LIST OF ABBREVIATIONS

COHSASA	Council for Health Service Accreditation of Southern Africa
HIV	Human Immunodeficiency Virus
SANC	South African Nursing Council
SSA	Sub-Saharan African
UK	United Kingdom
USA	United States of America

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

The dignity of people should at all times be respected as it refers to their worthiness as human beings (Milton, 2008:207; Andorno, 2014:45; Badcott & Leget, 2013:933). Patients and nurses are human beings and thus have dignity. When their dignity is not respected they feel embarrassed and humiliated (Gallagher, 2011:472). When their dignity is respected they feel valued (Bournes & Milton, 2009:56). Nurses also have professional dignity. When they are respected as professional persons, their value is acknowledged (Gallagher, 2007:360) enabling nurses to uphold their patients' dignity and to provide quality care (Sabatino, Stievano, Rocco, Kallio, Pietila & Kangasniemi, 2014:659). The professional dignity of nurses is not always respected (Khademi, Mohammadi & Vanaki, 2012:328). Disrespecting nurses' professional dignity might have a detrimental effect on nurses' self-esteem and on their belief in themselves to deliver quality nursing care (Stievano, Marinis, Russo, Teresa, Rocco & Alvaro, 2012:346). Nurses feel disrespected when the healthcare environment impacts negatively on their optimal functioning (Gallagher, 2011:472) and places additional demands on their ability to deliver quality care to patients (Sabatino, Kangasniemi, Rocco, Alvaro & Stievano, 2016:286; Lawless & Moss, 2007:234; Baillie, Ford, Gallagher & Wainwright, 2009:24).

Understanding the dynamics of the professional dignity of nurses can be of great value to nurse managers, thus enabling them to enhance the social processes responsible for the preservation of nurses' dignity (Jacobson, 2009:[6]). The aim of the current study was thus to develop strategies to preserve the professional dignity of nurses in a demanding healthcare environment. The study was conducted at two private healthcare facilities in South Africa.

1.2 BACKGROUND

To illustrate the rationale underlying the study, the historical development of the concept of dignity; nursing practice and dignity; nursing practice and professional dignity of nurses; and healthcare and the professional dignity of nurses will be discussed.

1.2.1 Historical development of the concept of dignity

Dignity has been relevant since antiquity. It is found in Greek and Roman writings and reflected upon in the Aristotelian tradition (Misztal, 2013:102). Christian writers described dignity during the Middle Ages as a value that humans possess due to their relationship with God (Jacobson, 2007:293; Andorno, 2014:47). During the Renaissance, dignity became a popular topic in the writings of Italian Humanists. Giovanni Pico della Mirandola described it with emphasis on the freedom of people to decide what dignity means to them (Van der Graaf & Van Delden, 2009:156; Andorno, 2014:47). During the Age of Reason not much attention was paid to dignity. Only at the end of this period the Kantian perspective of dignity (people are capable of moral action and thus of self-determination) was formulated. From modern times onward, dignity is related to being the corner stone of human rights (Van der Graaf & Van Delden, 2009:157; Andorno, 2014:45). Ethical debates on dignity-related issues continue (Badcott & Leget, 2013:933), with some regarding it as being a useless concept (Macklin, 2003:1420), while others defending it as a concept worthy of exploration (Baertschi, 2014:201; Schroeder, 2010:123).

1.2.2 Nursing practice and dignity

Patients are dignified when they are able to “live in accordance” with their standards and values (Barclay 2016:136). In nursing practice respect for the dignity of patients is valued (Yalden & McCormack, 2010:140; Gallagher, 2004:595; Adams 2016:[sp]). Respect is shown through providing good nursing care (Bailie & Gallagher, 2011:340; Jacobson & Silva, 2010:372; Abelsson & Lindwall, 2017:268) to facilitate the autonomy of patients which is a basic requirement for upholding of their dignity (Sayer, 2007:568; Chochinov, 2004:1338-1339). Good nursing care is delivered when all health needs of patients are addressed in a courteous manner to prevent embarrassment and

uncomfortable situations (Jacobson & Silva, 2010:371) irrespective of patients' social status or culture (Cheraghi, Manookian & Nasrabadi, 2014:920). Nurses thus have an ethical responsibility to protect patients from feelings of vulnerability (Gastmans, 2013:142) in order to enhance their feelings of dignity (Baillie & Gallagher, 2012:48).

1.2.3 Nursing practice and the professional dignity of nurses

When the professional dignity of nurses is respected by their colleagues and hospital management (Stievano, Alvaro & Russo, 2009:97) they can address the health needs of patients more effectively (Stievano, Rocco, Sabatino & Alvaro, 2013:120). The professional dignity of nurses refers to their own perspectives (Sabatino, et al. 2014:665) and the perspectives of others regarding their knowledge and skills (Sabatino, et al. 2014:663) and their abilities to function as autonomous professional people (Sabatino, et al. 2016:285).

Nurses develop negative perceptions towards themselves when their needs as professional people (such as the need for conducive work environments and respect from others) are not met (Andrews, Burr & Bushy, 2011:69). Nurses' perception of themselves and their profession deteriorates due to a poor work environment and a lack of respect from others (Emeghebo, 2012:e49). Patients and family members of patients might regard nurses' contributions to patients' recovery as being inferior to that of physicians (Malloy, Hadjistavropoulos, McCarthy, Evans, Zakus, Park, et al. 2009:726) while physicians might not acknowledge the nurses' inputs in this regard (Andrews, et al. 2011:72). Nurses who perceive a lack of support from hospital managers might regard themselves to be the lowest priority to be supported and cared for (Andrews, et al. 2011:72).

The autonomous practice of nurses is non-negotiable as it characterises their professional status and associated dignity (Varjus, Leino-Kilpi & Suominen, 2011:201). Without that they become subservient to other members of the health team (Ogle & Glass, 2014:10). Hospital managers should provide a work environment that supports the autonomous practice of nurses (Varjus, et

al. 2011:201,205; Corley, Minick, Elswick & Jacobs, 2005:388). When nurses are cared for (Gustafsson & Stenberg 2017:425; Seitovirta, Vehviläinen-Julkunen, Mitronen, De Gieter & Kvist, 2017:1048); empowered to act as professional people (Varjus, et al. 2011:203; Skår 2009:2226); and recognised for their contribution to the recovery of patients (Islam, 2011:2; Feather, Ebright & Bakas, 2015:130), they feel respected and their professional status is acknowledged.

1.2.4 Healthcare and the professional dignity of nurses

Nurses are globally exposed to demanding healthcare environments. In the United States of America (USA) public healthcare is costly. Although the citizens complain about its quality, it is responsible for the largest proportion of the state's expenditure (Arroliga, Huber, Myers, Dieckert & Wesson, 2014:246). The Magnet Hospital Recognition Program has been implemented in the USA to improve the work environment of nurses and to give nurses more recognition for their patient care inputs (Van den Heede & Aiken, 2013:141).

Health professionals in European countries face challenges regarding the care of ageing populations while containing healthcare costs. High demands for advanced technology healthcare are an expectation that nurses have to meet (Aiken, Sermeus, Van den Heede, Sloane, Busse, et al. 2012:e1717). In emerging countries, such as China and India, rapid economic growth goes hand in hand with higher healthcare demands with the result that pressure increases on existing services (Yip & Mahal, 2008:921). In poor countries, with high rates of Human Immunodeficiency Virus (HIV) infections and Tuberculosis, increased healthcare demands contribute to challenging work environments for nurses (Blumenthal & Hsiao, 2005:1169). Almost 25% of the world's disease burden occurs in the Sub-Saharan African (SSA) countries, but these SSA countries have merely 3% of the world's health workers (World Health Organization 2006:19), resulting in excessive workloads and challenging work environments for these workers (Kalipeni, Semu & Mbilizi, 2012:153). In South Africa, healthcare role players face ever increasing challenges in terms of disease burden and limited numbers of personnel, trying to balance resources between private and public healthcare services (Mayosi & Benatar,

2014:1344; Marten, McIntyre, Travassos, Shishkin, Longde, Reddy & Vega, 2014:2168).

South Africa has a two tier healthcare system. Public healthcare services are state funded through taxes and are responsible for the care of the majority (83%) of the citizens (Marten, et al. 2014:2169). Poor sanitation in many homes and high HIV infection, accident and crime rates cause high demands on healthcare in South Africa (Messenger & Vidal, 2015:6). Limited resources in public services are experienced as staff members leave the service to work in better equipped private hospitals and clinics (Messenger & Vidal, 2015:7). The lack of medical supplies, often experienced in public services, has a detrimental effect on the quality of patient care (Pillay, 2009:[1]). Private healthcare is funded by patients who pay out of their pockets or through medical insurance for the service. The hospitals are managed as businesses by boards and executive management officers to deliver high technological state of the art care (Pillay, 2009:[1-2]). The pace is fast and the expectations high from both patients (excellent service) and shareholders (return on investment) (Chan, Tam, Lung, Wong & Chau, 2013:1386).

Major shortages of nurses in both public and private healthcare services in South Africa, make it difficult to cope with the healthcare demands. Nurses often work overtime and have on average a 52-hour work week with negative effects on their performance (Messenger & Vidal, 2015:15, 24). Nurses are the face of the healthcare and patients expect nurses to meet their high expectations in terms of prompt and efficient care (Chan, et al. 2013:1386). However, nurses are often overloaded with work demands (Dwyer, Andershed, Nordenfelt & Ternestedt, 2009:190) and unsupportive work environments (Blignaut, Coetzee & Klopper, 2014:224). This situation causes a gap between ideal nursing care and actual achievable nursing care, with potentially detrimental effects on nurses' professional dignity, as perceived by themselves and others (Dwyer, et al. 2009:190).

1.3 PROBLEM STATEMENT

Dignity is absolute as all human beings possess it due to their human nature and it is also relative as it depends on the reaction of others towards the individual (Edlund, Lindwall, Post & Lindström, 2013:855). Patients and nurses are human beings and they therefore have absolute dignity (Van der Graaf & Van Delden, 2009:155). Relative dignity is bestowed on them when others regard them as people with dignity (Gallagher, 2004:591).

In nursing, the dignity of patients is respected through enhancement of their autonomy and quality care (Milton, 2008:207). In codes of professional nursing conduct, respect for the dignity of patients is emphasised (Gallagher, 2007:364). Poor nursing care reflects disrespect for the dignity of patients (Wainwright & Gallagher, 2008:52) and, in turn, impacts negatively on the professional dignity of nurses (Sabatino, et al. 2016:286). Nurses who are valued for their expertise (Van Eckert, Gaidys & Martin, 2012:903), appreciated for their contributions to patient care (Parse, 2010:97), and enabled to function autonomously (Stievano, et al. 2012:346) in a supportive work environment (Corley, et al. 2005:388) regard themselves as dignified professional people (Sayer, 2007:570). They are proud of their profession and are motivated to deliver quality patient care (Emeghebo, 2012:e49). Unreasonable workloads and restrictions on nurses' professional autonomy on the other hand, lead to violation of their professional dignity (Khademi, et al. 2012:328; Jacobson, 2009:[4]) and poor motivation to deliver quality care (Khademi, et al. 2012:335).

Demanding work environments of nurses are a global concern (Van den Heede & Aiken, 2013:141; Chan, et al. 2013:1387), posing a threat to safe patient care (Aiken, et al. 2012:e1717) and the professional dignity of nurses (Stievano, et al. 2013:122). Nurses are confronted with conflicting situations. They are expected to deliver quality care, while the work environment might not always be supportive. Staff shortages, limited resources or over-emphasis on cost-effective care are experienced. Their professional competence is also often disregarded (Khademi, et al. 2012:328). These circumstances lead to frustration and exhaustion (Goldman & Tabak, 2010:243; Dasgupta,

2012:528), contributing to high turnover rates among nurses (Stievano, et al. 2012:346).

Nurses in South Africa work in a demanding healthcare environment due to high demands for healthcare (Mayosi & Benatar, 2014:1345; Zumla, George, Sharma, Herbert & Masham, 2013:1765) and limited support from management structures (Blignaut, et al. 2014:229). A study by Coetzee, Klopper, Ellis and Aiken (2013:162) revealed that, in general, the work environment of nurses in South Africa does not support them to deliver quality care. A study in the Western Cape Province of South Africa provided results concerning ethical dilemmas related to nurses' daily work environments (Stellenberg & Dorse, 2014:1). Ethical dilemmas included verbal abuse from patients, exploitation in the workplace and issues of trust and transparency (Stellenberg & Dorse, 2014:7).

Staff members experience constant pressure from management to minimise costs in private healthcare facilities (Dasgupta, 2015:528). The budgeting process in private healthcare is complex due to the demands of the consumers (patients and their family members), shareholders' expectations of profits, requirements of health insurance companies (medical aid schemes) and government regulations (Del Vecchio, Fenech & Prenestini, 2015:356). Principles regarding "value for money" (Dasgupta, 2012:528) determine the management of private healthcare facilities. It results in pressure on nurses to ensure the shortest duration of hospitalisations and strict control over costs (Dasgupta, 2012:528). At the same time consumers (patients and their family members) of private healthcare facilities demand high quality care, including some luxuries such as immediate and perfect service, as they pay high fees (Chan, et al. 2013:1386). A demanding environment for nurses in private healthcare becomes inevitable (Dasgupta, 2012:528). Due to different circumstances in the private and public healthcare facilities in South Africa the current study focused on the development of strategies to preserve the professional dignity of nurses in private health care facilities.

An extensive literature search indicated that much research has been done on the dignity of patients while only a few studies were found on the professional dignity of nurses. According to Lawless and Moss (2007:234) “dignity is well described and embedded in nursing practice as a patient value, but there is a paucity of research in nursing that examines nursing dignity as an explicit value.” The current study attempted to address this identified “paucity of research”.

1.4 RESEARCH QUESTION

The research questions of the current study were: “What are nurses’ experiences regarding their professional dignity; and what support do nurses require to enable them to preserve their professional dignity in a demanding private healthcare environment?”

1.5 AIM OF THE STUDY

The aim of the study was to develop strategies to preserve the professional dignity of nurses in a demanding private healthcare environment.

1.6 RESEARCH OBJECTIVES

The objectives were to:

- Explore and describe how nurses in private healthcare facilities experience factors that impact on their professional dignity.
- Develop strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities.

1.7 SIGNIFICANCE OF THE STUDY

The study’s findings could contribute to the theoretical base of professional dignity of nurses as the researcher explored and described how nurses in private healthcare facilities experienced factors that impacted on their professional dignity. Strategies were developed to preserve the professional dignity of nurses. According to the reviewed literature, respect for the professional dignity of nurses by the health team and hospital management enables nurses to deliver quality patient care (Bournes & Milton, 2009:56; Gallagher, 2004:592; Lawless & Moss, 2007:234). A contribution could thus

be indirectly made to the improvement of the practice of nursing. By involving nurse managers in the research they could be made aware of the factors impacting on nurses' professional dignity.

1.8 CLARIFICATION OF THE KEY CONCEPTS

The following concepts were used in the study:

Professional dignity of nurses is a value-laden concept that refers to the dignity of nurses in their work life (Stievano, et al. 2012:351) determined by their perspectives of themselves as professional persons and the way others view their knowledge and skills (Sabatino, et al. 2014:663). It also refers to nurses' ability to function as autonomous professional people (Sabatino, et al. 2016:284-285). When nurses are respected for their knowledge, skills and contributions to patient care they feel valued (Stievano, et al. 2012:350). It also confirms their professional status (Stievano, et al. 2012:346-347). The professional dignity of nurses is enhanced by nurse managers when a supportive work environment is created and maintained (Sabatino, et al. 2016:287). In the current study, the professional dignity of nurses refers to their professional self-image developed by themselves and supported by members of the health team and the hospital management.

Professional nurses, refer to people "qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed [by the South African Nursing Council (SANC)] and who is capable of assuming responsibility and accountability for such practice" (Republic of South Africa Act 33 of 2005: sec 30.1). Nurses, in the current study, refer to professional nurses, including those in charge of general and specialised units in two selected private healthcare facilities.

Strategies, according to Chandler (cited by Mintzberg, 1978:935), refer to the development and implementation of long term goals and objectives of an organisation. Mintzberg (1978:935), the pioneer in defining the concept, describes it as "a pattern in a stream of decisions", that influences planning. A more recent view of the concept focuses on its strategic functions. It refers to

“strategic navigation” to move from one point to another even though the future might be unknown (Hillier, 2011:503). Strategies thus challenge companies towards making hard choices to mobilise managers (Martin 2014:79). There are two critical choices that lead to successful outcomes, namely the “where-to-play” and “how-to-win” choices. In the current study, “where-to-play” refers to the understanding of the experiences of nurses of the factors affecting their professional dignity. The “how to win” choice, in the current study, refers to the implementation of strategies to preserve the professional dignity of nurses (Martin, 2014:81). The consumer (patient) should always be the central reason (good patient care) underlying all strategies (Martin, 2014:82) and strategy execution should be supported by all executives (Sull, Homkes & Sull, 2015:61). In the current study strategies refer to corporate pathways that the researcher developed, for implementation by management, to preserve the professional dignity of nurses in private healthcare facilities.

Preserve, or the Swedish word ‘bevara’ (National encyklopedin 1996 translated by Anderberg, Lepp, Berglund & Segesten, 2007:638), is described as “keeping something in its original state or condition through measures that counteract destructive forceś”. Preserving thus refers to the protection of something (Anderberg, et al. 2007:638). To preserve dignity is to engage with a human being and to be aware and sensitive towards that individual in the moment (Lindwall & Von Post, 2014:338). In the current study preserve refers to upholding the professional dignity of nurses within a demanding environment of healthcare with factors posing threats to nurses’ dignity.

Demanding healthcare, refers to the rendering of care in a stressful environment (Berwick, 2003:448; Raftopoulos, Charalambous & Talias, 2012:1) associated with high demands concerning cost containment, the implementation of state of the art technology, the provision of specialised care, and dealing with declining nurse-patient ratios (Messenger & Vidal, 2015:6; Aiken, et al. 2012:e1717; Marten, et al. 2014:2168; Chan, et al. 2013:1386-1387). Demanding healthcare refers to those moments when healthcare professionals want to render quality care but are unable to do so due to

constraints (Dasgupta, 2012:528). In the current study demanding healthcare refers to the demands made on nurses in two private healthcare facilities to render quality care, within budgetary and staffing constraints in a fast paced high technology environment.

1.9 OUTLINE OF THE CHAPTERS

Chapter 1 provides an overview of the research topic, problem statement, significance of the study, research questions, aim of the study, research objectives, background and rationale.

Chapter 2 describes the paradigmatic perspective, philosophical framework and research methodology.

Chapter 3 presents the findings of phase 1 as analysed according to the experiences of participants reported during their unstructured phenomenological individual interviews.

Chapter 4 discusses the findings, contextualised within relevant literature, for developing strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities.

Chapter 5 covers phase 2 of the research, which is the formulation and refinement of the strategies.

Chapter 6 covers the description of the strategies, presents the final set of strategies, addresses the limitations of the study, suggests recommendations and formulates conclusions.

1.10 SUMMARY

This chapter has provided an overview of the concept of dignity, with specific reference to the professional dignity of nurses. It also described healthcare and the challenges experienced globally. The demands placed on nurses in healthcare environments were described. In chapter 2, the paradigmatic

perspective of the study will be described, including the philosophical framework and research methodology which guided the study.

CHAPTER 2

PARADIGMATIC PERSPECTIVE, PHILOSOPHICAL FRAMEWORK AND RESEARCH METHODOLOGY

2.1 INTRODUCTION

Research attempts to expand, refine and develop a body of knowledge. Nursing research improves the understanding of concepts central to nursing care and informs nursing practice through exploring the effectiveness of current practices and developing new or improved nursing interventions. Rising pressure from consumers, health insurance companies and government for appropriate effective nursing actions to contain costs, makes nursing research vital as an effective filter for enhancing and ensuring sound nursing practice and quality care. It serves as a mechanism whereby nurses take professional accountability and enhance their professional identity (Polit & Beck, 2017:3).

Although the research process is evolving with an ever increasing knowledge base, there are still ample unexplored phenomena with many unanswered questions still in the nursing profession (Polit & Beck, 2017:3). Current discoveries open up opportunities for specialised nursing practice and research contributions (Williams, Katapodi, Starkweather, Badzek, Cashion, Coleman, Fu, Lyon, Weaver & Hickey, 2016:117) while basic nursing research, such as infection prevention, has benefitted patients and communities (Baltzell, McLemore, Shattell & Rankin, 2017:765). Studies conducted by nurses in clinical practice situations are increasing (Polit & Beck 2017:4) ensuring relevant bedside research. Research utilisation is essential when preparing nurses for making independent practice-related decisions and for solving problems (Meherali, Paul & Profetto-McGrath, 2017:634). Accreditation programmes such as the Magnet Accreditation in the USA serves as an encouragement for nurses to actively engage in research (Kenner, 2017:1) to bring nursing research closer to the bedside (Cowman, Cert & Dip, 2016:73; Ahmad, 2017:2).

The aim of the current study, to develop strategies to preserve the professional dignity of nurses in a demanding private healthcare environment, is addressed through two objectives, namely: to explore and describe how nurses in private healthcare facilities experience factors that impact on their professional dignity; and to develop strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities. Each objective is researched during a specific phase of the study. In the first phase the meaning of nurses' experiences, regarding factors that impact on their professional dignity, was explored and described by conducting descriptive phenomenological research. The second objective is researched in phase 2. Strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities were developed, based on the findings of phase 1. Draft strategies were refined through conducting focus group interviews with professional nurses, members of the health team and management from the selected hospitals.

PHASE 1: EXPLORATION AND DESCRIPTION OF HOW NURSES WORKING IN PRIVATE HEALTHCARE FACILITIES EXPERIENCE FACTORS THAT IMPACT ON THEIR PROFESSIONAL DIGNITY

2.2 PARADIGMATIC PERSPECTIVE (PHASE 1)

A descriptive phenomenological study was conducted, guided by the assumptions of the constructivist research paradigm.

2.2.1 Research paradigm

A paradigm is an overarching philosophical world view and reflects a belief system of the world, the people in the world and the potential relations to the world and its components. Such beliefs are adopted in faith, and although debated comprehensively, they are not proven ultimate truths (Guba & Lincoln, 1994:107). Paradigms underpin the conceptual and philosophical framework of research decisions and choices concerning research designs (Filstead, 1979:34) serving as a framework for the construction of knowledge (Weaver & Olson, 2006:459).

A worldview answers **ontological** questions about the nature of reality and the relevant knowledge which can be acquired. The scientific view the researcher adopts is related to the worldview and concerns **epistemological** questions such as what counts as valid knowledge; and **methodological** questions regarding the methods chosen to obtain that knowledge (Guba & Lincoln, 1994:108).

The **constructivist paradigm** originated as a counter movement to positivist and post positivist paradigms whereby emphasis is placed on the rational and the scientific, assuming "objectivity" and researcher independency from participants and findings (Polit & Beck, 2017:10). These research designs are rigid (Polit & Beck, 2017:11) with a focus on the generalisation of findings (Polit & Beck, 2017:12).

In contrast, constructivist paradigms allow for flexible emergent designs with a declared dependence on the active participation of participants in the research process (Polit & Beck, 2017:12). The constructivist paradigm assumes "a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent cocreate understandings), and a naturalistic (in the natural world) set of methodological procedures" (Denzin & Lincoln, 2008:32). There is thus no single fixed reality or ultimate truth. Meaning derives from within a specific context and individuals have several interpretations of reality. Many realities are thus possible (Polit & Beck, 2017:12).

Constructivist researchers believe that ontological and epistemological assumptions are interlinked and cannot be considered in isolation from each other. When researchers interact with participants throughout the research process, they are able to gather knowledge and gain a better understanding of the multiple realities constructed in the minds of the participants (Appleton & King, 1997:14). By choosing constructivism as a paradigm, knowledge in the field of the professional dignity of nurses was constructed according to the lived experiences of the nurse participants (Trafford & Leshem, 2008:97).

2.2.2 Meta-theoretical assumptions: constructivist paradigm

Constructivist researchers operate under certain **ontological assumptions** about the world. They view the world not as an objective reality, but rather as subjective mental constructions, selected, built and enhanced by individuals based on their experiences (Krauss, 2005:760). In the constructivist paradigm, relativist ontology is assumed that implies that multiple realities of a phenomenon exist (Denzin & Lincoln, 2008:32). Constructivist researchers view reality as a construction of the interaction of human beings. Meanings are given to objects through the experiences of humans of the objects and events in their environment (Polit & Beck, 2017:12). The primary interest of constructivist researchers is "subjective and intersubjective social knowledge and the active construction and co-creation of such knowledge by human agents that is produced by human consciousness" (Denzin & Lincoln, 2008:269).

The researcher assumed that multiple realities of the phenomenon (factors that impact negatively or positively on the professional dignity of nurses) existed (Guba & Lincoln, 1994:110) and focused on the phenomenon as a reality in two private healthcare facilities.

Within the **epistemological assumptions,** underlying a constructivist paradigm, knowledge regarding a phenomenon is believed to be best understood when the researcher (inquirer) and the "object" interact to co-create understanding (Lincoln & Guba, 1985:37) thus assuming a subjectivist epistemology (Denzin & Lincoln, 2008:32). It implies that knowledge is constructed when the researcher and the participants interact and findings emerge (Guba & Lincoln, 1994:111).

