Tensions in Diabetes Care Practice: Ethical Challenges with a Focus on Nurses in a Home-Based Care Team

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Introduction

The prevalence of diabetes is rising worldwide and the condition has become a major health and economic problem. Diabetes is a chronic illness which results in a relentless, ongoing and incurable suffering, and an inseparable part of it is the suffering of the whole person. The appropriate management of diabetes care includes more than just glycaemic control. How to support patients to live well with diabetes is a tough lifelong task for both patients and healthcare professionals.

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Scholars have engaged in promoting the quality of diabetes care for a long time. Disease self-management and self-efficacy have been reported as important concepts in diabetes care and empowering patients to be active can lead to successful diabetes management (Moser et al. 2006; Shigaki et al. 2010). For patients and healthcare professionals, respecting the disease without letting it dominate the patient’s life is key (Ingadottir 2009, pp. 77–92). Normalizing the process of managing diabetes can encourage patients to regulate their lifestyles with respect to controlling the disease (Olshansky et al. 2008).

In diabetes care practice, an individual care plan tailoring to the patient’s needs and ongoing care provided by healthcare professionals who work together could be suggested as constituting good care (McDonald et al. 2012). A collaborative healthcare team can not only strengthen diabetes self-care in practice, but also ensure that effective medical, preventive and health maintenance interventions take place (Von Korff et al. 1997). The foregoing argumentation reinforces the need for implementation of “The Logic of Care” in diabetes care practice to achieve improvement.

“The Logic of Care” is based on Mol’s field research. Using methods such as ethnographic observations, background research and interviews with diabetes patients and medical practitioners in a hospital in the Netherlands, Mol (2008) engaged critically with the current healthcare models which see patients as consumers and citizens. In the light of Mol’s argumentation, care is not a limited product, but more like a dynamic and open-ended process (Mol 2008, p. 14). A caring process consists of interactive relationships among all of the caring actors (e.g. patients and professionals), and it can be shifted and adapted according to different care outcomes (Mol 2008, p. 20). With respect to the concept of patients as citizens who have abilities and rights to make their own choices and enact their will, Mol elaborated that the patient-citizens have little choice but to bracket a part of what they are and seek ways to live with a disease (Mol 2008, p. 35). Caring is therefore a matter of being attuned, respecting and being adaptable instead of controlling (Mol 2008, p. 36).

By Mol’s assumption, care has its own logic. But one kind of logic (e.g. the logic of care) is not always intrinsically better than other kinds of logic (e.g. the logic of choice) (Mol 2008, p. 92). In practice, we sometimes
need the logic of care, but it can be employed alongside other logics depending on the care situation. It is important that all caring actors be active (Mol 2008, p. 93). In this paper, we utilized “The Logic of Care” conceptualized by Mol for our research approach. Meanwhile, we stressed the ethical dilemmas occurring in a home-based care team.

The notion of the global marketplace has spread to the domain of health services, so that health has come to be seen as a commodity, with the body as its site and the patient as a customer (Parker 1999). Patients’ satisfaction has become a significant indicator to measure the quality of care when patient-centred care is supplied (Robin et al. 2008; Wagner and Bear 2009).

The challenge for healthcare workers is to work within, but also to resist the reductionist impetus of economically based and commercially driven approaches to healthcare (Parker 1999). Healthcare workers face the rigorous tasks of maintaining holistic care, preserving the personal and professional–recipient relationship and finding ways of demonstrating their capacity to deliver high-quality care in a cost-effective way (Parker 1999). Moral tensions may accordingly arise.

Moral tensions in care practice may additionally originate in the different understanding of illness and the distinct demands of diabetes care on healthcare professionals and patients. Patients focus more often on consequences and the impact on their daily life, while healthcare professionals pay more attention to the medical treatment and economic efficiency (Hörnsten et al. 2004). Whereas healthcare professionals pay much attention to the best interests of patients, they usually have to exercise both clinical and moral responsibilities in relation with patients. For this reason, care responsibilities are determined not only by considerations of the patients’ rights and respect for their freedom but also by consideration of the wider health needs of the individual and the community (Thompson et al. 2006).

In the healthcare system, medical orientation, hierarchy, authority and unequal power among physicians, patients and nurses are noticeable (Daiski 2004; Kramer and Schmalenberg 2003). The hierarchy between different professionals affects how a professional can act on his own moral position (Kälvemark et al. 2004). How do healthcare workers work within this kind of medical environment and simultaneously preserve their professional awareness? Which care problems and ethical dilemmas...
can be raised? How do healthcare workers practically reflect on care problems and ethical dilemmas? And how do healthcare workers deal with them in their daily work? To further grasp the ethical dilemmas in diabetes care, it makes sense to take a look at the actors and to review how authority, responsibility and trust play out among physicians, patients and nurses in everyday practice.

