


**ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE**

Patient perspectives of maintaining dignity in Indonesian clinical care settings: A qualitative descriptive study

Nurfika Asmaningrum^{1,2} | Yun-Fang Tsai^{3,4,5} ¹School of Nursing, The University of Jember, East Java, Indonesia²The Graduate Institute of Clinical Medicine Sciences, College of Medicine, Chang Gung University, Tao-Yuan, Taiwan³School of Nursing, College of Medicine, Chang Gung University, Tao-Yuan, Taiwan⁴Department of Nursing, Chang Gung University of Science and Technology, Tao-Yuan, Taiwan⁵Department of Psychiatry, Chang Gung Memorial Hospital at Keelung, Keelung, Taiwan**Correspondence**

Yun-Fang Tsai, School of Nursing, College of Medicine, Chang Gung University, Tao-Yuan, Taiwan.

Email: yftsai@mail.cgu.edu.tw

Funding information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors

Abstract**Aim:** To gain an understanding towards the perspectives of hospitalized inpatients in Indonesia regarding maintaining dignity during clinical care.**Background:** Dignity is a basic human right that is crucial for an individual's well-being. Respect for a person as a valuable human is a concept that is comparable to treating a person with dignity. Maintaining patient's dignity is an ethical goal of nursing care. Nevertheless, the concept is highly dependent on cultural context. This issue has not been well studied in Indonesia.**Design:** This study used a qualitative descriptive design.**Methods:** Thirty-five participants were recruited by purposive sampling from medical to surgical wards of six public hospitals in Eastern Java, Indonesia. Data were collected in 2016 through individual face-to-face semi-structured interviews. Inductive content analysis was applied to the data.**Findings:** Four major categories which described qualities of nursing care essential for maintaining a patient's dignity in clinical care settings were revealed: (1) responsiveness; (2) respectful nurse-patient relationships; (3) caring characteristics and (4) personalized service.**Conclusions:** Our findings provide a cultural viewpoint of dignity for care recipients in Indonesia. The findings provide empirical support for linking dignified care and person-centred care principles with regards to cultural sensitivity. Nurses must not only be clinically competent but also culturally competent. The ability to provide culturally competent care is important for nurses as a strategy to maintain patient dignity during hospitalized care.**KEYWORDS**

clinical care, content analysis, cross-culture, dignity in care, maintaining dignity, nursing, patient dignity, patient perspectives, qualitative descriptive, respect

1 | INTRODUCTION

Dignity is a basic human right crucial to an individual's well-being. However, the term 'dignity' is a multidimensional concept whose meaning is complex and ambiguous (Adib-hajbaghery & Aghajani, 2015). Consequently, the abstraction of dignity is difficult to apply

directly to the concrete setting of health care (Barclay, 2016). Thus, an interpretation of dignity is required that influences sociocultural environments and personal narratives (Franklin, Ternstedt, & Nordenfelt, 2006). As the diversity of countries escalates, assessing the phenomenon of dignity in a cross-cultural nursing setting brings increasing challenges to healthcare research.

Patients requiring hospitalization may be at greater risk for loss of dignity as a result of their illness (Borhani, Abbaszadeh, & Rabori, 2016). Accordingly, nurses must not only focus attention on the increased medical needs of patients, but also simultaneously maintain their dignity, equality and humanity (Jackson & Irwin, 2011). Promoting dignity is a major responsibility for healthcare providers (Baillie & Matiti, 2013). Perceiving patients as persons possessing dignity is important when establishing ethical and practical aspects of patient care (Tadd et al., 2011). The level of dignity patients perceive during their care can have an impact on positive patient health outcomes such as satisfaction, adherence to therapy and receipt of optimal preventive services (Beach et al., 2005).

Respecting patients' dignity and worth is a fundamental principle and obligation underlying nursing practices and all national and international nursing codes of ethics (Cheraghi & Manookian, 2014). Respecting a person's right to dignity is inherent in nursing (The International Council of Nurses [ICN], 2012). The Royal College of Nursing [RCN] (2008) reaffirmed the significance of dignity by promoting a code of ethics for healthcare organizations in western countries (American Nursing Association [ANA], 2010; Canadian Nurses Association [CNA], 2008; Nursing and Midwifery Board of Australia [NMBA], 2008; Nursing and Midwifery Council [NMC], 2008). Similarly, the Indonesian nurses' code of ethics requires nursing services to respect human dignity, regardless of nationality, ethnicity, skin colour, age, gender, political affiliation, religion and social status (Indonesian National Nurses Association [INNA], 2000).

