with her. She said that I was the first person she had met that looked into her eyes. She was present in our meeting and was pleased with that. This was most important for her, as I later understood, and it turned out that she had to be admitted to hospital with a suspected TIA (11).	Old lady with physical problems was received by a carer who took time to be present with her and it was appreciated by the lady.	Meeting the needs of the old
I used to help an old lady with everything when she is going to bed and we have a good contact. She was going to a party once and she wanted me to help her choose which clothes to wear, she knows I fancy clothes and colours and the lot. And she confided in me: Can you please remove the hair on my chin so I will look nice in the evening? (9)	When caring for the old, a good contact increases confidence and the possibilities of meeting other needs important to the old person.	

> met that looked into her eyes. She was present in our meeting and she was pleased with that. This was most important for her, as I later understood, and it turned out that she had to be admitted to hospital with a suspected she had TIA (11).

Pliability towards the old implied respecting them as individuals with different personalities and as ageing persons with diminished strengths and pace. By being pliable towards the old person's pace or individuality the carers acted ethically and morally. They acknowledged the importance of taking time with the old person in order to find out what would be best for individual needs, while at the same time using their professional knowledge to provide the most suitable care for the person. Being a carer in this setting implies working for some time with the old and appreciating their gradually declining health. This is accepted as a natural part of ageing, but when an old person is acutely ill the question arises of whether it is something that can (and ought to) be taken care of or just a step in the normal process of dying. For the carers this meant that a decision on appropriate action has to be based on both professional knowledge and ethical moral thinking. Confirmation and joy were given for a correct decision and care provision when the old person recovered and told the carers. For carers this meant relief for having chosen the right actions.

> When I started the day shift at 7.30 AM. he was very ill, and I realized that he had to go to hospital—and I felt that he trusted me, because when I entered his room he relaxed and he understood what was happening. It was an emergency situation and I took a lot of blood tests, and before I decided to send him to hospital I thought about what would be best for him. He was rather tense and worried before I came then he relaxed and it felt good, both for him and me, and helped him to co-operate. When you do not know whether you are going to survive or not, it is good not to be overwhelmed with death anxiety, but to have trust and to be cared for. And his symptoms could be dealt with and when he returned from hospital both he and his wife were grateful (3).

The ethical moral self is challenged when caring for very ill old persons in the elder care setting, also involving experiences of meeting and caring for aggressive old persons. For the carers this means feeling powerless if they are unable to reach the person or to handle the situation. An old person can suddenly show another side due to side effects of drugs, symptoms of abstinence or a stage of delirium. For the carers this means that their ethical moral self is challenged by their own safety but by also the risk of harming to the old person when coercive measures have to be taken. These are situations for which many are not prepared, not having experienced such situations before and not having these issues raised during their training.

> This old lady was very aggressive and she took it out on me. She hit me and she—pulled my clothes and—I tried to calm her down as well as I could—she was so angry and so sad and she took it out on

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> me physically—I was afraid that I would be hurt, be physically wounded in some way—and I was so frustrated that I could not help her (8).

Carers had difficulties in managing situations which challenged their ethical moral thinking and needed someone to discuss their experiences with. It was particularly hard when their own moral thinking did not coincide with how they perceived the organization, or if their managers, leaders and co-workers did not act in an ethical moral way.

Organizational and co-workers ethical moral actions

Support from managers, leaders and co-workers is important when strong reactions occur or when difficulties arise in caring for the old. This means carers have someone listening to them and trying to help them to understand what has happened. Co-workers, managers and leaders can confirm them in their care despite the carers themselves thinking that they have done something wrong. The relationship with co-workers is challenged when carers find that their co-workers offend the old persons. This is frustrating for the carers and trying to defend the old persons could mean a rebuke from their co-workers. If carers try to meet the perceived needs of the old persons, this can also mean problems in their relations with co-workers.

> When I entered her room I found that it would be good for her to take a shower so I helped her to take off her clothes and took care of her. Then one of my co-workers came asking for me, wondering where on earth I had gone. I explained the situation for her and she hissed at me, saying "Well you know, you have to draw the line otherwise you spoil them so they think they can have a shower every other day!" (5).

For carers this meant that welfare for the old person took precedence over their co-workers' reactions and lack of understanding for the choices made.

