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Nurse Perspectives of Maintaining Patient Dignity in Indonesian Clinical Care Settings: A Multicenter Qualitative Study

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Abstract

Purpose: Nurses have a professional obligation to maintain patient dignity when providing nursing care. The concept of dignity, however, is dependent on cultural context. The aim of this study was to elicit nurses' perspectives for maintaining patient dignity in Indonesian clinical care settings.

Design: A qualitative descriptive study was performed.

Methods: A total of 40 clinical nurse participants were recruited by purposive sampling from six general public hospitals in Eastern Java, Indonesia, including six medical and six surgical units. Data were collected in 2017 using individual face-to-face semistructured interviews. Inductive content analysis was employed.

Findings: The interview data revealed nurses considered three main elements were necessary to maintain patient dignity in clinical care: personalized care, which included prioritizing patients and treating as individuals; compassionate care, which included empathizing and providing emotional support; and patient care advocacy, which included protecting patient rights and being a representative for the patient.

Conclusions: This study provided knowledge on how to maintain patient dignity from the cultural perspective of clinical nurses in Indonesia. Our findings highlight the importance of providing dignified care in a manner that is congruent with culture. The nurses in our study considered compassion and beneficence necessary values for providing dignified patient-centered care, which might be qualities that are culturally sensitive for an Indonesian population.

Clinical Relevance: Strategies should be developed to improve dignity of care for hospitalized patients in Indonesia as well as other cultural settings, which could be incorporated into patient care. These should include improving patients' health literacy to increase patient-centered communication, eliminating mixed-gender wards to enhance patient privacy, and involving family members as partners in health care.

Dignity is an important topic in healthcare research as it informs nurses' perspectives regarding ethical care. The World Health Organization (2015) defined dignity as "an individual's inherent value and worth and is strongly linked to respect, recognition, self-worth and the possibility to make choices." To treat someone with dignity is to treat them in a way that is respectful of them as valued individuals (Royal College of Nursing, 2008). Therefore, the terms respect and dignity can be utilized interchangeably for exploring the concept of dignity.

Dignity is a core value of nursing practice, which includes the ethical responsibility to maintain patients' dignity (Baillie & Gallagher, 2011; Moen & Nåden, 2015). Patients rely on the integrity of healthcare providers to care for them in a dignified manner (Heijkenskjo, Ekstedt, & Lindwall, 2010). When caring for patients, nurses as well as other healthcare professionals may have an intuitive sense of dignity, although they may lack an in-depth perception of what is required to provide dignity in care (Tranvåg, Synnes, & McSherry, 2016). To understand dignity in care and utilize the concepts in practice require a clearer understanding of nurses' views about dignity, which could increase the opportunities for delivery of dignified care (Tranvåg et al., 2016).

Dignity is an abstract concept, which is difficult to apply directly in a concrete environment of a healthcare setting (Barclay, 2016). Therefore, the interpretation of dignity is required to gain individual perceptions, which might be uniquely interpreted, experienced, and predisposed by a broad range of factors: personal, social, cultural, ethnic, religious, political, organizational and professional (Tranvåg et al., 2016). Exploring dignity requires not only understanding the cultural context, but also the unique properties of culturally diverse countries (Asmaningrum & Tsai, 2018). Therefore, cultural diversity is an important consideration for studies on maintaining patient dignity (Cheraghi, Manookian, & Nasrabadi, 2014).

Few studies have investigated nurses' views of maintaining patient dignity in clinical settings in Indonesia. Indonesia is ranked fourth in population size among the world's countries. It is composed of thousands of islands scattered across Southeast Asia, which results in the demographics of Indonesia being one of the world's most ethnically diverse. As a consequence, ethnicity, language, and religion are varied, and regional interests and cultural elements are widely divergent (Phillips, 2005). Therefore, the aim of this qualitative study was to explore Indonesian nurses' perspectives toward maintaining patient dignity in clinical care settings, which could enrich views of cross-cultural nursing for research on global healthcare.

Methods

Study Design

This qualitative descriptive study was part of a larger multicenter study to determine nurse and patient perspectives for maintaining dignity in Indonesian clinical care settings. The benefit of a qualitative descriptive design for studies in health care is that interview data can capture detailed descriptions of participants' experiences in a straightforward and focused manner, which provides data that enhance the understanding of a phenomenon (Kim, Sefcik & Bradway, 2017).