The researcher assumed that both she and the participants would gain a deeper understanding of the phenomenon (professional dignity of nurses) by engaging with the participants (professional nurses) (Ponterotto, 2005:131).

Certain **methodological assumptions** are generic to the different methodologies and approaches used within a constructivist paradigm to

discover reality (Sobh & Perry, 2006:1195). In the constructivist paradigm an interpretative dialectical approach is assumed, implying that constructions of the phenomena can only surface through interaction between the researcher and the participants (Guba & Lincoln, 1994:111). Constructivist researchers seek to understand and interpret phenomena (Barkway, 2001:192) through a naturalistic methodological approach (Appleton & King, 1997:17). The aim is to conclude with refined constructions of the phenomenon (Guba & Lincoln, 1994:111). It is assumed that more than one truth might be discovered and that such viewpoints should be explored within their own context. It was thus assumed that no single truth (about nurses' dignity) would be possible and that the participants might hold beliefs different from those of the researcher (Appleton & King, 1997:15).

Phenomenology, described as a research approach within the constructivist paradigm, is a philosophy and a method of inquiry that aids researchers to discover the subjective reality of people as experienced by them in their everyday lives (in the current study the everyday work life of professional nurses in private health care facilities). It guides the researcher to see things as they are through the participants' experiences, without the pre-supposing knowledge of the researcher, while the phenomenon presents itself in its essence (Converse, 2012:28; Finlay, 2012:173). Essence is that "invariant structure" of a phenomenon which determines the very nature of the phenomenon. Without its essence the phenomenon would present as something different (Polit & Beck, 2017:470).

Phenomenological researchers are particularly interested in human beings, their existence in the world and their consciousness thereof. They engage with small numbers of people through in-depth discussions about their experiences of specific phenomena. They provide rich research reports and readers are able to gain new understanding and insight into the lived experiences of people (Polit, & Beck 2017:471).

The phenomenological research approach aims to describe a phenomenon as pure essence of consciousness of human beings as they experience the

objects in the world in which they live (Wojnar & Swanson, 2007:173), known as descriptive phenomenology.

The philosophical framework, associated with a descriptive phenomenological inquiry, is explained in the next section.

2.3 PHILOSOPHICAL FRAMEWORK (PHASE 1)

A descriptive phenomenological approach requires researchers to adopt a phenomenological standpoint. They attempt to understand phenomena as it is given to their consciousness and refrain from looking at things from a natural stance in how things are presented to them. Researchers also abstain from their pre-knowledge when phenomena are presented to them (Giorgi, 2012:4; Solomon & Higgens, 1996:251).

The descriptive phenomenological inquiry originated from the philosophy of the well-known German philosopher Edmund Husserl and is defined as the "scientific study of the essential structures of consciousness" (Solomon & Higgens, 1996:251). Husserl's philosophy was born from the ideas of his teacher, Franz Brentano, on the philosophy of the mind later known as descriptive psychology (Moran, 2000:8). Husserl had a particular epistemological interest in the theory of knowledge (Zahavi, 2003:1) with specific reference to the question of how knowledge is possible. Husserl questioned current metaphysical approaches at that time (Zahavi, 2003:8). In an attempt to identify the conditions for knowledge to be known he focused on two critical factors namely the object (logical) and the subjective (noetic). This led to his philosophy to go to the "things themselves" (Zahavi, 2003:11) and to examine consciousness, for it is only in "consciousness that something can appear" (Zahavi, 2003:12). Husserl's philosophy of descriptive phenomenology developed into a research approach based on three core principles, namely: transcendental subjectivity (open approach), eidetic essences (universal truths) and live-world approach (researcher-participant interaction). The ultimate aim is an accurate description of phenomena through the personal experiences of participants of the phenomena (Wojnar & Swanson, 2007:174).

2.3.1 Epistemological and ontological assumptions

Consciousness, as a core phenomenological principle, implies that people experience their life-world through the intentional consciousness thereof (Zahavi, 2003:14). It is the medium between a human being and the world and all experiences happen through the consciousness of people (Giorgi, 2005:76). In order to be able to study consciousness in a phenomenological way, the researcher had to clear her mind and distance herself from any association, perceptions or assumptions of the object under examination, by bracketing it out (Solomon & Higgens, 1996:251-252). The phenomenon emerged as pure essence, reflecting "the absolute pure consciousness" and experience as "intimate subjective flow" (Duhan, 1987:131).

A **phenomenon** is described as an object or a 'thing' that is part of the world and the experiences in the world. It comes from the Greek word 'phainomenon' which stems from 'phainesthai', meaning 'to show itself'. In phenomenology the object exists in relation to the subject, as experienced by the subject. The researcher has to go "to the things themselves" as it is experienced so that the things can be shown to the researcher (Dahlberg, Dahlberg & Nyström, 2008:32-33).

Intentionality refers "to the relationship between a person and the object or events of her/his experience, or more simply, one's directed awareness of an object of event" (Dahlberg, et al. 2008:47). Mental acts are always related to objects and thinking is never empty. People are constantly aware of something (Moran, 2000:16; Dowling, 2007:132). Within the phenomenological approach, intentionality of consciousness indicates that intention is directed to the world and all actions have meaning through intended consciousness (Sadala & Adorno, 2002:283). Consciousness is thus an intentional act directed at an object and the description thereof is the ultimate aim of a phenomenologist in understanding phenomena. Objects can be material or ideal objects which do not necessarily have to exist. It is possible to describe a phenomenon such as a dream (Solomon & Higgens, 1996:251).

Meaning evolves when people experience something that has meaning to them (Dahlberg, et al. 2008:47). When a conscious act is directed towards the object, the meaning capsulated in the object is released (Giorgi, 2005:82). It is thus meaning that provides consciousness with its object directedness (Zahavi, 2003:23).

Experience is based on the subjective encounter of phenomena. It is the most fundamental source of knowledge and therefore regarded as ultimately reliable. According to Husserl the real world is what we see and experience (Cogswell, 2008:90). In descriptive phenomenology researchers believe that phenomena can only be studied through the conscious experiences of the phenomenon by the people involved in the experience (Solomon & Higgens, 1996:251; Giorgi, 2012:6). The meaning of a phenomenon is constructed in interaction between people (in the current study the nurses who work in the selected private healthcare facilities) who experience the phenomenon of nurses' professional dignity (Barkway, 2001:193) and studied in interaction with the researcher (Converse, 2012:31). The lived experiences of the phenomenon (nurses' professional dignity) in the current study might differ from the lived experiences of nurses in other healthcare environments.

Essences represent the "whatness" of a phenomenon and its essential meaning. Essence is revealed when a phenomenon presents itself or is clarified (Dahlberg, 2006:11-12). In descriptive phenomenology, researchers believe that the essence of the phenomenon (professional dignity of nurses) can only be discovered through a process of reduction whereby researchers view the phenomenon directly as it is experienced by the participants (Rapport & Wainwright, 2006:232).

Intuition is the phenomenological method seeking for the 'essence' of mental phenomena while studying the experiences of people (Rapport & Wainwright, 2006:232). When phenomenology researchers study such experiences, they make use of a process of 'intuiting' (to call to attention what is given to us) to gain an "innate sense of what it might be like to live in the participant's skin" (Wojnar & Swanson, 2007:176). They remain open to the meanings of the

phenomenon by those who experience it (Offredy & Vickers, 2010:101) and refrain from premature understanding and interpretation (Wertz, 2005:168).

The **life-world** is the context whereby the experiences that we live occur before it is known. It includes occurrences of everyday living such as feelings, understandings and perceived relationships (Todres & Wheeler, 2001:3; Dahlberg, et al. 2008:33). It refers to those occurrences to which we always return when we acquire a certain frame of reference. The life-world ("not questioning the way things are") (Todres & Wheeler, 2001:3; Lopez & Willis, 2004:727) is always more complex than what is known about it. When the life-world is questioned, according to Husserl, the "taken for granted" becomes a phenomenon (Todres & Wheeler, 2001:3). The ultimate aim of phenomenological enquiry is to clarify the life-world with an open mind (without preconceptions or assumptions) to achieve understanding of the phenomena in question (Todres & Wheeler, 2001:3).

2.3.2 Methodological assumptions

Methodology refers to a theory of producing knowledge through research and provides a rationale for the way research proceeds (Appleton & King, 1997:16). It assists the researcher in choosing research methods and understanding the research assumptions underlying a particular study. Research methodology is considered according to research questions and problem statements and provides the logic behind the techniques and methods adopted within the context of a research study (Kothari, 2004:8). Research methods refer to the methods and techniques used to execute the research process in order to acquire research findings (Kothari, 2004:7).

The researcher assumed gaining rich data from participants' experiences through adopting a phenomenological methodology.

- **Phenomenological reduction**

The philosophical phenomenological method requires the philosopher to apply transcendental phenomenological reduction. Husserl's attempt to answer the epistemological nature of knowledge made him realise that it is impossible to

perform research and answer questions about the complexity of reality by accepting the metaphysical and epistemological assumptions as they appear in the daily lives of people (Zahavi, 2003:44). Husserl refers to this stand as the natural attitude in which people experience their reality in the world in which they live without questioning it (Dahlberg, et al. 2008:33). Philosophically, the existence of a "mind-, experience-, and theory-independent reality" cannot be regarded as a natural attitude determining its validity (Zahavi, 2003:44). The nature of consciousness is distorted by the incomplete assumptions of the nature of reality of the world as it appears in people's natural attitudes (Moran, 2005:26). Pure consciousness is nestled in another dimension as a "domain of meaning constitution" (Moran, 2005:27) and can only be grasped by putting the natural attitude "out of play" and bracketing it (Moran, 2005:26). The suspension of the natural attitude by temporarily disabling the researcher from any personal, theoretical or cultural influences is known as "epoché" (Moran, 2005:28). Epoché serves as the gateway for the researcher to enter the domain of transcendental reduction (Zahavi, 2003:46).

Phenomenological researchers distance themselves from their own cultural perceptions of the phenomenon (Converse, 2012:30). According to Husserl, the researcher returns to the natural stance of experience, where after the pre-given world (pre-knowledge) is entered in order to get to the third stage, standing aside from subjective experience ("transcendental reduction"), as described by Finlay (2012:176-177). In transcendental reduction the researcher gets "lifted off the ground, to look down and back upon a world" to constitute distance from the natural dimension of the phenomenon in order to become sensitive to the phenomenological dimension or meaning of the world (Rapport & Wainwright, 2006:232).

The reaching out to phenomena in the phenomenological attitude requires further reduction when pure essence is grasped (Solomon & Higgens, 1996:252). Real truth and knowledge is discovered through a process of eidetic reduction (Moran, 2000:135). It is assumed that the experience of a phenomenon has an unforeseen truth which originates outside or beyond the

experience regardless of what is revealed in the real world (Moran, 2000:133). Once the natural attitude has been bracketed and pre-beliefs suspended, it becomes possible to take hold of the essence of the phenomenon and its essential structures (Moran, 2000:135).

- **Descriptions from others**

  Husserl was interested in understanding and describing the essential nature of consciousness from a first-person perspective (Giorgi, 1997:235). Description is a reflective process whereby the essence (the given) is articulated as it presents itself. The researcher seeks for the essence through various expressions from the participant until the desired expression (the intentional object), which is unknown, is revealed (Giorgi, 2012:8). Such expression is then described as is ("whatever there is in front of a person's eyes"), without adding or leaving something out (Sadala & Adorno, 2002:283). The aim is not to explain but to present the phenomenon through accurate description (Giorgi, 2012:6).

- **Search for the invariant meaning**

  Through applying the eidetic reduction, the philosopher searches for the unvarying structures of phenomena. Such invariable components define the phenomenon's essence (Sadala & Adorno, 2002:283). In eidetic reduction the researcher discards all assumptions about the phenomenon (through a process of bracketing) to view the phenomenon as being different from how it appears, in its natural dimension (Zahavi, 2003:38-39).

  Researchers assume that there is more to the phenomenon than they observe in its natural dimension (Zahavi, 2003:39) and they thus focus on the essence of the phenomenon that gets revealed through conceptual analysis (Giorgi, 1997:239). Eidetic reduction has to do with 'eidos' which is the Greek word for essence (Dahlberg, et al. 2008:54).

2.4 RESEARCH METHODOLOGY (PHASE 1)

2.4.1 Research design

Research design guides researchers to achieve the aims of their study. It involves a critical thinking process to set out the proposed path to be followed by the researcher. In simple terms it answers the question of "how shall I do it"? It prompts the researcher to consider practicality, restrictions and capacity in conducting a specific research project (Trafford & Leshem, 2008:89).

Qualitative research is an emergent research design whereby the research process develops as the study progresses. It is a flexible design aiming to understand the viewpoints and realities of those under investigation with the active participation of the researcher (Polit & Beck, 2017:463). It requires from researchers to enter natural settings to collect data from participants' 'here and now' experiences in the world in which they live (Polit & Beck, 2017:464). The aim is to gather thick descriptions from small numbers of participants with a narrow inductive approach (Polit & Beck, 2017:503) and "depend on the in-depth understanding of meanings, contexts, and processes that qualitative research can provide" (Maxwell, 2012:655).

In the current study, qualitative descriptive phenomenological research was conducted to arrive at a detailed understanding of the meaning of the phenomenon (factors that impact on nurses' professional dignity) as experienced by the participants (professional nurses) (Welford, Murphy & Casey, 2012:30).

2.4.2 Research method

Descriptive phenomenology aims to explore the experiences of the participants through dialogue with them to get deeply rooted, particularised descriptions of the phenomenon (Finlay, 2012:181). The researcher thus had to go to the "the things themselves" as stated by Husserl, for the truth to be unveiled (Finlay, 2012:180; Willis, 2001:1). The thing refers to the phenomenon (factors impacting on the professional dignity of nurses) as experienced by the nurses (the subjects) (Dahlberg, et al. 2008:32,33).

Unstructured phenomenological individual interviews were conducted by the researcher as the data collection method during phase 1 of the study.

2.4.2.1 Assuming the phenomenological attitude

- **An open life-world approach**

  On entering the participants' life-world, the researcher adopted an open attitude when engaging with the phenomenon in a sensitive and open way. The researcher engages with the phenomenon by giving herself to it in the moment, taking up her full attention and concentration while listening, seeing and understanding the experiences and objects of the participants' life-world. The latter might then present itself differently from how it had been assumed (Dahlberg, et al. 2008:98). The researcher enters into an intersubjective relationship with the participant keeping in mind that such an encounter is unequal, giving preference to the phenomenon and the participant experiencing it. She guards against understanding "too well", not to see more than what has been revealed, thus allowing the natural attitude to dominate over the scientific attitude (Dahlberg, et al. 2008:114).

- **Bracketing**

  Bracketing refers to a process of identifying and putting aside any assumptions, pre-knowledge and judgment regarding the phenomenon by bracketing it out. The phenomenon can then be seen and described as it is (Finlay, 2012:176). According to Husserl, researchers are enabled through the process of bracketing to go "to the things themselves" and sift their viewpoints and pre-conceptions to see a phenomenon in its purest form (Cogswell, 2008:90).

  The keeping of a reflective diary enabled the researcher to set aside personal emotions and experiences. Regular contact with supervisors helped her to bracket feelings that could impact on her understanding of the meaning of the participants' experiences (Wojnar & Swanson, 2007:175). The researcher was cautious throughout the study with regard to personal judgment and the effect it might have on the trustworthiness of the findings.

2.4.2.2 Researcher's role

A naturalistic enquiry emerges from the interest, experiences and knowledge of the researcher in a particular field (Appleton & King, 1997:17). The researcher in the current study developed an interest in the phenomenon (factors impacting on nurses' professional dignity) being a nurse manager for more than 20 years in a private healthcare facility. Being familiar with the type of healthcare setting facilitated entry into the facility. The researcher realised that she had to request timeous entry into the facility to allow for proper planning, knowing the fast pace and high bed occupancy rates of the two participating private healthcare facilities. The researcher protected her own job title as nurse manager and introduced herself in the capacity of researcher to prevent participants from feeling intimidated. The researcher felt comfortable in the private healthcare environment which enhanced the instrumental role she had to fulfil when engaging with participants.

Phenomenological researchers become instruments to reveal phenomena from the moment they have their first encounter with the experiences of participants as revealed through verbal expression, to the final description of the phenomenon and the understanding thereof (Speziale, Streubert & Carpenter, 2011:88-89). The researcher thus became an instrument for participants to share their experiences during unstructured phenomenological individual interviews. She stayed calm and in control during some 'tense and emotional' moments, providing an emotionally safe climate for participants to speak freely. Being instrumental in the collection of rich data about the experiences of the factors that impacted on the professional dignity of nurses, the researcher adopted a phenomenological attitude to transform the data into an understanding of the experiences of the studied phenomenon. She remained focused on the data during the data analysis, being sensitive for those invariants which could determine the essence of the phenomenon and its constituents. The researcher brought new meaning to the professional dignity of nurses and transformed the data into a written document providing a deeper understanding of the experiences of the factors impacting on the professional dignity of nurses.

2.4.2.3 Research setting

The research setting comprised two private healthcare facilities; one in the in the Free State and one in the KwaZulu-Natal provinces of South Africa. The province of the Free State comprises a population of 2 817900 and KwaZulu-Natal 10 919 100 (Day & Gray, 2016:252). The location of the provinces is shown on the map of South Africa. The distance between the two private healthcare facilities is 560km.

Both facilities are accredited by the Council for Health Services Accreditation of Southern Africa (COHSASA), reflecting these facilities' commitment to provide quality patient care. Both facilities' bed occupancy rates exceeded 80%. The facilities serve a private paying and medically insured patient base of 402 672 in the Free State Province and 1 301 813 in the KwaZulu-Natal Province (Day & Gray, 2016:309) with high technology care being provided in multi-disciplinary private healthcare facility units. With an admission rate of over 45 000 patients per annum, the two facilities combined provide surgery (28 000 cases on average per annum) and medical treatment (17 000 cases on average per annum) to a variety of patients. Patients' major medical conditions include respiratory (pneumonia, asthma and bronchitis); cardiac (coronary artery disease, myocardial infarct, cardiac failure and hypertension) and systemic diseases such as diabetes mellitus. Highly specialised surgery (such as coronary artery bypass grafts, cardiac catheterisation procedures, joint replacements, spinal surgery, major general surgery and eye surgery), are performed. The facilities provide obstetric and neonatal services to mothers and new-borns and 24-hour emergency centres attending to more than 39 000 emergency cases per annum (Mediclinic, 2017).

The map showing the provinces of South Africa.

Source: https://lebona.de/empfehlungen/accommodations

The researcher is not employed at either of the participating healthcare facilities. Professional nurses who work in general and specialised units were interviewed.

2.4.2.4 Selection of participants

In the current study, the target population comprised professional nurses who worked in private healthcare facilities in South Africa. The accessible target population comprised 447 professional nurses working in two selected private healthcare facilities. Professional nurses in charge of units (36), working in specialised units (271), and working in general units (140) constituted the accessible target population. In private healthcare facility 1 there were 305 professional nurses of whom 24 were in charge of units, 190 worked in specialised units and 91 worked in general units. Private healthcare facility 2 employed 142 professional nurses of whom 12 were in charge of units, 81 worked in specialised units and 49 worked in general units. The facilities had general adult intensive care units, neonatal and paediatric intensive care units and cardiology units. Operating theatres, equipped with high technology form part of specialised units including emergency centres and obstetric units.

General units included orthopaedic, urology, oncology, neurology, gynaecology and medical units.

Purposive sampling is most commonly used in phenomenological inquiry to deliberately choose potential participants who can contribute to a rich description of the phenomenon (Polkinghorne, 2005:140). Participants should be chosen considering their potential for information richness. The purposive choice should be those candidates from which the researcher could learn most about the phenomenon under investigation (Patton, 1990:169). The following inclusion criteria were implemented: only permanently appointed fulltime professional nurses were recruited; professional nurses with at least one year's experience were recruited.

The researcher selected suitable candidates with the help of the nurse managers of the two selected private healthcare facilities. Experience, communication skills, and potential language barriers were considered in selecting candidates. Different levels of seniority and different types of private healthcare facility units were also considered.

Although the sample consisted of a homogeneous group, namely professional nurses, the researcher wanted maximum variation in terms of clinical exposure, experience and level of seniority. Maximum variation ensured rich information of the experiences of the factors impacting on the professional dignity of nurses (Polit & Beck, 2017:493). The researcher approached the nurse manager of private healthcare facility 1 to discuss the selection of participants to participate in the study. A brief description of the study served as background information. The researcher specified the inclusion criteria for selection and asked for suggestions for potential professional nurses to participate in the study. Each suggested participant was discussed and considered by evaluating the candidate against the inclusion criteria. The nurse manager had valuable background knowledge about the potential participants, their experience and exposure to clinical practice situations. A total of seven participants were identified. The selected participants represented general and specialised units with varied years of experience and

levels of seniority. They had at least one year of experience and were permanently employed by the healthcare facility. Follow-up discussions were arranged should any participant refuse to participate. Similar discussions took place with the nurse manager from private healthcare facility 2. Four participants were identified and purposively selected for their exposure to specialised units and three were chosen because they were in charge of their units. A total of 11 professional nurses were thus selected from the two private healthcare facilities. All purposely selected professional nurses agreed to participate in the study. Tables 2.1 and 2.2 summarise the demographic information of the participants.

Table 2.1 Demographic information of participants from the Free State Province (N=7)

Participant Number	Qualification	Unit	Years of experience	Age
1	Diploma in General Nursing; Diploma in Theatre Technique	Specialised	18	43
2	Diploma in General Nursing, Community Health, Psychiatry and Midwifery	General	23	54
3	Diploma in general nursing	General	10	46
4	Diploma in general nursing	General	12	37
5	Bachelor of Science in Nursing	General	5	31
6	Diploma in general nursing	General	5	36
7	B.Soc.Sc (Nursing)	Specialised	10	42

Table 2.2 Demographic information of participants from the KwaZulu-Natal Province (N=4)

Participant Number	Qualification	Unit	Years of experience	Age
8	Diploma in General Nursing,	Specialised	2	40

	Community Health, Psychiatry and Midwife Diploma in Intensive Care			
9	Diploma in General Nursing, Community Health, Psychiatry and Midwifery	Specialised	11	44
10	Diploma in General Nursing, Community Health, Psychiatry and Midwifery	Specialised	3	44
11	Diploma in General Nursing, Community Health, Psychiatry and Midwifery	Specialised	18	42

2.4.2.5 Data collection

Data collection was done by using unstructured phenomenological individual interviews and field notes.

- **Unstructured phenomenological individual interviews**

The researcher played an active role during the interview process. An unstructured and reflective approach was paramount during phenomenological interviewing while bracketing protected the data from contamination so that the phenomenon could present itself 'as is' (Wimpenny & Gass, 2000:1487). During phenomenological interviews, the aim is to explore and understand the phenomenon through the descriptions provided by the people. There is thus a subject-subject relation whereby the researcher relates to and is present with the participant. The researcher also shifts to a subject-phenomenon relation. The core interest is with the phenomenon as it is presented by the participant (Englander, 2012:25).

The researcher assumed that the phenomenon (professional dignity of nurses) would emerge as the research continued (in the natural environment of private healthcare services). Furthermore, the researcher also assumed that she had to play an active role (Appleton & King, 1997:19) to facilitate and participate

during interviews, while engaging with participants to create an environment of openness where the participant felt comfortable, to allow constructions of the meaning of the phenomenon to surface. In descriptive phenomenology researchers believe that some sort of expression of the experience under exploration is needed in order for the phenomenon to surface. Such experiences are expressed through communication (verbally and non-verbally) and leave the researcher with rough, raw data (the natural attitude of the phenomenon) (Giorgi, 2005:80).

Conducting a trial interview

The researcher conducted a trial interview at a private healthcare facility as preparation for the unstructured phenomenological individual interviews to be conducted at the two research facilities. The researcher approached a colleague to participate in the trial interview. It was confirmed that the session would serve as a trial session for non-research purposes only. The researcher attempted to simulate the session as closely as possible to the unstructured phenomenological individual interviews to be conducted. The invitation, documents, contacting the participant, venue and the conducting and audio-recording of the interview were planned as replicas of the processes to be followed at the two research facilities. The researcher was able to adjust the process as a result of the lessons learned while conducting the trial individual interview. She forgot to turn on the audio-recorders and felt clumsy in her handling of the equipment. She included a reminder in her notes to switch on the recorders before commencing with the interview and practised to use the audio-recorders confidently. She realised the need for a clock to help her keep track of the time and made arrangements accordingly for the subsequent interviews. Exposure to the process of conducting the interview and positive feedback from the nursing colleague enhanced the researcher's confidence to conduct the interviews at the two research facilities.

