Original Manuscript

Nursing Ethics
1–15

10.1177/0969733017720826
journals.sagepub.com/home/nej
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Patient's dignity in intensive care unit: A critical ethnography

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Abstract

Background: Maintaining patient's dignity in intensive care units is difficult because of the unique conditions of both critically-ill patients and intensive care units.

Objectives: The aim of this study was to uncover the cultural factors that impeded maintaining patients' dignity in the cardiac surgery intensive care unit.

Research Design: The study was conducted using a critical ethnographic method proposed by Carspecken.

Participants and research context: Participants included all physicians, nurses and staffs working in the study setting (two cardiac surgery intensive care units). Data collection methods included participant observations, formal and informal interviews, and documents assessment. In total, 200 hours of observation and 30 interviews were performed. Data were analyzed to uncover tacit cultural knowledge and to help healthcare providers to reconstruct the culture of their workplace.

Ethical Consideration: Ethical approval for the study from Ethics committee of Isfahan University of Medical Sciences was obtained.

Findings: The findings of the study fell into the following main themes: "Presence: the guarantee for giving enough attention to patients' self-esteem", "Instrumental and objectified attitudes", "Adherence to the human equality principle: value-action gap", "Paternalistic conduct", "Improper language", and "Non-interactive communication". The final assertion was "Reductionism as a major barrier to the maintaining of patient's dignity".

Discussion: The prevailing atmosphere in subculture of the CSICU was reductionism and paternalism. This key finding is part of the biomedical discourse. As a matter of fact, it is in contrast with dignified care because the latter necessitate holistic attitudes and approaches.

Conclusion: Changing an ICU culture is not easy; but through increasing awareness and critical self-reflections, the nurses, physicians and other healthcare providers, may be able to reaffirm dignified care and cure in their therapeutic relationships.

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Keywords
Areas of practice, clinical ethics, critical ethnography, dignity in care, ethics education, ethics of care/care ethics, intensive care, organizational ethics, professional ethics, respect, theory/philosophical perspectives, therapeutic relationship, topic areas

Introduction

Dignity is a key concept in ethics.[1] Most professional codes of ethics have referred to the importance of dignity. The professional code of conduct for nurses holds that "All graduated nurses need to respect patients through preserving and promoting their dignity."[2] Preserving and respecting patient's dignity have also been included in the code of ethics for Iranian nurses.[3] Moreover, medical ethics also require physicians to be polite with patients, preserve their privacy, and respect their beliefs and values.[4]

Dignity is derived from the Latin word *dignitas* or *dignus*; one of the meanings for dignity is worthy or valuable.[5,6] Dignity has several attributes such as respect, autonomy, empowerment, and communication.[6] It has been expressed as absolute dignity and relative dignity.[5] Moreover, dignity has been defined in two aspects of basic and personal dignity.[7] Dignity consists of four dimensions as follows: the first dimension, which can be considered as "basic dignity," is the dignity of *Menschenwürde* or universal human dignity: the intrinsic dignity which all humans have because they are human; it is related to human right without consideration of race, gender, social status, and other factors; dignity as a merit: a dignity which is due to one's own social position or acquired merit; the dignity of moral stature: a dignity which depends on one's own moral conduct; and the dignity of personal identity: refers to the integrity of mind and body; this aspect is considered as "dignity-of-self" or "self-respect" and "respect for others."[8,9] The dignity of identity has the strongest relationship with illness and hospitalization. Because affliction by illnesses undermines personal autonomy and threatens personal identity, it can negatively affect dignity.[10] Dignity of identity is also called social dignity, relative or personal dignity. It is contingent and comparative.[9] This can be affected by others' actions and different circumstances, so in terms of quality of healthcare, the way to maintain this aspect of dignity is important.[11]

In hospital settings, patients face unfamiliar people, deal with new things and activities performed by medical and nursing staffs, and develop new needs, all of which predispose them to the loss of dignity.[12,13] Issues like effective communication, culture of care, privacy, staff attitudes and behaviors, and confidentiality are connected to their dignity.[14–16]