Participants and Settings

Registered clinical nurses were recruited purposively from six public Indonesian general hospitals in four different districts of Eastern Java, Indonesia. To represent heterogeneous clinical care settings, nurses were recruited from medical units (six each) and surgical units (six each). Both types of units are divided into mixed-gender and single-gender wards containing six to eight beds, as well as private (single) rooms. Nurses were included if they met the following inclusion criteria: registered clinical nurse, employed at the hospital for a minimum of 2 years, and willing to participate voluntarily. Nurses were excluded if they were a nurse manager or an orientation nurse. The first author (N.A.) approached eligible nurses in their workplace to explain the nature of the study and the methods. Nurses were assured of confidentiality and anonymity of the data. If the nurse agreed to participate in the study, he or she provided written informed consent. A total of 43 nurses met the inclusion criteria. Three eligible nurses did not agree to participate due to other responsibilities. The mean age of the 40 participants was 33.6 years, and 42.5% had more than 11 years of nursing experience. Surgical and medical care nurses were equally represented. Demographic data are shown in Table 1. This study was approved by the university ethics committee (No. 943/H25.1.11/KE/2016).

Data Collection

Data were collected from January to April 2017 with individual, face-to-face, semistructured interviews using open-ended questions. Research nurses with experience in qualitative studies constructed the interview guide, which was tested with registered clinical nurses. After evaluating the nurses' responses to the questions, a few items were revised. Two core questions explored the phenomenon of dignity: "What behaviors do nurses exhibit which reflects high respect for a patient as a valuable human being? Please give examples and reasons" and "What should nurses do to maintain respect for patients as a valuable human being?" Prior to recruitment, the interviewer had no contact with eligible participants to assure there were no established relationships between interviewer and participant. The first author (N.A.) conducted all interviews in the workplace. Interviews were digitally audio-recorded and

Table 1. Demographic Data

Variable	*n*	%	Mean	*SD*
Gender				
Male	17	42.5		
Female	23	57.5		
Age (years)			33.6	5.8
25–35	26	65.0		
36–45	15	37.5		
>46	1	2.5		
Length of tenure (years)			10.5	6.1
1–5	12	30.0		
6–10	11	27.5		
>11	17	42.5		
Education				
Diploma	22	55		
Bachelor's	18	45		
Living area				
Rural	9	22.5		
Urban	31	77.5		
Ethnicity				
Javanese	28	70.0		
Madurese	10	25.0		
Java-Madurese	1	2.5		
Javanese-Bugis	1	2.5		
Religion				
Muslim	40	100		
Hospital care unit				
Medical	20	50		
Surgical	20	50		
Ward type				
Mixed gender[a]	20	50		
Single gender[b]	16	40		
Private room[c]	4	10		
Employment status				
Civil servant	21	52.5		
Non–civil servant	19	47.5		

[a]Mixed-gender wards contain six to eight beds and are occupied by both men and women in the same room.
[b]Single-gender wards contain six to eight beds and are occupied by either males only or females only.
[c]Private rooms are occupied by a single patient and have an adjacent toilet and washing facility.

duration ranged from 12 to 59 min. All participants were interviewed once only. A few participants preferred to be interviewed in their office, which allowed other staff to be present but did not disrupt the interview process. Field notes were maintained regarding observations of participants' behavior and nonverbal expressions, which augmented the data. Saturation of the data was reached at the 38th participant; however, interviews continued to the 40th participant to enrich the data. Data collection and transcription of the recorded interviews occurred simultaneously. Nurses did not receive copies of the transcripts; however, to allow for clarification of responses, the interviewer restated the participant's main ideas prior to terminating the interview. If there was any disparity in the interviewer's statement, the participant was invited to revise the statements or provide additional feedback.

Data Analysis

Qualitative content analysis was applied to the interview data. The coding-driven data employed inductive content analysis to gain important meanings regarding nurses' experiences of providing dignity in care. Inductive content analysis is composed of three stages: preparation, organization, and reporting (Elo & Kyngäs, 2007). During preparation, transcripts and field notes were reread in their entirety several times in order to make sense of and get close to the data. Organization of data involved open coding of the transcripts, grouping similar codes into subcategories, merging subcategories to create categories, and grouping categories to generate main categories. As a result, in the final step, the conceptual framework was drawn to report the abstraction of dignity in care's concept.

