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An ethnographic study of human dignity in nursing practice

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ABSTRACT

Background: The ethical values of nursing are crucial to the provision of humane care. Human dignity is a core value that must be preserved in order to deliver such care. No studies to date have compared the perceptions of nurses and/or patients regarding the components of dignified care embedded in actual clinical practice.

Purpose: To explore the delivery of dignified care by professional nurses. This was an ethnographic qualitative study combining inductive and deductive methods to identify emergent themes. A multicenter study carried out in the internal medicine units of four hospitals in Barcelona (Spain). Convenience sampling was used to recruit nurses from the four units.

Setting and sample: Multicenter study carried out in the internal medicine units of four hospitals in Barcelona (Spain). Convenience sampling was used to recruit nurses from the four units.

Method: We conducted 158 hours of participant observation of 27 nurses. Semi-structured individual interviews were undertaken with 20 of these nurses, with data saturation being reached. Data were collected between September 2014 and May 2016 and were analysed using ATLAS.ti 7.2 for Windows.

Results: Two themes emerged from the analysis: Delivering dignified care and Factors influencing the delivery of dignified care. The nurses regarded human dignity as one of the key values of their profession. However, there was a discrepancy between their perceptions of the care they offered and what they actually did, due mainly to a lack of awareness about their own practice. Respect, confidentiality, privacy and communication were identified as the key elements underpinning dignified care. Institutional policies were seen as the major obsta-

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cle to the delivery of humane care, the key issues being frequent shift rotations, a high patient-nurse ratio and excessive paperwork.

Conclusions: The results of this study underline the importance of delivering dignified care and the need to ensure that nurses' attitudes and behaviours are consistent with this goal. The ethnographic approach, combining participant observation with individual interviews, revealed discrepancies between nurses' perceptions of the care they offered, or should offer, and what they actually did. This suggests a need for professional forums in which nurses can become more aware of their own clinical practice.

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Background

Professional values can be defined as the preferred standards of action that are shared by all members of a profession (Altun, 2002; Martin, Yarbrough, & Alfred, 2003) and which serve as a benchmark for excellence (Zoboli & Schveitzer, 2013). As a result of the professionalization of nursing, a number of official bodies and associations (AACN, 2008; ANA, 2001; International Council of Nurses (ICN), 2012; Royal College of Nursing, 2008) proposed a set of professional nursing values. One value was respect for human dignity which was defined as showing consideration and respect toward others and acknowledging their worth as individuals (AACN, 1986; Royal College of Nursing, 2008). Both the (Royal College of Nursing, 2018) and the American Association of Colleges of Nursing (AACN, 2008), among others, list human dignity as one of the core values of the nursing profession, and certain behaviors of nurses are seen as crucial to preserving the patient's dignity.

Although nursing is regarded as a humanistic profession, the working day of nurses in practice is typically characterized by a fast work pace, an excessive amount of work, an increasing use of technology, increased demands for efficiency and stringent requirements for quality care and patient safety (Johansson, Hasson, & Johansson, 2013). This has had an impact on human relations, such that in the nursing context the patient at times is no longer the focus of care (Rasmussen & Delmar, 2014). This situation is aggravated by the need within health systems to increase efficiency through the use and prioritization of technology, to the detriment of the interpersonal dimension of the caring relationship (Galvin & Todres, 2013). All these aspects can lead to dissatisfaction among patients, a fact which highlights the importance of more patient-focused care (Rasmussen & Delmar, 2014).

Various authors have pointed out that dignity is a subjective concept whose definition may vary from one individual to another (Johnston et al., 2015). This is reflected in the fact that numerous studies have examined the perceptions of both nurses and patients regarding the meaning of dignity and qualities of dignified care (Heijkenskjöld, Ekstedt, & Lindwall, 2010; Lin, Watson, & Tsai, 2013; Matiti & Trorey, 2008; Sabatino, Kangasniemi, Rocco, Alvaro, & Stievano, 2016). However, although researchers have sought to describe the characteristics of dignified care, whether in general (Sabatino et al., 2016; Thompson et al., 2016) or focusing on specific aspects (Pols, 2013; Rodríguez-Prat, Monforte-Royo, Porta-Sales, Escribano, & Balaguer, 2016), it is unclear to what extent nurses' perceptions of such care coincide with what they actually do in practice. Therefore, the aim of the present study was to examine the delivery of dignified care by professional nurses. We also explored nurses' perceptions regarding dignified care, as well as potential barriers to its implementation.