Critically ill patients who are hospitalized in intensive care units (ICUs), such as patients who undergo open-heart surgeries, are more at risk for this loss because experience stressful conditions such as pain, are treated by sophisticated equipment, tubes and catheters, and confined to complete bed rest.[17,18] On the other hand, 7%–72% of patients experienced delirium, confusion, disorientation, clouding of consciousness due to postcardiotomy delirium, or pump syndrome.[19] Physical barriers such as endotracheal intubation make it difficult for healthcare professionals to provide holistic care and preserve patient's dignity.[20] Moreover, complicated and critical situations which need prompt actions may interfere with healthcare professionals' attempts to preserve patient's dignity.[21]

Due to its importance, several studies have been conducted so far in the area of dignity preservation in acute care settings and ICUs. The result of a qualitative study conducted by 88 h of direct observation about respect and dignity in two ICUs, surgical and medical, in Baltimore, Maryland, showed seven main themes, which included attentiveness, patient and family engagement, being respondent, seeing the patient as a person, introductions and greetings, and environment.[22] Experiences of family members of older critically ill adults at two southern New England hospitals were examined. The aim of this study was to explore the family members' experience of their hospitalized patient, especially with respect to dignity. Three main

themes were derived including: (1) the older patient's health condition and ICU experiences; (2) family roles, relationships, and goals; and (3) staff interactions with family members.[20]

Another study was carried out at an average-size ICU in Norway. The accommodating seven former ICU patients were interviewed to acquire knowledge of what contributes to preservation of the dignity of patients. They reported that respectful fulfillment of needs was an instance of dignity preservation while objectified conduct was an instance of dignity violation.[23] A phenomenological study was carried out in an acute care setting, at a university hospital in southern Finland. The participants were 10 older patients and 10 family members. The results showed that nurses' behaviors and responsiveness to patients' need are important for patients' sense of respect.[24] Also a case study was done in a 22-bed surgical ward in an acute hospital in England. The healthcare providers were observed in practice. The researchers conducted interviews with them and patients too. This study showed that patient's conditions, the immediate environment, and healthcare providers' behaviors affect patient's dignity in acute hospital settings.[25] There are other studies with focus on privacy. An action research was carried out in two ICUs in the United Kingdom with the aim of improving patients' privacy. In audit stage, the patient exposure was identified as a main problem and factors such as workload, resource pressures, and clothing shortages were identified as barriers to patients' privacy.[21]

In Iran, several studies have been conducted on patient's dignity, most of which dealt with patient privacy as an aspect of dignity,[26,27] older patients' dignity,[18] dying with dignity,[28] or patients' experiences of dignity.[12] Nonetheless, no study has yet been conducted in cardiac surgery intensive care units (CSICUs).

The organizational culture of CSICUs is a subculture of hospital, nursing, and social cultures, and thus, all these cultures can affect patient's dignity. Organizational culture includes values, beliefs, and role expectations shared among the members of an organization. It affects personal and collective behaviors in an organization, and thus, its exploration is of paramount importance to nurses who are patients' advocates.[29] The profession of nursing and the system of healthcare provision need to develop context-bound patient's dignity promotion programs. This study was conducted to uncover the cultural structures of power that hindered maintaining patients' dignity in CSICU.

Methods

The critical ethnographer examines that culture through the lens of power, prestige, privilege, and authority in response to an ethical responsibility and attempts to achieve effective social change.[30] The aim of this study was to uncover the social and political forces that shape the workplace culture and healthcare providers' beliefs about themselves and their practice. Undertaking critical ethnography provided a focus on what could be.[31] The study was conducted using a critical ethnographic methodology as outlined by Carspecken.[32] This framework comprises five stages (Table 1). The aim of first three stages was to reconstruct cultural themes and in final two describe systemic relations and articulate the findings in relation to broader sociocultural factors or existing theories.[32] These stages were taken circularly. The main researcher started to document her observations of the study setting. The documents produced in the first stage were turned into a whole story about events happened in different working shifts of a whole day. The subjective, objective, and normative declarations about patient's dignity (such as the contents of the patient's bill of rights) were also taken into account. The main researcher wrote and discussed her reflections with coauthors in order to enhance the accuracy of the data. She thought continuously about people who could answer the study questions, strategies to approve or decline the collected data from observations, areas which needed further explorations, and differences among what she had already seen or heard. Accordingly, the aims of repeated observations were explained to the participants and then formal and informal interviews were conducted in order to complete and support observational data after or during observations.

