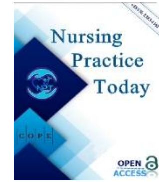
Tehran University of Medical Sciences

Nursing Practice Today

2025; Volume 12, No 3, pp. 316-326



Original Article

Preserving patient dignity in critical care units: A qualitative content analysis

Alireza Arman[1], Shahrzad Ghiyasvandian[1], Zahra Abbasi Dolatabadi[1,2], Meysam Khoshavi[3], Ali Yavari[4], Masoumeh Zakerimoghadam[1]*

[1]Department of Medical-Surgical Nursing, School of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran
[2]Nursing and Midwifery Care Research Center, Tehran University of Medical Sciences, Tehran, Iran
[3]Department of Cardiology, Imam Khomeini Hospital Complex, Tehran University of Medical Sciences, Tehran, Iran
[4]Department of Plastic and Reconstructive Surgery, Imam Khomeini Hospital Complex, School of Medicine, Tehran University of Medical Sciences, Tehran, Iran

ARTICLE INFO

Received 01 February 2025
Accepted 09 March 2025

Available online at:
http://npt.tums.ac.ir

Keywords:
dignity;
professional-patient relations;
patients;
intensive care units

Corresponding Author:
Masoumeh Zakerimoghadam, Department of Medical-Surgical Nursing, School of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran.
E-mail: zakerimo@tums.ac.ir

DOI: 10.18502/npt.v12i3.18980

ABSTRACT

Background & Aim: Patient dignity is a fundamental aspect of human rights, particularly when individuals are most vulnerable. Although maintaining patient dignity seemed to be challenging in Critical Care Units due to the complexity of medical procedures and critical condition of patients, a paucity of evidence exists exploring dignity preservation in Critical Care Units as well as its requirements from the patients' perspective. Thus, we aimed to explore patients' dignity in Critical Care Units and the requirements for its preservation.
Methods & Materials: This qualitative study was conducted on 20 patients selected from the Critical Care Units of Imam Khomeini Hospital, Tehran, Iran, through purposeful sampling. Data were collected via semi-structured interviews and were analyzed using Graneheim and Lundman's conventional content analysis method. Interviews explored patients' experiences and expectations regarding dignity preservation.
Results: The analysis revealed three main categories and nine subcategories essential for preserving patient dignity in critical care units: 1) Care Ethics: Informed Decision-Making, Respecting Patient Concerns, and realistic interaction; 2) Humanity Preservation: Empathetic Acceptance, Avoiding Objectification, and Maintaining Patient Privacy; and 3) Personalized Care: Identifying Needs Proactively, Adapting Care to Individual Conditions, and Ensuring Comfort and Well-being. Participants emphasized the importance of empathetic communication, respect for their personal values and preferences, and maintaining a clean, comfortable environment.
Conclusion: The findings highlight the necessity for healthcare professionals to engage in ethical care, foster empathetic patient interactions, and proactively address the unique needs of each patient to enhance dignity preservation in critical care settings.

Introduction

Human dignity is a crucial part of human rights, and according to scientific sources, human rights are inherent and universal across all eras, regardless of place, time, nationality, and religion (1). When an individual can live according to their standards and values, they are endowed with dignity. One of the most significant areas where the dignity of individuals can be compromised is during illness. When the body becomes weak and vulnerable, the individual's ability to maintain their core life standards and values is affected (2).

The concept of "protecting patient rights" dates back to Hippocrates' recommendations emphasizing the preservation of the patient's respect and dignity. In recent decades, with significant advances in the sciences, particularly medical sciences, and the subsequent emergence of ethical challenges, this concept has expanded greatly. In this context, the global human rights movement in the past two decades has drawn the attention of international scientific communities to the rights of specific social groups, including patients, as the most vulnerable social groups physically, psychologically, socially, and economically (3).

Researchers believe that in the nursing profession, the importance of ethical care surpasses therapeutic considerations (4). It should also be noted that nurses' opportunities to make decisions in complex situations are limited, and

Please cite this article as: Arman A, Ghiyasvandian S, Abbasi Dolatabadi Z, Khoshavi M, Yavari A, Zakerimoghadam M. Nurses' perception of reasons for turnover: Thematic synthesis of qualitative research studies. Nursing Practice Today. 2025; 12(3):316-26.

Copyright © 2025 Tehran University of Medical Sciences. Published by Tehran University of Medical Sciences.
This work is licensed under a Creative Commons Attribution-Noncommercial 4.0 International license (https:/creativecommons.org/licenses/by-nc/4.0/). Noncommercial uses of the work are permitted, provided the original work is properly cited

their ability to act based on personal values and norms is restricted. Consequently, a gap arises between the ideal ethical decision and actual ethical behavior (5).