Method

Design

This was a qualitative ethnographic study. This approach was chosen as it enables a detailed and in-depth description of the study phenomenon and allows comparison of nurses' perceptions with actual clinical practice (Hammersley & Atkinson, 2001; Silverman, 2007).

Participants

We recruited nurses working in internal medicine units of four hospitals in the province of Barcelona. Both morning and afternoon shifts were represented. Three of the hospitals were part of the same privately managed consortium (60% of activity outsourced from the public sector), while the fourth was a public hospital (Table 1). Convenience sampling was used with the aim of recruiting good informants with experience of the study phenomenon.

The inclusion criteria were as follows: (a) working on an internal medicine ward, (b) at least three years'

Table 1 – Description of the Research Context

Hospital	Type of Management	Number of Beds	Number of Professionals	Number of Nurses
A	Private	272	900	272
B	Private	215	780	260
C	Private	100	145	57
D	Public	753	3,239	983

Table 2 – Attitudes and Behaviors Associated with the Preservation of Human Dignity, According to the AACN

Value	Attitudes	Professional Behaviors
Human dignity	Consideration	Safeguard the individual's right to privacy
	Empathy	Addresses individuals as they prefer to be addressed
	Humaneness	Maintains confidentiality of clients and staff
	Kindness	Treats others with respect, regardless of background or personal characteristics
	Respectfulness	Shows respect for colleagues
	Trust	Designs and provides culturally competent care

Source: Fragment of Table 7-2 (Values and qualities of professionalism in nursing) in Arnold EC, Underman Boggs K. Interpersonal relationships: *Professional communication skills for nurses*. 7th ed. St Louis, MO: Elsevier Health Sciences; 2016.

professional experience, (c) fluency in Spanish or Catalan, (d) signing informed consent, and (e) employment contract for at least a further 6 months at the time of recruitment (so as to enable observational follow-up). In order to achieve maximum variation of responses within the sample, we selected participants of different age, gender, and years of experience.

Data Collection

Sociodemographic data were recorded for all participants. Between September 2014 and May 2016, we collected data by means of participant observation and informal questioning during the observation, as well as through semistructured interviews. In total, we conducted 158 hours of observation and 35 hours of interviews, with data saturation being reached. The semistructured interviews were held in rooms made available by the participating hospitals, while the informal questioning took place on the ward during the observation. Twenty nurses were interviewed, the selection being based on the criteria of best informant and variation in workplace. All the interviews (mean duration 68 minutes) were recorded for subsequent transcription. At the start of the interview the main researcher explained the purpose of the study and the involvement required of participants. The interview began with questions about broader concepts, before moving on to explore in more detail the specific attitudes and behaviors associated with the preservation of human dignity (AACN, 2008), as shown in Table 2. Postobservation discussions were held at the end of the interviews to allow participants the opportunity to articulate their views about the observed practice. Reference was also made to observations during the field work, comparing, and contrasting this with the nurses' responses during the interview. In addition, interview transcripts were returned to participants for validation corrections (Tong, Sainsbury, & Craig, 2007). None of the participants offered additional comments or requested changes to their interview transcript.

Alongside the interviews, the main researcher kept a field diary in which she recorded her observations, impressions and the informal conversations that took place during the field work. The frame of reference for both the observation guide and the interview questions were the attitudes and behaviors that the AACN associates with dignified nursing care (AACN, 2008).

The researchers maintained an attitude of constant reflexivity throughout to monitor her subjectivity and minimize her influence on the collection and analysis of data.

Data Analysis

For the purposes of data analysis we created two primary documents, one comprising the interview transcripts and the other with field notes. In the first stage, we then identified 1,032 units of meaning, which we grouped into 25 categories based on their similarity. Further examination of these categories yielded a set of six metacategories and, ultimately, two emergent themes that described the study phenomenon. The categories and metacategories were determined using the inductive method that is typical of qualitative research (Glaser & Strauss, 2007), whereas both inductive and deductive methods were employed to identify the themes, specifically by comparison of the emergent metacategories with the theoretical framework of the study (AACN, 2008). Data were analyzed using ATLAS.ti 7.2 for Windows.