Table 1. Carspecken's five stages of critical qualitative research.[32]

Stage	Description	Data collection	Analysis
1	Building a primary ethic record "What is going on here?"	Fieldwork: nonparticipant observer, monological unobtrusive, reflection	Cultural reconstruction (ethic)
2	Researcher interpretation	Preliminary reconstructive analysis (Perspective structural and contrast questions were used in order to do focused and selective observations, domain analysis, and taxonomic analysis)	Cultural reconstruction (ethic)
3	Dialogical (emic) data generation, collaborative stage	Fieldwork: participant observation, interactive, interviews, reflection	Cultural reconstruction (emic)
4	Describing systems' relations to broader context	Conducting systems analysis between locales, sites, and cultures (discovery)	System analysis (ethic)
5	Explaining relational systems	Link findings to existing macro-level theories (explanations)	System analysis (ethic)

Study setting

The setting of the study was both the adult CSICU I and CSICU II of a subspecialty teaching heart hospital in Isfahan, Iran. Most of the admitted open-heart surgery patients are old, addicted to smoking, and suffer from pump-syndrome symptoms, for example, confusion, delirium, disorientation, and clouding of consciousness, so most of them cannot express their desires and values owing to their medical conditions. The CSICU II was one of the rooms of the ward which had been turned into a CSICU. The unit contained four beds which are arranged two by two on either side. Patients who had undergone open-heart surgery were hospitalized from the second postoperative day in this unit. The CSICU I contained six beds. This unit was next to the operation room, and thus, patients were transferred to this unit immediately after undergoing open-heart surgery. Patients stayed in this unit for 48 or 72 h and then were transferred to CSICU II or surgical care unit, respectively. Participants included nurses, physicians, internal medicine specialists, cardiac surgeons, anesthesiologists, auxiliary nurses, radiology and laboratory technicians, physical therapists, clinical supervisors, as well as all patient education, quality improvement, and infection control staffs.

Data collection and analysis

Depending on the immediate situation, data collection tools and methods included observations, documents, data sheets and forms (such as consent forms), policies, field notes, and semi-structured interviews. Participant observation was the primary method of data collection and conducted by the main researcher. Prior to entering the field, researchers should develop a list of questions and potential aspects to be investigated.[32] We listed the study questions and issues in Table 2.

During the 18-month period of data collection, 200 h of observation and 30 interviews were performed. The length of formal interviews was 30–45 min. Informal interviews designed to illuminate the information gained through observation, shortly after a period of observation. The tone and body language were considered during observations and interviews. All interviews were tape-recorded after securing participants' consent. Observations were immediately documented while brief field notes were also written during observations. Data were analyzed hermeneutically and reconstructive to uncover tacit cultural knowledge

Table 2. Study questions.

