Human dignity in religion-embedded cross-cultural nursing

Mohammad A Cheraghi, Arpi Manookian and Alireza N Nasrabadi

Nurs Ethics 2014 21: 916 originally published online 27 March 2014
DOI: 10.1177/0969733014521095

Article

Nursing Ethics
2014, Vol. 21(8) 916–928

10.1177/0969733014521095
nej.sagepub.com

Human dignity in religion-embedded cross-cultural nursing

Mohammad A Cheraghi, Arpi Manookian and Alireza N Nasrabadi
Tehran University of Medical Sciences, Islamic Republic of Iran

Abstract

Background: Although human dignity is an unconditional value of every human being, it can be shattered by extrinsic factors. It is necessary to discover the authentic meaning of patients' dignity preservation from different religious perspectives to provide professional cross-cultural care in a diverse setting.

Research objective: This article identifies common experiences of Iranian Muslim and Armenian Christian patients regarding dignified care at the bedside.

Research design: This is a qualitative study of participants' experiences of dignified care elicited by individual in-depth semi-structured interviews.

Participants and research context: A purposeful sample of 10 participants (five Iranian Muslims and five Iranian Armenians) from various private and governmental hospital settings was chosen.

Ethical considerations: This study was approved by the ethics committee of Tehran University of Medical Sciences. All the participants were provided with information about the purpose and the nature of the study, the voluntary condition of their participation in this study, and the anonymous reporting of recorded interviews.

Findings: The common experiences of Christian and Muslim patients regarding dignity preservation emerged as "exigency of respecting human nobility" and "providing person-centered care."

Discussion and conclusion: It is essential to recognize the humanness and individuality of each patient to preserve and promote human dignity in diverse cross-cultural settings. The findings support and expand current understanding about the objective and subjective nature of dignity preservation in cross-cultural nursing.

Keywords

Caring, Christian, cross-cultural nursing, culture, human dignity, Iran, Muslim

Background

Human dignity is an ultimate and irreducible phenomenon, valued incommensurably higher than other values.[1] This standpoint about dignity is consistent with religious perspectives, where dignity is considered as the ultimate and inherent intrinsic worth of every human being. In monotheistic religions, such as

Corresponding author: Arpi Manookian, Faculty of Nursing and Midwifery, Tehran University of Medical Sciences, Tohid sq., 1419733171, Tehran, Islamic Republic of Iran.
Email: manookianarpi@yahoo.com

Islam and Christianity, which believe in a supreme God, human dignity is one of the most emphasized themes in their Holy Scriptures. They agree that God created human beings to be in a supreme position, endowed with divine blessing.[2,3] Given the transcendental source of human dignity in the Abrahamic religions, it is inevitable that patients' dignity is articulated as a religious absolute, especially in a religious context.[4]

The notion of human dignity is at the center of many philosophical perspectives, too. For Kant, dignity is a worth that has no price, no equivalent for which the object evaluated.[1] The "absolute dignity" or "basic dignity" of human beings is the foundation of human rights. It is considered objectively as an inconvertible quality, while the subjective perspective on human dignity also takes into account individual differences and idiosyncrasies.[5,6]

Both the objective and subjective perspectives on human dignity are emphasized in nursing profession; respecting patients' inherent dignity and worth is a fundamental principle and obligation that underlies all nursing practices and highlighted in the first statement of all national and international nursing code of ethics; meanwhile, respecting each patient's individuality and uniqueness is considered as a significant nursing obligation worldwide.[7–9]

According to the subjective perspective, the sense of dignity can be shattered by extrinsic factors such as events, beliefs, behaviors, and actions of other people.[10,11] In the vast corpus of literature on dignity, it is considered a complex, subjective, and multidimensional concept,[12,13] influenced by personal, cultural, social, religious, and spiritual constructs and contexts.[11,14–16] Given that a culture is recognized by its learned and shared values, beliefs, and behaviors, and is defined by the specific religious and ethnic actions and customs,[17–19] it is important to consider a person's religious beliefs and value systems. Human dignity as a central value is therefore expressed variously in diverse cultural settings.[20] Religion, too, has a significant role in social identity formation. In this regard, therefore, Nordenfelt describes the notion of personal and social identity, as the "dignity of identity."[21–24] In nursing delivery systems, that the patients' perspectives, values, needs, and expectations related to uniqueness and individuality of each patient and emanating from a specific culture, religion, or ideology are recognized as the bases of individualized care.[24] In some contexts, such as in Iran, where religion is synonymous with spirituality—considering the patients' spirituality as the individual and religious value systems—it is a crucial aspect of providing dignified and individual care.[25,26]

Consequently, in nursing and healthcare professions where interactions with patients occur within environments influenced by specific social, cultural, and spiritual factors, [14–16,26,27] the impact of cultural diversity on dignity preservation should be taken into great consideration. Indeed, this is an important focus of cross-cultural nursing that is emphasized by national and international nursing standards.[7–9] The North American Nursing Diagnosis Association highlights the significance of patients' dignity preservation by considering the "risk of compromising human dignity" when making a nursing diagnosis, where the first defining characteristic is "cultural incongruity."[28]

