"A Summoning Stone in the Shoe": staff's perception of abuse in health care a qualitative study

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TITLE: "A Summoning Stone in the Shoe": staff's perception of abuse in health care a qualitative study

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ABSTRACT

Objective: The study aim was to apprehend changes in the attitude of health care staff to abuse in health care (AHC) after an intervention, based on 'Forum Play'.

Design: In a baseline study, we interviewed 21 staff members who were eligible for participating in the intervention. In this study we interviewed 10 staff members who had participated in the intervention. The interviews were analysed by constant comparative analysis.

Setting: A Swedish Women's Clinic.

Participants: Two female and one male gynaecologist, one female administrator, four female midwives and two female auxiliaries.

Intervention: During January 2008 - January 2009, all staff members (N=136) were invited to participate in Forum Play workshops led by professional Forum Play leaders. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held.

Primary outcome measures: Staffs attitudes towards AHC.

Results: The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'.

The most important result was the informants' reports that Forum Play had demonstrated possibilities to act even in seemingly "impossible" situations, that they had acted in such situations, and that the taboo status of AHC was broken at the clinic.

When our results were compared to those in the pre-intervention study, we found an *increased* awareness about AHC, *more* concrete examples of AHC, a *stronger* empathy for patients, and *fewer* explanations, justifications and trivialisations of AHC.

Conclusion: After an intervention with Forum Play workshops, staff showed a greater willingness not only to acknowledge AHC, but also to take on the responsibility to act in

order to stop or prevent AHC. The imperative to act against abuse in health care in the present study stands out as the most important result of the intervention.

INTRODUCTION

Criticism of health care work is a sensitive issue. Medical errors have to be investigated but what if there was no medical error, but the patient was still dissatisfied or even hurt?

In previous research based on The NorVold Abuse Questionnaire [1-5], we showed that abuse in health care (AHC, defined in Table 1) is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [3, 6-8] The prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent, while the prevalence in other Nordic male patient and population samples is unknown. [9]

When we asked patients in qualitative interviews what AHC meant to them, both female and male patients expressed feelings of being disempowered and devalued. The core category in the female sample was a feeling of being "nullified" and in the male sample "mentally pinioned". [10, 11] However, when staff was asked the same question (in the pre intervention study), the answers were quite different. They explained theoretically what AHC could be, e.g. transgression of ethical principles, but they were also occupied with explanations and justifications as to why AHC occurred, and the core category was "ethical lapses". In accordance with their ambiguity and inability to handle AHC, it was treated with silence and as a taboo. [12] Moreover, staff's awareness of AHC was dependent on their possibilities to act; no possibility to act no awareness. [13]

For this study we returned to the pre-intervention informants (staff) with the same research question, "What is AHC?" after an intervention against AHC based on Forum Play. Our aim was to evaluate the intervention by means of a design allowing the findings from pre intervention to be compared to those from post intervention qualitative interviews.

METHODS

Intervention

Augusto Boal, a Brazilian theatre director and pedagogue, developed many different theatre techniques to liberate people, and Theatre of the Oppressed (TO) is a characterising name used for all his techniques. Influenced by Paulo Freire's *Pedagogy of the Oppressed*, TO became a grassroots movement from the nineteen sixties and on, offering techniques based on empowerment to equip people to transform the conditions in which they were living. [14, 15] Although TO is used worldwide to promote change evaluations of mechanisms and success rates are scares. [16]

The essence of Forum Play is to create a safe place in a group session, to make the moral conflict clear, to allow feelings but focus on action, and to practice and evaluate new alternatives to act. Discovering and acting out many different solutions to a situation that at first seemed impossible to solve, instils hope in Forum Players. In this intervention, Forum Players are assumed to gradually feel brave enough to transfer their experiences into real life, and try out alternative ways at their work-place to handle or prevent AHC.

During the period January 2008 - January 2009, all staff members at the study clinic (N=136) were invited to participate in Forum Play workshops led by professional Forum Play leaders. [17, 18] All workshops were announced at the local hospital Intranet where staff could also register. Participation was voluntary and there was no limit to the number of workshops a staff member could participate in. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held (74/136=54%).

During the workshops, staff re-enacted (role-played) situations that they had experienced or heard of when patients had felt abused in health care. The situation typically included a bystander who was not intervening but felt that he or she ought to do something, but did not

act, as the situation seemed to be without possible "solutions". The scene was repeated until it was clear to everyone what the moral conflict was, and who was suffering the moral conflict. [15] Then the scene was played again and the audience was encouraged to intervene. They could enter the scene and try to change the outcome by taking on the role of the person who suffered the moral conflict.

One example: during a routine pelvic examination the patient says, "please stop, it hurts," and the gynaecologist answers, "I am nearly done". The gynaecologist continues although the patient is crying loudly. A midwife holds the patient's hand but does not say anything. In this situation, one possible intervention for a bystander, in this case the midwife, could be to reinforce the voice of the patient by asking her, "I see that you are crying - would you like us to stop this examination now?"

Material and procedure

In a baseline study, we interviewed 21 staff members who were eligible for participating in the Forum Play intervention, and who represented four different staff categories. [12, 13] Eligible for the present study were those 14 informants from the original sample who had participated in the intervention (three staff members had left the clinic, and four had not participated in the intervention). Four declined participation (one gynaecologist and three auxiliaries). All interviews were booked by a coordinator employed at the clinic.

The two authors interviewed ten informants: two female and one male gynaecologist, one female administrator, four female midwives and two female auxiliaries.

The analysis presented in this study is based on answers to open-ended questions that were similar to those in the pre-intervention study. The main question used for comparing pre/post results was: "When I say abuse in health care, what is the first thing that comes to your

mind?" Interviews lasted on average 60 minutes. All interviews were tape-recorded and transcribed verbatim by a secretary.

Written informed consent was obtained from all participants before the interview. Our request to conduct the study had been approved by the regional ethical review board (Registration number 194-06).

Analysis

We choose a qualitative approach to collect and analyse data according to Barney Glaser but were also inspired by later work of Janice Morse and Kathy Chamaz. [19-22] Constant comparative analysis was used to process data [20]. The transcribed interviews were analysed line by line according to Glaser's scheme of open coding to generate substantive codes, i.e., words or sentences with a relationship to the research question. [19, 20] The substantive codes were constantly compared between interviews to generate new substantive codes and categories. Finally, the relationship between the categories was analysed and a core category that answered our research question was identified. [19] No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation. All categories are described in the result section and presented in Table 2. The interaction between the categories are described under the headline "core category" in the result section

RESULTS

Dehumanising the patient

This category was built on three substantive codes:

1. *"Not finding out where the patient is"*

According to the informants, AHC could signify several things:

Not to imagine what the patient is going through:

*"You have to **imagine**, and **understand** the things you **say**; what **are** the consequences…what do you **do** and what will be the consequences. How will it be in **this** situation? For sometimes an act can **be** rather innocent, and in some situations, [certain] behaviour can be completely **catastrophic**."*

To belittle a patient's problem by comparing with other patient's problems:

"Yes, to listen to what the other is talking about…to be focused on the one in front of you. Yes, seriously, even [when you] think that's a silly little thing compared to the death [a dying person]…in the next room."

To be judgmental:

"If someone is admitted, there are not so many of them here but, gipsies…Have you locked away your handbag? Where is my purse? They are judged awfully hard."

Lack of cultural awareness:

Expecting that patients with a foreign background live by and accept Swedish norms like in the following example might also render in AHC, according to one informant who had had to console a crying patient after an examination.

*"When she came it was a shock for her [that it was a male gynaecologist] and she told them that…she was going to see a female [gynaecologist] and then they had answered her that well but you can't always get…what you ask for…if you seek help at such short notice then you have to take what you can get. Everything was supposed to be quick and she just felt that she was just…**trouble** for them... And she was…so sad afterwards."*

2. *"Saying things that are very abusive"*

According to the informants, AHC can be something you say or the way you say it; a few words may turn a situation into a disaster for a patient.

One example: a patient with cancer was constantly throwing up. Staff had provided her with bags and bowls but nothing helped, repeatedly there was vomit everywhere: on the bedside table, in the bed and all over her things. Staff thought that she was capable of using the bags and bowls, and discussed between them if she did it on purpose. There were sighs among the staff, sometimes even audible to the patient, according to the informant. One day, a staff member asked the patient if she was going to continue like this when she would go home.

Another informant remembered her own first delivery: the baby's heart sounds were getting worse, the suction cup did not work, she had intravenous fluids running in both arms, and she was screaming in pain. Then the doctor came up to her and said, "Are we going to cooperate for hell's sake!" Afterwards she felt abused and despite her longing for another child it took years before she decided to have a second baby.

Informants said that they used to think that AHC had to be a major thing, but that they now realised that AHC was often an unexpectedly small thing, and that a good situation could turn

into a disaster because of a small thing. As mentioned above, the sex of the examiner might sometimes be crucial for the patient for religious or other reasons, while some staff members may consider it a small thing.

3. *"They must have felt very vulnerable"*

An informant told us about a patient that she had known for a long time whom she thought of as extremely nervous and inadequate. The patient had told her that she was afraid of hospitals. Later she also told her that she had been forced to go through a gynaecological examination when she was a child, on suspicion that she had been sexually abused by or involved with an older boy.

*"… she [the mother] only said, 'now we are going to **town**'. And then they brought her to the gynaecological ward and then they **fixated her tightly** and she was examined. And she **screamed** and she **kicked** and she was **struggling** with them. And she said that she can't forget this …it is stuck with her that…that they pushed her down and **forced** her, and so on. So I think that's a typical example of abuse in the health care and for **ten** years I've been wondering what's wrong with this girl."*

Power and power imbalance in relation to AHC was mentioned in several ways, e.g., the exposed position a woman has during a gynaecological examination or the patients' dependency on staff's willingness to help and to be gentle to them: *"You are not your own master then."*

One informant was also pondering about her ability to really understand what it meant to be dependent and exposed as a patient:

"…I still think that I can feel…that you can imagine…the dependency…get an understanding about how it is…I can never understand, but I can feel humble…I can share it…I can have respect and understand that she has something else with her that I haven't got."

AHC could also mean that advantage is taken of the power inherent of one's position, symbolised by, e.g., the uniforms: *"…when you put on your work clothes, then you have a kind of…how to say it, a power position."*

Unacceptable: you are bound to act!

The informants were prone to positioning themselves against AHC by, e.g., talking about how they had (re)acted against AHC, and that it could be done in a good way, *"…but then I think you have an obligation… to rebuke. In a loving way."* They also emphasised that the bystander had a very important role in noticing and stopping or preventing AHC, *"because sometimes I think that it is the person who stands by…maybe more often senses when something goes wrong than the person who is [active] in the situation".*

There were different strategies for intervening against potentially abusive situations:

One informant was concerned about open doors and meant that staff leaving doors open jeopardised a patient's integrity. She was struggling with this problem:

"…it is an indication that you probably can't miss [with laughter in her voice]. No, but sometimes when you have been sitting in the auxiliaries' expedition, there is just a sliding door…there are patients sitting right outside and then I close the door…or when you…hear…that they…are in a room talking and so on. Close the doors…and I close that door [the sliding door] and then it's open again! And I close it."

Practical arrangements for preventing AHC were discussed:

*"…there are more discussions about this [now]. **About**…for example, open the door into a room where a patient is and…how to **place** patients in a room, and how many really have to come into a room. So, these kinds of questions."*

It was also put forward that small talks over a cup of coffee could raise awareness about AHC among staff, but to talk to the patient, either before or after AHC had occurred, was seldom mentioned as an intervention. One informant interpreted this particular kind of silence as fear: *"It must be some kind of …fear to…realise that you are not perfect. Maybe!...Of course if you ask then you have to be prepared…to do something about what the patient might bring up."*

In other words, asking a patient about AHC might force staff to take action, e.g., towards a colleague. Some informants stressed the importance of being earnest in such situations and talk directly to the staff involved as soon as possible. This was what the informant did who told us about the patient who expected to be examined by a female gynaecologist. When she had comforted the patient she asked her if she could talk to the staff member who had examined her, and if the patient wanted to participate in such a meeting. The patient declined t *"…I was allowed to tell…how she had experienced it…I was so disturbed by what she told me. So I felt that I had to find out if that was how it had happened. But he had not really experienced it that way..."*

Furthermore, there was a possibility to report upwards in the hierarchy: *"**I** would not hesitate to…contact…[silence] a foreman, my bosses [if a patient was abused]."* And there was a consensus on having an open climate at the clinic, and that it was important to be made aware when a patient was abused. Speaking up against AHC was considered an option for most informants:

"That you say,' you can't behave like that'. So I believe that…people would tell you…I believe that there are few who would not dare to speak up…I believe they would speak to a colleague."

