Article

Nursing Ethics
19(3) 328–340

10.1177/0969733011433926
nej.sagepub.com

Nurses' experiences of violation of their dignity

Mojgan Khademi
Tarbiat Modares University, Iran
Eesa Mohammadi
Tarbiat Modares University, Iran
Zohreh Vanaki
Tarbiat Modares University, Iran

Abstract
Dignity is a human right and a base for human health. This right must be observed in work environments as a moral obligation. This qualitative study aimed to understand nurses' experiences of violation of their dignity at work and to explore its dimensions. The participants were 15 nurses working in two hospitals in Tehran. The data were collected through 26 unstructured interviews and analyzed using content analysis. The dimensions of violation were 'irreverence', including experiences of abuse and violence, humiliation, and being ignored; 'coercion and violation of autonomy', consisting of the control of relationships, lack of privacy, rigidness, and imposition; 'ignoring professional and scientific ability', indicating impossibilities in applying nurses' knowledge; and 'denying the value of nurse/care', being the theme that verified the dominance of treatment/cure and lack of recognition of care value. Health systems should take the promotion of the nurses' dignity into account through providing a dignified work environment.

Keywords
Dignity, nursing, qualitative research, violation of dignity, work

Introduction

Dignity is an ideal and a valuable human right.[1] Such a value has always been taken into account by political theory, philosophy, law, and theology,[2,3] being considered as a foundation for health.[4]

The concept of dignity is frequently used in nursing and biomedical texts.[5] Respect for dignity is an axial phenomenon[6] and inextricably linked to nursing.[7] It is a duty and a right in professional codes and human rights framework, and it should be considered as a two-pronged professional value: as another-regarding value and as a self-directed value.[8] Through experiencing respect for his or her dignity, a person gets an

Corresponding author: Eesa Mohammadi, Nursing Department, Medical Sciences Faculty, Tarbiat Modares University, Tehran 14115-331, Iran
Email: mohamade@modares.ac.ir

insight about the patients' needs and behaves respectfully.[6] Therefore, dignity as a nurse's right should be followed in working environment as an ethical necessity.[9,10]

Dignity has different levels including preserved and different levels of loss, and it is always at the risk of being lost.[11–13] It is especially important in work environments. Sayer[12] states that work environment impacts people's lives with dignity and job satisfaction significantly. Its compliance creates feelings of strength and positive self-image, value, and self-confidence.[6] However, people's sense of threat or violation of dignity causes loss of control, being considered less important, deterioration of humanity, and emotional reactions like anger, anxiety, humiliation, and embarrassment.[6,11] These consequences get much more complex for nurses because the whole care system becomes involved. According to Lawless,[10] when nurses' dignity is not observed, they may not respect themselves, and as a result, their ability to respect others will decrease.

Respect for the dignity of others is a familiar professional prescription, having a robust theoretical basis. But dignity as a nurse's right is given less attention.[8] A few theoretical studies have been carried out to investigate the nurses' rights.[14] Evidence shows that the dimensions of the dignity of patients/clients have been clarified.[5,11,15–18] But very few studies have been carried out on the dignity of nurses. Lawless[10] believes that such a gap in knowledge is because of the fact that dignity is a new issue in work environments; it has been taken into account only during the last decade.

In discussions related to dignity in health, its broad areas have been ignored, and merely some components of dignity have been viewed.[2] The current related studies in dignity in work environment focus on bullying and harassment,[19] and in nursing, extensive studies have been carried out about the nature and its effects.[20–22] Although it seems that bullying and harassment are serious indicators of violation of dignity in work environments, it is a widespread issue; thus, this vague concept needs discussion.[12,19]

There has been an agreement on challenges about definitions of this vague, partial, multivalence, and complex concept and related terms.[2,10,11,23] The interpretation of dignity is related to culture, social values, and the context in which it is experienced.[10] So different groups might experience it in different ways.[11,19,23] Among the nurses, values, shared beliefs, and expectations of their professional group affect the construct of dignity and make it necessary to have a clear definition of dignity in nursing field.

Evaluation of the observation of degree of dignity depends on subjective perception of the presence or absence of certain features, which make it a special situation.[10] Thus, violation of dignity is an individual experience, and it is hard to convert it into clear examples, and no single scenario can reflect all the variables that threaten dignity.[23] It is possible to define dignity through recognizing situations in which dignity is violated, or at a risk of being lost.[24] This concept remains vague as long as the criteria that enable us to identify violations of dignity are absent.[25]

The importance of the nurses' dignity and the necessity of providing relevant knowledge in the international arena are clear. In national perspectives, Iranian nurses, despite having academic degree and literacy, are challenging their social status.[26,27] In a survey by authors, the most frequently elicited response to the questions about care was 'How do you ask about quality of care in environments in which our dignity is violated?' This experience was an incentive to study the nurses' experiences of the violation of dignity.