Preparing for the interview

Comprehensive preparation prior to interviewing created a phenomenological mind-set. The researcher considered the opening question carefully to focus on the phenomenon for all participants within the same framework. The

researcher applied the principles of bracketing prior to and during the interviews. She made sure that she had an accurate understanding of the phenomenon under investigation and her own pre-understanding thereof (Dahlberg, et al. 2008:201). She reflected on her own 'knowing' and feelings regarding the phenomenon in her reflective diary on the evening prior to the interviews (refer to Annexure H). She acknowledged her own exposure to private healthcare for 21 years and wrote about her own encounters regarding the phenomenon. She recorded experiences of violation of professional dignity. She recorded incidents that came to mind where she acted as an advocate for professional nurses when factors in the work environment impacted on their professional dignity. She became aware of one particular event which affected her own professional dignity deeply and reflected on her feelings. She also recorded the factors she perceived as influencing the professional dignity of nurses and what was known about it through previous research. Nurse-doctor collaboration came to mind and the researcher recalled many experiences in the workplace in this regard. The researcher engaged in a phenomenological mind-set and bracketed her 'knowing' and feelings regarding the phenomenon. She cleared her mind by suspending these 'knowing' and feelings outside the bracketed phenomenon. She wanted to see the experiences of the factors impacting on the professional dignity of nurses with fresh eyes. She was sincere in her seeking of the truth regarding the phenomenon to be explored.

Written permission to conduct the research was obtained from the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria (reference no. 260/2016) before commencement of data collection (Refer to Annexure A). Permission to conduct the study in the selected private healthcare facilities was obtained from the hospital management (refer to Annexure B). The researcher approached the nurse managers of the two private healthcare facilities for assistance with the prior arrangements for conducting the interviews. These arrangements included assistance with the identification and selection of participants, determining suitable dates for interviewing, and finding an appropriate interviewing facility and providing contact details of the selected participants. Seven participants were identified

in healthcare facility 1 and four participants in healthcare facility 2. The boardroom was found to be an appropriate facility in private healthcare facility 1 and the training room in private healthcare facility 2 for providing privacy, minimum disturbance and comfort during the interviews.

During an initial telephone conversation, the researcher introduced herself to the candidates and briefly explained the study. Willingness to participate was agreed upon and documents to follow electronically were explained. These documents included the participant information and informed consent leaflet and a permission letter to conduct the study at the two selected private healthcare facilities. The date and time for each interview was negotiated with each participant and the nurse manager was informed. The researcher informed the senior and regional managers of the two facilities about the intended interviews. A participant information group session was conducted one day prior to the interviews at healthcare facility 1. Participants and their managers were invited to the session. The nurse manager, a deputy nurse manager, four unit managers and six participants attended the meeting. The study was explained briefly and there were opportunities for asking questions. Arrangements for the scheduled interviews were finalised. Four interviews were scheduled on the first day of interviewing between 09.00 and 19.00 and three interviews were scheduled on the following day between 09.00 and 16.00. The researcher explained the purpose of the study prior to interviewing to one participant who did not attend the group session. An orientation session was not conducted at healthcare facility 2 due to the smaller sample size of the group. Information was communicated to individual members telephonically and per email prior to each interview. Four interviews were scheduled from 09.00 until 14.00 at facility 2.

The researcher prepared the interview venue prior to the interviews. She took care to provide comfort and privacy and set the tone for opening each discussion. Comfortable seating was arranged by placing chairs facing each other. Air-conditioning was set in advance to provide a comfortable room temperature. A ‘Do not disturb’ sign was placed on the door to ensure minimal disturbance during interviews. A pocket of tissues was placed discretely in

close proximity of each participant if needed in case of emotional moments. The researcher was prepared to facilitate debriefing sessions should the need arise. Options for referral were considered. A small gift (chocolate) as a token of appreciation was prepared for each participant. Two audio recorders were tested and charged and placed close to the participant's seat. Copies of informed consent were available for participants who might not have brought their signed copies. Copies of demographic information were prepared for completion prior to each interview. The researcher kept a list with the initial question and possible probing questions to guide each interview (refer to Annexure E). The researcher made notes in her reflective diary concerning the method to be followed prior to the onset of each interview to serve as a reminder (such as switching on the audio recorder on before each interview). Interviews were scheduled with one hourly intervals to allow time for reflection and for compiling field notes between interviews.

Conducting the interviews

The researcher welcomed each participant and briefly explained the interview process and the purpose of the study. Voluntary participation in the study was confirmed and informed consent was finalised. Demographic information was obtained. The concept, 'professional dignity of nurses,' was explained briefly. Questions were clarified and readiness to commence with the interview was confirmed. The recorders were switched on and the participant was reassured that all recorded information would be anonymous and managed confidentially.

The interviews were conducted in English. The researcher encouraged participants to ask for clarification and verbalise their thoughts in their home language if they should experience difficulties expressing themselves in English. The researcher started the discussion by asking the following main question: 'How do you experience factors that impact on your professional dignity?' She used communication skills such as open questioning, attentive listening and an open body language (nodding, smiling, looking interested) to encourage the free flow of information with minimum interruptions. She explained some concepts for example "perceive" in Afrikaans ("hoe sien jy

dit?") when Afrikaans speaking participants found it difficult to understand a particular question. She made use of supportive noises (such as "hmmm") to put participants at ease and to enhance rapport with participants. The researcher further utilised silence as a therapeutic moment to think about and reflect on what was said and what to say next.

When the researcher sensed that a participant had nothing more to say following the main question, she made use of probing questions (refer to Annexure E) to prompt the participant to elaborate on the phenomenon. Probing questions were additional to the main question and were only used when the discussion needed some direction. Participants were able to continue the conversation with ease once prompted with a probing question. Probing questions were not used as a rule but were found to be a very helpful tool to stimulate discussion and to provide opportunities for deeper experiences to surface.

The researcher ensured that she clarified unclear phrases with each participant and reflected on remarks at suitable times (Gill, Stewart, Treasure & Chadwick, 2008:292-293). She reassured participants when they found it difficult to express themselves and encouraged them to say the words even when it meant that they had to use a different language. The researcher showed empathy during emotional moments and provided comfort and time to recover before continuing with the interview.

The interviews lasted 21-45 minutes and were audio-recorded with the permission of the participants. The researcher was cautious not to rush and waited patiently for a true reflection regarding the experiences to emerge (McNamara, 2005:699).

- **Field notes**

  Field notes provide valuable context to transcribed data for the researcher to gain deeper insight into the collected data (Sutton & Austin, 2015:227). The researcher made field notes recording methodological, ethical and personal decision making during the research process. This included notes during or

immediately after the interview process to reflect on a participant's body language and gestures. Notes were made of what was seen, thought, heard and experienced throughout each interview (Taylor, Bogdan & DeVault, 2016:79). The notes were recorded as descriptive, methodological, theoretical and personal notes as briefly described in the following section (Polit & Beck, 2017:521-522).

Descriptive notes

Descriptive notes portray observations made by the researcher during fieldwork. It includes descriptive notes on actions, discussions and context as observed and recorded during or as soon as possible after a research event (interviews in the current study) took place. The aim is to record such observations as comprehensively and objectively as possible (Polit & Beck, 2017:521; Dahlberg, et al. 2008: 227; Polkinghorne, 2005:143). The researcher's descriptive notes described non-verbal behaviour of participants and contextual aspects following each individual face-to-face interview. It helped her to gain a deeper understanding of the experiences of the factors impacting on the professional dignity of participants and added to the richness of the baseline data (the transcribed interviews).

Examples of descriptive notes
Participant T: The participant expressed difficulty following her interview in expressing her deeper experiences in English. She became emotional when speaking about theatre nursing management and caring for sub-ordinates. I did not explore the underlying reason for the emotion. The participant appeared uncomfortable and reserved at the time. She recovered quickly and appeared comfortable during the rest of the interview. There were good silent moments when I observed the participant was thinking before speaking. We were both comfortable during such moments. The interview lasted 45 minutes
Participant A: The participant appeared very tense. She was not a natural conversationalist. She had to be prompted to speak about her experiences. She almost had a lack of confidence to speak. The interview lasted 21 minutes.

Methodological notes

Researchers reflect on research approaches and methods during research and make methodological notes to guide and remind them about effective approaches and new approaches when something has been observed which could be improved. It keeps track of the techniques used during data gathering (Polit & Beck, 2017:522). The researcher kept notes about the initial communication with each participant prior to the interview. She made instructional notes to remind her about the required preparations such as communication with nurse managers to confirm fieldwork, paperwork to prepare (copies of consent forms) and booking of accommodation at the research settings. The notes helped her to keep track of all the actions that needed to take place prior to conducting the interviews. The researcher made methodological notes following interviews to reflect on the effectiveness of the interview facilitation. She noted proposed changes and new suggestions for probing questions.

Example of methodological notes
Following interview 002-008: I have completed the seven interviews at the first research setting and have obtained rich data from the participants. I think it would be beneficial to add one probing question to further probe description of factors unique to private healthcare during the interviews at the next setting. I am going to add the following question: 'If you think of private health specifically, what are those factors unique to private health care services that impact on the professional dignity of nurses'.

Theoretical notes

Theoretical notes are notes about meanings attached to observations during data gathering. It reflects the researcher's thought processes while trying to "make sense of what is going on" (Polit & Beck, 2017:522) and is considered as "preliminary understanding" (Dahlberg, et al. 2008:227). The researcher made notes about the experiences of factors impacting on the professional dignity of nurses that stood out with possible attached meanings.

Example of theoretical notes
Following interview 002-008: So far, all the participants have described uncomfortable experiences in their collaboration with medical practitioners. It appears to be a major factor impacting on their professional dignity. Not being able to connect with patients because of the constant 'busyness' in private healthcare appears to hinder them from feeling dignified. There is also a definite new and old generation experience which causes inner conflicts and frustrations.

Personal notes

Researchers reflect on their own feelings, as experienced during fieldwork, and make personal notes about their experienced emotions. Personal notes sensitised the researcher's awareness about feelings which might influence her observance and role in the field (Polit & Beck, 2017:522), supporting the reflective approach in a phenomenological study (Dahlberg, et al. 2008:224). The researcher had to reflect and bracket her own experiences while conducting the interviews. As the researcher was knowledgeable about private healthcare and had experienced factors which impacted on her own professional dignity, the keeping of personal notes was crucial.

Example of personal notes
Participant Pb: I "felt like I was a bruised woman, like I've been battered". The researcher suspended her feelings and emotions through bracketing as the participant described verbal abuse from a medical practitioner.

Reflective journal

A reflective journal is often used in phenomenological research to facilitate phenomenological reduction and is a valuable tool for self-monitoring, reflecting on one's own emotions, thinking processes and personal factors which might influence the researcher throughout the study. It is thus a method to support reflexivity (Berger, 2013:221). The keeping of a reflective journal serves as a supportive tool for phenomenological researchers to note their assumptions through the process of bracketing (Wojnar & Swanson, 2007:175). It serves as a self-reflective mirror and provides evidence of the

process of reflexivity and surfacing biases and the deliberate suspension thereof (Morrow, 2005: 254). Researchers reflect on emerging concepts of "how they come to know what they know", in reflective journals (Watt, 2007:96). A recent study suggests a modern approach in reflective journaling going beyond the written text. An electronic reflective portfolio makes provision for collages, drawing scenes, photograph clippings, comics and illustrations (DeFelice & Janesick, 2015:1584). The researcher kept a reflective journal (refer to Annexure H) during the research process to reflect on any emotions which could have influenced the research process. She also reflected on thought processes during data analysis and kept track of a to-do list during fieldwork. At times the reflective diary was used purely as a personal soundboard to gain perspective and to re-direct thought processes.

2.4.2.6 Data analysis

Data analysis reduces raw data into smaller pieces, keeping the 'initial whole' in mind (Dahlberg, et al. 2008:233). An attitude of "bridling" was assumed, striving not to jump to conclusions but to spend time and allow adequate thinking about the data in order to perceive the phenomenon as it is "lived" by the participants (Dahlberg, et al. 2008:241-242). The researcher adopted a disciplinary attitude when analysing the data, transforming the raw data into new meaning (the phenomenological attitude) within her disciplinary framework. The data (experiences of the factors impacting on the professional dignity of nurses) became non-specific towards the individual and fulfilled the scientific standard that knowledge had to be general (Giorgi, 2005:81), thus contributing to the theoretical base concerning the professional dignity of nurses.

- **Eidetic reduction**

  The researcher attempted to part with her own pre-conceptions and knowledge regarding the phenomenon and to view it from the perspective of the participants, when engaging with the data (Wertz, 2005:172). The researcher adopted a phenomenological attitude through "bridling" (Dahlberg, 2006:16), a unique way of waiting for a description of the phenomenon to

emerge from the research, “knowing not to make definite what is indefinite” (Dahlberg, et al. 2008:241), prematurely.

- **Essences**

  Essences refer to the essential structures of meaning of a phenomenon which determine the phenomenon and its unique character (Dahlberg, 2006:11). When a phenomenon comes to light as “something”, its essence is presented (Dahlberg, 2006:12; Moran, 2000:154). Essences are thus not mysterious or hidden concepts. Essences form part of persons’ everyday lifeworld experiences (Dahlberg, 2006:11). When an apple tree is seen by someone, it is because of an immediate “grasp” of the essence (Dahlberg, 2006:12). A phenomenon has an original form which makes the phenomenon what it is. It is the phenomenon in its original form which presents its essence. This implies that there is a “stop” to an essence when it presents as something else. The something that remains, and differentiates the phenomenon from other phenomena, is the essence (Dahlberg, 2006:13). A change in the essential meaning constitutes a different phenomenon (Dahlberg, 2006:13; Beck, Keddy & Cohen, 1994:255).

  Describing phenomena requires rich information with ample variations and nuances for essences to be found. The experiences of phenomena present differently as concrete or imagined depending on the intentions (Dahlberg, 2006:12). Essences are never cast in stone and can never be completely clarified and described. Meaning changes as life world experiences changes (Dahlberg, 2006:16). Essences can, however, never be separated from their phenomena (Dahlberg, 2006:18).

  In the current study essences and their complete structures are presented. An essence, with its constituents, is described. Constituents are those “particulars” which belong to the essential structure and are referred to as “individualisations” of the essence (Dahlberg, et al. 2008:255). Thick descriptions of the professional dignity of nurses enabled the researcher to identify the essences as the truly reflected phenomenon’s “way of being”, the

invariant that revealed itself from multiple variants, the phenomenon ‘as is’ (Dahlberg, 2006:18).

- **Descriptive analysis**

  The researcher entered into the phase of descriptive analysis with a phenomenological attitude. With an “attitude of wonder”, she left “her own world behind” to enter into the world of the participants (Wertz, 2005:172). She was thus open to the experiences of participants concerning the factors impacting on their professional dignity. She applied “epoché” throughout all phases of the analysis, free of judgement and own pre-assumptions, to purely reflect on what had been given to her as experienced by the participants (Finlay, 2014:122). Premature understanding of the content was prevented as phenomenology researchers prefer the “indefiniteness” (of possible meaning) to “last as long as possible” while they question and ponder upon possible understanding and meaning of the experiences of the participants (Dahlberg, et al. 2008:241).

Preparation of data

The data, including audio-taped interviews, were prepared for an in-depth eidetic analysis. Field notes were prepared as supplementary information, in addition to transcribed data, and formed part of the data analysis. All field notes, transcriptions and audiotaped interviews were secured electronically on a computer protected by a password and on a hard drive which was kept in a secured location. An additional electronic copy was kept in storage in the cloud in Dropbox. The original audio recordings, hard copy transcriptions and field notes were locked in a safe. The researcher kept a list correlating each participant’s name with her number in case any audits might be required in future. The researcher kept a hard copy of this list securely locked up at her home and no such document existed on any computer. The audio-taped interviews were transcribed verbatim by the researcher (refer to Annexure F). Non-verbal communication and mannerisms such as laughing, sighing or signs of discomfort were noted (Sutton & Austin, 2015:228). The researcher verified the transcribed interviews for accuracy by checking it with the original audio-recordings once completed. Copies of the audio-recordings and the

transcriptions were shared with the study's supervisor for evaluation and feedback.

The data will be securely stored for three years. Should the researcher want to destroy the data, hard copies would be shredded and electronic copies destroyed using appropriate software designed for such purpose.

The initial whole

The researcher familiarised herself with the research data by reading the verbatim transcriptions repeatedly to acquire a picture of the 'whole' of the participants' experiences (Kleiman, 2004:14; Wertz, 2005:172) before data analysis commenced (Giorgi, 2012:5). She also listened to the recorded interviews repeatedly.

The researcher opened her mind to the data and remained close to the data, waiting for the surprise element/s to emerge from the data. She did not intend to transform the data during this phase and aimed to discover the "otherness" in the data as the data started to 'speak' to her. She got a good sense of the data as a whole and became prepared for a new understanding of the meaning of the phenomenon (Dahlberg, et al. 2008:238).

Phenomenological parts

The researcher's attention during this step was focused on parts of the data beginning to emerge. With the whole of the data in mind she began to identify units of meaning by dividing the data into smaller meaning units (Kleiman, 2004:14; Giorgi, 2012:5). Redundant data and irrelevant expressions were excluded (Wertz, 2005:172). The aim was to better understand and know the data (Dahlberg, et al. 2008:243). During the next step of the data analysis process the researcher grouped data units of similar meaning into clusters of meaning. This allowed her to structure the data in such a way that she could be "sensitive to nuances and changes" in the meaning as the essence of the phenomenon (and its constituents) began to reveal itself, continuously moving between the whole and its parts (Dahlberg, et al. 2008:244).

The researcher made side notes on the transcribed interviews to serve as potential codes to be grouped at a later stage. She went through the process more than once. Codes were grouped on A3 posters and put up to be visible to the researcher to reflect, think and digest. The researcher went back to the transcribed interviews and added codes while others were re-phrased. A new set of themes emerged and were again recorded on A3 posters. The researcher took time to think about and reflect on the experiences described by the participants. She drew pictures and flow charts and looked at the data repeatedly. A concept of 'professional being' started to surface as a golden threat with eight emerging constituents.

Searching for an essence of the phenomenon – a new whole

The researcher was sensitive to the essence of the phenomenon to reveal itself as she was looking for the things that stood out in the detail of the transcripts (Dahlberg, 2006:13). The researcher looked beyond the natural dimension of the experiences in order to become aware of the phenomenological dimension (an understanding) of the factors that impacted on the professional dignity of the participants (Finlay, 2012:185; Solomon & Higgens, 1996:251). The characteristics of the phenomenon were identified through free imaginative variation. Concrete examples of the participants' experiences were "imaginatively" varied in all possible ways to identify essential elements from those that were "accidental or incidental" (Wertz, 2005:168; Kleiman, 2004:15). When a change in the characteristic transformed the identity of the phenomenon, it was considered to be essential (Beck, et al. 1994:255). Once the essence of the experiences had been revealed, the clusters of meaning units were related to one another and incorporated in constituents (Dahlberg, et al. 2008:245). The degree to which the clusters substantiated the essence determined their inclusion in the list of constituents (also called themes) (Dahlberg, et al. 2008:255).

2.4.2.7 Description of findings

The researcher described the meaning structure as derived from the data analysis starting with a short description of the essence of the phenomenon, thus presenting a more abstract and general description of the phenomenon.

A description of the constituents of the essential meanings followed. Constituents are the individualised particular meanings that constitute the essence and present the lived meanings of the participants, supported by quotations from the participants as transcribed from the participants' interviews (Dahlberg, et al. 2008:255). The essence and its constituents are presented in chapter 3 of this thesis. The description of the constituents was supported by quotations from the participants as transcribed from their recorded interviews (Dahlberg, et al. 2008:256). Pure description, without referring to relevant literature, ensured remaining close to the phenomenon during the presentation of Phase 1's findings, obtained during the 11 individual interviews (as presented in chapter 3). Constituents, contextualised within relevant literature, will be presented in chapter 4 of this thesis. The data were clarified by relevant theory and research findings from similar studies (Dahlberg, et al. 2008: 273).

2.4.2.8 Literature review

Phase 1 of the study comprised an enquiry into the experiences of professional nurses concerning factors impacting on their professional dignity. Based on the adopted phenomenological philosophy, the researcher aimed to discover the subjective lived experiences of professional nurses in their everyday work lives regarding their professional dignity. Guided by such philosophy the researcher wanted to see things as presented to her by the participants while being sensitive for the essence to emerge from the data. After pinpointing the essence, it had to be accurately phrased in words. Thereafter the constituents, supporting the essence, were uncovered. The essence and its constituents were presented, without referring to literature sources, to reflect accurate descriptions, as presented by professional nurses during their interviews, of the experiences of factors impacting on their professional dignity.

To broaden the understanding of the phenomenon of the experiences of the factors impacting on the professional dignity of nurses an extensive literature study was done. The researcher explored theory and other descriptions and findings relating to the findings of factors impacting on the professional dignity

of nurses. Literature served to illuminate and to contextualise the current study's findings. The aim was to further clarify the phenomenon. The researcher took care to remain focused on the phenomenon preventing it from being presented too abstractly. Moving too far away from the phenomenon might result in "not seeing it at all" (Dahlberg, et al. 2008:273). The findings, and the discussion of the findings with a literature contextualisation, served as basis information for the development and refinement of the strategies to preserve the professional dignity of nurses as presented during phase 2 of the current study. (The literature review was presented in chapter 4 of the thesis).

2.4.3 Measures to ensure trustworthiness

The trustworthiness of qualitative research is measured by the principles of truth value, applicability, consistency and neutrality. The criteria to assess the research process are determined by the philosophical framework adopted by the specific study (Krefting, 1991:217). In the current study a phenomenological approach, within a constructivist paradigm was followed. The researcher thus applied the criteria of credibility, authenticity, transferability, dependability and confirmability to account for the trustworthiness of the current study (Polit & Beck, 2017:747).

Researchers have to account for the trustworthiness of the research process by answering the following question: "How can I be confident that my account is an accurate and insightful representation?" (Polit & Beck, 2017:558-559). Phenomenological researchers are instruments in the data collection process and have to accurately describe the meaning of the experiences of the participants they engage with to ensure the trustworthiness of a study's findings (Polit & Beck, 2017:60). The researcher used bracketing as a technique to minimise bias during data collection and analysis. She determined and described the epistemological, ontological and theoretical frameworks guiding the current study. She bracketed her knowledge, personal feelings and experiences of the phenomenon by suspending it outside the 'bracketed phenomenon'. She focused on the phenomenon, participants' experiences of factors impacting on nurses' professional dignity, to identify multiple emerging variances of the phenomenon and its essential structures

(Gearing, 2004:1433). “Unbracketing”, after data collection and data analysis, ensured the re-integration of the bracketed data into the research investigation, supporting the description and discussion of findings by using a complete and comprehensive understanding and knowledge of the phenomenon (Gearing, 2004:1434).

A discussion of the criteria (credibility, authenticity, transferability, dependability and confirmability) applied to ensure trustworthiness in the current study will be presented in sections 2.4.3.1-2.4.3.4 of this thesis.

2.4.3.1 Credibility

Credibility is achieved when the research findings reflect a true picture of the phenomenon as described by the participants (Polit & Beck, 2017:559). The researcher put her pre-understanding of the phenomenon on hold in order to ensure the revelation of the true essence of the phenomenon (Starks & Trinidad, 2007:1376). This process is referred to as bracketing (Cogswell, 2008:91). Credibility is enhanced through using well-established research methods (Shenton, 2004:65). The researcher conducted unstructured phenomenological individual interviews within a phenomenological framework and followed the proposed methodology diligently. A reflective diary was kept to reflect on thoughts, feelings and research methods. Field notes added to the richness of the data (Shenton, 2004:68). Being a nurse manager, for more than twenty years in private healthcare facilities, supported the credibility of the researcher as a data collection instrument. She understood the context and research setting which supported her investigative skills. She utilised her interpersonal communication and interviewing skills to enhance the facilitation of the unstructured phenomenological individual interviews. The researcher conducted a trial individual interview session in preparation for her fieldwork (Krefting, 1991:220; Shenton, 2004:68). Participants’ honesty was achieved by applying the ethical principles of voluntary participation and support with respect for the right of withdrawal should any participant want to do so (Shenton, 2004:66). The researcher applied the principles of peer review and triangulation (Anney, 2014:276-277; Shenton, 2004:65-67; Krefting, 1991:219)

to further enhance the credibility of the study as discussed in the following sections of this thesis.

Triangulation

Credibility was achieved through data triangulation by using more than one data collection method. Unstructured phenomenological individual interviews (audio-recorded and transcribed) and participant observations (field notes) were conducted (Krefting, 1991:219). Data source triangulation ensured credibility by maximising the range of data sources to conclude the best possible outcome for understanding the phenomenon. A range of participants was deliberately chosen, including participants from different shifts, units and levels of responsibility, as indicated in section 2.4.2.4 of this thesis (Krefting, 1991:219; Shenton, 2004:66). Site triangulation enhanced the trustworthiness of the results (Shenton, 2004:66; Polit & Beck, 2017:563) by using two research facilities located in the KwaZulu-Natal and the Free State provinces of South Africa.

Peer review

Scrutiny of research projects assists researchers to refine research methodologies (Shenton, 2004:67; Polit & Beck, 2017:568). The researcher received input from academics (two lecturers from the Department of Nursing Science of the University of Pretoria) at an in-house presentation during the initial development phase of the proposed research. A lecturer from the Faculty of Health Sciences of the University of Pretoria and an external lecturer from the University of South Africa further scrutinised the proposed study and gave feedback after a presentation by the researcher at a research public proposal defence.