Ubiquitous

AHC was often described in a broad sense as something that can happen to anyone at any age: patients, staff, relatives and friends to the patient. Anybody can become a victim or an agent (actor or bystander) of AHC: *"…we are abusing each other…all the way down to the patient…"*

AHC was also interpreted as staff being abusive against other staff, for instance by making remarks in a harsh way. It was also pointed out that a patient who had witnessed staff treating each other badly might feel hesitant to ask even important questions for their own sake.

One abusive situation between members of staff described as common was when a midwife called for a doctor and that doctor called for another doctor, and the two of them did not involve the midwife when they discussed the patient.

It was also hypothesised that staff experiencing abuse from other staff might subconsciously take it out on someone else: *"…if I am abused then I will look for someone…that…I have power over."* And that someone is likely to be a patient: *"…it is easier to abuse when there is some kind of power relation… and when there is a kind of malady between us."*

However, patients abused by staff were considered the most serious kind of AHC: *"…the most serious is if we, the staff…abuse patients or relatives. That is another situation I believe."*

Informants also agreed that patients were the most common victims of AHC, and that if patients abused staff it should be understood differently: *"Because there might be…patients who abuse staff in many ways, so to say. But on the other hand, they are in another position…worry can turn you…rather nasty, really."*

Unintentional

AHC was believed to be a common experience among patients. Most informants said that AHC was usually unintentional on behalf of the staff, and that often involved staff was not even aware that it had happened. *"…they are not aware, surely. But then I have to…become aware of how people might experience what I do."*

A variety of explanations of the occurrence of AHC were brought forward, and it was pointed out several times that AHC did not come from evilness in staff members, but rather from a lack of consideration and empathy.

Not being reflective could result in a routine manner or performance. One example given was that of an authority, like the gynaecologist who was often believed to be under time restraints, who simply follows an old habit: focusing on getting things done instead of on the patient.

"…it's so easy to follow… the same footsteps all the time…"

Another example of unintentional AHC was when staff members made jokes between themselves about, e.g., someone being fat, and other staff members were laughing without reflecting on what they were laughing at, or if they ought to put an end to it.

It was also brought forward that unawareness of AHC could be due to inadequate communication skills, e.g., if staff was not sensible enough to read the patient's body language.

The uniqueness in each and everyone's characters was appreciated, but sometimes, if a colleague was known to be harsh without meaning it or even noticing it her- or himself, there was a moral conflict. A bystanding staff member would in such a situation understand that the patient might feel abused, and at the same time know that the "harsh" staff member did not mean to abuse the patient. This was considered a difficult situation, but as one informant concluded,

"…it's about personality, too, so it's really difficult to know how to tackle it. It's interesting that people are different, but on the other hand you don't want those differences to befall the patients so that they feel abused, or maltreated."

Relative

The informants were provoked by the word "abuse" in AHC, and prone to take a defending position against it. They thought of "abuse" (kränkning in Swedish) as a very strong word, that was sometimes used too often and in an inappropriate way. The informants thought that, especially in the rest of the society (outside the hospital), the word "abuse" had suffered inflation. *"I think that 'abuse' may be a tough word…It's a worn out word or a word that is used incorrectly..."*

Informants agreed that AHC was a difficult concept to define. On the one hand, AHC was considered a strong word, and yet AHC could be a small thing. *"…there is no such…scientific quantitative concept [saying] that this is abuse."*

The wording seemed important to the informants and a more neutral word for AHC was desired by the informants, e.g., (negative) encounters (bemötande in Swedish).

AHC was considered a personal experience, and it was expressed that patients were more or less vulnerable to this experience. It was also brought forward that there were reasonable experiences that made some patients more vulnerable to AHC than others, e.g., through a history of abuse.

Core category

The three categories 'Dehumanising the patient ', 'unacceptable: you are bound to act!' and 'ubiquitous' are strongly linked to each other in many ways, not the least because of their potentially patient protective components. The category 'Dehumanising the patient' implies

not being seen as a human being, stripped of human value. The codes that filled out this category were characterised by moral imagination and respect for the patient's situation. The informants showed great insight into patients' vulnerability and their own responsibility in relation to AHC. The fact that the informants gave several detailed examples of AHC underlined their emotional engagement. This engagement was a strong reason for staff to adopt a clear position against AHC, expressed in the category 'unacceptable: you are bound to act!' It was also made clear that acting against AHC was beneficial not only for the patient but also for staff: *"…that's what we really ought to do [talk to each other when we think a patient might feel abused]…we take responsibility for each other that way."*

The open attitude among staff toward AHC, represented in the category 'ubiquitous', indicated that the informants were now more prone to recognise AHC. This openness could be seen as a mediator that enabled staff to talk about AHC, which probably contributed to a milieu where staff felt some pressure to also act against AHC. However, there were contradictions in the staff's definitions of AHC. To claim that AHC was 'unintentional' was a way to describe a fact, and at the same time make AHC trivial. Likewise, the discussion that rendered a 'relative' definition of AHC could be seen as a diversion from a topic that provoked awkward feelings. Both of these categories could be used to legitimize AHC. Despite this "resistance", the overall conclusion is that AHC summons responsibility and urges an itch to act among staff. From having been considered a matter of mishaps - "ethical lapses" - AHC had become "a summoning stone in the shoe". By this is meant that acting against AHC had become an imperative. See also Table 2!

DISCUSSION

This study evaluates, by means of qualitative "post" interviews, if there was a change in staff members' attitudes towards AHC after an intervention based on Forum Play.

In our earlier pre-intervention studies, staff reported detached attitudes towards AHC and AHC had a taboo status at the study clinic. [12, 13] They recognised AHC as 'transgressions of ethical principles' but stated that these actions were often justifiable from a staff perspective for various reasons. [12] Staff's awareness of AHC also turned out to be a complex phenomenon restricted by their possibilities to act e.g., caused by hierarchies or because they did not know what to do since they had no tools or training in handling AHC. [13] The strongest expressions of change in the present study, when compared to the pre-intervention studies, was the *increased* awareness about AHC, *stronger* empathy for patients displayed in *more* concrete examples of, and *fewer* explanations, justifications and trivialisations of AHC. The increase of concrete examples of AHC was most likely a manifestation of the increased awareness of AHC among staff.

Moreover, the answers to the question, "what is AHC?" in the present study, are closer to the experiences of both female and male patients than those of the study that posed the same question to staff prior to the intervention, where the core category was 'ethical lapses'. [10-12] Apparently, staff's perspective had moved closer to the patient's perspective.

AHC had become 'a summoning stone in the shoe' i.e., something nagging, that they were aware off and had to "take out" to be comfortable again. The imperative to act against AHC in the present study stands out as the most important result of the intervention.

The mechanisms for the effect that we saw are most likely, 1. Forum Play had showed staff that there were possibilities to act, and 2) the taboo status of AHC had been broken at the

clinic. The informants told us that AHC was present more often in their daily conversations, and it was even discussed during coffee breaks, i.e. AHC had become a shared problem. According to Galtung, direct events of violence are always accompanied and legitimised by cultural and structural violence, forming a vicious triangle. [23, 24] While events of direct violence often are visible, cultural and structural violence are often not. A taboo can exemplify cultural violence. Breaking the taboo should be seen as a way to delegitimize direct events of AHC, and Forum play seems to have been a useful tool for this purpose since the "culture" had changed between the pre and post intervention interviews and talking about and acting against AHC had become "the right thing to do".

The resistance against and disavowal of AHC found in the pre-intervention studies had not only decreased, it had also changed character. [12, 13] For example, before the intervention informants strongly emphasized that they were abused too. Now they had attained a more general and less defensive view; anybody could get involved in AHC as an actor or a victim. Moreover, it was considered much worse if a patient was abused by staff, because staff had more powerful positions than patients and they were entrusted with the patients' vulnerability. AHC was still considered to be acted out unintentionally, but the argument was no longer used to explain or justify AHC. Instead it was used as an incentive to become more aware about AHC.

How to define AHC was still problematic to the informants. Obviously AHC had been a new terminology for them, but the wish to rename AHC into a more "comfortable" concept is interesting. It is likely that the concept AHC gradually will be exchanged for the more neutral "a failing encounter" at this clinic.

To conduct qualitative interviews pre and post intervention gave us a deeper understanding of changes that might have been pointed out but not thoroughly explained by means of e.g. repeated quantitative measures. On the other hand the approach also involves risks, e.g. the

authors' involvement in the project could be assumed to increase the risk for bias both on behalf of the researchers, i.e. doing interpretations favourable to the project's success rate, as well as on behalf of the informants, i.e., a social desirability bias. [25] In an effort to counteract these biases, external independent researchers repeated interviews as well as analyses. An external researcher analysed de novo the interviews in the present study. This analysis also showed that staff's attitudes toward AHC had approached the patient perspective (submitted paper). New interviews were conducted by a consultant who was not involved in the project and with a different sample of staff who had also participated in the intervention. The results described a positive change from before till after the intervention, not only in attitudes but also in action. Several examples were given where staff members had been "experimenting" with different ways to prevent or handle AHC, also where it meant confronting a colleague. [26]

CONCLUSION

After an intervention with Forum Play workshops, staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or prevent AHC.

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Table 1. Questions in NorAQ about abuse in health care.

	ABUSE IN HEALTH CARE
Mild abuse Moderate abuse Severe abuse	Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion - in such a way that you were later disturbed by or suffered from the experience? Have you ever experienced that a "normal" event while visiting health services, suddenly became a really terrible and insulting experience, without you fully knowing how this could happen? Have you experienced anybody in health service purposely - as you understood - hurting you physically or mentally, grossly violating you or using your body and your subordinated position to your disadvantage for his/her own purpose?
	ANSWER ALTERNATIVES (THE SAME FOR ALL QUESTIONS)
	1 = No, 2 = Yes, as a child (<18 years), 3 = Yes, as an adult (≥18 years), 4 = Yes, as a child and as an adult

Table 2. Categories and Core category answering the research question: what is abuse in health care?

Categories **Abuse in health care is:**	**Function?**	**Core category**
Relative 7	Legitimizing AHC?	Abuse in health care is a summoning stone in the shoe!
Unintentional 8	Legitimizing AHC?	
Unacceptable: you are bound to act! 8	Protecting the patient from AHC?	
Ubiquitous 9	Protecting the patient from AHC?	
Dehumanising the patient 10	Protecting the patient from AHC?	

Note: Figures represent the number of interviews represented in each category.

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	KS and BW
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD / PhD
3. Occupation	What was their occupation at the time of the study?	BW: senior consultant gynaecologist KS Nurse
4. Gender	Was the researcher male or female?	F / F
5. Experience and training	What experience or training did the researcher have?	akademic training professor / ass. professor
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Information meeting
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Professional results from earlier research
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Engagement in the intervention is discussed
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Grounded theory
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	convenience
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	face to face by coordinator
12. Sample size	How many participants were in the study?	10

13. Non-participation	How many people refused to participate or dropped out? Reasons?	11 Not eligible 4 refused
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	clinic
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	NO
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Different staff categories
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	yes not app repeted interviews
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	10
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	AUDIO
20. Field notes	Were field notes made during and/or after the inter view or focus group?	yes
21. Duration	What was the duration of the inter views or focus group?	appr. 60 mn
22. Data saturation	Was data saturation discussed?	yes
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	NO
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	one
25. Description of the coding tree	Did authors provide a description of the coding tree?	no
26. Derivation of themes	Were themes identified in advance or derived from the data?	from data
27. Software	What software, if applicable, was used to manage the data?	—
28. Participant checking	Did participants provide feedback on the findings?	—
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	yes no
30. Data and findings consistent	Was there consistency between the data presented and the findings?	yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	yes

Once you have completed this checklist, please save a copy and upload it as part of your submission. When requested to do so as part of the upload process, please select the file type: *Checklist*. You will NOT be able to proceed with

Staff's perception of abuse in health care: a Swedish qualitative study.