Although one aspect of human dignity is culture-bound and has different manifestation in various traditions and cultures, undoubtedly, it is also a concept common to all humanity.[29,30] Because of the universal nature of dignity defined as "basic or absolute," it is the most common value in different cultures and religions.[6,23] We should therefore make great efforts to go beyond our differences and share our common values in order to deliver person-centered care. Indeed, if we are blind to patients' humanity or individual uniqueness, we undermine the value of the care we give and become objects, too.[31]

It is worthy to clarify that given the definition of the culture concept mentioned before, encompassing variety of shared values, beliefs, and practices, especially the religious ones among a group of people, this study focused on two diverse religious groups to discover the meaning of human dignity preservation in cross-cultural nursing.

Context

Cultural and religious diversity exists even among communities within the same country. Iran, officially the Islamic Republic of Iran, is an ancient country with over 2500 years of rich history, culture, and civilization in a population of over 75 million in 2011.[32] Islam is the dominant religion in Iran,[26] with Shia Muslims (89%), Sunni Muslims (10%), and other religious populations, including Zoroastrians, Christians, and Jews.[33] Armenians are Iran's largest Christian minority, having a long history of interaction with Persia/Iran. Indeed, some shared cultural and social values among Armenian Christians and Iranian Muslims go back many centuries.[34] Today the Armenian population is concentrated in Tehran, Tabriz, and Isfahan. Armenians have their own two representatives in the Iranian Parliament, in accordance with the Iranian Constitution.[35] Respecting different religious and cultural values is highly regarded in the Iranian bioethics field. Sanjari et al.[7] declared that "Iranian nationality encompasses a variety of ethnicities whose cultures and beliefs must be taken into consideration" (p. 25). This is also emphasized in the National Nursing Codes of Iran, whereby nurses must recognize and respect cultural sensitivity in every encounter with the patients.[36]

Methods

This study was conducted using a qualitative approach, the aim of which was to explore and understand the common ground of dignified care in the two different cultural and religious perspectives. The findings described in this article were part of the broader study, entitled "Iranian patients' lived-experiences of dignity maintenance."

Participants

In this study, 10 participants were recruited by purposive sampling from medical and surgical wards of two governmental and two private hospitals in Tehran. Given the significance of the data richness in the qualitative studies,[37] in some cases there was a need to conduct a follow-up interview to gain deep information about the participants' perspectives on dignified care; accordingly, in total, 16 interview sessions were carried out in this study. The inclusion criteria for participation in the study were age over 18 years, being Muslim or Christian, at least 48 h hospitalization experience, the ability to speak Persian, absence of signs of delirium or dementia that might interfere with informed consent, the need for being familiar with this topic, as well as willingness to attend an interview and to explain their experiences and perspectives. The 10 participants included five Iranian Muslims and five Iranian Christians, seven women and three men aged between 30 and 64 years old, with the length of hospital stay between 2 and 30 days.

Data collection

The participants' experiences of their dignity preservation were elicited using individual in-depth semi-structured interviews with probing questions. They were asked to respond to questions such as: "What is the meaning of dignified care for you?" "What do you understand by the term preserving patients' dignity?" "What is your own experience of receiving dignified care?" "Can you describe a situation when you came across a violation of patients' dignity?" The digitally recorded interviews lasted on average 45 min and were conducted by the second author (A.M.) at the participants' preferred location, such as a hospital ward or other places such as the participant's home or workplace. The data collection took place between May and August 2012.

Data analysis

Inductive conventional content analysis was used as data were concurrently collected and analyzed. Qualitative content analysis aims to classify the collected information into a valid number of categories, while representing similar meanings. Indeed, during the inductive content analysis process, researchers immerse themselves in the raw data, whereby coding categories and related themes are derived.[37] In this regard, the researchers took three steps including open coding, creating categories, and abstraction.[38] At the first, A.M. read the transcribed text of each interview to obtain a general idea of the interview content; the extracted codes were written in the text while reading it; transcripts of Muslims and Armenians were coded separately; similar codes between both groups were identified; after the open coding step and comparison between extracted codes, they were classified into their belonging subcategories or subthemes. At the end of this process, the created subcategories were collapsed into higher order categories and the research team members came to a common interpretation at the abstraction process through which the main categories or main themes of this study were concluded.