Consideration of Rigor

Rigor was ensured by applying the four criterias proposed by Calderón (2002), namely epistemological adequacy, relevance, reflexivity, and validity. During the analysis, the findings were triangulated among the researchers in order to allow for discussion of the interpretation of data and the homogeneity of emergent categories. The observational data were also triangulated with participants during the individual interviews.

Ethical Considerations

The study was approved by the ethics committee of each of the participating hospitals and all necessary institutional permissions were obtained. Prior to any data being collected, participants were informed about the aims of the study and it was made clear that they could withdraw their consent at any point. All participants signed an informed consent, including for the

recording of interviews. Only the first author had access to the full recordings.

Findings

A total of 36 nurses agreed to take part, although only 27 (25 women and 2 men) remained available for follow-up observations. The reasons for sample loss were transfer to another unit ($n = 5$), change of shift ($n = 2$), and maternity leave ($n = 2$).

The main characteristics of the final sample are shown in Table 3.

Two inter-related themes emerged from the analysis: *Delivering dignified care* and *Factors influencing the delivery of dignified care*. Table 4 shows the two themes, along with their corresponding main categories and metacategories. Supplementary tables 1 and 2 contain examples from the interviews and observations to illustrate these themes and categories. In the excerpts shown below, the abbreviation "NI" indicates that the quotation comes from a nurse interview, whereas "OB N" refers to observational material from field notes.

Delivering Dignified Care

This theme refers to the attitudes and behaviors that nurses considered to be important for the delivery of dignified care. The theme comprised of four metacategories: respect, confidentiality, privacy, and communication.

Respect

During the interviews the nurses referred to respect as a key element in preserving the patient's dignity, although consensus was lacking in regards to what this meant in practice. An issue, in this case, has to do with the fact that Spanish and Catalan have both a formal and informal "you." Thus, for the majority of nurses, respect was rooted in the way of addressing the patient, that is, using the formal "you" (*usted*) regardless of the patient's age and leaving the use of the informal *tú* to the patient's discretion.

> "With older people I always use *usted* until they ask me to speak to them as *tú*. And in fact, they usually say 'don't be so formal with me'." *NI 7 (1:1208)*

However, despite there being broad agreement that the form of address should be at the patient's discretion, many participants considered that the formal *usted* had an outdated connotation and was a marker of distance in the relationship.

> "I never call anyone *usted*. For me, *usted* puts distance between the two of you and it seems outdated." *NI 16 (1:706)*

Furthermore, the observations revealed that in most cases nurses did not in fact leave it to the patient to choose the form of address.

> ['What do you (informal *tú*) think, shall we do the spray again? (referring to the nebulizer) (. . .) Have you (informal *tú*) rinsed your mouth? (. . .)'] *OB N23 (3:931)*

Another key aspect related to respect concerned the positive impact of calling the patient by his or her name. The nurses interviewed considered that using a person's name was a way of acknowledging his or her individuality and that it helped to establish a warmer and more empathic relationship, thus increasing the patient's trust.

> "Someone who's empathic isn't going to enter a room without knowing what the patient's called." *NI 3* (1:1450)

> "Using the patient's name makes them more relaxed and trusting. She recognises me, knows who I am, where my pain is, what it is I need . . . she knows my history'." *NI 6 (1:215)*

However, although the nurses often knew the names of their patients, they also frequently used colloquial terms of endearment. For instance, even when the patient's name was indicated on the wall above the bed, some nurses were observed to using expressions such as "love" or "dear":

> [Addresses older patient: "Morning, my love".] *OB N8 (3:190)*

> ['Sorry my dear, but they haven't taken you off that. You can't stop the oxygen'.] *OB N27 (3:888)*

Confidentiality

Confidentiality was another aspect that was considered crucial for preserving the patient's dignity.