Rigor

Rigor of the qualitative content analysis study was enhanced by promoting authenticity, credibility, conformability, dependability, and transferability (Elo et al., 2014; Lincoln & Guba, 1985). To enhance dependability, participants were purposively recruited until data saturation was achieved. Participants were encouraged to speak freely while sharing opinions and perceptions, which were accurately transcribed to foster authenticity. An accurate English transcription of the interviews using back-translation was generated prior to data analysis to enhance the accuracy of participants' perceptions of dignity because one of the authors was not an Indonesian speaker. To promote conformability, two researchers, who had extensive experience in qualitative studies, reviewed the codes and agreed with the analysis. Credibility was ensured by rereading both the original and translated transcripts several times to understand the whole context of the interview content. Thick descriptions for each subcategory enriched the explanation of the data and strengthened transferability.

Findings

Nurses' Perspectives on Dignity

Our study provided multiple perspectives regarding practice elements nurses considered essential for maintaining

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patient dignity during hospitalized care. Data analysis generated 2,432 codes, which were clustered into 60 distinct subcategories and were described by at least 10% of participants. From the nurses' viewpoints, the following three main categories were crucial for maintaining patient dignity: personalized care, compassionate care, and patient care advocacy. Representative quotes associated with subcategories were selected based on their clarity and consistency for illustrating the views and diversity of the sample.

Personalized Care

The first main category, personalized care, was considered essential for maintaining patient dignity. Nurses described the importance of seeing the patient "as a person" when providing care rather than focusing on the patient's illness. The patient (and by extension, the patient's family) was at the center of attention. Nurses believed person-centeredness could enhance patients' feelings of respect and importance. The four subcategories of personalized care are described below.

Respectful relationships

The subcategory of respectful relationships involved building respectful nurse–patient relationships, which was initiated by asking the patient for permission to begin a procedure. Using proper manners, such as greetings, smiling, and introducing themselves when initiating interactions, were important. Behaving in a manner considered polite enhanced patients' feelings of comfort, importance, and being valued, which enabled nurses to build a relationship of mutual respect through reciprocity.

> We have to obtain permission (for wound care) from the family and patient. When we change an intravenous (IV) line I say "ma'am, this IV has run out," then, "excuse me, may I change the IV?" (P10)

> On morning shift, I first greet them [patients] as usual, saying "Good morning, ma'am, how are you today?" After introducing ourselves, we interact directly. I smile and greet them like that so patient feels comfortable. (P17)

Patient-centered communication

Patient-centered communication involved communicating using language that was easily understood by the patients, which was important for patients with inadequate health literacy. Nurses described the importance of knowing whether the patient was able to readily understand their medical information. The use of nonmedical terms (plain language) during communications was often required for explanations and interpretation of test results. Clarification in simple language ensured the information was understood and nurses were willing to inform patients about their health as much and as often as needed. Cooperating with a family member who was designated as a spokesperson for the patient enabled nurses to communicate more effectively.

> We have to be aware if the patient doesn't easily understand. I must give a simple explanation. The best way is matching our language to language that patients understand, an ordinary language that can be understood by the patient. Do not use medical or uncommon terms. (P9)

> We provide the assessment results. For example, after measuring blood pressure, we say, "ma'am, this is your blood pressure: 120" or "Sir, your blood pressure yesterday was 160, now it is 140, which means you are getting better." (P2)

Patient as a priority

Patient as a priority referred to nurses keeping the best interests of the patient in mind. The patient's care was not only a responsibility, but also an obligation. Nurses met patients' needs before attending to necessary nursing tasks, which nurses perceived as behaving altruistically. Participants believed responding promptly to meet patient needs, without undue delay, would be perceived by patients as respecting their needs and feelings. Arranging time for patient care through regular interactions was an important element of dignified care.

> We have to realize that we are nurses. Our duty is to care for and help patients. A nurse must be aware of that to help and care for the patients. Therefore, we have to prioritize patients… that is why we have to do that. In our mind, we prioritize the patient first. (P27)

> If a patient asks for help, a few times or many times, I do not keep count, I respond quickly whenever the patient has a complaint. (P13)

Patient as an individual

Treating the patient as an individual rather than a disease acknowledged the uniqueness of each patient. Meeting a particular patient's needs that is customized to the individual requires knowledge of the patient's background. Nurses initiated this individualized care by addressing the patient by name, rather than "sir" or "ma'am." The nurse learned about the patient and continued to adopt "everyday living room" language to enhance the patient's understanding of the circumstances surrounding their condition.