Carers were content when they found that their managers and leaders supported them in situations where they for various reasons had difficulties caring for the old. They could then carry on and be satisfied with their care provision even though the situation itself had been difficult and unpleasant, something that could occur when caring for old with dementia. The carers lacked knowledge about dementia and that it is difficult to communicate with and understand persons who do not have their cognitive functions. This also meant frustration and the carers realized that the old persons are also frustrated when they do not understand what is going to happen or why their carers do not understand them. The old persons could then react aggressively and they could also violate the integrity of the carers as an outcome of their symptoms.

> We had this old man who had some kind of frontal lobe dementia and he was ever so unpleasant. He was sexually obsessed and I was to help him taking a shower. He was poking on my body everywhere and I got so terribly angry ... I mean when a man I do not know starts poking on my body, on my breasts, poking between my legs. This is something I cannot accept ... well I tried to protect myself. I knew that our manager had said "I support you whatever happens even if you lose your temper" and I do not know if that actually happened. (2).

Organization flaws where the fiscal thinking is influencing the carers and the care they provide. They are forced to hurry through their required duties, care plans are run to routines and there is no room for meeting the old as the unique persons they are, with specific individual needs emerging from ethical, moral actions. Instead, old independent persons are placed storage, living a humdrum life defined by routines. For the carers this meant a stressful work situation at mealtimes or bedtime, when there are many old persons needing attention and help at the same time, with a limited number of staff is limited available.

> And in my ward we barely have the time to fetch the all residents from their rooms after getting them all up during the morning shift—and at the same time the others from the other ward are serving lunch so there is no time to catch your breath before lunch starts (6).

The stressful situation meant that a heavy work load and carers reflect on whether there is ethical moral thinking within the organization and by their managers and leaders.

The relation with the old persons and their relatives

In caring there is a relation with the old person, meaning that a community is reached and that the old persons are regarded as the unique individuals they are. This community turns into a communion when the carers and the old person together can undertake something beyond the routines in care. Taking a trip out, meeting as two people and not as a carer and an old person, means a challenge and a new understanding of the old for the carers. An outing to an earlier home for a picnic, or a walk in well-known areas allows a totally new side of the old

person to emerge. The carers are then helped in identifying the culture of the old person and the specific cultural manifestations inherent in this. This knowledge and understanding of an earlier life can include the old person being given the possibility to listen to music from the home country, the carer and the old person dancing together or arranging a party for former neighbours and friends.

> We took our time and went for a walk. It was a beautiful day and we just strolled along talking. She was very talkative and I think she found it pleasant having company ... and I think she just wanted to get away from the assisted living and make something of the day—and it was quite close to the city centre. We talked about everything under the sun and when we reached the centre she had a minor errand to run (14).

This knowledge of the old person gives satisfaction and closeness in the care, but the relation with the old person also demands something that can be difficult for the carers to fulfil. When an old person is moved to a different assisted living facility or back to the private home, and the carer is no longer responsible for the care, it can be difficult to break off the existing relation. The old person demands that the carer come for a visit, drawing a fine line between what the carer can (and wants to) do in private when the professional responsibility is completed. An ethical moral dilemma occurs for the carer. Community and communion in the caring relation provide the conditions for a person-centred care but are also demanding. Situations can occur involving both fear and uncertainty for the carers, where their own ethical and moral thinking makes them continue the care while they would rather escape. The carers cannot betray the old person although they are unsure and fearful for what might happen.

> We were always two carers with her ... and when you came to her apartment you went into her bedroom, took her to the kitchen and prepared some food and sat down to feed her. And when you fetched her from the bedroom she did not want to walk, she stopped and started pinching you in the hands, she did not have a wheel chair so you held her hands and she went blazing mad and screamed and pinched my face and I was afraid. This is not something I am used to in my daily life so to speak ... and it could just as easily happen if we were out for a walk with her. Then you just cannot run away and leave her right there on the street, she cannot stand on her feet by herself you know (10).

The close relatives of the old person can be demanding and this is strenuous for the carers. They do whatever they can but can face severe criticism, frustration and aggressiveness from the close relatives. Despite the carers intellectually understanding the reactions of close relatives, it is trying and turns particularly difficult if the close relatives are threatening the carers.