1.1 | Background

The World Health Organization [WHO] (2015) defines dignity as inherent in an individual's feeling of worth or value, which is closely associated with respect, recognition, self-worth and the ability to make choices. Conceptually, dignity includes how people feel, think and behave in relation to the worth or value of themselves and others. The RCN describes treating someone with dignity as acting in a manner that is respectful of their value as individuals (RCN, 2008). Accordingly, respect can be used interchangeably with dignity, allowing both words to be used for exploring the concept of dignity. Respect is strongly associated with dignity (Allen & Dennis, 2009) and is one of the most frequently cited definitions of dignity embedded in national/local policies, guidelines and protocols (Cairns et al., 2013).

Dignity has been identified as a core ethical value that should be actualized in professional nursing practice as a standard of patient care (Andorno, 2013; Fagermoen, 1997). Maintaining patient dignity is an important ethical nursing value (Griffin-heslin, 2005; Nayeri, Karimi, & Sadeghee, 2011), which influences nurses' goals, strategies and actions (Jormsri, Kunaviktikul, Ketefian, & Chaowalit, 2005; Shahriari, Mohammadi, Abbaszadeh, & Bahrami, 2013). Accordingly, maintaining patient dignity is essential for effective relationships between healthcare professionals and patients and plays a prominent role in health care and nursing practices (Baillie & Gallagher, 2011).

Why is this research needed?

- Dignity is recognized as a fundamental human right, which is highly dependent on cultural context, which plays a prominent role in how dignity is perceived and maintained.
- The increasing diversity of countries brings challenges for healthcare providers to deliver cross-cultural sensitive care.
- Exploring viewpoints that define dignity in diverse multicultural settings is necessary for improving global understanding of this human right.

What are the key findings?

- Dignity of patients was maintained when healthcare staff treated patients as a relative and maintained cultural etiquette in line with local customs.
- Responding promptly to patient needs and encouraging respectful nurse-patient relationships through communication, reciprocity and understanding reflected person-centred care.
- Providing person-centred care that was culturally competent maintained patients' dignity.

How should the findings be used to influence policy/practice/research/education?

- Treating patients with "respect as a valuable human being" should be incorporated in hospital policy to promote patient dignity in a culturally diverse hospital setting.
- Designing a context-based instrument, which includes items culturally sensitive to dignity, could quantitatively measure patient's self-perceived dignity.
- Development of a model for maintaining dignity in care derived from a conceptual framework should be integrated into practice protocols and disseminated to nurses in clinical care settings.

Maintaining patient dignity in diverse multicultural and global communities depends on various circumstances (Matiti, 2005). The concerns and perspectives for patients vary by country not only due to cultural differences, but also as result of differences in the organization of health care (Adib-hajbaghery & Aghajani, 2015). Different patient perspectives of dignity can be obtained by assessing the meaning and interpretation with regards to cultural context. Globally, culture provides the context for health care and social services in diverse conditions, settings and situations (Schim & Doorenbos, 2010), which indicates the importance of investigating the concept of dignity not only with regards to cultural context, but also

individual countries. Because there is a lack of information regarding how patients in Indonesia perceive dignity during hospitalized care, the aim of this study was to explore the concept of dignity, from the point of view of hospitalized Indonesian patients.

2 | THE STUDY

2.1 | Aim

The aim of this study was to obtain an understanding of hospitalized patient perspectives towards maintaining dignity in clinical care settings.

2.2 | Design

A qualitative descriptive design was used. Dignity and respect for a person as a valued individual were used interchangeably to explore the concept of dignity. A qualitative descriptive design is an empirical method. In healthcare research, it is beneficial for describing the informant's perception and experience of the phenomena (Neergaard, Olesen, Andersen, & Sondergaard, 2009) and produces a straightforward explanation of participants' experiences using their own words (Sandelowski, 2000), which provides new insight and deep comprehension based on experiences.

2.3 | Participants

Patients were recruited by purposive sampling from medical to surgical wards. The study settings consisted of six public hospitals located in four different districts in Eastern Java, Indonesia. To represent heterogeneous clinical care settings, three different classes of hospital wards were represented: first, second and third class. In Eastern Java, classification is determined by the characteristics of the facilities in the room. Healthcare practitioners invited patients to participate in the study. To ensure no prior relationship had been established between the researchers and the patients, the researchers had no contact with the participants until after recruitment. Participants were included if they met the following inclusion criteria: (1) admitted for care as an inpatient and hospitalized for at least 3 days; a timeframe chosen to recruit a population of patients adapted to the hospital environment who could provide information regarding their experience of nursing care; (2) able to communicate in Javanese/Indonesian; (3) at least 20 years of age; (4) mentally competent; and (5) willing to participate voluntarily. Of the patients who met the inclusion criteria, only four did not agree to participate because they were preparing for hospital discharge. Patients were excluded if there were complications resulting from their disease or if they had any cognitive impairment.

