Health Communication

Interactional Communication Challenges in End-of-Life Care: Dialectical Tensions and Management Strategies Experienced by Home Hospice Nurses

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This study examines the dialectical tensions experienced by home hospice nurses in interactions with patients, families, and health care providers. In-depth, semistructured interviews were conducted with 24 home hospice nurses from a mid-size for-profit hospice organization serving approximately 230 patients on an annual basis. Interviews revealed hospice nurses experience both interpersonal and organizational dialectics during hospice interactions: authoritative–nonauthoritative, revelation–concealment, independence–collaboration, and quality of care–business of care. Dialectics often resulted as a by-product of (a) responding to expectations and care choices of patients and families particular to the emotionally charged home context, (b) obtaining authorization from health care providers who are not members of the interdisciplinary team, and (c) pressures associated with providing quality patient care while fulfilling organizational role requirements. The praxis strategies used to negotiate tensions included segmentation, balance, recalibration, and spiraling inversion. Specifically, nurses employed strategies such as ascertaining family/patient acceptance, using persuasive tactics when communicating with external health care providers, relying on effective time management, and working off the clock to provide more in-person care. Although functional for patients and hospice organizations, nurses who continually rely on these strategies may experience job stress when their interpersonal commitments repeatedly conflict with organizational role demands.

The American population 65 years and older has steadily grown, with projections estimating 55 million by 2020, an increase of 36% since 2010 (Administration on Aging, 2011). As life expectancy rates continue to climb, hospice programs have seen an increase in referrals for end-of-life care. The National Hospice and Palliative Care Organization (2012) reports approximately 1.65 million patients and families received hospice services in 2011, a 7% increase in 1 year. As one of the fastest growing medical specialties, hospice continues to play an instrumental role in the American health care system (Han, Remsburg, McAuley, Keay, & Travis, 2006).

Hospice provides end-of-life care for terminally ill patients diagnosed with 6 months or less to live and no longer responding to curative treatment. The hospice philosophy emphasizes comfort and dignity while addressing the emotional, psychological, and spiritual needs of patients and their families (Hospice Foundation of America, 2012). Specifically, hospice offers pain management assistance for patients, as well as respite, counseling, and bereavement services for families and caregivers (Pace, 2006). Although hospice care is delivered in a variety of settings (i.e., nursing home, inpatient facility), most patients receive services in private residences, with many getting financial assistance

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from the Medicare hospice benefits program (National Hospice and Palliative Care Organization, 2012).

Interdisciplinary teams (IDTs) function as the foundation of hospice's holistic model and consist of diverse health professionals collaborating together to deliver end-of-life care (Oliver, Wittenberg-Lyles, & Day, 2006). Given that hospice nurses are responsible for patient intake and often have the most contact hours with patients and families, they play a central role in hospice interdisciplinary teams. Additionally, registered nurses make up the largest group of full-time direct patient care staff in hospice organizations (30.2%) (National Hospice and Palliative Care Organization, 2012). As a result, they serve on the frontline in helping patients and families cope with the dying process.

Hospice nursing shares similar duties with acute and managed care nursing, such as conducting physical assessments, evaluating symptoms, collaborating with other health care professionals, coordinating patient care, evaluating symptoms, and meeting the needs of multiple parties (Apker, 2001; see Apker, Propp, & Zabava Ford, 2005). Hospice nursing is unique, however, in four major ways. First, hospice nurses frequently participate in and/or initiate meaningful conversations about the dying process, which is often avoided by acute care nurses due to general discomfort communicating about death and dying or the lack of end-of-life training (Mee, 2002; Schulman-Green, McCorkle, Cherlin, Johnson-Hurzeler, & Bradley, 2005). Second, hospice nurses purposefully focus on comfort and pain management in end-of-life care, distinguishing them from nursing colleagues who focus on curative or preventative models (Nurses for a Healthier Tomorrow, n.d.). Third, home hospice nurses actively involve families in care plans since family caregivers often serve as proxy decision makers and advocates for terminally ill hospice patients (Oliver, Demiris, Wittenberg-Lyles, & Porock, 2010; Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008). Fourth, due to the context of care, home hospice nurses spend more time working independently in private homes and therefore must be more assertive, innovative, and imaginative in order to perform the "autonomous activities and judgments" required for the job (Amenta, 1984, p. 419).

