Original article

Dignity and respect for nurses with different levels of experience from physicians, colleagues, patients and their family members

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Abstract

Background and Purpose: Experience and clinical competence are the important factors affecting the level of dignity and respect for nurses. This study aimed to evaluate the observance rate of respect for nurses from physicians, colleagues, patients and their family members.

Methods: This study was conducted on 200 nurses selected by census sampling from hospitals of Sanandaj, Kurdistan, Iran in 2014. Data collection was performed using self-report questionnaires with 15 questions on different variables, such as respect, communication, capability and independence. Validity and reliability of the questionnaires was determined by subjects and expert comments, and using Spearman's correlation coefficient (r=0.80). Data analysis was performed using SPSS V.20.

Results: Significant differences were observed between the viewpoints of experienced and inexperienced nurses regarding independence, self-confidence for consultation with physicians (P<0.04), communication with physicians (P<0.03), capability and sufficient skills (P<0.04), respect by physicians (P<0.04), and physicians' and colleagues' trust (P<0.001, P<0.003) in their capabilities. However, no statistically significant difference was observed in the comparison of the observance rate for dignity from patients and their family members in the viewpoint of the subjects.

Conclusion: The highest levels of violation to the dignity of nurses came from physicians, while the lowest level was from patients and their family members. This study could be used for the promotion of dignity and respect among the nursing community.

Keywords: Clinical, Experience Dignity, Nurses

Introduction

Dignity is the state or quality of being worthy of honor and respect, which has two general aspects of human dignity and social dignity. Human dignity is defined as the inherent and integral value granted to an individual. Human dignity is in close correlation with social dignity, and proper recognition of an individual plays a pivotal role in determining this parameter (1). Dignity is described within areas such as respect, independence, capability and communication (2).

In a study on the evaluation of clinical experience, Skar defined professional independence as the awareness of the individual regarding his/her strengths and weaknesses. Professional independence means having confidence, knowledge, power of judgment and decision-making, and the freedom to act with an appropriate understanding based on the concept of autonomy (3).

In the nursing community, respect is defined as the honoring of nurses in terms of rights, privacy and human dignity by physicians, patients and their

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family members, and other nurses (4). Capability is defined as the proper acquisition of occupational skills, knowledge and experience in a profession (5). Among nurses, dignity could be achieved through professional interactions with patients (6), their family members (7), other nurses, medical educators, nursing students and physicians (8).

According to several studies, respecting the dignity of patients is a fundamental concept in the field of nursing (1, 9). Of course, this is a mutual affair; in other words, nurses need to receive equal respect by the patients and other individuals in their professional setting. Evidence suggests that nurses are targeted by verbal, physical and even sexual threats more often than other professionals, which will eventually lead to reduced levels of dignity (10). In a study performed by Aghjanloo et al., it was indicated that 18.3% of nursing students experienced physical assaults, 9.8% encountered occupational hazards, and 23. 2% had undergone verbal abuse (11).

With proper management in clinical practice, occupational stress could be alleviated, and a safe working environment could be provided for nurses, which will help inexperienced staff to improve their skills. Additionally, empowering the nursing staff with high levels of experience and knowledge could promote their dignity remarkably (12-14).

According to the published literature, some of the reasons for the negligence of dignity for nurses include inadequate experience, lack of confidence in communication due to the domination of technology at workplace, and the pressure caused by executive orders on nurses, which may suppress their reason and rationality (15, 16). Therefore, supporting and valuing of the services offered by the nursing staff could contribute to the development and enhancement of knowledge and skills, which will result in the promotion of respect and dignity for these health professionals.

In order to attain sufficient knowledge, experience and support, nurses should perform their duties without haste. Furthermore, they need to be capable of rational thinking and scrutiny, effectual decision-making, providing necessary interventions in long-term treatment procedures and avoiding medical complications as much as possible (17).

To date, several studies have been performed to evaluate the dignity of patients and nursing staff separately; however, no studies have compared the compliance of dignity between nurses and other individuals. In the review of literature, no studies were found on the assessment of nursing staff dignity based on the clinical experience.

Given the importance of dignity and respect for nursing staff in the promotion of health care services, this study aimed to evaluate the observance rate of respect for nurses from physicians, colleagues, patients and their family members.

