



DIGNITY-CONTRIBUTING FACTORS IN CLINICAL CARE SETTINGS: A MULTISITE QUALITATIVE DESCRIPTIVE STUDY

Nurfika Asmaningrum¹, Luluk Huriyah², Yun-Fang Tsai³

1. Assistant Professor, Faculty of Nursing, University of Jember, Jember, East Java.
2. Clinical Nurse, Balung General Hospital, Jember, East Java.
3. Professor, Nursing Department, Chang Gung University, Taiwan, ROC.

ABSTRACT

The illnesses are treated in a hospital care environment could increase the risk of loss of patient's dignity. Hence, simultaneously preventing the risk of loss of dignity and maintaining patient dignity are equally important. Nevertheless, maintaining patient dignity depends on the knowledge of the factors influencing it. The present study was aimed at exploring the factors associated with dignified care in clinical care settings. The study design was a multisite qualitative descriptive study carried out in six general hospitals located in East Java, Indonesia. The participants involved were 40 clinical nurses recruited purposively from 36 medical and surgical wards. Data were analyzed using inductive content analysis. Three main overarching categories were found, which contribute towards maintaining dignified care: nurse related factors including commitment, competency and self-control; patient related factors including personal traits and perception of care; and organization related factors involving staffing level and tangible resources. The study adds the understanding of factors contributing towards maintaining patient dignity gathered from healthcare provider viewpoints. These factors could act either as dignity-promoting factors or dignity-threatening factors. Our findings expanded on the operationalization of the three areas as potential elements which could act as means to enhance dignity within hospital care.

Keywords: Dignity, dignified care, nurse, contributing factors, qualitative descriptive

ABSTRAK

Kondisi individu yang tengah sakit ditunjang adanya keharusan perawatan dirumah sakit dapat meningkatkan risiko hilangnya martabat pasien. Oleh karena itu penting untuk secara simultan mencegah risiko hilangnya martabat pasien dan memelihara perawatan secara bermartabat kepada pasien dalam tatanan klinik rumah sakit. Namun upaya memelihara martabat pasien bergantung pada pengetahuan mengenai faktor yang mempengaruhi perawatan bermartabat tersebut. Studi ini bertujuan untuk menggali faktor yang berkontribusi terhadap perawatan bermartabat di tatanan klinik rumah sakit. Studi ini menggunakan desain kualitatif deskriptif dengan pendekatan multicenter yang dilaksanakan pada enam rumah sakit umum di Jawa Timur, Indonesia. Partisipan adalah 40 staff perawat klinik yang direkrut secara purposive dari 36 ruangan rawat inap medikal dan bedah rumah sakit. Data dianalisis menggunakan induktif konten analisis. Tiga kategori utama berperan sebagai faktor yang berkontribusi dalam perawatan bermartabat yakni faktor perawat, faktor pasien dan faktor organisasi. Faktor perawat terdiri dari komitmen, kompetensi dan kontrol diri. Faktor pasien terdiri dari karakter personal pasien dan persepsi tentang layanan. Faktor organisasi meliputi tingkatan staf dan sumber daya fisik. Studi ini menambah pemahaman tentang faktor yang berkontribusi terhadap perawatan bermartabat dari perspektif perawat sebagai pemberi layanan keperawatan. Faktor-faktor yang berkontribusi tersebut dapat berperan sebagai faktor penunjang sekaligus penghambat perawatan bermartabat kepada pasien. Hasil penelitian ini memperluas operasionalisasi tiga area sebagai elemen yang potensial sebagai sarana untuk meningkatkan perawatan bermartabat dalam tatanan klinik.

Kata kunci: martabat pasien, perawatan bermartabat, perawat, faktor dan kualitatif deskriptif

BACKGROUND

The occurrence of disease can definitely threaten human dignity (Raee, Abedi, & Shahriari, 2017); and when the illness is treated in a hospital care environment, this increases the risk of patients being deprived of their dignity (Borhani, Abbaszadeh, & Rabori, 2016). Thus, hospitalized patients have a greater risk of losing their dignity due to their vulnerability (Hosseini, Momennasab, Yektatalab, & Zareiyan, 2018). Hence, simultaneously preventing the risk of loss of dignity and maintaining patient dignity is important.