Aim

The objective of this study was to understand the nurses' experiences of violation of their dignity at work and to explore its dimensions.

Methods

A qualitative method with conventional content analysis approach was selected. Because naturalistic paradigm and qualitative methods accept that reality is context based and also accept multirealities, such approaches are useful to study the lesser known areas.[28,29]

Setting and participants

Following Polit and Beck,[29] in order to preserve the natural environment, this study was carried out where the phenomenon occurred. That is, it was carried out in general surgery, oncology, and orthopedics wards and the intensive care unit (ICU) of two university hospitals in Tehran. The participants were selected through purposeful sampling among clinical nurses and nursing managers. General inclusion criteria, according to Holloway and Wheeler,[30] were awareness of the phenomenon under the study, the willingness and ability to communicate experience, and some more specific criteria, including full-time or part-time employment with at least 6 months of experience.

The participants of the study were 14 female and 1 male nurses. The age of the participants varied between 24 and 50 years. The study included 2 head nurses, 10 nurses, 1 staff, and 1 matron. One of the participants was a nurse who had changed her major to biochemistry. They all had rich experiences of violation of dignity. They also had 8 months to 20 years of work experience in various wards such as bone marrow transplantation, pediatric and infants, dialysis, neurology, medical, surgical, and emergency wards.

Data collection

The data of the study were collected through unstructured interviews from July 2009 to August 2010. Having analyzed each interview, in terms of ambiguities and in order to probe into participants' experiences, the interview was repeated to clarify different aspects of the subject, if needed. Totally, 26 face-to-face interviews with 15 participants were conducted. Each interview lasted between 15 to 80 min. The interviews began with general questions, such as 'When do you feel your dignity is violated?' Then it was continued with exploratory questions such as 'Can you give an example to clarify what exactly you felt, so that I can understand your feeling?; ... then what happened?' The interviews were continued to obtain deeper and richer data and stopped when no new information was obtained.

Data analysis

In accordance with the Elo and Kyngäs[31] in the preparation stage, the entire interview, which can be a good field of meaning units, was selected as the most appropriate unit of analysis. In order to deeply understand the data, each interview was reviewed several times. In the organizing stage, open coding was done via rereading the interviews and writing notes and headings on the margins. After several interviews, grouping began. The above process continued for each new interview, new headings were added, and new categories were developed. Through comparing and merging categories, we reduced the number of primary categories. Subcategories with similar incidents and events were grouped as a category (Table 1). After analyzing all the data, four main themes were extracted.

Consideration of rigor

Prolonged engagement in the field from July 2009 to August 2010 helped establish some trust and rapport with participants, providing an opportunity to collect the data. Maximum variation sampling was used based on age, work experience, position, and so on. To make sure that the analysis reveals the participants'

Table 1. Example of analysis process

Meaning unit	Code	Subcategory	Category
A 175-hour working shift and 80 compulsory hour overtime working	Mandatory overtime	Imposition and rigidity	Coercion and violation of the autonomy
I wanted to go out but the head nurse did not allow and called matron . . . (she said) I must stay	Resistance to workplace changes		
They ask us not to be friendly with the crew. They say 'we are nurses and should not talk to them'. We cannot tolerate this. How long can we show off in such an unfriendly environment?	Control of personal relationships	Violation of privacy	
They installed hidden camera. It means that they want to monitor and control us.	Control territory		

experience, member checking was performed during the data collection, wherever needed, some changes were done. To confirm dependability and confirmability of the data, the interviews and results of the analyses, that is, the initial codes and the categories, were audited by some experts.

Ethical considerations

Before data collection, an approval from ethics committee of Tarbiat Modarres University and hospitals was obtained. All the participants were informed about the importance, purposes, and methods of the study and especially interview recording. They were informed that participation in the study was voluntary, so they could refuse to participate or withdraw from the study at any time without being penalized or losing any benefits. Moreover, the participants were reassured about confidentiality and anonymity. Also decision about time and place of the interviews has been made mutually. Finally, they were informed about the researchers' profile and how to achieve the results of the study.

Findings

Experiences of violation of dignity include seven categories and four main themes: irreverence, coercion and violation of autonomy, ignoring scientific and professional abilities, and denying the value of nurse/care (Figure 1).

Irreverence

Irreverence was the most remarkable experience in interactions with nursing managers, physicians, and patients' relatives, which includes a variety of behaviors such as implicit humiliation and physical attacks.