2.4 | Data collection

Data were collected in 2016. Nurse researchers experienced in qualitative studies developed this study's interview guide. The guide was pilot tested with a sample of hospitalized patients; after evaluating

their responses, a few questions were revised. Questions were asked in the order shown in the interview guide (Table 1). The first three questions explored participants' experiences about their hospitalization and gave them an opportunity to become comfortable with the interview process. Questions 4, 5 and additional open-ended or specific questions in response to the participant's comments were used to explore the concept of dignity. The additional questions, which further probed the participant's experiences, clarified their meaning and allowed the researchers an opportunity to gain an in-depth understanding of the phenomenon, included 'Can you tell me more about that?', 'Is there anything else?', 'What do you mean about...?' and 'What kind of experience did you have...'. The first author conducted all interviews. The duration of the interviews ranged between 16 and 35 min. Individual face-to-face semi-structured interviews with open-ended questions were conducted in the participant's hospital room and were digitally audio-recorded. During the interview process, field notes were maintained to capture situations where participants used a non-verbal response to questions, which augmented information collected for the data analysis. Family members accompanied nearly two-thirds (68.6%) of participants during the interview because they considered themselves the patient's guardian. Although they remained in the room during the interview process, family members did not disrupt the interview process.

Data collection and verbatim transcription of the interviews occurred simultaneously; all participants were interviewed only once. Participant recruitment continued until the data were saturated. Although saturation was reached on the 25th participant, the interviews continued to increase the richness of the data (Elo & Kyngäs, 2007). Patients did not receive a copy of the transcribed interviews. Therefore, to allow for clarification of the content of their responses, the interviewer restated the patient's main ideas prior to terminating the interview. The participants confirmed the interviewer's statement; if there was any discrepancy, the participant provided additional comments, or clarified their statements.

2.5 | Ethical considerations

Prior to conducting interviews, the first author approached patients who met the inclusion criteria by visiting them in their hospital room and explained the objective and nature of the study. Participants were assured of confidentiality and anonymity. If the patient agreed

TABLE 1 Open-ended interview guide

Question
1 What were the reasons you were admitted to hospital?
2 What was the daily routine care you received from the nurses during your hospitalization?
3 What were your feelings and experiences throughout your hospitalization?
4 What behaviours did nurses exhibit, which reflected high respect for you as a valuable human being? Please give an example.
5 What should nurses do to maintain respect for you as a valuable human being?

to participate in the study, they signed a written informed consent form. The Research Ethical Committee of the first author's institution approved the study (No. 943/H25.1.11/KE/2016).

2.6 | Data analysis

Qualitative content analysis was applied to the data. To generate the important meanings regarding the experience of dignity elicited from participants' perspectives, inductive content analysis was employed. In this regard, the analysis was conducted in three steps: open coding, creating categories and abstraction (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005). Initially, transcripts and notes were read several times in their entirety to make sense and get close to the data. Raw data were then organized using open coding of the transcripts, grouping similar codes into subcategories. Subsequently, categories were created by merging subcategories and then determining a general description through abstraction. A framework of the conceptual map was drawn based on the final result.

2.7 | Rigour

The rigor and trustworthiness of this qualitative study was enhanced by fostering authenticity, credibility, criticality and integrity (Whittemore, Chase, & Mandle, 2001). The research design incorporated purposive sampling, data saturation and a flexible sequence for the question guide. Both researchers reviewed the codes and agreed on the analysis, which ensured dependability of the data. Participants were assured they could speak freely and share their opinions and perceptions, which were accurately transcribed to promote authenticity. Because one of the authors was not an Indonesian speaker, an accurate English transcription of the interviews was obtained prior to data analysis to enhance the accuracy of participants' perceptions of dignity. The Indonesian transcripts were translated to English and then back-translated by an Indonesian bilingual nurse, who was blinded to the original version. This process ensured the semantic equivalence of the original Indonesian and the English translation. Finally, understanding the whole context by re-reading the transcripts several times ensured authenticity and credibility.