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KEYWORDS: abuse in health care; quality of care; ethics; qualitative method

WORD COUNT: 4594

ABSTRACT

Objective: The study aim was to apprehend staff's perception of abuse in health care (AHC) after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients. AHC can be described as a failing encounter from the patient's perspective.

Design: Qualitative interview follow up study.

Setting: A Swedish Women's Clinic.

Participants: In a pre-intervention study 21 staff members were interviewed. Eligible for the follow up study were 14 informants who had participated in the intervention. Four declined participation leaving ten informants for this study.

Intervention: During January 2008 - January 2009, all staff members (N=136) were invited to participate in Forum Play workshops. Seventy-four participants took part in at least one of the seventeen half-day workshops.

Primary outcome measures: Staffs perception of AHC.

Results: The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'.

Forum Play had demonstrated possibilities to act even in seemingly "impossible" situations, and that the taboo status of AHC was altered at the clinic.

When our results were compared to those in the pre-intervention study, we found an *increased* awareness about AHC, *more* concrete examples of AHC, a *stronger* empathy for patients, and *fewer* explanations, justifications and trivialisations of AHC.

Conclusion: In this follow-up study staff's perception of AHC was closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or

prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

INTRODUCTION

Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.

Many of these negative encounters have to be investigated but what if there was no medical error or misconduct committed but the patient still felt abused?

Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]

AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14]

When we asked Swedish patients in qualitative interviews what AHC meant to them, both female and male patients expressed feelings of being disempowered and devalued. The core category in the female sample was a feeling of being "nullified" and in the male sample "mentally pinioned". [15, 16] However, when staff was asked the same question (in the pre intervention study), the answers were quite different. They explained theoretically what AHC could be, e.g. transgression of ethical principles, but they were also occupied with explanations and justifications as to why AHC occurred, and the core category was "ethical lapses". In accordance with their ambiguity and inability to handle AHC, it was treated with silence and as a taboo. [17] Moreover, staff's awareness of AHC was dependent on their possibilities to act; low awareness was seen when there were few possibilities to act. [18]

High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The

intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24].

The interviews with staff mentioned above serves as a starting point in the present study that was conducted after workshops based on Forum play where the same group of staff could participate.

There is a long tradition of interventions that addresses the interpersonal component of quality of care. [25] Role play is one technique used for this purpose. [26, 27] What makes this study different is our focus on AHC. Augusto Boal, a Brazilian theatre director and pedagogue, developed many different theatre techniques to liberate people, and Theatre of the Oppressed (TO) is a characterising name used for all his techniques. Influenced by Paulo Freire's *Pedagogy of the Oppressed*, TO became a grassroots movement from the nineteen sixties and on, offering techniques based on empowerment to equip people to transform the conditions in which they were living. [19, 28] Although TO is used worldwide to promote change evaluations of success rates are scares. [29]

The essence of Forum Play is to create a safe place in a group session, to make the moral conflict clear, to allow feelings but focus on action, and to practice new alternatives to act. Discovering and acting out many different solutions to a situation that at first seemed impossible to solve, instils hope in Forum Players. In this intervention, Forum Players are assumed to gradually feel brave enough to transfer their experiences into real life, and try out alternative ways at their work-place to handle or prevent AHC.

For this study we returned to the pre-intervention informants (staff) with the same research question, "What is AHC?" after an intervention against AHC based on Forum Play.

The study aim was to apprehend staff's perception of AHC after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients.

METHODS

Procedure and material

During the period January 2008 - January 2009, all staff members at the study clinic, a women's clinic at a county hospital in the south of Sweden (N=136), were invited to participate in Forum Play workshops led by professional Forum Play leaders. [30, 31] All workshops were announced at the local hospital Intranet where staff could also register. Participation was voluntary and there was no limit to the number of workshops a staff member could participate in. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held (74/136=54%).

During the workshops, staff re-enacted (role-played) situations that they had experienced or heard of when patients had felt abused in health care. The situation typically included a bystander who was not intervening but felt that he or she ought to do something, but did not act, as the situation seemed to be without possible "solutions". The scene was repeated until it was clear to everyone what the moral conflict was, and who was suffering the moral conflict. [19] Then the scene was played again and the audience was encouraged to intervene. They could enter the scene and try to change the outcome by taking on the role of the person who suffered the moral conflict.

In a baseline study, we interviewed 21 staff members who were eligible for participating in the Forum Play intervention, and who represented four different staff categories. [17, 18] Eligible for the present study were those 14 informants from the original sample who had participated in the intervention (three staff members had left the clinic, and four had not participated in the intervention). Four declined participation (one gynaecologist and three auxiliaries). All interviews were booked by a coordinator employed at the clinic.

The two authors conducted ten individual semi-structured interviews: two female and one male gynaecologist, one female administrator, four female midwives and two female auxiliaries. Individual interviews were preferred due to the sensitive nature of the topic that might evoke feelings of guilt and shame.

The analysis presented in this study is based on answers to open-ended questions similar to those in the pre-intervention study. The main question used for comparing results was: "When I say abuse in health care, what is the first thing that comes to your mind?" Interviews lasted on average 60 minutes. All interviews were tape-recorded and transcribed verbatim by a secretary.

Written informed consent was obtained from all participants before the interview. Our request to conduct the study had been approved by the regional ethical review board (Registration number 194-06).

Analysis

We choose a qualitative approach to collect and analyse data according to Barney Glaser but were also inspired by later work of Janice Morse and Kathy Chamaz. [32-35] Constant comparative analysis was used to process data [33]. The transcribed interviews were analysed line by line according to Glaser's scheme of open coding to generate substantive codes, i.e., words or sentences with a relationship to the research question. [32, 33] The substantive codes were constantly compared between interviews to generate new substantive codes and categories. Finally, the relationship between the categories was analysed and a core category that answered our research question was identified. [32] No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation. In order to balance individual biases the transcripts were read and analyzed by both authors, a physician and a nurse with different amount of experiences in research and clinical

work. The authors reached agreement on their coding through discussion. All categories are described in the result section and presented in Table 2.

RESULTS

The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'. Each category is described separately below. The interaction between the categories are described under the headline "core category" at the end of the result section.

Dehumanising the patient

This category was built on three substantive codes:

1. *"Not finding out where the patient is"*

According to the informants, AHC could signify several things:

Not to imagine what the patient is going through:

*"You have to **imagine**, and **understand** the things you **say**; what **are** the consequences…what do you **do** and what will be the consequences. How will it be in **this** situation? For sometimes an act can **be** rather innocent, and in some situations, [certain] behaviour can be completely **catastrophic**."*

To belittle a patient's problem by comparing with other patient's problems:

"Yes, to listen to what the other is talking about…to be focused on the one in front of you. Yes, seriously, even [when you] think that's a silly little thing compared to the death [a dying person]…in the next room."

To be judgmental:

"If someone is admitted, there are not so many of them here but, gipsies…Have you locked away your handbag? Where is my purse? They are judged awfully hard."

Lack of cultural awareness:

Expecting that patients with a foreign background live by and accept Swedish norms like in the following example might also render in AHC, according to one informant who had had to console a crying patient after an examination.

*"When she came it was a shock for her [that it was a male gynaecologist] and she told them that…she was going to see a female [gynaecologist] and then they had answered her that well but you can't always get…what you ask for…if you seek help at such short notice then you have to take what you can get. Everything was supposed to be quick and she just felt that she was just…**trouble** for them... And she was…so sad afterwards."*

2. *"Saying things that are very abusive"*

According to the informants, AHC can be something you say or the way you say it; a few words may turn a situation into a disaster for a patient.

One example: a patient with cancer was constantly throwing up. Staff had provided her with bags and bowls but nothing helped, repeatedly there was vomit everywhere: on the bedside table, in the bed and all over her things. Staff thought that she was capable of using the bags and bowls, and discussed between them if she did it on purpose. There were sighs among the staff, sometimes even audible to the patient, according to the informant. One day, a staff member asked the patient if she was going to continue like this when she would go home.

Another informant remembered her own first delivery: the baby's heart sounds were getting worse, the suction cup did not work, she had intravenous fluids running in both arms, and she

was screaming in pain. Then the doctor came up to her and said, "Are we going to cooperate for hell's sake!" Afterwards she felt abused and despite her longing for another child it took years before she decided to have a second baby.

Informants said that they used to think that AHC had to be a major thing, but that they now realised that AHC was often an unexpectedly small thing, and that a good situation could turn into a disaster because of a small thing. As mentioned above, the sex of the examiner might sometimes be crucial for the patient for religious or other reasons, while some staff members may consider it a small thing.

3. *"They must have felt very vulnerable"*

An informant told us about a patient that she had known for a long time whom she thought of as extremely nervous and inadequate. The patient had told her that she was afraid of hospitals. Later she also told her that she had been forced to go through a gynaecological examination when she was a child, on suspicion that she had been sexually abused by or involved with an older boy.

*"… she [the mother] only said, 'now we are going to **town**'. And then they brought her to the gynaecological ward and then they **held her tightly** and she was examined. And she **screamed** and she **kicked** and she was **struggling** with them. And she said that she can't forget this …it is stuck with her that…that they pushed her down and **forced** her, and so on. So I think that's a typical example of abuse in the health care and for **ten** years I've been wondering what's wrong with this girl."*

Power and power imbalance in relation to AHC was mentioned in several ways, e.g., the exposed position a woman has during a gynaecological examination or the patients' dependency on staff's willingness to help and to be gentle to them: *"You are not your own master then."*

One informant was also pondering about her ability to really understand what it meant to be dependent and exposed as a patient:

"…I still think that I can feel…that you can imagine…the dependency…get an understanding about how it is…I can never understand, but I can feel humble…I can share it…I can have respect and understand that she has something else with her that I haven't got."

AHC could also mean that advantage is taken of the power inherent of one's position, symbolised by, e.g., the uniforms: *"…when you put on your work clothes, then you have a kind of…how to say it, a power position."*

Unacceptable: you are bound to act!

The informants were prone to positioning themselves against AHC by, e.g., talking about how they had (re)acted against AHC, and that it could be done in a good way, *"…but then I think you have an obligation… to rebuke. In a loving way."* They also emphasised that the bystander had a very important role in noticing and stopping or preventing AHC, *"because sometimes I think that it is the person who stands by…maybe more often senses when something goes wrong than the person who is [active] in the situation".*

There were different strategies for intervening against potentially abusive situations:

One informant was concerned about open doors and meant that staff leaving doors open jeopardised a patient's integrity. She was struggling with this problem:

"…it is an indication that you probably can't miss [with laughter in her voice]. No, but sometimes when you have been sitting in the auxiliaries' expedition, there is just a sliding door…there are patients sitting right outside and then I close the door…or when you…hear…that they…are in a room talking and so on. Close the doors…and I close that door [the sliding door] and then it's open again! And I close it."

Practical arrangements for preventing AHC were discussed:

*"…there are more discussions about this [now]. **About**…for example, open the door into a room where a patient is and…how to **place** patients in a room, and how many really have to come into a room. So, these kinds of questions."*

It was also put forward that small talks over a cup of coffee could raise awareness about AHC among staff, but to talk to the patient, either before or after AHC had occurred, was seldom mentioned as an intervention. One informant interpreted this particular kind of silence as fear:

"It must be some kind of …fear to…realise that you are not perfect. Maybe!...Of course if you ask then you have to be prepared…to do something about what the patient might bring up."

In other words, asking a patient about AHC might force staff to take action, e.g., towards a colleague. Some informants stressed the importance of being earnest in such situations and talk directly to the staff involved as soon as possible. This was what the informant did who told us about the patient who expected to be examined by a female gynaecologist. When she had comforted the patient she asked her if she could talk to the staff member who had examined her, and if the patient wanted to participate in such a meeting. The patient declined t

"…I was allowed to tell…how she had experienced it…I was so disturbed by what she told me. So I felt that I had to find out if that was how it had happened. But he had not really experienced it that way..."