Abuse and violence. Hearing profanity and threats were commonly observed. Death and delay in transfer or care of patients, which were partly out of nurses' control, because of work overload and lack of time, were the main factors that led to insult and aggression. Although announcements about legal penalties for aggressive attack on the treatment team were put on bulletin boards and guards were present, the nurses had experienced physical attacks and the feeling of insecurity. One of the nurses (no. 6) stated:

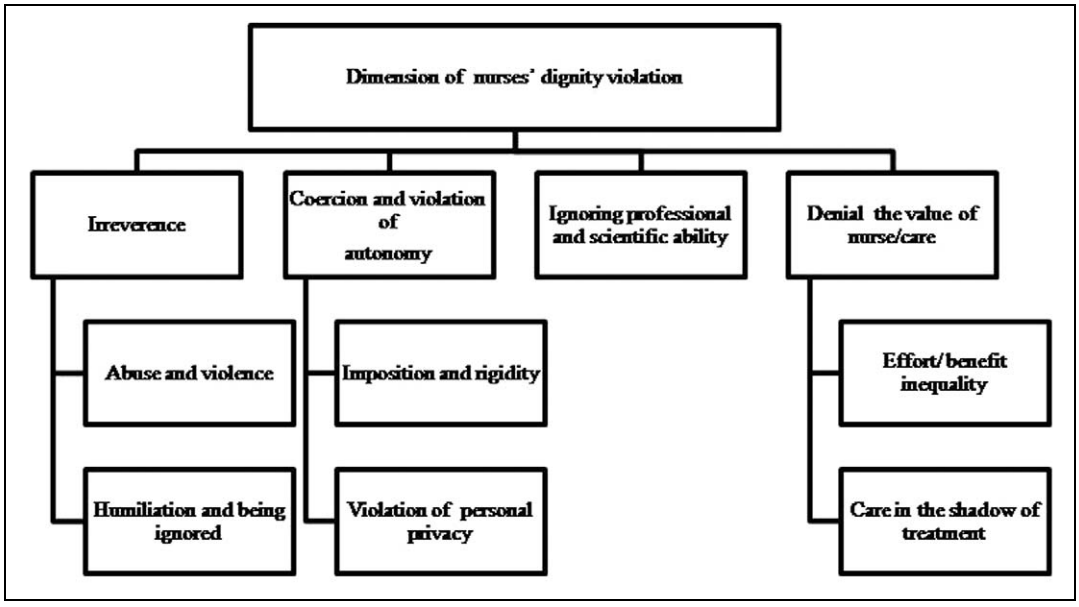

Figure 1. Dimensions of nurses' rights violation

> There was no bed available in the ICU. The patient's relatives said why don't you transfer the sick man. We explained everything to him ... One of our colleagues who was responsible to take care of the patient came to the station. He threw a vase at her ... We do not feel security here,...

Almost all nurses were unaware of the legal centers in charge of supporting them, and they were uncertain about their support. In addition, they considered the patients and their families as needy. That is why, the nurses avoided making legal complaints.

Humiliation and being ignored. The nurses had experienced disrespect by the system and their colleagues frequently and viewed it as very serious. Although the management system tried to provide facilities for the nurses, they did not find such services compatible with their dignity. Moreover, inappropriate qualities of such services led to a humiliating experience for them. The above-mentioned nurse no. 6 said:

> Our health system arranged a camping for us but if you pay attention you will see that it is nothing but a kind of humiliation. Even the place which they hired downgraded our dignity.

The nurses have also been humiliated by dehumanizing communications, instrumental relationships, and communications based on position by managers and physicians. A nurse (no. 14) stated:

> I am just thinking about how to leave this field ... I am an important person but while another person of higher rank comes, I am not important at all and no one pays attention to what I say.

Offensive verbal communications, inattention, and ignoring the nurses and their needs were just some incidents that portended dignity violations. Nurse no. 5 stated:

> While I could not stand up . . . the head nurse said that I am impolite. She said it to me in the presence of other nurses. She said you do not understand and you should stand up . . . while I am talking to her, she does not care and she talks to Mr. X or Mrs. Y. she doesn't consider us as human

The results of irreverence and disrespect are feelings such as insecurity, worthlessness, humiliation, demoralization, and intention to leave the profession. Nurse no. 15 said:

> . . . I was poisoned . . . The supervisor told me not to pretend that I am sick, and avoid such phony shows . . . That was . . . the reason I escaped from nursing.