3 | FINDINGS

3.1 | Participant's characteristics

Thirty-five patients agreed to participate in the study. Characteristics of the participants are shown in Table 2. Males and females were nearly equally represented (51.4%-48.5%, respectively); most participants were between 41-60 years of age (45.8%). The percentage of participants residing in urban areas was 54.3%; the remainder lived outside the city in rural communities. Housewife- and agriculture-dominated employment status (31.4% and 28.6%, respectively). The number of participants hospitalized in medical or surgical units was similar. The mean number of days of hospitalization was 4.43 (SD 2.24). Most participants (97.1%) identified their religious affiliation as Muslim, which is representative of the demographics of Eastern

TABLE 2 Demographics of the participants (N = 35)

Variable	M (SD)	N	%
Gender			
Male		18	51.4
Female		17	48.6
Age (years)			
	46.6 (15.1)		
20-30		6	17.1
31-40		7	20
41-50		8	22.9
51-60		8	22.9
>61		6	17.1
Education			
Illiterate		4	11.4
Literate		31	77.1
Living area			
Rural ^a		16	45.7
Urban ^b		19	54.3
Ethnicity			
Javanese		17	48.6
Javanese Osing		3	8.6
Madurese		15	42.9
Language			
Indonesian		25	71.4
Javanese		5	14.3
Madurese		5	14.3
Religion			
Muslim		34	97.1
Catholic		1	2.9
Employment status			
Housewife		11	31.4
Agriculture		10	28.6
Pensionary		6	17.1
Entrepreneur		8	22.9
Hospital care unit			
Medical		17	48.6
Surgical		18	51.4
Duration of hospitalization (days)			
	4.43 (2.24)		
<3		16	45.7
3-10		17	48.6
>10		2	5.7
Admissions for hospitalization			
First admission		11	31.4
Re-admission		24	68.6
Method of payment			
Insurance		20	57.1
Self		15	42.9

M, mean; SD, standard deviation.

^aUrban was defined as living within a city with government services, social services and economic activities.

^bRural was defined as living in a village community.

Java; 57.1% of participants were Javanese and 42.9% were Madurese; 71.4% used Indonesian language. This was the first hospital admission for 28.6% of participants.

3.2 | Perspectives on dignity

The Indonesian participants provided multiple perspectives regarding elements they believed necessary for maintaining dignity during hospitalization. Data analysis generated 1910 codes, which were in line with how all participants perceived dignity. The codes were clustered into 159 subcategories and four major categories. The four categories described patients' experiences of dignified care: (1) responsiveness; (2) respectful nurse–patient relationships; (3) caring characteristics; and (4) personalized service. The distribution of importance among participants for the categories was as follows: all four categories (37%); three categories (40%), two categories (20%) and one category (3%). Each major category was supported by related subcategories, which were described by at least 10 percent of the participants. The categories and subcategories are further illustrated in the framework in Figure 1.

3.2.1 | Responsiveness

Responsiveness emerged as a category for most of the participants (74.3%, $n = 26$). They described the importance of the speed and manner in which nurses reacted to requests for medical needs as well as feeling the nursing staff was attuned to their needs.

Prompt response

Participants reported the length of time between asking for and receiving help during hospitalization was important because their needs were being met quickly:

When I reported that my (intravenous) drip had ended, the nurse immediately came to replace it with a new one, which is good, right? I was really pleased. Another time when I reported the same thing and it was immediately fixed, I was even more pleased. (P8)

One time I had a complaint and the nurse came immediately. That's all that patients need. Patients want problems to be handled fast and directly. (P30)

Therefore, promptness of care as well as the manner in which the nurse provided the care was highly appreciated.

Proper response

Many participants felt respected when they believed the nurse gave them a proper and appropriate response to care needs or handled complaints during a "critical time" or an emergency situation:

When I used the urinary catheter, it caused me severe pain and I had great discomfort. I couldn't sit down; I couldn't stand up. I was having pain when I peed; my pain was severe. During that time, I felt I wanted to be