Dignity is an imperative value in nursing (Moen & Nåden, 2015), which plays an important role as a standard for concrete health care decisions at the bedside (Andorno, 2013). According to the Royal College of Nursing (2008), treating patients with dignity means to treat them in a way that is respectful as well as valued individuals. Hence, preserving dignity is essential to ensure high-quality healthcare, which is considered as one of the key aspects and ethical concerns in healthcare and nursing care (Amininasab, Lolaty, Moosazadeh, & Shafipour, 2017). As well as this, respect for patients' dignity is essential for the development of professional nursing practice, either nationally or internationally (Royal College of Nursing, 2008).

In practice, promoting patients' dignity is regarded as one of the main duties for healthcare providers (Baillie & Matiti, 2013). However, since a large part of the requirements of patient care is centralized on the work of nurses (Hughes, 2008), the nurses have the responsibility of ascertaining which nursing actions will safeguard the patient's rights and making sure the provision of care is delivered with respect to dignity (Lindwall & Post, 2014). Hence, the nurse's viewpoints can lead to an increase in the knowledge and awareness of this concept among healthcare professionals and are of great benefit in the endeavour to maintain patients' dignity.

As dignity represents the essence of nursing care, it is a professional duty to elucidate the factors which may threaten or could promote patients' dignity and how

to provide more dignified care. As the factors influencing dignity are regarded as dynamically subjective which might be affected by external events, circumstances, and interactions with people; thus, exploring different factors can influence the preservation of patient dignity at the bedside (Manookian, Cheraghi, & Nasrabadi, 2014) is important. By recognizing and focusing on these factors, this could help nurses to establish practical measures for preserving patients' dignity and to provide more dignified care at the bedside (Manookian et al., 2014).

Nevertheless, factors affecting dignity preservation are not well known (Sharifi, Borhani, & Abbaszadeh, 2016), whereas studies have shown that maintaining patient dignity depends on the health providers' knowledge of the factors influencing it. In such conditions, the understanding of factors contributing towards the preservation and augmentation of patient dignity may increase the patient's sense of value and meaning (Periyakoil, Noda, & Chmura Kraemer, 2010). As part of a wider study investigating the dignity of care in Indonesian clinical care settings, the aim of the current article is to explore the factors associated with providing dignified care within clinical care settings.

METHOD

Research Design

The current study is part of a wider study investigating maintaining the dignity of care in Indonesian clinical care settings. The present article reports the factors related to the enhancement of dignified care. This study used qualitative descriptive design which provides a straightforward descriptive compendium of the data that is organized in a logical manner (Lambert & Lambert, 2012).

Participants and setting

This study was a multisite study conducted in six general hospitals located in East Java, Indonesia. The study involved 40 clinical nurses which were purposively recruited from three different classes (1st, 2nd, and 3rd) of medical and surgical units. Thus, a total of 36 wards were included. The participants' inclusion

criteria were a) a registered nurse; b) a clinical staff nurse; c) a minimum work experience of 2 years; and d) willing to participate in the study. Eligible nurses were excluded when they were on furlough.

Data Collection

The data collection was undertaken in hospital settings from January to April 2017. Data were collected using one-on-one semi structured interviews. Each participant was approached in-person with the first author as the interviewer. The relationships between interviewer and participants were not established prior to the initial contact during the recruitment process. Open ended questions were asked to participants including the core question: which factors contribute to promoting patient dignity in clinical care? A digital audio recorder was used during the interviews with participant’s permission. To enrich the comprehensiveness of the data, field notes were recorded to capture participant’s non-verbal responses during interviews. All the interviews ranged from between 12 and 59 minutes long and were performed once only for each participant. The data saturation was reached at the 38th participant, but the interviews were continued to ensure the saturation and representation of multicentered participant’s views.