Furthermore, there was a possibility to report upwards in the hierarchy: *"**I** would not hesitate to…contact…[silence] a foreman, my bosses [if a patient was abused]."* And there was a consensus on having an open climate at the clinic, and that it was important to be made aware when a patient was abused. Speaking up against AHC was considered an option for most informants:

"That you say,' you can't behave like that'. So I believe that…people would tell you…I believe that there are few who would not dare to speak up…I believe they would speak to a colleague."

Ubiquitous

AHC was often described in a broad sense as something that can happen to anyone at any age: patients, staff, relatives and friends to the patient. Anybody can become a victim or an agent (actor or bystander) of AHC: *"…we are abusing each other…all the way down to the patient…"*

AHC was also interpreted as staff being abusive against other staff, for instance by making remarks in a harsh way. It was also pointed out that a patient who had witnessed staff treating each other badly might feel hesitant to ask even important questions for their own sake.

One abusive situation between members of staff described as common was when a midwife called for a doctor and that doctor called for another doctor, and the two of them did not involve the midwife when they discussed the patient.

It was also hypothesised that staff experiencing abuse from other staff might subconsciously take it out on someone else: *"…if I am abused then I will look for someone…that…I have power over."* And that someone is likely to be a patient: *"…it is easier to abuse when there is some kind of power relation… and when there is a kind of malady between us."*

However, patients abused by staff were considered the most serious kind of AHC: *"…the most serious is if we, the staff…abuse patients or relatives. That is another situation I believe."*

Informants also agreed that patients were the most common victims of AHC, and that if patients abused staff it should be understood differently: *"Because there might be…patients who abuse staff in many ways, so to say. But on the other hand, they are in another position…worry can turn you…rather nasty, really."*

Unintentional

AHC was believed to be a common experience among patients. Most informants said that AHC was usually unintentional on behalf of the staff, and that often involved staff was not even aware that it had happened. *"…they are not aware, surely. But then I have to…become aware of how people might experience what I do."*

A variety of explanations of the occurrence of AHC were brought forward, and it was pointed out several times that AHC did not come from evilness in staff members, but rather from a lack of consideration and empathy.

Not being reflective could result in a routine manner or performance. One example given was that of an authority, like the gynaecologist who was often believed to be under time restraints, who simply follows an old habit: focusing on getting things done instead of on the patient.

"…it's so easy to follow… the same footsteps all the time…"

Another example of unintentional AHC was when staff members made jokes between themselves about, e.g., someone being fat, and other staff members were laughing without reflecting on what they were laughing at, or if they ought to put an end to it.

It was also brought forward that unawareness of AHC could be due to inadequate communication skills, e.g., if staff was not sensible enough to read the patient's body language.

The uniqueness in each and everyone's characters was appreciated, but sometimes, if a colleague was known to be harsh without meaning it or even noticing it her- or himself, there was a moral conflict. A bystanding staff member would in such a situation understand that the patient might feel abused, and at the same time know that the "harsh" staff member did not mean to abuse the patient. This was considered a difficult situation, but as one informant concluded,

"…it's about personality, too, so it's really difficult to know how to tackle it. It's interesting that people are different, but on the other hand you don't want those differences to befall the patients so that they feel abused, or maltreated."

Relative

The informants were provoked by the word "abuse" in AHC, and prone to take a defending position against it. They thought of "abuse" (kränkning in Swedish) as a very strong word, that was sometimes used too often and in an inappropriate way. The informants thought that, especially in the rest of the society (outside the hospital), the word "abuse" had suffered inflation. *"I think that 'abuse' may be a tough word…It's a worn out word or a word that is used incorrectly..."*

Informants agreed that AHC was a difficult concept to define. On the one hand, AHC was considered a strong word, and yet AHC could be a small thing. *"…there is no such…scientific quantitative concept [saying] that this is abuse."*

The wording seemed important to the informants and a more neutral word for AHC was desired by some of the informants, e.g., (negative) encounters (bemötande in Swedish).

AHC was considered a personal experience, and it was expressed that patients were more or less vulnerable to this experience. It was also brought forward that there were reasonable experiences that made some patients more vulnerable to AHC than others, e.g., through a history of abuse.

Core category

The three categories 'Dehumanising the patient ', 'unacceptable: you are bound to act!' and 'ubiquitous' are strongly linked to each other in many ways, not the least because of their potentially patient protective components. The category 'Dehumanising the patient' implies

not being seen as a human being, stripped of human value. The codes that filled out this category were characterised by moral imagination and respect for the patient's situation. The informants showed great insight into patients' vulnerability and their own responsibility in relation to AHC. The fact that the informants gave several detailed examples of AHC underlined their emotional engagement. This engagement was a strong reason for staff to adopt a clear position against AHC, expressed in the category 'unacceptable: you are bound to act!' It was also made clear that acting against AHC was beneficial not only for the patient but also for staff: *"…that's what we really ought to do [talk to each other when we think a patient might feel abused]…we take responsibility for each other that way."*

The category 'ubiquitous', indicated that the informants were now more prone to recognise AHC. This openness could be seen as a mediator that enabled staff to talk about AHC, which probably contributed to a milieu where staff felt some pressure to also act against AHC. However, there were contradictions in the staff's definitions of AHC. To claim that AHC was 'unintentional' was a way to describe a fact, and at the same time make AHC trivial. Likewise, the discussion that rendered a 'relative' definition of AHC could be seen as a diversion from a topic that provoked awkward feelings. Both of these categories could be used to legitimize AHC.

DISCUSSION

This study focuses staff members' perception towards AHC after an intervention based on Forum Play.

Comparing interviews from before and after the intervention

In our pre-intervention studies, staff reported detached perceptions of AHC and AHC had a taboo status at the study clinic. [17, 18] They recognised AHC as 'transgressions of ethical principles' but stated that these actions were often justifiable from a staff perspective for various reasons. [17] Staff's awareness of AHC also turned out to be a complex phenomenon restricted by their possibilities to act e.g., caused by hierarchies or because they did not know what to do since they had no tools or training in handling AHC. [18] The strongest expressions of change in the present study, when compared to the pre-intervention studies, was the *increased* awareness about AHC, *stronger* empathy for patients displayed in *more* concrete examples of, and *fewer* explanations, justifications and trivialisations of AHC. The increase of concrete examples of AHC that staff had seen or heard of was most likely a manifestation of the increased awareness of AHC among staff [18].

Moreover, the answers to the question, "what is AHC?" in the present study, are closer to the experiences of both female and male patients than those of the study that posed the same question to staff prior to the intervention, where the core category was 'ethical lapses'. [15-17] Apparently, staff's perception of AHC were closer to the patient's perspective.

The core category

Despite the "resistance" we found, the overall finding is that AHC summons responsibility and urges an itch to act among staff. From having been considered a matter of mishaps - "ethical lapses" - AHC had become "a summoning stone in the shoe" [17]. By this is meant that acting against AHC had become an imperative.

The imperative to act against AHC in the present study stands out as the most important finding. The possible mechanisms for this finding could be that, 1. Forum Play had showed staff that there were possibilities to act, and 2) the taboo status of AHC had been broken at the clinic. The informants told us that AHC was present more often in their daily conversations, and it was even discussed during coffee breaks, i.e. AHC had become a shared problem. According to Galtung, direct events of violence are nurtured and legitimised by cultural and structural violence, forming a vicious triangle. [20, 23] While events of direct violence often are visible, cultural and structural violence are often not. A taboo can exemplify cultural violence. Breaking the taboo could be seen as a way to delegitimize direct events of AHC, and Forum play may have been a useful tool for this purpose since the "culture" had changed, and talking about and acting against AHC had become "the right thing to do". However, it cannot be ruled out that any intervention against AHC that merely drew attention to the topic would have been useful. Therefore it would be interesting to compare different strategies to counteract AHC in future studies.

From disavowal to responsibility

The resistance against and disavowal of AHC found in the pre-intervention studies had not only decreased, it had also changed character. [17, 18] For example, before the intervention informants strongly emphasized that they were abused too. Now they had attained a more general and less defensive view; anybody could get involved in AHC as an actor or a victim.

Moreover, it was considered much worse if a patient was abused by staff, because staff had more powerful positions than patients and they were entrusted with the patients' vulnerability. AHC was still considered to be acted out unintentionally, but the argument was no longer used to explain or justify AHC. Instead it was used as an incentive to become more aware about AHC.

How to define AHC was still problematic to the informants. Obviously AHC had been a new terminology for them, but the wish to rename AHC into a more "comfortable" concept is interesting. It is likely that the concept AHC gradually will be exchanged for the more neutral "a failing encounter" at this clinic.

Limitations

One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff's experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that yet another interview could have added new information.

To conduct qualitative follow-up interviews gave us a deeper understanding of changes that might have been pointed out but not have been thoroughly explained by means of e.g. repeated quantitative measures. On the other hand, the approach also involves risks, e.g. the authors' involvement in the project could be assumed to increase the risk for bias both on behalf of the researchers, i.e. doing interpretations favourable to the project's success rate, as well as on behalf of the informants, i.e., a social desirability bias. [36] In an effort to counteract these biases, external independent researchers repeated interviews as well as analyses. An external researcher analysed de novo the interviews in the present study. This

analysis also showed that staff's perception of AHC had approached the patient perspective [37]. New interviews were conducted by a consultant who was not involved in the project and with a different sample of staff who had also participated in the intervention. The results described a positive change from before till after the intervention, not only in perception but also in actions. Several examples were given where staff members had been "experimenting" with different ways to prevent or handle AHC, also where it meant confronting a colleague. [38]

CONCLUSION

In this follow-up study staff's perception of AHC were closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

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Table 1. Questions in NorAQ about abuse in health care.

	ABUSE IN HEALTH CARE
Mild abuse Moderate abuse Severe abuse	Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion - in such a way that you were later disturbed by or suffered from the experience? Have you ever experienced that a "normal" event while visiting health services, suddenly became a really terrible and insulting experience, without you fully knowing how this could happen? Have you experienced anybody in health service purposely - as you understood - hurting you physically or mentally, grossly violating you or using your body and your subordinated position to your disadvantage for his/her own purpose?
	ANSWER ALTERNATIVES (THE SAME FOR ALL QUESTIONS)
	1 = No, 2 = Yes, as a child (<18 years), 3 = Yes, as an adult (≥18 years), 4 = Yes, as a child and as an adult

Table 2. Categories and Core category answering the research question: what is abuse in health care?

Categories **Abuse in health care is:**	**Function?**	**Core category**
Relative 7	Legitimizing AHC?	Abuse in health care is a summoning stone in the shoe!
Unintentional 8	Legitimizing AHC?	
Unacceptable: you are bound to act! 8	Protecting the patient from AHC?	
Ubiquitous 9	Protecting the patient from AHC?	
Dehumanising the patient 10	Protecting the patient from AHC?	

Note: Figures represent the number of interviews represented in each category.

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	KS and BW
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD / PhD
3. Occupation	What was their occupation at the time of the study?	BW: senior consultant gynaecologist KS Nurse
4. Gender	Was the researcher male or female?	F / F
5. Experience and training	What experience or training did the researcher have?	akademic training professor / ass. professor
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Informal one meeting
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Professional results from earlier research
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Engagement in the intervention is discussed
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Grounded theory
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	convenience
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	face to face by coordinator
12. Sample size	How many participants were in the study?	10

13. Non-participation	How many people refused to participate or dropped out? Reasons?	11 Not eligible 4 refused
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	clinic
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	NO
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Different staff categories
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	yes not app repeted interviews
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	10
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	AUDIO
20. Field notes	Were field notes made during and/or after the inter view or focus group?	yes
21. Duration	What was the duration of the inter views or focus group?	appr. 60 mn
22. Data saturation	Was data saturation discussed?	yes
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	NO
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	one
25. Description of the coding tree	Did authors provide a description of the coding tree?	no
26. Derivation of themes	Were themes identified in advance or derived from the data?	from data
27. Software	What software, if applicable, was used to manage the data?	—
28. Participant checking	Did participants provide feedback on the findings?	—
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	yes no
30. Data and findings consistent	Was there consistency between the data presented and the findings?	yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	yes

Once you have completed this checklist, please save a copy and upload it as part of your submission. When requested to do so as part of the upload process, please select the file type: *Checklist*. You will NOT be able to proceed with

Staff's perception of abuse in health care: a Swedish qualitative study.