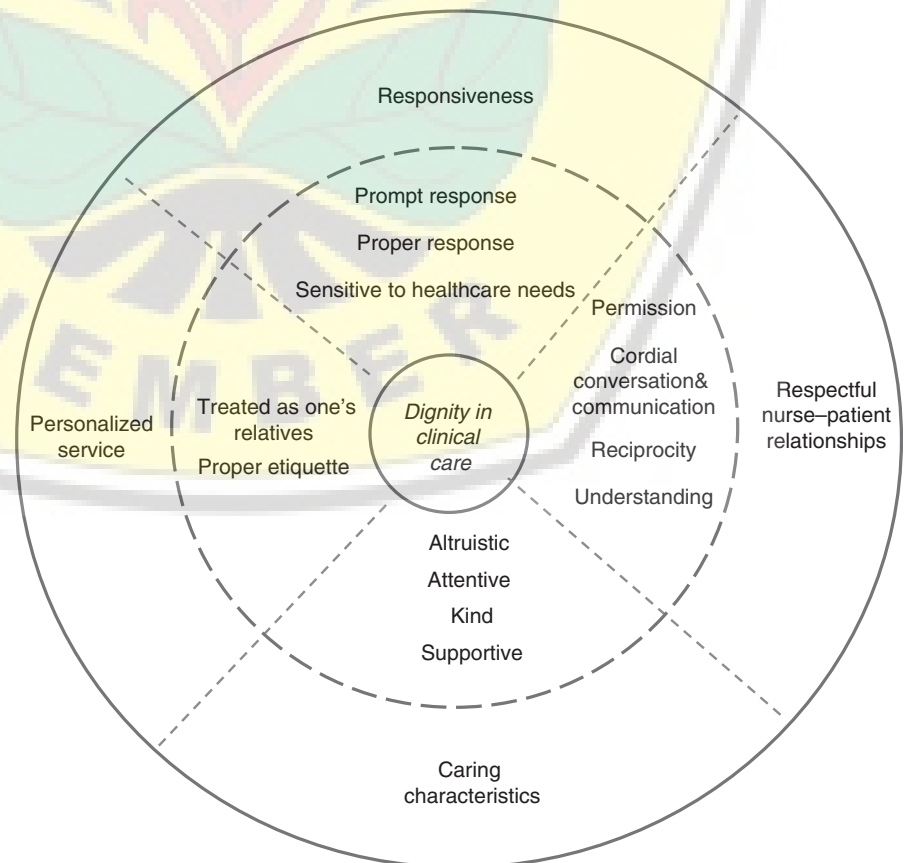


FIGURE 1 Framework showing qualities of nursing care, which preserved patients' dignity in a clinical care setting

dead. My son was so panicky and he gave me warm water to try reduced the discomfort. Then, the nurse came and pulled on the catheter and, surprisingly, it totally relieved my pain. I am so thankful to the nurse. Then, he said that the catheter position wasn't appropriate. I thought the nurse actually understood the appropriate treatment. (P34)

My infusion was blocked. Then, the nurse came; then she brings something. I think it was to rinse this (she pointed to her infusion). I think, rather than using water, it is better use that; it is more sterile (P23)

Thus, participants felt the nurse who cared for them was competent, which enhanced trust in the relationship between nurse and patient by providing proper care.

Sensitive to healthcare needs

Patients felt it was important that nurses were committed to providing care and assisting them with activities:

One nurse told a patient, 'Ma'am, if no one accompanied you, I will be here later. I will feed you, if you need something, but no one accompanied you, please tell us. I will help you.' (P6)

In the situation when I was alone, the nurse asked, 'Who accompanied you?' Then I said, my husband only, but he was going back home, in Ajung, which is close by here. The nurse said, 'Miss, if you need something, please tell me, if you need ice pack or something, just tell me. (P23)

When nurses offered assistance without participants requesting help it reflected sensitivity to their needs.

3.2.2 | Respectful nurse-patient relationships

A respectful nurse-patient relationship, reported by 68.6% of the participants, was the second most significant category. Building relationships through respectful interactions and communications supported patients' feelings of comfort, being in control and being valued. When nurses asked a participant's permission to obtain consent for procedures by communicating openly and easily, patients perceived the nurses understood them and considered them important. Participants wanted to be respected, but also believed mutual respect was important.

Permission

It was important to participants that nurses ask permission and obtain consent before performing a procedure, which included daily routine procedures such as injections, measuring vital signs, replacing an intravenous line and wound care. For instance, two participants described the following interactions as making them feel respected:

They said (the nurse) 'excuse me miss, I want to check your blood pressure...then I want to measure your

temperature, check out your parenteral infusion.' (When they say) things like that, it's nice. (P18)

The nurse wants to check and says 'excuse me ma'am' like that. Then if the nurse is finished, the nurse asks permission again. (P31)

Cordial conversation and communication

Participants reported they expected nurses to be able to speak with them in a pleasing tone and kind manner regarding their care needs.