One of the most critical areas where nurses play a fundamental role in preserving patient dignity is the Critical Care Units (CCUs). The vulnerability of CCUs patients, due to their clinical and psychological conditions and the complexity and specialized nature of medical care procedures, is more pronounced (6, 7). The CCUs environment, given its technical nature, critical conditions, patient limitations, family anxiety, economic issues, and significant decisions made during hospitalization, creates unique complexities that can compromise respectful behavior towards patients (8).

Despite the emphasis and importance of maintaining patient dignity in CCUs, evidence indicates that the level of dignity preservation in these units is low (9). Globally, limited qualitative studies have specifically focused on the requirements for preserving patient dignity in CCUs (10). In Iran, a qualitative study has described the preservation of patient dignity from the perspective of doctors and nurses using an ethnographic method (7). However, there has been no comprehensive study examining the requirements for preserving patient dignity from the patients' perspective using qualitative methods. Considering Human Dignity Theory (11) and the Patient-Centered Care Model (12) to explain dignity preservation in CCUs could provide a more insightful understanding. Human Dignity Theory considers dignity as both an inherent right and influenced by social factors, focusing on respect, autonomy, and ethical care. The Patient-Centered Care Model emphasizes individualized care, patient preferences, and emotional well-being as important for maintaining dignity. These theories help to understand how patients perceive and experience dignity in critical care settings. Therefore, this research aims to describe the requirements for preserving patient dignity from the perspectives of Iranian patients and nurses in CCUs using qualitative content analysis, mainly grounded in Human Dignity Theory and the Patient-Centered Care Model.

Methods

Study design and setting

This study utilized qualitative content analysis to gain a deep understanding of patient dignity in CCUs and determine perceived needs based on the theoretical context of CCUs patients. Due to the limited knowledge about the phenomenon under study, data were analyzed using a conventional content analysis method based on Graneheim and Lundman's approach. Content analysis is a qualitative research method that systematically and objectively describes the content derived from communications by categorizing words and phrases in the text. This method is suitable for this study's objectives (13). The study setting was the CCUs of Imam Khomeini Hospital affiliated with Tehran University of Medical Sciences.

The researcher established a suitable relationship and explained the study's objectives to eligible participants before scheduling interviews. There was no prior acquaintance between the interviewer and the participants before the interviews.

Participants

Purposeful sampling was used to select participants. All participants were hospitalized in CCUs, with the ability and willingness to communicate. A total of 21 participants were selected using purposeful sampling until data saturation was reached. Data saturation occurs when no new information is added during data collection, and the extracted information confirms and validates previous data, at which point sampling is concluded.

Data collection

Data were collected and analyzed by the primary researcher through interviews. Semi-structured interviews lasting 30 to 90 minutes were recorded. During each interview, participants were asked to describe a day during their hospital stay and their understanding of the interactions and situations related to maintaining their dignity. The interviews continued with the following probing questions to achieve a broader understanding of the phenomenon under study: "What are your expectations for preserving

patient dignity in CCUs? Can you explain it?" Data saturation was achieved in the 20th interview, with no new data codes identified.

Data analysis

Qualitative content analysis was used to analyze the data. Data were transcribed verbatim by the researcher and analyzed to highlight participants' perceptions. Each interview was read multiple times by the primary researcher to gain a general understanding of the content. Then, all words and sentences related to dignity were coded. These meaning units were compared and categorized based on similarities into categories and subcategories. Finally, after several revisions, three main categories and nine sub-categories were identified. Collected data and interpretations were shared with participants to verify perceived accuracy and reactions. Identified codes were assessed by three other colleagues to confirm coding accuracy.

Trustworthiness and rigor

To ensure the trustworthiness and rigor of the data, criteria such as credibility, dependability, confirmability, and transferability, as suggested by Lincoln and Guba for evaluating scientific accuracy in qualitative research, were used (14). Credibility was achieved through prolonged engagement with participants and data, allocating sufficient time for data collection, establishing trust-based relationships with participants, member checking, and incorporating their feedback. Dependability was ensured through audit trails and peer review of the data. Confirmability was guaranteed by presenting quotations as extracted from each interview. Transferability was enhanced by detailing the entire research process, participant characteristics, and research context, and selecting participants with maximum diversity.