Interactions shape the end-of-life context and impact how death and dying are experienced by patients, families, and health care professionals (Golden, 2010–2011). Way and Tracy (2012) point out that beyond a few notable studies, communication research has sparsely investigated the "evergrowing but largely isolated business" of hospice (p. 293). To date, researchers have focused on collaborative, spiritual, and compassionate communication experienced by hospice interdisciplinary team members (Wittenberg-Lyles, 2005; Wittenberg-Lyles, Oliver, Demiris, & Regehr, 2009), families of dying patients (Golden, 2010–2011), and hospice workers in general (Considine & Miller, 2010; Way &

Tracy, 2012). Findings from previous research indicate that communication during end-of-life care often creates dialectical contradictions for interactants. Hospice nurses may face unique dialectics due to their multifaceted interactions with patients, families, interdisciplinary teams, and health care providers. Therefore, this exploratory study will increase our understanding of the tensions particular to care enacted in the home context, which may ultimately impact nurse well-being, self-care, and organizational effectiveness (Foxall, Zimmerman, Standley, & Bene, 1990; Tunnah, Jones, & Johnstone, 2012).

DIALECTICAL THEORY

Dialectical theory is based on four major assumptions: (a) contradiction, (b) change, (c) praxis, and (d) totality. *Contradiction* refers to the interplay of simultaneous oppositional tendencies unified within a larger social context (Baxter & Montgomery, 1996). *Change* describes the continual flux evident in relationships due to the presence of contradictions that inspire ongoing change (Ford, Ray, & Ellis, 1999). *Praxis patterns* are communicative strategies used to manage dialectical tensions and may differ in worthiness based on levels of (dys)functionality (Bochantin & Cowan, 2008). *Totality* acknowledges the influence of setting, participants, and context on the contradictory process (Baxter, Braithwaite, Golish, & Olson, 2002).

The communication discipline has a long history of examining dialectics in familial, friendship, romantic, and workplace relationships (e.g., Bochantin & Cowan, 2008; Braithwaite, Toller, Daas, Durham, & Jones, 2008; Goldsmith, 1990; Johnson, Wittenberg, Villigran, Mazur, & Villigran, 2003). Although underexplored, inquiries analyzing dialectical processes in health care organizations have begun to emerge (e.g., Olufowote, 2011). According to McGuire, Dougherty, and Atkinson (2006), dialectical research "has great potential for unraveling the intricacies involved in health care-related organizational communication" (p. 423). For example, nursing-home and hospital nurses face emotionality–rationality, autonomy–connection, detachment–attachment, and equal–subordinate tensions during IDT interactions and the delivery of care (Apker et al., 2005; Jameson, 2004; Levy-Storms, Claver, Gutierrez, & Curry, 2011; Miller, 2007). The manner in which nurses communicatively negotiate these tensions impacts individual and organizational outcomes such as workplace stress, collaborative conflict management, perceptions of professional identity, organizational climate, and quality patient and family care.

End-of-life care is a setting rich for dialectical tensions, "as health care providers deliver expertise and family members and patients utilize relational history as knowledge"

(Goldsmith, Wittenberg-Lyles, Ragan, & Nussbaum, 2011, p. 449). Research has provided an initial glimpse into the communicative challenges experienced by a wide array of hospice employees including social workers, nurses, care aides, spiritual providers, bereavement staff, volunteers, and facility staff. Considine and Miller (2010) found that hospice workers experience leader-follower dialectics during spirituality discussions with patients and families. More importantly, nurses selected management strategies based on their expertise in the dying process, personal spiritual beliefs, family pressure, organizational rules, and the hospice philosophy, which considers patients and families as the care experts. Additionally, Way and Tracy (2012) emphasize the communicative challenges inherent in the holistic model of hospice care and conclude that inpatient hospice employees often face dilemmas when attempting to recognize patient needs, relate or connect with patients, and (re)act appropriately during the delivery of compassionate care.

To date, researchers have overlooked the distinctive nature of dialectics experienced by nurses in the home hospice context. Unlike other hospice employees, home hospice nurses are intensely involved with patients, families, IDTs, and other health care providers. Therefore, like palliative-care nurses, they may face distinct tensions related to patient care plans, family support, patient advocacy, and the facilitation of collaborative team communication (Ragan et al., 2008). Furthermore, as the ones most likely to initially visit prospective clients, home hospice nurses may experience additional tensions since patients and families often have trouble accepting the terminal nature of patient prognosis, referrals to hospice, or the probability of imminent death during transitions from curative to hospice care (Boyd, Merkh, Rutledge, & Randall, 2011). Since no rulebook exists for interacting with patients, families, and IDT members (Considine & Miller, 2010), it is important to examine the recurring dialectical tensions experienced by home hospice nurses and how they impact end-of-life communication. Additionally, exploring the praxis patterns used to negotiate these tensions is needed since patterns differ based on social context.

The purpose of this study is to extend our understanding of the dialectical approach through an in-depth examination of home hospice nursing. Fagerström (2006) states that if "nursing care as a phenomenon is understood as consisting of 'complex caring situations,' dialectics can be used as a fruitful method of revealing [its] complexity" (p. 631). Therefore, the following research questions were examined:

RQ1: What dialectical tensions do home hospice nurses experience in their interactions with patients, families, and health care providers?