The researcher worked closely with the study's supervisor and co-supervisor who provided inputs throughout the research process during contact sessions, telephone conversations and electronic communication. These sessions supported the researcher to actualise the real truth and to maintain a phenomenological mind-set (Shenton, 2004:67). Frequent discussions during the data analysis phase supported the formulation of the essence and

constituents and ensured congruence of the findings with the research data. Active engagement with three colleagues provided opportunities for reflection during the current study.

2.4.3.2 Authenticity

Authenticity refers “to the extent to which researchers fairly and faithfully show a range of different realities and convey the feeling tone of lives as they are lived” (Polit & Beck, 2017:572). It requires from the researcher to honour and seek for different constructions (Morrow, 2005:252) of the phenomenon from participants.

Authentic fairness was achieved by taking all participants’ constructions into consideration and reflecting on them equally. The researcher engaged with the data over a period of three months and was cautious not to hurry or to jump to pre-mature findings. On-going reflexivity whereby the researcher reflected on emotions, self-assumptions and intersubjective research processes ensured a conscious awareness of self during the construction of knowledge (Finlay, 2002:532). An emic approach added to a climate where participants felt comfortable sharing their experiences (Manning, 1997:106). The researcher thus stayed close to the reality of the phenomenon as reflected in the natural setting in nursing practice situations of the two participating private healthcare facilities.

The researcher further took care to fully understand the phenomenon, as described by the participants, regarding them as co-partners in the research process. Data were regarded as belonging to the participants which required pure reflection, without contamination by the researcher’s pre-knowledge or own assumptions, thus fulfilling the requirement of tactical authenticity (Manning, 1997:111).

2.4.3.3 Transferability

Transferability refers to the “extent to which findings can be transferred to or have applicability in other settings or groups” (Polit & Beck, 2017:560). Rich and detailed descriptions could enable future readers to identify and apply the

current study's results to their own situation and/or other settings (Lincoln & Guba, 1985:316; Shenton, 2004:69). Description of the setting, the sample and the step by step data collection process provided sufficient context and detail for the reader to make transferability decisions. The onus is on the reader (receiver of information) to make a transferability decision, and not on the researcher (sender) (Shenton, 2004:70; Morrison-Beedy, Côté-Arsenault & Feinstein, 2001:51).

2.4.3.4 Dependability and Confirmability

Dependability allows future researchers to repeat the study (Polit & Beck, 2017:559). Research processes were described in detail and the research design in the study was discussed within a descriptive phenomenological framework. Step by step description of the data gathering process was included in the current study. Quotations from the transcripts were incorporated in the description of the findings to prove the correlation of the description of the phenomenon and the lived experiences thereof by the participants (Dahlberg, et al. 2008:256). According to Giorgi (1988) findings have to reflect the true essence of the phenomenon to be valid (Beck, et al. 1994:258).

2.5 PHASE 2: DEVELOPMENT OF STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN THE DEMANDING HEALTHCARE ENVIRONMENT OF PRIVATE HEALTHCARE FACILITIES

In this phase strategies were developed to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities. The findings of phase 1 were used as basis information for the development of the strategies. The factors that impacted either positively or negatively on the professional dignity of nurses in two private healthcare facilities, as described in phase 1 of the current study, were incorporated in draft strategies that were refined through conducting two focus group interviews with 16 participants. The focus group interviews included professional nurses, members of the health team and management from the two selected private healthcare facilities.

The principles of strategic navigation were incorporated during the development of the draft strategies. Strategic navigation deals with current reality and how it emerged together with exploring opportunities which might have potential to develop into new pathways (Hillier, 2011:503). Future possibilities to determine strategies were sought to identify new future pathways to preserve the professional dignity of nurses. A detailed description of the development and refinement of the strategies and the strategy development processes is discussed in chapter 5.

2.5.1 Philosophical assumptions

In the description of the philosophical assumptions underlying phase 1 of the current study, the researcher integrated assumptions of the constructivist paradigm with phenomenology. Only the constructivist paradigm is applicable to phase 2 of the current study.

2.5.2 Ontological assumptions

In the constructivist paradigm researchers assume that multiple realities of a phenomenon exist (Denzin & Lincoln, 2008:32) and that reality is "mentally constructed by individuals" (Polit & Beck, 2017:10). The researcher thus included people (professional nurses, health team and hospital management) who were involved in preserving the professional dignity of nurses to participate in the current study, as discussed in chapter 5 of this thesis.

2.5.3 Epistemological assumptions

In research in the constructivist paradigm "findings are the creation of the interactive process" (Polit & Beck, 2017:12) and knowledge is constructed when the researcher and the participants interact (Guba & Lincoln, 1994:111). In focus group interviews with interactions between representatives from the professional nurses, the health team and hospital management, the strategies to preserve the professional dignity of nurses, were refined.

2.5.4 Methodological assumptions

Flexible emergent research designs are associated with the constructivist paradigm (Polit & Beck, 2017:12) that promotes interaction among the

participants and between the participants and the researcher (Guba & Lincoln, 1994:111). A focus group interview, “involves some kind of collective activity and discussion determined by the researcher” (Botma, Greeff, Mulaudzi & Wright, 2010:210). In the current study the researcher aimed to encourage interaction between the role players that could enhance the professional dignity of nurses. She assumed that when professional nurses hold themselves in high esteem, their autonomous practice would be respected by members of the health team. The creation of supportive environments by management could furthermore enhance the professional dignity of nurses.

2.5.5 **Research design**

Research design is considered within the ontological, epistemological and methodological framework including the purpose and goals of the research. In this phase of the study the focus was on the refinement of strategies to preserve the professional dignity of nurses. When research involves human perspectives and their understanding of a specific phenomenon, qualitative research is the design of choice (Ritchie, Lewis, Nicholls & Ormston, 2003:1). There are multiple ways of conducting qualitative research. Naturalist research, through a constructivist inquiry, was conducted (Polit & Beck, 2017:12) in the current study. It involves a process of inductive reasoning through which conclusions and theories can be developed (O’Reilly & Kiyimba, 2015:23).

A descriptive qualitative research approach was followed and focus group interviews were used for the refinement of the proposed strategies to preserve the professional dignity of nurses.

2.5.6 **Research method**

Descriptive qualitative research is not rooted in specific disciplinary approaches such as phenomenology, ethnography, grounded or critical theory and is conducted as pure qualitative research within a specific disciplinary frame such as for example the discipline of nursing (Polit & Beck, 2017:486). It is the design of choice for the description of phenomena close to the data (Sandelowski, 2000:334). Descriptive qualitative research methods are seen

as “living entities that resist simple classification” (Sandelowski, 2010:77). Descriptive qualitative studies aim to “draw a picture” of a phenomenon or situation as it occurs naturally (Gray, 2014:36) within the “real world” context (Ritchie, et al. 2003:34). In the current study such ‘pictures’ represent strategies as pathways which can be followed to preserve the professional dignity of nurses.

2.5.6.1 Focus group interviews as a research method

The researcher aimed to refine the strategies to preserve the professional dignity of nurses through the views and opinions of groups of participants interacting during focus group discussions. In such discussions concepts are scrutinised, ideas are shared and knowledge is constructed through debate (Jayasekara, 2012:412-413). The researcher, as the main facilitator of the focus group interviews, guided the interaction to ensure that the discussions remained focused on the refinement of the draft strategies to enhance nurses’ professional dignity (Ritchie, et al. 2003:185).

Focus group interviews are often used as a qualitative research technique (Carey, 2016:731). It originated in 1940 during World War II under the influence of a respected sociologist, Robert Merton. Merton came to realise that people are more likely to share their ideas in a group where they feel safe among people who are similar to them (Krueger & Casey, 2015:32). Although academics, at that time, did not grasp the concept of focus group interviewing and focused more on quantitative approaches with a positivist nature, market researchers and businesses adopted focus group interviews as a valuable tool in market research during the 1950s (Krueger & Casey, 2015:33; Kamberelis & Dimitriadis, 2013:3). It was only in the 1980s that academics revisited focus groups interviews as a research technique and went back to the roots of it as developed by Merton (Krueger & Casey, 2015:34).

Focus groups interviews are “a form of group interview that capitalises on communication between research participants in order to generate data” (Kitzinger, 1995:299). The focus as a “priori” is on a specific topic (Kamberelis & Dimitriadis, 2013:7) and its power is in the synergy (Plummer, 2017a:297;

Kamberelis & Dimitriadis, 2013:6) which is created between the group members in interaction, resulting in sharing deep enriched data (Morrison-Beedy, et al. 2001:48; Kitzinger, 1995:299). When focus group participants give their views and opinions, such views are reflected upon by other members of the group. As participants hear and listen to other views and opinions and the views on what they themselves have said, their opinions are broadened and sharpened. It leads to deeper meaning, understanding and insight than attainable during individual interviews (Ritchie, et al. 2003:171; Krueger & Casey, 2015:31).

Focus group interviews serve as useful tools when specific ideas need to be expanded (Plummer, 2017a:297; Jordan & Haines, 2017:117) or 'pilot-tested'. Krueger and Casey (2015:39) describe a three phase focus group process in the development of a programme or service. During the first phase detailed understanding is gained from the shared experiences of the focus group participants (target audience) who provide data for the detailed design of the program (Krueger & Casey, 2015:39). During the second phase the proposed design with its prototypes (actions) is pilot-tested against the opinions and ideas from participants (potential users of the programme) of a second focus group. Data collected during this phase aid the 'fine-tuning process' of the design for implementation. A final plan for the programme is developed. A third focus group, following implementation, is utilised for evaluating the effectiveness of the programme (Krueger & Casey, 2015:40). In the current study data were collected through unstructured phenomenological individual interviews during phase 1 regarding the experiences of the factors impacting on the professional dignity of nurses. A draft set of strategies (proposed design) to preserve the professional dignity of nurses was developed from the findings of phase 1 during the second phase of the study. The researcher used focus group interviews to 'pilot-test' and 'fine-tune' the draft set of strategies to preserve the professional dignity of nurses. A final set of strategies (final plan) was developed to serve as long term pathways for private healthcare facilities to preserve the professional dignity of nurses.

- **Understanding focus group interview dynamics**

  The unique group dynamics attached to focus group interviews added 'richness' to the inputs for refining the strategies (Polit & Beck, 2017:511). The ways in which group dynamics emerge play an important role in the progression of the group discussion (Flick, 2009:200). Group dynamics with members, unknown to each other, might differ from those group discussions where members are familiar with each other. Strangers are more likely to go through all phases in the typical group dynamics of small groups (Flick, 2009:200). Focus group participants in the current study were familiar with each other. The researcher sensed trust and respect among group members. Opinions from different perspectives within private healthcare facilities were respected and contributed to active participation of focus group participants. Participants showed sincere interest in the refining of the strategies.

  Understanding the dynamics which evolve in small groups might be useful to researchers planning to facilitate focus group interviews. During the initial phase, known as the 'forming phase', focus group participants might be on their guard and be cautious as to whether they are going to be accepted in the group. Discussions tend to be directed by the facilitator and group members might not yet perceive themselves as being part of the group. Proceeding into the next phase ('storming'), individualism emerges. Some group participants might dominate discussions while others might play the expert role and some might remain silent. Strong disagreements about specific opinions might be present and members might try to adapt themselves to find their specific spots in the group. Thereafter the uneasiness should be replaced by a more cooperative spirit and the focus group participants should become more familiar and comfortable with each other. During this phase known as 'norming', common ground is discovered and ground rules (as set by the facilitator) are considered. Focus group participants should then be ready to proceed to the 'performing' phase to cooperate productively and in synergy. Interaction becomes open and more relaxed and allows for the facilitator to adopt a less participative role in leading the discussion. Researchers should thus strive to dwell in this phase as long as possible before proceeding to the final phase of 'adjourning' (Ritchie, et al. 2003:175-176; Tuckman & Jensen,

1977:419; Jordan & Haines, 2017:118). Final thoughts and statements are shared before the researcher summarizes the participants' major contributions, thanks the participants and adjourns the meeting. The phases described are interactive and dynamic and the sequence and presence might present differently in various groups (Ritchie, et al. 2003:175-176; Flick, 2009:200).

Sensitivity in identifying these phases assists researchers to adapt their facilitation style to secure the best possible focus group outputs. Focus group participants in the current study moved almost immediately into the 'performing' phase and they were focused and productive. Distribution of the draft strategies to focus group participants prior to the focus group interview contributed to the readiness of participants to discuss the strategies. A "deliberate discussion approach" was thus a useful tool to enhance the richness of the data (Rothwell, Anderson & Botkin, 2016:734).

- **Facilitating focus group interviews**

  Facilitating focus group interviews is a skill and encourages optimal participation of focus group participants. All opinions should be heard and listened to. Discussion is guided without the active participation of the facilitator (Gill, et al. 2008:293). Part of the interviewer's role of interviewer might at times be taken over by the participants themselves while the researcher assumes on a more passive role by listening to the conversation (Ritchie, et al. 2003:171). Reflective listening promotes active and expressive participation. At times, facilitators might find it necessary to clarify discussions between group members while reflecting (through paraphrasing) ensuring that the facilitator understands the content of what has been said. Reflecting on participants' feelings and summarising expressions could enhance all participants' understanding of discussions. Facilitators might need to adopt a non-reflective style during discussions with limited verbal and non-verbal responses. This is an effective way of allowing focus group participants to speak openly about their thoughts. (Doody, Slevin & Taggart, 2013:[sp]). There is thus a fine balance between knowing when to intervene and when not to maximise the flow of rich group inputs (Ritchie, et al. 2003:172). The focus

group participants might at times divert into a direction which might seem to be insignificant but which could potentially turn out to be valuable. It requires a fine facilitating art to distinguish when to allow wondering and when not to do so (Smith, 2015:64).

The researcher portrayed herself in a friendly and professional manner throughout the facilitation of the focus group interviews. Ground rules of respect for individual opinions were set at the outset of each interview session. The researcher explained the value of each individual opinion in the refining of the strategies and the need for multiple opinions to ensure the gaining of rich inputs from the focus group participants. She took care not to dominate the discussion but to give focus group participants' opportunities to respond to others' opinions and to synergise the group's ideas. Although remaining in the background, the researcher deliberately guided group members to focus on the strategy and actions under discussion when they were tempted to divert. The researcher took care to ask for the opinions of all group members including the quiet participants.

2.5.6.2 Researcher's role

The researcher played an instrumental role in the development of the draft set of strategies to preserve the professional dignity of nurses. She utilised her newly gained understanding of the experiences of factors impacting on the professional dignity of nurses and her insight into and experience of working in private healthcare facilities to develop a draft set of strategies to preserve the professional dignity of nurses. Experience and skills as a nurse manager of more than 21 years enabled the researcher to facilitate the focus group interviews with confidence. She sensed the focus group dynamics intuitively and reacted accordingly. The researcher thus played an active role in facilitating the focus group interviews to ensure focused and open group discussions which helped to refine the strategies to preserve the professional dignity of nurses.

2.5.6.3 Research setting

The study was conducted at two private healthcare facilities in the Free State and KwaZulu-Natal provinces of South Africa. Both facilities were accredited by the Council for Health Services Accreditation of Southern Africa (COHSASA), reflecting their commitment to providing quality patient care. Both facilities' bed occupancy rates exceeded 80%, and served private paying and medically insured patients with high technological care in multi-disciplinary hospital units. Professional nurses, members of the health team and hospital management participated in the focus group interviews.

2.5.6.4 Selection of participants for the refinement of the strategies

The target population for the current study comprised managers, professional nurses and members of the health team working in private healthcare facilities in South Africa. The accessible target population comprised health professionals who were associated with the selected private healthcare facilities, including 447 professional nurses, 20 hospital management members (general managers, doctors and nurse managers) and 395 health team members (members other than nurses). Health team members comprised of 273 medical practitioners, 106 practitioners (physio therapists, dietitians and occupational therapists) and 16 pharmacists.

Purposive sampling was applied in selecting participants to be included in the focus group interviews for refinement of the strategies to preserve the professional dignity of nurses. Purposive sampling is a method used to deliberately choose a sample of participants for their unique characteristics to contribute to the research topic (Ritchie, et al. 2003:78). Researchers ask the following question in considering participants for a purposive research study sample: "What types of people have the greatest amount of insight on this topic?" (Krueger & Casey, 2015:57).

2.5.6.5 Inclusion criteria

The researcher considered a sample (Krueger & Casey, 2015:137) of participants involved in the private healthcare facilities in caring for patients either directly (clinical) or indirectly (management). Criteria taken into account

were expertise and experience in clinical care or management in private healthcare. For variation she considered nurses, members of the health team (medical practitioners, physiotherapists, and pharmacists), and hospital management (general and nurse managers) to be included in the sample. A group size of eight participants per group was considered for optimal interaction (Eaton & Brown, 2017:8).

The researcher approached the nurse managers of the respective healthcare facilities for assistance with the selection, recruitment and contact details of potential participants in the focus group interviews. The selected participants were approached telephonically to determine their willingness, availability and capacity to participate in the current study. A discussion with the co-facilitators confirmed their willingness to assist the researcher with the taking of field notes during the focus group discussions. The researcher considered up to four focus group interviews during the initial planning of the proposed research depending on how the research emerges, with 5-10 participants per focus group. However, after two focus groups discussions, with eight participants in each group, had been conducted, it was decidedly jointly with the study's supervisors that further focus group discussions were unlikely to produce additional information. Consequently only two focus group discussions were conducted, one at each participating private healthcare facility. Each focus group consisted of professional nurses, hospital and nursing management and other health team members. Professional nurses who took part in phase 1 of the study were excluded from participating in the focus group interview during phase 2 of the current study.

- **Focus group 1**

  The researcher selected the focus group participants in collaboration with the nurse manager of the selected healthcare facility. Nurses, hospital and nursing management and members of the health team were selected. A purposive sample of eight focus group participants was chosen based on their area of private healthcare expertise, experience and potential interaction with nurses in the workplace. Participants were invited to participate with the assistance of the nurse manager of the healthcare facility which had been followed by

electronic and telephone communications. Table 2.3 provides a summary of the descriptive information about focus group participants who participated in the refinement of the strategies to preserve the professional dignity of nurses.

Table 2.3: Descriptive information about focus group 1's participants

FOCUS GROUP 1's PARTICIPANTS			
No	**Position**	**Experience**	**Representation**
1	Hospital general manager	15 years of hospital management private healthcare experience with a total of 26 years work experience	Hospital management
2	Clinical manager	14 years clinical and clinical management in private healthcare with a total of 24 years work experience as a medical practitioner	Hospital management
3	Nurse manager	14 years nursing manager experience in private healthcare with a total of 24 years work experience as a professional nurse	Nursing management
4	Medical practitioner	26 years medical practitioner experience in private practice	Health team
5	Pharmacy manager	14 years pharmacy	Health team

		management experience	
6	Unit manager	3 years nursing unit manager experience in private healthcare with a total of 20 years work experience as a professional nurse	Nursing management
7	Senior professional nurse	10 years senior professional nurse experience in private healthcare with a total of 18 years work experience as a professional nurse	Nurse
8	Professional nurse	9 years professional nurse experience	Nurse

- **Focus group 2**

  The researcher selected the focus group participants in collaboration with the nurse manager of the selected healthcare facility. Nurses, hospital and nursing management and members of the health team were selected. A purposive sample of eight focus group participants was chosen based on their area of private healthcare expertise, as well as their experience and potential interaction with nurses in the workplace. Participants were invited to participate with the assistance of the nurse manager of the healthcare facility followed by subsequent electronic and telephone communication. Table 2.4 provides a summary of the descriptive information about focus group participants who participated in the refinement of the strategies to preserve the professional dignity of nurses.

Table 2.4: Descriptive information about focus group 2's participants

FOCUS GROUP 2's PARTICIPANTS			
No	**Position**	**Experience**	**Representation**
9	Hospital general manager	4 years of hospital management private healthcare experience with a total of 21 years work experience as a professional nurse	Hospital management
10	Financial administrative manager	17 years of financial private healthcare experience with a total of 21 years work experience	Hospital management
11	Nursing manager	12 years nursing management experience in private healthcare with a total of 30 years work experience as a professional nurse	Nursing management
12	Pharmacy manager	17 years pharmacy management experience	Health team
13	Unit manager	8 years nursing unit manager experience in private healthcare with a total of 21 years work experience as a professional nurse	Nursing management

14	Clinical facilitator	2 years clinical facilitation experience in private healthcare with a total of 12 years work experience as a professional nurse	Nurse
15	Senior professional nurse	8 years senior professional nurse intensive care experience in private healthcare with a total of 39 years work experience as a professional nurse	Nurse
16	Deputy nursing manger	4 years deputy nursing management experience in private healthcare with a total of 27 years work experience as a professional nurse	Nursing management

2.5.6.6 Data collection

Data were collected during two focus group interviews and by keeping field notes. The researcher assumed that rich in-depth data could only emerge if she actively engaged in the interaction process by encouraging group members to express their views, ponder on the topic and debate any differences in a constructive way. The researcher waited patiently for the data to surface by allowing the interaction to flow freely among the group members (Ritchie, et al. 2003:185).

- **Focus group interviews**

  The group discussions were based on the draft strategies formulated by the researcher, based on the results obtained during phase I of the research. The purpose of the focus groups was to encourage the participants to refine the strategies by commenting on the clarity, applicability, and feasibility of each strategy. Their inputs in re-formulating the strategies were appreciated.

  Preparing for the focus group interview

  The researcher prepared a draft set of strategies to preserve the professional dignity of nurses from the findings in phase 1 of the experiences of nurses of the factors impacting on their professional dignity. The draft set of strategies is included in Chapter 5 of this thesis. The nurse managers of the two healthcare facilities were approached for assistance with the identification and selection of participants, suitable dates for interviewing, an appropriate interviewing facility and for the provision of contact details of the selected participants. Eight focus group interview participants and a co-facilitator were identified in private healthcare facility 1. Participants included the hospital general manager, clinical manager, nurse manager, medical practitioner, pharmacy manager, unit manager, senior professional nurse and professional nurse. Eight focus group interview participants and a co-facilitator were identified in private healthcare facility 2. Participants included the hospital general manager, financial administrative manager, nurse manager, pharmacy manager, unit manager, clinical facilitator, senior professional nurse and deputy nurse manager. The boardroom was found to be an appropriate facility for privacy, minimum disturbance and comfort in both private healthcare facilities. The researcher confirmed the availability and booking of the board room at both facilities.

  The researcher contacted the participants by email to confirm their willingness to participate and to provide participants with the draft set of strategies and the participant information leaflet and informed consent form. These documents ensured informed consent and provided information to participants so that they could make informed decisions as to whether or not they were interested in participating in focus group discussions (refer to Annexure D). Participants

were requested to familiarise themselves with the documents prior to the group session. The operations executive and regional clinical manager were informed of the researcher's intent to conduct a focus group in the healthcare facility as a gesture of courtesy. The researcher attempted to make telephone contact once with each participant prior to the focus group. Due to the busy schedules of participants not all participants could be reached for a telephone discussion. All participants confirmed their willingness to participate by email or with the nurse manager or clinical manager.

The researcher took care to be flexible with proposed dates and times considering the busy schedules of participants and made sure all focus group participants were aware of the estimated duration of the group session (two hours). She arranged for a separate time to engage with a medical practitioner who was unable to attend the focus group discussion due to clinical commitments.

A power point presentation was prepared about the draft strategies for discussion during the focus group interview at healthcare facility 1. The researcher confirmed the final arrangements with the nurse managers prior to travelling to the respective private healthcare facilities. The researcher prepared herself mentally (Krueger & Casey, 2015:177) on the evening prior to each focus group interview. She reviewed the draft set of strategies and practised introducing the focus group interview. She checked the power point presentation for correctness and made sure all supporting documents and seating preparations (pens, snacks and gifts) were ready. She made sure that she set aside enough time for a good night's rest.

The researcher arrived at the venue two hours prior to the scheduled interview to prepare the venue. She prepared the venue for comfort and privacy to set the tone for open group discussions and debates. Comfortable seating was arranged around the boardroom table. Air-conditioning was set in advance to provide for a comfortable room temperature. A 'Do not disturb' sign was placed on the door to ensure minimal disturbance during interviewing. Snacks, a small gift of appreciation (chocolate) and bottled water were placed at each

seat. A copy of informed consent and participation leaflet and the power point presentation and a pen were also placed at each seat. The researcher decided on informal seating arrangements and no seats were allocated to specific participants. Equipment such as the projector was tested. The researcher made notes in her reflective diary with regards to the methodology to be followed prior to the onset of the interview to serve as a reminder, for example a reminder to ask the participants to make notes on the copy of the power point presentation and to hand it in after the conclusion of the focus group interview.