> "Safeguarding confidentiality and being aware of the conversational space is essential. At times you start talking and you need to be aware of where you are, because you're talking about someone who is your patient." *NI 5 (1:522)*

However, participants acknowledged that despite their best efforts it was often difficult to ensure confidentiality was maintained:

> "Patients have nothing better to do, they get bored with the tele and so they turn their attention to what's going on around the ward, and well, we're not discreet. You hear everything in the rooms. We're often there, making the bed, and saying things like: 'Did you see how he spoke to me?'. They notice everything." *NI 17 (1:994)*

The observations also revealed some of the skills that nurses employ in order to preserve confidentiality. These included altering their tone of voice, covering

Table 3 – Demographic Characteristics of Participants

Participant	Gender and Age	Living Situation	Level of Education and/or Training in Professional Values	Years Working at Hospital	Time in Current Post
N1	F 40	Married One child	Postgraduate qualification in counseling and mindfulness Master's in Health Research (current)	19	4 years
N2	F 31	Single	Postgraduate qualification in pediatric primary care In-service training in assertiveness and problem solving No training in professional values	8	4 years
N3	F 50	Separated One child	No training in professional values	22	11 months
N4	F 32	Single	No training in professional values	6	*
N5	F 27	Married No children	Master's in Intensive Care No training in professional values	6	5 years
N6	F 32	Single	No training in professional values	12	12 years
N7	M 29	Single	Postgraduate qualification in oncology No training in professional values	5	*
N8	F 39	Married Two children	Postgraduate qualification in cardiology No training in professional values	18	18 years
N9	F 47	Married Two children	Postgraduate course on grief No training in professional values	20	20 years
N10	F 31	Married One child	Postgraduate qualification in critical care No training in professional values	10	10 years
N11	F 34	Single	No training in professional values or other courses or postgraduate studies	9	9 years
N12	F 51	Married Two children	In-service training on professional values, emotional intelligence, emotion management and teamwork	29	8 years
N13	F 50	Married Three children	In-service training on professional values, emotional intelligence, emotion management and teamwork	30	6 years
N14	F 39	Married One child	Master's in Critical Care In-service training on professional values, emotional intelligence, emotion management and teamwork	15	11 months
N15	F 55	Married Two children	In-service training on professional values, communication and empathy	35	2 years
N16	F 50	Divorced Two children	Degree in Social and Cultural Anthropology Training in professional values: neurolinguistic programming and Gestalt therapy	23	23 years
N17	F 37	Single One child	No training in professional values	15	5 years
N18	F 29	Married No children	Postgraduate qualification in critical care No training in professional values	8	8 years
N19	F 36	Single	Training in professional values: stress management	12	12 years
N20	M 26	Single	Master's in Emergency Care No training in professional values	11	*
N21	F 57	Single	Postgraduate qualification in community nursing Training in professional values: stress management	9	8 years
N22	F 29	Single	Postgraduate qualification in surgical nursing Training in professional values: On happiness	8	*
N23	F 34	Married Two children	Postgraduate qualification in psychotherapy and psychology of cancer Courses related to happiness	13	10 years
N24	F 36	Single	Master's in Alternative Medicine Training in professional values: emotional ecology	8	8 years
N25	F 39	Divorced Two children	Postgraduate qualification in internal medicine Master's in Emotional Ecology Coaching in nursing for the cardiology patient	18	7 months
N26	F 26	Single	Postgraduate qualification in polytrauma care No training in professional values	6	6 years
N27	F 57	Separated Three children	Master's in Speech Therapy Training in professional values: psychology of the emotions	36	23 years

F, Female; M, Male; N, Nurse.
*Covers shifts (no fixed assignment).

Table 4 – Synthesis of Results. Components of the Emergent Themes

Categories	Metacategories	Themes
Addressing the patient (use of formal or informal 'you')	Respect	**Delivering dignified care**
Value of using the patient's name		
Using colloquial terms of endearment		
Inappropriate conversations in front of the patient	Confidentiality	
Professional skills used to preserve confidentiality		
Not noticing a breach of confidentiality		
Exposing the patient's body	Privacy	
Not noticing a loss of privacy		
Not respecting the patient's space		
Empathy as a means of preserving privacy		
Using patient's preferred language (Spanish or Catalan)	Communication	
Adapting the kind of language used to the patient's sociocultural level		
Nurse-patient relationship focused on the person or on technical aspects		
Interest in knowing how the patient feels		
Talking with colleagues about other things in front of the patient		
Frequent shift rotation/staff changes	Institutional policies	**Factors influencing the delivery of dignified care**
Patient-nurse ratio		
Excessive workload		
Too much paperwork		
Work context		
Burnout and consequences for the patient		
Impact of personal problems on relationship with patient	Emotion management	
Professional experience and training		
Empathy		
Personal experience of illness		

confidential documents, and avoiding sharing information in the presence of people unrelated to the patient:

> [The doctor appears and, in order to report on the patient he enquires about, the nurse lowers her voice so that others cannot hear.] *OB N6 (3:33)*

> [A patient and his family members approach the nurses' station prior to discharge and the nurse sends them back to the room to avoid giving explanations in the corridor. She covers up the paperwork she is doing as they approach.] *OB N3 (3:209)*

Similarly, nurses sometimes avoided answering an indiscreet question on the part of a patient so as to maintain confidentiality regarding other patients:

> [Patient asks] "Has the patient opposite died?" [The nurse doesn't answer and continues to ask the patient about how she's been this morning. The patient continues pressing for information] "It's just that I heard crying…" [Nurse does not answer.] *OB N26 (3:956)*

Despite these observed efforts to maintain confidentiality, the nurses agreed that in hospital units there tend to be breaches which go unrecognized:

> "Confidentiality… it isn't really respected. People are very free with words. And there are times when you have to tell them, 'watch what you're saying'. You don't realise that you're sharing confidential information about your patient." *NI 3 (1:521)*

Privacy

Privacy was also seen as important for preserving the patient's dignity, which the nurses distinguished between privacy of the body and that of personal space. In regards to the body and how it was treated, all the participants agreed that it was important to avoid exposing the patient's body beyond what was strictly necessary.

> "I always try to protect their privacy. I never leave the patient naked. If I'm giving a bed bath I do one part at a time so that they don't feel uncomfortable. For me, this is a really important issue." *NI 6 (1:156)*

This statement contrasts strongly with the actual practice of some participants, especially when giving bed baths or carrying out certain procedures. Consider, for example, the following observation:

> [The nurse prepares to give the patient a bed bath. She agrees with the nursing assistant who is with her that one of them will begin at the top and the other at the bottom. Eventually the patient is left completely naked.] *OB N6 (3:200)*

> [Nurse enters the room and closes the door behind her. She then draws the curtain that separates the two beds. Despite these precautions, the relatives who are visiting the other patient are able to see what she is doing as she treats a wound in the sacral area.] *OB N6 (3:152)*

In regards to personal space, several participants pointed out that patients view their room as home during their stay in the hospital. They added, however, that this was not given the importance it merits, and it was often patients themselves or their relatives who pointed out the need to respect this space.

> "For patients the room is their home, and sometimes we knock, sometimes we don't. The door is closed, and when we've finished we leave it open. We forget that this is the patient's living space, their territory. We forget this at times, and see the room as a work space. It's their chance of some privacy, the little they can have. You see how some patients get up and close the door because they need to feel that sense of shelter. This is where we can fail to respect their privacy." *NI 10 (1:294)*

This idea was reflected in the observations. Generally speaking, nurses did not knock before entering the room, regardless of whether the door was closed or open, although they were more likely to do so if it was closed.

> [Door closed, knocks before entering. The nurse leaves the room without closing the door behind her and the patient calls to ask her to do so.] *OB N8 (3:189)*

Several nurses referred to the importance of empathy and how this could help them to take steps to respect the patient's privacy.

> "'What we need to do more of is put ourselves in the patient's shoes and ask ourselves: how would I feel if they had to wash me like that?" *NI 3 (1:1430-1434)*

Communication

Another factor associated with the patient's dignity was communication. All the nurses felt that using the patient's preferred language (Spanish or Catalan) and adapting the kind of language used to the patient's sociocultural level were important strategies for ensuring that patients understood what they were being told, as well as for making them feel more comfortable in the relationship with nurses.

> [Nurse uses both Spanish and Catalan with different patients. I ask her about this and she says that she uses the language that the patient is more comfortable with.] *OB N1* (3:562)

> [How are you?... Is the pain better?... I'm going to give you something to help you breathe (referring to the nebulizer).] *OB N20 (3:3389)*

In addition, the majority of nurses took the opportunity during care procedures to ask patients how they were and what they needed.

> [She explains what she is going to do and while administering the medication she asks the patient how he's been since yesterday, her previous shift.] *OB N12 (3:532)*

However, there were also numerous occasions when, during their care duties, nurses talked with each other about other things in front of the patient.