RQ2: How do home hospice nurses manage these tensions?

METHOD

Site and Participants

Founded in 1979, Midwest Hospice Organization (MHO)[1] is a mid-size, for-profit hospice organization serving approximately 230 patients on an annual basis. At the time of data collection, MHO had two offices in a 7-county area with 78 employees, including 29 full-time nurses. Its mission is to provide compassionate care to terminally ill patients and families through services such as day-to-day medical care, spiritual counseling, social services, and bereavement support. In line with the hospice goal, MHO utilizes IDTs to deliver services, with each team consisting of a medical director, nurse, social worker, chaplain, volunteer and/or volunteer coordinator, and certified nurse assistant.

After gaining access to MHO through the executive director, the first author met with the nurse coordinator to discuss the goal of the study. Following this meeting, the nurse coordinator assisted in the recruitment process by presenting this voluntary research opportunity and an introductory letter to nurses at staff and IDT meetings. The primary prerequisite for participation was actively working as a hospice nurse in the home setting. After the names of interested nurses were collected, the first researcher contacted them to explain the study further and set up one-on-one face-to-face interviews.

Twenty-four hospice nurses (2 males, 22 females) volunteered to participate in this study. The age of recruited nurses ranged from 28 to 64 years ($M = 49.6$ years). In the sample, 23 nurses were Caucasian and one was African American. The length of nursing experience prior to hospice was 6 months to 27 years ($M = 12.48$ years), with reported experience in hospice nursing ranging from 4 months to 15 years ($M = 7.33$ years). All nurses were full-time RNs with four primary responsibilities: (a) administer admission assessment of prospective patients, (b) conduct physical assessment of current patients (e.g., check vital signs, listen to heart and lungs, evaluate pain symptoms, assess for pain control), (c) request orders and communicate updates to physicians, and (d) manage patient care plans. No compensation was given for participation.

Procedures

In-depth interviews were conducted over a 4-week period. First, nurses completed an approved informed consent form describing the voluntary nature of participation and guaranteeing confidentiality through pseudonyms. Following the collection of demographic information, a semistructured protocol was used to guide interviews while also providing the flexibility to explore interesting subjects brought up

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[1] Midwest Hospice Organization (MHO) is a pseudonym.

by participants (McCracken, 1988). Specifically, open-ended questions focused on two topic areas: hospice nurse role dialectics (e.g., "What contradictions or tensions have you regularly experienced as a hospice nurse?") and management strategies (e.g., "What specific strategies have you used to manage or cope with the tensions you have mentioned?"). The length of interviews ranged from 25 to 56 minutes. All interviews were audiotaped and transcribed verbatim, resulting in 122 pages of single-spaced text.

Data Analysis

Both researchers used the constant comparative method, individually and collaboratively, to analyze data (Glaser & Strauss, 1967). First, we independently read and reread transcripts to increase familiarity with the data. Simultaneously, we individually used open coding to create preliminary categories by "breaking down, examining, comparing, conceptualizing, and categorizing data" using analytic memos (Strauss & Corbin, 1990, p. 61). Specifically, we compared categories against each other for similarities and differences and created new categories when differences emerged (Strauss & Corbin, 1998). After sharing our individual categories via e-mail and phone conversations, we repeatedly combined, added, and revised categories until no further adjustments were needed (Strauss & Corbin, 1998), resulting in seven open codes.

Next, we collaboratively used axial coding to identify relationships between categories and form themes (Strauss & Corbin, 1990). We deliberated multiple times via phone conversations and e-mail exchanges to reevaluate our initial categories from open coding, rearrange categories into themes by linking similar meanings and traits, discuss contrasting opinions, and elaborate on interpretations. Some initial dialectics (e.g., self-doubt versus confidence) were eliminated because they did not explicitly focus on hospice interactions. This process continued until full consensus was met regarding the reorganization and naming of themes as well as participant quotes representing each theme (Strauss & Corbin, 1990; Toller & Braithwaite, 2009).

FINDINGS AND INTERPRETATION

The interview data revealed home hospice nurses experience distinct, yet interrelated, interactional dialectical tensions. First, hospice nurses described the complexity of navigating two dialectics when communicating with patients and family members inside the private home context: authoritative–nonauthoritative and revelation–concealment. Second, hospice nurses experienced two dialectics when attempting to negotiate organizational role requirements: independence–collaboration and quality of care–business of care. Additionally, hospice nurses articulated strategies used to manage each dialectical tension.

Authoritative–Nonauthoritative Dialectic

During our interviews, hospice nurses repeatedly described themselves as authorities regarding the death and dying process. Although this belief is consistently present throughout all of the dialectical tensions revealed in this study, the authoritative–nonauthoritative tension was experienced most when home hospice nurses perceived their expertise was ignored or rejected in light of patient and family preference for care.

