



# Calling for Inclusive Sampling, Stakeholder Representation, and Ethical/Privacy Considerations: Methodological Reflections on a Qualitative Study of Unaccompanied Care [Letter]

Fei-Yi Zhao <sup>1-4</sup>, Qiang-Qiang Fu <sup>5</sup>, Jie Qian <sup>5,6</sup>

<sup>1</sup>Department of Nursing, School of International Medical Technology, Shanghai Sanda University, Shanghai, 201209, People's Republic of China;

<sup>2</sup>Sydney School of Health Sciences, Faculty of Medicine and Health, The University of Sydney, Camperdown, NSW, 2050, Australia; <sup>3</sup>School of Health and Biomedical Sciences, RMIT University, Bundoora, VIC, 3083, Australia; <sup>4</sup>Shanghai Municipal Hospital of Traditional Chinese Medicine, Shanghai University of Traditional Chinese Medicine, Shanghai, 200071, People's Republic of China; <sup>5</sup>Yangpu Hospital, School of Medicine, Tongji University, Shanghai, 200090, People's Republic of China; <sup>6</sup>Shanghai Mental Health Center, Shanghai Jiao Tong University School of Medicine, Shanghai, 200030, People's Republic of China

Correspondence: Qiang-Qiang Fu, Yangpu Hospital, School of Medicine, Tongji University, Shanghai, 200090, People's Republic of China, Tel + 86 021-6569 0520, Fax + 86 021-6569 6249, Email qiangqiang.fu@tongji.edu.cn; Jie Qian, Department of Clinical Psychology, Yangpu Hospital, School of Medicine, Tongji University, Shanghai, 200090, People's Republic of China, Tel + 86 021-6569 0520, Fax + 86 021-6569 6249, Email bsb.qianjie@tongji.edu.cn

## Dear editor

Unaccompanied care has been proposed to reduce family and societal burdens, decrease labor costs, and improve ward environment and order, yet it also poses considerable challenges for nursing staff.<sup>1</sup> Currently, this model is being piloted in only a limited number of tertiary hospitals in China. We commend He et al for addressing this emerging social issue through a qualitative study exploring multilevel factors influencing the implementation of unaccompanied care among elderly inpatients in China.<sup>2</sup> While their work provides valuable exploratory evidence on early-stage practices of this care model, we seek to discuss certain aspects of the study design and implementation to allow a more nuanced interpretation of the findings and to guide future research.

## Blending Two Care Delivery Forms Compromises Internal Validity

He et al clearly outlined two current forms of unaccompanied care in China: (1) all basic and daily care tasks are provided by nurses or full-time care workers (also referred to as nursing assistants); and (2) patients are generally admitted without family attendants, or a relative may remain solely for emotional support (“accompany but not care”), while professional staff deliver comprehensive nursing and daily care.<sup>2</sup>

In practice, these two models differ substantially in service scope, staffing arrangements, cost structures, and patient/family experience.<sup>3</sup> The first model requires nurses and care workers to perform higher-intensity, continuous bedside care, relying heavily on staffing levels, training quality, and management systems, with clearer service fees and responsibility boundaries. The second model retains some degree of family emotional support. Professional care needs, risk distribution, and patient acceptance of “care substitution” likely vary between the two.<sup>3</sup>

We note, however, that He et al did not clearly specify which form respondents (patients, families, or providers) experienced or evaluated during data analysis. Merging experiences and perceptions across different service models equates to discussing outcomes without defining the independent variable. This can introduce conceptual ambiguity into the identified influencing factors. For instance, it becomes difficult to attribute specific barriers—such as role conflict, or



distrust—to one form or the other, thereby weakening the precision and internal validity of the authors' conclusions and reducing the relevance of their policy suggestions.

## Recommendations

Future studies should clearly define unaccompanied care operationally and distinguish between service delivery forms during sampling and analysis, or at least include contextual annotations and comparative discussion. Doing so would strengthen the explanatory power and generalizability of findings, offering more instructive evidence for healthcare institutions with varying resources and policy goals.

## Exclusion of Frontline Care Worker Voices Undermines Understanding of Service Barriers

He et al included 15 stakeholders—nurses, nurse managers, physicians, and administrators—in their study. However, care workers, who provide 24-hour bedside and daily living care to elderly inpatients under nursing supervision, were not represented.<sup>2</sup>

Care workers are the core frontline implementers and direct service providers of unaccompanied care. Their workload, training and assessment mechanisms, professional identity, collaboration with clinical staff, and emotional labor in high-intensity settings directly impact the quality, safety, and sustainability of the service.<sup>4–6</sup> The absence of their perspectives means that themes such as “insufficient organizational support” and “interpersonal collaboration barriers” are interpreted only through managerial or professional narratives. This likely obscures the structural pressures care workers face—such as inadequate staffing ratios, demanding shift schedules, ambiguous career pathways, and the specific challenges of building trust with patients and families. Without their input, the understanding of implementation barriers remains partial, and recommendations such as “strengthening competency-based training” and “clarifying division of labor” risk being superficial, lacking grounding in frontline experience.