> "We enter a room talking about whatever. 'On Sunday I did this or that...'. I always like to at least say 'good morning', but I realise that sometimes we're there talking about the weekend. I don't like that. I think it could be avoided". *NI 16 (1:2033)*

Factors Influencing the Delivery of Dignified Care

The second theme concerned factors—both facilitators and barriers—that influenced the delivery of dignified care. This theme comprised of two metacategories: institutional policies and emotion management.

Institutional Policies

The participants considered that institutional policies, that is, the decisions taken by hospital management with regard to all aspects of staff rostering and costs, were what most influenced the delivery of dignified care. One of the key issues they identified in this regard was frequent shift rotations and staff changes. Some of the nurses said that this led them to be less professional in their role as it undermined continuity of care and, as a consequence, made it difficult to offer personalized care to patients.

> "It's no good, you can't work in a different place every day. You're just filling in. Why am I going to try to do something differently if tomorrow the regular nurse will simply do whatever she's been doing? What's the point of me changing the way we care for the patient? So I just do things the way they're being done. That's all I can do. But it wears you down." *NI 7 (1:3940)*

> "Today for example there's a lot of bank staff, different people in the morning and the afternoon. If the patients were the priority, this wouldn't happen; we'd have some stability. As it is, you drive the patient crazy: one face today, another tomorrow, another the next day. There are a lot of casual staff, who could at least be kept on the same shift, or on the same ward. Some of them come in the morning the first day, in the afternoon the next day and at night the day after that. In my view, this isn't good patient care: I don't feel that the patient is the priority." NI 12 (1: 4447)

Other policy-related issues that the nurses referred to were the high patient-nurse ratio, the workload, the amount of paperwork, slow computer systems, and frequent interruptions (telephone, call bell), all of

which reduced the amount of time they could actually spend with patients and undermined the quality of communication with them.

> "What the hospital management can do to support us is to provide more staff, so that we have more time to talk to patients. It doesn't mean we're going to be there for half an hour, but if they need it, then at least be able to listen to them and attend to their needs." *NI 16 (1:2023)*

In relation to the pressure they worked under, the nurses also referred to burnout and the consequences this has for the patient when, as professionals, do not respond adequately.

> "You're under strain and eventually it's the patient who pays the price. It might be that you snap at them, and it's not their fault, the poor things, they're the ones who are ill". *NI 7 (1:4138)*

> "I often complain, and I think: there are times when I'm here for two hours doing paperwork, and I don't want that. I want to spend those two hours with patients." *NI 3 (1:1375)*

Emotion Management

The way they managed their own emotions was another aspect which nurses felt had an influence on the delivery of dignified care, since it had a direct impact on their relationship with patients.

> "If you fail to live up to your own standards because you don't know how to manage an angry outburst from a patient, well, you might see yourself as altruistic or empathic or whatever, but if your immediate response is to start shouting at the patient in the corridor, then where are your supposed standards?" *NI 1 (1:118)*

In this context, they referred to the importance of professional experience and training as key elements in achieving better emotional control.

> "You feel bad when they say, 'No!'. But that's what it's about, learning, so the next time you don't get angry and you tell yourself: 'OK, if they don't want to do it, no problem'... I shouldn't snap at them or whatever, but if I don't work on it, then that's what will happen." *NI 1 (1:90)*

Empathy was also seen as playing an important role in the provision of dignified care because it implies treating patients as one would wish to be treated and means that one is interested in understanding their experience.

> "Of all the personal values, the ability to empathise with the patient is perhaps the most important." *NI 14 (1:4840)*

> "I always try to think about how I'd like to be treated. I'd like them to explain things to me, to show some warmth, and without it all being rushed, or making me feel that I'm fussing. I think the most important thing is to always remember that this could be you, or one of your relatives." *NI 5 (1:1098-1101)*

Empathy was also seen as important in terms of understanding situations when a patient was disrespectful. For instance, they understood that this could sometimes happen when patients projected their feelings of impotence about their illness onto the nurse.

> "They're worried, and you become a dumping ground, somewhere they can let off steam because of all they've been through, it all comes your way. It might even sound like a threat... 'I don't see why I have to put up with all this' And you have to say to them: 'Look, I understand that you feel bad, that you're going through all this. But there's no need to speak to me like that'." *NI 23 (1:556)*

Several nurses stated that their own experience of illness had helped them to be more empathic and understand what patients go through.