On the one hand, nurses felt confident in their ability to alleviate patient discomfort and, thus, provide expert advice and support during end-of-life care. Many hospice nurses viewed themselves as prime sources of understanding and comfort for patients and families. Janice, a 7-year hospice nurse, described the self-assurance, expertise, and authority nurses bring to this setting: "I'm a confident person and that's how I walk in. I walk in confident and if they have a question, you know, 99% of the time, I have the answer." Similarly, Andrea, a 2-year hospice nurse, reinforced the perception that families look to them for advice and answers:

> You've got to be able to take control of a situation and be the boss. Sometimes you find that the family needs somebody to boss them around. [They] need to have that person [they] can go to who always has the right answer.

Home hospice nurses noted that they were looked to for answers and reassurance amidst high levels of patient and family uncertainty regarding comfort care. Edith, a 3-year hospice nurse, recounted a common experience in which a family asked her

> to come see how [the patient] was doing. They were scared. He had taken his last breaths and they were ready to tell him goodbye and he started breathing again, so they asked me to sit with him. So I sat with him while they left the room and I put my arms around him and prayed with him and told him it was okay.

As such, hospice nurses felt most at liberty to provide advice and exhibit their authority in response to explicit requests for comfort from patients and/or family.

On the other hand, nurses felt the need to defer their expert advice in lieu of patient/family preference for care, even when they believed family decisions compromised quality of care. According to Beth, a 7-year hospice nurse, "sometimes the things patients want don't follow the mold of what you think they should have [for] better pain control. And sometimes it's difficult when you see people struggling in pain, but that's what they want."

Similarly, Valerie, a 12-year hospice nurse, highlighted what it felt like when patient/family requests for care seemingly contradicted her expertise and authority.

> Sometimes I feel it's like looking through a window and you want to help but you just, they won't allow you to do the

certain things. You have to be very respectful in doing what they want you to do.

Oftentimes, misunderstandings about hospice care influenced what was (not) done when enacting care. Sally, a 14-year hospice nurse, recalled an experience when her advice was overruled because the family misinterpreted what was happening, or should happen, to their loved one during the dying process.

> The family wanted [the patient] on IV fluids which is a misconception. People think that dehydration is a terrible thing and that it is torturous to let a loved one die of dehydration. Well it's a natural part of the dying process and you use medication to control the comfort.

Sally described this dilemma as "one of those situations that gets really tough" because she felt compelled to defer to the family's wishes even though she believed it impeded patient comfort.

Nurses often struggled with the need to elevate patient/family choice at the expense of their authority in home hospice care because they felt families had not "allow[ed] us to help as much as we [could]." This tension was most challenging in instances when nurses felt patients and families were "not listening to what you have to say" regarding care decisions or the dying process, particularly when hospice nurses believed family members were making care choices "selfishly." In these situations, Valerie adds, "I hate to say that, but they are selfish. . . . They're not thinking of their loved one and the discomforts and procedures that their loved one has to go through. That's frustrating."

Nurses primarily negotiated the authoritative–nonauthoritative tension using segmentation. With this praxis pattern, "certain topics or activities are 'off limits' with respect to the fulfillment of a given polarity, while other topics or activities are appropriately suited to fulfill that polarity" (Baxter & Montgomery, 1996, p. 63). Thus, hospice nurses attempted to ascertain patient and family responses to determine which polarity was (in)appropriate to help them manage this ongoing tension. For example, Cheryl, a 15-year hospice nurse, acknowledged that "the hardest thing we do is just figuring out how to communicate with each person. They're so different, [we try] to meet them where they're at."

Nurses favored the authoritative polarity when interacting with highly uncertain patients and families who were perceived as receptive to the goals of comfort care. For example, Kate, a 4-month hospice nurse, discussed an experience in which she was concerned about whether the family members understood the plan of care and what they needed to do to facilitate the patient's care and comfort because they were "stressed and unsure about everything." Kate emphasized the authoritative polarity because she perceived both the patient and his family as "being appreciative of anything

that we had to offer." As a result of their perceived openness to hospice care measures, she deemed it appropriate to exercise her authority by showing the family how to use medications correctly and set up a schedule for dispensing medications.

Overwhelmingly, however, nurses segmented their communication by emphasizing their nonauthoritative role when they were communicating with patients and families who were suspect or unsure of hospice care. In these situations, nurses labeled themselves as *guests* to accentuate the limitations of their authority. As self-labeled guests, nurses felt compelled to defer to patient and family decisions, even when those decisions contradicted what they believed to be best for patients. For example, nurses mentioned they could not make patients stop smoking in bed, force patients to take pain medication, or require family members to keep a patient on hospice if they wanted to pursue acute care. Randy, a 7-year hospice nurse, explained:

> When I'm in somebody's home, I always tell them I'm a guest in their home. I'm not the nurse, I'm a guest. If a family member has a different way they want to do something other than what I want to do, I allow them to do it.