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ABSTRACT

Objective: The study aim was to apprehend staff's perception of abuse in health care (AHC) after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients. AHC can be described as a failing encounter from the patient's perspective.

Design: Qualitative interview follow up study.

Setting: A Swedish Women's Clinic.

Participants: In a pre-intervention study 21 staff members were interviewed. Eligible for the follow up study were 14 informants who had participated in the intervention. Four declined participation leaving ten informants for this study.

Intervention: During January 2008 - January 2009, all staff members (N=136) were invited to participate in Forum Play workshops. Seventy-four participants took part in at least one of the seventeen half-day workshops.

Primary outcome measures: Staffs perception of AHC.

Results: The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'.

Forum Play had demonstrated possibilities to act even in seemingly "impossible" situations, and that the taboo status of AHC was altered at the clinic.

When our results were compared to those in the pre-intervention study, we found an *increased* awareness about AHC, *more* concrete examples of AHC, a *stronger* empathy for patients, and *fewer* explanations, justifications and trivialisations of AHC.

Conclusion: In this follow-up study staff's perception of AHC was closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or

prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

ARTICLE SUMMARY

Article focus' (up to three bullet points on the research questions or hypotheses addressed);

• The study objective was to apprehend changes in the attitude of health care staff to abuse in health care (AHC) after an intervention, based on 'Forum Play', developed by Augusto Boal.

• Our aim was to evaluate the intervention by means of a design allowing the findings from pre intervention to be compared to those from post intervention qualitative interviews.

'Key messages' (up to three bullet points showing the key messages or significance of the study);

• Informants' reported that Forum Play had demonstrated possibilities to act even in seemingly "impossible" situations, that they had acted in such situations, and that the taboo status of AHC was broken at the clinic.

• When our results were compared to those in the pre-intervention study, we found an increased awareness about AHC, more concrete examples of AHC, a stronger empathy for patients, and fewer explanations, justifications and trivialisations of AHC.

• After an intervention with Forum Play workshops, staff showed a greater willingness not only to acknowledge AHC, but also to take on the responsibility to act in order to stop or prevent AHC. The imperative to act against abuse in health care in the present study stands out as the most important result of the intervention.

and a 'Strengths and limitations of this study' section.

• To conduct qualitative interviews pre and post intervention gave us a deeper understanding of changes that might have been pointed out but not thoroughly explained by means of e.g. repeated quantitative measures.

• On the other hand the approach also involves risks, e.g. the authors' involvement in the project could be assumed to increase the risk for bias both on behalf of the researchers, i.e. doing interpretations favourable to the project's success rate, as well as on behalf of the informants, i.e., a social desirability bias.

INTRODUCTION

Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.

Many of these negative encounters have to be investigated but what if there was no medical error or misconduct committed but the patient still felt abused?

Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]

AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14]

When we asked Swedish patients in qualitative interviews what AHC meant to them, both female and male patients expressed feelings of being disempowered and devalued. The core category in the female sample was a feeling of being "nullified" and in the male sample "mentally pinioned". [15, 16] However, when staff was asked the same question (in the pre intervention study), the answers were quite different. They explained theoretically what AHC could be, e.g. transgression of ethical principles, but they were also occupied with explanations and justifications as to why AHC occurred, and the core category was "ethical lapses". In accordance with their ambiguity and inability to handle AHC, it was treated with silence and as a taboo. [17] Moreover, staff's awareness of AHC was dependent on their possibilities to act; low awareness was seen when there were few possibilities to act. [18]

High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The

intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24].

The interviews with staff mentioned above serves as a starting point in the present study that was conducted after workshops based on Forum play where the same group of staff could participate.

There is a long tradition of interventions that addresses the interpersonal component of quality of care. [25] Role play is one technique used for this purpose. [26, 27] What makes this study different is our focus on AHC. Augusto Boal, a Brazilian theatre director and pedagogue, developed many different theatre techniques to liberate people, and Theatre of the Oppressed (TO) is a characterising name used for all his techniques. Influenced by Paulo Freire's *Pedagogy of the Oppressed*, TO became a grassroots movement from the nineteen sixties and on, offering techniques based on empowerment to equip people to transform the conditions in which they were living. [19, 28] Although TO is used worldwide to promote change evaluations of success rates are scares. [29]

The essence of Forum Play is to create a safe place in a group session, to make the moral conflict clear, to allow feelings but focus on action, and to practice new alternatives to act. Discovering and acting out many different solutions to a situation that at first seemed impossible to solve, instils hope in Forum Players. In this intervention, Forum Players are assumed to gradually feel brave enough to transfer their experiences into real life, and try out alternative ways at their work-place to handle or prevent AHC.

For this study we returned to the pre-intervention informants (staff) with the same research question, "What is AHC?" after an intervention against AHC based on Forum Play.

The study aim was to apprehend staff's perception of AHC after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients.

METHODS

Procedure and material

During the period January 2008 - January 2009, all staff members at the study clinic, a women's clinic at a county hospital in the south of Sweden (N=136), were invited to participate in Forum Play workshops led by professional Forum Play leaders. [30, 31] All workshops were announced at the local hospital Intranet where staff could also register. Participation was voluntary and there was no limit to the number of workshops a staff member could participate in. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held (74/136=54%).

During the workshops, staff re-enacted (role-played) situations that they had experienced or heard of when patients had felt abused in health care. The situations were different from one workshop to another, but typically included a bystander who was not intervening but felt that he or she ought to do something. The bystander usually did not act because the situation seemed to be without possible "solutions". The scene was repeated until it was clear to everyone what the moral conflict was, and who was suffering the moral conflict. [19] Then the scene was played again and the audience was encouraged to intervene. They could enter the scene and try to change the outcome by taking on the role of the person who suffered the moral conflict.

In a baseline study, we interviewed 21 staff members who were eligible for participating in the Forum Play intervention, and who represented four different staff categories. [17, 18] Eligible for the present study were those 14 informants from the original sample who had participated in the intervention (three staff members had left the clinic, and four had not participated in the intervention). Four declined participation (one gynaecologist and three auxiliaries). All interviews were booked by a coordinator employed at the clinic.

The two authors conducted ten individual semi-structured interviews: two female and one male gynaecologist, one female administrator, four female midwives and two female auxiliaries. Individual interviews were preferred due to the sensitive nature of the topic that might evoke feelings of guilt and shame.

The analysis presented in this study is based on answers to open-ended questions similar to those in the pre-intervention study. The main question used for comparing results was: "When I say abuse in health care, what is the first thing that comes to your mind?" Interviews lasted on average 60 minutes. All interviews were tape-recorded and transcribed verbatim by a secretary.

Written informed consent was obtained from all participants before the interview. Our request to conduct the study had been approved by the regional ethical review board (Registration number 194-06).

Analysis

We choose a qualitative approach to collect and analyse data according to Barney Glaser but were also inspired by later work of Janice Morse and Kathy Chamaz. [32-35] Constant comparative analysis was used to process data [33]. The transcribed interviews were analysed line by line according to Glaser's scheme of open coding to generate substantive codes, i.e., words or sentences with a relationship to the research question. [32, 33] The substantive codes were constantly compared between interviews to generate new substantive codes and categories. Finally, the relationship between the categories was analysed and a core category that answered our research question was identified. [32] No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation. In order to balance individual biases the transcripts were read and analyzed by both authors, a physician and a nurse with different amount of experiences in research and clinical

work. The authors reached agreement on their coding through discussion. All categories are described in the result section and presented in Table 2.

RESULTS

The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'. Each category is described separately below. The interactions between the categories are described under the headline "core category" at the end of the result section. Quotes are used to illustrate our findings.

Dehumanising the patient

This category was built on three substantive codes:

1. *"Not finding out where the patient is"*

According to the informants, AHC could signify several things:

Not to imagine what the patient is going through:

*"You have to **imagine**, and **understand** the things you **say**; what **are** the consequences…what do you **do** and what will be the consequences. How will it be in **this** situation? For sometimes an act can **be** rather innocent, and in some situations, [certain] behaviour can be completely **catastrophic**."*

To belittle a patient's problem by comparing with other patient's problems:

"Yes, to listen to what the other is talking about…to be focused on the one in front of you. Yes, seriously, even [when you] think that's a silly little thing compared to the death [a dying person] …in the next room."

To be judgmental:

"If someone is admitted, there are not so many of them here but, gipsies…Have you locked away your handbag? Where is my purse? They are judged awfully hard."

Lack of cultural awareness:

Expecting that patients with a foreign background live by and accept Swedish norms like in the following example might also render in AHC, according to one informant who had had to console a crying patient after an examination.

*"When she came it was a shock for her [that it was a male gynaecologist] and she told them that…she was going to see a female [gynaecologist] and then they had answered her that well but you can't always get…what you ask for…if you seek help at such short notice then you have to take what you can get. Everything was supposed to be quick and she just felt that she was just…**trouble** for them... And she was…so sad afterwards."*

2. *"Saying things that are very abusive"*

According to the informants, AHC can be something you say or the way you say it; a few words may turn a situation into a disaster for a patient.

One example: a patient with cancer was constantly throwing up. Staff had provided her with bags and bowls but nothing helped, repeatedly there was vomit everywhere: on the bedside table, in the bed and all over her things. Staff thought that she was capable of using the bags and bowls, and discussed between them if she did it on purpose. There were sighs among the staff, sometimes even audible to the patient, according to the informant. One day, a staff member asked the patient if she was going to continue like this when she would go home.

Another informant remembered her own first delivery: the baby's heart sounds were getting worse, the suction cup did not work, she had intravenous fluids running in both arms, and she

was screaming in pain. Then the doctor came up to her and said, "Are we going to cooperate for hell's sake!" Afterwards she felt abused and despite her longing for another child it took years before she decided to have a second baby.

Informants said that they used to think that AHC had to be a major thing, but that they now realised that AHC was often an unexpectedly small thing, and that a good situation could turn into a disaster because of a small thing. As mentioned above, the sex of the examiner might sometimes be crucial for the patient for religious or other reasons, while some staff members may consider it a small thing.

3. *"They must have felt very vulnerable"*

An informant told us about a patient that she had known for a long time whom she thought of as extremely nervous and inadequate. The patient had told her that she was afraid of hospitals. Later she also told her that she had been forced to go through a gynaecological examination when she was a child, on suspicion that she had been sexually abused by or involved with an older boy.

*"… she [the mother] only said, 'now we are going to **town**'. And then they brought her to the gynaecological ward and then they **held her tightly** and she was examined. And she **screamed** and she **kicked** and she was **struggling** with them. And she said that she can't forget this …it is stuck with her that…that they pushed her down and **forced** her, and so on. So I think that's a typical example of abuse in the health care and for **ten** years I've been wondering what's wrong with this girl."*

Power and power imbalance in relation to AHC was mentioned in several ways, e.g., the exposed position a woman has during a gynaecological examination or the patients' dependency on staff's willingness to help and to be gentle to them: *"You are not your own master then."*

One informant was also pondering about her ability to really understand what it meant to be dependent and exposed as a patient:

"…I still think that I can feel…that you can imagine…the dependency…get an understanding about how it is…I can never understand, but I can feel humble…I can share it…I can have respect and understand that she has something else with her that I haven't got."

AHC could also mean that advantage is taken of the power inherent of one's position, symbolised by, e.g., the uniforms: *"…when you put on your work clothes, then you have a kind of…how to say it, a power position."*

Unacceptable: you are bound to act!

The informants were prone to positioning themselves against AHC by, e.g., talking about how they had (re)acted against AHC, and that it could be done in a good way, *"…but then I think you have an obligation… to rebuke. In a loving way."* They also emphasised that the bystander had a very important role in noticing and stopping or preventing AHC, *"because sometimes I think that it is the person who stands by…maybe more often senses when something goes wrong than the person who is [active] in the situation".*

There were different strategies for intervening against potentially abusive situations:

One informant was concerned about open doors and meant that staff leaving doors open jeopardised a patient's integrity. She was struggling with this problem:

"…it is an indication that you probably can't miss [with laughter in her voice]. No, but sometimes when you have been sitting in the auxiliaries' expedition, there is just a sliding door…there are patients sitting right outside and then I close the door…or when you…hear…that they…are in a room talking and so on. Close the doors…and I close that door [the sliding door] and then it's open again! And I close it."