Facilitating the focus group interviews

Trial focus group interview

The researcher conducted a trial focus group interview at a private healthcare facility as preparation for the focus group interview to be conducted at the two research facilities. Informal approval was obtained from the hospital general manager of the facility. It was confirmed that the session would serve as a trial session for non-research purposes only. The researcher attempted to simulate the session as closely as possible to the research focus group interviews to be conducted. Invitations, documents, contacting participants, venue, power point presentation and the composition of the focus group were planned as a replica of the processes to be followed at the two participating research facilities. The researcher was able to adjust the process as a result of the lessons learned in conducting the trial focus group interview. The duration of the session was changed from one hour to two hours. Participants preferred a hard copy of the power point presentation to make notes instead of the full set of draft strategies. Hard copies of the power point presentation were thus provided to participants of the research focus group interviews as suggested during the pre-test focus group interview. A request for a structured hard copy from the co-facilitator to make notes was noted and a document was designed and used accordingly. Exposure to the process of conducting a focus group, and positive feedback from participants of the trial focus group interview, enhanced the researcher’s confidence in facilitating the subsequent focus group interviews at the two research facilities.

Focus group interview 1

Permission to conduct focus group interviews was obtained from the 1st participating private healthcare facility prior to commencement of phase 1 of the study (Refer to Annexure B). This 377 bedded healthcare facility is one of the largest private healthcare facilities in South Africa and is well known as a super speciality city hospital with state of the art equipment and facilities. Multi-disciplinary intensive care and general units provide medical and nursing care serving all major specialities such as cardiac and cardiothoracic disciplines.

The researcher received a warm and friendly welcome from the managers on the day of the focus group interview. The researcher met the medical practitioner prior to the focus group interview for a face-to-face discussion. Relevant strategies and actions were discussed. The discussion took 30 minutes. Although no suggestions or changes were made during the discussion, appreciation for the discussion was expressed and the relevance of the topic was confirmed. The board room was available one hour prior to the commencement of the focus group interview to prepare the facility. After confirmation of all participants' attendance the researcher introduced herself and welcomed all participants. The focus group participants were familiar with each other, rendering the introduction of participants unnecessary. A brief introduction of the study and the purpose of the focus group discussion were presented. Informed consent was discussed and the documents were signed and handed to the researcher. Opportunity for questions was given and group ground rules discussed and agreed upon. The role of the co-facilitator was clarified and the process of refinement of the strategies was explained. A power point presentation was used to facilitate the discussion and revise and refine strategies with actions one by one. Participants were provided with a hard copy of the power point presentation and were encouraged to make notes on the document during the discussion. Each strategy with actions were brainstormed and debated comprehensively. Changes were agreed upon by all group members before moving on to the next strategy. Group members' conduct was professional. They remained focussed and provided inputs and suggestions for changes. Some participants engaged more actively in

discussions than others but all members gave inputs at some stage of the group session. Members' familiarity with each other enhanced the open spirit of group members' participation.

The researcher briefly summarised the discussion to conclude the session and allowed opportunities for questions. All participants were thanked for their participation and were requested to leave their documents with notes on their desks when the meeting adjourned. The duration of the meeting was one and a half hour. A letter of thanks was sent by email to all participants following the meeting. The researcher prepared a new refined set of strategies for the focus group at the next facility which took place the following week.

Focus group interview 2

Permission to conduct focus group interviews was obtained from the healthcare facility prior to commencement of phase 1 of the study (Refer to Annexure B). This 238 bed healthcare facility is a medium sized city hospital with state of the art equipment and facilities and provides intensive care and general units serving all major specialties in accordance to the unique disease patterns of the area.

The researcher drafted a new refined set of strategies for preserving nurses' professional dignity for focus group interview 2, guided by the responses from focus group 1's participants. She considered inputs from the focus group interview and the notes made by participants during focus group interview 1. Changes were made as suggested by the group, grammar errors were corrected and some words were rephrased. Field notes, compiled by the co-facilitator, were considered. The nurse manager and participants were approached in the same manner as during the preparation phase of focus group 1. The refined strategies were discussed and debated one by one and changes were made from the participants' inputs. The researcher enjoyed a very active participating focus group interview comprising divergent participants. This focus group discussion lasted two hours. The group composition was similar to that of focus group 1 but had more diverse participants. The clinical manager was replaced by the financial administrative

manager representing hospital management. The researcher was unable to secure the participation of a medical practitioner and a pharmacy manager participated as a member of the health team during the focus group discussion. A final set of strategies to preserve the professional dignity of nurses was formulated by implementing the recommendations of the focus group's participants.

- **Field notes**

  The researcher decided on field notes as a primary data source for data analysis. Limited opportunities existed for the generation of new data during the focus group interviews. A co-facilitator took detailed notes of the inputs of different participants during the focus group interviews. Focus group participants were provided with copies of the power point presentation and were encouraged to make notes and comments throughout the focus group interview. They were requested to hand their notes to the researcher on completion of the focus group discussion. Notes were taken on the reformulation, adding or removing statements from the draft set of strategies.

  The researcher followed the steps as described by Eaton and Brown (2017:17) in preparing the data for data analysis. She revised the field notes and checked that the notes were legible and that it made sense. All notes were anonymised by removing the participants' real names from the notes. A summary was prepared by combining the researcher's, the co-facilitator's and the focus group participants' notes into one document to serve as a baseline database for the data analysis after completion of focus group interview 1. A second summary was prepared following focus group interview 2 (refer to Annexure G). The researcher omitted to collect demographic information from focus group participants during the focus group interviews. She requested the information afterwards and the received emails were stored electronically to serve as an audit trail.

2.5.6.7 Data organisation and analysis

There is no set formula for analysing data obtained during focus group interviews (Krueger & Casey, 2015:232) and the processes followed might

differ depending on the aim and purpose of the study (Basch, 1987:417). Focus group data analysis involves a process of identifying themes, patterns, perspectives and experiences from the views and opinions of focus group participants in an orderly manner (Eaton & Brown, 2017:18). The researcher should consider unique group dynamics when analysing the data to ensure accurate interpretations of individual statements and views within the broader influence of other focus group participants (Kitzinger, 1995:301; Morrison-Beedy, et al. 2001:48; Gill, et al. 2008:294). It is recommended to analyse data as soon as possible after each focus group discussion to prevent data from being influenced or distorted by subsequent focus group interviews (Krueger & Casey, 2015:232). Well prepared data, including all dimensions of the focus group interview, ensure accurate description. The data to be analysed should include the context, process, focus group dynamics and the environment in which the interview took place (Morrison-Beedy, et al. 2001:51). Transcriptions from recorded interviews are one form of data analysis and it includes a large amount of data to be categorised and themed to be presented as findings (Krueger & Casey, 2015:234). A note-based analysis might be used when focus group interviews are facilitated for the purpose of the “pilot-testing of ideas”. Field notes form the primary source of data (Krueger & Casey, 2015:235). Note-based data analysis was used in the current study using field notes as a primary source to refine the strategies to preserve the professional dignity of nurses.

Data collection and data analysis are simultaneous processes (Krueger & Casey, 2015:223). The researcher thus played an active role in analysing the data, suggesting changes and statements during the debates that took place between the focus group participants to conclude with final statements as refined statements per strategy. She reflected on views, asked for more opinions, and opened debates when opinions changed and she reflected on sensed body language (Krueger & Casey, 2015:226). She worked with real time debates as dynamic data as a process of refinement by analysing it simultaneously with data collection.

The researcher continued with the data analysis of focus group interview 1 on the evening after the focus group interview. She read through the prepared field notes to get an overview of the suggested refined statements from the inputs of focus group participants. The researcher compared and considered the notes of the co-facilitator, the participants and her own (mostly reflected notes written immediately after the group discussion). Most notes were similar presenting the concluded refined statements agreed upon by the focus group participants. The researcher gave extra attention to any notes that differed from the agreed upon statements to be analysed. She considered the unique group dynamics and individual contributions within the group and drafted a refined set of strategies for consideration and further refinement during focus group interview 2. Copies of the revised strategies were made available to participants of focus group 2. She followed the same process after focus group interview 2 and drafted a final set of strategies to preserve the professional dignity of nurses. The focus group interview data were simplistic, concise and focused on the topic. Minimum new data were collected.

An audit trail was kept as proof of the refinement of the strategies. The input of each focus group was reflected in the audit trail. The result of the analysis was a final set of strategies to preserve the professional dignity of nurses in the demanding environment of private healthcare facilities.

2.5.7 **Trustworthiness**

The principles of trustworthiness (credibility, dependability, confirmability and transferability) were applied (Polit & Beck, 2017:747) within the methodological paradigm of a naturalistic inquiry asking the following question: “How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?” (Lincoln & Guba, 1985:290).

Knowledgeable and experienced focus group members contributed to the trustworthiness of the focus group. Each strategy was discussed until consensus had been reached to ensure that the refined/revised strategy reflected the opinions of all the members (Lincoln & Guba, 1985:307). The

researcher ensured that the revised strategies were the product of the group discussions and were not influenced by her own perceptions on how the professional dignity of nurses should be preserved (Polit & Beck, 2017:60). She kept an audit trail to ensure that people who wanted to audit the process would be able to do so (Shenton, 2004:43). The trail focused on methodological and analytical aspects of the process to refine the strategies (refer to Annexure G). The presence of a co-facilitator, who recorded the focus group processes, further enhanced the dependability and confirmability of the study. Making use of focus groups and the synergy of group members' inputs ensured rich inputs in the refinement process of the strategies while the unique insight of group members in private healthcare enhanced the transferability potential of the strategies. Group participants left their own notes for the researcher following the group session to ensure that all group inputs were considered. The researcher thus made use of participants' reflective notes and group session inputs during the refinement of the strategies. The researcher reflected on the focus group experiences with her study leader throughout the focus group research process (Plummer, 2017b:346).

2.6 ETHICAL CONSIDERATIONS

Conducting research in an ethical manner requires researchers to portray honesty and integrity in their methodological approaches towards their participants. Careful consideration should be given to informed consent, confidentiality, anonymity and courtesy while engaging with research participants (Walliman, 2011:43). The researcher considered the ethical principles of beneficence, respect for human dignity and justice, as stipulated in the Belmont Report, in conducting both phases of the current study (Polit & Beck, 2017:139).

2.6.1 Beneficence

Beneficence refers to the principle of "do good" and "do not harm" (Scott, 2017:196). Participants thus have the right to freedom from harm and discomfort and to be protected from exploitation (Polit & Beck, 2017:139).

The researcher considered the anticipated possible psychological discomfort of participants during the unstructured phenomenological and focus group interviews. Sharing personal experiences, regarding the factors impacting on their professional dignity, might require recalling some painful or challenging experiences. Questions about their personal views and experiences might require revealing information which is deeply personal (Polit & Beck, 2017:139) and it could result in moments of emotional discomfort. The in-depth exploration of the phenomenon required sensitivity and careful consideration from the researcher. Therefore, the researcher let the interview flow at the pace of the participants. She re-assured and provided comfort during some emotional moments and made provision for those participants to recover before continuing with the interview. No incidents identified required formal debriefing. The researcher was prepared to facilitate debriefing sessions and it was decided that should participants become distressed as a result of the interview, the researcher would contact Dr Annatjie van der Wath (012) 354-2274 for debriefing and to deal with any emotional crisis that might arise from the interview process. Participants might also be referred to the counsellor/support systems of their own choice should they so wish. However, no such referrals were necessary during the unstructured phenomenological individual and focus group interviews.

Participants need to be protected from exploitation and feel safe when revealing information that could be used against them (Polit & Beck, 2017:139). The researcher invited the line managers of participants to an information session prior to conducting the unstructured phenomenological individual interviews. It created an emotionally safe environment for participants knowing their managers supported their participation in the research. The researcher took care not to take advantage of the valuable time of participants by adhering as closely as possible to the allocated time frames of the interviews. All participants, with the exception of one, participated during their on-duty times. Participants were ensured about confidentiality as stated in the participant information leaflet (refer to Annexures C and D).

2.6.2 **Respect for human dignity**

Respect for human dignity, as an ethical consideration, refers to participants as autonomous human beings capable of their own actions and decision making. Their right to self-determination and voluntary informed decisions should be respected (Polit & Beck 2017:140; Walliman 2011:47).

The participants of the current study were provided with a detailed explanation of the purpose of the study in the form of written and verbal explanations. They were informed about their rights to decide to participate in the study without any form of coercion and about their rights to withdraw from the study at any stage without fear of being discredited. The participants were provided with information sheets and explanations of the objectives and research methods of the study (refer to Annexures C and D). Participation was voluntary and the participants of phase 1 of the study were assured that the unstructured phenomenological individual interviews would be conducted privately and that their contributions would remain confidential and anonymous. The participants of phase 2 of the study were assured that their names would not appear in the research report and participants were asked to treat all shared information with strict confidentiality. Informed consent was obtained prior to each interview. The researcher made sure that all participants' questions had been answered before informed consent was obtained from participants.

Written permission to conduct this research was obtained from the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria (reference no. 260/2016) before commencement of data collection (Refer to Annexure A). Permission to conduct the study in the selected private healthcare facilities was obtained from the private healthcare facilities' management (refer to Annexure B).

2.6.3 **Justice**

The principle of justice refers to participants' rights to fair treatment and privacy, including the protection of the data by adhering to strict confidentiality (Polit & Beck 2017:141). All participants in the current study were treated the

same irrespective of their background. No participant was given preference over the others. All participants were chosen purposively using the same set of criteria for inclusion and exclusion to participate in the study. Participants were treated with respect and the diversity of their contributions was acknowledged. The researcher made sure that participants were comfortable to withdraw from the study at any time without fear of being treated in a prejudicial manner.

Participants' right to privacy was respected by providing private venue, away from their private healthcare facility units, free from disturbances. The researcher took care to ensure the anonymity of participants. The researcher used pseudonyms during transcription of data so that no information could be linked to any specific participant. Each participant had the opportunity, prior to the onset of each interview, to choose a letter of the alphabet as his/her pseudonym during data analysis and the description of the findings. The participants were addressed by their own names during the interviews if they preferred this option, but the names were not used anywhere in the report. The participants were guaranteed that all the information they provided would be treated with confidentiality. Audio-recordings were kept on a hard drive in a locked cupboard and they would be informed how the findings of the current study would be disseminated.

2.7 SUMMARY

In this chapter the researcher described the paradigmatic perspective, philosophical framework and research methodology used to conduct the current study. Phenomenology was discussed as both a philosophy and a method for studying human experiences. Research methodology including the design, setting, population, sample, data collection and data analysis was described in detail followed by trustworthiness and the ethical considerations which guided the study. In Chapter 3 the findings of phase 1 of the current study will be presented.

CHAPTER 3

PRESENTATION OF FINDINGS OF THE STUDY (PHASE 1)

3.1 INTRODUCTION

This chapter presents and describes the findings of the study on strategies to preserve the professional dignity of nurses in a demanding private healthcare environment. During phase 1 of the study data were collected using unstructured phenomenological individual interviews and field notes. Purposive sampling was used. Interviews took place in the natural setting of two private healthcare facilities with 11 participants. The aim was to explore and describe how nurses in private healthcare facilities experience factors that impact on their professional dignity.

During the initial phase of the data analysis, interview scripts were read more than once to get an overall view of the data. While putting aside any assumptions, pre-knowledge and judgement regarding the phenomenon through bracketing (Finlay, 2012:176), the researcher guarded against understanding “too well”, not to see more than what had been revealed, thus allowing the natural attitude to dominate over the scientific attitude (Dahlberg, et al. 2008:114). After pondering about the initial whole the researcher was ready to adopt a phenomenological attitude. The researcher waited patiently for the description of the phenomenon to emerge from the data, knowing not to make the “indefinite” definite (Dahlberg, 2006:17), prematurely.

Being sensitive to the essence of the phenomenon to reveal itself, the researcher looked for things that ‘stood out’ in the detail (Dahlberg, 2006:13). Looking beyond the natural dimension of experiences, the researcher became aware of the phenomenological dimension, finding meaning and understanding of the factors that impacted on the professional dignity of the participants who were professional nurses (Finlay, 2012:185).

The essence (‘the new whole’) of the findings is described followed by the constituents (meaning units). The description of the constituents is supported by relevant quotations from the participants as transcribed verbatim from

audio recorded interviews (Dahlberg, et al. 2008:255). Pure description, without references to the literature, ensured sustained focus on the phenomenon during the presentation phase of the study's findings in this chapter. Constituents, contextualised within relevant literature, will be discussed in the next chapter where the findings will be clarified by references to relevant theory and to similar research findings reported by other researchers (Dahlberg, et al. 2008: 273).

3.2 DESCRIPTION OF THE ESSENCE OF THE PHENOMENON AND ITS CONSTITUENTS

The essence of the phenomenon is described first followed by a description of the constituents. The essence is reflected upon in a more abstract manner (Dahlberg, et al. 2008:255). No excerpts from the transcriptions of the interviews with participants are used during this description in order to present 'the new whole' in a pure and concise manner. References are made to philosophical sources in the description of the essence. The essence of the phenomenon (experiences of factors that impact on the professional dignity of nurses) was shown as 'professional standing due to own and others' percipience'. Percipience is also referred to as conscious perceptions.

Professional nurses perceive themselves to be professionals of equal standing with other members of the healthcare team. They value their academic background and clinical experience enabling them to contribute to the well-being of their patients. Being at the bedside 24 hours per day, nurses regard themselves as guardians over their patients wanting to stand in for them and protect them while the patients are vulnerable due to illness. In their professional being, nurses desire to give rather than to receive. Nurses find meaning in the closeness with their patients being able to connect and make a personal difference. Being a professional in a business and financially-driven environment, nurses working in private healthcare facilities, are challenged by impersonal expectations to 'get the job done as quickly as possible' scenario, separating them from their inner sense of meaning something for someone. Their own professional values conflict with those of the private healthcare facility's expectations.

Being a professional nurse can sometimes pose challenges when the nurse's own nursing standards do not correlate with the standards of others. In such circumstances professional nurses may become impatient and angry with team members who do not pull their weight to the same extent as the nurses. Then nurses may experience embarrassment for losing their 'professional cool' towards their colleagues. In dealing with patients and members of the public, however, professional nurses stay in control, being gentle and kind. They keep their composure and are aware of having good manners and showing respect.

While having control over their own professional standing and their behaviour towards others, the picture of professional standing changes for professional nurses in their daily encounter with patients, patients' family members, and members of the health team and the public. Their professional standing is challenged by the actions and judgements of others towards them as professional nurses. Participants reflect on the dual experiences of respect and disregard from others. While some medical practitioners reportedly respect nurses' knowledge and skills, most doctors are perceived to be 'looking down' on professional nurses. Nurses' experiences are similar when dealing with private health consumers and members of the public being treated as not having much value as a professional person/nurse. Participants reflect on the experience of being humiliated in the presence of patients as most un-dignifying. Feeling upset and hurt they find it challenging to remain friendly after such incidents. Some nurses react defensively and want to be treated with their perceived deserved recognition while others keep quiet knowing that they will not win these battles. Being resilient or using kindness, serve as a valuable counteraction for some professional nurses. Most professional nurses report having effective nurse and general managers who provide a safety net for coping with many challenges faced in a private health care facility.

Participants are thus conscious of their professional standing in their workplace. They have a natural tendency towards professional standing as an 'other regarding' concept (to take care of others). Professional standing as a

‘self-regarding’ concept (to take care of self) is neglected as they had been taught to give and to suppress their own needs. The participants experience an inherent need of being worthy and recognised as professionals. Their professional standing is honoured by excelling in their patient care and by being proud of their profession. When they are unable to fulfil their commitment towards patients and their profession, their professional standing is affected in such a way that they develop feelings of disappointment and shame. Such experiences violate their professional dignity.

Being a professional, in a private healthcare facility, is experienced as a balancing act between ‘being for self’ and of ‘being for others’, both concepts described through an existentialist view as part of a phenomenological philosophy. People are conscious of the world they live in. They are also conscious of ‘their own being’ in the world (Cox, 2009:36). When they are alone they are free from the judgement of others. They see themselves as they want to even if it is not a real picture of the persons they are. They transcend into an almost superior being experiencing the world in their own “oyster” as a free ‘being for self’. Living in the world alone is inevitably impossible. When other people enter their world they are no longer a free ‘being for self’ but becomes a ‘being for other’ (Cox, 2009:37). They become an object for other people who are now free to judge them. They are at risk to be either humiliated by the others or they might be respected or admired by the others. They are thus influenced in their actions and behaviours in their desires to be admired, respected or feared by other people. They are now no longer free subjects for themselves but have become un-free subjects for ‘the others’ (Cox, 2009:40).

Nurses are seldom alone as they are almost always in contact with others. They seek being for themselves where they are free to serve others without judgement which is not always possible. In their being for others they become objects of the others who are free to humiliate or to admire and appreciate them. Participants describe a mixture of experiences when they are being supported, appreciated and respected or humiliated by patients, patients’ family members, healthcare practitioners and managers. However, there are

circumstances when nurses are able to descend into a 'being with' moment, experiencing total synergy in their 'being-with-others' (Cox, 2009:44). They reflect on such experiences as moments of dignity.

The following constituents of the essence were uncovered and supported how nurses in private healthcare facilities experienced factors that impacted on their professional dignity: perceiving one's own professional dignity; having contradictory experiences; being proud to be a professional nurse; receiving support, appreciation and respect; providing care in complex situations; performing as a professional nurse; valuing patient well-being; and being humiliated by others. These eight constituents will be described below and substantiated by verbatim quotations from participants.

3.2.1 **Perceiving one's own professional dignity**

Professional standing due to own and others' percipience is experienced through the lens of perceiving one's own professional dignity. Although this concept was not well known, participants were able to reflect on it even when it was the first opportunity of thinking about it: "*It is actually the first time I allow me to think of it. It's not something that I actually know*" (Pl). Professional nurses are strong believers in their purpose as nurses in making a difference: "*That's why I'm here*" (Pt). Being true to an oath to preserve life, patients were regarded as nurses' first priority. They believed they were made to be nurses. They were proud of who they were and what they had become through hard work and dedication. They were sincere in their desire to nurse and loved what they were doing: "*I'm so happy to do what I do currently*" (Pl). The professional nurses conducted themselves with integrity and self-respect and believed that dignity started with oneself being a good nurse. They were dignified when they felt good about who they were. They had a positive association with their uniform and professionalism and felt safe and confident in uniform. They valued their knowledge and skills as part of their professional standing: "*So that always make me feel good about my profession and the roots I have chosen*" (Pr). They regarded themselves to be mature professionals who had a valuable role to play in the well-being of their patients: "*But I believe that if*

for our care is lack, the stay of the patient increase, the side effects or the co morbidities increase. That's the fact" (Pe).

In their 'being for others' they desired to be regarded as professional nurses with dignity. Participants described experiences of hiding their own emotions to enable their patients to feel safe. They focussed on the smooth running of their units in order to preserve their dignity. They tried to act in a friendly manner towards patients, being visible and available to the patients. Professional nurses would perform tasks of other healthcare professionals to maintain good nursing standards: "*to keep my dignity and my pride on the best level*" (Pe). Nurses thus covered their colleagues' sub-standard work to retain their own dignity.

Keeping one's composure in your professional standing despite being humiliated by others was valued as an important attribute to be perceived as a professional with dignity. It was the dignity that kept nurses from talking without thinking: "*but then it's that dignity that keep you, from talking your heart, from speaking your heart but wait, just first listen and think*" (Pl). Professional nurses perceived total professionalism in their professional standing for self as the ultimate to be perceived as nurses with dignity. Nurses would therefore sacrifice themselves emotionally for the well-being of their patients.

Being more familiar with their own human dignity and the dignity of patients, participants viewed their professional dignity as being a concept closely linked to their human dignity. Participants described their personal and professional values as being important pillars for perceiving their professional dignity. Such values included honesty, transparency, integrity and respect. Respect for self, others and the profession was perceived as an integral part of professional dignity. When nurses respected and valued themselves it supported them to respect their patients' dignity: "*If you have self-respect, and if you have respect for other people around you, things start to fall in place*" *(Pm); "if I respect you I will feel good about myself and you will feel good about yourself.*

If you respect the patients, they cooperate, so your dignity remains intact" (Pa).

Receiving respect from others, on the other hand, was described as being important for being dignified, including being treated like a human being with emotions and not only as a means to get the job done: "*If somebody treats you with respect, you feel dignified, you feel like a human being and not just like an object*" (Pm).

Participants reflected on attributes, such as portraying a professional image and making a good impression on patients, for perceiving their professional dignity. These attributes included a good professional composure, physical appearance and standing proud as a professional. How they viewed themselves and the profession, what they stood for and believed in, formed an important part of their perceived professional dignity. Participants regarded moments of professional success as part of professional dignity. Accurate patient care was highly regarded. When a job was not done precisely, it affected the nurses' professional dignity adversely.

Professional dignity was ultimately seen as going beyond duty which reflected the inherent value of nursing as a calling. It was reflected upon as nursing with the heart which could never be merely a job, because nurses were perceived to be born to care. If nurses "can *put their hearts in their hands and they can work for the patients…maybe everybody's professional dignity will be secured and everybody will be respected and dignified for the work, they do*" (Pe).

3.2.2 **Having contradictory experiences**

"I'm standing here with my epaulettes on my shoulder, being confident, presenting myself in a professional manner with my uniform… How can you judge me by just looking at me" (Pd)? This was a question posed by a participant who faced experiences that contradicted her perception of her own professional standing. Patients and patients' family members might have preconceptions of professional nurses' capabilities. Having to prove oneself,

to others while knowing one's own knowledge and skills, could conflict with one's own being for self, standing proud as a professional.