Similarly, Kaitlin explained how the guest role guided her in situations when patients did not want to take their pain medications: "That's their home. We don't want to overstep our boundaries and we want them to be able to make their own decisions. We can't force them to do anything; they've got to make that decision." Consequently, nurses frequently segmented their communication by emphasizing the nonauthoritative polarity for fear that, as guests, they might inhibit patient and family autonomy.

Revelation–Concealment Dialectic

As specialists in end-of-life care, nurses discussed the necessity to be open and honest with families to prepare them for the dying process. However, they also acknowledged the dilemma of this approach when families were perceived as unwilling or unable to cope with the terminal nature of a loved one's illness.

Many hospice nurses believed they should reveal all elements of the hospice experience to family members. Kara described the importance of complete disclosure when first entering the home context.

> You go into the home and just really explain [to families] what hospice is about, make sure that they understand we are all about comfort. So you really try to explain as much as you can. That's the most important thing. I think it is essential when you get in the door.

Cheryl added that one of her goals is to "prepare a family step by step, keeping ahead of any possibility." Full disclosure was valued because nurses believed the more patients and family members knew, "the more comfortable [they'd]

feel" with the hospice process, ultimately resulting in lower levels of stress for all parties involved. Similarly, Tamara, a 4.5-year home hospice nurse, was convinced that disclosing the goals of hospice to patients and families enhanced care. "I think once the family understands the concept and we start having a really good rapport, things generally go smooth and there's really good communication with the doctor and the whole hospice team."

Although nurses expressed a desire to communicate openly, they also acknowledged the need to occasionally conceal information about the terminal diagnosis and their role as a hospice nurse. For example, before being introduced to patients, some families asked nurses not "to introduce [themselves] as a hospice nurse" or "wear [their] nametag." In these situations, families asked nurses to be more vague and tell patients they were there "simply [to] provide some extra special attention" because family members did not want their loved ones to know they were on hospice. Similarly, Gina, a 9-year hospice nurse, referenced experiences with patients and families who did not want to discuss the future because they wanted to concentrate on the present and did not "want to dwell on death." For the most part, concealment was deemed as most preferable when families were perceived as unwilling or unable to acknowledge the extent of their loved ones' decline.

The revelation–concealment tension was most pronounced when hospice nurses felt obligated to explicitly "prepare someone for the [dying] process" while simultaneously trying to be sensitive to patient and family readiness to accept such truths, particularly when families were "still looking for other avenues." Ginny, a 3-year hospice nurse, pointed to the dilemma of this tension:

> I feel like they need to have the full truth but some people can't deal with the full truth. What is most difficult is when the families aren't quite ready for hospice, even though [their loved one] is already in it. It's all about the expectations of family members. It may be the children [or] the siblings that really are confused about what we're doing.

Once again, home hospice nurses relied primarily on the segmentation praxis strategy to determine which polarity was privileged, given the perceived readiness of family members to accept the inevitability of their loved one's death. When nurses perceived family members as unable or unwilling to accept the impending death of a loved one, home hospice nurses avoided explicit talk about dying and death. For example, Gina said:

> I've noticed that if we're going a little bit too far for [people], you know more than what they can handle at that moment, I'll just ask them, "Do you want it sugar coated?" If they say, "Yes, okay," then [I say], "You're doing great," and you know, I'll just leave it at that because it's different for every person.

After Gina determined what family members could (not) handle, she segmented her communication because "if that's what they want, that's what I give them."

On the other hand, when family members were perceived as willing to accept the inevitability of their loved one's impending death, nurses communicated more explicitly. In these situations, nurses chose to communicate unambiguously about what was happening to their loved one and what would likely occur throughout the dying process. When Paige, a 2-year hospice nurse, discerned family members to be "ready" to accept such truths, she believed it was "a lot easier to explain and to help them through [the process] than the ones that are fighting it."

In addition to segmentation, nurses also relied on balance to manage the revelation–concealment tension. According to the balance strategy, each polarity is "legitimated at once in compromise, although each opposition is fulfilled only in part because of the underlying zero-sum nature of the totality of oppositions" (Baxter & Montgomery, 1996, p. 64). For instance, Randy recalled a situation in which certain family members had difficulty accepting a loved one's impending death. Despite his four siblings' acceptance, during the last stage of death, one son was still asking Randy, "Are you sure Dad's going to die?" In these situations, home hospice nurses sought to balance both implicit and explicit communication. Instead of saying, "Your dad's going to die," Randy attempted to utilize balance by responding, "If these [signs and symptoms] continue, then I believe your Dad is going to die at some point in time between 24 and 48 hours." Similarly, amid varying levels of family understanding and/or tolerance, Andrea called attention to the nuanced approach nurses employ when attempting to balance revelation–concealment:

> Your teaching is going to take on a kind of different role in that you are going to be more gentle. You are going to be more general with them. I mean you can be specific with statements but at the same time you want to use a lot of examples and make sure they understand.