Yeah, they talked nicely, help me feel comfortable and talked about good things. (P2)

...Their voice was smooth whenever they were talking; they did not use a high-pitched voice. (P22)

A cordial conversation included speaking smoothly, with a pleasant speaking voice that made them feel comfortable.

Communication from nurses that was kindhearted was perceived as respectful by participants:

But here (hospital), that young man (male nurse) is easy to talk with, the point is easy to talk to patients (P24)

I'm impressed with one nurse who helped me to pull out my catheter when I suffered pain. It was apparent he was kind and easy to communicate with. (P35)

When nurses displayed kindness during communication patients were more overt with their complaints and more willing to interact with nurses.

Reciprocity

Many participants thought reciprocal interactions between nurse and patient were important. Interactions with patients perceived as showing respect, were responded to in kind by participants:

Actually, here every one of us respects each other's feelings; they are like this, miss. It must be a balance; I want to recover and the nurse wants to be appreciated also. (P33)

They respect me. I respect them too, sometimes. However, only if both (nurse and patient) can behave appropriately. That's all, ma'am, if both can behave appropriately. Yes, so there is respect for each other. (P15)

However, rude behaviour from nurses was likely to result in patients responding rudely.

Understanding

The ability for patients and nurses to understand each other and tolerate differences enabled mutual respect:

Both of them have to know their position. The nurse has to understand about the patient's situation and the patient also. It's like this patient, miss, will be a burden because of the disease, right? (P4)

Yes, so there is tolerance of each other, between me and the nurse. I know she serves many patients and they (nurses) know my needs to recover quickly as a patient here. (P26)

Their attempt to understand each other's inherently different positions fostered respect.

3.2.3 | Caring characteristics

The third category, caring characteristics, was reported by 62.9% of participants. The personal characteristics of the nursing staff influenced participant's' feelings about nursing care.

Altruistic

The nurse's ability to recognize the patient as an important person resulted in the patient's perception that their needs and feelings were of a higher priority than other nursing tasks. When patients viewed their nursing care as a priority, their perception was the nurse's behaviour of attending to their needs was altruistic:

When I needed help and the nurses were busy with other tasks, they prioritized my needs rather than their own. (P5)

The nurse left their other business when it (infusion line) ran out. They changed it immediately. (P23)

These characteristics provided patients with feelings of importance and being valued.

Attentive

When nurses actively asked the patient about the progress of their condition, regularly monitored them and helped control their treatment, it indicated to participants that they were the focus of the nurse's attention:

When a nurse says, 'How is your condition, ma'am? Already good? Already recover?' that is nice talk for me. (P5)

I am always checked (by the nurse) in very short intervals. They come often...check every hour. They ask, 'Have you already taken your medicine?... have you eaten?'. I'm given a lot of meals... Checking and monitoring me frequently all the time... (P19).

Thus, nurses' attentiveness predisposed the patient to feel secure and in control.

Kind

The characteristic of nurses that participants most frequently reported as an indication of caring was kind behaviour towards them as a patient:

Everyone here is good when they give treatment; all of the nurses in here are very kind (P13)

I see they are kind. If I see their age is the same as my age, or the same age as my children, but they are still polite, that's totally good. (P11)

Supportive

When nurses listened to patient concerns and encouraged them to get better, it was perceived as emotional support and participants felt respected:

They listen to a patient's complaints. That is more respectful, miss, patient's complaints, including... small or big ones, they listened. (P35)

(The nurses) talking to me, gives me encouragement, so I'll be better soon. If I have some urgent needs as a patient, that I want...as soon as possible...a nurse directly attends to my complaint (P10)

3.2.4 | Personalized service

The category of personalized service was reported as important by 54.3% of participants, which involved the manner in which the nurses acted towards patients. Being treated as a family member and being addressed using etiquette considered "proper" resulted in feeling respected.

Treated as one's relative

The perception of being treated as a relative resulted in patients feeling valued and important:

Yeah, they (nurses) care for me like I am their parent. Really. Daughters usually treat parents with care. I don't know how to say this, but the main point is they (nurses) provide better treatment; it's like they are parents or family. They treat us like their own relatives. Yes, more trustful and truly caring; as if they are relatives. (P1)

Consequently, patients felt they received the best care, which provided comfort as well as pleasure.