> "When I had my operation here I was in a lot of pain, and I remember a colleague saying to me 'come on, it's not that bad'. I was in terrible pain, and I said to myself: 'Never again will I doubt someone's suffering, the pain they're in'. Since then I think I'm more careful and I value certain things more". *NI 5 (1:1287)*

Some nurses also acknowledged that although they perceived themselves as empathic, the way they were treated by patients could subconsciously impact their ability to provide dignified care.

> "I think the way they treat us has an effect. If I enter a room and the patient is really unpleasant, well, maybe I'm less cheerful in my approach, there isn't the same closeness. I don't get so close to this type of patient." *NI 25 (1:2361)*

> "Although we might not want to consciously, there'll always be something in what we say or do that is different because of that time when we felt badly treated by this patient. I think it has an effect, even if we're not aware of it... you try to carry on as if nothing had happened, to forget that time when you felt badly treated by the patient." *NI 23 (1:3115)*

Several nurses considered that colleagues who failed to show empathy are cold in their treatment towards patients and work in a mechanical way.

> "A lot of people don't have any empathy. They're cold. It's all very mechanical: they enter the room, hello

and goodbye. They do whatever it is that needs doing and then they're off. We all do it at times, because you're swamped with work... it's not that you're cold, you're simply having to be practical'." *NI 6 (1:233)*

Discussion

This ethnographic study sought to examine the implementation of dignified care by professional nurses. The analysis of data obtained through both participant observation and individual interviews revealed two inter-related themes which we labeled *Delivering dignified care* and *Factors influencing the delivery of dignified care*.

The first theme refers to the ways in which nurses may seek to preserve the patient's dignity. A number of key aspects were identified here, including showing respect by knowing and using the patient's name and adapting the kind of language used to his or her sociocultural level, safeguarding confidentiality, and protecting the patient's privacy, both with respect to the body and personal space. These attitudes and behaviors are consistent with those of other authors (Kaya, Işik, Şenyuva, & Kaya, 2017; Lin et al., 2013; Pols, 2013; Rasmussen & Delmar, 2014; Thompson, McArthur, & Doupe, 2016) and international organizations (AACN, 2008; ANA, 2001; International Council of Nurses (ICN), 2012; Royal College of Nursing, 2008) considered to be fundamental to dignified care, and to the extent of which they are implemented by professional nurses will determine whether the patient's dignity is preserved or undermined (Thompson et al., 2016). The importance of ensuring that information is shared with patients in a language that they can understand has also been highlighted in other reports (Cheraghi, Manookian, & Nasrabadi, 2015; Galloway, 2011; Lin et al., 2013), since greater understanding can enhance the patient's autonomy and decision-making capacity.

The second theme concerns those factors which may facilitate or act as barriers to the provision of dignified care. In this respect, participants identified two kinds of barrier: internal (emotional management) and external (institutional policies). The key aspect which nurses felt made it difficult to deliver dignified care was institutional policies. This is consistent with previous reports that have underlined the importance of institutional hospital management policies (Corley, Minick, Elswick, & Jacobs, 2005) and organizational culture (Royal College of Nursing, 2008) being aligned with professional nursing values (Corley et al., 2005; Royal College of Nursing, 2008). The main issues raised by the nurses in our study were frequent shift rotations/staff changes, high patient-nurse ratios and excessive paperwork, all of which were considered as barriers to dignified care. This scenario, characterized by reduced staff ratios of registered nurses and pressure to control health care costs, can lead to moral distress (Corley et al., 2005) as it hampers nurses' ability to provide the kind of patient care they believe is appropriate from an ethical point of view. Furthermore, our participants also felt that shift rotations and excessive workload often led to burnout. This is supported by previous studies (Altun, 2002; Dyrbye et al., 2010) showing a negative correlation between burnout and the possibility of implementing professional nursing values.

One of the specific points made by the nurses we interviewed was the need to spend more time with patients in order to establish better communication and provide more individualized care. This is consistent with the findings of a study by Johnston et al. (2015), in which both patients and relatives highlighted the importance of nurses taking time to talk. Other aspects that have previously been identified as important for maintaining patients' dignity include adequate human resources and professional commitment to ethical principles (Manookian, Cheraghi, & Nasrabadi, 2014).