Potential issues to be investigated	Information that needs to be collected to address these issues	Data collection
How do they respect patients in CSICU?	Communications, culture of respect and dignity	Participant observations
How is patient's dignity described by healthcare provider?	Social routines and rituals in the unit and their subjective knowledge	Non-participant observations and interviews
What do they call their patients?	Interactions, communications, power network	Participant observations, interviews, organization structure
What are differences among physicians, nurses, and other healthcare providers regarding their communication with and respect for?	Policy documents, strategies, individual versus group dynamics	Participant observations, interviews, organization structure
Does patients' social status affect the quality of healthcare providers' communication with them, and how?	Sociopolitical and historical aspects of preservation patient's dignity	Participant observations, interviews
How do personal and shared values and beliefs affect healthcare providers' communication with and respect for patients?	Sociopolitical and historical aspects of preservation patient's dignity	Interviews and subjective experiences
As a member of the healthcare system, how do you establish communication with patients?	Personal and shared understanding	Interviews and subjective experiences
How much do you pay attention to patients' self-esteem when communicating with them?	Personal and shared understanding	Interviews and subjective experiences
Which points do you take into account in order to maintain patient's dignity?	Personal and shared understanding	Interviews and subjective experiences
What factors can affect respectful communication with patients?	Personal and shared understanding	Interviews and subjective experiences

and to help healthcare providers to reconstruct the culture of their workplace.[32,33] In the reconstructive process, observations, all field notes, and transcripts obtained from interviews were reviewed several times. The potential meanings that Carspecken named as "meaning fields" were identified and coded. A list of primary codes was derived. Next, relationships among the codes were identified and thereby categories and final assertion were generated. Reflection was used to prevent probable biases. Then, the categories were brought together to generate main themes and final assertion.

It is noteworthy to mention that concurrently with data collection and analysis, the policies and sociopolitical aspects of the study setting were studied in order to compare findings and prevent biases. We especially attempt to explain the meaning fields by linking them to normative-evaluative claims.

Rigor

Credibility, conformability, dependability, and transferability were considered to ensure the validity and reliability of the study.[34] Observational data were discussed with the participants during informal interviews in order to establish credibility while dependability was maintained through collecting data in different work shifts and using different methods such as observation, interview, and filed note writing. The main researcher's continued presence in the study setting as well as the exact description of the setting and the

participants helped establish the transferability of the findings. Moreover, confirmability of the findings was ensured through peer debriefing and data collection from key informants such as in-charge nurses and quality improvement staffs.

Reflection

Reflection or self-reflection is a key element of ethnographic studies. When the researcher is familiar with the study subject matter, his or her experiences help improve the validity of the study.[35] The main researcher of this study had an 11-year working experience in the study setting and the study question—that is, how to preserve patient's dignity in ICUs—was among her main concerns. With the emic–etic spectrum in mind, she sometimes immersed in the culture of the setting in order to acquire better understanding about it, while sometimes adopted an etic view in order to obtain a general understanding and act as a researcher.

Ethical considerations

After obtaining ethical approval (Ethics Committee reference number: 394489) for the study from Ethics committee of Isfahan University of Medical Sciences, the main researcher referred to the study setting and made necessary adjustments with its authorities. The researcher explained process of observations and research goals to participants. Written informed consent was provided by each participant before any interview and observation and was able to withdraw from the study. In ethnographic studies, participants' consent should be secured continuously. Thus, whenever it was needed, we provided necessary explanations to the participants and secured their consent. Main researcher also wore a badge to show her identity as an ethnography researcher.

Data, including interview transcripts and field notes, were labeled by anonymous codes. In case of any wrong behavior toward the patients, the Quality Improvement Committee would be informed anonymously.

Findings

Findings showed a tension between maintaining patients' dignity and the actual practice in the CSICU. The final assertion was "reductionism as a major barrier to the maintaining of patient's dignity." A range of subthemes contributed to the final assertion. These are presented in Table 3. The findings are explained below; with selected quotes from field notes or interviews presented in *italics.* In addition, a sample of listed dichotomies between interviews and observations is noted in Table 4.

Presence: the guarantee for giving enough attention to patients' self-esteem

Most of the times, the participants' unawareness of their words about a patient in the presence of others could cause the patient to feel ashamed and affect his or her self-esteem. In other words, they failed to protect patients' informational privacy. They were talking loudly about a patient in the presence of others:

> In handover time, a nurse said loudly: "This guy had two to three considerable defecations last night and was changed." (Observation 3; CSICU II)

Additionally, patients' reactions to such situations (such as hanging head or making apology) indicated that they felt ashamed. These behaviors caused the patients feel indebted. Subsequently, those participants who understood patients' feeling of shame, attempted to compensate such a feeling, for example, they have applied humorous sentences:

Table 3. Final assertion, themes, and subthemes.