Materials and Methods

This comparative, cross-sectional study was conducted on 200 nurses (male and female) with different clinical experience and education status. Samples were selected via non-random, census sampling from different hospitals of Sanandaj, located in Kurdistan, Iran in 2014. Samples were divided into two groups of nurses with high and low levels of experience. In addition, the subjects were matched in terms of clinical experience, gender and education status.

Based on the literature review, high levels of clinical care experience are established with at least 3 years of clinical experience in health care staff (18). Therefore, nurses with the clinical experience of <3 years were considered as less experienced, while those with the clinical experience of >3 years were considered as highly experienced nurses in this study.

Data collection was performed using self-report questionnaires, which were designed by the researchers and consisted of 15 questions. The questions focused on different areas, including communication, capability and independence. Each item was rated on a 0-4 Likert scale (always, often, sometimes, rarely and never).

In general, the questionnaires were composed of two main sections; the first section concerned the demographic characteristics of the subjects (e.g., age, gender, education status), and the second section focused on variables associated with the respect and dignity of the nursing staff (14 items).

In this section, the main areas of evaluation were respect (3 items), communication (3 items), independence (3 items) and capability (5 items). The main theme of the questions was based on the data extracted from various books and articles, and the items were prepared and arranged in accordance with the objectives of the study.

Validity and reliability of the questionnaires were determined based on the comments of subjects and other medical experts, and the Spearman's correlation coefficient (r=0.80), respectively. Data analysis was performed using descriptive and inferential statistics, such as Chi-square test, T-test and Kendall's coefficients, in SPSS V.20.

Results

In this study, 53% of the subjects (N=106) were female and 47% (N=94) were male. In addition, 93% of the participants (N=186) had bachelor degrees in nursing, 50% (N=100) had clinical experience of <3 years and 50% (N=100) had clinical experience of >3 years. Mean age of the participants was estimated at 33 years, and no significant difference was observed between nurses with high and low levels of experience in terms of gender and education status; however, the difference in the age of the subjects was considered to be statistically significant (P<0.0001) (Table 1).

Comparison of the viewpoints of both study groups regarding respect and dignity indicated physicians to be responsible for the highest level of violation to the nursing staff, while patients and their family members caused the least significant violations. Moreover, the highest rate of dignity violation was reported in nurses with inadequate clinical care experience (Table 2).

With respect to the area of professional independence, nurses with insufficient clinical experience had lower confidence to consult with physicians in comparison with experienced nursing staff (P<0.04). On the other hand, no significant difference was observed between the study groups regarding independent nursing interventions in the health care team, as well as the acknowledgement of independence by patients and their family members (Table 2).

In the area of communication and interaction, nurses with higher levels of experience tended to have more effective collaborations with physicians compared to those with inadequate clinical care experience (P<0.03). As for interactions with patients, their family members and colleagues, no statistically significant difference was observed between the two study groups (Table 2).

With respect to the area of capability, nurses with lower levels of experience had less confidence in their skills and ability for patient care (P<0.04). Correspondingly, physicians (P<0.001) and colleagues (P<0.003) were observed to have poor confidence in the skills and capabilities of the nurses with insufficient experience (P<0.04). However, there was no significant difference in this regard among the patients and their family members. Regarding the ability of nurses to defend their occupational rights, there was no statistically significant difference between the two study groups (Table 2).

In the area of respect, nurses with lower levels of experience captured less respect from physicians compared to experienced nurses (P<0.04), while the respect given by patients, their family members and colleagues had no statistically significant difference

Table 1. Demographic Characteristics of Nurses in terms of Clinical Background

Demographic Characteristics Groups	Gender						Age BS		Education Status							
	Male		Female		Total				MS		PhD		Total			
	F	%	F	%	F	%	Mean	SD	F	%	F	%	F	%	F	%
Nurses with Low Experience Level	44	44	56	56	100	50	28.6	4.39	97	97	1	1	2	2	100	50
Experienced Nurses	50	50	50	50	100	50	38.2	6.01	89	89	7	7	4	4	100	50
Total					200	100									200	100
Test P-Value	Chi-square Test Df=2 P= 0.06						T-test Df=198 P= 0،001		Chi-square Test Df=1 P=0.2							

Table 2. Comparison of Nurses with Different Experience Level in terms of Respect and Dignity from Physicians, Colleagues, Patients and their Family members