Finally, some nurses used the balance strategy by providing a variety of possible care options when family members disagreed about treatment strategies. Despite slight differences in the use of the balance strategy, each nurse sought to communicate truthfully but with enough ambiguity to rhetorically make room for caregiver hope.

Independence–Collaboration Dialectic

Hospice nurses regularly faced role-specific dialectics when communicating with providers "outside the hospice circle." Although nurses often desired autonomy when managing patient pain, they also recognized the necessity and benefits of incorporating the perspectives of other providers to maximize patient care.

Due to their self-described expertise in pain management and close proximity to patients, hospice nurses often felt doctors and pharmacists did not fully understand what and how much pain medication was needed to improve patients' comfort levels. Kate wanted more self-sufficiency when it came to making pain management decisions for her patients because she wanted to "make sure patients have long act- ing pain medicine to help cover their pain needs 24 hours and make sure that it is breakthrough pain medicine." Moreover, hospice nurse preference for independence esca- lated in instances when they believed misperceptions existed about the use of medication to control patient pain. Sally described the frustration she experienced when trying to obtain a prescription from a physician while watching her patient suffer.

> It's amazing to me those physicians that are hesitant to pre- scribe narcotics and we are not talking about overdosing. I had a broken hip patient that I had a terrible time trying to get medication for because the doctor had this misguided perception that [the] elderly do not respond well to narcotics because it might make them more lethargic or confused, so he didn't want to prescribe it, which is ridiculous.

Nurses expressed more irritation when patients needed immediate relief. For example, Madelyn, a 7-year hospice nurse, said, "I do not have the time to call 20 different peo- ple and get permission." At times, nurse dissatisfaction led to feelings of isolation in their organizational role. As one hospice nurse aptly summarized, "We should be working as a team. It shouldn't be me against them, it should be us." Thus, interactions with health care providers who misunderstood the purpose of hospice or underestimated the pain manage- ment expertise of home hospice nurses were characterized as frustrating and were typically viewed with suspicion.

Although hospice nurses expressed irritation and disap- pointment with the procedures and decision-making pro- cesses that necessitated approval from certain providers, they also acknowledged the value of the team approach to hospice care. Paige commented on the benefit of the collaborative nature of the interdisciplinary team.

> We have the support of each other. We have a[n] [IDT] team meeting once a week that discusses all of our patients [and] their current treatment plans. We are all able to sit down and talk about the patients and the families and whatever prob- lems or concerns that they're having at that time. We discuss them and then develop some type of plan of care to take care of it.

Most importantly, hospice nurses took solace in knowing they never were alone. According to Madelyn, "The interdis- ciplinary teams help give support. You're never alone which is the best part. If I need support, I can get it or help. You know sometimes we need people to talk to." Ginny reiterated the value of the collaborative approach in hospice: "You

have experienced nurses, you have pharmacists, everybody around here has knowledge, so your resources are available and plentiful." Specifically, nurses expressed the benefit of being able to "call other admissions nurses or supervisors to talk about what would be best for the patient." According to Valerie, "We are individuals out in the field by ourselves although we can always call someone."

The independence–collaboration dialectic highlights the inherent challenges nurses face when communicating with other health care providers to ensure quality hospice care services. As primary advocates for patients, nurses often wished to autonomously handle comfort care for patients, but as interdisciplinary team members, they also recognized the benefit and necessity of different perspectives to ensure the highest quality patient care. In an attempt to manage this tension, nurses relied on persuasive techniques to make their case to health care providers.

Hospice nurses responded to the independence– collaboration tension through recalibration, which "transcends the form of contradiction without altering its ongoing presence" (Baxter & Montgomery, 1996, p. 66). This strategy underscores how nurses enacted an advocacy role in interactions with physicians, who do not serve as IDT members at this organization. For example, home hospice nurses were required to call physicians to get clearance for "the medication, the dose, the frequency, and the route [they] wanted" to give patients. However, nurses acknowledged they often relied on persuasive tactics when negotiating patient care plans with health care providers, specifically doctors, whom they believed were misinformed or unfamiliar with ideal hospice care practices. Through strategic use of persuasive strategies, nurses felt they regained self-sufficiency over patient care plans without threatening required collaboration with outside providers.