> The causes of diseases vary and each patient is unique. Therefore, they cannot be treated the same. When we explain a serious disease, some patients understand, others cannot, and some ask to discuss [the disease] further. Patients don't accept being treated the same. (P29)

> When we see a patient, we use their name. When we use the patient's name, he feels he is known. For example, the patient's name is Ahmad, so I say "Bapak [Mr.] Ahmad, how are you?" which seems more familiar. (P34)

Compassionate Care

The second main category for dignity in care was practicing compassionate care. Nurses attempted to connect with the patients' perceived feelings of suffering and respond accordingly. Patients are often anxious or in distress during hospitalized care; thus, responding compassionately was important for respectful care. The three subcategories of compassionate care are described below.

Clinical empathy

The subcategory of clinical empathy involved understanding patients' perceived feelings in a clinical context, and then acting in a helpful manner. The ability to listen to a patient's concerns and preferences with kindness and sincerity was frequently mentioned by our participants as important for providing empathy. Some nurses reported empathizing with the patient by caring for them as a family member. Participants believed empathizing with patients enhanced patients' feelings of being valued and respected.

> During clinical care, we treat patients like our own relatives, our own parents. If we treat them like our own relatives, we will not treat them carelessly. I assume [the patient] is my family, my parent, or me, or my husband, or my little brother, like that. (P33)

> Each time patients report or maybe complain about anything, we listen. When he's at the hospital, he feels appreciated, feels he is being listened to. For example, if he says, "Ms., why is this painful?" we listen and then explain it. (P39)

Understanding patient needs

The subcategory of understanding patient needs required nurses to have patience and be attentive. The nature of illness is dynamic. Therefore, how an illness affects the patient's personal needs is ever changing. A nurse's willingness to help patients voluntarily and without being asked was perceived as respecting the patient. Nurses accepted patients' individual behaviors in order to deliver care appropriately.

> Sometimes patients respond differently toward treatments and conditions. One patient is rude. Another is easily annoyed, like that. So, we, as nurses, have to maintain patience in order to treat all kinds of patients. (P27)

> During interventions, we interact with patients and ask about their complaints. "What seems to be the matter today, sir? Have you eaten or not?" That question is a must. When we give an injection, we ask whether there is any complaint. (P23)

Emotional support

Nurses also provided compassionate care in the form of emotional support, which promoted the patient's healing by reducing factors that might cause psychosocial distress. Emotional support involved strategies to assure the patient's well-being, such as providing motivation, encouragement, humor when appropriate, and implementing a comforting tone of voice. Patients responded by feeling respected and valued.

> If we are with a patient when the doctor visits, we ask how they are feeling. Sometimes we joke with the patient, yeah,

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patients feel happy, comfortable. We match the joke with education level, or age, jokes are more mature for older patients, if for children, we tell kids' jokes, to be proper for each patient. (P21)

Most of the patients here are villagers, they usually talk with a lower voice. We start talking that way (with a lower voice) to the patient. If we talk nicely that way, the patient feels they are well treated, appreciated. (P2)

Patient Care Advocacy

Patient care advocacy was the third main category for maintaining patient dignity. Patient advocacy required nurses to respect the patient as a human in order to protect patient rights. Patient care advocacy encapsulated protecting patient rights and integrating care delivery in a manner that promoted patients' healthcare needs. Advocacy is a means of safeguarding good patient care. Implementing patient care advocacy required nurses to act as the patient's representative to integrate care delivery, or manage an interprofessional healthcare team and ensure patients' rights were protected during care. The two subcategories of compassionate care are described below.

Protecting patient rights

Protecting patient rights involved upholding a patient's rights to privacy, confidentiality, and patient equality. Participants believed it was important to advocate for adequate physical privacy during treatment for patients in the multibed wards. Discussions of personal matters were conducted in private in order to protect patient confidentiality regarding personal and medical information. Nurses also believed it was their duty to treat patients without discrimination, which meant ensuring every patient received the same care, and was treated with respect.

We need to minimize visitors. We say, "ma'am, excuse me, we need to do a wound intervention." Then we close the curtains. That's how to humanize humans. I invite the patient's family to our office. I always try not to talk in a patient's room. Each patient's information is confidential. (P39)

For me, we have to care about our work. Our treatment implementation is the same, regardless of a patient's payment status. Either BPJS insurance [Indonesian medical insurance] or general [private] payment, the treatment is the same. (P2)

Patient's representative

When patients are hospitalized, they are in varying states of vulnerability and may be unable to represent themselves adequately. Nurses acted as a patient's representative in order to integrate critical aspects of patient care, which ensured concerns were addressed, and standards of care upheld. Nurses were liaisons with other healthcare services, as well as the hospital's administration, healthcare staff, and physicians. Patient advocates can be a resource to help patients and their families by facilitating financial aspects of healthcare services and integrating care sources, depending on the patient's needs.