Nurses have hitherto played a barely visible role in the German healthcare system, but they have implicitly been expected to fulfil the dominant care role. The nurse is not only the person who provides the care in practice, but also the one who has the most contact with patients and who understands patients better than other healthcare professionals (Rich 2008). We would like to take home-care nurses as an example in this paper to explore how tensions arise and how they are dealt with in the field of patient care.²

**Methods and Materials**

This study is a case study with a qualitative approach. This paper concentrates on home-care nurses’ experiences and tensions in diabetes care practice where complex care takes place involving a multi-professional team.

The home-care centre at the university hospital Freiburg in southwest Germany served as the setting for the research case.³ A field observation and in-depth interviews were implemented to collect empirical data. The interview participants were six home-care nurses who had a diabetes care education or a background of diabetes care experience and had held their current position in the German home-care context for at least two years.

From April to November 2012, direct and participant observations and structured face-to-face interviews with home-care nurses took place. Narrative thematic interviews were performed using an interview guide covering topics related to the experience in diabetes management, the experience of multi-professional team work and needs in diabetes care.⁴

Interviews and feedback sessions were audiotaped and transcribed verbatim for the thematic analysis of the content. Some selected transcripts of interviews were coded by a research group to identify additional
insights. Data management was facilitated by the use of a computer program (NVivo 10). The analysis of the interviews was guided by Creswell’s thematic analysis (2007, pp. 147–176). A two-level coding scheme was used, starting with a provisional list of codes based on selected concepts identified in the literature, with new codes added based on the data (Miles et al. 2013). In an iterative process of coding and condensing the data, recurring themes emerged. In terms of an ethical scheme, three abstracted themes were identified as underlying or latent messages in diabetes care practice; these were then confirmed as being common to all categories.

Findings

By analysing the empirical data focused on the experience of home-care nurses, three themes emerged: identification of care receivers, performance of care actions and foundations of care relationships. These frame the tensions home-care nurses face while working with patients and with other healthcare professionals in the diabetes care context. The tensions around the three themes are:

- The identification of care receivers: Tension between patients and customers.
- The performance of care actions: Tension between an ongoing process and finding an end by acceptance.
- The foundations of care relationships: Tension between authority and responsibility.

Patients Versus Customers

In diabetes care, home-care nurses stated that they treat their care receivers as patients instead of customers. For nurses, the person who receives medical treatment is considered a patient in the nurse–patient relationship, whether his disease is acute or chronic. This way, nurses are able to provide continuous medical care for outpatients from hospitals to the
surrounding where they live. The care relationship ends the day when nurses accept that patients don’t want it and hand over the responsibility to them:

So we call all of our patients ‘patients’. So we don’t have customers. Because we get most of our patients directly from the hospital and they have been treated as patients there. Therefore, they will also be simply treated as patients by us. I cannot call a part of my patients ‘customers’ and the other part of them ‘patients’. […] When patients are independent someday, like Mr. Harry, then we can leave them and say that the patient relationship is closed. But as long as we take care of a patient, he is a patient for us. He won’t be a customer sometimes only because of his chronic disease. (I-NN-01)

When nurses talked about good care, it meant that all of the patients, nurses and physicians feel satisfied with their care outcome. A good care outcome for diabetes care was quickly linked to good blood sugar values: “For me, good care means simply that the patient is satisfied, we are satisfied and the family doctor is satisfied with the blood sugar values” (I-NN-01).

In care practice, nurses avoided to challenge patients’ autonomy and respected their right to choose the way they live. Nurses think that they can’t force patients to act, but can only offer suggestions. However, offering suggestions doesn’t always lead to success:

I can’t force anybody to do anything. I can only suggest to them to do things which are good for their bodies and I can always try to say, ‘You should move more often’, but it doesn’t always work. (I-NN-05)

An Ongoing Process Versus Finding an End by Acceptance

Nurses recognized that creating fear and exerting control is not a good idea for diabetes care. They said, “We are not there to control” (I-NN-01). Indeed, nurses cannot control what their patients eat or what they do throughout the day since they only come for a short visit. Instead of
controlling, it is more important to offer an alternative way of keeping in touch with patients. However, attempts to work with alternatives have run into difficulties in practice. Eight minutes are planned in the schedule for one home-visit with a diabetes patient. The time pressure and insufficient knowledge limit nurses’ work a lot. In particular, nurses have no chance to try alternatives if their patients reject their advice:

It would be very good if we could take more care of diabetes patients, including offering advice on nutrition. But we have no time, and in many cases we don’t have current knowledge. We simply don’t have enough knowledge on nutrition counselling. And some patients do not want it either. They reject it. (I-NN-04)

Nurses expressed that continually trying to achieve their care goals is their wish as a healthcare professional, and a few nurses believed that “constant dripping wears the stone” (I-NN-06). Unfortunately, patients’ lack of intention to follow up on the principles of diabetes management restrains nurses from going further during the care process. In the following case, a nurse tried to motivate her patients at the beginning, but after some failed attempts, the nurse eventually accepted her patient’s decision even though this decision was against her will. However, this outcome led to an uncomfortable feeling on the part of the nurse and hurt the patient–nurse relationship as well:

The patient was exasperated one day and told me, ‘Stop now, I don’t want to hear about it [diabetes care] any more’. Then I said, ‘Okay, let’s let it go’. Then I said nothing about it any more. I had argued with him because of his diabetes. But he still eats chocolate, doesn’t change his life. Then he has to inject more and more Insulin and is getting fatter. He wants that. One day you have to say, ‘Okay’ and accept it. Although it is a difficult decision, but what should I do? I cannot beat him and push him on the way, right. (I-NN-06)

The tension, however, creates a lot of stress for nurses when they have to accept undesired outcomes. Nurses feel pity and are disappoint about situations in which improvements cannot be made: “This is of course an
example in which one has a bad feeling. At this point, you will ask yourself about what you still expect” (I-NN-03). Sometimes, nurses face critical care situations without the possibility of making a difference. Nurses then have to deal with feelings of fear and guilt:

It happened often that his blood sugar values were 18 mg/dl or something like that. That’s a very, very uncomfortable situation. And I have faced such tense situations twice. That’s a very unsettling and scary situation. But as I said, it cannot be changed. (I-NN-01)

**Authority Versus Responsibility**

In home-care practice, nurses usually identify as mediators vis-à-vis the healthcare team and see themselves as advocates for the patients. Nurses reported that their mission in practice is to create a bridge between physicians and patients:

We can actually only play the role of a mediator or a messenger when, for instance, the patient has difficulties to communicate with his family doctor or when the family doctor doesn’t visit his patient regularly. Then we have to call the doctor and inform him, ‘The patient’s values are not good and we need to do something to change it’. In this case, we play the role of an advocate for the patient. So we are simply mediators and advocates. (I-NN-01)

Good cooperative teamwork is important for healthcare, but not always seen in practice. Information flows are often interrupted in a variety of ways between different medical organizations. In practice, home-care nurses often receive a medical plan without the related background. This is neither a satisfying nor a safe situation for nurses. For one thing, nurses are then unsure about their work. In addition, they cannot explain changes in their care to the patients. Nurses have pointed out that they have to take responsibility for the care they offer, and that they therefore want to get clear answers. Nevertheless, they are sometimes too fearful to clarify their questions with physicians because of the strict hierarchy and the nurses’ low position in the current healthcare system:
I would like to know why the doctor raised the Insulin dosage. I’m still not sure what I should do now. Should I contact with the family doctor or a diabetes specialist? Should I send a fax to the family doctor and ask him why he has raised the dosage? But I think that sending a fax is so impersonal. I do not know him. Maybe he will feel that I am stepping on his toes if I, as a ‘lowly’ nurse, ask him something about his medical plan. But I couldn’t explain to my patient why he needs more Insulin now, and I was also surprised about it myself. […] I am not one to merely follow orders. I also have a responsibility for what I do. (I-NN-06)

Many nurses have mentioned that communication with physicians is not always a comfortable experience. Nurses have complained that it is difficult to reach physicians or to talk to them. Sometimes nurses have tried to communicate with physicians via the patients. However, this indirect way may lead to inter-professional mistrust. Furthermore, nurses have sometimes suggested to their patients to change their family physician in order to create a safe care environment and allow for cooperative teamwork:

When I inform a family doctor that his patient is in a bad condition, then he must respond to my request and do something. […] If he doesn’t act, I will say to the patient, ‘It took such a long time until your doctor came. Maybe you should consider taking another doctor who comes quickly’. I have already done that. Whether the patient does it or not is another matter, because patients usually say, ‘Oh, we have already had that doctor for 20 years and he has always come’. (I-NN-06)