Data Analysis

The interviews were transcribed verbatim and were subsequently analyzed

using inductive qualitative content analysis. The objective of the analysis was to systematically transfigure a large amount of text into a highly organized and condensed summary of key results (Erlingsson & Brysiewicz, 2017). To achieve the key results, three steps of qualitative analysis were performed including open coding, creating categories and abstraction (Elo & Kyngäs, 2007). For the data consistency, a subcategory was supported by at least ten percent of participants.

Ethical Consideration

The research ethical committee of medical faculty in one of the university’s institutions approved the study (No. 943/H.25.1.11/KE/2016). The participants received information about the purpose of study and were told that all data would be kept anonymously and confidentially. When the participants agreed to partake in the study, they signed a written consent form.

RESULT

Demographics Data

The profile of participants is depicted in Table 1. As shown in this table, a total of 40 registered clinical nurses participated in this study. The participants involved were 23 female and 17 male nurses with an average age of 33.6 years old. More than half of the nurse participants were civil servants. They had on average 10.5 years of clinical experience.

Table 1. Demographics Data

Variables		n	%	Mean ± SD
Gender	Male	17	42.5	
	Female	23	57.5	
Marital Status	Married	33	82.5	
	Single	6	15.0	
	Other	1	2.5	
Age Group (years)	25-28	10	25	33.6 ± 5.8
	29-32	8	20	
	33-36	11	27.5	
	37-40	5	12.5	
	41-44	4	10	
	45-48	2	5	
Ethnicity	Javanese	28	70	
	Madurese	10	25	
	Other	2	5	
Religion	Muslim	40	100	
	Other	0	0	

Variables		n	%	Mean ± SD
Nursing education	Diploma	22	55	10.5 ± 6.1
	Nurse Bachelor	18	45	
Length of tenure (years)	2-4	9	22.5	
	5-7	6	15	
	8-10	6	15	
	11-13	2	5	
	14-16	8	20	
	17-19	2	5	
	20-22	4	10	
Hospital Care Unit	Medical	20	50	
	Surgical	20	50	
Ward Type	Single Gender Ward	16	40	
	Mixed Gender Ward	20	50	
	Private Room	4	10	
Employment Status	Civil Servant	21	52.5	
	Non-Civil Servant	19	47.5	

The Main Findings

The present study revealed the factors contributing to the preservation of dignified care during hospital care. The findings showed that the views of participants on the factors influencing dignified care were grouped into three main overarching categories namely:

nurse related factors, patient related factors, and organizational related factors. These overarching categories emerged in response to the following question “what are the associated factors for maintaining patient’s dignity during hospitalized care?”. Figure 1 shows the conceptual map drawn from the emerged categories.

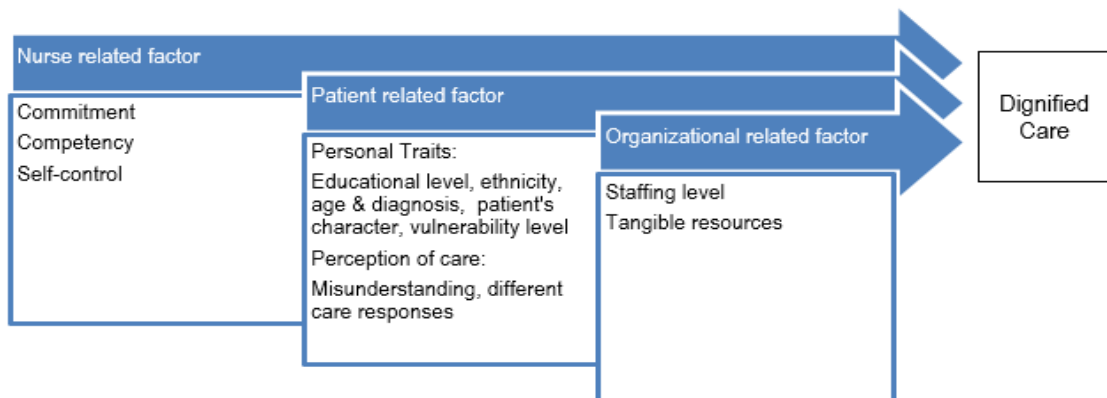


Figure 1:
 The conceptual map drawn from the categories

Nurse-related factors. To preserve patient dignity in clinical care, our participants described that the nurse’s aspects and its relatedness were one of the main factors. This overarching category consisted of three following sub-categories: commitment, competency, and self-control.