The rigor of the findings was conducted on Lincoln and Guba's gold standards: credibility, dependability, confirmability, and transferability. The credibility of the findings was established by prolonged contact with participants, asking complementary questions to resolve any ambiguity and deep involvement with and immersion in the data. Also, including both Christian and Muslim researchers in this study and the dialogue among them was another approach to gain credibility of the researchers. The researchers illustrated the study's dependability by showing how decisions were arrived at about data collection and analysis process. In addition, by recording the activities and steps in data analysis and by illustrating the processes which led to conclusions, and also by presenting some evidences and examples, they provide the opportunity for the readers to be able to confirm the findings. Choosing the participants from various age ranges, sexes, religions, cultures, length of stay in hospital, as well as participants with different medical problems from both governmental and nongovernmental settings helped to satisfy the data transferability.[39–41]

Ethical consideration

This article is based on the results of an approved study titled ''Iranian patients' lived-experiences of dignity maintenance'' and was approved by Tehran University of Medical Sciences ethics committee (ethics approval number 90/130/2691). Written information about the purpose of the study was given to all participants and written consent was obtained. All participants were provided with information about the voluntary condition of their participation in the study and about the anonymous reporting of recorded interviews.

Findings

The common experiences of Christian and Muslim patients regarding dignity preservation emerged as two main themes: ''exigency of respecting human nobility'' and ''providing person-centered care.'' From the participants' perspectives, the exigency of upholding patients' dignity is rooted in their sublime nature as human beings. In this regard, ''respecting human rationality,'' ''respecting human equality,'' ''having benevolent attitude,'' and ''being with the patient'' were identified as the subthemes. The second theme, ''providing person-centered care,'' derived from two subthemes: the participants emphasized on the necessity of ''respecting cultural and religious values'' and ''considering personal preferences.''

Exigency of respecting human nobility

Most of the participants indicated that being treated like an object compromises the patient's dignity. Participants emphasized the value of the human body and its spiritual value and cited related verses and narratives of their sacred Scriptures. Because of the sublime value of the human body, they expected to be treated not as an object but as a human being who possesses unconditional value. They placed much importance on the need for nurses to keep in mind that the patient is a human being, considered as *khalif allah* (a successor of God in the world), who deserves dignified and respectful behavior. A Muslim man said,

> A patient expects respect regarding his rational and spiritual essence ... undoubtedly I am not an inanimate object like a bed, a blanket or a desk ... Islam emphasizes that the human body is animated by a spiritual and divine soul; therefore every human being should respect others' dignity as a religious duty.

Regarding the "respecting human rationality" subtheme, participants expressed that respecting their attitudes and being involved in the issues of concern to them led them to feel valued and not ignored. Most of them mentioned that preparing patients' educational needs and informing them regarding their conditions is part of the provision of dignified care. According to a Muslim woman,

> It really bothered me that they didn't recognize the importance of providing detailed information about my surgery and its consequences ... Sometimes they forget that the patient is a reasonable person.

A young Christian woman said,

> Dignity to me is to be taken into account ... I need to be talked to, I need to be informed about what is being done to me ... it is so dehumanizing to be addressed by a bed number instead of my own name ...

Similarly, a Young Muslim man added,

> Some of them were so polite and were introducing themselves when entering the room ... mostly I welcomed them with warm greetings ... I think manners reflect that you are being recognized as someone who deserves respect ...

The sublime essence of a human being raises the necessity of acting toward one another in a spirit of brotherhood and sisterhood; it is related to people's equality by sharing the same humanity. The participants appreciated the healthcare staff's high regard for the whole person and described that treating patients as equals regardless of their gender, position, race, and religion led to ensuring that they are valued as human beings. Indeed, "respecting human equality" subtheme was highlighted in most participants' statements. A Muslim woman expressed her feelings as follows:

> When you perceive to be neglected or when someone treats you badly or with a frown on the face, spontaneously you ask yourself "Am I less valued than others"? I think equal attention, affection and favor should be shown to all patients; this is what I call dignity preservation.

Also, a Christian woman stated,

> I think maintenance of patient dignity means respecting his or her humanity. There was no difference for doctors or nurses if I am a Christian or Muslim patient; they were treating all equally as a person.

Regarding the "having benevolent attitude" subtheme, participants indicated that the concept of "equality" is somehow associated with the concept "benevolence." They stated that nurses and other healthcare

professionals should treat patients as they would want themselves or their family members to be treated. Keeping this in mind would be helpful in treating all patients equally and recognizing that they have equal rights to access professional and dignified care. This statement was made repeatedly:

> While someone in the family is sick, we try to do everything for her or him to feel better . . . we even want every small and fiddling thing, such as giving a glass of water . . . to be helpful. I think healthcare professionals should possess the same perspective regarding patients.

"Being with the patient" is concerned with recognizing and paying attention to the patient's holistic needs and making an effort in meeting them unconditionally. The patients felt more dignified if the nurses made them to feel listened to, understood, supported, and showed eagerness to be with them. According to their experiences, this can be achieved if healthcare staff provide opportunities for patients to express their own feelings, opinions, and expectations without any apprehension. They stressed the need for empathic behavior and pointed out that nurses' reluctance and apathetic behavior compromised their own dignity as the patients expected the nurses to express their real emotions instead of pretending to empathize:

> The nurse was so considerate. Her kindness and empathic listening was appreciated; she constantly asked me about my condition and encouraged me to tell her any problem I had; her manner reflected that my every little problem is important for her.