## Recommendations

Future studies should explicitly incorporate care workers as key stakeholders, employing in-depth interviews or focus groups to explore their role identity, skill requirements, emotional support needs, and team collaboration experiences. This would help uncover real implementation bottlenecks of unaccompanied care and inform more targeted and actionable institutional and human resource policies.

## Overlooking Enrollment Mechanisms and Dropout Perspectives Risks Skewed Conclusions

The study included only patients currently enrolled in unaccompanied care and their participating family members.<sup>2</sup> Two methodological limitations, therefore, warrant attention.

### (1) Unclear Enrollment Mechanisms

He et al did not fully clarify how patients were referred, screened, or self-selected into this care model.<sup>2</sup> In practice, enrollment is often non-random and may be influenced by factors such as family support, economic capacity, or pre-existing acceptance of the model. Without transparent reporting of these entry pathways, the sample may systematically over-represent individuals or families already inclined toward the service. Consequently, findings may emphasize feasibility and positive experiences while under-reporting implementation challenges and potential failures, potentially skewing the conclusions.

### (2) Missing Dropout Perspective

The study did not include patients or families who discontinued unaccompanied care after initial uptake, nor did it examine when or why they withdrew.<sup>2</sup> Dropout experiences are critical for identifying key barriers to acceptability and sustainability—such as unmet emotional needs, perceived care-quality gaps, or financial strain—which may be less

visible among continuing users. Excluding this group risks “survivorship bias,” thereby underestimating practical resistance and overstating the model’s sustainability.

## Recommendations

Future research should explicitly report the initiation, referral, and inclusion processes for unaccompanied care services and explicitly address potential selection bias in the analysis to improve transparency and interpretive rigor. Additionally, incorporating retrospective interviews with individuals who discontinued the service would allow comparison between continuers and dropouts, yielding a more comprehensive and dynamic understanding of service trajectories, decision turning points, and critical barriers to sustained use, thereby informing service optimization and the development of early risk identification and mitigation strategies.

## Neglecting Disease-Specific Heterogeneity May Obscure Key Factors

While the study restricted patient inclusion based on self-care ability (Barthel Index  $\leq 60$ ), it did not differentiate participants by disease type.<sup>2</sup> Care needs, risks, and reliance on professional care within the unaccompanied model may vary substantially across conditions.<sup>7</sup> For instance, postoperative orthopedic patients may require more functional training and mobility assistance,<sup>8</sup> whereas those with advanced cancer may prioritize pain management, emotional support, and dignity-conserving care.<sup>9</sup>

Such differences are particularly relevant in unaccompanied care, as the alignment between care workers’ services and disease-specific needs directly influences patient and family acceptance of the model. Combining experiences across diverse conditions may lead to generalized influencing factors, masking unique barriers or facilitators for specific patient groups and limiting the clinical applicability of the findings.

## Recommendations

Future studies should adopt stratified sampling to ensure representation of major high-need disease categories. Subgroup analysis by diagnosis should also be performed to compare experiences and influencing factors across conditions, advancing the unaccompanied care model from general exploration toward precise, condition-specific implementation.

## Inadequate Attention to Privacy and Relational Boundaries May Overlook Critical Barriers

While the study notes that care workers provide monitoring and emotional support, it did not explore the privacy exposure and relational boundary issues inherent in such high-contact, low-familiarity care.<sup>2</sup> In unaccompanied care, patients’ physical, psychological, and even family information becomes accessible to non-family workers, raising significant ethical and privacy concerns.<sup>10,11</sup>

In the absence of systematic discussion on privacy protection, information boundaries, and emotional boundaries, the study may overlook situations in which patients refuse or only reluctantly accept unaccompanied care due to privacy concerns. Moreover, it offers limited empirical guidance for the development of professional conduct standards and ethical guidelines for care workers in unaccompanied care settings, thereby constraining the applicability of the findings to institutional governance and ethical regulation.

## Recommendations

Future research should explicitly incorporate privacy protection, data security, and relational boundaries into interview frameworks to capture the perceptions and expectations of patients, family members, and care workers. Key questions may include which care scenarios most commonly elicit privacy concerns, which communication strategies and safeguards foster trust and reduce anxiety, and what training is required for care workers to manage boundary-related issues professionally. Addressing these dimensions would support the ethical and sustainable implementation of unaccompanied care while safeguarding patient dignity, autonomy, and privacy, in alignment with a person-centered care philosophy.