Commitment. The first sub-category within nurse factors was commitment. This sub-category was related to the nurse’s responsibility for treating the patients with dignity, as a form

of dedication to the nursing profession. Whilst the nurses’ awareness to obligate the provision of care was enhanced, it intrinsically developed a self-commitment to deliver high quality care which further maintained patient dignity:

“We have to realize that we are nurses. Therefore, our main responsibility is helping patients. It must be reverted to the nurses itself. Our awareness is to help those patients. Because we know about the patient’s progress and what

the doctor advises the patient” (P15: surgical female nurse; 28 years old).

Competency. The second sub-category within the nurse factors was competency. It referred to the nurse’s ability to perform their nursing tasks efficiently. The nurses’ competency was indicated by their adequate knowledge during care provision to support the preservation of patient dignity. It was also beneficial to improve collaborative teamwork across healthcare providers.

“The most important thing is competency. From my experience, lacking this aspect can be problematic. If I talked about something with doctors, if we could exhibit the sufficient knowledge they want to listen to it. Hence, number one is knowledge that is required to be enhanced... I mean the most important thing is that we need to improve our knowledge, thus we can be on the same level with them, that’s the most important” (P31; surgical male nurse; 41 years old).

Self-control. The third sub-category within the nurse factors was self-control. This sub-category is related to the nurse’s ability to control their emotions, thoughts, and limit poor behavior in order to achieve goals. No doubt that nurses have a busy day of work. Therefore, facing crowded, uneasy, and even difficult situations in the nurse’s daily work routine may lead to some disruptive behavior. Thus, the ability to self-manage becomes an important factor to maintain patient dignity.

“Sometimes a patient’s condition may provoke us to become emotional but we keep calm. The point is that we have to control ourselves. We should not easily get angry” (P7; medical female nurse; 36 years old).

Patient-related factors. The second overarching category influencing patient dignity preservation was patient factors; that means that the elements were derived from the patient’s aspect. It consists of two categories: personal traits (education level, ethnicity, personality, and vulnerability level) and perception of care (care responses and misunderstanding).

Personal Traits. The first subcategory within patient factors was the patient’s personal attributes. Our nurse participants reported that the patient’s personal traits might affect the perceived quality of care. It involves educational level, ethnicity, age and diagnosis, patient’s character, and vulnerability level.

Educational level. This sub-category refers to patient’s educational background which is measured by the duration they spent acquiring formal education. Besides the impact on patient understanding, education creates opportunities for gaining better health. Facing patients with different educational levels needs different approaches and patience.

“Sometimes, a patient’s education level influences it. Some patients can easily understand the explanation that the nurse gives. However, some other patients do not understand although the nurse has already given the explanation. Sometimes the person who doesn’t understand will keep asking the nurse. This person who keeps asking questions may become a challenge from the emotional side, yeah, there are many challenges, at least we know when the patient doesn’t understand, so this is about how we give the explanation so the patient will understand more about his current condition” (P6; surgical male nurse; 26 years old)

Ethnicity. This sub-category is related to the patient’s cultural background which represents various characters, language, and even the attitude and behavior. Hence, the nurse must treat the patients individually with culture-based adjustment.

“I (sometimes) observed that Madurese and Javanese people are different. They are different, although I don’t know what exactly the differences are. But it needs a different way to manage them. Problem from each person (patient) is different, we may see from the person (patient) himself, sometimes there is a person who asks us seriously, depending on the person, sometimes there is person who prefers

a relaxed situation, more open, he can be open with us, trust our intervention and vice versa” (P29; medical male nurse, 39 years old).

Age and diagnosis. The third subcategory referred to the patient's age combined with the medical diagnosis which illustrated the patient's illness condition. The extent of the illness' severity and the patient's age are described as general patient status which are identified as one of the important factors affecting the endeavour to preserve patient dignity at the bedside. This subcategory implied that as patients get older and have a higher level of disease severity it can lead to more serious and sensitive situations, which requires the nurse's greater attention.