The most repeated code in this regard was "emotional support," referring to staff taking psychological and spiritual care into consideration to keep patients confident and relaxed:

> After my orthopedic surgery, the staff came and just by saying a few words, a kind smile and a confidential look assured me that I am able to walk without help . . . their sincere behavior and mutual understanding fulfilled all my expectations.

As we believe that patients are first and foremost persons and members of human society, taking this perspective toward patients as being rooted on their personhood can provide all the means necessary for dignified care. Indeed, considering them as intellectual and emotional beings requires giving them opportunities to express their feelings, needs, and requests and be involved in decision making. By upholding the points made, such as referring to them by name, welcoming them warmly, and being polite, we can maintain their dignity and not reduce their value to the level of things or objects.

Providing person-centered care

Both the Christian and Muslim patients pointed out that providing dignified care means being aware and sensitive to patients' values, beliefs, customs, expectations, preferences, habits, and also lifestyle. Most of the participants stated that considering patients' cultural and religious values and related caring preferences impact on patients' dignity conservation. Indeed, each patient has an individual and unique value system that should be regarded respectfully. They noted that dignified care requires providing situations and facilities that are compatible with their value systems and also personal preferences. In this regard, two subthemes extracted were "respecting cultural and religious values" and "considering personal preferences."

Most of the Christian patients stated that being treated in a respectful manner by healthcare professionals regarding their cultural and religious customs was very important to them to feel valued as individuals:

> It was so important for me to keep the holy cross underneath my pillow and the staff were very considerate in this regard.

> I was hospitalized during the Great Fast [Lent] period . . . I asked my doctor to let me continue my abstinence . . . According to Great Fast tenets it is prohibited to eat meat and only to have plant-based foods . . . I was very pleased to see all the medical team eagerly trying to help me to adhere to my traditions and given such attention to my opinions.

They also mentioned that being interested in their cultural customs or language or even asking the meaning of their name made them feel respected. Indeed, it is important to demonstrate some interest in the customs, traditions, topics, and values related to patients:

> The nurses were eager to make friendly relationship by asking different questions about the Armenian culture or language, like what's the meaning of your name; or how do I greet you in the Armenian language?

Similarly, Muslim participants cited the importance of respecting the religious and personal values of patients. Most of them were satisfied with the respectful and considerate manner shown by staff. The significant role of the religious views on dignity preservation was also reflected by Iranian Muslims. As human dignity is the foundation of a religious perspective, respecting one's own dignity requires one to honor and adhere to one's own religious rituals, such as prayer and unique traditions:

> One of the staff tried to give me confidence by resorting to my beliefs in sharing his deep-rooted opinions with me . . . He encouraged me by saying "if you say 'Besmelah' [in the name of God] before taking your first step, God will help you to overcome." It was so difficult for me to put on the surgical cap, as according to my religious values and principles I should put on something to covers my neck totally. . . . I would have preferred to have someone who could really understand me and offer me a more compatible option.

The participants explained that human dignity is strengthened when there is acknowledgment by healthcare professionals that the individual's preferences and priorities are taken into account. They also described how the acknowledgment of their "personal preferences" led to more satisfaction with their care and affected their sense of dignity preservation and maintenance of personal identity. Upholding both perspectives, being sensitive to the patients' personal habits, and acknowledging different aspects of their lifestyle meant that the patients' individuality is of value and worth. A Muslim man described his expectations and preferences as follows:

> On the first day I asked nurses to knock on the door before entering my room. I consider this as a basis of not intruding into one's privacy and personal identity. I do the same at home and in my office.

A Christian woman said,

> They really respected my bathing habits . . . I felt comfortable and experienced a nice inner peace.

Dignity maintenance means different things to different people. It seems that expanding our understanding of diversity will help shape dignified care for patients. Recognizing their values and preferences without biased judgment and responding appropriately to the patients in the clinical encounter is an essential aspect of cross-cultural nursing care.

Discussion

According to this study's findings, some common experiences regarding dignified care were evident between Muslim and Christian patients, categorized into the two main themes of "exigency of respecting human nobility" and "providing person-centered care." In line with other studies,[12,24,31,42–45] the exigency

of being seen as a valued person rather than an object and being treated as an equal was highlighted by participants of this study. The notion is based on human personhood, which is rooted in human spiritually and because of this spiritual dimension the human person should not be reduced to the level of objects or animals.[46] As noted before, according to Monotheistic religions, the contributions such as equal inner worth transcend position of humanity and shared humanity of the people, described as the objective aspect of human dignity, and are grounded in and came from a divine source, which require significant consideration and obligation.[1–3] Mawlana Jalāl ad-Dīn Muhammad Rūmī (604–672 A.H.), perhaps the most famous Persian Muslim poets, paid special attention to the dignity inner values and nobility of human beings in his poem *Mathnavi*. He believed that man's status of being prostrated to is because of the knowledge he had gained from the Divine Attributes.[47] It is worthy to mention some part of his famous poem in this regard:

Each breath is a song of love

From left and right, pass us by

We'll return to the world above

Such fate no-one can defy.