Coercion and violation of autonomy

Ignoring the nurses' right of decision making and forcing them to coercion constitute a great part of daily experiences of the nurses. These are experienced in the following dimensions:

Violation of personal privacy. Nurses experienced the managers' interference in interpersonal relationships between the employees and their attempts to control informal relationships through legislation. This violated the nurses' privacy and their rights for decision making. Nurse no. 10 said:

> I am told why I talk to the servants and I should not get involved with the physicians . . . I am told not to talk with physicians.

Although managers believed that their main goals were to protect the dignity of the nurses, adverse effects of this approach such as feeling of coercion, lack of the atmosphere of cooperation, and losing motivation have occurred. Violation of dignity also includes controlling the environment and dressing. Nurse no. 6 said:

> A hidden camera is installed here . . . What does it mean? . . . . it means that they want to control me.

Imposition and rigidity. Imposition to work schedule, rigid division of daily work, mandatory overtime, and scheduling regardless of the nurses' experiences and preferences were some of the major experiences of the nurses. Imposition and rigidity not only deprived the nurses of their rights in making decisions and taking control over their lives but also resulted in making them tired, exhausted, energyless with lack of interest, and in difficulties family relations due to long hours of work.

Some experienced nurses have tried to appeal to higher rank managers to make a change, but their attempts were fruitless and led to some negative consequences, and the resistance of the managers resulted in a feeling of lack of autonomy, powerlessness, and inability. Nurse no. 5 stated:

> The head nurse said: I make decision about your program. So you are not allowed to tell the matron. Whether you like it or not you have no other choice. Now you are free to complain to whomever you like.

Less experienced nurses have also experienced lack of right in making decisions and compulsion both explicitly and implicitly through the negative responses, which they received, and threatening and insecure working atmosphere. Nurse no. 10 said:

> You've got no right to complain because they will take revenge on us. They may reprimand us.

The managers' resistances against the nurses' requests for altering their shifts and wards and forcing them to accept the shifts and wards unwillingly are clear instances of violation of dignity. Nurse no. 11 said:

> They suddenly called me ... and they forced me to change my ward ... I was shocked; I had no other choice. This is the decision they made and I have to obey.

Ignoring scientific and professional capabilities

Lack of understanding of nursing as a discipline and the traditional image of nurses as a nonprofessional person were humiliating experiences for nurses. Nurse no. 8 said:

> My friends tell me that simple drug injection is your specialty ... I feel humiliation I am not interested in my work ... When there is something wrong with the patients, their relatives ask us to call the physicians. They say the nurses know nothing about the treatment. They disrespect us. ...

Restrictions and bans on doing some treatment tasks by the nurses and considering some tasks beyond the abilities of the nurses were the main impediments in the application of nursing knowledge. The same nurse said:

> We can do many things but we are allowed to do only dressing and injection. Whatever is downgrading for others is assigned to us.
>
> I am a member of CPR team but feel ashamed of what I do. They think we are servants. They order us to give them gloves. We are not allowed to intubate because residents will complain.

Despite the nursing managers' dissatisfaction with this prevalent process, the nurses view them as responsible for such unpleasant experiences. Novice nurses believe that the constant evaluation means a kind of distrust while ignoring their ability and skills. One of the novice nurses (no. 10) said:

> We're constantly being evaluated, checked, and assessed. I'm suctioning a patient while the staff nurse comes to me and asks why his SPO2 is low. Doesn't it mean that I know nothing after such long hours of working?

Experienced nurses also view lack of participation in decision-making process as ignoring their professional abilities, which finally tempts them to take revenge on the managers and system. Nurse no. 6 stated:

> I know there is something wrong with what they are doing but I don't say anything .The reason is that they do not let me say anything. In a healthy system, it is not important who the head is. Everyone has a right to contribute to the system somehow.

Denial of the value of nurse/care

Lack of acknowledgement of the value of nursing services in professional interactions with managers, with physicians, and in policy making of the health system as well as the unfair consequences were the basic subject in the nurses' professional life, which challenged the dignity of the nurses. Such an experience has two dimensions explained as follows:

Care in the shadow of treatment. Focusing on the value of medical treatment, assigning the responsibility of the patients to the physicians, and ignoring the value and role of nursing care in the process of medical care were induced to nurses via messages and feedbacks received directly or indirectly. Such a perception led to the spread of the perception of being an instrument and a means to an end among the nurses. A head nurse (Nurse no. 12) is typical of this theme:

> You know we are ladders for the others' progress. . . . a patient who did not feel well, came here and got cured. All people say oh it was because of doctor X's efforts. They do not notice our efforts at all.

One source of this experience was physicians who underestimated the value of nursing care due to poor interprofessional relationships with the nurses and ignored their colleagues' roles in the process of care. Consequently, they practice a hierarchical relationship and lack of team work. The nurses' response to such a humiliating relation was a kind of selective cooperation. Nurse no. 6 stated:

> Our relationship is a sort of superior and inferior one. I will not inform the physicians anything about the patients. I only inform them when I think that a patient is going to die because it is not important to them whether I am cooperating with them or not.