“Patients may respond differently towards care depending on: firstly their age, and secondly their diagnosis. If the diagnosis shows that the age is more than 40 years. Every human is different, from intonation itself, we think if his voice is loud, it means he is angry. So, we have to realize if patients need comfort, we are servants so we have to be patient, right Ms.?” (N24; medical male nurse; 32 years old).

Patient's character. This subcategory refers to the particular combination of patients' personal qualities that make them different from others. Whilst nurses must face diverse patient characters, it requires a different approach to build nurse-patient rapport.

“Patients in here are not all the same, there are some who have the patience to wait, and there some others who do not. In fact, we have something important here, yeah the response, there is one who ... sometimes is picky, there are patients like that, patients are not the same, every human's character is very unique” (N19; medical female nurse; 37 years).

Vulnerability level. The state of being ill affects not only the patient's physical condition, but also their mental situation. Although the level of severity may differ from one patient to another, the

condition of being ill puts them into a state of vulnerability. This vulnerability makes them more sensitive.

“We have to realize that if there are patients who are ill, indeed not only physically but also mentally ill, then they often feel stressed” (P2, medical female nurse, 42 years old).

Perception of care: The second category in patient factors referred to the patient's ability to see, hear, or be aware of the circumstances of the hospital care, which develops their understanding to interpret it. Patients can perceive care either positively or negatively. This category involves:

Misunderstanding. A failure to understand something correctly may occur among patients and may affect their perception of care. This excerpt exemplifies a common misunderstanding arising from patients.

“Sometimes from the patient himself, even if we already serve them to the best that we could do, sometimes the patient doesn't understand “oh yeah, this is the doctor's area” so at that time the patient's family feels that they are not appreciated. Sometimes because one patient's family doesn't know about nurse's work area, even if the nurse already explains that this is the doctor's job, but sometimes the family, that is a bit rude, feels that if they are not appreciated” (N6).

Different care responses. Every patient has different values, preferences, and desired to health outcomes based on his or her unique background, experience, and lifestyle. As a result, it may lead to different responses arising from the patient when they receive patient care. Many patients are very satisfied with their health care. All patients are unique individuals who respond to everything in their own particular ways.

“They are happy even when I put an IV many times, no, they do not complain. They are happy instead “Oh, thanks ma'am”. they said ‘never mind’ even if we are wrong. those who are treated in the third class can accept it. Even when they are treated, or their blood is taken

many times, they remain silent. They are happy, happy even when their blood sample is taken several times. In the first class, even if we put the needle only once, there is a burden if we failed” (surgical female nurse, 38 years old).

Organizational-related factors.

The third overarching category was organizational factors acquired from the hospital institutional aspect referred to as resource availability. This includes staffing level and tangible resources.

Staffing level. Due to staff shortages, there is an impact due to the imbalanced proportion of nurses' to patients. If the nurses have a heavy workload they are unable to provide optimal care because of the high volume of patients.

“There are some who report and report again about something that is not worth reporting, but the number of nurses here are limited. In such conditions, we treat many patients. Out of 16 patients, there were 2 or 3 family patients who act like that. Then it make us very busy” (N19; medical female nurse, 37 years old).

Tangible resources. The availability of facilities and medical equipment could affect the preservation of patient dignity. Lacking those amenities may influence the delivery of care services in terms of delayed responses that cause longer waiting times to receive care services.

..This room has a lack of facilities and equipment, ma'am. For example, we want the ambu bag, but the ambu bag was deflated. Sometimes, when we did the intervention for critical patients in such a situation, it is embarrassing “what happens with this ambu bag?” Then, we use another method. So, we change to manual CPR. A similar situation happened with the nebulizer. The nebulizer was demanded but we didn't get it on time. That is about the facilities (N8; surgical female nurse, 38 years old)

DISCUSSION

This qualitative study provides important visions relevant as factors

contributing to dignity which are broadly considered as one of the essential principles of the ethics of care through the nurses' lens who serve in public hospitals in Indonesian settings. This study showed that there are three related overarching categories, which were identified as factors contributing to patient's dignity, namely: patient related factors, nurse related factors and organizational related factors. As mentioned by Manookian et al (2014), different factors may influence the preservation of patient dignity at the bedside.