We have come from the skies

Befriended angels in heaven

To the same place we will rise

To that city past skies seven.

We are above the skies

And angels we transcend ...

(www.rumionfire.com/shams/rumi044.htm)

Indeed, the poem implies that absolute dignity of human makes him unique among all creatures. Also, it should be considered that the human beings have the capacity to acquire a new level of dignity which corresponds to the actualization of the conscious life and the development of unique capacities of the individual person. This issue could be discussed in the light of human becoming school of thought in nursing, where becoming is considered as unitary human's emerging. Watson reminds the nurses that the nursing profession provides an opportunity to consider and reflect on what resides deep within themselves and also within their patients as a human being and calls them to discover new ways of knowing, being, becoming, and doing through their shared humanity, which led to a deeper connection with the patient as a fellow human being[48,49]

The objective and subjective nature of human dignity discussed in this study are also highlighted in other similar articles.[5,6,23,50,51] The objective aspect of dignity is expressed as common humanity and equal rights [6,50–52] and has also been described as the "common membership of the human species"[5] and the "generalized other."[51] The subjective aspect of dignity implies diverse characteristics, perspectives, and values that lead to differentiations. This subjectivity contributes to people's constituted world and meanings arise from their interactions,[53] in providing respectful and culture-sensitive care.[54,55]

In this regard, it should be kept in mind that the recipient of care is considered a whole person and a specific individual with contextually constituted needs, preferences, particular cultural and religious beliefs, and a unique way of living in this world.[9,56] Cultural and religious values affect personal beliefs relating to human dignity and consequently shape the meaning of dignified care for the recipient of care.[15,20,27] Tirgari et al.[26]

argued that there is a consensus in the literature about the relationship between patients' dignity preservation and their spirituality. Recognizing patients' spirituality means meeting patients as relational, cultural, and religious beings, which makes them experience a sense of inner peace, emotional well-being, and simultaneously feel to be a valued person. In other words, the personality of a patient corresponds to his or her spirituality,[46] which is an inherent human quality influenced by cultural and social contexts.[25]

This existing evidence points to the fact that although all patients possess equal worth, they are unique and fundamentally different from each other. Therefore, it is assumed that the cornerstone of cross-cultural nursing is to treat every patient uniquely and with respect and never to reduce a person to an object.[57] According to the Royal College of Nursing, "Valuing diversity is about recognizing rather than judging the different qualities people have and dignified care is not possible without that recognition: recognizing and respecting the right of others to be different from you."[58] In this regard, this study showed that providing dignified care for culturally different patients requires recognizing their unique needs, which may be influenced by specific religious values, beliefs, costumes, and practices. Furthermore, as noted above, it should be considered that culture is defined as a set of symbolic meanings shared among peoples, including religious ones that constitute the whole way of life for them.[59]

Patients' dignity has been intertwined with the concept of caring and acknowledged by our caring capacity. Caring is a moral attitude and is a characteristic of humans by acknowledging another person's self-determined ends as one's own to maintain or promote them.[56,60] If a nurse is more prepared to consider and interpret the patient's own point of view, needs, and ends, he or she will be more able to actualize patient dignity promotion. Indeed, by its nature caring creates possibilities to immerse oneself in the patients' world and discover their essence.[56,61] The main goal of caring—incorporating dignity into nursing practice—will be achieved when the nurses are present physically, emotionally, and energetically with the patient, which conveys their willingness to hear, know, appreciate, and attend to the true nature of the patient.[62] We believe that "being with the patient" serves as a ground for respecting "patients' absolute dignity" and also their "dignity of identity," where their differences should be taken into account. Råholm and Lindholm[63] believe that "being there" and confirming patients' absolute dignity and compassion requires an inner disposition to go with others to the places where they are weak, vulnerable, lonely, and broken. As caring is a human-to-human relationship, it cannot remain an authentic caring relationship with patients without compassion,[64] emotional involvement, and listening to one's own feelings, experiences, and reactions.[18] This is also emphasized in other studies where establishing effective communication patterns, devoting enough time in interactions, listening to patients, giving psychological support, encouraging, giving choice, and controlling and sharing information with patients are considered as prerequisites for eliciting and integrating diverse patients' needs, preferences, and expectations.[13,16,31,42–45]