	Likert Scale	**Perspective of Experienced Nurses**						**Perspective of Nurses with Low Experience Level**						**Kendall's Coefficients**
Area	Responses by Nurses	Always	Often	Sometimes	Rarely	Never	Total	Always	Often	Sometimes	Rarely	Never	Total	P- Value
Professional Independence	Self-confidence and Independence in Cooperation and Consultation with Physicians*	27	44	21	5	3	100	18	41	29	7	5	100	0.04
	Autonomy in Nursing Interventions in Medical Team	29	38	23	8	2	100	18	43	23	12	4	100	0.08
	Acceptance of Autonomy by Patients and their Family	10	54	21	13	2	100	15	41	25	15	3	100	0.55
Communication and Interaction	Communication and Interaction between Physicians and Nurses*	39	45	12	3	1	100	26	47	22	2	3	100	0.03
	Communication and Interaction between Patients and Nurses	70	20	10	0	0	100	64	27	6	3	0	100	0.42
	Communication and Interaction between Colleagues	58	35	6	1	0	100	46	42	9	3	0	100	0.06
Capability	Self-confidence in Skills	48	48	4	0	0	100	38	49	11	1	1	100	0.04
	Physicians Ensured in Nursing Skills*	31	55	9	2	3	100	18	44	27	6	5	100	0.001
	Colleagues Ensured in Nursing Skills*	44	47	7	2	0	100	25	59	11	4	1	100	0.003
	Patients and Family Members Ensured in Nursing Skills*	32	52	9	2	5	100	18	44	27	6	5	100	0.40
	Ability to Defend Rights in Nurses	24	29	26	14	7	100	18	32	30	13	7	100	0.57
Respect	Respect from Physicians for Nurses*	19	46	27	8	0	100	12	44	26	11	7	100	0.003
	Respect from Colleagues for Nurses	32	49	16	2	1	100	27	56	10	5	2	100	0.63
	Respect from Patients and Family Members for Nurses	15	46	25	12	2	100	18	47	22	6	7	100	0.57

Statistically Significant Difference *

between the two study groups (Table 2).

Discussion

According to the results of this study, nurses with high and low levels of experience both attained the respect of patients and their family members. For the most part, patients and their family members were observed to recognize nurses as independent parts of medical teams. In general, these groups of individuals were found to have a desirable relationship with nurses. Similarly, the findings of Elliott reported the nurse-patient relationship as the most satisfactory form of medical interactions (7).

In another study, Wolf reported that due to the predominant stress and critical conditions of patients in emergency units, the nursing staff engaged in these sections had limited opportunity

to communicate with patients or physicians; consequently, the efficacy of their decision-making, as well as their level of dignity, was negatively affected (19).

In the present study, the most significant problems regarding the respect and dignity from the perspective of the nursing staff were related to the behavior of physicians, mostly in case of nurses with insufficient clinical experience. In their research, Pretz and Folse found that nurses with lower levels of clinical experience were occasionally inefficient in critical decision-making for patient care (20).

According to the findings of the current study, nurses with lower experience level had poor confidence to consult with physicians, and attained lower respect from physicians compared to experienced nurses. In one study, Yang and Thompson indicated that nurses with insufficient experience, as well as the nursing students, had poor self-confidence and accuracy in the provision of clinical care (21). Furthermore, inexperienced educators were observed to play a pivotal role in this regard since they lacked adequate knowledge and critical thinking dispositions to implement the appropriate clinical education (22).

In the viewpoint of the participants in the current study, the aforementioned factors were among the most significant barriers against consultation with physicians, which affected the dignity and respect of the nursing staff negatively. However, nurses with higher levels of experience tended to foster more professional cooperation and interaction with physicians.

In the present study, nurses with low clinical experience believed that they had insufficient skills, which was the main cause of distrust among physicians and other health care staff. In a study conducted by Traynor et al., it was reported that some of the nursing staff relied on the routine and personal experiences, rather than the medical evidence, in patient care; this was observed to hinder frequent interactions with physicians. On the other hand, nurses who exploited their skills in accordance with experience, reasoning and evidence were able to make appropriate clinical decisions without difficulty, while interacting with physicians and other medical professionals efficiently (23).