A participant described her journey, progressing from the lowest nursing category to becoming a unit manager. Professional standing, as a unit manager, proved to be contradictory to her expectations of being in a leadership role: "*Not knowing when you are there…what are the things you are going to face… Now I am facing reality. So really here you…you really take the punches and some of the things really make you feel down"* (Pf). Contradictory priorities, within a general management team, became challenging when professional nurses focussed on patients "*because our business is patient care*" (Pr) while other managers have finances at heart. For nurses, patient care was the priority having "*freedom to enjoy what I do to the best*" (Pl) while other managers hindered such freedom to render the desired service to patients. The nurses' being for self was hindered by the perceived expectations of others of what the nursing role comprised or should comprise.

Fulfilling the calling of being a nurse was a valued responsibility. Participants reflected on their vision for making a difference, wanting to be the best possible nurse at all costs. With patients at the centre of their calling, nurses desired to be seen as professionals taking good care of patients: "*I want them to see me as somebody they can feel safe with, somebody they can trust, they must know I'll take good care of them…what is important for me is to let people know that what I'm going to do now is very important to me and I'll do my best for what I'm going to do now*" *(Pt).*

Nurses faced contradictory circumstances in their work lives. Participants described experiences where they were unable to fulfil their calling of being a good professional nurse. Not being able to render the desired care to patients, they questioned their value and purpose as a nurse: "*Why am I still doing this? Why am I here? What's my role here?*" (Pt). Participants reflected on experiences where work processes and the work pace diverted their focus from their patients. "*Actually I'm nursing a doctor, not a patient anymore*" (Pt). They wanted to give the patients in their care a special experience but were

caught up in patient-less actions and keeping the peace with prominent role players such as the medical practitioners. Nursing became just a job to be done in time while they desired for it to be more.

Nurses described the importance of maintaining high standards in their being for themselves, contradictory to experiences of working with professionals who did not uphold the same standards. Struggling to maintain and uplift nursing standards in the work environment resulted in frustration. When nurses became impatient or lost their tempers they felt embarrassed and it affected their professional dignity. This was also true when facilitating junior nurses in clinical practice. When they were not able to influence nurses to perform their duties according to the standards that were taught to them, they doubted their own abilities and self-worth: "*What's my use here?*" (Pt).

Nurses had been socialised within a frame of conduct guiding day-to-day nursing actions. Nurses were taught during their training to behave according to a set of nursing standards emphasising professional conduct and nursing ethics. According to participants in the current study, nurses were taught to give and serve their patients and to suppress and control their own emotions. They were more comfortable preserving the dignity of their patients than to preserve their own dignity: "*It's much easier for me to talk about the dignity of the patient, but the moment it's my own...*" (Pl). Lacking focus on their own professional dignity, and the inability to express their right to be respected, impacted negatively on their professional dignity. Participants described contradictory experiences in their encounters with the private healthcare facility's financial managers in a business like environment. Although nurses were reportedly taught during their training that 'nurses don't talk about money', they were confronted in the private healthcare facilities with the reality of being required to consider financial aspects on a daily ongoing basis. Finding themselves in the middle of a patient requiring care but being unable to pay and a health care practitioner being unwilling to render medical services without payment, nurses might experience challenges wanting to provide the best care to the patient: "*and you know your heart is to care*" (Pb). Similar contradictory experiences impacted on nurses when acting as a patient's

advocate: "*So it does, it questions your professional dignity. Because I mean to respect this doctor, he's my senior. I mean to be the patient's advocate and then who's there for me*" *(Pb).*

A participant reflected on being disillusioned in the profession to such extent that she did not want her own children to pursue nursing careers. Nursing was regarded as being an emotional drain "*we give so much of ourselves*" (Pr), which impacted on their professional dignity. While regretting the sacrifices of family and self they also had some positive feelings: "*I don't want to change it. I enjoy it*" (Pl), portraying mixed emotions and inner conflicts.

3.2.3 **Being proud to be a professional nurse**

To stand proud as a professional in percipience of oneself formed an integral part of one's own being for self in the nursing profession. Performing a job to precision left professional nurses with a sense of accomplishment and feeling dignified: "*I am a person with the personality to do it perfectly...to have the best outcome in the hospital*" (Pe). They were passionate about nursing, putting their nursing science to work in caring for their patients: "*and to bring her back to life*" (Pb). Participants described experiences of participation in quality improvement programmes to uplift care standards as being most rewarding, making them feel good about who they were. They took care to show respect to others and to perform their duties in a professional manner. They displayed good leadership in providing clinical guidance to others and in maintaining open communication channels with the people with whom they interacted. Unit managers were proud to manage their units: "*so it's a nice well-oiled machine*" (Pr) and in developing teamwork in their nursing teams: "*but in terms of dignity and respect for each other… we pick it up for each other*" (Pr).

When nurses gave their best at work they felt proud. Taking pride in a job well done and being able to make a difference, impacted on their professional dignity. Participants reflected on experiences of being able to channel all their knowledge and skills towards the care and improvement of their patients, describing nursing under such circumstances as effortless: "*…but that for me,*

spoke such professional dignity, made me feel like what I've been trained and taught, through my ethos, through social science and just my general anatomy and physiology put everything into perspective when it comes to patient care and made it seem like this is an effortless job" (Pb).

Although there were moments of dignity when excellent patient care had been provided, nurses' professional dignity was adversely affected when a nursing error occurred. Being responsible and wanting the best for their patients, they felt disappointed and ashamed when they made a mistake: "*So I was feeling undignified. My knowledge was not up to date, or my care was not up to date*" (Pe).

When nurses were able to solve the problems they encountered in the workplace, they felt proud. Taking ownership of problem solving empowered nurses: "*I've learned myself to handle the problems immediately, don't run to somebody, see if I can resolve it first. I felt actually good about it…I feel proud*" (Pa). A participant reflected on a moment of dignity, taking own initiative to recover a violation of dignity by confronting a healthcare practitioner face-to-face in a professional manner: "*I said to him, doctor, I see it as one of the most un-respected un-respectful things in life, to throw down a phone in someone's ear… I think I deserve just little more good manners… since that day, the two of us worked wonderful in a good relationship*" (Pl).

Being respected for their knowledge and skills contributed to the professional dignity of nurses. Professional nurses were proud to care for patients 24 hours per day and felt they should be trusted and respected for their suggestions about patient care. When their opinions were valued as professionals, their professional autonomy was acknowledged as being equal members of the health care team: "*He prescribed a Razon and I saw this patient was allergic to Sulphas…and it was like… Sister, jy is baie skerp [Sister, you are very sharp]… and then I felt like, wow, this is good*" (Pf).

Participants perceived respect as being something which could be earned, being influenced by producing work of a high standard. When a nurse carried

out a certain task, she put her personal professional stamp on it. When her work was consistently of a high standard, other professionals learned to respect her work. When performing nursing tasks in a "*slap dash way*" (Pr) people would disrespect such a nurse as a professional: "*And I think that's the difference between being dignified as a nurse, or having your dignity constantly be taken away from you*" (Pr).

Some nurses were proud of the profession and wanted to carry and uplift the profession: "*Because there are a few of us, the proud ones, that really wants to carry our name … and to show the world what we are*" (Pm). They were proud of their academic achievements and wanted to be recognised accordingly. They were committed to high nursing standards and to being skilled and knowledgeable professional nurses. They wore their uniforms with pride and were proud to be nurses. They were proud of other nurses portraying a good professional image such as their nurse managers: "*I always look at her and I wonder how she gets it right. She's very much a lady, always a lady… she's very principled, if she addresses a staff member on anything…she goes on principle…I always am amazed at how she manages, to stay composed. Like I always say, factual and in a diplomatic way. If she is presenting herself to the staff, she's always professional, lady-like and principled*" (Pr).

However, according to the current study's participants, some nurses lacked professional conduct. They did not adhere to the prescribed dress code and used electronic devices inappropriately (such as cellular phones) in the presence of patients and the public. Participants described some professionals, including newly trained professionals, as having no pride in the quality of their work and lacking commitment and respect. These professionals were regarded as being an embarrassment to the profession. The role of training schools in socialising students into the profession was questioned.

3.2.4 **Receiving support, appreciation and respect**

Professional standing due to one's own and other's percipience was experienced through receiving support, appreciation and respect in the work

environment. Nurses felt dignified when their managers supported and appreciated them. Positive feedback and open communication were valued as important attributes in nurse-manager relations. The data revealed that most nurse managers (including nurse unit managers) cared for the nurses: "*I have good managers. They care for me, they look after me, I'm really happy. I'm grateful*" (Pl). The nurse managers respected the decisions of their staff and were sincere in their efforts to address challenges: "S*he goes out of her way to settle things and make it right again*" (Pm). Some managers were willing to roll up their sleeves to provide clinical support at times. Such gestures from managers supported the dignity of nurses and their perceived self-worth.

Being accused of doing something wrong could put nurses in vulnerable positions: "*I felt like I was a crook, like I was going to jail… that's how bad I felt*" (Pn). The way in which managers acted upon such situations, influenced the professional dignity of nurses. Being listened to and not being judged impacted positively on nurses' professional dignity: "*They were very very supportive, they made me feel like yes, we value, you are important to us*" (Pn). When a manager opposed abusive behaviour towards nurses they were honoured and valued. A participant described an event where she was physically abused by a family member of a patient as the most humiliating experience. To her surprise the hospital manager, after listening to what had happened, requested the patient to leave and revoked his admission rights. Being supported by a manager in such a way made recovering from an unpleasant experience much easier: "*And to me it was the most incredible feeling…I felt so, I felt like a human again. The way I was treated, and the fact that he was just fair, and eventually decided money is not an object here, that he need his nurses to be safe, creating I think that safe environment… that was for me a moment that stood out and many years after that. I've thought about it, and it is actually something you don't see quite often*" (Pm).

Receiving recognition and appreciation from others played an important role in the work life of professional nurses. When a nurse did something special for a patient and it was appreciated, she felt dignified. It was valued more than capabilities and abilities: "*Here's the Sister, here's the face that I've been*

looking for the whole week! For me it was like wow" (Pd); "*and it made me feel ja; this is what a profession is supposed to be like*" (Pn). Receiving recognition from management was equally important. A participant reflected on an experience, from a hospital manager, complementing her on the smooth running of her unit as being rewarding and dignifying.

Some patients and patients' family members no longer regarded nurses as 'being special'. They did not value nurses as professional persons. "*When somebody doesn't see the value in something that you've done*" (Pr), nurses felt unappreciated for their efforts to render good service and care to their patients. Most nurses would not disappoint their patients on purpose but when giving their best efforts to meet their patients' needs were not regarded as being good enough, it impacted negatively on their dignity.

Nurses encountered similar experiences with other members of the health team. Participants described experiences where they felt they were not valued as human beings but were only perceived as objects to get the job done. A participant reflected on a manager being extremely hard on meeting work standards: "*I was under a line manager that was extremely hard on me, uhm…and maybe because of her being so hard I always felt myself being pushed into a corner and never been good enough, uhm…in the workplace. So having to prove myself constantly which impacted on my family life, where I would stay longer than I needed to, because I needed to make sure deadlines were done, I needed to make sure that everything was perfect before I left*" (Pb).

The ability to complete a task effectively impacted on the professional dignity of nurses. It was demotivating and demoralising when a task could only be completed halfway due to not having sufficient resources. Participants described experiences of colleagues working in government hospitals as de-motivating due to the lack of adequate resources. However, one of the most prominent attributes in private health care facilities was described by participants as having adequate resources to perform their jobs. Nursing actions were supported by the presence of adequate supplies, equipment,

good organisational structures and standards. "*I think in terms of what it has to offer in terms when you gonna talk about resources, I think they're a positive impact on your dignity there, whereas you able to fulfil your duties as a nurse, because there is enough resources to complete your job, most time*" (Pr).

Professional nurses experienced pressure to utilise staff and staff budgets appropriately. When they required more staff they felt as if they wanted to waste resources. This impacted on their professional autonomy in judging the staff needs of their units. Some nurse managers lacked insight into the reality of nursing and did not understand units' adequate staff allocations. Participants experienced such circumstances as being risky being unable to provide safe patient care to patients: "*And again for me it is now risking a patient…and at the end of the day you as a professional is going to take responsibility if anything happens to that patient*" (Pd). General managers did not always have insight into nursing staff requirements, resulting in a lack of autonomy of professional nurses to make decisions appropriate to their unique units' needs: "*So I think they just know or sit here and see the positive report or something and they just count the heads of the patients in the unit. But they don't know what is physically in the bed. Ja, I think what they must really know they must just once come and work in the ward, physically and then they will experience. They see this is patients, ok, there are 43 patients but sometimes it doesn't feel like 43, it feel like 100 patients*" (Pf).

Being unaware of the unique nursing dynamics and circumstances in caring for patients, general managers were sometimes perceived as being hard on nurses' mistakes which impacted negatively on their professional dignity: "*If they just took the time to understand*" (Pr).

3.2.5 **Providing care in complex situations**

Professional standing due to one's own and others' percipience in a private health care facility entails being exposed as a professional to unique and complex situations. Professional nurses were exposed to a different kind of nursing and what was expected from them. Their 'being for others' was not in equilibrium with what they had been taught during their training. Participants

described standards and values taught during their training as being contradictory to current practices. Nurses were trained to establish good rapport between themselves and their patients. They were expected to let patients feel reassured and safe in their care and to connect with patients on a level where they felt that they were understood as human beings: "*we must let them feel or reassured them and they must feel that we connect with them on a level that we understand them as a person and that we feel something for them while they are vulnerable*" (Pt).

The participants wanted to take care of their patients but they were expected to 'push' theatre lists to please the surgeons, possibly compromising their responsibility towards their patients. They wanted to follow procedures as they had been taught but time pressures and business factors forced them to take short cuts. Standing firm in their being for self was difficult because "*you are taught that your beliefs or your feelings don't come first*" (Pl). They were thus afraid to act according to their knowledge and skills because when they acted they were questioned why and if they did not act it was also 'not right'. Professional nurses should do the same things that they had been taught in college but medical practitioners sometimes wanted nurses to act differently. Some professional nurses were trained to adhere to good work ethics: "*It comes from the first standard I can say from the school, that attitude and that behaviour*" (Pe). Staffing a unit with too few staff members due to budget constraints left unit managers suspended between 'being for self' in doing the right thing and 'being for others' doing what is expected by business.

Participants described being a professional in a diverse environment as an on-going effort to break through diversity barriers in their encounters with self, patients, public and members of the healthcare team. Having to win culturally and racially diverse patients' trust, impacted on nurses' professional dignity when patients refused to communicate in a universal language or insisted on being treated by a health care practitioner of the same race: "*But we don't have any words to say then, I just go on, slowly…slowly so that after a few minutes maybe she will recognise my work, my hard work, my politeness, my honest towards her and she will be fine. Some of the patients do understand*

that and some of the patients respect my care and my honesty but some do not" (Pe).

Participants described their experiences of working in a diverse team as being challenging. Language barriers and cultural differences influenced nurse-to-nurse relations. For example, being unfamiliar with different ways of showing respect when greeting someone, could cause misunderstanding and cultural mistrust: "*Say Sesotho, they are respecting people differently…they want you to greet them first. That's their sign of respect. I expect them to greet me first because I'm their senior. So that can be a problem*" (Pa). Being of a different age group and coming from different training schools resulted in conflicting work ethics and conduct in the work place. Some professional nurses were brought up respecting people older than them and of a higher rank, thus preferring to keep a professional distance. Experiencing disrespect towards themselves and towards senior managers from junior staff members resulted in conflicting values and expectations. Participants referred to the 'new generation' and described this group of professionals as having a lack of commitment towards their job. They experienced frustration with some colleagues not wanting to be taught or corrected. Older professionals found themselves being isolated from the larger group of younger nurses doing things differently. The older nurses felt that they were expected to feel and think in the same way as the younger nurses did. They were expected to adapt to different work ethics thus experiencing frustration and inner conflict: "*It's difficult to understand the young people and to keep them motivated and that sometimes let me feel not umm living out my roll*' (Pt); *'Our training was very strict. We were taught respect for each other. It originates from home. People are different than they used to be. We've lost something from those years*" (Pm).

Working in a volume-driven and business-orientated private health care facility impacted on the participants' professional dignity. "*Time is money*" (Pt) is a slogan very familiar in a private work environment, especially in the operating theatre environment. Every minute wasted has a financial implication for either the patient or the organisation. There was often no time to show empathy to

patients. Participants felt their patients were neglected and that there was insufficient time to ensure that patients were comfortable and reassured. Feeling responsible for the well-being of patients they asked: "*Where's the patient in it*" (Pt)?

Participants described experiences being exposed to a fast working pace, racing against time to get the job done. They were unable to connect with their patients and did not have time for maintaining a holistic approach towards their patients. Care became a tick list with robotic nursing actions to cope with volumes and high turnover rates of patients: "*There is too much pressure to deliver, deliver, deliver…it's almost like an abattoir…so you just doing*" (Pb). Rushing to finish tasks in time and having to complete a lot of paperwork, resulted in a misplaced nursing focus risking nursing errors. Participants experienced disappointment by being unable to ensure that their patients felt safe in their care: "*I drop my patient*" (Pt). A participant regretted being unable to work exactly according to the standards she taught the junior nurses: "Y*ou feel like if you if you pretending and that's not the person you want to be*" (Pt). This contrast with nursing values taught during training caused inner conflict and guilt.

Facing the expectations and demands of patients and patients' family members was becoming increasingly complex. Participants described their experiences caring for the so called "Google public". Patients entered health care facilities being well informed. They dictated their treatment plan, disregarding the autonomy of nurses to care for them according to their clinical knowledge and skills: "*So where does it put me as your carer… where's your trust relationship with me…my professional dignity*" (Pb)? The situation was even more complex in a healthcare facility where money played an important role in serving private and medically insured patients. Participants described experiences of having to deal with many complaints relating to healthcare costs. Patients perceived private healthcare facilities as being money-driven just wanting to take patients' money. The cost of private healthcare created misconceptions about nurses. They saw nurses as being willing to care for patients only because of their payment. Some patients entered the facility

requiring care without money to pay for private healthcare. Such patients were often abusive, aggressive and disrespectful towards nurses: "*As if they come in and is told to open up a file to see a doctor and they must pay money. Already you can see nostrils flaring. And then the language starts that this facility only wants money, that's all we after, and then it's blurted in the waiting area and that impacts on the next patient and the next patient and by the time they come in their perceived care is that you only caring for them, because they've paid. You know it is… the workplace violence is real*" (Pb).

3.2.6 **Performing as a professional nurse**

Professional standing due to one's own and others' percipience could impose a dual responsibility on professional nurses in their 'being for self and others'. True to the integrity and work ethics of a professional nurse, 'being for self' forced professional nurses to perform beyond expectations, doing more than just performing a job. While setting high standards in their 'being for self', they simultaneously had to perform to the standards and expectations of their 'being for others'.

Professional nurses, as independent practitioners, remain responsible and accountable for their actions and ultimately for patient care. Being part of a team, professional nurses rely on colleagues and subordinates to care for the patients entrusted to them. Participants described uphill battles and challenges in their current professional work life. Some nurses did not pull their weight and lagged behind: "*You must pull them the whole time*" (Pa). They then have to carry most of the workload as one individual: "*It feels for me all the work is coming to one person… everything from thinking, doing, everything*" (Pa).

The quality and work output of some staff members, who were not professional nurses, were described as being unsupportive towards professional nurses. They hid behind their scope of practice, being unwilling to walk the extra mile. Their conduct was unprofessional and they lacked insight into the care of their patients and ignored tasks delegated to them. Participants felt that such nurses could not be trusted and the professional

nurses then rather did the work themselves. They also experienced difficulties when a unit was staffed with too many persons who were not professional nurses. Then the professional nurses' workloads became more demanding: "*Some of the categories that really affect the teamwork which affects the dignity*" (Pe). Participants described some support service staff as being disrespectful and unprofessional. They disregarded unit standards and rules to the disadvantage of the unit and its patients: "*And they can just ignore you*" (Pm).

Patients relied on experienced professional nurses to care for them. When patients received good care from a professional, they expected that professional nurse to assist them in even the most basic tasks: "*I'm gonna rather call the sister the whole time because the sister is willing to help me*" (Pm), adding to the already heavy workload of such a professional nurse. There is pressure on experienced and skilled professional nurses working in a team with inexperienced professionals with a lack of clinical insight and knowledge. Participants experienced pressure needing to mentor and guide colleagues while coping with the workload and taking responsibility for more work than other staff members. They felt whenever any work had not been done, regardless of who was responsible, that it reflected negatively on the professional nurse, impacting on her dignity and pride. The same happened when a unit was inadequately staffed and something went wrong.

Professional nurses sometimes found themselves in the midst of disruptive behaviour in their work environment. Participants described such situations as being strenuous, having to maintain professionalism while they were struggling themselves: "*Let the patient feel safe even if you not feeling safe*" (Pt).

Professional nurses thus encountered challenges to cope with their current workload and work demands: "*It gets harder and harder*" (Pm). Participants described signs of physical and emotional burnout feeling tired, overworked and exhausted. They started their days feeling tired and they ended their days in the same way, giving almost more than they could: "*I need to use all of me*

to be a good nurse" (Pr). The participants were expected to be everything to everybody and to fix everything at work and regretted having no energy left for their families. They ended up not looking or feeling good and they described such exhaustion as impacting negatively on their professional dignity: "*It has such a powerful effect on your total human being*" (Pl).

3.2.7 **Valuing patient well-being**

Participants had no doubt about who got preferential treatment in their work environment: "*In my workplace my patient is number one*" (Pa). When they were able to contribute to the well-being of their patients the participants felt dignified: "*So I felt very dignified. My team did very well, we rescued the patient and I feel very honoured in that situation*" (Pe). They were willing to sacrifice themselves in the best interest of their patients always trying to put themselves in the patients' shoes to understand their circumstances. They regretted their inability to provide small gestures of comfort to their patients due to a lack of commitment and/or time: "*We forgot the patient in the whole situation*" (Pt). They found themselves in circumstances where they were unable to focus on the well-being of patients, but their focus was directed at maintaining peace: "*Let's do this work as good as possible to prevent the doctor's to come down at us*" (Pt).

Looking after the well-being of patients was a team effort. When patient care was not up to standard it had consequences for the well-being of the patients. Some categories of staff were unreliable to provide patient care. If patients were neglected due to the lack of care of colleagues it impacted on professional nurses' dignity: "*Then I feel disrespect and my dignity…I'm not a good nurse. What happened here*?" (Pa). A participant described an experience where a patient's privacy had not been respected by a nurse. Such disregard for a patient's dignity was detrimental to her own professional dignity: "*And I felt so naked, I felt like she really thinks all nurses are like this, ja, really I felt so…really… Where is the dignity now*" (Pf)?

Professional nurses are at patients' bedsides 24 hours a day. Thus they witnessed the entire range of patient care and observed where a patient's

well-being had been compromised by other health professionals, impacting on the nurses' professional dignity. They described medical care as being disjointed and financially driven lacking a holistic approach: "*there's no one voice*" (Pb). Professional nurses also witnessed the impact of financial decisions on patient care. A participant described an experience where the well-being of a patient had been compromised without valid reasons. Medical treatment was refused based on the patient's previous encounters with a medical practitioner. Professional nurses also witnessed rudeness towards patients which affected them: "*I was so angry…more because of the patient…you don't do that to your patient, ever ever don't*" (Pn).

Professional nurses thus found their dignity in the way patients had been cared for: "*So always do it properly. Make sure that your dignity is intact; make sure that you treat everybody with dignity, because if you cannot maintain your dignity you will never be able to maintain somebody else's* (Pn).

3.2.8 **Being humiliated by others**

Threats to nurses' professional standing, due to their own and others' percipience was experienced during interactions with patients, healthcare practitioners, colleagues, managers and the general public. Professional nurses could not work in isolation and their work life was influenced by their interactions with the people around them. Participants described experiences of being humiliated not only as professionals but also as human beings especially when it occurred in the presence of patients and colleagues: "*Most of the nurses and sisters will agree with me, there's nothing that brings you down like a doctor screaming in front of the patient. And there's nothing that like the colleagues also screaming at each other or someone disrespecting you in front of the patient*" (Pf).

Medical practitioners' interactions with nurses were experienced as being negative and demotivating. Participants described humiliating verbal remarks, mannerisms and sarcasm towards them as professionals. A participant felt annoyed when a medical practitioner called her with his finger. Another participant shared an experience when a phone had been thrown down during

a telephone conversation. Being shouted at and being judged unfairly for something for which they were not responsible, especially in the presence of patients, caused embarrassment and despondency to the extent that they struggled to continue with their work for the rest of the day.

Most participants described experiences of disregard for their professional autonomy concerning patient care, nursing suggestions and decisions: "*Like you don't know anything. You don't have a right, to do even the basic stuff; I mean we intelligent people… its degrading. It makes you feel actually worthless of the end of the day*" (Pm). They perceived medical practitioners to be 'looking down' on nurses.

Some participants reflected on noxious experiences. One participant described exposure to physically threatening behaviour and verbal abuse from a medical practitioner: "*It was the most un-dignifying experience I've ever had where I was insulted as a professional. I was told that I must leave if I can't run my department. I was told that I am nothing. And he literally had me up against my chair in the corner of my office…for me, that was very un-dignifying and I went home and felt like I was a bruised woman, like I've been battered*" (Pb). Another participant described experiencing humiliating remarks despite her vast knowledge and clinical expertise:

"It doesn't take away from the fact that they often will humiliate you at work… insult you… call you an idiot… you stupid… I would have never expected such stupidity from you… things like that… For things that are sometimes really out of your control" (Pr).