Hospice nurses stressed the importance of using their "people skills" when trying to "win [health care providers] over." More specifically, they pointed out the need to identify the problem clearly, communicate a well-defined solution, and proactively address concerns when trying to gain agree- ment from outside providers. According to Kate, "The thing is to explain why I'm asking for what I'm asking for and how it's going to help the patient." Similarly, Valerie said when she is at a home and needs to call a doctor to modify the patient's pain medication, "You've got to have a plan and say what you want."

Overall, nurses expressed the importance of intentional- ity and preparation when asking for "certain orders" from outside health care professionals. For instance, when nurse requests for pain medication were approved, they attributed this success to their persuasive ability to overcome the doubts or initial objections of outside health care professionals who were described as having a "huge learning curve" when it came to proper end-of-life care.

Quality of Care–Business of Care Dialectic

Nurses repeatedly mentioned their desire to spend more time interacting with patients in their homes, yet also experienced pressures related to the business aspects of hospice care. On the one hand, nurses wanted to provide the best possible quality of care, which was often articulated as the amount of in-person home care. However, hospice nurses simultaneously recognized the challenge of fulfilling organizational role requirements they believed reduced the amount of time they could physically spend with each patient.

Hospice nurses mainly wanted to interact with patients and family members as much as possible because they believed the needs of the dying and family members were "paramount" and "unending." According to Daphne, a 4-year hospice nurse:

> Every patient needs more care than we can give them. I think we could all spend more time with the clients that we have and it would be more beneficial for them. Families, a lot of times, they're just as equally in need of certain kinds of emotional support and understanding. I think if we had more time with them that we could be of better service to them.

Thus, ideal hospice care was conceived as spending more time with patients and families in the home context, especially when the individual needs of patients and families escalated as they entered the active stage of the dying process.

Nurse concerns with quality of care, however, were often weighed against organizational demands such as paperwork, patient caseload demands, and travel to and from patients' homes. First, nurses expressed the complexity of caring for patients and families while ensuring they completed paperwork required to satisfy Medicare requirements. According to Randy:

> Every visit, every time I see a patient, even if I walk into the room and listen to their lungs, I still have to do a two-page assessment. So it makes us do some things different than we used to do. Documentation will always be an ongoing conflict.

Second, nurses often felt demanding caseloads resulted in less time for patients and families. In particular, they were frustrated that, at any given time, individual patients and families might require more care than they could provide because "you only have 40 hours to get to all of your patients." This tension was especially challenging when patient needs were thought to conflict with organizational cost considerations, like overtime, which restricted the amount of time nurses could spend with individual patients. For instance, nurses expressed "hat[ing] to leave" patients who were in the active stage of dying because that is when "they need you the most" but, at the same time, nurses recognized they only had 40 hours to care for all of their patients while also attending to office needs.

Third, in order to enact care, nurses had to navigate to and from patients' homes. This essential, but often-overlooked, organizational task complicated quality of care. Tamara said,

> Driving to unfamiliar places, that was stressful. You had to consider drive time. You had to consider how long you could be with the patient so you could get them all seen in one day. It was a totally different structure [than hospital or nursing home settings].

In sum, the quality of care–business of care dialectic emerged as nurses tried to negotiate spending more time "out in the field" with patients and families while also attempting to fulfill bottom-line requirements of the job.

Nurses primarily perceived the quality of care–business of care dialectic as a zero-sum game whereby more attention to quality patient care meant less attention to business of care requirements. Thus, nurses attempted to balance both poles of this dialectic by relying on effective time management. Acknowledging the legitimacy of each pole of this tension, nurses repeatedly stated that better time management helped them "get their paperwork done quicker" and "keep up with [patient] care plans," ultimately allowing more time for patients and families. Technology, such as laptops, pagers, and cell phones, were frequently credited as essential tools for fulfilling the requirements of paperwork more efficiently, which allowed for more face time with patients. Additionally, satellite-driven navigational devices were believed to help reduce the stress and logistical challenges associated with traveling to patients' homes, since spending too much time trying to locate homes threatened precious time allocated for patient care.

Some hospice nurses, however, acknowledged that trying to balance patient needs with business/caseload requirements meant certain patients and families missed out on needed in-person care. In these situations, nurses negotiated these demands with the spiraling inversion praxis strategy whereby a "pole of a given contradiction is dominant at a given point in time" (Baxter & Montgomery, 1996, p. 62). Occasionally, nurses spoke of "working off the clock" to provide more in-person time when they believed the needs of patients and family members were most pronounced. James, a 6-year hospice nurse, recalled staying with a patient many hours beyond what had been scheduled "because the patient was real close to passing on." James justified working off the clock because when a patient and family "really needs you the most, you hate to leave." For these nurses, the needs of patients and family members during the active stage of dying simply could not be met within their organizationally mandated time limitations. Thus, quality of care dominated when patient and family needs were thought to be the greatest.