Effort/benefit inequality. Effort/benefit inequality was an index of denial of the value of care. The meaning of small wages versus such an important duty of care from nurses' points of views was underestimating the value of nursing by policymakers. This led to the feeling of ignoring the value of nursing, job dissatisfaction, and reduction in work efficiency. Nurse no. 2 stated:

> Early morning we are so busy. Some patients are taken to operation room and some others are discharged. We have to take care of many cases but we are not paid well. We owe banks a lot because we have a lot of long and short term loans. No one cares for these details. Well, it is clear that our work efficiency will decrease.

Such an inequality in interactions with nursing managers was seen in form of lack of encouragement and appreciation for the care taken. This indicates not only denial of the value of care but also ignoring nurses. The participants believed that this may lead to loss of motivation and willingness to work. Nurse no. 5 stated:

> Never ever does a head nurse thank me. She never introduces me for promotion to high level managers, why? We work so hard for hospitals but this is not important for even matrons to thank us.

Discussion

The nurses' experiences revealed dimensions of violation of dignity, including 'irreverence', 'coercion and violation of autonomy', 'ignoring scientific and professional ability', and 'denial the value of care/nurse'. Also, it was revealed that some influential factors include patients and their families, physicians, the structure and principles of the governing system, and particularly the nursing managers. Lawless[10] reported that violation of dignity occurred where the above factors were not in line with the nurses' expectations and beliefs and a nurse did not feel being valued and respected in her interactions.

The commonality in meaning of sources and dimensions of violation of dignity can be due to the nature of nursing and nurses' encounter with patients who have low toleration level. It seems that the hierarchical structure of the discipline, autocratic management, the dominance of medical model, and hierarchical structure in the interactions with medical profession are other factors that lead to commonalities in different studies. The distinguishing feature of the present study is that these subjects were taken into account in other

studies from the organizational point of view not in the point of view of the dignity of nurses as human beings.

'Irreverence' is a dimension of violation of dignity in the present study. Rapid growth of irreverence particularly in hospitals has been reported.[20,22,32,33] World Health Organization defined violence as, 'The intentional use of power which leads to physical and psychological hurt, threatened or actual'.[22] This definition is relatively in the same line with the present study.

According to Yalden and McCormack,[1] respect is an important dimension of dignity. In the present study, verbal irreverence by nursing managers and threats and attacks by patients and their families were obvious as visible dimensions of disrespect. The patients and their families' rudeness and insult, verbal bothering and lack of cooperation by physicians,[10] psychological bothering,[34] horizontal and hidden disrespect by colleagues,[33] and the spread of instrumental relations[1] have been reported in previous studies. In this study, verbal bothering by physicians was not reported but implicit and hidden disrespects such as instrumental and inhuman relations were experienced.

The scope of disrespect in the findings of the present study exceeds the current definitions. Nurses have also viewed inefficiency of the provided services to them as violation of dignity. Such a view is beyond 'awareness', which is emphasized by World Health Organization and adds unaware behaviors to the realm of 'irreverence'.

'Irreverence' experience was followed by feelings of inferiority, insecurity, and readiness to leave and escape from the profession. Other studies also show that the occurrence of 'irreverence' creates similar destructive effects for the victims and the observers. It also has physiological, psychological, and behavioral consequences. So, some organizations have designed guidelines for the prevention or protection of victims.[20–22,32] However, most nurses did not pursue their complaints. In a study, the main reason of this was that they considered profane treatment as a part of their job, and they had no hope to receive responses from managers.[35] In this study, some instances of profane and degrading treatment were so subtle and complex that it was impossible to prosecute them, as reported previously.[33] It is believed that managers are responsible for providing a safe working environment free from violence for nurses.[21]

Others believe that humanistic models such as the balance of power and open dialogue in the management are required.[36] In this study, 'coercion and violation of autonomy', which was the result of interactions among managers and nurses, indicates such a need while Yalden and McCormack[1] state that dignity 'is about self-command, and autonomy'. It exists when a person is making decisions and controlling himself or herself.[4,11] However, in this study, lack of control and freedom in the decision making and choice in various areas such as informal communication and work schedule were experienced. In another study encouragement for open relations with other health team members and resolving conflicts with them were managers' activities to promote the autonomy of nurses.[37] Having the choice of how to communicate with colleagues is one aspect of clinical autonomy.[38] Restriction of informal communications results in reduction of motivation and cooperation among the nurses and the clinical team. According to Morrison,[39] socioaffective variables are very effective in promoting productivity and decreased turnover intentions. According to the theory of structural empowerment, social structures that provide strong interpersonal relationships are empowering.[40]