Many nurses believe that patients’ have a lot more trust in their physicians than in nurses. According to the nurses’ experience, patients follow what their doctors say, no matter what it is. This creates a tension for nurses. Even if the nurses disagree with the physicians’ opinions, they will still obey the physicians’ orders. Nurses do so not only because physicians have the legal right to have “the last word”, but also because the nurses don’t want to confuse patients with two opposing sets of advice:

What doctors say is right. So even if I sometimes don’t agree with what the doctors say, I don’t want to confuse my patients. I cannot just go to a
patient and say, ‘What a nonsense your doctor told to you’, because the patient will become totally uncertain. I have experienced that one time, when I said to the patient, ‘We must do that’, and the patient answered, ‘Oh, but my doctor told me something quite different.’ And then he became very uncertain. (I-NN-02)

Discussion

Can Care Receivers Be Both “Customers” and “Patients”?  

The first theme of the research interprets the tension regarding the identification of care receivers as customers and patients. According to the research, home-care nurses consider their care receivers “patients” because this helps nurses provide a continuum of care with different organizations. Nevertheless, consumer sovereignty is usually taken into consideration in healthcare. It is reflected in nurses’ care activities in that they avoid putting pressure on patients. For instance, when a patient rejects a nurse’s offer of a nutrition consultant’s services, this approach to care is discontinued in practice. In this case, the logic of choice is at work and the care receiver is treated more like a customer than a patient.

Since consumer sovereignty has high priority in the healthcare market, patients are often practically treated as customers and as citizens and choices are made following the patients’ wishes (Ryl and Horch 2013). Nurses then have difficulties carrying out interventions against patients’ will. As a nurse explained, “I cannot force anybody to do anything” (I-NN-05). Nurses often have to compromise, which may run counter to their professional awareness. While the understanding of care receivers as patients and of the value of the person’s wholeness is rooted in the identity of the nursing professional, the way nurses have to act is often contrary to this identity in practice. This contradiction can produce a moral tension in nursing work. It might lead to frustration with the caring process or damage the trust-relationship between nurses and patients. We will discuss these two themes later in the second and third sections.
In home-care practice, satisfaction has been used as the main indicator to decide if good care is offered. The terms “quality in care service” and “patient satisfaction” are often connected and brought on the healthcare agenda (Bostan et al. 2007). Patient satisfaction is derived from the marketing perspective. Patients are the most important clients of health institutions and their satisfaction is hence the main product of health institutions (Torpie 2014). Patient satisfaction has been explained in terms of adding value and creating a service exceeding or meeting patients’ expectations (Torpie 2014). However, when healthcare professionals only focus on patients’ satisfactions during a care process, they provide their services often as commodities according to the customers’ desires (Mol 2008, p. 28).

There is a danger in thinking of care as a commodity, as a service for purchase. First, the diverse care goals and needs patients and nurses have may result in a tension for nurses. This is because patients place a lot of trust in those who care for them and for nurses to respond in a trustworthy way, they must care about their patients, not just for them (De Raeve 2002; Hörnsten et al. 2004). Second, when healthcare professionals begin to talk in terms of commodification, they too quickly begin to slip into thinking of the time and cost for a service instead of the needs of those cared for (Olshansky et al. 2008; Tronto 2010). Third, caring for patients is a kind of caritas. Caring for ill people is valuable and meaningful in and of itself and cannot be calculated and priced as a commodity (Maio 2009).

In the words of Duttweiler (2007), health is not a product that can be sold and a patient is not a customer who buys a product, but a person who needs professionals’ help to deal with his diseases. In this sense, care professionals have a duty to ensure that patients are able to give their agreement to the care process by, for instance, ensuring their empowerment, which is considered a transformative way of autonomy (Duttweiler 2007). Thus, thinking of care receivers as patients doesn’t mean ignoring their autonomy or denying their rights to make decisions about their needs, but providing alternatives, sources of legitimacy and information as counter-acting forces (Tronto 2010).

To take care of patients’ satisfaction, to respect patients’ rights of make their own choices or to empower patients are different ways of caring.
The concern in diabetes care is not which one is better, but which one is more appropriate to a situation and what can be done in practice (Mol 2008, p. 92). That means that patients’ satisfaction can be one of the indicators to measure the quality of care, but it shouldn’t be the only one. Consumer sovereignty should be respected, but all of the patients’ expectations should not necessarily be fulfilled in practice without thinking of the actual needs for care, especially when dealing with diabetes.

Can “Finding an End” Be Acceptable in an Ongoing Care Process?

The second theme summarized from the research findings is around care actions. Within the logic of care, care is an interactive, open-ended process that may be shaped and reshaped depending on its results (Mol 2008, p. 23). Nevertheless, nursing care has its boundaries in practice. In the research, a tension emerged between continually trying for care improvements and finding an end by accepting an undesired care outcome.