When we treat the patient, we have to follow the existing standard of procedures. If we can do better, just do it…. Those are our guidelines. Since we were in college, we have been taught about ethics which need to be implemented. (P24)

He [the patient of an electrical injury] was re-admitted several times; he had financial problems. Finally got his BPJS card, but could not use it because it needs 15 days after being activated. The point is, I humanized him by helping them to obtain their rights. That's what I believe. (P31)

Discussion

Our findings describe the views of Indonesian nurses regarding practices for maintaining patient dignity in the clinical care setting of Eastern Java, Indonesia. All nurse participants were Muslim, which reflects the dominant religion in the Indonesian population. Indonesia is also multiethnic and participants were from multiethnic backgrounds, also reflecting the distribution of the largest indigenous ethnic groups: Javanese (70%) and Madurese (20%). Java itself (Indonesian: Jawa) is known as the heartland of Indonesia because it is the most populated island (Phillips, 2005).

Recruiting nurses from multicenter hospital-based settings has been shown to result in a variety of nurses' assumptions, beliefs, values, and priorities (Boykin,

2014). Our participants represented diverse healthcare organizations, workforces, and patients, which provided a heterogeneous perspective of the healthcare culture. Despite the diversity of nurses in our study, three main categories described shared universalities and commonalities regarding the essential components for maintaining patient dignity during hospitalized care: personalized care, compassionate care, and patient care advocacy. These findings enrich our knowledge regarding cultural views for promoting dignified care in a clinical nursing setting.

The link between personalized care and patient dignity has previously been demonstrated (Baillie & Matiti, 2013; Cheraghi et al., 2014). The participants in our study believed a respectful relationship was an important aspect of dignified care. This finding is similar to Indonesian patient perspectives that described nurse–patient interactions, initiated with greetings, smiling, and introductions, as being important Indonesian cultural signs of respect (Asmaningrum & Tsai, 2018). Respect for others is an important value, which is rooted in Asian culture (Hatah, Lim, Ali, Shah, & Islahudin, 2015). In Indonesia, failing to demonstrate proper respect denotes a lack of good manners. Requesting a patient's permission prior to performing a procedure was considered an important aspect of personalized care and has been shown to increase patients' feelings of being respected during treatment (Geller et al., 2015) and has been linked to dignity of care (Whitehead & Wheeler, 2008).

Nurse participants considered patient-centered communication important for maintaining dignity. Nurses in other diverse countries, such as the United Kingdom, share this perspective (Baillie & Gallagher, 2011). Nurses in Indonesia serve a diverse population of patients with varying levels of education, and many are from rural areas with inadequate levels of health literacy (Asmaningrum & Tsai, 2018). Therefore, the limited medical language of the Indonesian patients prompted nurses to adopt simple, "everyday living room" language to more accurately communicate medical information to patients. Use of plain language to relay health information to educate patients regarding their medical care not only improves health literacy but is essential for patients to feel respected (Geller et al., 2015).

Communicating with the patient's family members is important in Indonesia; therefore, nurses understood the importance of acknowledging a family member as a spokesperson to share patient information, such as test results, in an accessible language. The collectivist culture of Indonesia stresses family and community; therefore, including family members is significant for patient healthcare in Indonesia. Similarly, nurses in South Africa reported family involvement was one of the most important aspects of patient-centered care (Jardien-Baboo, van Rooyen, Ricks, & Jordan, 2016).

Personalized care included prioritizing and individualizing patient care. Prioritizing and individualizing patients is a main concern for nurses in the United Kingdom (Nursing and Midwifery Council, 2015). To our knowledge, previous studies have not linked these qualities with nurses' perspectives on dignity in patient care. However, patients reported dignity in care was received when nurses responded promptly and understood their needs, which they saw as altruistic (Asmaningrum & Tsai, 2018). Individualized care requires knowledge of what is important to the patient (Baillie & Gallagher, 2011). Part of this individualized care included addressing the patient as Mr./Mrs./Ms. (Indonesian: Bapak/Ibu/Sdr), which is considered polite in Indonesia's culture. Addressing a patient by name during nurse–patient interactions can increase individualized care and foster mutual respect with patients and families (Carrese et al., 2015).