Mandatory overtime, inflexible schedule, and compulsory assignments were some other factors that violate the right for choice and decision making. According to 'Cash',[38] the right to choose the manner of performance and the patient are two dimensions of clinical autonomy. In a study, the nurses reported that their executives 'sometimes' encouraged them to make decisions independently.[41] But the results of several studies indicate that autocratic management,[34,42] dehumanizing behaviors, and the lack of autonomy[34] are prevalent. The concept of 'illusion of control' has been used to illustrate lack of real control at work.[43] The sense of lack of control is associated with the risk of violence and loss of dignity. People who find the environments nonresponsive will stop taking actions because they find it useless. Such an outlook can lead to learned helplessness.[24]

Self-determination and privacy for more meaningful work have been reported as two aspects of dignity,[1,44] whereas, in this study, lack of privacy while doing the caring was an indicator of violation of autonomy. Self-control as an important feature of nursing was replaced by hidden cameras. Although it has occurred in the past, its destructive effects on the feelings and dignity of the person were easily seen. Attree reported that frustration will occur from discrepancies between the nurses' high level of professional responsibility and low level of autonomy. The application of a new wave management is recommended because it is consistent with Mac Gregor's theory Y and is more humanistic.[43]

Decentralized decision making will affect autonomy.[45] The participants of this study saw the nurses' participation not as a dimension of autonomy but as a way of respecting their professional abilities. Lack of participation was associated with feelings of being marginalized and despondency. This has also been reported in other studies,[43] which can be associated with the nurses' powerlessness, negative consequences for the patients,[45] dissatisfaction and tendency to leave the hospital and country,[46] lack of innovation and change, motivation loss, and discouragement.[47]

Competition over the clinical practices and assigning advanced practices to the physicians were associated with a sense of disrespect, an underestimation of the ability of the nurses, and a feeling of professional knowledge being useless. According to Sadeghi and Dehghan Nayeri,[4] dignity of individuals includes interactions between positions and abilities, and it exists when individuals' abilities are used effectively.[23] Study of the nurses' experiences of transition into new roles and advanced performance showed inter-and intraprofessional competitions restricting confirmation and implementation of these roles.[48] Many problems occur in cooperation between the physician and nurses due to differences in perceptions of the nurses' roles.[49]

It seems that limitations in presentation of capacities play an important role in inducing nonprofessional images of nurses in the minds. In a study, nurses described 'power' as a dimension of dignity and being accepted by people as competent, reliable, and knowledgeable.[1] Power is knowledge and competence while, like the findings of this study, there are some other studies that verify the existence of negative stereotypes to nurses as nonprofessionals.[27,34] This leads to the feeling of frustration, feeling of despair, and an ambiguous sense of social identity and being wrong in the choice of nursing major.[27]

Recognition, appreciation, and acknowledgement of the value of one's role in corporate work are basic needs for a human being and a requirement for personal and professional development.[50] Recognizing the value of the nurses' role is one of the supporting factors[51] and a standard in healthy work environments.[50] The experience of 'denial of the value of nurse/care' and putting care in the shadow of treatment indicates valuation of medical treatment and ignoring the value of nursing care. In the health sociology literature, the dominance of medicine is seen as a structural dimension of the health system.[52]

The first step for good cooperation is to understand and respect the roles of others,[49] whereas the concept of 'denial of the value of nurse/care' indicates that nurses have not found a valuable image of self in the eyes of others. They had considered 'themselves' equal to their 'job'; thus, they consider denying the value of nursing care as denying the value of the nurse and her or his role. The findings of a study also verified that there is a significant relationship between the dignity and the nurses' perception of the value and meaning of their job.[10]

The behavior of head nurses was one of the most important sources of denial of the value of nurse/care and the experience of inequality of attempt/benefit. According to Blegen et al.,[53] the most meaningful recognition that head nurses can provide is salary increases, commensurate with performance levels; private verbal feedback; and written acknowledgment. Several studies indicate the nurses' dissatisfaction with lack of significant recognition[50,51] and inadequate financial resources and salary.[26,46,52] According to the theory of 'person–environment fit', understanding the existence of fit between the needs of employees, such as adequate recognition and salary, and responses received from the environment improve favorable work behaviors.[54]

Conclusion

The violation of nurses' dignity has vast dimensions and influences their professional life. Therefore, it is necessary to provide them with healthy and humanistic work environments, which will certainly promote their dignity. Such a necessity is justified not only due to devastating effects of violation of dignity on health systems and productivity but also due to the fact that nurses are human beings, and it is their right to have a healthy life.