This kind of distress is usually connected with the differences in care goals between patients and nurses, as well as their different perspectives on what “good” is. A care intervention such as asking patients to follow strict nutrition rules may be considered as good for diabetes management, but may limit patients’ day-to-day life and happiness a lot. Patients may therefore reject an approach to care during a care process. The logic of care implies the need to pay attention to the information obtained from care practice without passing judgment as to what is good or bad, so that healthcare professionals and patients respect each others’ experience and are attuned to each others’ strengths and limitations (Mol 2008, p. 65).

While healthcare professionals are carrying out their duty of ensuring patients’ safety and devoting themselves to keeping risk and harm away from patients’ bodies, patients’ wishes and/or desires may often be ignored. For instance, if a nurse tries to prohibit her patient from eating chocolate, which is his favourite food, that patient may suffer from the feeling of being controlled. On the contrary, if the nurse knows more...
about the background of her patient, she may be able to understand better why the patient takes a given care decision and why the decision is important for him. If nurses can, in their care, balance the priorities and concerns of both patients and healthcare professionals and find a common denominator leading to an outcome in which the patient’s safety is ensured, nurses may accept that letting it go can, in some cases, be the best option for a patient, even if it doesn’t meet the nurses’ expectation of the care process. As Mol explained, “The logic of care is not preoccupied with our will, and what we may opt for, but concentrates on what we do”. (Mol 2008, p. 8) Unfortunately, nurses do not, in practice, have the time to get all the relevant information or the space and ability to reflect on these kinds of dilemmas in care during their busy and stressful work.

Modifying one’s lifestyle is part of diabetes treatment, but it is the most difficult part of diabetes management. In the practice of care, the patients’ intentions to follow through on a care intervention influence the care professionals’ motivation as well. It is often seen in diabetes care that nurses stop trying to offer a care improvement (e.g. a nutrition consultation) if they recognize that their patients have no interest in it. Likewise, when patients show the will to take part in care activities, nurses do more for them. Yet, a clinician–patient relationship requires more than a customer service oriented by customers’ decisions. It is a therapeutic relationship which focuses on caring for an individual more than on customer service (Torpie 2014). In other words, it is sometimes necessary in care practice to push patients to do things for their bodies, just like a diabetes patient must inject insulin regularly if they want to stay alive (Mol 2008, p. 45).

Encouraging patients to be active by sharing doctoring and care responsibility with other care professionals is advisable in diabetes care (Duttweiler 2007; Mol 2008, p. 65). From this point of view, it is important that patients, as customers in the medical market, have to realize their limitations in professional care, to trust their care professionals and to accept help (Duttweiler 2007). Patients have to be educated about their disease and to act themselves during their disease management. Care professionals have to provide support until patients get a full understanding of their disease management and are able to integrate it into their life (Maio 2009; Raspe 1999). It is a long-term process which costs
time, money and manpower. When working within a medical care system organized on the basis of economic efficiency, it is unfortunately difficult to bring theory into practice. As a nurse told us, “It would be very good if we could take more care of diabetes patients. […] But we have no time, and in many cases, we don’t have current knowledge. […] And some patients do not want it either. They reject it” (I-NN-03).

Accepting an undesired care outcome is symptomatic for an ambivalence to their professional awareness for home-care nurses and leads to feelings of uncertainty and disappointment. As a nurse said, “[…] at this time, you will ask yourself what you still expect” (I-NN-03). In keeping with their professional identity, nurses expect that a care improvement can be implemented and patients’ safety can be ensured. In reality, nurses can have to deal with critical care situations without any possibility of changing the situation. Nurses might therefore fall into a kind of moral distress, doubting themselves and feeling fear and guilt. During nurses’ daily work, especially in home-based care practice, nurses have only few opportunities to exchange their experiences in care with their care team or to discuss ethical dilemmas with others.

ANA (2008) noted in the “ANA Nursing Code of Ethics” 10: “The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth”. The research data reflected the requirement to enhance nurses’ personal and professional growth. The “Code of Ethics” further articulated: “Nurses are required to have knowledge relevant to the current scope and standards of nursing practice, changing issues, concerns, controversies and ethics. Where care required is outside the competencies of the individual nurse, consultation should be sought or the patient should be referred to others for appropriate care” (ANA 2008). The logic of care states a similar aspect: “A care process involves a team and tasks are divided between the members of that team in ever-changing ways” (Mol 2008, p. 21). It is essential to develop efficient networking among different care professionals in diabetes care practice. Meanwhile, each care professional has to learn how to work together with other care professionals and has to rethink collaborative ways of working within a team.
Can Care Responsibility Play Out Within Trust-Relationships Without Authority?