CONCLUSIONS

Based on our findings, home hospice nurses experience four major types of dialectics during hospice care interactions: authoritative–nonauthoritative, revelation–concealment, independence–collaboration, and quality of care–business of care. Four major conclusions can be drawn from these dialectical tensions and the manner in which nurses attempt to manage them.

First, home hospice interactions cannot be understood apart from the totality of the hospice setting, participants, and societal context that seemingly invites ongoing communication contradictions (Baxter & Montgomery, 1996). The interpersonal dialectics experienced inside patients' homes emphasize the challenges of navigating an indistinguishable line between providing advice as experts in hospice care and allowing family members to "express their needs and desires" (Guido, 2010, p. 128). In our study, nurses repeatedly referred to patients' homes as places full of "high tensions," "high emotions," and "unresolved issues" as patients and family members attempt to make sense of the dying process. In these highly charged care contexts, communication tensions are inevitable and ongoing when the goals of hospice come into conflict with patient/family expectations and wishes. Consequently, nurse dialectics and management strategies reinforce the relational aspects of job stress, well-being, and organizational role effectiveness, which cannot be understood apart from the constellation of relationships necessary to home hospice care. For example, Madelyn identifies inherent communication challenges in end-of-life care:

> Everybody's different. Families are different. You have to take each individual in the family into consideration. You have to take in to account the caregiver, the decision-making person, [and] the durable power of attorney. You have to take into account the people who don't understand death.

Second, home hospice nurses repeatedly experience dialectical tensions as a by-product of having to ascertain and respond to others' preferences. In addition to pinpointing important nuances of the already established leading–following dialectic (Considine & Miller, 2010), the authoritative–nonauthoritative and revelation–concealment dialectics demonstrate how nurse communicative choices are often constrained when nurses feel compelled to continually assess and adapt to patient and family expectations, wishes, acceptance, and care choices. Although this finding reinforces the important role of patients and families in hospice care, it also underscores how ongoing interactional negotiations with patients and families occasionally contribute to feelings of frustration and powerlessness. Hospice organizations, however, can lessen the impact of these tensions on individual nurses by providing communication training that emphasizes praxis strategies aimed at managing interpersonal dialectics endemic to home hospice interactions.

Third, nurses often feel organizational role dialectics pit them against others and thereby limit the potential for quality home hospice care. Like Wittenberg-Lyles and colleagues (2009), our study confirms the important relationship between hospice organizational structure and nurse interpersonal experiences. Depending on the structure of individual hospice organizations, nurses may be required to obtain authorization from health care providers who are not members of the interdisciplinary team. In this study, barriers to meaningful collaboration were attributed to nurse dissatisfaction with the time-consuming nature of the external approval process and doctor misperceptions regarding end-of-life care. As a result, all providers, both within and outside hospice organizations, impact nurse perceptions of team cohesiveness and individual role effectiveness.

Fourth, since "dialectical tensions promise more agency" (McGuire et al., 2006, p. 444), it is no surprise that home hospice nurses primarily employ organizationally functional communicative strategies to manage tensions. For example, nurses emphasize the importance of balance strategies, such as time management, and disclose a desire to work off the clock to spend more time with patients. Ultimately, strategy selection is impacted by nurse desire to provide the best hospice care to patients and families in light of ongoing tensions. Although functional for patients and organizations, nurses may be unable to rely on these strategies indefinitely due to their close and ongoing proximity with patients and families. Consequently, home hospice nurses may be particularly prone to job stress when their interpersonal commitments repeatedly conflict with organizational role demands (Gray-Toft & Anderson, 1986–1987; Melvin, 2012).

Limitations and Future Research

The majority of home hospice nurses interviewed were women (2 males, 22 females), thereby limiting the ability to determine whether the dialectical tensions were, in part, affected by sex. However, given the overall demographics of hospice nurses, participants in this study reflect the trend of females outnumbering males in the hospice nursing profession (Whitesides, 2011). Moreover, this study examined the dialectical tensions among hospice nurses without distinguishing between first-year hospice nurses and those with longer tenure, which may limit our ability to ascertain how, if at all, these dialectical tensions change over the course of one's career. Similarly, this study did not account for prior nursing experience as a means of assessing how previous nursing experiences might affect use of praxis strategies in home hospice.

Since the majority of our respondents had worked as hospice nurses for some time ($M = 7.33$ years), future research should examine how the length of a nurse's tenure in other nursing contexts might impact the dialectical tensions and management strategies experienced after

becoming a hospice nurse. In addition, this study examined the tensions and praxis strategies of hospice nurses in one hospice organization. Future research should explore multiple hospice organizations to ascertain the role organizational culture and organizational-specific rules may play in determining the type and scope of dialectical tensions and management strategies.

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