Ethical considerations

The institutional ethics committee of the joint research organization of the Schools of Nursing, Midwifery, and Rehabilitation at Tehran University of Medical Sciences approved this study with the ethics code (IR.TUMS.FNM.REC.1401.020). Before starting the interviews, participants were informed about the study's objectives, and written and verbal informed consent was obtained from all participants, along with permission to record the interviews.

Results

A total of 21 eligible patients aged between 28 to 68 years were selected. All patients were included from the cardiac care unit, of whom 8 had heart failure, 6 had myocardial infarction, 4 had cardiac arrhythmia, and 2 were cardiac transplantation candidates. Their hospitalization duration ranged from 4 to 40 days, and 10 had previous hospitalization experiences. Eleven patients had university degrees, seven had secondary education, three were illiterate, and about half (52%) were married. According to participants, the requirements for preserving patient dignity were categorized into three main categories and nine main sub-categories (Table 1).

Table 1. Overview of the study structure: Categories, primary and secondary sub-categories

Categories	Main subcategories	Sub- categories
Ethical care	Informed decision making	Providing information for patient participation in treatment decisions Considering patient choice
	Respecting patient concerns	Understanding the patient's emotional sensitivity Respectful behavior and subtlety in communication with the patient Patient's concern about the behavior towards their companion
	Realistic interaction	Realistic training Need for communication with the patient Eliminating the patient's mental ambiguities Preparing the patient for the reality of the disease
Humanity preservation	Empathetic acceptance	Therapeutic interaction with the patient Compassionate empathy Expectation of empathy
	Avoiding objectification	Human perspective towards the patient Conveying a sense of worth to the patient Preventing feelings of inferiority in the patient

Categories	Main subcategories	Sub- categories
		Feeling captive in bed Ignoring Attention to spiritual needs
	Privacy preservation	Gender separation of patients Providing shame-free defecation Maintaining patient privacy in all conditions
Personalized care	Identifying and meeting needs before patient requests	Timely identification of patient needs Meeting needs Patient's fear and hesitation in expressing requests
	Tailoring care	Psychosocial care Tailoring care to the patient's age
	Ensuring comfort and welfare	Attention to the patient's sleep comfort Ensuring patient welfare Quality attention to food service Cleanliness and hygiene of the ward environment Attention to the patient's hygiene and cleanliness

Ethical care

This category is summarized into three subcategories: The Right to Informed Decision-Making, Considering Patients' Concerns, and Realistic Interaction

The right to informed decision-making

Patients stated that the right to informed decision-making is one of their fundamental needs. This subcategory includes two further subdivisions: informing patients to participate in treatment decisions and respecting patients' right to choose. Patients expect to have a choice in treatment and care decisions, and that the healthcare staff seek their permission before any procedures. Additionally, they want to be clearly informed by nurses or doctors about decisions they do not fully understand to enable informed decision-making, ultimately leaving the final decision to the patient.

"Everything they do is for me, but no one asks me the reason or explains why they are doing it or seeks my permission. The patient's opinion should be considered in their treatment, not completely ignored." (Patient)

"I believe that the patient's opinion should be considered. Even if the patient doesn't know, they should be given information to participate and then allowed to make a decision." (Patient)

Considering patients' concerns

Respectful behavior and speech are important to patients. Additionally, some patients reported increased sensitivity to others' behavior and speech due to their illness. They expected to be understood and treated with respect. They also did not see themselves as separate from their families and companions and were concerned about how healthcare staff treated their families and companions.

"After a major surgery like a heart transplant, one's sensitivity increases, and they can get upset more easily."

"More important than medication and treatment for me is proper and respectful behavior. I believe that if a patient is respected, they will recover faster. Respect, in my opinion, means proper behavior."

"My companion is here because of me, and I worry that they might be treated badly."

Realistic interaction

Realistic interaction refers to honesty in speech, clear and unexaggerated communication with patients, and understanding the emotional and mental state of patients and their families when conveying news. Some patients reported that exaggeration was sometimes used to enforce compliance with instructions, and diagnoses and treatments were explained using vague or technical terms, causing confusion. They expect their emotional and mental states to be considered when receiving diagnoses and bad news, preferring to be gently and clearly informed about their condition and procedures.

"I prefer to do what I can myself rather than being limited. I feel fine, but I'm not allowed to get out of bed. When I ask why, they rudely say: 'If you get up, you'll die!"

"They only told me that 10% of my heart is working, but didn't say whether there is treatment or not, or what they plan to do. This left me with many uncertainties, and no one explained anything."

"It's better to communicate a patient's problems gently rather than suddenly giving them bad news directly. Patients and their families face many issues and need to be understood."