This is the third theme associated with the foundations of care relationships. In this section, trust in a nurse-physician relationship and in a nurse-patient relationship is embedded within a healthcare environment full of a sense of responsibility without authority while professional care responsibilities are not made explicit.

The phrase of “responsibility without authority” has been widely used in various scholarly discussions such as social, economic, management, political, medical and healthcare discourses. It often designates the tension in relationships part of a hierarchy, for instance, in a nurse–doctor relationship (Burston and Tuckett 2013; Pendry 2007; Pullon 2008). While analysing the research data and reviewing the literature, it became clear that the expression “responsibility without authority” appeared within the relationships among physicians, nurses and patients in home-based diabetes care practice. While nurses are expected to be responsible for their work, they often experience powerlessness to act within the hierarchical healthcare system where physicians have both the authority and the patients’ trust.

In the German healthcare system, medicine is considered as powerful and medical care is seen as a professional endeavour in care practice. The centralization of medical care in society causes an uneven power distribution in professional relationships. Physicians have the power to take medical decisions and nurses have the responsibility to implement them. A moral dilemma can appear in the hierarchy between different professionals when a person who is lower in the hierarchy has to carry out orders from a superior against their own conviction (Kälvemark et al. 2004). Burston and Tuckett (2013) have illustrated how nurses suffer from this care dilemma as “nurses [are] faced with the choice of either overstepping the boundary and acting, or waiting for the physician, watching the suffering of their patients”. The problem in this relationship may stem from the different approaches to healthcare delivery, such as a curative as opposed to a care-based approach (Burston and Tuckett 2013).
Traditionally, physicians have authority in medical care and patients trust their physicians as well. A nurse described how she experienced physicians’ authority during her daily work in that “what doctors say is right. So even if I sometimes don’t agree with what the doctors say, I don’t want to confuse my patients” (I-NN-02). This quote reveals how authority, responsibility and trust play out in a care team: The patient trusts his physician; the nurse recognizes what doctors say may not always be right; the nurse experiences difficulties in influencing the decision of her patient; the nurse admits that physicians have the right to have the last word; the nurse knows that she has to be responsible for what she does; the nurse might communicate with the physician or she might be not; the nurse consequently follows the doctor’s orders. The care responsibility seems to be silently transferred from one hand to another when the nurse thinks that physicians are in charge. Actually, nurses still have to take responsibility for the care implementation and patients have the right to be informed. Physicians also have to take responsibility for ensuring the safety of medical care. From the above case, we can also observe that physicians’ authority invisibly exists within a nurse–patient relationship. Even on the scene, where physicians are not present in a care activity, their authority affects the interactions between nurses and patients.

Another nurse highlights how she is under the physicians’ authority in that, “Maybe he (a family doctor) feels his toes are being stepped on if I, as a ‘lowly’ nurse, ask him something about his medical plan” (I-NN-06). According to the research data, nurses feel dissatisfied and uncertain when communication within a care team is not flowing, when their voices are not heard or not accepted, or when they don’t have the authority to negotiate within a care team. Pendry (2007) affirmed that nurses have to carry a lot of responsibility, but lack the necessary executive authority to do anything about a situation. From nurses’ point of view, some of the most painful practical tensions arise because they lack the authority to act on their own, to exercise their own judgment, to take the initiative and to go against physicians’ orders (Thompson et al. 2006). An international study demonstrated similar findings: “Nurses felt that they lacked either power to speak against physicians’ opinions”, or “[n]urses believed that their opinions would not be accepted” (Malloy et al. 2009).
To hand over the care responsibility or to accept an undesired care outcome are not pleasant experiences for nurses. Nurses usually feel mistrust and disappointment about themselves, and sometimes about physicians and/or the healthcare system. This tension, as Burston and Tuckett (2013) have articulated, may not only manifest internally or externally, but may harm the individual, others and/or the system. It may further induce feelings of anger towards oneself, self-doubt, diminished self-esteem, depression and even burnout and feelings of anger, bitterness, dismay and frustration towards others (Burston and Tuckett 2013).

An approach whereby all care team members, including physicians, nurses and patients, share the doctoring and the responsibility may help in dealing with this kind of tension in practice. That way, when nurses recognize that physicians are unable to make an optimal decision for a given care situation, nurses would be able to communicate with physicians, enabling them to better take responsibility for the patients’ safety. The relevant professional care competencies should be taught in nursing courses and in practice in the field. Physicians also have a responsibility to enhance their professional competencies, including by creating an intensive networking with other healthcare professionals to share doctoring. Additionally, healthcare institutes should be able to organize better cooperative teamwork so that an open and effective dialog among multiple professionals can take place.