> When she turned up it was a terrible shock for her, she wanted desperately to be present when her father passed away and her frustration in her shock made her take it out on me and she yes she—I have never gone through something like that before in my life. She, she turned quite mad and screamed ... verbally very difficult words to me and she also threatened me. Threats like she would make sure I lost my job, so that I would not be able to carry on with my work anymore (3).

The close relatives can also show appreciation for care given and support the carers when the old persons are aggressive or accuse them of theft or neglect. Meetings with the close relatives can at times be difficult and carers wish someone else could make the decisions for them and explain to the relatives why certain measures are to be taken. Situations that require a great deal of the carers' ethical and moral thinking are when demands from the close relatives are supported by managers, leaders and physicians, and the carers have to provide a care contradictory to their own view of what is right. They are left alone in their fight for the rights and welfare of the old.

> The sons of this old lady talked with the nurses, our managers and the physician and demanded that we should not give her any more food. I think they were so tired of visiting her and they just wanted to get on with their own lives without obligations towards their mother. And we had meetings and our physician, our managers and nurses said "Now we stop giving her food, it is in the best interest for her" and I was outraged. I declared my view, "this is murder, she can live for many more years and she at least has the right to have food" but no way did they change their mind. And as we cared for her, I will never as long as I live forget her eyes. The way she looked at us, she just could not understand why she could not have something to eat. And she lived for 30 days before she finally died—it was just terrible (18).

The relation with the old person and their close relatives, and the ethical and moral strain this implies, means that also the organization, managers,

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leaders and co-workers have an impact on the ethical and moral feeling of the carers.

Comprehensive understanding and reflections

The ethical moral self of the carers can be understood as their moral autonomy to make a free moral choice among values they found to be just and right (Rendtorff & Kemp, 2000). To carry an autonomous morale implies making a personal decision and having a sincere choice. This means that the carers had relied on their personal moral thinking when caring for the old in different situations. Nordenfeldt (2009) suggests that a central aspect of the care of older people is respect for the individuals' right to decide for themselves. This is what the carers tried to do meeting the individual's needs and wishes. In doing so, the carers were attentive to the needs and wishes of the old persons, they took responsibility for caring for them and meeting their needs, they used their competence and they received a response from the old persons on the care provided. This is in line with the four elements of an ethic of care described by Tronto (1993); attentiveness, responsibility, competence, and responsiveness. Being attentive to the needs of others also implies having knowledge of what to look for, what needs to be cared so they can be addressed and taking responsibility. This attentiveness meant that the carers were pliable towards the old persons and their needs in their vulnerable and deteriorating condition. The joy of confirmation from the old persons that the decisions and care were right meant that the carers received responsiveness in line with an ethic of care. This can also be understood as the carers holding the competence they needed to provide the care that they themselves, the old persons and their relatives considered necessary.