Some patients treated professional nurses "*like nobody*" (Pm) and degraded them to nothing more than their personal assistants. They expected nurses to assist with even the most basic tasks which might have nothing to do with nurses "*as a professional being*" (Pm). Some patients judged, confronted and questioned nurses' skills on face value: "*Sister, are you sure you know what you are doing*" (Pd)? Participants shared experiences of being accused falsely for giving the wrong medicines and even of stealing patients' money: "*And*

there goes my dignity" (Pd). Such disregard caused professional nurses to feel powerless and valueless: "*so I felt really bad there, I'm hopeless there, I'm helpless*" (Pe).

Although managers should provide a safety net for their staff members, managers sometimes contributed to professional nurses' humiliating experiences. Participants experienced that abusive behaviour continued although it had been reported. They were unaware of actions taken by managers following such events and they did not receive any feedback in this regard. Participants described such approaches adopted by managers as being 'sensitive' because the hospital needed the medical practitioners in their hospitals in order to provide medical care to patients and for the facility to survive financially.

Experiences of a lack of confidentiality with regard to personal matters, and a lack of trust when reporting sick, aggravated nurses' feelings of being humiliated by their managers. A participant, who was a unit manager, described being reprimanded in front of another staff member by her nurse manager: "*So I really felt like… the way she was speaking to me in front of that one…I felt so undignified*" (Pf). Participants reflected on experiences with patients' unreasonable demands. When managers failed to protect staff members during such events, they felt humiliated and valueless: "*And to me it was so degrading. That nobody actually just stood up to him and told him it's not fair what you expected of this sister now*" (Pm).

Being humiliated by others impacted on professional nurses' dignity and on patient care: "*I think the dignified moments have the best outcomes for patient care, the undignified moments unfortunately is either biased care on your patients or a lack of proper care or quality care for patients*" (Pb). Participants felt that patients lost trust in their abilities following humiliating behaviour in the presence of patients. They described feelings of disappointment and anger towards themselves and the situation but mostly carried on performing their duties. They kept quiet and did the job properly, but they lost their enthusiasm

for the rest of the day: "*and it does take away from my confidence and from my, how I feel about myself*" (Pr).

Some participants reacted by remaining resilient, claiming their own professional dignity regardless of the situation: "*I mean I'm very proud and for myself being what I am. I'm proud of myself…to me actually that's enough. I feel I am dignified and that I don't let other people get me down, or drag me down*" (Pm).

Another way of dealing with humiliating situations was shifting into an empathy role. A participant described her way of dealing with patients' rudeness. She put herself in their shoes trying to imagine what it would be like being in hospital away from home. She pretended as if they were close family members and responded in a friendly and forgiving way: "*That is how I take it. So, whenever they make me feel like I'm as small as an ant or as big as whatever, I treat them the same because at the end of the day too you need to realise that the way you treat somebody is the way you expect to be treated*" (Pn); "*They not comfortable, they here, so they will have a bit of aggression, you know that bit of rudeness, but once they get to know you they will come around*" (Pn).

3.3 SUMMARY

Chapter 3 presented the description of nurses' experiences of the factors that impacted on their professional dignity. The essence, and its supporting constituents, were described. In chapter 4 a discussion of the essence of the findings and the supporting constituents will be presented using literature contextualisation.

CHAPTER 4

DISCUSSION OF THE FINDINGS, WITH A LITERATURE CONTEXTUALISATION, FOR THE DEVELOPMENT OF STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN PRIVATE HEALTHCARE FACILITIES (PHASE 1)

4.1 INTRODUCTION

In chapter 3 the researcher described the essence of the phenomenon (experiences of factors that impacted on the professional dignity of nurses) shown as 'professional standing due to own and others' percipience'.

The following constituents of the essence were uncovered and supported the essence: perceiving one's own professional dignity; having contradictory experiences; being proud to be a professional nurse; receiving support, appreciation and respect; providing care in complex situations; performing as a professional nurse; valuing patient well-being; being humiliated by others.

In this chapter the essence and its constituents will be discussed. The essence will not be discussed with references to literature. The essence will be presented within a phenomenological framework considering the perspectives of Husserl, concerning the subject, the object and the meaning of the essence (Dahlberg, et al. 2008:47; Giorgi, 2005:82; Zahavi, 2003:23). The constituents will be discussed and contextualised within relevant literature to provide a deeper understanding of the phenomenon (Dahlberg, et al. 2008:273). Relevant literature sources from various academic disciplines were reviewed and will be utilised during the discussion of the constituents.

4.2 PROFESSIONAL STANDING DUE TO OWN AND OTHERS' PERCIPIENCE

From a phenomenological perspective 'professional standing due to own and others' percipience' is seen as lived experiences of professional nurses' 'being for self' and 'being for others'. Professional nurses desire the freedom to take care of others in a world of 'being for self'. The opportunity to care for patients in an "oyster" (Cox, 2009:37) without interference and judgement from others is highly regarded in their 'being for self' as dignified professionals.

However, while striving to be free of the external elements and influences in their 'being for others', the latter may not always be possible. Nurses are in continuous interaction with other role players in healthcare and cannot escape the world and its influences. The business-like private healthcare environment in which nurses find themselves, can impose an ongoing required balancing act between their desire to care (being for self) and the demands and dynamics of private healthcare facilities (being for others).

Professional nurses want to be equally regarded in their professional standing in the health team. They took pride in their academic standing, knowledge and skills. They see themselves as 24-hour guardians over the well-being of patients and find fulfilment and meaning in their closeness to patients. Their professional standing is honoured when they render exceptional care to their patients.

Professional nurses experience a contradictory work environment being pressurised to conform with an impersonal task-orientated business-like environment in their professional standing while experiencing disregard for their professional autonomy and facing humiliating behaviour from patients' family members and from patients as well as from members of the health team and from some managers. Such experiences violate nurses' professional dignity.

4.3 DISCUSSION OF CONSTITUENTS

4.3.1 Perceiving one's own professional dignity

Professional standing due to one's own and others' percipience is experienced through the lens of perceiving one's own professional dignity. It is determined by the way nurses view themselves and is influenced by the behaviour of other members of the health team towards nurses (Sabatino, et al. 2014:663). The professional dignity of nurses is a concept not well known or thought about by nurses. There is much focus on the dignity of patients in nursing literature (Lawless & Moss, 2007:227), while the dignity of nurses appears to be underexplored (Lawless & Moss 2007:228).

Standing as professionals in their own percipience of themselves, professional nurses believe in their purpose to make a difference as nurses. When nurses are able to fulfil their purpose they are dignified, reaching the top level in Maslow's Hierarchy of Human Needs (Smith-Trudeau, 2017:3). Purpose is one of the main pillars for finding meaning in life. It is defined as "a sense of core goals, aims, and direction in life" (Martela & Steger, 2016:531). Professional nurses find meaning in serving their patients as their first priority and being a nurse becomes a way of living, wanting to be and enjoying being a nurse. Such meaning is reflected in the words of philosopher Ralph Waldo Emerson quoted by Smith-Trudeau (2017:4): "*The purpose of life is not to be happy. It is to be useful, to be honorable, to be compassionate, to have it make some difference that you have lived and lived well".*

Professional nurses are dignified when they feel good about themselves. Their professional dignity is influenced by their nursing professional and personal values and beliefs (Aydin Er, Sehiralti & Akpinar, 2017:238; Kaya, Işik, Şenyuva & Kaya, 2017:716). A recent study reported a moderately strong association between nurses' sense of personal dignity and self-esteem (Sturm & Dellert, 2016:384) while a positive correlation between professional nursing values and levels of self-esteem was found in a study among student nurses (Iacobucci, Daly, Lindell & Griffin, 2013:479). Participants valued themselves as professionals with integrity and self-respect, being knowledgeable and skilful. Putting their knowledge and skills to work in caring for their patients is perceived as being an integral part of their professional dignity (Sabatino, et al. 2016:284). However, disrespect towards their contribution to patient care from other members of the health team and hospital and nurse managers impacts negatively on their professional dignity (Stievano, et al. 2012:346; Stievano, et al. 2009:97; Adam & Taylor, 2014:1243; Khademi, et al. 2012:332).

Wearing a uniform with pride and acting in a mature professional manner made participants feel confident about who they were. Professionalism is characterised by a strong association with the expected conduct and values of a particular profession. Competence and continuing education were found to

be strong attributes for professionalism in a study conducted on 89 nurses in north-western Turkey (Dikmen, Karataş, Arslan & Ak, 2016: 95). A study in the United Kingdom held empathy, smart appearance and work ethic as attributes valued by more experienced and older nurses for professionalism (Walker, Clendon & Walton, 2015:12).

Pretending, for the sake of one's own professional dignity, was experienced by participants as a daily reality. Keeping one's professional conduct "positive, civil, and courteous" in the midst of any provocation to act unprofessionally (Stratton, 2016b:280) ensures the retention of one's professional dignity. Professional nurses should stay true to their professionalism and to their core nursing values in performing their daily work (Stratton, 2016b:280).

Participants believed dignity started with oneself being a good nurse. Some attributes of being a good nurse included professional competence, a good sense of responsibility, love of nursing and patience, calmness and empathy. Scientific curiosity and geniality were identified at an educational level while honesty was listed as a nursing value as part of being a good nurse (Aydin Er, et al. 2017:238). Professional nurses in the current study reflected on assuming more responsibilities than their own assigned tasks, to maintain nursing standards in the keeping of their own professional dignity.

The concept of professional dignity was reflected upon by participants as being closely linked with their own human dignity. This finding of the current study, correlates with studies in Italy, identifying dignity as "an expression of humanity" (Stievano, et al. 2012:341) and intrinsic to every human being (Stievano, et al. 2012:341; Sabatino, et al. 2016:277). Participants considered values (professional and personal) such as honesty, integrity, transparency and respect as part of their professional dignity. Values are "beliefs of what is right, good or desirable". It directs the decisions and behaviour of individuals and groups of people such as professional nurses (Kaya, et al. 2017:716).

One value implying dignity is respect (Bournes & Milton, 2009:50). Respect for self and others was described by participants as being part of the professional standing of professional nurses. Being imbedded in nurses as human beings and as workers (Stievano, Bellass, Rocco, Olsen, Sabatino & Johnson, 2016:1), respect plays an important role in professional nurses' percipience of their own professional dignity.

Professional dignity is ultimately seen as going beyond duty reflecting on nursing as a calling and not just a job. "*There is no greater gift you can give or receive than to honor your calling. It's why you were born. And how you become most truly alive*" (Oprah Winfrey cited by Smith-Trudeau, 2017:3).

4.3.2 **Having contradictory experiences**

"I'm standing here with my epaulettes on my shoulder, being confident, presenting myself in a professional manner with my uniform… How can you judge me by just looking at me" (Pd)? Facing prejudice has been part of nursing history as early as the 17th century and found root in the secularisation of care during the Protestant reform. Skewed and invalid perceptions of the nursing profession have been a burden and remains a dilemma for those facing prejudice despite being educated, knowledgeable and skilled (Jesus, Marques, Assis, Alves, Freitas & Oguisso, 2010:165). It could be attributed to the myth that physicians' education is superior to that of nurses and that nurses perform inferior activities in relation to other healthcare professionals (Jesus, et al. 2010:167). Professional nurses face prejudice as a daily reality. They cope by relying on their professionalism and competency by remaining scientifically, politically and ethically correct when debating about issues concerning their profession (Jesus, et al. 2010:168). The necessity to prove oneself to others, while being knowledgeable and skilled, conflicts with one's own 'being for self', being proud as a professional nurse.

Being promoted to a unit manager is an opportunity many professional nurses strive to achieve. Facing ample challenges and demands as a unit manager might be contradictory to prior expectations. A recent study describes current unit mangers being emotionally exhausted with exposure to numerous work

demands (Van Bogaert, Adriaenssens, Dilles, Martens, Van Rompaey & Timmermans, 2014:2622). Having to spend time on excessive amounts of administration competes with the unit manager's responsibility to maintain a clinical presence in the unit (Udod & Care, 2012:74) which might be contradictory to his/her perceived core responsibility for patient care.

Unit managers are expected to take responsibly for the totality of nursing care in the unit. They are exposed to contradictory circumstances. They are challenged knowing the right thing to do but not having the power to implement it (Shirey, McDaniel, Ebright, Fisher & Doebbeling, 2010:84). Unit managers reported knowing their units' staffing needs but having to plead with and motivate to external departments (such as the financial department) to acquire sufficient staff members on a daily basis. It leaves them disempowered and frustrated (Shirey, et al. 2010:85). Having "more responsibility than authority" is contradictory to leadership expectations of being an in-between manager, upholding quality and a good workplace while balancing business budgets (Athlin, Hov, Petzäll & Hedelin, 2014:234). Their 'being for self' is hindered by the perceived expectations of others of what their nursing role is or should be. While other managers have finances at heart, unit managers perceive their core business as being patient care.

Professional nurses enter the profession of nursing because of an inherent calling to care and help people. They strongly identify with the value of being a nurse "at heart". Having the opportunity to care for people is perceived as the best part of their job (Eley, Bertello & Rogers-Clark, 2012:1550).

Participants in the current study reflected upon their desire to be seen as professionals taking good care of patients. The inherent need of nurses 'to care' correlates with the expectations of healthcare users. Healthcare users want nurses to be knowledgeable and skilled. However, they also desire nurses to display 'softer skills' such as empathy and individual care, wanting to be listened to and cared for with a non-judgemental attitude (Griffiths, et al. 2012:125 cited by Darbyshire & McKenna, 2013:306).

People have a natural desire to contribute to life. Every person wants to leave a legacy (Leider, 2015:3). Participants experienced contradictory circumstances in their work life, being unable to fulfil their calling of being a professional and a good nurse. They questioned their value and purpose as a nurse: "*Why am I still doing this? Why am I here? What's my role here*" (Pt)? Purpose is inherent in all human beings (Leider, 2015:3). It is "that deepest dimension within us - our central core or essence-where we have a profound sense of who we are, where we came from, and where we're going" (Leider, 2015:1). Asking questions is the process of finding a fresh or renewed direction in life (Leider, 2015:2). Being at peace with one's purpose allows people to experience fulfilment in their careers (Leider, 2015:4).

Participants reflected on experiences where work processes and work pace were directing their focus away from their patients. A recent study found that the operating theatre environment posed challenges to nurses being exposed to fast daily patient care processes. Theatres were identified as work environments where civility and collaboration principles could easily be compromised (Stratton, 2016b:280).

Professional nurses want to be person-centred, kind and caring in looking after their patients (Lyneham & Levett-Jones, 2016:86) but are caught up in patient-less actions and keeping the peace with prominent role players, such as medical practitioners. They desire to be seen as persons who truly care (Catlett & Lovan, 2011:59-60). When they are able to do "good" and "do no harm" (Lyneham, 2010:642) while nursing their patients, nurses are dignified. When nurses feel their workplace prevents them from being able to care, they might consider abandoning the nursing profession. It is thus crucial for healthcare facilities to address factors inhibiting nurses' ability to care. Addressing the latter might improve the retention of nurses in the workplace (Eley, et al. 2012:1553).

Nurses described the importance of maintaining high standards in their 'being for themselves' as contradictory to experiences of working with other professionals who did not uphold the same standards. A lack of competence

of other healthcare providers was described as being morally distressing in a recent study (Varcoe, Pauly, Storch, Newton & Makaroff, 2012:491). Concerns about the competency of others have been described as a “constant battle” of “working around” incompetence (Varcoe, et al. 2012:493). Individual nurses cannot function in isolation in caring for their patients. Providing safe quality care is a team effort and team members rely on each other for performing nursing tasks. When team members are not equally competent and committed to good and safe patient care, it results in missed nursing care opportunities which impact on the quality of care rendered to patients. Team work accounts for 11% of missed nursing care, critical for providing quality and safe care (Kalisch & Lee, 2010:238).

Professional nurses, who participated in the current study, experienced difficulties to influence staff members while trying to teach them. When staff members did not respond positively to clinical facilitation and training, the professional nurses doubted their own abilities and self-worth. A recent study describes the difficulties encountered by nurse educators when they were challenged by some students, showing a lack of interest in lessons and care practices. The latter impacts on nurse educators’ morale (Duarte, Lunardi, Silveira, Barlem & Dalmolin, 2017:301). The professional nurses’ desire (in that study) to obtain good quality outcomes was contradictory to students’ commitment to learning.

Socialisation into the nursing profession provides nurses with a frame of conduct which guides nursing actions in their day-to-day functions. Nurses are taught during their training to behave according to a set of nursing standards of which professional conduct and nursing ethics form part. Professional socialisation is an interactive and ever changing process whereby values and behaviour of the nursing profession are internalised while a professional identity is being developed (Dinmohammadi, Peyrovi & Mehrdad, 2013:32). Professional socialisation takes place through “learning, interaction, development, and adaptation”. Professional nurses are moulded by sound nursing educational programmes and the execution of clinical knowledge and skills through the exposure to clinical practice. Having competent role models

is equally important (Dinmohammadi, et al. 2013:26). Exposure to excellent classroom and educational experiences might be insufficient to prepare nurses for clinical practice which could contradict what they had been taught (Dinmohammadi, et al. 2013:32; Hovland & Johannessen, 2015:47). Similar contradictory experiences are described in a study of Norwegian student nurses being exposed to clinical practice in hospitals in Africa, including South Africa. Students reflected that what they had learned in Norway was contradictory to their experiences in the African hospitals (Hovland & Johannessen, 2015:47). In South Africa, professional nurses might experience the Batho Pele principles as being contradictory to the patients' services they are able to provide due to a lack of resources and unrealistic expectations and demands from patients in public hospitals (James & Miza, 2015:1).

According to the current study's participants, they were taught to give and serve their patients and to suppress their own emotions, ignoring their own needs for the benefit of their patients. These findings correlate with nursing practice as reported by a recent study on fatigue among hospital nurses. Their desire to give and to care for patients outweighed their tiredness which could pose a potential risk factor impacting negatively on quality patient care (Steege & Rainbow, 2017:24). These authors identified the so called "super nurse" culture which has been internalised during training as part of the attributes of being a good nurse (Steege & Rainbow, 2017:20). Nurses might be uncomfortable to voice practice issues, feeling "silenced" when encountering practice issues, being perceived as not having a "voice" (Kay, Evans & Glass, 2015:66).

Lacking focus on their own professional dignity, and their inability to express their right to be respected as such, impacted on the professional dignity of nurses. Self-care for nurses, including the basic principles of maintaining a healthy physical and mental lifestyle, was identified as a critical factor for providing compassionate and safe patient care (Hofmeyer, Toffoli & Vernon, 2016:17-18). Participants came to realise caring for oneself was not selfish and a principle to be continually aware of (Hofmeyer, et al. 2016:18). The inclusion of self-care training and compassion in undergraduate nursing

curricula should emphasise the importance of self-care for providing compassionate safe patient care (Hofmeyer, et al. 2016:22).

Being a nurse in a financially driven private healthcare environment imposes a threat to her/his professional standing. Patient-centred care, as a nursing value, might be contradictory to the business expectations from shareholders and executive healthcare managers. Professional nurses, working in private healthcare facilities, could witness patients' care needs but patients might be unable to pay for their care. Under these circumstances, nurses might experience the financial side of business as being obstructive to providing the best care to the patient: "*and you know your heart is to care*" (Pb). The term "value dissonance" describes the contradiction between how nurses want to practise and how they actually practise in a healthcare environment that prevents nurses from realising their humanistic nursing values (Rook, 2017:152-153).

Nurses found themselves in similar contradictory circumstances in their 'being for others' (patients and medical practitioners), and when acting as patients' advocates. Standing ethically as a professional for the safety of the patient, nurses feared social punishments from either the patient or the medical practitioner when they did not meet any of their expectations. When speaking up as the patient's advocate, nurses might be confronted and labelled as being obstructive or be humiliated in the presence of others by being shouted at by medical practitioners (Striley & Field-Springer, 2016:86). Nurses might thus face a moral risk "when it is good to be bad" (Striley & Field-Springer, 2016:86).

Being a nurse in a private healthcare facility, might require personal and emotional sacrifices. A participant reflected on being disillusioned with the profession to such extent that she did not want her own children to pursue nursing careers. Nursing is seen as an emotional drain "*we give so much of ourselves*" (Pr), impacting negatively on nurses' professional dignity. These results are similar to those reported by Mokoka, Oosthuizen & Ehlers (2010:[5]), indicating that South African nurses experienced their sacrifices as

not being worthwhile considering the disrespect and public image of nurses. Continuous exposure to prolonged suffering and the deaths of patients could be emotionally draining experiences. Hard work is often met with disrespect from patients and their families, leaving nurses questioning the value of nurses' inputs (Walsh & Buchanan, 2011:356). Difficult working conditions, with a high incidence of severe disease patterns and patients' attitudes to nurses could contribute to nurses' despondency levels (Mokoka, et al. 2010:[4]).

The love of nursing was identified as a core nursing attribute of being a good nurse (Aydin Er, et al. 2017:238). Professional nurses want to nurse despite facing daily challenges. While regretting the sacrifices imposed on their families and on themselves, the current study's participants also had positive feelings: "*I don't want to change it. I enjoy it*" (PI), comprising mixed emotions and inner conflicts.

4.3.3 Being proud to be a professional nurse

To be proud of being a professional nurse in percipience of oneself forms an integral part of one's own 'being for self'. There is no scarcity in literature reflecting on professional nurses' 'being proud' (Rauen, Ceballos & Risch, 2015:71; Gilson, 2017:1; Hall, 2015:5). The concept of pride has been debated for centuries evolving from a philosophical and religious perspective being either negative or positive (Tracy, et al. 2010:163). The word proud found close meaning in the modern Greek word '*kamari*', which is associated with "puffing out one's chest" (Tracy, et al. 2010:164). Feelings of pride are associated with positive emotions and people who experience pride feel good about themselves (Tracy, et al. 2010:168).

Professional nurses are proud to do their best at work. They feel good in who they are when they contribute to improving nursing standards (Rauen, et al. 2015:71). They are leaders in the clinical guidance of others. There is no compromise in their professional commitment to complete nursing tasks according to standards (Sneltvedt & Sørlie, 2012:15). Performing a job precisely gives them a sense of accomplishment and dignity. Hintistan and

Topcuoglu (2017:49) reported that most nurses (67.9%) who participated in their study, wanted to execute their tasks according to the set nursing standards and they had suitable skills and knowledge to conduct themselves as professionals.

When professional nurses channel their knowledge and skills into taking care of their patients they experience feelings of recognition and respect enhancing their professional dignity (Sabatino, et al. 2016:284). A participant in the current study reflected on such a moment of being dignified: "*…but that for me, spoke such professional dignity, made me feel like what I've been trained and taught, through my ethos, through social science and just my general anatomy and physiology put everything into perspective when it comes to patient care and made it seem like this is an effortless job*" (Pb). When nursing becomes an effortless act, caring becomes an art with "beautiful and sublime" moments experienced by nurses (Siles-González & Solano-Ruiz, 2016:154). Being proud to be a professional nurse transpires from such moments. "Beautiful and sublime" moments (Siles-González & Solano-Ruiz, 2016:154) experienced by professional nurses include conducting one's duties in a respectful and professional manner (Walker, et al. 2015:13). Being professional implicates staying calm and in control of one's own emotions amidst the turmoil of daily nursing activities while showing respect to people regardless of the circumstances. It entails following one's code of conduct "effortlessly" (Walker, et al. 2015:12).

The current study's participants described being proud when they witnessed professionalism in their work environment. They were proud of other nursing professionals portraying a good professional image such as their nurse managers: "*I always look at her and I wonder how she gets it right. She's very much a lady, always a lady… she's very principled, if she addresses a staff member on anything…she goes on principle…I always am amazed at how she manages, to stay composed. Like I always say, factual and in a diplomatic way. If she is presenting herself to the staff, she's always professional, lady-like and principled"* (Pr).

When professional nurses are able to solve encountered problems in the workplace, they feel proud. Being proud, as autonomous professional nurses, impacted positively on their professional dignity. An Italian study found higher levels of professional dignity among professional nurses who had opportunities to make autonomous decisions (Stievano, et al. 2013:122). Being assertive in conflicting and abusive situations is an art of which professional nurses are proud. Assertiveness is defined as the "ability to stand up for oneself or one's patients by expressing thoughts, feelings, opinions, or needs without being aggressive or hurting others" (Hodgetts, 2011:41). Portraying assertive behaviour enhances the self-confidence of professional nurses (Matney, Staggers & Clark, 2016:7).

Professional nurses are proud of their important role in healthcare providing a 24-hour service. They regard their relationship with patients as being special and unique to nurses (Eley, et al. 2012:1550-1551). When nurses are respected in their work environment they feel good about themselves (Antoniazzi, 2011:752-753). They earn respect in their interaction with other healthcare professionals such as physicians in being competent, professional and well prepared. Such attributes are perceived to counteract physicians' superiority (Farhadi, Elahi & Jalali, 2016:22). Professional nurses are proud of their academic achievements. It is perceived less of a challenge for graduate professional nurses to step up and engage in equal collaboration with other health professionals, such as physicians (Jesus, et al. 2010:169). Respectful nurse-physician conversations are regarded as being pleasant and dignifying experiences (Farhadi, et al. 2016:23).