**Can Professional Identity and Care Competencies Support Trust-Relationships?**

Trust toward other professionals as well as towards patients directly and indirectly influences healthcare workers’ motivation in providing care (Okello and Gilson 2015). The research indicates that nurses sustain relationships of mistrust with physicians and patients. This originates in the hierarchal medical society, the institutional organization and the care legislation. Nonetheless, nurses’ limited professional identity and insufficient professional care competencies are revealed as additional reasons which may frustrate communication with a care team and may further lead to mistrust between nurses, physicians and patients.
Pullon (2008) articulated that the identification and separation of vocational and business roles and the development of a professional identity form the basis for the development of trust in the nurse–physician relationship. In home-care practice, nurses identified their professional roles as mediators and advocates in diabetes care. These two roles are indispensable in the home-based care context because they support interprofessionalism as a platform for the exchange of information. Some studies hold the same point of view and reason that nurses and patients have a closer relationship compared to other healthcare professionals because nursing care occupies an “in between” position in the organization of the public response to the patients’ needs. Nurses act to follow up and address their needs appropriately (Rich 2008). Nurses’ role as mediators means not only delivering messages from patients to physicians; it consists of the missions to create efficient communication, to share care plans and to identify problems to the care team. Likewise, nurses’ role as advocates involves conveying patients’ needs in meaningful ways. That is to say that nurses should not only be able to protect patients’ rights when something goes wrong, but should also be able to establish a nourishing and safe caring environment. These expanded missions have to be taken into account when we talk about “good care” in home-based diabetes management.

Following Pullon’s argumentation, (2008) “[p]rofessional identity is related to the demonstration of professional competence, in turn it is related to the development of mutual inter-professional respect and enduring inter-professional trust”. Nurses’ professional competencies influence inter-professional trust and patients’ trust as well. On the basis of the research data, unequal trust-relationships between patients, nurses and physicians can be observed in home-care practice. Rørtveit and her colleagues (2015) explained that patients’ trust in nursing is dependent on the nurses’ knowledge, on their level of commitment to dialogue and to creating and developing the relationship and on contextual issues. Yet, the research conveyed a message that nurses are becoming aware of their insufficient knowledge and care competencies in diabetes care. Smith (2012) identified that, “[a]ntecedents to personal and external motivations include the attribution of and integrating of knowledge into practice, experience, critical thinking, proficient skills, caring, communication,
environment, motivation, and professionalism”. According to his argumentation, issues such as confidence, safe practice and holistic care belong to the caring competencies as well (Smith 2012). In the current healthcare environment, nurses are too overwhelmed to develop the expected competencies and meet the expanded professional roles.

Responding to the argumentation by Maio (2009, p. 32), “[o]ne big problem in modern medical care is that healthcare workers are not reflecting and not able to think about themselves, their identity and the reason why they provide care” (Ein großes Problem der modernen Medizin ist somit ihre Unreflektiertheit, ihre Unfähigkeit, über sich selbst, über ihren Ursprung, über ihre Identität nachzudenken). Encouraging nurses to face ethical dilemmas and to reflect on their nursing work is getting more and more important in care practice. Improving the theoretical and practical training in diabetes care during nursing training and further education programmes may offer a possibility of change. A nourished nursing practice has to be established, wherein nurses have time and space to keep trying to achieve improvements in care. Well-structured institutional regulations for diabetes care may additionally offer legal support for nursing work.11 It is also necessary to encourage nurses to get a clear understanding of external influences related to nursing education, health legislation and health policy. As Tronto (2010) advocated to healthcare professionals, “recognition and debate/dialogue of relations of power within and outside the organization of competitive and dominative power and agreement of common purpose” should allow nurses not only to recognize the ethical tensions raised in care practice and to learn to reflect on them but also to be able to push a dialogue with the healthcare team, the healthcare system and society. There will be new roles for nurses to grow into and to fill in their practice.

Conclusion

Nurses work within a healthcare system oriented towards economic efficiency. Nurses are, on the one hand, limited by the business approach of serving “customers” and, on the other hand, motivated by the professional awareness of offering medical care for “patients”. Nurses attempt to
provide patients’ with care regulated by their professional identity while satisfying customers’ expectations that are dominating the healthcare market. When customer sovereignty and patients’ autonomy are emphasized, nurses often have to accept a compromise against their own will. The nursing professional awareness hardly translates into care practice and ethical dilemmas may therefore occur.