Practical arrangements for preventing AHC were discussed:

*"…there are more discussions about this [now]. **About**…for example, open the door into a room where a patient is and…how to **place** patients in a room, and how many really have to come into a room. So, these kinds of questions."*

It was also put forward that small talks over a cup of coffee could raise awareness about AHC among staff, but to talk to the patient, either before or after AHC had occurred, was seldom mentioned as an intervention. One informant interpreted this particular kind of silence as fear: *"It must be some kind of …fear to…realise that you are not perfect. Maybe!...Of course if you ask then you have to be prepared…to do something about what the patient might bring up."*

In other words, asking a patient about AHC might force staff to take action, e.g., towards a colleague. Some informants stressed the importance of being earnest in such situations and talk directly to the staff involved as soon as possible. This was what the informant did who told us about the patient who expected to be examined by a female gynaecologist. When she had comforted the patient she asked her if she could talk to the staff member who had examined her, and if the patient wanted to participate in such a meeting. The patient declined t *"…I was allowed to tell…how she had experienced it…I was so disturbed by what she told me. So I felt that I had to find out if that was how it had happened. But he had not really experienced it that way..."*

Furthermore, there was a possibility to report upwards in the hierarchy: *"**I** would not hesitate to…contact…[silence] a foreman, my bosses [if a patient was abused]."* And there was a consensus on having an open climate at the clinic, and that it was important to be made aware when a patient was abused. Speaking up against AHC was considered an option for most informants:

"That you say,' you can't behave like that'. So I believe that…people would tell you…I believe that there are few who would not dare to speak up…I believe they would speak to a colleague."

Ubiquitous

AHC was often described in a broad sense as something that can happen to anyone at any age: patients, staff, relatives and friends to the patient. Anybody can become a victim or an agent (actor or bystander) of AHC: *"…we are abusing each other…all the way down to the patient…"*

AHC was also interpreted as staff being abusive against other staff, for instance by making remarks in a harsh way. It was also pointed out that a patient who had witnessed staff treating each other badly might feel hesitant to ask even important questions for their own sake.

One abusive situation between members of staff described as common was when a midwife called for a doctor and that doctor called for another doctor, and the two of them did not involve the midwife when they discussed the patient.

It was also hypothesised that staff experiencing abuse from other staff might subconsciously take it out on someone else: *"…if I am abused then I will look for someone…that…I have power over."* And that someone is likely to be a patient: *"…it is easier to abuse when there is some kind of power relation… and when there is a kind of malady between us."*

However, patients abused by staff were considered the most serious kind of AHC: *"…the most serious is if we, the staff…abuse patients or relatives. That is another situation I believe."*

Informants also agreed that patients were the most common victims of AHC, and that if patients abused staff it should be understood differently: *"Because there might be…patients who abuse staff in many ways, so to say. But on the other hand, they are in another position…worry can turn you…rather nasty, really."*

Unintentional

AHC was believed to be a common experience among patients. Most informants said that AHC was usually unintentional on behalf of the staff, and that often involved staff was not even aware that it had happened. *"…they are not aware, surely. But then I have to…become aware of how people might experience what I do."*

A variety of explanations of the occurrence of AHC were brought forward, and it was pointed out several times that AHC did not come from evilness in staff members, but rather from a lack of consideration and empathy.

Not being reflective could result in a routine manner or performance. One example given was that of an authority, like the gynaecologist who was often believed to be under time restraints, who simply follows an old habit: focusing on getting things done instead of on the patient. *"…it's so easy to follow… the same footsteps all the time…"*

Another example of unintentional AHC was when staff members made jokes between themselves about, e.g., someone being fat, and other staff members were laughing without reflecting on what they were laughing at, or if they ought to put an end to it.

It was also brought forward that unawareness of AHC could be due to inadequate communication skills, e.g., if staff was not sensible enough to read the patient's body language.

The uniqueness in each and everyone's characters was appreciated, but sometimes, if a colleague was known to be harsh without meaning it or even noticing it her- or himself, there was a moral conflict. A bystanding staff member would in such a situation understand that the patient might feel abused, and at the same time know that the "harsh" staff member did not mean to abuse the patient. This was considered a difficult situation, but as one informant concluded,

"…it's about personality, too, so it's really difficult to know how to tackle it. It's interesting that people are different, but on the other hand you don't want those differences to befall the patients so that they feel abused, or maltreated."

Relative

The informants were provoked by the word "abuse" in AHC, and prone to take a defending position against it. They thought of "abuse" (kränkning in Swedish) as a very strong word, that was sometimes used too often and in an inappropriate way. The informants thought that, especially in the rest of the society (outside the hospital), the word "abuse" had suffered inflation. *"I think that 'abuse' may be a tough word…It's a worn out word or a word that is used incorrectly..."*

Informants agreed that AHC was a difficult concept to define. On the one hand, AHC was considered a strong word, and yet AHC could be a small thing. *"…there is no such…scientific quantitative concept [saying] that this is abuse."*

The wording seemed important to the informants and a more neutral word for AHC was desired by some of the informants, e.g., (negative) encounters (bemötande in Swedish).

AHC was considered a personal experience, and it was expressed that patients were more or less vulnerable to this experience. It was also brought forward that there were reasonable experiences that made some patients more vulnerable to AHC than others, e.g., through a history of abuse.

Core category

The three categories 'Dehumanising the patient ', 'unacceptable: you are bound to act!' and 'ubiquitous' are strongly linked to each other in many ways, not the least because of their potentially patient protective components. The category 'Dehumanising the patient' implies

not being seen as a human being, stripped of human value. The codes that filled out this category were characterised by moral imagination and respect for the patient's situation. The informants showed great insight into patients' vulnerability and their own responsibility in relation to AHC. The fact that the informants gave several detailed examples of AHC underlined their emotional engagement. This engagement was a strong reason for staff to adopt a clear position against AHC, expressed in the category 'unacceptable: you are bound to act!' It was also made clear that acting against AHC was beneficial not only for the patient but also for staff: *"…that's what we really ought to do [talk to each other when we think a patient might feel abused] …we take responsibility for each other that way."*

The category 'ubiquitous', indicated that the informants were now more prone to recognise AHC. This openness could be seen as a mediator that enabled staff to talk about AHC, which probably contributed to a milieu where staff felt some pressure to also act against AHC. However, there were contradictions in the staff's definitions of AHC. To claim that AHC was 'unintentional' was a way to describe a fact, and at the same time make AHC trivial. Likewise, the discussion that rendered a 'relative' definition of AHC could be seen as a diversion from a topic that provoked awkward feelings. Both of these categories could be used to legitimize AHC.

DISCUSSION

This study focuses staff members' perception towards AHC after an intervention based on Forum Play.

Comparing interviews from before and after the intervention

In our pre-intervention studies, staff reported detached perceptions of AHC and AHC had a taboo status at the study clinic. [17, 18] They recognised AHC as 'transgressions of ethical principles' but stated that these actions were often justifiable from a staff perspective for various reasons. [17] Staff's awareness of AHC also turned out to be a complex phenomenon restricted by their possibilities to act e.g., caused by hierarchies or because they did not know what to do since they had no tools or training in handling AHC. [18] The strongest expressions of change in the present study, when compared to the pre-intervention studies, was the *increased* awareness about AHC, *stronger* empathy for patients displayed in *more* concrete examples of, and *fewer* explanations, justifications and trivialisations of AHC. The increase of concrete examples of AHC that staff had seen or heard of was most likely a manifestation of the increased awareness of AHC among staff [18].

Moreover, the answers to the question, "what is AHC?" in the present study, are closer to the experiences of both female and male patients than those of the study that posed the same question to staff prior to the intervention, where the core category was 'ethical lapses'. [15-17] Apparently, staff's perception of AHC were closer to the patient's perspective.

The core category

Despite the "resistance" we found, the overall finding is that AHC summons responsibility and urges an itch to act among staff. From having been considered a matter of mishaps - "ethical lapses" - AHC had become "a summoning stone in the shoe" [17]. By this is meant that acting against AHC had become an imperative.

The imperative to act against AHC in the present study stands out as the most important finding. The possible mechanisms for this finding could be that, 1. Forum Play had showed staff that there were possibilities to act, and 2) the taboo status of AHC had been broken at the clinic. The informants told us that AHC was present more often in their daily conversations, and it was even discussed during coffee breaks, i.e. AHC had become a shared problem. According to Galtung, direct events of violence are nurtured and legitimised by cultural and structural violence, forming a vicious triangle. [20, 23] While events of direct violence often are visible, cultural and structural violence are often not. A taboo can exemplify cultural violence. Breaking the taboo could be seen as a way to delegitimize direct events of AHC, and Forum play may have been a useful tool for this purpose since the "culture" had changed, and talking about and acting against AHC had become "the right thing to do". However, it cannot be ruled out that any intervention against AHC that merely drew attention to the topic would have been useful. Therefore it would be interesting to compare different strategies to counteract AHC in future studies.

From disavowal to responsibility

The resistance against and disavowal of AHC found in the pre-intervention studies had not only decreased, it had also changed character. [17, 18] For example, before the intervention informants strongly emphasized that they were abused too. Now they had attained a more general and less defensive view; anybody could get involved in AHC as an actor or a victim.

Moreover, it was considered much worse if a patient was abused by staff, because staff had more powerful positions than patients and they were entrusted with the patients' vulnerability. AHC was still considered to be acted out unintentionally, but the argument was no longer used to explain or justify AHC. Instead it was used as an incentive to become more aware about AHC.

How to define AHC was still problematic to the informants. Obviously AHC had been a new terminology for them, but the wish to rename AHC into a more "comfortable" concept is interesting. It is likely that the concept AHC gradually will be exchanged for the more neutral "a failing encounter" at this clinic.

Limitations

One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff's experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that yet another interview could have added new information or that people who declined to participate in the follow up interviews might have had very different views to those who did participate.

To conduct qualitative follow-up interviews gave us a deeper understanding of changes that might have been pointed out but not have been thoroughly explained by means of e.g. repeated quantitative measures. On the other hand, the approach also involves risks, e.g. the authors' involvement in the project could be assumed to increase the risk for bias both on behalf of the researchers, i.e. doing interpretations favourable to the project's success rate, as well as on behalf of the informants, i.e., a social desirability bias. [36] In an effort to

counteract these biases, external independent researchers repeated interviews as well as analyses. An external researcher analysed de novo the interviews in the present study. This analysis also showed that staff's perception of AHC had approached the patient perspective [37]. New interviews were conducted by a consultant who was not involved in the project and with a different sample of staff who had also participated in the intervention. The results described a positive change from before till after the intervention, not only in perception but also in actions. Several examples were given where staff members had been "experimenting" with different ways to prevent or handle AHC, also where it meant confronting a colleague. [38]

CONCLUSION

In this follow-up study staff's perception of AHC were closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

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Table 1. Questions in NorAQ about abuse in health care.

	ABUSE IN HEALTH CARE
Mild abuse Moderate abuse Severe abuse	Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion - in such a way that you were later disturbed by or suffered from the experience? Have you ever experienced that a "normal" event while visiting health services, suddenly became a really terrible and insulting experience, without you fully knowing how this could happen? Have you experienced anybody in health service purposely - as you understood - hurting you physically or mentally, grossly violating you or using your body and your subordinated position to your disadvantage for his/her own purpose?
	ANSWER ALTERNATIVES (THE SAME FOR ALL QUESTIONS)
	1 = No, 2 = Yes, as a child (<18 years), 3 = Yes, as an adult (≥18 years), 4 = Yes, as a child and as an adult

Table 2. Categories and Core category answering the research question: what is abuse in health care?

Categories **Abuse in health care is:**	**Function?**	**Core category**
Relative 7	Legitimizing AHC?	Abuse in health care is a summoning stone in the shoe!
Unintentional 8	Legitimizing AHC?	
Unacceptable: you are bound to act! 8	Protecting the patient from AHC?	
Ubiquitous 9	Protecting the patient from AHC?	
Dehumanising the patient 10	Protecting the patient from AHC?	

Note: Figures represent the number of interviews represented in each category.

TITLE: Staff's perception of abuse in health care: a Swedish qualitative study.

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ABSTRACT

Objective: The study aim was to apprehend staff's perception of abuse in health care (AHC) after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients. AHC can be described as a failing encounter from the patient's perspective.