Indeed, the caring process requires considering the patient as a whole person and the products of a specific culture.[9,56] Wainwright and Gallagher[24] stressed that it is essential for nurses to pay more attention to what it means for patients to be respected and provided appropriate culturally sensitive care. This refers to "providing person-centered care," where different features of a person's life contributing to diverse backgrounds are acknowledged.[58] According to Carrillo et al.,[65] person-centered care is derived from research in cross-cultural care. Dignity-enhancing cross-cultural care implies that the patient receives optimal support on the physical, psychological, relational, historical, social, and spiritual level and preserves his or her own identity.[57]

Based on related literature, it is evident that there is a lack of understanding about some aspects of ethical issues in cross-cultural care, especially in non-Western cultural contexts.[57,66] Although we found no studies regarding dignity preservation from different patient perspectives in any cross-cultural setting, some studies cited shared meaning of dignified care based on nurses' interpretations. Coenen et al.[67] describe findings of nursing interventions of dignified dying in four culturally different countries: Ethiopia, Kenya, India, and the United States; some common themes emerged.

The common aspects of patients' dignity preservation presented in this study might therefore be regarded as a means of bringing together different ethical values in diverse cultural settings, given that the shared meaning of dignified care from two different cultural and religious perspectives (Armenian Christians as a minority ethnic group and Iranian Muslims as the majority population of Iran) is described. Aramesh[20] asserted that more international dialogues based on different perspectives of human dignity are needed to go beyond diversities. This could be a starting point for valuing and managing diversities[54] as it is inconceivable to respect diversities without articulating, understanding, interpreting, and making sense of them.

Preserving and respecting patients' human dignity is not only about keeping to national and international codes of ethics; it is necessary to discover the authentic meaning of human dignity preservation from different perspectives to apply it in nursing practice in diverse settings. Therefore, nurses should learn to focus on patients' interpretations of fundamental issues such as human dignity. According to Carrillo et al.,[65] two main components of cross-cultural care are awareness of differences and effective use of interpretations. The core of the global duty of cross-cultural caring is achieved through recognition of patients' perspectives, interpretations, values, and priorities, and respecting differences while trying to promote unity in spite of diversity.

Considering Kant's notion that dignity has an elevated position among values and is raised above other things,[1] and citing the religious doctrine that human dignity has a divine origin, we believe that the centrality of human dignity makes it possible to actualize the main purpose of cross-cultural nursing: to integrate the main values and beliefs of different cultures.[57]

Conclusion

The findings of this study support and expand the current understanding of the objective and subjective nature of dignity preservation in cross-cultural nursing. The findings revealed that dignity preservation implies "exigency of respecting human nobility" (as the objective nature of dignity) and "providing person-centered care" (as the subjective nature of dignity) based on two different cultural and religious perspectives. It seems necessary to understand human dignity as the common ground of the human universal community. This makes it possible to recognize, understand, interpret, and respect different ethical values and at the same time to unify and integrate different cultural values in a diverse context.

Given that human dignity is a common notion in all contexts and is also a fundamental value in nursing, the findings of this study may enhance cross-cultural nursing knowledge worldwide. Indeed, this study showed that actualization of patients' dignity preservation in nursing practice requires considering both universal and specific attitudes regarding human dignity. According to this study's findings, some aspects of human dignity such as respecting human rationality, equality, and so on, imply shared meaning worldwide, while other meanings of human dignity may be affected from cultural and religious values and beliefs. Therefore, each patient's cultural and religious safety should be examined in nursing delivery systems. To actualize human dignity preservation in nursing practice, it is essential to assess, implement, and evaluate each patient's unique set of values, beliefs, and practices throughout the nursing process. Also, according to this study's findings, we emphasized that nurses' cultural competency is a priority of providing dignified care for the populations they serve. Consequently, nurses are expected to have specific knowledge, skill, and sensitivity to assess and implement culturally congruent care for an increasingly diverse patient population.

As there is a dearth of literatures regarding this topic, especially in the Eastern countries, further research is needed to be carried out in different cultural contexts in order to address the gap of knowledge in this regard. Indeed, the findings of this and similar studies could be used in nursing to uncover the shared meaning of basic and substantial ethical issues from different patient perspectives and incorporating these understandings into reflective nursing care, going beyond diversities and enhancing nursing professional integrity. An enhanced and enriched understanding of human dignity based on a cross-cultural perspective provides nurse administrators and educators of different contexts with an efficient mean for an alternative

and different look at the authentic meaning of dignified care to address strategies of delivering more dignified and holistic care worldwide.

Conflict of interest

The authors declare that there is no conflict of interest.

Funding

This research received funding from Tehran University of Medical Sciences, International Campus.