Compassionate care was the second element required for maintaining patient dignity. Nurses believed compassion could enhance the patient's psychosocial well-being. In the context of nurse–patient relationships, compassion can play a vital role in alleviating suffering (Tierney, Seers, Reeve, & Tutton, 2017). Compassionate care included providing clinical empathy and emotional support, which has been demonstrated as an important element for maintaining dignity in clinical practice (Lin & Tsai, 2010). Nurses made an effort to speak in a quiet tone or manner, because the Javanese consider this polite. They also asked how the patient was feeling, and sometimes used humor. Appropriate humor assisted nurses in providing emotional support when faced with an irritable patient. Our nurse participants described the importance of treating hospitalized patients as if they were their own relative as a means to generate empathy and respond compassionately.

Nurses described a strong association between patient advocacy and dignity in care, which has been reported in previous studies of Western and Asian cultures (Cohen & Ezer, 2013; Lin & Tsai, 2010; Walsh & Kowanko, 2002). Confidentiality was seen as a key component of patient advocacy, which has also been reported (Lin, Tsai, & Chen, 2011). In our study, confidentiality included protecting a patient's medical history from an unconcerned third party. Advocacy included providing equality of care, regardless of financial status or insurance coverage. Nurses are often a better resource for mitigating the financial difficulties of obtaining needed healthcare services (Hussung, 2016).

Maintaining patient privacy was also one of the advocacy roles of the participants, as half of the nurses provided care to mixed-gender wards. Patients in mixed-gender wards often experience embarrassment and anxiety, not only due to lack of personal privacy but also due to cultural unacceptability (Smith & Field, 2011). These discomforts may be more significant in an Indonesian setting composed of a religious population that is 88% Muslim (Phillips, 2005). Muslims who strictly follow the teachings of the Quran emphasize the importance of privacy between males and females (Othman, Aird, & Buys, 2015). Exposure of the body in a mixed-gender environment in and of itself threatens patient dignity, and mixed-gender wards occur regularly due to bed shortages (Baillie, 2009). Nurses recognized their responsibility to ensure patient privacy at all times in order to avoid patients experiencing embarrassment. Nurses also functioned as an advocate by speaking on the patient's behalf, which served as a liaison between the patient and the healthcare team. This advocacy allowed them to integrate all aspects of patient care, ensuring that concerns were addressed and standards were upheld.

Our Indonesian nurse participants elucidated how patients are respected as valuable human beings in a traditional hierarchical context, which has been identified as an important Indonesian cultural value (Hays, 2015). A hierarchical structure allows healthcare providers more authority than patients, positioning them as experts who know what is best for patient care (Gottlieb, Feeley, & Dalton, 2006). This quality upholds the principle of beneficence, which is one of the fundamental ethics of professional caregiving (Kinsinger, 2009) that allows nurses to deliver dignified care to patients during hospitalization.

Limitations

Our findings may be limited by the use of a qualitative descriptive design, which allows for a less rigorous interpretation of data than grounded theory or hermeneutic phenomenology (Vaismoradi, Turunen, & Bondas, 2013). However, because dignity is a multifaceted and somewhat vague concept, qualitative content analysis is well suited for simplifying an understanding of nurses' perceptions of dignity of care.

Conclusions

Our findings augment the cross-cultural perspective regarding promotion of dignified care in clinical nursing. Three main categories described the framework supporting dignity in care—personalized care, compassionate care, and patient care advocacy—which were incorporated as key concepts of patient-centered care and have been reported in other studies in Western settings. The relationship between respect, compassion, and dignity is the foundation of ethical and professional care. Patient advocacy for the promotion of patient interests and quality of care is critical for nursing professionals.

The ability of nurses to provide dignity of care in Indonesia may be challenging due to the cultural orientation of a hierarchical structure and inadequate health literacy of the patient population. However, nurses regarded upholding the principle of beneficence as an important value for maintaining best-care practices and facilitating health literacy. Reducing language barriers, involving patient's family members, and improving language skills with the availability of bilingual nurses could facilitate communication and increase patients' satisfaction in cross-cultural care settings. The importance of eliminating mixed-gender accommodations and arranging of single-gender wards could ensure patient privacy. In response to the increasingly diverse populations, it is important for nurses to build cultural sensitivity and improve their ability to respond to a culturally diverse population. Further research is suggested to explore the practice of maintaining dignity through observation, which could be a basis for item development to measure patients' perceived dignity during hospitalized care.

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Clinical Resource

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Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web site:

Figure S1. Figure S1. COREQ (Consolidated criteria for Reporting Qualitative research) Checklist