In another study, Cranley et al. indicated that nurses with inadequate clinical experience were not able to practice all their medical skills together; this would cause physicians to be suspicious of their clinical diagnoses, which ultimately reduced their respect and dignity in the perspective of these medical professionals (24). The findings of the aforementioned studies are in line with the results of the current study, indicating that insufficient work experience led to the lower level of respect by physicians and other specialists for nurses.

In the present study, incompetence was reported to be one of the main causes of physicians' mistrust in nurses with low clinical experience. It could be concluded that in order to attain the desirable respect and dignity, it is necessary that inexperienced nurses be supported by the medical and nursing staff, which will help these professionals to acquire more practical skills.

In one study based on Kolb's experiential learning theory, Boyd found that supporting learners will eventually push them from the beginner's level to achieving expertise (25). Therefore, nursing schools are required to provide a context in which nursing students could be nourished and supported in different clinical fields and promote their dignity and respect in professional settings (26).

In another study, Benner suggested that the level of experience played a pivotal role in the general independence and confidence of nurses (18). Furthermore, Petrucci et al. revealed that the autonomy of the nursing staff in decision-making was significantly correlated with their level of expertise (27).

According to the findings of the present study, independence of the nursing staff could be negatively affected by lack of support from physicians and other medical experts (12). In several studies, factors such as structural flaws, limitations in nurse managements and cultural or organizational variations have been reported to substantially impact the independence of nurses (28). As role models in the field of health care, nurses should promote their routine approach, implement physician orders, and avoid independent interventions (29).

In one study, Seidi et al. observed that improper attitude and unnecessary interference of nursing managers in the occupational and legal matters of nurses were among the factors leading to the lack respect and dignity for nurses (30, 31). According to the results obtained by Skar, higher independence was reported in nurses with the ability to communicate properly with patients during their hospitalization, which caused physicians to respect these nurses for their effectual decision-making (3).

According to the literature, dignity and respect for nurses are associated with different parameters, including independence, capability and communication. This is compatible with the results of the present study. In addition, lack of respect for nurses was observed to be correlated with their clinical experience and competence, which was confirmed by all the participants in this study.

Conclusion

According to the results of this study, clinical experience and competence were the two main factors affecting the promotion of respect and dignity in the nursing community. In this regard, supporting of the inexperienced nurses by health care organizations, medical experts and other nurses could contribute to the promotion of respect and dignity for these individuals, leading to their independence for performing medical interventions effectually. In conclusion, it is recommended that further investigations be conducted in order to discover new strategies to enhance respect and dignity for the nursing community. The findings of the present study could be used in the training of nursing ethics, efficient nursing practices and appropriate nursing management and organization.

Conflicts of Interest

The authors declared that they had no competing interests.

Author's Contributions

B.Najafi was in charge of the study design , data collection, the manuscript draft and data. J.Seidi was responsible for the study design and study conception. Sh.Modanloo was in charge of the study conception. V. fahimi managed data analysis.

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References

1. Sadeghi T, Dehghan Nayyeri N. Patients' dignity: patients' and nurses' perspectives. Iran J Med Ethics Hist 2009; 3(1):9-19 (Persian).
2. Torabizadeh C, Ebrahimi H, Mohamadi E. The Relationship between Patients' Privacy and Dignity. Iran J Med Ethics 2012; 1(19):120-33 (Persian).
3. Skår R. The meaning of autonomy in nursing practice. J Clin Nurs 2010; 19(15-16):2226-34.
4. Karimi R, Dehghan Nayyeri N, Sadeghi T, Mehran A. Patients dignity: a comparative study between the perspective of nurses and adolescents. Iran J Med Ethics Hist Med 2008; 1(4):53-62.
5. Adib-Hajbaghery M, Aminoroayaei Yamini E. Nurses perception of professional support. Feyz J 2010; 14(2):140-53 (Persian).
6. Quinn C, Happell B. Sex on show. Issues of privacy and dignity in a Forensic mental health hospital: Nurse and patient views. J clin nurs 2015; 24(15-16):2268–76.
7. Elliott N. Mutual intacting: a grounded theory study of clinical judgement practice issues. J Adv Nurs 2010; 66(12):2711–21.
8. West C, Usher K, Delaney LJ. Unfolding case studies in pre-registration nursing education: lessons learned. Nurse Educ Today 2012; 32(5):576-80.
9. Koksvik GH. Dignity in Practice: Day-to-Day Life in Intensive Care Units in Western Europe. Med Anthropol. 2015:1-16.
10. Shoghi M, Mirzaei G, Salemi S, Sanjari M, Heidari S, Shirazi