Our nurses also referred to their own emotional management skills as a factor influencing the delivery of dignified care. Empathy and personal experience were seen as making a fundamental contribution to the relationship with the patient, especially when it came to acknowledging the emotional impact that illness can have on patients (Fernández-Feito, Palmeiro-Longo, Hoyuelos, & García-Díaz, 2017).

Importantly, the ethnographic approach used in the present study revealed something of a dichotomy between, on the one hand, nurses' beliefs regarding what dignified care entails and the kind of care they were providing, and on the other, what they actually did in practice. For example, although they all agreed that the degree of formality used when addressing patients should be left to the patient's discretion, our observations showed that it was generally the nurse who took the lead in establishing these aspects of the interaction. This behavior is not consistent with what other authors have recommended in order to preserve the patient's dignity (Matiti & Trorey, 2008), and highlights, in our view, the importance of ensuring that the patients' feelings and values in this regard are seen as paramount, ideally from the first contact (Baillie, 2009).

A similar discrepancy emerged in relation to the patient's privacy. Thus, all our nurses agreed that it was important to protect the privacy of the patient's body when performing care tasks such as bed baths or wound management (Walsh & Kowanko, 2002). However, unnecessary exposure of the patient's body was observed on occasions, and furthermore, the nurses were unaware of this until the observational material was shared with them during the individual interviews. The fact that a threat to the patient's dignity can go unnoticed should not be underestimated, because authors such as Marín (2010) point out, an awareness of what one is doing is inherent to the practice of care. Our findings in this respect are also consistent with the literature on perception accuracy, which has shown that people's views of their own behavior often differ considerably from what they are observed to do by others (Brycz, 2011).

Taken together, the results of our study suggest that it would be useful to create forums in which professional nurses could gain greater awareness of their own practice in relation to the ethical aspects of care. Such forums might also address any additional training needs that emerge in the process. In this respect, we agree with Jacobson (2007) that awareness, responsibility, and the active defense of dignity-preserving behaviors are the foundation of dignified nursing care. We would also argue that both undergraduate and postgraduate nurse education programs need to do more to raise nurses' self-awareness about their professional practice, so as to address the dichotomy observed in our study between nurses' perceptions of the care they offer or should offer and what they actually do. In this respect, further research examining how professional values develop and are maintained over time would help to identify key points in a nurse's career when additional training of this kind might be most productive.

The fact that the perceptions of the nurses we interviewed coincide with the findings of studies conducted in other countries shows that this is far from being a local problem. As such, our data adds to the international body of knowledge on this topic.

Limitations

This study has a number of limitations. The first is the study objective and the fact that we did not analyze the effect of institutional factors on the delivery of dignified care. As such, the findings in this regard represent a partial account based on nurses' perceptions about the impact of institutional policies, and on observation of their clinical practice.

Another limitation is that only two of the 27 participants were men, although it should be noted that they were the only two male nurses employed in the units where the field work was carried out. Nonetheless, it is unclear whether the present findings are subject to a gender bias. A further sample-related issue is that all the participants were providing care to adults admitted to internal medicine units, and as such their experience may not reflect that of nurses working in other clinical specialties.

The possibility of social desirability bias must always be contemplated in studies of this kind, and in order to reduce this, we spent a considerable amount of time in the units where the field work was conducted. In addition, all the data were triangulated both among researchers, and with participants, in the individual interviews. Finally, we sought to limit the potential for bias in data collection and analysis by ensuring that the researchers bracketed their own views and conceptions regarding dignified care.

Conclusion

The results of this study underline the importance of delivering dignified care and the need to ensure that nurses' attitudes and behavior are consistent with those recommended by the AACN (2008). The ethnographic approach, combining participant observation with individual interviews, proved appropriate for our goals and, importantly, revealed discrepancies between what nurses actually did and what they believed they should do or were doing.

Emotional self-awareness can enhance nurses' capacity for empathy and their ability to relate to the patient, and it is therefore crucial to the delivery of dignified and individualized care. The present results suggest there is a need for professional forums in which nurses can become more aware of their own clinical practice.

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Supplementary materials

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