Proper etiquette

Participants also reported feeling impressed when nurses exhibited appropriate or "proper" etiquette. This included greetings, smiling, apologizing and saying 'thank you', which represent local customs

that are recognized as correct Indonesian manners for interacting with people:

They said, 'Sir, excuse me, 'Assalamualaikum' (a greeting for Muslim people in Bahasa) as a greeting to me whenever we meet or they wanted to do something. When the nurse came in (my room) and said the greeting, it was like that, then the nurse smiled at me. (P32)

When she wants to check on me, she will say, 'oh excuse me'. Later if they have completely finished a task, they say, 'thank you'. . . I also confirmed they were finished by saying 'thank you. . . yes. . . (P18)

4 | DISCUSSION

Our qualitative descriptive study was conducted to elucidate an understanding of the perspectives of Indonesian hospitalized patients on maintaining dignity in clinical care settings. Our findings revealed patients perceived dignity was maintained when healthcare providers were responsive to patient needs, created respectful nurse-patient relationships, exhibited caring characteristics and delivered personalized service. These findings support and expand the current understanding towards the nature of dignity in cross-cultural nursing care. Our Indonesian sample reflects the ways dignity was preserved during hospitalized care in a demographically diverse population of gender, ethnicity, language, living area, educational level and employment status. Although demographics differed, participants embodied similar values, thoughts and ideas viewed as crucial to their hospital care. Knowledge of an individual's background, language and beliefs, is required to build cultural sensitivity (Fornada, 2008), which is necessary to tailor interventions to a patient's culture (Guidry, 2000).

The effect of cultural background has an impact on different value systems depending on cultural orientation (Darwish & Huber, 2003; Zha et al., 2006). Cultural values play a central role in determining whether one's culture is individualistic or collectivistic (Lombardo, 2014). Individualistic cultures tend to be independent, depending on their own internal thoughts, feelings and actions for direction, rather than those of others. In contrast, collectivistic cultures, such as Indonesian culture, tend to have an interdependent perspective, which depends more on interpersonal relationships (Zha et al., 2006). As a result, this interdependence and social cohesion (Chadda & Deb, 2013) may influence patient's interpretation of nurses' behaviour, with an emphasis on the importance of social interactions during clinical care.

Recognizing a patient's diversity requires nurses to acknowledge a patient's uniqueness and individuality. Nurses who recognized and responded to individual needs was an important quality underpinning personalized care for our participants. The Department of Health (as cited in Matiti, 2007) stated that offering personalized service, which regards a person as an individual, is a challenge for nurses because

the term dignity is unclear. Nurses who were skilled at listening, communicated in a manner interpreted as polite and considerate and provided information and explanations were seen as regarding patients as individuals. Treating patients as individuals retains patient dignity during a stressful period; it is important for building good patient experiences (National Clinical Guideline Center [NGCC], 2012) and frames the meaning of dignified care (Kinnear, Williams, & Victor, 2014).

Personalized service for the hospitalized patients in Indonesia incorporated being treated in a manner like one's own relative; participants appreciated being cared for as if they were a family member. Being cared for as a close relative resulted in the perception of being regarded as a valued and important person. The use of 'family' is generally considered an intimate term (Firth & Firth, 2003) that is functionally a focal point for forming deep relationships, which are the basis for future personal interactions (Kaakinen, Coehlo, Steele, Tabacco, & Hanson, 2015). Family integrity is important for collectivist cultures (Triandis, 1988) and is readily observable in Indonesian society (Mangundjaya, 2005). The right of family members to voice decisions regarding health care in the Indonesian implicitly acknowledges the importance of family involvement in person-centred care (Boise & White, 2004).

Key findings from our study regarding responsiveness and caring traits resonate with previous studies. Responsiveness has been demonstrated to be a fundamental element for maintaining dignity in health care (Beach et al., 2015; Darby, Valentine, Murray, & De Silva, 2000; Lin, Tsai, & Chen, 2011; Nayeri et al., 2011) and is believed to promote patient-centred care (NCGC, 2012). Previous studies have reported nurses' caring characteristics provide dignity (Beach et al., 2015; Lin et al., 2011). Participants' perception that their care resulted from the nurse's altruism was an important caring characteristic in our study. Altruism has been described as a framework for caring (Gormley, 1996; Watson, 2007) and is perceived as an essential component of nursing in many countries (Shahriari et al., 2013). Altruism can help to establish a trusting relationship between patient and care provider (Schout, de Jong, & Zeelen, 2010). Being attentive, kind and supportive of patient's complaints, are qualities that increase a patient's experience of dignity in care (Dawood & Gallini, 2010; Lin et al., 2011; Matiti & Trorey, 2008). Emotional support can increase the quality of patient-centred care (Gesell & Wolosin, 2004), which can improve patient satisfaction (Adamson et al., 2012).