F. Verbal abuse against nurses in hospitals in Iran. koomesh J 2008; 9(4):273-8 (Persian).

11. Aghjanloo A, Harririan H, Ghafurifard M. Violence during clinical training among nursing students of Zanjan universities of medical sciences. Iran J Nurs Res 2010; 5(17):46-54.
12. Karanikola MN, Albarran JW, Drigo E, Giannakopoulou M, Kalafati M, Mpouzika M, et al. Moral distress, autonomy and nurse–physician collaboration among intensive care unit nurses in Italy. J Nurs Manag 2013; 22(4):472-84.
13. Gray-Stanley JA, Muramatsu N, Heller T, Hughes S, Johnson TP, Ramirez-Valles J. Work stress and depression among direct support professionals: the role of work support and locus of control. J Intellect Disabil Res 2010; 54(8):749-61.
14. Hutchinson TL, Janiszewski Goodin H. Nursing student anxiety as a context for teaching/learning. J Holist Nurs 2013; 31(1):19-24.
15. Garfield FB, Garfield JM. Clinical judgment and clinical practice guidelines. Int J Technol Assess Health Care 2000; 16(4):1050-60.
16. Gillespie M, Peterson BL. Helping novice nurses make effective clinical decisions: the situated clinical decision-making framework. Nurs Educ Perspect 2009; 30(3):164-70.
17. Jensen R, Meyer L, Sternberger C. Three technological enhancements in nursing education: informatics instruction, personal response systems, and human patient simulation. Nurse Educ Pract 2009; 9(2):86-90.
18. Benner P, Tanner CA, Chesla C. Expertise in Nursing: Caring, Clinical Judgment, and Ethics. 2nd ed. Newyork: Springer Publishing; 2009.
19. Wolf L. Acuity assignation: an ethnographic exploration of clinical decision making by emergency nurses at initial patient presentation. Adv Emerg Nurs J 2010; 32(3):234-46.
20. Pretz JE, Folse VN. Nursing experience and preference for intuition in decision making. J Clin Nurs 2011; 20(19-20):2878-89.
21. Yang H, Thompson C. Nurses' risk assessment judgements: a confidence calibration study. J Adv Nurs 2010; 66(12):2751-60.
22. Wangensteen S, Johansson IS, Björkström ME, Nordström G. Critical thinking dispositions among newly graduated nurses. J Adv Nurs 2010; 66(10):2170-81.
23. Traynor M, Boland M, Buus N. Autonomy, evidence and intuition: nurses and decision-making. J Adv Nurs 2010; 66(7):1584-91.
24. Cranley LA, Doran DM, Tourangeau AE, Kushniruk A, Nagle L. Recognizing and responding to uncertainty: a grounded theory of nurses' uncertainty. Worldviews Evid Based Nurs 2012; 9(3):149-58.
25. Boyd LD. Development of reflective judgement in the pre-doctoral dental clinical curriculum. Eur J Dent Educ 2008; 12(3):149-58.
26. Samuels JG, Leveille DM. Senior nursing students' clinical judgments in pain management. Nurse Educ 2010; 35(5):220-4.
27. Petrucci AM, Nouh T, Boutros M, Gagnon R, Meterissian SH. Assessing clinical judgment using the Script Concordance test: the importance of using specialty-specific experts to develop the scoring key. Am J Surg 2013; 205(2):137-40.
28. Thompson C, Stapley S. Do educational interventions improve nurses' clinical decision making and judgement? A systematic review. Int J Nurs Stud 2011; 48(7):881-93.
29. Thirsk LM, Moules NJ. "I can just be me": advanced practice nursing with families experiencing grief. J Fam Nurs 2013; 19(1):74-98.
30. Seidi J, Alhani F, Salsali M. Exploration of structure of clinical judgment of nurses: a grounded theory study. J Qual Res Health Sci 2014; 2(4):297-309 (Persian).
31. Seidi J, Alhani F, Salsali M. Professional support as a facilitator to the development of Iranian nurses' clinical judgment: a content analysis. Iran J Nurs Midwifery Res 2014; 19(7 Suppl 1):S13-8.