## Summary

Overall, the study by He et al provides timely and valuable insights into the early implementation of unaccompanied care in China. However, a more precise conceptualization, broader inclusion of stakeholders, and greater methodological transparency are needed to fully capture the complexity of this care service model. Future research should move beyond exploratory descriptions toward more differentiated, ethically informed, and context-sensitive analyses, integrating disease-specific needs, frontline workforce dynamics, and longitudinal service trajectories. Such efforts will be crucial for generating robust evidence to inform scalable, equitable, and person-centered unaccompanied care policies within rapidly aging healthcare systems.

## Data Sharing Statement

Data availability is not applicable as no new data was generated or analyzed in this communication.

## Funding

No funding was received.

## Disclosure

The authors declare no competing interests in this communication.

## References

- Jiaqi Q, Lixia L, Rongmei L, et al. Progress of research on the application of the unaccompanied care model in clinical settings. *Ann Clin Case Rep.* 2023;8:2531.
- He Y, Li R, Jiao T, Liu C, Chen Y, Li L. Factors influencing the implementation of unaccompanied care for older inpatients in Chinese tertiary hospitals: a qualitative study. *Patient Prefer Adherence.* 2026;20:1–15. doi:10.2147/PPA.S564683
- Fan WY, Chen Y, Lin YY. Construction and application of a management scheme for nursing assistants in unaccompanied hospitals. *Chin J Nurs.* 2024;59(1):85–92. doi:10.3761/j.issn.0254-1769.2024.01.012
- Zhi M, He Z, Ji J, et al. Patient satisfaction with non-clinical nursing care provided by the nursing assistant under different management models in Chinese public tertiary hospital. *Appl Nurs Res.* 2022;67:151431. doi:10.1016/j.apnr.2021.151431
- Fan J, Shi H. A three-stage supply chain scheduling problem based on the nursing assistants' daily work in a hospital. *J Comb Optim.* 2021;42(4):896–908. doi:10.1007/s10878-019-00500-3
- Tu J, Mei X, Fang C. Indispensable outsiders: a qualitative study of the working experiences of hospital care workers in China. *J Nurs Manag.* 2021;29(2):268–276. doi:10.1111/jonm.13149
- van Beek L, Goossen WT, van der Kloot WA. Linking nursing care to medical diagnoses: heterogeneity of patient groups. *Int J Med Inform.* 2005;74(11–12):926–936. doi:10.1016/j.ijmedinf.2005.07.006
- Taraldsen K, Sletvold O, Thingstad P, et al. Physical behavior and function early after Hip fracture surgery in patients receiving comprehensive geriatric care or orthopedic care—a randomized controlled trial. *J Gerontol a Biol Sci Med Sci.* 2014;69(3):338–345. doi:10.1093/gerona/glt097
- Purkayastha A, Sarin A, Sharma N, Singh S, Bisht N. Knowledge, attitude and practice of paramedical staff and nursing assistants towards cancer pain management in a tertiary cancer care centre. *Clin Oncol.* 2018;3:1439.
- Milholland DK. Privacy and confidentiality of patient information. Challenges for nursing. *J Nurs Adm.* 1994;24(2):19–24. doi:10.1097/00005110-199402000-00008
- Riaz S, Khan EA, Jafar T. Ethics in health care settings: practices of healthcare professionals and perceptions of patients regarding informed consent, confidentiality and privacy at two tertiary care hospitals of Islamabad, Pakistan. *J Ayub Med Coll Abbottabad.* 2017;29(3):472–476.

Dove Medical Press encourages responsible, free and frank academic debate. The content of the Patient Preference and Adherence 'letters to the editor' section does not necessarily represent the views of Dove Medical Press, its officers, agents, employees, related entities or the Patient Preference and Adherence editors. While all reasonable steps have been taken to confirm the content of each letter, Dove Medical Press accepts no liability in respect of the content of any letter, nor is it responsible for the content and accuracy of any letter to the editor.

Patient Preference and Adherence

Publish your work in this journal

Patient Preference and Adherence is an international, peer-reviewed, open access journal that focusing on the growing importance of patient preference and adherence throughout the therapeutic continuum. Patient satisfaction, acceptability, quality of life, compliance, persistence and their role in developing new therapeutic modalities and compounds to optimize clinical outcomes for existing disease states are major areas of interest for the journal. This journal has been accepted for indexing on PubMed Central. The manuscript management system is completely online and includes a very quick and fair peer-review system, which is all easy to use. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/patient-preference-and-adherence-journal>

**Dovepress**  
Taylor & Francis Group