References

1. Sensen O. *Kant on human dignity*. Berlin: Walter de Gruyter, 2011, p. 148.
2. The Noble Quran. 15:29, pp. 17–70, http://quran.com.
3. Holy Bible. *Genesis 1: 26-28, Genesis 2: 7* (New International Version). London: Hodder and Stoughton, 1982.
4. Aavani G. A question and answer session on the meaning of being human, with Dr. Gholamreza Aavani. *Sophia Perennis* 2009; 6: 5–21.
5. Gallagher A. Dignity and respect for dignity — two key health professional values: implications for nursing practice. *Nurs Ethics* 2004; 11: 587–599.
6. Burns L. What is the scope for the interpretation of dignity in research involving human subjects? *Med Health Care Philos* 2008; 11: 191–208.
7. Sanjari M, Zahedi F, Aaelae M, et al Code of ethics for Iranian nurses. *Iran J Med Ethics Hist Med* 2012; 5: 17–28.
8. Nursing and Midwifery Council. The code: standards of conduct, performance and ethics for nurses and midwives, http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/ (2008, accessed 6 July 2013).
9. American Nurses Association. Code of ethics for nurses with interpretive statements, http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf2001 (2001, accessed 1 June 2013).
10. Milton CL. The ethics of human dignity: a nursing theoretical perspective. *Nurs Sci Q* 2008; 21: 207–210.
11. Jo KH, An GJ and Doorenbos AZ. Attitudes of Korean adults towards human dignity: a Q methodology approach. *Jpn J Nurs Sci* 2012; 9: 101–111.
12. Haddock J. Towards further clarification of the concept dignity. *J Adv Nurs* 1996; 24: 924–931.
13. Baillie L and Gallagher A. Respecting dignity in care in diverse care settings: strategies of UK nurses. *Int J Nurs Pract* 2011; 17: 336–341.
14. Matiti MR and Baillie L. *Dignity in healthcare: a practical approach for nurses and midwives*. Abingdon: Radcliffe Publishing Ltd, 2011, p. 70.
15. Rykkje LL, Eriksson K and Råholm MB. Spirituality and caring in old age and the significance of religion—a hermeneutical study from Norway. *Scand J Caring Sci* 2013; 27: 275–284.
16. Manookian A, Cheraghi MA and Nasrabadi AN. Factors influencing Iranian patients' dignity: a qualitative study. *Nurs Ethics*. Epub ahead of print 21 October 2013. DOI: 10.1177/0969733013498526.
17. Katz A. Cultural diversity: caregiving in cultural. *J Prof Nurs* 2005; 21: 139–140.
18. Hanssen I and Alpers LM. Utilitarian and common-sense morality discussions in intercultural nursing practice. *Nurs Ethics* 2010; 17: 201–211.
19. Lipson J and Dibble SL. *Culture & clinical care*. San Francisco, CA: UCSF Nursing Press, 2005, p. xiv.
20. Aramesh K. Cultural diversity and bioethics. *Iran J Public Health* (A supplementary issue on Bioethics) 2008; 37: 28–30.
21. Sacks J. *The dignity of difference: how to avoid the clash of civilizations*. London: Continuum, 2002, p. 46.
22. Hollins S. *Religions, culture and healthcare: a practical handbook for use in healthcare environments*. 2nd ed. Oxford: Radcliffe Publishing Ltd, 2009, p. 2.
23. Nordenfelt L. *Dignity in care of older people*. Chichester: Wiley-Blackwell, 2009, p. xii.