Preserving humanity

This category includes three subcategories: Empathetic Acceptance, Avoiding Objectification, and Maintaining Patient Privacy

Empathetic acceptance

Patients emphasized the need for communication and empathy from healthcare staff. They stated that attention and friendly conversation make them feel better. They need a listening ear and empathy during illness, and expect healthcare interactions to involve communication and concern for their well-being.

"Nobody here asks how I am. One nurse would just write something down without talking to me and leave, not even looking at me!"

"Some of the nurses here are very good. Even though they weren't my nurses, they would ask how I was doing when they passed by, showing they cared."

"We will all be in this hospital bed one day, so doctors and nurses should put themselves in the patients' shoes."

Avoiding objectification

Participants emphasized the importance of respecting patients' individuality and humanity. Patients expressed concerns about being treated impersonally and expected attention to their physical and emotional needs based on their culture. They felt that neglecting their needs led to feelings of humiliation and inferiority. Some patients also highlighted the importance of spiritual needs, expecting facilitation of their religious practices, as spirituality aids their recovery.

"Help me as a disabled patient. I am also human; I have lost some abilities and feel alienated here."

"Neglecting a patient's needs is worse than a hundred humiliations. Repeatedly requesting something without a response makes one feel unnoticed."

"Being hospitalized shouldn't reduce one's connection with God. Here, I need to pray even more. I arranged my prayer conditions myself. For example, they should ensure I stay clean for prayer during bedpan changes."

Maintaining patient privacy

Patients stated that due to their long and continuous hospitalization, they need a comfortable environment with preserved privacy. Some expressed discomfort with mixed-gender wards and preferred gender-segregated sections. They experienced anxiety and a sense of imminent death upon seeing resuscitation efforts and critically ill patients, which they considered a violation of their privacy. Many patients were particularly concerned about maintaining dignity during bedpan use while on bed rest, feeling significant embarrassment and preferring death over such indignity.

"It's uncomfortable being in a mixed-gender ward. Imagine being here 24 hours a day and feeling awkward if the staff or even patients are of the opposite gender."

"Seeing patients with the same diagnosis die made me very anxious and affected everything."

"I've eaten very little in the past two days to avoid needing the toilet. I'm so embarrassed about using a bedpan in bed that I'd rather die."

Personalized care

Patients emphasized that care should provide comfort and peace based on individual characteristics and cultural beliefs. They expected flexible care that doesn't drastically alter their lifestyle or at least changes it gradually to prevent discouragement.

Identifying and meeting needs before patients request

Patients stated they need nurses' help for recovery, but sometimes hesitate to express their needs due to shyness or fear of rude reactions. They preferred nurses to proactively identify and address their needs.

"They say clothes are scarce, but if we ask, they give us more. It would be better if they changed our clothes before we asked."

"Patients need care, which is why they're hospitalized. If a nurse is rude, I usually ignore my needs because they might say something hurtful."

Adapting care to individual conditions

Patients stated that nurses should consider their age, emotional, and physical conditions. Older patients expected more respect and a quieter environment, while younger patients felt more anxiety about future incapacity.

"There are different ages here, and they don't consider us old men (laughs). I expect more respect and consideration. At home, it's very quiet, and I barely sleep. Here, I haven't slept well once this week because of the noise."

"Being sick at a young age made me hopeless. I wondered how I'd live with this illness for a lifetime."

"They should ask about one's habits on the first day. Not everyone is the same. For example, I can't stand the smell of cleaning agents but love the scent of perfume."

Ensuring comfort and well-being

Patients expressed concerns about noise from devices, staff, and other patients at night, disrupting sleep and leaving them tired during the day. They expected a calm environment at night. They also expected basic amenities such as proper lighting, ventilation, heating, and cooling. Some patients noted the importance of food quality and temperature, associating it with respect. They reported that broken refrigerators and lack of water coolers were ongoing issues that needed attention.

"I couldn't sleep because of severe coughing and shortness of breath. The nurse did nothing except give me a glass of water and said I'd be fine. I was awake all night."

"It's very hot in the ward. The patient next to me brought a fan from home, making it bearable."

Patients valued cleanliness and expected nurses to ensure a clean environment and personal hygiene. They wanted bathing facilities that met their habits and clean clothes as needed.

"I don't use the hospital bathroom because it's not clean. They should provide shampoo and soap for patients."

"I used to bathe daily at home, but I haven't bathed in five days and feel terrible. No one has asked about it."

"I hadn't changed my clothes for a week. No one asked; I thought they'd follow up themselves."