Limitations and strengths

In qualitative research, the emerged patterns and constructs are dependent on the context. This influences the applicability of the findings. However, sampling with the maximum variance from different wards is one of the strengths of this study, increasing its applicability. Moreover, the review of the literature supports these findings and reveals transferability of the findings.

Implications for nursing

This research contributes to improvement of knowledge about nurses' dignity; in addition, it contributes to the integration of the existing literature. Development of a context-based instrument will help quantitative studies on dimensions and severity of the violation of nurses' dignity. This study provides policymakers, nursing managers, and researchers with a new insight to contemplate about management and leadership in nursing. It is useful for policy making and education of nursing managers. Also, this study guides managers to provide a dignifying work environment.

Acknowledgements

We appreciate the contribution of the university, research field, and participants.

Funding

This article is from the thesis sponsored by School of Medical Sciences, Tarbiat Modarres University.

Conflict of interest

The authors declare that there is no conflict of interest.

References

1. Yalden JB and McCormack B. Constructions of dignity: a pre-requisite for flourishing in the workplace? *Int J Older People Nurs* 2010; 5: 137–147.
2. Jacobson N. Dignity and health: a review. *Soc Sci Med* 2007; 64: 292–302.
3. Heijkenskjöld KB, Ekstedt M and Lindwall L. The patient's dignity from the nurse's perspective. *Nurs Ethics* 2010; 17: 313–324.
4. Sadeghi T and Dehghan Nayeri N. Patients dignity: review of literature. *J Med Ethics Hist Med* 2009; 3: 9–19.
5. Milton CL. The ethics of human dignity: a nursing theoretical perspective. *Nurs Sci Q* 2008; 21: 207–210.
6. Griffin-Heslin VL. An analysis of the concept of dignity. *Accid Emerg Nurs* 2005; 13: 251–257.
7. International Council of Nurses. *The ICN code of ethics for Nurses*. Switzerland: International Council of Nurses, 2006.
8. Gallagher A. Dignity and respect for dignity—two key health professional values: implications for nursing practice. *Nurs Ethics* 2004; 11: 587–599.
9. Haddock J. Towards further clarification of the concept 'dignity'. *J Adv Nurs* 1996; 24: 924–931.

10. Lawless J. *Dignity in the work lives of clinical nurses*. Dissertation, Victoria University, Wellington, New Zealand, 2009.
11. Clark J. Defining the concept of dignity and developing a model to promote its use in practice. *Nurs Times* 2010; 106: 16.
12. Sayer A. Dignity at work: broadening the agenda. *Organization* 2007; 14: 565–581.
13. Seedhouse D and Gallagher A. Undignifying institutions. *J Med Ethics* 2002; 28: 368–372.
14. Kangasniemi M, Viitalähde K and Porkka S. A theoretical examination of the rights of nurses. *Nurs Ethics* 2010; 17: 628–635.
15. Jacelon CS, Connelly TW, Brown R, et al. A concept analysis of dignity for older adults. *J Adv Nurs* 2004; 48: 76–83.
16. Jacelon CS. The dignity of elders in an acute care hospital. *Qual Health Res* 2003; 13: 543–556.
17. Drum CE, White G, Taitano G, et al The Oregon Death with Dignity Act: results of a literature review and naturalistic inquiry. *Disabil Health J* 2010; 3: 3–15.
18. Baillie L. Patient dignity in an acute hospital setting: a case study. *Int J Nurs Stud* 2009; 46: 23–37.
19. Bolton SC. *Dimensions of dignity at work*. London: Butterworth-Heinemann, 2007.
20. Katrinli A, Atabay G, Gunay G, et al. Nurses' perceptions of individual and organizational political reasons for horizontal peer bullying. *Nurs Ethics* 2010; 17: 614–627.
21. Rocker C. Addressing nurse-to-nurse bullying to promote nurse retention. *OJIN* 2008; 13.
22. Edwards SL and O'Connell CF. Exploring bullying: implications for nurse educators. *Nurs Educat Pract* 2007; 7: 26–35.
23. Fenton E and Mitchell T. Growing old with dignity: a concept analysis. *Nurs Older People* 2002; 14: 19–21.
24. Stabell A and Nåden D. Patients' dignity in a rehabilitation ward: ethical challenges for nursing staff. *Nurs Ethics* 2006; 13: 236–248.
25. Macklin R. Dignity is a useless concept. *BMJ* 2003; 327: 1419–1420.
26. Adibhajbaghery M and Salsali M. A model for empowerment of nursing in Iran. *BMC Health Serv Res* 2005; 5: 24–35.
27. Nikbakht Nasrabadi AN, Lipson JG and Emami A. Professional nursing in Iran: an overview of its historical and sociocultural framework. *J Prof Nurs* 2004; 20: 396–402.
28. Strubert Speziale H and Carpenter D. *Qualitative research in nursing, advancing the humanistic imperative*. 4th ed. Philadelphia, PA: Lippincott, Williams & Wilkins, 2007.
29. Polit DF and Tatano C. *Essentials of nursing research, methods, appraisal, and utilization*. 6th ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2006.
30. Holloway I and Wheeler S. *Qualitative research for nurses*. Oxford: Wiley-Blackwell, 1996.
31. Elo S and Kyngäs H. The qualitative content analysis process. *J Adv Nurs* 2008; 62: 107–115.
32. Royal College of Nursing. *Working well initiative bullying and harassment at work, a good practice guide for RCN negotiators and health care managers*. London: Royal College of Nursing, 2005.
33. McKenna BG, Smith NA, Poole SJ, et al Horizontal violence: experiences of registered nurses in their first year of practice. *J Adv Nurs* 2003; 42: 90–96.
34. King LA and McInerney PA. Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. *Curationis* 2006; 29: 70–81.
35. Anonymous. Clinical nursing; recent findings from Curtin University of Technology highlight research in clinical nursing. *Health & Medicine Week* 2010; 20: 1698.
36. Wade GH, Osgood B, Avino K, et al. Influence of organizational characteristics and caring attributes of managers on nurses' job enjoyment. *J Adv Nurs* 2008; 64: 344–353.
37. Mrayyan MT. Nurses' autonomy: influence of nurse managers' actions. *J Adv Nurs* 2004; 45: 326–336.
38. Cash K. Clinical autonomy and contractual space. *Nurs Philos* 2001; 2: 36–41.