Final assertion	Themes	Subthemes
Reductionism as a major barrier to the maintaining of patient's dignity	Presence: the guarantee for giving enough attention to patients' self-esteem	Failure to informational privacy causing patients feel indebted
		Stressful behavior
	Instrumental and objectified attitudes	Body-centered care
		Using pronoun "this" in addressing
		Labeling patients
		Greater attention to financial aspects
	Adherence to the human equality principle: value-action gap	Respect for the intrinsic equality
		The difficulty of providing care to patients with low social status
		Paying greater attention to some particular patients
		Personality
	Paternalistic conduct	Authoritative behaviors
		Blaming the patients
	Improper language	Improper words
		Responding to patients ridiculously
		Using sentences with negative connotations
	Non-interactive communication	Impatience
		Heavy workload
		The diversity of patients' informational needs
		Compassion fatigue
		Routine-oriented therapeutic relationship

Table 4. Sample of listed dichotomies and tensions between interviews and observations.

Observation (*subtheme, **interpretation)	Interview (*subtheme, **interpretation)
The nurse said, "This guy had two to three considerable defecations last night and was changed"	*"Not yet. But if we want to assess a shift from this perspective, we need to change most of our words and behaviors because they are stressful for patients (a nurse in CSICU II).*
The patient hung his head. At the end, the nurse touched the patient's shoulder, laughed, and said, "This is a good guy." The patient laughed again and hung his head.	
*Talking about a patient in the presence of others	**Stressful behaviors*
**Failed to protect patients' informational privacy	***Need to change in stressful behavior for patient*
The nurse while writing the note said: this patient is very talkative	*We think that we should just treat patients' bodies while their souls may need more attention.*
	Unfortunately, physicians do not pay attention to patients' souls and minds.
*Using pronoun "this" in addressing	*Body-centered care
**Confirmation objectified attitudes in observation	**Confirmation objectified attitudes by participant
It is important to accept the wholeness of patients. Patients' social status or drug abuse should not be important to us	*I have seen discriminations in protecting the dignity of foreigner (like Arab or Afghani) patients compared with gentle patients who are accompanied by gentle family members*
*Respect for the intrinsic equality	*Difficult to accept patients with low social status
**Believed value about equality	**Unintentional flaws in their clinical practice and behaviors

> The patient hung his head . . . the nurse touched the patient's shoulder, laughed, and said, "This is a good guy." (Observation 3; CSICU II)

They reported that their conduct is mostly stressful for patients and thus it needs change:

> But if we want to assess a shift from this perspective, we need to change most of our words and behaviors because they are stressful for patients. (P22)

In summary, comparisons between observations and interviews showed a wide gap between the participants' values and their conducts. There were unintentional flaws in their clinical practice and behaviors.

Instrumental and objectified attitudes

Despite the healthcare providers that believed the need for holistic approach, they accepted their body-centered care:

> Patients' physical health is the only focus in the medical and nursing systems. We think that we should just treat patients' bodies while their souls may need more attention. (P4)

Great focus on patients' bodies instead of viewing them as a unified whole with several biological, psychological, social, cultural, and spiritual aspects was plainly evident in the setting.

The participants referred to patients using expressions such as "bed number . . . " or the pronoun "this." Similarly, they talked about a patient hospitalized in their unit as if the patient was not in the unit and talked about their patients using labels:

> A nurse while writing the note said: this patient is very talkative. (Observation 6; CSICU II)

Interviews and assessment of documents identified greater attention to financial aspects among the physicians:

> Unfortunately, physicians do not pay attention to patients' souls and minds. Most of them just value the financial aspects of the surgery as well as the necessity to do surgeries on a daily basis. (P10)

In addition, managerial committees had allocated a certain quota to each cardiac surgeon regarding the permissible number of their monthly elective surgeries. Our assessment of documents revealed that some surgeons exceeded their allocated quotas. It caused inconsistency in the system, leading to an increased number of canceled surgeries. Documents showed that the patients and their families were complained of canceled surgery. These consequences were in contrast with maintaining patients' dignity.