Discussion

This study indicates that preserving patient dignity in CCUs requires a holistic view, which encompasses three interconnected aspects such as Care Ethics, Humanity Preservation, and Personalized Care. Previous limited studies in both special and general wards have shown that patient dignity is compromised, emphasizing the need for further research in this area (7, 15). Our findings support Human Dignity Theory (11), which explains dignity as both a natural right and a concept influenced by healthcare interactions. The identified themes are related to this theory, focusing on autonomy, respect, and individual attention in CCUs. The results also match the Patient-Centered Care Model (12), which highlights the importance of considering patient preferences, emotional needs, and cultural values. Concerns about informed decision-making and realistic interaction are linked to shared decision-making, while privacy and gender preferences show that dignity is also a cultural matter. Using these theories, this study explains how dignity can be maintained in critical care, emphasizing the need for ethical, respectful, and personalized care.

We found that many patients expect to have a choice in matters concerning them. This finding aligns with the study by Angel and colleagues in 2015, which examined challenges in achieving patient participation (16). That study concluded that optimal patient participation is achievable only within a framework that allows enough time for patients and health professionals

to build relationships and shared knowledge. We also found that the patients experience psychological distress such as anxiety and depression, which need to be understood by healthcare professionals. This finding is consistent with Fumis and colleagues' study (17). According to Ramnarain and colleagues, managing patients' emotional conditions requires an interdisciplinary and multifaceted approach in primary care (18).

Sometimes, patients feel like a burden on their families. This finding is confirmed by a study conducted by Gay and colleagues (19). Also, healthcare staff sometimes exaggerate or misrepresent information to patients to ensure compliance. Patients perceive this as a violation of dignity and unethical. It should be noted that providing incorrect information can increase patients' anxiety (20) and disrupt their trust in healthcare staff, leading to non-cooperation (21). According to the study by Zafarnia and colleagues, honesty with patients is part of the ethical competency of nurses and contributes to ethical care (22). Moreover, we found that patients may experience multiple ambiguities and subsequent anxiety due to encountering specialized terms, procedures, and equipment. A study identified inadequate information about health status and poor communication between nurses and patients as barriers to preserving patient dignity (23). Another study by Bagherian and colleagues on cancer patients revealed that one of the identified sub-classes was the gentle disclosure of bad news (24). The person responsible for delivering bad news must have cultural competence and an accurate understanding of the patient's and family's physical, psychological, and cultural conditions (25).

Our study also revealed that preserving patient dignity requires attention to the human aspects of care. Due to the CCUs unique environment, patients are more susceptible to dignity violations. These findings are consistent with the study by Norouzinia and colleagues (26). Also, patients may feel inferior due to their dependency and lack of awareness of their condition, which can lead to controlling and paternalistic behavior by healthcare staff. This finding aligns with the study by Fountouki and colleagues (27). Moreover, many bedridden patients experience a sense of captivity. Prolonged bed rest can cause both physiological complications and psychological issues (28). Therefore, nurses should explain the necessity of bed rest to patients and plan for their mobilization as soon as possible.

For some patients, spirituality plays a significant role in influencing both their physical and mental well-being. As a result, addressing spiritual needs and offering spiritual care are vital responsibilities for nurses (29). Nonetheless, the ability to provide such care is deeply influenced by the personal beliefs and values of the nurses themselves (30). This might be due to various reasons, including the secularization of contemporary society, reluctance to provide spiritual care, lack of time, heavy workloads, feelings of inadequacy in providing spiritual care, and the absence of such training in undergraduate and graduate programs (31). Many female patients in this study preferred same-gender healthcare providers due to cultural and religious norms in Iran, where Islamic values emphasize modesty and gender segregation (32). Similar findings have been reported in Saudi Arabia, where religious expectations shape healthcare preferences (33). However, in Western countries like Sweden and the UK, gender preference is less significant, as professional care is prioritized over gender-specific considerations (34). In Latin America, dignity is linked more to familial presence than to gender segregation (35). These variations highlight that dignity preservation is both a universal and culturally specific issue. Future research should explore how evolving societal norms influence gender preferences in healthcare, especially in multicultural settings.

One of the emphasized points by most patients was their reluctance to use bedpans. The primary reason for this concern was the lack of privacy during defecation. Therefore, it is crucial to maintain patients' privacy during bedpan use. Additionally, sometimes due to poor communication between doctors and nurses, inadequate teamwork, or staff shortages, there might be delays in getting patients out of bed, even when bed rest is no longer necessary (36).