24. Wainwright P and Gallagher A. On different types of dignity in nursing care: a critique of Nordenfelt. *Nurs Philos* 2008; 9: 46–54.
25. Delgado C. A discussion of the concept of spirituality. *Nurs Sci Q* 2005; 18: 157–162.
26. Tirgari B, Iranmanesh S and Cheraghi MA. Meaning of spiritual care: Iranian nurses' experiences. *Holist Nurs Pract* 2013; 27: 199–206.
27. Rooda L and Gay G. Staff development for culturally sensitive nursing care. *J Nurs Staff Dev* 1993; 9: 262–265.
28. Nursing Diagnosis for Nurses and BSN students. Nursing diagnosis—risk for compromised human dignity, http://nandanursingdiagnosis.org/nursing-diagnosis-risk-compromised-human-dignity (2012, accessed 4 January 2013).
29. Holland K and Hogg C. *Cultural awareness in nursing and health care: an introductory text*. 2nd ed. Boca Raton, FL: CRC Press, 2010, pp. 60–95.
30. Johnson DH. *The meaning of life in the 21st century: tensions among science, religion and experience*. Bloomington, IN: iUniverse, 2008, p. 35.
31. Buckley S. *Patient dignity: the significance of relationship*. Open access Dissertations and Theses, McMaster University, Hamilton, ON, Canada, Paper 7412, http://digitalcommons.mcmaster.ca/opendissertations/7412 (2012, accessed 11 June 2013).
32. Implementation of the 2011 Iranian Population and Housing Census in autumn, http://www.amar.org.ir/Default.aspx?tabid=765 (2011, accessed 22 June 2013).
33. Cheraghi MA, Payne SH and Salsali M. Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran. *Int J Palliat Nurs* 2005; 11: 468–474.
34. Dadoyan SB. *The Armenians in the Medieval Islamic world: paradigms of interaction seventh to fourteenth centuries*. New Brunswick, NJ: Transaction Publishers, 2011, p. 1.
35. Islamic Parliament of Iran, http://www.parliran.ir (accessed 22 June 2013).
36. Zahedi F, Emami Razavi SH and Larijani B. A two-decade review of medical ethics in Iran. *Iran J Public Health* 2009; 38: 40–46.
37. Krippendorff K. *Content analysis: an introduction to its methodology*. 2nd ed. Newbury Park, CA: Sage, 2004, p. 10.
38. Hsieh HF and Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res* 2005; 15: 1277–1288.
39. Holloway I and Wheeler S. *Qualitative research in nursing and healthcare*. 3rd ed. Ames, IA: Wiley-Blackwell, 2010.
40. Streubert HJ and Carpenter DR. *Qualitative research in nursing: advancing the humanistic imperative*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2011.
41. Hays DG and Singh AA. *Qualitative inquiry in clinical and educational settings*. New York: Guilford Press, 2012.
42. Walsh K and Kowanko I. Nurses' and patients' perceptions of dignity. *Int J Nurs Pract* 2002; 8: 143–151.
43. Matiti MR and Trorey GM. Patients' expectations of the maintenance of their dignity. *J Clin Nurs* 2008; 17: 2709–2717.
44. Bagheri H, Yaghmaei F, Ashktorab T, et al. Patient dignity and its related factors in heart failure patients. *Nurs Ethics* 2012; 19: 316–327.
45. Lin YP, Tsai YF and Chen HF. Dignity in care in the hospital setting from patients' perspectives in Taiwan: a descriptive qualitative study. *J Clin Nurs* 2011; 20: 794–801.
46. Aguas JJS. The notions of the human person and human dignity in Aquinas and Wojtyla, http://www.kritike.org/journal/issue_5/aguas_june2009.pdf (2009, accessed 12 June 2013).
47. Asatourian F and Ale Osfour MA. Dignity of man in Mathnavi. *J Soc Sci Humani Shiraz Univ* 2007; 26: 27–42.
48. Watson J and Smith MC. Caring science and the science of unitary human beings: a trans-theoretical discourse for nursing knowledge development. *J Adv Nurs* 2002; 37: 452–461.
49. Watson J.Love and caring. Ethics of face and hand—an invitation to return to the heart and soul of nursing and our deep humanity. *Nurs Adm Q* 2003; 27: 197–202.

50. Pols J. Washing the patient: dignity and aesthetic values in nursing care. *Nurs Philos* 2013; 14: 186–200.
51. Mok YS. Respect-based toleration. *Nurs Philos* 2005; 6: 274–277.
52. Lazenby M. On the humanities of nursing. *Nurs Outlook* 2013; 61: 9–14.
53. Nairn S. Social structure and nursing research. *Nurs Philos* 2009; 10: 191–202.
54. Walsh S. Formulation of a plan of care for culturally diverse patients. *Int J Nurs Terminol Classif* 2004; 15: 17–26.
55. Poss JE. Providing culturally competent care: is there a role for health promoters? *Nurs Outlook* 1999; 47: 30–36.
56. Miller SC. *The ethics of need: agency, dignity and obligation*. New York: Routledge, 2012, pp. 77–96.
57. Denier Y and Gastmans C. Realizing good care within a context of cross-cultural diversity: an ethical guideline for healthcare organizations in Flanders, Belgium. *Soc Sci Med* 2013; 93: 38–46.
58. Royal College of Nursing. Dignified differences, http://www.rcn.org.uk/development/practice/cpd_online_learning/dignity_in_health_care/dignified_differences (2013, accessed 18 June 2013).
59. Hulsether M. Religion and culture. In: Hinnells JR (ed.) *The Routledge companion to the study of religion*. New York: Routledge, 2005, p. 491.
60. Gastmans C. Care as a moral attitude in nursing. *Nurs Ethics* 1999; 6: 214–223.
61. Benner PE. *Interpretive phenomenology: embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: Sage, 1994, p. 18.
62. Delgado C. Meeting clients' spiritual needs. *Nurs Clin North Am* 2007; 42: 279–293.
63. Råholm MB and Lindholm L. Being in the world of the suffering patient: a challenge to nursing ethics. *Nurs Ethics* 1999; 6: 528–539.
64. Watson J. *Human caring science: a theory of nursing*. 2nd ed. Mississauga, ON, Canada: Jones & Bartlett, 2011, p. 43.
65. Carrillo JE, Green AR and Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med* 1999; 130: 829–834.
66. Lee TFD. Privacy and dignity in residential care homes: cross-cultural issues. *Int J Older People Nurs* 2010; 5: 3–4.
67. Coenen A, Doorenbos AZ and Wilson SA. Nursing interventions to promote dignified dying in four countries. *Oncol Nurs Forum* 2007; 34: 1151–1156.