Adherence to the human equality principle: value-action gap

This main theme included subthemes such as "respect to the intrinsic equality," "The difficulty of providing care to patients with low social status," and "paying greater attention to some particular patients."

The participants held firm beliefs in the human equality principle:

> It is important to accept the wholeness of patients. Patients' social status or drug abuse should not be important to us. (P12)

However, their care practice was affected by patients' performance and social status. They considered it unpleasant to provide care to addict patients or patients with communicable diseases while felt greater responsibility toward patients with high social status:

> Yet, these realities are very important for some of my colleagues, even may frighten them. Thus, if somebody says them that a patient is suspected [to have communicable disease], they immediately refer to check the patient allocation sheet. (P15)

> I have seen discriminations in protecting the dignity of foreigner patients compared with gentle patients who are accompanied by gentle family members. (P1)

Nonetheless, situational factors, healthcare providers' personality characteristics (such as pride), and interpersonal relationships affected the application of this principle:

> One of the factors behind hospital workers' conduct is their personality. For example, due to their pride, some of them may not protect patient's dignity. (P3)

Paternalistic conduct

This main theme consisted of two subthemes: "authoritative behaviors" and "Blaming the patients." The important point observed during participant observations and approved by the interviews was that most participants forgot that their patients were vulnerable and disabled, hence they were mostly impatient and used imperative words. Consequently, a superior-inferior relation between healthcare providers and patients was seen:

> The patient was a 34 year-old young man . . . Suddenly, he developed hypotension. He avoided going to ICU bed. An ancillary staff said to him, "Go to the bed." He answered, "I'd like to go home." The staff pushed the patient toward the bed and said, "This is not the right time for such sayings." (Observation 19, CSICU II)

In some cases, blaming patients for their harmful health behavior could threaten their dignity. In fact, the blaming sentences can interfere with patient autonomy:

> Blaming patients for their unhealthy habits such as smoking can affect their dignity. (P7)

Improper language

The participants used improper language particularly when they were fulfilling basic bodily needs of patients. The improper words were evident in observation:

> Bed 1 seemed to have expelled feces. The auxiliary worker said, "Shit." (Observation 2; CSICU2)

Additionally, the participants confirmed that answering ridiculously could be in contrast with patients' dignity:

> When I explain patients' conditions using words with negative connotations (such as your heart valve is non-beneficial) or answer ridiculously, their dignity may hurts. (P7)

In support of the above findings, the improper words were reported to the complaint committee by patients and their families:

> One of the patients' main complaints is about staffs' improper words. (P8)

Non-interactive communication

Our observational and interview data revealed that patients' psychosocial needs were mostly taken for granted. The issues such as impatience, heavy workload, and the diversity of patients' informational needs caused non-interactive communication between healthcare providers and patients:

> When we are impatient, the workload is heavy, and a patient is asking many questions, we cannot answer him/her. (P9)

The compassion fatigue in providing care was preventive factor on the way interactive communication between healthcare providers and their patients. Constant suffering and sorrow critically ill patients, they had exhausted:

> The large number of patients with such conditions has reduced our sensitivity, particularly when the prognosis is poor. (P16)

The main reason for the compassion fatigue was noted loss of sensitivity. Also the participants confirmed the routine-oriented therapeutic relationship as a barrier:

> Over time, we lose our sensitivity and thus, do not get deeply involved in patients' worlds. We just come here to do our [technical] job and go home. (P11)