Communication emerged as another crucial factor influencing patient dignity. Patients

expressed a strong need for honest, clear, and compassionate communication, particularly regarding their medical condition and treatment options. Respect for patient autonomy was also a recurrent theme, as participants emphasized the importance of being involved in decision-making and having their choices respected by healthcare providers. Similarly, privacy, especially in mixed-gender wards and during personal care, was consistently raised as an important aspect of dignity. These findings suggest that preserving patient dignity in CCUs requires a multi-dimensional approach, where patients' physical, emotional, and psychological needs are all addressed. Preserving patient privacy requires maintaining their independence, which can be achieved through proper staffing, teamwork, and policy implementation (37). Moreover, the ward environment and the patient's bed are considered the patient's personal space. In conditions where patients are unable to maintain their privacy, it is essential to recognize that witnessing the distress of other critically ill patients, invasive procedures like resuscitation, and specialized conversations at the bedside can cause anxiety and a sense of impending death in conscious and relatively healthier patients. These findings are consistent with other studies (38). Therefore, it seems better to separate critically ill patients from others.

According to the study results, the CCUs should be designed to ensure comfort. The ward's lighting and appearance should not disrupt patients' sleep and rest at night, while providing adequate daylight during the day. Staff should be educated and emphasize maintaining a quiet ward during patient rest times. Basic amenities such as refrigerators and microwaves should be accessible to patients. Proper ventilation and heating/cooling systems should ensure patient comfort. Ensuring patient comfort can lead to a sense of peace and a positive physiological response, aiding recovery (39). The study results indicate the importance of maintaining cleanliness and hygiene in the ward. Patient and bed hygiene should be part of daily nursing care. Maintaining cleanliness and grooming could enhance the patient's sense of worth (40).

While this study highlights environmental concerns such as noise and cleanliness, the broader impact of CCU physical design on patient dignity remains underexplored. Studies suggest that well-designed CCU environments, incorporating private rooms, noise reduction measures, and improved spatial layouts, significantly enhance patient comfort and dignity (39). Private rooms provide greater privacy, minimizing exposure during personal care and sensitive procedures while reducing psychological distress (38). Noise reduction strategies, such as silent alarms, sound-absorbing materials, and soft-closing doors, can alleviate stress and improve sleep quality (41). Additionally, optimizing ventilation, lighting, and space allocation fosters a more therapeutic and dignity-preserving environment (38). Future research should explore how these architectural modifications can be systematically implemented to enhance dignity-centered care in CCUs.

This study emphasizes the importance of dignity preservation in CCUs and suggests necessary changes in clinical practice, training, and policies. Healthcare institutions should establish training programs to improve communication skills, empathy, and cultural awareness among CCU staff. These programs should focus on clear, compassionate communication and the need for staff to listen to patient concerns, especially during difficult medical decisions. Additionally, role-playing exercises and simulations can help develop empathy and ensure that dignity and autonomy are prioritized in patient care. Policy changes should prioritize patient dignity in resource-limited settings, including team-based care and ensuring personalized care through proper staff training, adequate staffing levels, and standardized care protocols that address the individual needs of each patient.

Conclusion

The study results show that the requirements for preserving dignity in CCUs are based on three principles: Care Ethics, Humanity Preservation, and Personalized Care. The first principal highlights that the care

context should be ethically oriented. The second principle refers to the intrinsic human need for dignity in all conditions. It should be noted that the first two principles are generally applicable to all patients. However, the third principle shows that individual differences necessitate different care approaches. In essence, care planning should be tailored to the unique physical, psychological, and cultural conditions of each patient. As the perspectives of healthcare providers, such as nurses, are important in preserving patient dignity the researchers plan to expand this study in the future to include the viewpoints of healthcare providers. Furthermore, studies among populations with diverse socioeconomic status are warranted for more clarification.

Acknowledgments

We appreciate the Education, Research, and Technology Deputy and the Medical-Surgical Nursing Department at the School of Nursing and Midwifery affiliated with TUMS for the thesis approval.

Conflict of interest

All the authors declare no conflict of interest.

Funding Statement

The study was financially supported by Tehran University of Medical Sciences (grant number: 57398).