However, a serious form of not being attentive is unwillingness to direct attention to others' particular concerns (Tronto, 1993). This is understood as uncaring (*cf*. Halldorsdottir, 1996) and such an uncaring attitude was difficult for carers when observed amongst their co-workers. This can be understood as moral distress when the carers could not reach the old person or when they were subjected to aggressiveness and violent actions from the old person (*cf*. Jameton, 1984). Not being able to care for or reach out to an old person, and being subjected to violence when trying to be attentive to needs, meant that the ethical moral self was threatened. In some instances the carers were frightened for their own personal safety. To handle such experiences the carers need managers, leaders and co-workers with whom they can discuss what has actually taken place, their concerns and worries as well as their own moral, ethical dilemmas. This was particularly difficult if the carer did not have anyone to discuss their moral thinking with, or when they found that the organization, co-workers or managers did not work from an ethical, moral view. Ulrich, Hamric, and Grady (2011) suggest that giving voice and recognition to moral distress is a first step towards changing the atmosphere in a work place where there are divergent interests and where carers find that their ways of thinking or acting are not well received. Lützén, Cronqvist, Magnusson, and Andersson (2003) suggest that moral stress can be understood as carers being aware of ethical principles at stake in specific situations but external factors preventing them from making a decision that would reduce the conflict. Therefore, the climate in organizations where the carers work, what subjects are permitted to be discussed and how the managers, leaders and co-workers acknowledge each other—the inherent problems in care giving to old, vulnerable persons—are most important for the carers' moral stress and distress (*cf*. Jameton, 1984; Lützén, Blom, Ewalds-Kvist & Winch, 2010; Severinsson & Hummelvoll, 2001). Being a whistle-blower and not being listened to, as in the case of the carer who protested against not providing an old lady with any more food and leaving her to die, is a tremendous undertaking when finding oneself alone in opposition to the organization, leaders, co-workers and family of the old person. Courage involves being able to stand up for what is valued as right, balancing this with being foolhardy in order to ascertain when it is right to whistle-blow (Silfverberg, 2005). It takes courage (Day 2007; LaSala & Bjarnasson, 2010; Lindh, Barbosa da Silva, Berg & Severinsson, 2010) to protest and to conquer the prevailing viewpoint. Lindh et al. (2010) suggests that two conditions must be fulfilled in order to describe courage as a moral virtue; "(1) the moral agent's experience and recognition of others' suffering; and (2) the moral agent's possession and feeling of compassion or sympathy towards those who are in need of help" (pp 561–562). This is what the carer did, but it had no effect on the decision-making, leaving her with feelings of anger, frustration and disappointment at having to provide the care she did not want to. Facing the anguish in the eyes of the old lady and not being able to respond to her needs and wishes is strenuous, and experiences such as this may spark thoughts of leaving the profession and workplace. Gustafsson, Norberg, and Strandberg (2008) found that the meaning of being and becoming burned-out for health care staff was being unable to unite one's ideal picture with reality and experiencing an overwhelming feebleness.

However, when the carers found that they had managers and leaders who listened to them, when they could discuss and talk with their co-workers about situations they found difficult, they were satisfied to go on with their work even though it meant violating their own ethical, moral self and not meeting the needs of the old. This underlines the importance for an organization of valuing the ethical and moral implications in the work of carers and putting this forward in organizational directives (LaSala & Bjarnasson, 2010); also that leaders and managers in the work place regard and support caring as the main goal for their staff (*cf* Bondas, 2003, 2006). Thus, what is needed is a radical development in health care organizations where the fiscal aspects, such as keeping to the budget and cutting costs, do not imply that the number of staff and beds is reduced without taking into consideration the needs of the population. Consistent with global trends, we have an increase in the older population and increasing levels of both morbidity and multimorbidity (Hunter & Levett-Jones, 2010; Summer Meranius, 2010). Tuckett et al. (2009) suggest that good caring is manifested when it is central for the organization, but that restrictive factors like cutting staff numbers will impede caring. Therefore, development in the organizations responsible for care of old people in Sweden is of utmost importance, particularly since managers and leaders are generally not Registered Nurses and do not know or understand the problems involved in caring (Josefsson & Hansson, 2011; Gustafsson, Asp & Fagerberg, 2009). In order to meet the needs of older people in the future this study point at the importance of developing organizations in the care of the old. These organizations need to value the ethical and moral implications in the work of carers but also to promote an ethical leadership. When a leader works from an ethical, morale standpoint, the care of the old is the loadstar.

Methodological considerations

The results in this study are based on a limited number of interviews, something that needs to be taken into consideration when transforming the results to other settings and cultures. In all, 100 persons indicated interest in participating in an interview but only every fifth person was drawn and offered participation. This can be considered a strength and a weakness; a strength in that so many were interested, indicating the importance of the subject. On the other hand, in order to have a manageable number of interviews with acceptable depth and quality for analysis, we had to limit participation. Thus, every fifth person was drawn and accepted. It turned out that the participants had different educational levels and experiences and the interviews yielded rich and varying narratives of the phenomenon. Still, a question to be asked is whether it was those with the most positive views of care of the old that indicated their interest and accordingly were selected. We do not know why a large majority did not want to participate, whether it was due to negative experiences of care of the old, not wanting to spend time being interviewed or whether there were other reasons.

Analysing rich data is a delicate matter and the authors have been careful to acknowledge that the understanding reached is only one of several possible (*cf.* Ricoeur, 1976). The analyses have at different stages been subjected to critical examination during seminars and in discussions with experienced colleagues in research and in the care of the old. Therefore, the understanding presented here is the most useful understanding for the authors.

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