The study revealed that nurse factors including commitment, competence and self-control were associated with dignified care. Commitment referred to the nurses' commitment to providing patient care, which was related to loyalty, dedication, motivation and duty (Mekwa, Uys, & Vermaak, 1992). As a consequence, the accessibility of patient's care, and nurse's personal and professional growth were improved (Mekwa et al., 1992). Nursing competence referred to the main ability that is required to fulfill nursing responsibilities (Fukada, 2018), which is acquired through experience and learning. Self-control includes self-assessment, patience, restraint, and calm behaviour as well as presenting a good moral character, which are all part of a nurse's moral competence (Zafarnia, Abbaszadeh, Borhani, Ebadi, & Nakhaee, 2017). These characteristics enable the nurses to patiently attend to others' assessment and evaluation of their actions.

In the patient factors, this study found that personal traits and perception of care affected the provision of dignified care. The patient's factor category was rooted in the fact that patients are unique and different individuals, who can not be treated in the same way. Each patient experiences healthcare in a unique and individual way (treating the patient as a unique human being is related to dignified caring (Nyholm & Koskinen, 2017). Thus, the result implied that individualized care must be promoted. Treating the patient as an individual rather than as a disease can help to acknowledge the patient's uniqueness (Asmaningrum & Tsai, 2018).

This patient's category was corroborated by a previous study (Bagheri, Yaghmaei, Ashktorab, & Zayeri, 2012). The patients' character and individual circumstances are among the factors affecting human dignity (Borhani et al., 2016)

In the organizational factors, this study revealed that staff relatedness and tangible resources affected the provision of dignified care. The findings were similar to a previous study, which found that resources were related to dignity (Bagheri et al., 2012); and that the physical environment affected the organization of care (Periyakoil et al., 2010). A qualitative descriptive study found in Brazil, Calegari, Massarollo, & Dos Santos (2015) identified overwork as a barrier that made providing humanized care more difficult, since it prevents healthcare professionals from giving time and attention to patients, forcing them to make choices in response to the demands presented, which then results in not meeting patient needs and expectations.

In terms of contributing factors, this study suggested that these factors could be regarded as either dignity-promoting factors--when these factors were evaluated as good practice--or dignity-threatening factors--when the factors were evaluated as being poor practice. It is necessary to take the appropriate measures to moderate threatening factors and to promote good factors. Identification of such factors should help patients to maintain their dignity (Sharifi et al., 2016).

Our findings expanded on the operationalization of the three areas as potential to increase or decrease the implementation of dignity in care (Royal College of Nursing, 2008), representing the people, places and the processes which affect dignity. During hospital care, those three factors are primarily rooted from nurse-patient interaction. This interaction plays a vital part in determining the quality of care received, patient satisfaction, and outcome of the patient's well-being (Murata, 2014). Providing dignified care is part of moral care (Zafarnia et al., 2017). As respecting dignity care is part of ensuring quality in healthcare (Barclay, 2016), it could not be separated from the output of interaction

between patient and healthcare provider. Patients' and providers' personal factors, healthcare organization related factors and the broader environment all affect the quality of healthcare services (Mosadeghrad, 2014).

Yet, the study was limited in several ways. Firstly, the study employed the qualitative descriptive method, which is regarded as a less theoretical approach when compared to other qualitative methods. Secondly, the study did not use in-depth interviews, hence the information gathered from participants may be limited.

CONCLUSION AND RECOMMENDATION

This study sought to understand the contributing factors for providing dignified care. To promote dignified care practices in hospital care settings, the contributing factors need to be managed. This is because the goal of patient care is not merely to provide them with high quality technical care but also to ensure that their humanity is kept intact. Since the study found that competence affects the provision of dignified care, we suggest future studies should explore which specific nursing competencies are required in order to provide dignified patient care.

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