Design: Qualitative interview follow up study.

Setting: A Swedish Women's Clinic.

Participants: In a pre-intervention study 21 staff members were interviewed. Eligible for the follow up study were 14 informants who had participated in the intervention. Four declined participation leaving ten informants for this study.

Intervention: During January 2008 - January 2009, all staff members (N=136) were invited to participate in Forum Play workshops. Seventy-four participants took part in at least one of the seventeen half-day workshops.

Primary outcome measures: Staffs perception of AHC.

Results: The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'.

Forum Play had demonstrated possibilities to act even in seemingly "impossible" situations, and that the taboo status of AHC was altered at the clinic.

When our results were compared to those in the pre-intervention study, we found an *increased* awareness about AHC, *more* concrete examples of AHC, a *stronger* empathy for patients, and *fewer* explanations, justifications and trivialisations of AHC.

Conclusion: In this follow-up study staff's perception of AHC was closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or

prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

INTRODUCTION

Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.

Many of these negative encounters have to be investigated but what if there was no medical error or misconduct committed but the patient still felt abused?

Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]

AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14]

When we asked Swedish patients in qualitative interviews what AHC meant to them, both female and male patients expressed feelings of being disempowered and devalued. The core category in the female sample was a feeling of being "nullified" and in the male sample "mentally pinioned". [15, 16] However, when staff was asked the same question (in the pre intervention study), the answers were quite different. They explained theoretically what AHC could be, e.g. transgression of ethical principles, but they were also occupied with explanations and justifications as to why AHC occurred, and the core category was "ethical lapses". In accordance with their ambiguity and inability to handle AHC, it was treated with silence and as a taboo. [17] Moreover, staff's awareness of AHC was dependent on their possibilities to act; low awareness was seen when there were few possibilities to act. [18]

High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The

intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24].

The interviews with staff mentioned above serves as a starting point in the present study that was conducted after workshops based on Forum play where the same group of staff could participate.

There is a long tradition of interventions that addresses the interpersonal component of quality of care. [25] Role play is one technique used for this purpose. [26, 27] What makes this study different is our focus on AHC. Augusto Boal, a Brazilian theatre director and pedagogue, developed many different theatre techniques to liberate people, and Theatre of the Oppressed (TO) is a characterising name used for all his techniques. Influenced by Paulo Freire's *Pedagogy of the Oppressed*, TO became a grassroots movement from the nineteen sixties and on, offering techniques based on empowerment to equip people to transform the conditions in which they were living. [19, 28] Although TO is used worldwide to promote change evaluations of success rates are scares. [29]

The essence of Forum Play is to create a safe place in a group session, to make the moral conflict clear, to allow feelings but focus on action, and to practice new alternatives to act. Discovering and acting out many different solutions to a situation that at first seemed impossible to solve, instils hope in Forum Players. In this intervention, Forum Players are assumed to gradually feel brave enough to transfer their experiences into real life, and try out alternative ways at their work-place to handle or prevent AHC.

For this study we returned to the pre-intervention informants (staff) with the same research question, "What is AHC?" after an intervention against AHC based on Forum Play.

The study aim was to apprehend staff's perception of AHC after an intervention based on 'Forum Play', and make comparisons to pre intervention interviews and interviews with male and female patients.

METHODS

Procedure and material

During the period January 2008 - January 2009, all staff members at the study clinic, a women's clinic at a county hospital in the south of Sweden (N=136), were invited to participate in Forum Play workshops led by professional Forum Play leaders. [30, 31] All workshops were announced at the local hospital Intranet where staff could also register. Participation was voluntary and there was no limit to the number of workshops a staff member could participate in. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held (74/136=54%).

During the workshops, staff re-enacted (role-played) situations that they had experienced or heard of when patients had felt abused in health care. The situations were different from one workshop to another, but typically included a bystander who was not intervening but felt that he or she ought to do something. The bystander usually did not act because the situation seemed to be without possible "solutions". The scene was repeated until it was clear to everyone what the moral conflict was, and who was suffering the moral conflict. [19] Then the scene was played again and the audience was encouraged to intervene. They could enter the scene and try to change the outcome by taking on the role of the person who suffered the moral conflict.

In a baseline study, we interviewed 21 staff members who were eligible for participating in the Forum Play intervention, and who represented four different staff categories. [17, 18] Eligible for the present study were those 14 informants from the original sample who had participated in the intervention (three staff members had left the clinic, and four had not participated in the intervention). Four declined participation (one gynaecologist and three auxiliaries). All interviews were booked by a coordinator employed at the clinic.

The two authors conducted ten individual semi-structured interviews: two female and one male gynaecologist, one female administrator, four female midwives and two female auxiliaries. Individual interviews were preferred due to the sensitive nature of the topic that might evoke feelings of guilt and shame.

The analysis presented in this study is based on answers to open-ended questions similar to those in the pre-intervention study. The main question used for comparing results was: "When I say abuse in health care, what is the first thing that comes to your mind?" Interviews lasted on average 60 minutes. All interviews were tape-recorded and transcribed verbatim by a secretary.

Written informed consent was obtained from all participants before the interview. Our request to conduct the study had been approved by the regional ethical review board (Registration number 194-06).

Analysis

We choose a qualitative approach to collect and analyse data according to Barney Glaser but were also inspired by later work of Janice Morse and Kathy Chamaz. [32-35] Constant comparative analysis was used to process data [33]. The transcribed interviews were analysed line by line according to Glaser's scheme of open coding to generate substantive codes, i.e., words or sentences with a relationship to the research question. [32, 33] The substantive codes were constantly compared between interviews to generate new substantive codes and categories. Finally, the relationship between the categories was analysed and a core category that answered our research question was identified. [32] No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation. In order to balance individual biases the transcripts were read and analyzed by both authors, a physician and a nurse with different amount of experiences in research and clinical

work. The authors reached agreement on their coding through discussion. All categories are described in the result section and presented in Table 2.

RESULTS

The core category, 'a summoning stone in the shoe', was constructed of five categories: **'**Dehumanising the patient ', 'Unacceptable: you are bound to act!', 'Ubiquitous', 'Unintentional' and 'Relative'. Each category is described separately below. The interactions between the categories are described under the headline "core category" at the end of the result section. Quotes are used to illustrate our findings.

Dehumanising the patient

This category was built on three substantive codes:

1. *"Not finding out where the patient is"*

According to the informants, AHC could signify several things:

Not to imagine what the patient is going through:

*"You have to **imagine**, and **understand** the things you **say**; what **are** the consequences…what do you **do** and what will be the consequences. How will it be in **this** situation? For sometimes an act can **be** rather innocent, and in some situations, [certain] behaviour can be completely **catastrophic**."*

To belittle a patient's problem by comparing with other patient's problems:

"Yes, to listen to what the other is talking about…to be focused on the one in front of you. Yes, seriously, even [when you] think that's a silly little thing compared to the death [a dying person] …in the next room."

To be judgmental:

"If someone is admitted, there are not so many of them here but, gipsies…Have you locked away your handbag? Where is my purse? They are judged awfully hard."

Lack of cultural awareness:

Expecting that patients with a foreign background live by and accept Swedish norms like in the following example might also render in AHC, according to one informant who had had to console a crying patient after an examination.

*"When she came it was a shock for her [that it was a male gynaecologist] and she told them that…she was going to see a female [gynaecologist] and then they had answered her that well but you can't always get…what you ask for…if you seek help at such short notice then you have to take what you can get. Everything was supposed to be quick and she just felt that she was just…**trouble** for them... And she was…so sad afterwards."*

2. *"Saying things that are very abusive"*

According to the informants, AHC can be something you say or the way you say it; a few words may turn a situation into a disaster for a patient.

One example: a patient with cancer was constantly throwing up. Staff had provided her with bags and bowls but nothing helped, repeatedly there was vomit everywhere: on the bedside table, in the bed and all over her things. Staff thought that she was capable of using the bags and bowls, and discussed between them if she did it on purpose. There were sighs among the staff, sometimes even audible to the patient, according to the informant. One day, a staff member asked the patient if she was going to continue like this when she would go home.

Another informant remembered her own first delivery: the baby's heart sounds were getting worse, the suction cup did not work, she had intravenous fluids running in both arms, and she

was screaming in pain. Then the doctor came up to her and said, "Are we going to cooperate for hell's sake!" Afterwards she felt abused and despite her longing for another child it took years before she decided to have a second baby.

Informants said that they used to think that AHC had to be a major thing, but that they now realised that AHC was often an unexpectedly small thing, and that a good situation could turn into a disaster because of a small thing. As mentioned above, the sex of the examiner might sometimes be crucial for the patient for religious or other reasons, while some staff members may consider it a small thing.

3. *"They must have felt very vulnerable"*

An informant told us about a patient that she had known for a long time whom she thought of as extremely nervous and inadequate. The patient had told her that she was afraid of hospitals. Later she also told her that she had been forced to go through a gynaecological examination when she was a child, on suspicion that she had been sexually abused by or involved with an older boy.

*"… she [the mother] only said, 'now we are going to **town**'. And then they brought her to the gynaecological ward and then they **held her tightly** and she was examined. And she **screamed** and she **kicked** and she was **struggling** with them. And she said that she can't forget this …it is stuck with her that…that they pushed her down and **forced** her, and so on. So I think that's a typical example of abuse in the health care and for **ten** years I've been wondering what's wrong with this girl."*

Power and power imbalance in relation to AHC was mentioned in several ways, e.g., the exposed position a woman has during a gynaecological examination or the patients' dependency on staff's willingness to help and to be gentle to them: *"You are not your own master then."*

One informant was also pondering about her ability to really understand what it meant to be dependent and exposed as a patient:

"…I still think that I can feel…that you can imagine…the dependency…get an understanding about how it is…I can never understand, but I can feel humble…I can share it…I can have respect and understand that she has something else with her that I haven't got."

AHC could also mean that advantage is taken of the power inherent of one's position, symbolised by, e.g., the uniforms: *"…when you put on your work clothes, then you have a kind of…how to say it, a power position."*

Unacceptable: you are bound to act!

The informants were prone to positioning themselves against AHC by, e.g., talking about how they had (re)acted against AHC, and that it could be done in a good way, *"…but then I think you have an obligation… to rebuke. In a loving way."* They also emphasised that the bystander had a very important role in noticing and stopping or preventing AHC, *"because sometimes I think that it is the person who stands by…maybe more often senses when something goes wrong than the person who is [active] in the situation".*

There were different strategies for intervening against potentially abusive situations:

One informant was concerned about open doors and meant that staff leaving doors open jeopardised a patient's integrity. She was struggling with this problem:

"…it is an indication that you probably can't miss [with laughter in her voice]. No, but sometimes when you have been sitting in the auxiliaries' expedition, there is just a sliding door…there are patients sitting right outside and then I close the door…or when you…hear…that they…are in a room talking and so on. Close the doors…and I close that door [the sliding door] and then it's open again! And I close it."

Practical arrangements for preventing AHC were discussed:

*"…there are more discussions about this [now]. **About**…for example, open the door into a room where a patient is and…how to **place** patients in a room, and how many really have to come into a room. So, these kinds of questions."*

It was also put forward that small talks over a cup of coffee could raise awareness about AHC among staff, but to talk to the patient, either before or after AHC had occurred, was seldom mentioned as an intervention. One informant interpreted this particular kind of silence as fear: *"It must be some kind of …fear to…realise that you are not perfect. Maybe!...Of course if you ask then you have to be prepared…to do something about what the patient might bring up."*

In other words, asking a patient about AHC might force staff to take action, e.g., towards a colleague. Some informants stressed the importance of being earnest in such situations and talk directly to the staff involved as soon as possible. This was what the informant did who told us about the patient who expected to be examined by a female gynaecologist. When she had comforted the patient she asked her if she could talk to the staff member who had examined her, and if the patient wanted to participate in such a meeting. The patient declined t *"…I was allowed to tell…how she had experienced it…I was so disturbed by what she told me. So I felt that I had to find out if that was how it had happened. But he had not really experienced it that way..."*

Furthermore, there was a possibility to report upwards in the hierarchy: *"**I** would not hesitate to…contact…[silence] a foreman, my bosses [if a patient was abused]."* And there was a consensus on having an open climate at the clinic, and that it was important to be made aware when a patient was abused. Speaking up against AHC was considered an option for most informants:

"That you say,' you can't behave like that'. So I believe that…people would tell you…I believe that there are few who would not dare to speak up…I believe they would speak to a colleague."