Discussion

This study sought to explore the culture of preserving patient's dignity in the CSICUs of a teaching hospital located in Isfahan, Iran. Findings revealed the assertion of "reductionism as a major barrier to the preservation of patient's dignity." The concept of reductionism is opposite to holism. A study in Iran reported that one of the main components of patients' lived experiences of respect toward them (as one aspect of dignity concept) was holistic care. The study showed that attentiveness and respect depended on nurses' "caring presence."[36] Similarly, one of the main themes of our study was "presence: the guarantee for giving enough attention to patients' self-esteem," denoting that beside physical presence, adequate attentiveness during presence is needed in order to take all aspects of patients' health into account and promote their self-esteem. Nurses who participated in a qualitative study into critical care nurses' understanding of patient-centered care in Iran also equated patient centeredness as a factor behind the preservation of patient's dignity and respect.[37] Our participants also noted that patient's dignity is attentiveness to all aspects of patients' health instead of viewing them just as bodies. Nonetheless, the theme "instrumental and objectified attitudes" indicated the dominance of reductionism in the study setting. The participants personally referred to their own instrumental attitude. Instrumental attitude was considered as a violation of patient's dignity in Norway.[23] Moreover, the prevalence of paternalism and reductionism in modern care settings is confirmed by some authors.[38] The results of a study in Sweden also showed that altruism preserved patient's dignity while view them as objects violated their dignity.[39] Moreover, patients who had been receiving mechanical

ventilation for long periods of time reported violation of their dignity by saying that they were treated by healthcare workers as soulless bodies.[40]

Not only such an objectified and instrumental attitude contradicts nurses' holistic professional values, but also violates medical ethics. Yet, giving more attention to patients' physical problems is normal and inevitable and is considered as the most possible thing that can be done for patients. In other words, the dominant perspective in hospital settings is the biomedical perspective. The outcomes of such an attitude and perspective include, but not limited to, giving lesser importance to patients' psychological and mental problems and deviating from the holistic patient care.[41] Although the discipline of nursing has outdone the profession of medicine in redefining its paradigmatic and metaparadigmatic concepts based on the principles of anthropology and sociology and in line with the needs of human communities, the dominant care delivery model in clinical settings is still the biomedical one. Factors such as the greater dominance of the positivist paradigm, the lesser importance of the naturalistic hermeneutic paradigm, the higher social status and power of medicine and physicians, and the powerlessness of nurses are reasons behind the dominance of biomedical perspective in clinical settings. Consequently, nurses are suffering from a paradigm-action mismatch which is manifested in abandoning the holistic approach and adopting the systemic and reductive approach of physicians.[42]

Respect to dignity is explained as considering the individuality of each patient with his or her own existential aspects irrespective of his or her status, age, and race as well as considering all patients as equal human beings and respecting their values, beliefs, and preferences.[43] Respecting the equality of human beings and avoiding their humiliation are associated with a sense of self-worth for them. Paying attention to the humanity of patients and respecting them also reported as the most important aspects of patient's dignity.[44] Similarly, this is believed that dignity is to behave in such a way that patients do not feel humiliated.[25] As an outcome of damage to self-esteem, humiliation can damage patient's dignity.[45]

In the study setting, most patients had no control over their status and bodies, and thus, healthcare providers' words, looks, and conduct gave them feelings of shame and humiliation. Some of the study participants have perceived such feelings and attempt to compensate it, for example, they have applied humorous sentences such as "This is a good guy."

Paying attention to high social status patients denoted that care and cure delivery were affected by power relations in healthcare systems while according to ethical principles, service delivery should be independent from any external factors such as feelings of pride or supremacy.[41]

We also observed in the study setting authoritative and paternalistic behaviors. These behaviors seriously threaten patient's dignity.[23] Although patient empowerment is among the main goals of all healthcare organizations, achieving this goal is difficult due to the unique conditions of patients and the unique environment of healthcare settings. Patient empowerment requires proper balance of power and greater attention to patients' benefits. Thus, the most effective strategy to minimize paternalistic behaviors may be the focus on behaviors which guarantee patient's dignity and respect and facilitate patient empowerment.[46]

