A qualitative study on discrimination and ethical implications in stroke care in contemporary Greece

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Contemporary stroke care is diverse, contributing to complex ethical dilemmas and controversies. In Greece, continuing austerity measures and an ageing population are expected to increase the burden of stroke on health care delivery. We sought to explore ethical views and stances of health care professionals caring for stroke patients in Greece. Forms of discrimination against elderly hospitalized patients were also addressed. A qualitative design was adopted whereby an informal focus group interview and follow-up, face-to-face individual interviews were undertaken. The sample consisted of 12 nurses working in clinical areas with stroke patients. Their mean age was 31 years with a mean work experience of 10 years. Individual discussions were audio taped after subject consent and were transcribed verbatim subsequently for keywords-in-context analysis. Analysis of the focus interview revealed several recurring themes, namely, ward destination, admission policies, the concepts of age as related to stroke. Individual interviews highlighted several other topics, such as preferences for specific types of patients, communication capacity of the patient's condition, and his or her individual characteristics as a favoring or limiting factors, and challenges to age-related criteria for treatment. There is an age-related criteria of 65 years for ward destination after stroke as set by a ministerial decree, which is still practiced. Moreover, younger stroke patients may be offered more thorough assessments and clinical tests and therapies. Discrepancies in the level of care pose an ethical concern regarding levels of care for older stroke patients in Greece. A longstanding, age-related national policy in Greece regarding hospital admission criteria is shown to be a detrimental influence on ward admission for stroke patients. This policy, coupled with prehospital care protocols, was shown to promote ageism against this patient group. The age-related agenda in the Greek health care system has suffused care delivery with pockets of discrimination. (J Vasc Nurs 2015;33:138-142)

Stroke care poses a mix of complex ethical dilemmas and controversies, including when, where, and how to treat a patient; patient selection; resource allocation; and consent issues.[1,2] Owing to the increasing elderly population worldwide, stroke prevalence and incidence are increasing, becoming more lethal, debilitating, and costly.[3] This is especially true for the Western world, where ageing populations are expected to increase the burden of stroke-related disability on health care systems.[4,5]

Despite the considerable amount of global research and renewed interest of the disease, the condition remains life threatening and devastating for individuals, families, and societies worldwide. Yet, in many parts of the world prejudices and superstitions continue to infiltrate many societies regarding stroke services provision and levels of care offered[6,7]

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Furthermore, there is an abundance of international literature regarding attitudes to stroke patients, often referred as "heavies," who require a lot of help with toileting, feeding, and moving in bed, as reflected by a very low Barthel Index score, and are often viewed as "unpopular to treat" both in the hospital or at home.[8–10] Clearly, these attitudes are unethical within a contemporary nursing scope of professional conduct, working culture, and ethos.

Dobson[11] points out the urgent need for action on ageism in treating stroke patients. Ageism is the discrimination or unfair treatment based on a person's age. According to the Ontario Human Rights Commission,[12] the term "ageism" refers to a socially constructed way of thinking about older persons based on negative attitudes and stereotypes about aging and, furthermore, is accompanied by a tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons.

In this context, up to 3 decades ago, treatments for stroke consisted mainly of supportive care and the prevention of complications.[13] Furthermore, in many parts of the world this practice still prevails, usually coupled with a stigmatized and fatalistic view that the condition is associated only with age and degeneration. This has incorporated a subtle but insidiously negative aspect of "ageism," which is strongly associated with the condition. This notion has been exacerbated by poor outcomes and the mistaken belief that stroke only happens to the very old and is therefore not of concern to the young.[14,15]

Therefore, stroke has been viewed for many centuries, even among medical professionals, as untreatable and not preventable.[16] Often, patients with severe stroke symptomatology have faced therapeutic nihilism with instructions by the attending physician of "do not resuscitate." These attitudes may have lead to self-fulfilling prophecies of the "untreatable" and "terminal" manner of the condition and to a pessimistic overestimation of symptoms.[17] In the case of stroke care, these set attitudes can be even more noticeable. Thus, to tackle this perceived reality, first one needs to analyze and describe exactly what is happening in hospital settings with regard to equity in stroke services provision.[18,19]

In contemporary Greece, stroke care is delivered in 3 different types of ward. These can be a stroke bay (SB), a neurology ward (NW), and a medical ward (MW). Typically, Greek hospitals care for stroke on either an internal medical ward or NW. However, prefecture hospitals may not have a NW; the majority of city hospitals have both types within the same setting. However, there are only 3 SBs in the country in the capital and second capital.