Nurse-patient interactions have an impact on dignity (Baillie & Gallagher, 2011) when patient's feelings are respected by the nurse (Griffin-heslin, 2005). Our findings revealed nurses' respectful communications and interactions with patients, as well as proper etiquette, could also influence patients' perceptions of dignity. Carrese et al. (2015) explored patients' experiences of dignity in intensive care units in the United States and found polite expressions, greetings and responses between medical staff and patients were viewed as demonstrating respect and dignity and enhanced patients' care experience. Similar results were reported by patients in a general hospital in Italy; nurse-patient interactions were important for preserving patient dignity (Ferri, Muzzalupo, & Lorenzo, 2015). Our

participants reacted to nurses who were respectful, understanding and tolerant by responding similarly towards the nurses, which resulted in reciprocity, which has been shown to be an important component of a patient's dignity (Papastavrou & Andreou, 2014). Our study found reciprocity was linked to mutual respectful interactions, which has been previously identified as one component of cultural sensitivity (Ethnic Harvest, 2015). Improving communication and building relationships encourages respect for people as valued individuals (Baillie & Gallagher, 2011); nurses' style of communication can also maintain patients' dignity (Henderson, Ma, Pearson, James, & Henderson, 2009).

This study illustrates a link between dignity, cultural competence and person-centred care. Person-centred care is a universal principle considered a necessity for protecting a person's dignity (The Australian College of Nursing, 2014), which requires each person be treated as an individual. Person-centred care can support dignity in care by acknowledging and valuing each person's diversity (Baillie & Matiti, 2013). Consistent with providing person-centred care, participants in our study wanted to be valued and acknowledged as diverse individuals. To meet the needs of culturally diverse groups, health care providers must become culturally competent (Campinha-Bacote, 2003), which benefits cross-cultural interactions (Epner & Baile, 2012). Cultural competence requires acknowledgement of patient differences and similarities and treating patients with dignity, respect and fairness, which will contribute to building a truly inclusive culture (Galloway, 2011).

4.1 | Limitations

The use of a qualitative descriptive design may result in a less rigorous interpretation of the data than grounded theory or hermeneutic phenomenology (Vaismoradi, Turunen, & Bondas, 2013). However, qualitative descriptive studies in health care can bring insight about phenomena from personal experiences or perspectives (Neergaard et al., 2009).

5 | CONCLUSION

We explored Indonesian patients' viewpoints of maintaining "dignity" during hospital care guided by the phrase "respect as a valuable human being". Our findings contribute to understanding dignity in a cross-cultural setting that represents Asian countries as part of Eastern culture. Patients' perceptions of dignity were associated with both clinically and culturally competent care, suggesting nurses must not only understand their patients from the standpoint of symptoms, diagnosis and treatment, but also their culture. Providing culturally competent care is important for maintaining patient dignity (Galloway, 2011). Incorporating person-centred care should be a consideration when developing strategies for promoting dignity for hospitalized patients. Therefore, it is important for nurses to recognize and acknowledge a patient's cultural diversity to work effectively with people from other cultures.

Managing patients' cultural diversity challenges the healthcare provider to treat patients as an individual and understand their uniqueness. Our findings could educate nursing staff by providing concrete examples of maintaining dignity, which are adjusted to address patients' local customs. Recognizing the individual, the group and society's cultural orientation could enable nurses to develop appropriate cross-cultural communication and include supporting factors that influence patients' care decisions and preferences.

Embedding dignity of care into health systems remains a challenge for nurses. Healthcare organizations could increase dignity of care by incorporating the value of dignity into education and practice protocols. Our findings are important in terms of increasing our understanding of the phenomenon of dignity, which could facilitate cross-cultural patient care from a nursing care perspective and could be the basis for developing a context-based instrument to measure the level of self-perceived patient dignity, which could be useful for future quantitative studies regarding dignity.

ACKNOWLEDGEMENTS

Our sincere appreciation goes to the Ministry of Research Technology and Higher Education of The Republic of Indonesia. We also acknowledge the contribution of the hospital institutions, and all participants who shared their valuable opinions.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

ORCID

Yun-Fang Tsai  <http://orcid.org/0000-0002-2148-314X>

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How to cite this article: Asmaningrum N, Tsai Y-F. Patient perspectives of maintaining dignity in Indonesian clinical care settings: A qualitative descriptive study. *J Adv Nurs*. 2017;00:1–12. <https://doi.org/10.1111/jan.13469>

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