Healthcare providers' "improper language" affected patient's dignity. In agreement with this finding, it is found that using appropriate ways to address patients and respecting their needs to be treated politely were related to patient's dignity even though healthcare providers often failed to adopt these strategies. These findings were attributed to healthcare providers' lack of knowledge about the relationships of these strategies with patient's dignity.[47] Reflection before behaving can guarantee the preservation of patient's dignity.[12] In fact, most healthcare professionals have difficulty in using their ethics-related knowledge in their clinical practice.[48] Our participants confirmed such a lack of self-reflection and sensitivity in their behaviors, as expressed that "they do not yet pay attention to their words in communication with their patients." They confirmed the need to change their stressful behaviors for their patients.

Another manifestation of holism and consequently dignity preservation are devoting enough time, and compassionate and respectful behaviors. However, most of our observations revealed instances of

non-interactive communication. The participants also confirmed this type of interaction and attributed it to factors such as their impatience, heavy workload, and compassion fatigue. The participating nurses also confirmed that their great focus on routine tasks and the diversity of patients' informational needs prevented them from interactive communication with their patients. Staff shortage and heavy workload were reported as major managerial barriers to ethical practice.[49] Our participants also noted that patients and families' poor understanding of clinical settings, their frequent questions, and their insistence on their expectations cause nurses to have no proper control over their behaviors, resulting in their non-interactive communication. In Iranian healthcare settings, cultural characteristics, limited ICU visitations, patients and families' concerns and lack of knowledge, and lack of an integrated patient education system have turned nurses into the only source for fulfilling patients' informational needs and alleviating their concerns. In line with these findings, previous studies also showed nurses' physical and mental fatigue or compassion fatigue as the outcomes of their job burnout and factors behind their poor performance.[50] One of the factors behind healthcare providers' respect for patients' rights is the recognition of their own rights by others. In other words, when the rights of healthcare providers are not well recognized, no one should expect them to have ethical clinical practice. Thus, effective measures should be developed at different managerial levels in order to alleviate healthcare providers' physical and mental burnout and recognize their rights.[51]

Our findings indicated that reductionism and paternalism predominated in the study setting. According to our discussion, one of the factors contributing to this finding can be the predominance of the biomedical perspective in Iranian clinical settings. Interpersonal communication is greatly affected by power and knowledge. Power determines the types and styles of communication.[52] As an extension of communication, healthcare provider-patient communication is also affected by power. Moreover, the communication in turn affects patient's dignity because care and cure do not occur in a vacuum and are determined by environment, interactions, and social, political, and financial structures of the immediate context.

Conclusion

The key finding of this study is that despite commitment to dignified care based within a therapeutic relationship, the healthcare providers were constrained by various cultural factors. So they experienced tensions between values and actions and unintentional flaws in their practice. A dichotomy is revealed between healthcare providers' values and their actions. It is important to understand that healthcare providers did not intentionally choose their actions. The healthcare providers were influenced by a dominant reductionism attitudes and workplace cultural atmosphere. Changing an ICU culture is not easy; through increasing awareness and critical self-refection, healthcare providers such as nurses, physicians, and others may be able to reaffirm dignified care and cure. If healthcare providers were supported to achieve a common language to clarify relationship between patients' dignity and dominant discourses, it is likely that they could be empowered to achieve the values, denoted in dignified care.

Implications

It is suggested to focus on the results of this study and others to provide solutions regarding the mitigation of reductionism attitudes in ICUs. In addition, the findings of this study can be applied to various areas in medical and nursing discipline such as research, education, and practice especially for areas of professional ethics. Our study findings may be useful for understanding and bridging such a gap between values and actions, or theory and practice by healthcare policy-makers, managers, and providers to preserve patient's dignity. This study was conducted in specific context; therefore, further ethnographic studies in other settings would be helpful to address the gap of value and action in this regard.

Acknowledgements

The authors would like to express their deep gratitude toward the participating physicians, nurses, and staffs of the study setting as well as the authorities of a study hospital in Iran.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The research project had been financially supported by Isfahan University of Medical Sciences.

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