Within the hierarchical German medical care system, nurses experience responsibility without authority in the care field. Without authority, nurses find it difficult to engage in teamwork while they are carrying out care responsibilities. Relationships of mistrust towards the care team also come with this. Additional reasons arise from limited professional care competencies and a narrow professional identity. Nurses are overwhelmed in diabetes care, especially in dealing with ethical tensions. To improve personal and professional growth for all healthcare workers and to enhance patients’ engagement in disease management is essential. It is also important to create a nourishing and safe care environment wherein professional awareness can be encouraged and acted upon by sharing doctoring and responsibility. The insights gained through this research may assist nurses and other healthcare professionals in reflecting on home-based care teamwork and improving diabetes care in general.

Notes

1. Robin and his colleagues (2008) indicated that patient-centered care (PCC) promotes adherence and leads to improved health outcomes. The fundamental characteristics of PCC were identified as patient involvement in care and the individualization of patient care. Effective PCC practices were related to communication, shared decision making and patient education. However, our research findings showed that an effective PCC is difficult to carry out in practice because of the commercial healthcare market, insufficient competencies on the part of nurses and the hierarchy that arises when patients’ satisfaction is used as the indicator to measure the quality of care.

2. Our research does not aim to measure the ethical competencies of healthcare workers or to resolve the ethical tensions that deeply affect the hierarchy. The purpose of this paper is to offer support for healthcare
workers to get a better understanding of the ethical tensions in diabetes care by reflecting on the interactions within a healthcare team, as well as enhancing the sensibility of healthcare workers towards these tensions and inspiring them to think about what can be done in care practice.

3. The Ethics Committee of the University Hospital Freiburg (EK-Freiburg 43/12) approved the study and the participants received the usual assurance about anonymity, confidentially and the right to withdraw at any point.

4. Research questions were asked like: “Can you tell me how you experience caring for patients with diabetes?”; “How do you experience working together with other healthcare professionals such as physicians?”; “Can you tell me an example of how you have reacted to a conflict in care practice?” and “Can you describe what good diabetes care is for you?”

5. The German healthcare is organized as a ‘Third Party Payer System’. Patients don’t pay healthcare providers directly for their medical treatment within this healthcare system. The healthcare providers calculate the cost of medical services and then receive payments from healthcare insurance (Tscheulin and Dietrich 2010). Thus, patients have a customer status in relation to the health insurance as well as to the service provider, but their “needs” have been considered more often than their “demands” (Raspe 1999; Tscheulin and Dietrich 2010). Nursing care has been talked about as customer care according to the regulations of healthcare insurance as well (Raspe 1999). However, from the perspective of patient care, patients are not customers because their status has been greatly reduced by illness or injury and their sovereignty is therefore limited (Duttweiler 2007; Maio 2009; Raspe 1999; Torpie 2014). It is worth to take a detailed look at how healthcare workers think about their care receivers and how their understanding of care receivers influences their care activities in the field.

6. In the edited volume, “Socio-material will-work”, Annelieke Driessen elaborated how healthcare workers applied three kinds of will-work as alternative ways to deal with the wanting of patients to provide good care in the dementia care context.

7. In the discussion part, we draw up some questions formed around tensions to introduce our debate. But our purpose is not to offer clear answers. Instead, we would like to encourage our readers to rethink the tensions based on a variety of discourses. Thus, answers can be different from divergent perspectives, and care work can be presented with a variety of faces.
8. Consumer sovereignty is a phrase often translated as ‘the customer is king’ and it lays the emphasis on the rights of consumers. Ryl and Horch (2013) indicated that sovereignty is usually presented in healthcare as citizen- and patient-centred care in order to improve the quality of care. In Germany, medical care responds to patients’ needs through patient-centred care. In the past ten years, the concept of citizen- and patient-centred care has further developed in the legal and political spheres in the German healthcare system (Ryl and Horch 2013).

9. Björn Freter took a philosophical view of caring for the whole person to discuss the norms for diabetes care. Please see the edited volume (Chapter “Nursing as Accommodated Care. A Contribution to the Phenomenology of Care. Appeal—Concern—Volition—Practice”).

10. ANA is the acronym for the American Nurses Association. The Code of Ethics for Nurses was developed as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession (ANA 2008).

11. For more on the role of institutional regulation in care, please see the edited volume by Tim Opgenhaffen (Chapter “Regulation as an Obstacle to Care? A Care-Ethical Evaluation of the Regulation on the Use of Seclusion Cells in Psychiatric Care in Flanders (Belgium)”) with the legal perspective.

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