AIM

The purpose of this study was to explore current views and ethical stances of health care professionals in a Greek hospital with all different settings of stroke care delivery. In addition, an attempt is made to uncover and discuss issues concerning discrimination against hospitalized stroke patients.

METHOD AND MATERIALS

To meet the study's aim, a qualitative investigation via a focus group informal interview and follow-up individual interviews was undertaken. This arrangement was chosen, because participants who were able to initially convey thoughts or feelings during a group meeting were also given the chance to elaborate further on an individual basis. In this sense, the focus group acted as a precursor to further qualitative exploration and verification. The rationale of starting with an informal focus group was based on the premise that such groups are less threatening to participants, and an open environment enables research subjects to elaborate and reflect on perceptions, ideas, opinions, and deeper thoughts.[20]

This was part of a larger study looking at stroke care services in contemporary Greece. Ethical approval for this study was granted by the hospital's Scientific Committee and data was collected during spring 2013.

The sample was composed of 12 nurses working with stroke patients in a hospital in northern Greece. Their mean age was 31 years with a mean work experience of 10 years. There were 10 female and 2 male nurses working on 3 different wards dealing with stroke in a busy, tertiary care hospital in Greece. This sample was drawn from a city hospital with all 3 different stroke settings—SB, NW, and MW. As mentioned, this is 1 of only 3 Greek hospitals that offers this particular arrangement of services. In this light, this investigative research may be viewed as a case study.

Within the focus group meeting, the researcher–moderator posed a series of open discussion topics intended to gain insight about the way the group views elderly care. This was to gain personal, honest, and insightful responses rather than seeking for the sample to narrate accounts of ethos specific facts and events. Furthermore, this sample of stroke nurses in Greece might offer insights consistent with those shared by the wider Greek National Health Service working force regarding contemporary stroke care in Greece.

After the focus group meeting, further individual interviews were conducted to verify key points arising from the group discussion and explore issues not fully explored in the group meeting. Interviews lasted between 10 and 25 minutes and were undertaken at mutually convenient times in the hospital grounds, usually after work shifts.

For data analysis purposes, individual discussions were audio taped after obtaining subjects' consent. These were subsequently verbatim transcribed for the purpose of keywords-in-context analysis that followed. The aim of the analysis was to determine how certain key words in the text were used in relation to the narration or the flow of conversation.[21] This process was performed in 3 steps:

i) Initially, multiple thorough readings of the verbatim transcripts to identify keywords were undertaken;
ii) Subsequently, use of the surrounding words to understand the underlying and contextual meaning of the keyword was performed, and
iii) Finally, this was repeated in a source (focus group discussion) and across sources (individual interviews).

This method of analysis was chosen owing to the interactive nature of focus groups, which may facilitate different context for the same key word, that is, "old," and therefore providing insights into the culture of specific words as represented within the ethos of a health care environment.[22,23]

RESULTS

Focus group

Keywords-in-context analysis from the group meeting revealed that ward destination after stroke is often made in the Accident and Emergency department (A&E) where the diagnosis is set usually via CT. However, there is a longstanding national policy in Greece on hospital admission criteria that stipulates age limits of admission to ward destination specifically for stroke patients. When asked about the admission policy, the nurse ward manager of a busy NW responded holding the following viewpoint:

> It's a local policy endorsed by ministerial doctrine so we admit patients up to 65 years old. That's because after 65 years you can't do much for a stroke patient so we don't want to 'occupy' our ward beds with such patients.

However, there are occasions when the ministerial doctrine is waived, especially when life-saving treatment is an option or in some cases when family and friends of staff or some other privileged citizens are involved. As 1 interviewee points out, patients over 65 years are not necessarily admitted only to the MW as clearly stated in the conversation below.

> Interviewer: Is there an informal age limit for (thrombolytic) treatment?
>
> Subject: In Greece it is not informal, in fact it is formal and is defined by law decree with an age of 65 years, that is if a stroke patient is under 65 he goes to a neurology ward and if he is over 65 he will go a internal medicine