Ubiquitous

AHC was often described in a broad sense as something that can happen to anyone at any age: patients, staff, relatives and friends to the patient. Anybody can become a victim or an agent (actor or bystander) of AHC: *"…we are abusing each other…all the way down to the patient…"*

AHC was also interpreted as staff being abusive against other staff, for instance by making remarks in a harsh way. It was also pointed out that a patient who had witnessed staff treating each other badly might feel hesitant to ask even important questions for their own sake.

One abusive situation between members of staff described as common was when a midwife called for a doctor and that doctor called for another doctor, and the two of them did not involve the midwife when they discussed the patient.

It was also hypothesised that staff experiencing abuse from other staff might subconsciously take it out on someone else: *"…if I am abused then I will look for someone…that…I have power over."* And that someone is likely to be a patient: *"…it is easier to abuse when there is some kind of power relation… and when there is a kind of malady between us."*

However, patients abused by staff were considered the most serious kind of AHC: *"…the most serious is if we, the staff…abuse patients or relatives. That is another situation I believe."*

Informants also agreed that patients were the most common victims of AHC, and that if patients abused staff it should be understood differently: *"Because there might be…patients who abuse staff in many ways, so to say. But on the other hand, they are in another position…worry can turn you…rather nasty, really."*

Unintentional

AHC was believed to be a common experience among patients. Most informants said that AHC was usually unintentional on behalf of the staff, and that often involved staff was not even aware that it had happened. *"…they are not aware, surely. But then I have to…become aware of how people might experience what I do."*

A variety of explanations of the occurrence of AHC were brought forward, and it was pointed out several times that AHC did not come from evilness in staff members, but rather from a lack of consideration and empathy.

Not being reflective could result in a routine manner or performance. One example given was that of an authority, like the gynaecologist who was often believed to be under time restraints, who simply follows an old habit: focusing on getting things done instead of on the patient.

"…it's so easy to follow… the same footsteps all the time…"

Another example of unintentional AHC was when staff members made jokes between themselves about, e.g., someone being fat, and other staff members were laughing without reflecting on what they were laughing at, or if they ought to put an end to it.

It was also brought forward that unawareness of AHC could be due to inadequate communication skills, e.g., if staff was not sensible enough to read the patient's body language.

The uniqueness in each and everyone's characters was appreciated, but sometimes, if a colleague was known to be harsh without meaning it or even noticing it her- or himself, there was a moral conflict. A bystanding staff member would in such a situation understand that the patient might feel abused, and at the same time know that the "harsh" staff member did not mean to abuse the patient. This was considered a difficult situation, but as one informant concluded,

"…it's about personality, too, so it's really difficult to know how to tackle it. It's interesting that people are different, but on the other hand you don't want those differences to befall the patients so that they feel abused, or maltreated."

Relative

The informants were provoked by the word "abuse" in AHC, and prone to take a defending position against it. They thought of "abuse" (kränkning in Swedish) as a very strong word, that was sometimes used too often and in an inappropriate way. The informants thought that, especially in the rest of the society (outside the hospital), the word "abuse" had suffered inflation. *"I think that 'abuse' may be a tough word…It's a worn out word or a word that is used incorrectly..."*

Informants agreed that AHC was a difficult concept to define. On the one hand, AHC was considered a strong word, and yet AHC could be a small thing. *"…there is no such…scientific quantitative concept [saying] that this is abuse."*

The wording seemed important to the informants and a more neutral word for AHC was desired by some of the informants, e.g., (negative) encounters (bemötande in Swedish).

AHC was considered a personal experience, and it was expressed that patients were more or less vulnerable to this experience. It was also brought forward that there were reasonable experiences that made some patients more vulnerable to AHC than others, e.g., through a history of abuse.

Core category

The three categories 'Dehumanising the patient ', 'unacceptable: you are bound to act!' and 'ubiquitous' are strongly linked to each other in many ways, not the least because of their potentially patient protective components. The category 'Dehumanising the patient' implies

not being seen as a human being, stripped of human value. The codes that filled out this category were characterised by moral imagination and respect for the patient's situation. The informants showed great insight into patients' vulnerability and their own responsibility in relation to AHC. The fact that the informants gave several detailed examples of AHC underlined their emotional engagement. This engagement was a strong reason for staff to adopt a clear position against AHC, expressed in the category 'unacceptable: you are bound to act!' It was also made clear that acting against AHC was beneficial not only for the patient but also for staff: *"…that's what we really ought to do [talk to each other when we think a patient might feel abused] …we take responsibility for each other that way."*

The category 'ubiquitous', indicated that the informants were now more prone to recognise AHC. This openness could be seen as a mediator that enabled staff to talk about AHC, which probably contributed to a milieu where staff felt some pressure to also act against AHC. However, there were contradictions in the staff's definitions of AHC. To claim that AHC was 'unintentional' was a way to describe a fact, and at the same time make AHC trivial. Likewise, the discussion that rendered a 'relative' definition of AHC could be seen as a diversion from a topic that provoked awkward feelings. Both of these categories could be used to legitimize AHC.

DISCUSSION

This study focuses staff members' perception towards AHC after an intervention based on Forum Play.

Comparing interviews from before and after the intervention

In our pre-intervention studies, staff reported detached perceptions of AHC and AHC had a taboo status at the study clinic. [17, 18] They recognised AHC as 'transgressions of ethical principles' but stated that these actions were often justifiable from a staff perspective for various reasons. [17] Staff's awareness of AHC also turned out to be a complex phenomenon restricted by their possibilities to act e.g., caused by hierarchies or because they did not know what to do since they had no tools or training in handling AHC. [18] The strongest expressions of change in the present study, when compared to the pre-intervention studies, was the *increased* awareness about AHC, *stronger* empathy for patients displayed in *more* concrete examples of, and *fewer* explanations, justifications and trivialisations of AHC. The increase of concrete examples of AHC that staff had seen or heard of was most likely a manifestation of the increased awareness of AHC among staff [18].

Moreover, the answers to the question, "what is AHC?" in the present study, are closer to the experiences of both female and male patients than those of the study that posed the same question to staff prior to the intervention, where the core category was 'ethical lapses'. [15-17] Apparently, staff's perception of AHC were closer to the patient's perspective.

The core category

Despite the "resistance" we found, the overall finding is that AHC summons responsibility and urges an itch to act among staff. From having been considered a matter of mishaps - "ethical lapses" - AHC had become "a summoning stone in the shoe" [17]. By this is meant that acting against AHC had become an imperative.

The imperative to act against AHC in the present study stands out as the most important finding. The possible mechanisms for this finding could be that, 1. Forum Play had showed staff that there were possibilities to act, and 2) the taboo status of AHC had been broken at the clinic. The informants told us that AHC was present more often in their daily conversations, and it was even discussed during coffee breaks, i.e. AHC had become a shared problem. According to Galtung, direct events of violence are nurtured and legitimised by cultural and structural violence, forming a vicious triangle. [20, 23] While events of direct violence often are visible, cultural and structural violence are often not. A taboo can exemplify cultural violence. Breaking the taboo could be seen as a way to delegitimize direct events of AHC, and Forum play may have been a useful tool for this purpose since the "culture" had changed, and talking about and acting against AHC had become "the right thing to do". However, it cannot be ruled out that any intervention against AHC that merely drew attention to the topic would have been useful. Therefore it would be interesting to compare different strategies to counteract AHC in future studies.

From disavowal to responsibility

The resistance against and disavowal of AHC found in the pre-intervention studies had not only decreased, it had also changed character. [17, 18] For example, before the intervention informants strongly emphasized that they were abused too. Now they had attained a more general and less defensive view; anybody could get involved in AHC as an actor or a victim.

Moreover, it was considered much worse if a patient was abused by staff, because staff had more powerful positions than patients and they were entrusted with the patients' vulnerability. AHC was still considered to be acted out unintentionally, but the argument was no longer used to explain or justify AHC. Instead it was used as an incentive to become more aware about AHC.

How to define AHC was still problematic to the informants. Obviously AHC had been a new terminology for them, but the wish to rename AHC into a more "comfortable" concept is interesting. It is likely that the concept AHC gradually will be exchanged for the more neutral "a failing encounter" at this clinic.

Limitations

One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff's experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that yet another interview could have added new information or that people who declined to participate in the follow up interviews might have had very different views to those who did participate.

To conduct qualitative follow-up interviews gave us a deeper understanding of changes that might have been pointed out but not have been thoroughly explained by means of e.g. repeated quantitative measures. On the other hand, the approach also involves risks, e.g. the authors' involvement in the project could be assumed to increase the risk for bias both on behalf of the researchers, i.e. doing interpretations favourable to the project's success rate, as well as on behalf of the informants, i.e., a social desirability bias. [36] In an effort to

counteract these biases, external independent researchers repeated interviews as well as analyses. An external researcher analysed de novo the interviews in the present study. This analysis also showed that staff's perception of AHC had approached the patient perspective [37]. New interviews were conducted by a consultant who was not involved in the project and with a different sample of staff who had also participated in the intervention. The results described a positive change from before till after the intervention, not only in perception but also in actions. Several examples were given where staff members had been "experimenting" with different ways to prevent or handle AHC, also where it meant confronting a colleague. [38]

CONCLUSION

In this follow-up study staff's perception of AHC were closer to the patient's perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.

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Table 1. Questions in NorAQ about abuse in health care.

	ABUSE IN HEALTH CARE
Mild abuse Moderate abuse Severe abuse	Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion - in such a way that you were later disturbed by or suffered from the experience? Have you ever experienced that a "normal" event while visiting health services, suddenly became a really terrible and insulting experience, without you fully knowing how this could happen? Have you experienced anybody in health service purposely - as you understood - hurting you physically or mentally, grossly violating you or using your body and your subordinated position to your disadvantage for his/her own purpose?
	ANSWER ALTERNATIVES (THE SAME FOR ALL QUESTIONS)
	1 = No, 2 = Yes, as a child (<18 years), 3 = Yes, as an adult (≥18 years), 4 = Yes, as a child and as an adult

Table 2. Categories and Core category answering the research question: what is abuse in health care?

Categories **Abuse in health care is:**	**Function?**	**Core category**
Relative 7	Legitimizing AHC?	Abuse in health care is a summoning stone in the shoe!
Unintentional 8	Legitimizing AHC?	
Unacceptable: you are bound to act! 8	Protecting the patient from AHC?	
Ubiquitous 9	Protecting the patient from AHC?	
Dehumanising the patient 10	Protecting the patient from AHC?	

Note: Figures represent the number of interviews represented in each category.

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	KS and BW
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD / PhD
3. Occupation	What was their occupation at the time of the study?	BW: senior consultant gynaecologist KS Nurse
4. Gender	Was the researcher male or female?	F / F
5. Experience and training	What experience or training did the researcher have?	akademic training professor / ass. professor
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Informal one meeting
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Professional results from earlier research
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Engagement in the intervention is discussed
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Grounded theory
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	convenience
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	face to face by coordinator
12. Sample size	How many participants were in the study?	10

13. Non-participation	How many people refused to participate or dropped out? Reasons?	11 Not eligible 4 refused
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	clinic
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	NO
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Different staff categories
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	yes not app repeted interviews
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	10
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	AUDIO
20. Field notes	Were field notes made during and/or after the inter view or focus group?	yes
21. Duration	What was the duration of the inter views or focus group?	appr. 60 mn
22. Data saturation	Was data saturation discussed?	yes
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	NO
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	one
25. Description of the coding tree	Did authors provide a description of the coding tree?	no
26. Derivation of themes	Were themes identified in advance or derived from the data?	from data
27. Software	What software, if applicable, was used to manage the data?	—
28. Participant checking	Did participants provide feedback on the findings?	—
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	yes no
30. Data and findings consistent	Was there consistency between the data presented and the findings?	yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	yes

Once you have completed this checklist, please save a copy and upload it as part of your submission. When requested to do so as part of the upload process, please select the file type: *Checklist*. You will NOT be able to proceed with