References

1. Rezaei M, Seyedfatemi N, Najafi Ghezeljeh T. Challenges of implementing family-based dignity intervention. Nursing Practice Today. 2023;10(3):173–5. doi:10.18502/npt.v10i3.13426
2. Barclay L. In sickness and in dignity: A philosophical account of the meaning of dignity in health care. International Journal of Nursing Studies. 2016;61:136-41. https://doi.org/10.1016/j.ijnurstu.2016.06.010
3. Voigt DK-H, Lenz P, Friederichs H. Physicians' comprehension of the German Patients' Rights Act: A cross-sectional study. Health Policy. 2018;122(11):1249-54. https://doi.org/10.1016/j.healthpol.2018.08.017
4. Safavi F, Yousefi Z, Bavani SM, Khodadadi E. The relationship between nurses' ethical reasoning with the quality of nursing care. International Journal of Applied and Basic Medical Research. 2022;12(3):196-202. https://doi.org/10.4103/ijabmr.ijabmr_637_21
5. Atashzadeh-Shoorideh F, Mohtashami J, Farhadzadeh M, Sanaie N, Fathollah Zadeh E, Beykmirza R, Abdoljabari M. Humanitarian care: Facilitator of communication between the patients with cancer and nurses. Nursing Practice Today. 2020;8(1):70–8. doi:10.18502/npt.v8i1.4493
6. Khademi M, Mohammadi E, Vanaki Z. On the violation of hospitalized patients' rights: A qualitative study. Nursing Ethics. 2019;26(2):576-86. https://doi.org/10.1177/0969733017709334
7. Bidabadi FS, Yazdannik A, Zargham-Boroujeni A. Patient's dignity in intensive care unit: A critical ethnography. Nursing Ethics. 2019;26(3):738-52. https://doi.org/10.1177/0969733017720826
8. Brown SM, Azoulay E, Benoit D, Butler TP, Folcarelli P, Geller G, et al. The practice of respect in the ICU. American Journal of Respiratory and Critical Care Medicine. 2018;197(11):1389-95. https://doi.org/10.1164/rccm.201708-1676CP
9. Mehdipour-Rabori R, Abbaszadeh A, Borhani F. Human dignity of patients with cardiovascular disease admitted to hospitals of Kerman, Iran, in 2015. Journal of Medical Ethics and History of Medicine. 2016;9:8.
10. Nyholm L, Koskinen CA. Understanding and safeguarding patient dignity in intensive care. Nursing Ethics. 2017;24(4):408-18. https://doi.org/10.1177/0969733015605669
11. Jacobson N. Dignity and health: A review. Social Science & Medicine. 2007;64(2):292-302. https://doi.org/10.1016/j.socscimed.2006.08.039
12. America CoQoHCi. Crossing the quality chasm: A new health system for the 21st century. National Academies Press; 2001.
13. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Education Today. 2004;24(2):105-12. https://doi.org/10.1016/j.nedt.2003.10.001
14. Polit DF, Beck CT. Essentials of nursing research: Appraising evidence for nursing practice. Lippincott Williams & Wilkins; 2010.
15. Cheraghi MA, Manookian A, Nasrabadi AN. Human dignity in religion-embedded cross-cultural nursing. Nursing Ethics. 2014;21(8):916-28. https://doi.org/10.1177/0969733014521095
16. Angel S, Frederiksen KN. Challenges in achieving patient participation: A review of how patient participation is addressed in empirical