39. Morrison R. Informal relationships in the workplace: associations with job satisfaction, organisational commitment and turnover intentions. *New Zeal J Psychol* 2004; 33.
40. Laschinger HK, Almost J and Tuer-Hodes D. Workplace empowerment and magnet hospital characteristics: making the link. *J Nurs Adm* 2003; 33: 410–422.
41. Mrayyan MT. *Hospital staff nurses' perceptions of nurse managers' actions that influence nurses' autonomy*. Dissertation, University of Iowa, Iowa City, IA, 2002.
42. Dehghan Nayeri N, Nazari AA, Salsali M, et al Iranian staff nurses' views of their productivity and management factors improving and impeding it: a qualitative study. *Nurs Health Sci* 2006; 8: 51–56.
43. Attree M. Nursing agency and governance: registered nurses' perceptions. *J Nurs Manag* 2005; 13: 387–396.
44. Kalb KA and O'Conner-Von S. Ethics education in advanced practice nursing: respect for human dignity. *Nurs Educ Perspect* 2007; 28: 196–202.
45. Taylor M. *The relationship between autonomy and job satisfaction among registered nurses*. Dissertation, University of New Hampshire, Durham, NC, 2008.
46. El-Jardali F, Alameddine M, Dumit N, et al. Nurses' work environment and intent to leave in Lebanese hospitals: implications for policy and practice. *Int J Nurs Stud* 2011; 48: 204–214.
47. Rahimaghaee F, Dehghan Nayeri N and Mohammadi E. Managers' roles in the professional growth of Iranian clinical nurses. *Nurs Health Sci* 2010; 12: 470–476.
48. Currie G, Finn R and Martin G. Role transition and the interaction of relational and social identity: new nursing roles in the English NHS. *Organ Stud* 2010; 31: 941.
49. Yildirim A, Ates M, Akinci F, et al. Physician-nurse attitudes toward collaboration in Istanbul's public hospitals. *Int J Nurs Stud* 2005; 42: 429–437.
50. *Literature review on meaningful recognition in nursing*. Psychological Associates and DAISY Foundation, 2009.
51. American Association of Critical Care Nurses. *AACN standards for establishing and sustaining healthy work environments: a journey to excellence*. Aliso Viejo, CA: American Association of Critical Care Nurses, 2005.
52. Adamson BJ, Kenny DT and Wilson-Barnett J. The impact of perceived medical dominance on the workplace satisfaction of Australian and British nurses. *J Adv Nurs* 1995; 21: 172–183.
53. Blegen MA, Goode CJ, Johnson M, et al. Recognizing staff nurse job performance and achievements. *Res Nurs Health* 1992; 15: 57–66.
54. Takase M, Maude P and Manias E. Explaining nurses' work behaviour from their perception of the environment and work values. *Int J Nurs Stud* 2005; 42: 889–898.