studies. International Journal of Nursing Studies. 2015;52(9):1525-38. https://doi.org/10.1016/j.ijnurstu.2015.04.008
17. Fumis RRL, Ranzani OT, Martins PS, Schettino G. Emotional disorders in pairs of patients and their family members during and after ICU stay. PLoS One. 2015;10(1):e0115332. https://doi.org/10.1371/journal.pone.0115332
18. Ramnarain D, Aupers E, den Oudsten B, Oldenbeuving A, de Vries J, Pouwels S. Post Intensive Care Syndrome (PICS): An overview of the definition, etiology, risk factors, and possible counseling and treatment strategies. Expert Review of Neurotherapeutics. 2021;21(10):1159-77. https://doi.org/10.1080/14737175.2021.1981289
19. Gay EB, Pronovost PJ, Bassett RD, Nelson JE. The intensive care unit family meeting: Making it happen. Journal of Critical Care. 2009;24(4):629.e1-12. https://doi.org/10.1016/j.jcrc.2008.10.003
20. Ussher JM, Parton C, Perz J. Need for information, honesty and respect: Patient perspectives on health care professionals' communication about cancer and fertility. Reproductive Health. 2018;15:1-12. https://doi.org/10.1186/s12978-017-0441-z
21. Ozaras G, Abaan S. Investigation of the trust status of the nurse-patient relationship. Nursing Ethics. 2018;25(5):628-39. https://doi.org/10.1177/0969733016664971
22. Zafarnia N, Abbaszadeh A, Borhani F, Ebadi A, Nakhaee N. Moral competency: Meta-competence of nursing care. Electronic Physician. 2017;9(6):4553-61. https://doi.org/10.19082/4553
23. Fuseini AG, Rawson H, Ley L, Kerr D. Patient dignity and dignified care: A qualitative description of hospitalised older adults perspectives. Journal of Clinical Nursing. 2023;32(7-8):1286-1302. https://doi.org/10.1111/jocn.16286
24. Bagherian S, Sharif F, Zarshenas L, Torabizadeh C, Abbaszadeh A, Izadpanahi P. Cancer patients' perspectives on dignity in care. Nursing Ethics. 2020;27(1):127-40. https://doi.org/10.1177/0969733019845126
25. Sharifi N, Adib-Hajbaghery M, Najafi M. Cultural competence in nursing: A concept analysis. International Journal of Nursing Studies. 2019;99:103386. https://doi.org/10.1016/j.ijnurstu.2019.103386
26. Norouzinia R, Aghabarari M, Shiri M, Karimi M, Samami E. Communication barriers perceived by nurses and patients. Global Journal of Health Science. 2015;8(6):65-74. https://doi.org/10.5539/gjhs.v8n6p65
27. Fountouki A, Andrades Sanchez M, Theofanidis D. Paternalism vs patient empowerment: Nursing challenges from Spain and Greece. International Journal of Caring Sciences. 2020;13(3):2288-93.
28. Brower RG. Consequences of bed rest. Critical Care Medicine. 2009;37(10 Suppl):S422-8. https://doi.org/10.1097/CCM.0b013e3181b6e30a
29. Rachel H, Chiara C, Robert K, Francesco S. Spiritual care in nursing: An overview of the measures used to assess spiritual care provision and related factors amongst nurses. Acta Bio Medica Atenei Parmensis. 2019;90(Suppl 4):44-50.
30. Chiang YC, Lee HC, Chu TL, Han CY, Hsiao YC. The impact of nurses' spiritual health on their attitudes toward spiritual care, professional commitment, and caring. Nursing Outlook. 2016;64(3):215-24. https://doi.org/10.1016/j.outlook.2015.11.012
31. Baldacchino D. Spiritual care education of health care professionals. MDPI; 2015. https://doi.org/10.3390/rel6020594
32. Mujallad A, Taylor EJ. Modesty among Muslim women: Implications for nursing care. MedSurg Nursing. 2016;25(3):169-74.
33. Almutairi KM. Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. Saudi Medical Journal. 2015;36(4):425-9. https://doi.org/10.15537/smj.2015.4.10133
34. Bäck E, Wikblad K. Privacy in hospital. Journal of Advanced Nursing. 1998;27(5):940-5. https://doi.org/10.1046/j.1365-2648.1998.t01-1-00576.x
35. Costa DGd, Moura GMSSd, Pasin SS, Costa FGd, Magalhães AMMd. Patient experience in co-production of care: Perceptions about patient safety protocols. Revista Latino-Americana de Enfermagem. 2020;28:e3272. https://doi.org/10.1590/1518-8345.3352.3272
36. Allen C, Glasziou P, Del Mar C. Bed rest: A potentially harmful treatment needing more careful evaluation. The Lancet. 1999;354(9186):1229-33. https://doi.org/10.1016/S0140-6736(98)10063-6
37. Molina-Mula J, Gallo-Estrada J. Impact of nurse-patient relationship on quality of care and patient autonomy in decision-making. International Journal of Environmental Research and Public Health. 2020;17(3):835. https://doi.org/10.3390/ijerph17030835
38. Gezginci E, Goktas S, Orhan BN. The effects of environmental stressors in intensive care unit on anxiety and depression. Nursing in Critical

Care. 2022;27(1):113-9. https://doi.org/10.1111/nicc.12553

39. Turner-Cobb J, Smith P, Ramchandani P, Begen F, Padkin A. The acute psychobiological impact of the intensive care experience on relatives. Psychology, Health & Medicine. 2016;21(1):20-6. https://doi.org/10.1080/13548506.2014.997763

40. Van Paasschen J, Walker SC, Phillips N, Downing PE, Tipper SP. The effect of personal grooming on self-perceived body image. International Journal of Cosmetic Science. 2015;37(1):108-15.
https://doi.org/10.1111/ics.12176

41. Hsu T, Ryherd E, Waye KP, Ackerman J. Noise pollution in hospitals: Impact on patients. Journal of Communication in Healthcare. 2012;19(7):301-9.