Some professional nurses, who participated in the current study, were proud of the profession and wanted to enhance the professional image of nursing: "*Because there are a few of us, the proud ones, that really wants to carry our name … and to show the world what we are*" (Pm). Wearing a uniform serves as a symbol of pride supporting professional nurses in their professional identity and self-image. It enhances confidence to improve clinical performance (Shaw & Timmons, 2010:21). Patients associate clean and neat professional uniforms with professional knowledge and skills (Clavelle,

Goodwin & Tivis, 2013:175). Patients perceive casual non-conventional attire negatively with regard to nurses' professional image (Porr, Dawe, Lewis, Meadus, Snow & Didham, 2014:149).

However, not all nurses adhere to professional conduct, the prescribed dress code and/or the use of electronic devices. Cellular phones might be used inappropriately in the presence of patients and the public. Participants described that some nurses adopted inappropriate dress codes, such as wearing excessive jewellery and painting their nails with inappropriate colours, impacting negatively on the professional image in an Italian study. A nurse dressed conservatively in a clean uniform would earn more respect from patients (Sabatino, et al. 2016:285).

Professional nurses perceive themselves to be vulnerable in their pride in themselves and in their profession due to many reasons. Some professional nurses wanted to perform their tasks perfectly. Although this striving for excellence is a driver to provide excellent care it could also cause emotional distress (Melrose, 2011:1). Professional nurses could become emotionally exhausted in striving to provide high quality care with inadequate resources while being exposed to ethical challenges (Msiska, Smith & Fawcett, 2014:101). Nurse managers regretted the loss of professional pride by some professional nurses, blaming burnout as the cause thereof (Msiska, et al. 2014:97).

Participants in the current study, expressed similar feelings of vulnerability when a nursing error occurred, affecting their professional dignity and pride. These findings correlate with those of a study conducted in Swiss university hospitals. The Swiss study's participants reported similar feelings of regret affecting their work life. Some changed their speciality or the unit where they were working. Others experienced sleep disturbances and stress-related illnesses causing them to take sick leave (Courvoisier, Agoritsas, Perneger, Schmidt & Cullati, 2011:e23138).

Newly qualified nurses enter the profession with integrity and pride, wanting to do a good job. They are eager to gain knowledge and skills and take great interest in the science of nursing (Sneltvedt & Sørlie, 2012:15). It is a critical time to guide them into their professional role, strengthening their pride and commitment (Sneltvedt & Sørlie, 2012:13).

However, the current study's participants described some professional nurses, including newly trained professionals, as having no pride in the quality of their work and lacking commitment and respect. These professionals were regarded as an embarrassment to the profession. Some studies described younger nurses as lacking professionalism, respect and purpose (Mokoka, et al. 2010:[7]; Duarte, et al. 2017:301). The role of training schools in socialising students into the profession has been perceived as being questionable.

The nursing profession cannot abandon young professionals by turning a blind eye to their lack of professionalism, respect and purpose. Older more experienced professional nurses have a responsibility to be professional role models and to be clinical practitioners who meet the standards of nursing practice (Houghton, 2014:2367). Interactions with other professional nurses in clinical practice portray the attributes of good nurses as example to be followed. Nursing professional values are developed in interaction with nurses in clinical practice situations (Lyneham & Levett-Jones, 2016:86) while the role of nursing education remains the foundation for teaching the principles underlying caring and compassion (Darbyshire & McKenna, 2013:307).

Professional nurses in strategic positions should be utilised more actively to inform the public about the content of their work, according to Ten Hoeve, Jansen and Roodbol (2014:295). Nursing research, impacting on patient outcomes, should be shared with the public to improve the image of nursing. Members of the public might be unaware of the educational requirements of professional nurses. Professional nurses should work harder to portray their professionalism and be more visible to actively influence the image of the profession (Ten Hoeve, et al. 2014:295).

Nurses should take pride in their work and acknowledge that they are part of a remarkable profession (Stratton, 2016a:382). They should recognise and value their unique contribution to healthcare. They are the most multifaceted healthcare provider group to impact on cost, quality and accessibility of healthcare (Greenwood, 2016:4).

4.3.4 Receiving support, appreciation and respect

Professional standing due to own and others' percipience is experienced through receiving support, appreciation and respect in the work environment. Nurses feel dignified when their managers support and appreciate them. Nurse managers who show care and appreciation to their staff create an environment where they feel ethically safe to care for their patients. When staff members are appreciated they feel "good enough" as nurses and their self-esteem is supported. Nurses are burdened with emotions being exposed to complex care practices with high levels of responsibility. Nurse managers should serve as safe harbours for nurses to soundboard and ventilate their feelings (Gustafsson & Stenberg, 2017:425).

Participants in the current study described their need for managers to listen to them and to maintain open communication channels. They felt supported when their managers were committed to attend to their problems. These findings of the current study correlate with similar expectations of nurse participants who wanted to be listened to and felt supported when their managers understood their situations even if the manager was unable to address their problems. Receiving a 'thank you' was an expectation not to be ignored (Atefi, Abdullah, Wong & Mazlom, 2014:357; Feather, et al. 2015:125; Pompeii, Schoenfisch, Lipscomb, Dement, Smith & Conway, 2016:860) while visits from senior managers to nursing units were deeply appreciated (Seitovirta, et al. 2017:1048). Some managers were willing to roll up their sleeves to provide clinical support at times. Such gestures from managers enhance the dignity of nurses and their worthiness.

Most nurse managers (including nursing unit managers) care for nurses. A study found that the majority of nurses (70-80%) perceived their nurse

managers to be friendly, respectful and reliable (Eneh, Vehviläinen-Julkunen & Kvist, 2012:163). When nurse managers 'shielded' their staff in difficult situations by acting as their advocates the nurses felt supported (Gustafsson & Stenberg, 2017:419; Loveridge, 2017:25). Participants in the current study described experiences of being accused of doing something wrong as being stressful and feeling like "a crook" (Pn). Being listened to and not being judged were gestures from nurse managers which supported nurses' dignity and worthiness. Radiating non-tolerance for unethical behaviour is regarded as an important attribute in supportive management (Gustafsson & Stenberg, 2017:419).

Some participants in the current study described experiences where they felt not valued as human beings but were regarded as objects to get jobs done. A participant in the current study, reflected on a manager being extremely hard on her to meet work standards. Participants in a study regarding nurse manager role stress felt unappreciated when managers did not respect their off duty time. Consideration for work-life balance was regarded as being important for feeling supported. When nurse managers tried to 'micro-manage' units and disregarded the autonomy of professional nurses, these nurses felt that they were not trusted to do their jobs (Loveridge, 2017:24) and it impacted on their professional dignity (Khademi, et al. 2012:333). They experienced feelings of 'not being good enough' (Loveridge, 2017:25).

A participant in the current study described an event where she was physically abused by a family member of a patient as being a most humiliating experience. The support provided by the hospital manager, who took a stand against the culprit, was described as a moment that stood out in her nursing career for many years. Workplace violence is a frequently reported phenomenon and studies report nurse' exposure to verbal abuse as being as high as 91.6% (Esmaeilpour, Salsali & Ahmadi, 2011:130). Studies reveal that staff members do not report such incidents due to the perceived lack of support and absence of actions taken by managers (Kitaneh & Hamdan, 2012:469; Taylor & Rew, 2011:1072). Staff members expressed dissatisfaction with the manner in which reported events had been managed

(Esmaeilpour, et al. 2011:130) describing it as “useless” (Esmaeilpour, et al. 2011:134). Some staff members felt reporting “into a black hole” as it was unclear what happened after an event had been reported (Pompeii, et al. 2016:859). Some reporting systems were found to be too complex and time consuming to use (Hogarth, Beattie & Morphet, 2016:75). Some staff members omitted reporting due to the focus on customer service and patient satisfaction and accepted abuse as part of their jobs (Pompeii, et al. 2016:858). Shift huddles, when staff members on a shift gather for a discussion, were reported to serve as a valuable support mechanism for staff following an abusive event. Security personnel were perceived to be unsupportive and not much help during workplace violent incidents (Pompeii, et al. 2016:859). Staff expressed a need for managers to engage in discussions and to show support and understanding concerning all incidence of violence (Pompeii, et al. 2016:860).

Organisations should consider strategies to prevent psychosocial hazards in workplaces (Nguyen, Teo, Grover & Nguyen, 2017:1415). Managers should act upon workplace violence to support the professional dignity of nurses as their most valuable workforce.

When a nurse does something special for a patient and it is appreciated, she feels dignified. It is valued more than capabilities and abilities. Nurses discover their worth as professionals through the favourable feedback they receive from their patients (Tseng, Wang & Weng, 2013:163; Seitovirta, et al. 2017:1048). Nurses experience a sense of personal satisfaction when they are able to help their patients and fulfil their needs when they are vulnerable (Atefi, et al. 2014:355).

Participants regretted the perception of the public towards nurses. They felt that some patients and members of the public did not value nurses as ‘professional beings’ nor their valuable contribution to healthcare. The professional image of nurses is influenced by their perception of the image public reflects on them (Rezaei-Adaryani, Salsali & Mohammadi, 2012:83). Patients might be ignorant about the nature of nurses’ work (De Azevedo

Amorim, De Oliveira Souza, Da Silva Pires, Ferreira, De Souza & Vonk, 2017:1918). A study of Greek nurses' perception of their public image revealed similar findings. They were not perceived to be scientific nursing professionals but were regarded as 'servants' carrying out the most basic tasks in hospitals (Karanikola, Papathanassoglou, Nicolaou, Koutroubas & Lemonidou, 2011:110). A better image of nurses, as perceived by the South African public, was revealed in a South African study. Most respondents (80%) perceived nurses as being hardworking while 78.2% of respondents perceived nurses as being caring and understanding (Meiring & Van Wyk, 2013:3).

The experiences, of participants in the current study, in dealing with patients and public were described as being challenging. Nurses felt unappreciated for their efforts to render good service and care to their patients. While providing their best care to patients it was often regarded as being 'not good enough'. Patients and patients' family members were perceived as becoming ruder and more demanding making it harder to meet their expectations, as reported by Dawson, Stasa, Roche, Homer and Duffield (2014:5).

The ability to complete a task effectively impacts on the professional dignity of nurses. It is demotivating and demoralising when a task can only be completed halfway due to not having sufficient resources. Participants in the current study described the experiences of colleagues working in government hospitals as being de-motivating due to the lack of adequate resources. Iranian nurses reported similar circumstances having to work with very old and dysfunctional equipment preventing them from rendering quality care to their patients (Atefi, et al. 2014:356). In South-Africa, the scarcity of resources were found to exist in public healthcare services. (Messenger & Vidal, 2015:7). A lack of medical supplies experienced in South Africa's public health services have detrimental effects on the quality of patient care (Pillay 2009:[1]). However, one the most prominent traits in private health care facilities is described by participants as having adequate resources to perform their jobs. The resources included supplies, equipment, good organisational structures and standards to care for their patients. A research comparison between private and public healthcare facilities in a recent study confirmed well-

resourced and managed private health care facilities in South Africa (Ranchod, Adams, Burger, Carvounes, Dreyer, Smith, et al. & van Biljon, 2017:101).

Professional nurses feel unsupported when they have to cope with inadequate numbers of staff members, impacting negatively on their professional dignity. Participants in the current study experienced insufficient nurse-patient ratios as posing a risk to safe patient care. These findings correlate with those reported by several studies where nurses perceived inadequate staffing levels as being a barrier to complete tasks on time and to provide good patient care (Atefi, et al. 2014:356; Voget, 2017:52).

Participants in the current study described difficulties in trying to balance staffing needs with the expected budgetary requirements and their lack of autonomy to determine their own staffing needs impacted negatively on their professional dignity. General managers, according to the participants in the current study, were perceived to be lacking insight into nursing resulting in professional nurses having a lack of autonomy to take decisions about their unique units' staffing needs. Participants wished these managers could work in their units for one day. Similar findings from another study revealed that top level managers made decisions and enforced policies without consulting the unit managers, impacting negatively on providing quality care to patients (Dawson, et al. 2014:5). Being unaware of the unique nursing dynamics and circumstances in caring for patients, some general managers were experienced as being hard on nurses' mistakes which impacted negatively on their professional dignity: "*If they just took the time to understand*" (Pr).

4.3.5 **Providing care in complex situations**

Professional standing due to own and others' percipience in a private health care facility entails being exposed as a professional to unique and complex situations. Professional nurses are exposed to a different kind of nursing in private healthcare with demanding expectations from them as professionals. They find themselves in complex situations and the workplace demands the provision of the desired level of care.

A lack of time to provide comprehensive nursing care poses a threat to the values of professional nurses taught during their training (Walsh & Buchanan, 2011:357). They are exposed to a fast work pace and high turnover rates of patients (Udod & Care, 2012:73; Rasoal, Kihlgren, James & Svantesson, 2016:830) and have to rush to complete their tasks on time (Valizadeh, Zamanzadeh, Habibzadeh, Alilu, Gillespie & Shakibi, 2016a:6). The latter poses a risk for providing safe patient care (Rasoal, et al. 2016:829). Staffing ratios were reported to be major obstacles for providing holistic care to patients by various authors (Msiska, et al. 2014:101; Voget, 2017:52). A nurse manager described "walking a tight rope" (Udod & Care, 2012:73) all the time trying to balance patients' needs with the fast pace and high turnover rates of patients. Seeing patients being discharged who would be unable to cope in the community conflicted with her values of taking good care of patients holistically (Udod & Care, 2012:73; Rasoal, et al. 2016:830).

Participants in the current study described similar experiences. The standards and values taught during their training were contradictory with the current practices to which they were exposed. A theatre nurse practitioner described wanting to take care of patients safely but being expected to push theatre lists and to please surgeons, thus compromising her own professional standards. Pressure from medical practitioners to act against the standards they had been taught was reflected on in another nursing unit.

Professional nurses might be ethically challenged to provide good and safe care (Rasoal, et al. 2016:829). They might experience difficulties to remain firm in complex situations. When professional nurses acted against medical orders for the safety of their patients they risked being humiliated and extradited by the healthcare team. A study reported that some professional nurses rather faced the consequences of their actions of "doing right" than exposing themselves to moral risks but some conformed to potentially unsafe practices to avoid social risks (Striley & Field-Springer, 2016:86) impacting on nurses' professional dignity.

Private healthcare work environments are usually volume and task driven with strict financial control. The current study's participants revealed that getting the job done within the shortest possible time posed a challenge to operating theatre nurses who were constantly being reminded that "time is money" (Pt). Such continuous pressure to get the job done might make it difficult to engage in meaningful relationships with patients when nursing care amounts to ticks on a checklist. Being unable to care for their patents as they should, and dissatisfied patients, impacted negatively on nurses' professional dignity (Valizadeh, et al. 2016a:6). Nurses had to face the consequences of working under time pressure, even though they had no control over unreasonable work volumes (Valizadeh, Khoshknab, Mohammadi, Ebrahimi & Bostanabad, 2016b:112). In South Africa, nurse managers confirmed the difficult working conditions of professional nurses aggravated by long shifts and mandatory overtime (Mokoka, et al. 2010:[5]).

Working under constant time pressure, could contribute to nurses' errors and/or inability to provide the required care. Reportedly, in National Health Service hospitals in the United Kingdom (UK), many nurses (86%) were unable to complete all care activities during their shifts. Patient engagement (66%) was the most frequently neglected activity followed by patient education (52%) (Ball, Murrells, Rafferty, Morrow & Griffiths, 2014:116). A South-African study also reported that "small things" were left undone in order to complete the most critical tasks (Voget, 2017:56). Adequate staffing was a major factor for ensuring the execution of required nursing actions (Kalisch & Xie, 2014:880). Healthcare practitioners were affected when they made mistakes (Courvoisier, et al. 2011:e23138).

Participants in the current study described being disappointed in themselves when they were unable to care for their patients safely. A nurse in theatre regretted not always being able to work exactly according to the standards she taught her subordinates: "you *feel like if you if you pretending and that's not the person you want to be*" (Pt). These findings correlate with reported experiences of moral distress when nurses' actions were inconsistent with their beliefs of what was "right" (Forozeiya, 2017:47). Workplace demands

posed major obstacles to maintain high standards (McIntosh & Sheppy, 2013:35). Taking shortcuts was often the result of inadequate staffing (Voget, 2017:57).

Participants in the current study described being a professional in diverse environments as an ongoing effort to break through diversity barriers in their encounters with self, patients, public and members of the healthcare team. Older nurses might find it difficult to work with the younger nurses with different work ethics and values. According to Mokoka, et al. (2010:[6]), young nurses are energetic and 'alive' and put their own needs before the needs of the patients while older nurses are tired and emotionally drained but put their patients' needs first. Younger nurses might be perceived to lack professionalism and respect. Mature professional nurses and nurse leaders should teach young nurses about values of respect and nursing work ethics (Mokoka, et al. 2010:[7]). Understanding the uniqueness of each generational group would be beneficial to nurse managers to retain and maintain quality patient care. Active engagements with these groups could bring new insight and knowledge to adapt leadership and the work environment accordingly (Stanley, 2010:851). Organisations should provide development opportunities for every generational group while having an individual approach in their leadership engagements (Stanley, 2010:850). Findings further placed emphasis on training schools in having a closer focus on value-based training with a sound socialisation process to groom young individuals into the profession (Jiménez-López, Roales-Nieto, Seco & Preciado, 2016:79).

Rendering care to diverse clients (patients and public) was described by participants in the current study as being challenging. Having to win a patient's trust due to cultural and racial differences had an impact on nurses' professional dignity. Participants were exposed to circumstances of patients refusing to use a universal language or insisted on being treated by healthcare practitioners of a similar race.

A recent study revealed that Japanese nurses encountered difficulties to maintain their professional autonomy when nursing non-Japanese patients

(Kuwano, Fukuda & Murashima, 2016:567). Most of these nurses (61%) had no training to care for non-Japanese patients in training schools while 62.7% had no in-service training on coping with patient diversity in their hospitals. Communication was the major obstacle to provide care (Kuwano, et al. 2016:569; Truong, Gibbs, Paradies & Priest, 2017:39). Nurses need to communicate effectively with patients of non-dominant cultures having limited understanding of English. Nurses need to ensure good outcomes and safe aftercare in procedures such as ophthalmic surgery (Wright, 2011:7). It is challenging to explain procedures and to communicate bad news or ethical decisions such as 'do-not-resuscitate' to patients from a different culture, especially when language barriers exist (Kalafati & Paikopoulou, 2011:49). Exposure to cultural training and experience of working in a diverse clinical environment influenced the provision of diverse patient care (Cruz, Alquwez, Cruz, Felicilda-Reynaldo, Vitorino & Islam, 2017:219).

Caring for private paying and medically insured patients is complex, considering patients' demands attributable to their payment for health services. The quality of services influences patients when choosing a healthcare facility (Luigi, Iuliana, Alma & Bilan, 2014:63; Moreira & Silva, 2015:262). Patients' demands could be demotivating to overburdened nurses doing their best to meet patients' needs. Nurses felt 'left alone' due to unsupportive managers and the assumption that 'the patient is always right' (Voget, 2017:70). Nurses reported difficulties experienced during emotional outbursts of patients and members of the public using an aggressive tone of voice in expressing their needs and threatening to report staff members. Some managers supported the nurses while others tried to 'please' patients and members of the public. Staff reported being exhausted from dealing with the emotional outbursts of patients and patients' family members (Rasoal, et al. 2016:829). However, some nurses were able to diffuse emotional outbursts and aggression by giving patients their undivided attention (Lindwall & Von Post, 2014:339).

Nurses' desire to provide humanised care (Calegari, Massarollo & Dos Santos, 2015:43) is in line with patients' expectations of personalised care

(Darbyshire & McKenna, 2013:306). It is thus crucial for healthcare facilities to develop new strategies to meet the needs of both providers and consumers of care for maintaining a focused humanised care approach (Calegari, et al. 2015:41).

4.3.6 **Performing as a professional nurse**

Professional standing due to one's own and others' percipience places dual responsibility on professional nurses in their 'being for self and others'. True to the integrity and work ethics of a professional nurse, 'being for self' drives professional nurses to perform beyond expectations, doing more than just performing their jobs. While setting high standards in their 'being for self', they simultaneously have to perform to the standards and expectations in their 'being for others'.

Professional nurses advocate for and safeguard their patients and want to provide good care with kindness and empathy. Being responsible professionals they are committed to their work, making sure that all nursing actions are carried out timeously and precisely. They have the highest regard for the dignity of patients and want to meet their patients' needs diligently. They perform their duties with integrity being faithful in always doing the right thing (Burhans & Alligood, 2010:1693; Catlett & Lovan, 2011:59). Professional nurses, as independent practitioners, remain responsible and accountable for their actions and ultimately for the quality of patient care. The Code of Ethics for Nursing Practitioners in South Africa states: *"As professionals, Nursing Practitioners will be personally accountable for all actions and omissions while carrying out their responsibilities in their profession and must always be able to justify all decisions taken and carried out*" (SANC, 2013:4).

Participants in the current study experienced pressure due to being part of a team, relying on colleagues and other categories of nurses, to assist them in providing care to patients entrusted to them. Some nurses did not perform their duties to the expected standards. Then the professional nurse had to cope with the workload as one individual. Similar experiences were reported in a South African study exploring the effect of multiskilling of nurses, reporting

that some team members had to be ‘pushed’ to complete their tasks (French, Du Plessis & Scrooby, 2011:6).

Teamwork was fundamental to the professional dignity of nurses (Stievano, et al. 2012:347). When team members co-operate they get the work done, being sensitive to each other’s workload and assisting each other till everyone’s work has been completed (Kalisch & Lee, 2010:239; Atefi, et al. 2014:355). Such teamwork supports the role of the professional nurses enabling them to ensure that their patients are well looked after.

The current study’s participants revealed that team work was impeded when other categories of nurses and support services staff members were unsupportive and produced sub-standard outputs. When professional nurses cannot trust the staff working with them they tend to rather do the work themselves. The workload of the professional nurse becomes much harder under such circumstances, potentially affecting the professional dignity of nurses.

In a recent South African study professional nurses reported experiencing disrespect, unhelpfulness and unwillingness to co-operate from other categories of nurses (enrolled nurses and from enrolled auxiliary nurses) who disregarded delegated tasks. Professional nurses were challenged in the presence of other staff members and patients (Voget, 2017:58). Some junior nurses were willing to share tasks, especially when they were exposed to multiskilling, while others feared acting beyond their scope (French, et al. 2011:5). A South African study, conducted in the Western Cape Province, questioned the current utilisation of care workers who might sometimes perform nursing tasks, constituting a risk to patient safety. (Stellenberg & Dorse, 2014:8; Aylward, Crowley & Stellenberg, 2017:1).

Participants in the current study experienced their extended role as professional nurses to be a burden having to be ‘everything to everyone’. Patients relied on professional nurses for help even with the most basic tasks. Similar experiences were described by professional nurses who questioned

their professional role of being responsible for everything and taking on diverse roles in providing basic nursing care and performing secretarial activities (Atefi, et al. 2014:356). A lack of understanding what the role of the professional nurse entails, contributed to the misuse of professional nurses being pulled in many directions by administrators, nurses, physicians and other hospital departments (Antoniazzi, 2011:756). Nurses were even expected to fix technical problems and electrical equipment (Braganca & Nirmala, 2017:100).

Inadequate staffing levels presented an obstacle to render safe patient care preventing professional nurses from using their knowledge and skills optimally (Atefi, et al. 2014:356). Participants in the current study experienced pressure being required to mentor and guide colleagues, coping with the workload and taking on more work than other staff members. Lack of time to mentor junior nurses also emerged in the findings of a recent study indicating that junior nurses experienced limited or no support and mentoring from senior professional nurses (Drury, et al. 2014:522).

Participants in the current study described violent situations as being strenuous, having to maintain professionalism while they were struggling to compose themselves: "*Let the patient feel safe even if you not feeling safe*" (Pt). Disruptive behaviour is a global phenomenon with physician-related aggression most commonly occurring in operating theatres while physical aggression occurred mostly in emergency and mental health units (Edward, Ousey, Warelow & Lui, 2014:653). A nurse working in an operating theatre reflected on her experiences in the theatre environment. She described having to keep her 'pose' and not talk back in the midst of disruptive behaviour while the patient was on the operating table as being extremely hard (Higgins, 2009:56).

Professional nurses might thus feel the punches with their current workload in facing their work demands. Nurses could experience signs of physical and emotional burnout feeling tired, overworked and exhausted, having a powerful effect on them as human beings.

Fatigue is an anticipated consequence when being exposed to continuous work overload (Chen, Davis, Daraiseh, Pan & Davis, 2014:593; Raftopoulos, et al. 2012:1) and poses a risk to providing safe patient care. When nurses were tired, they were less alert and unable to concentrate while caring for their patients, resulting in perceived diminished physical performance (Sagherian, Clinton, Abu-Saad Huijer & Geiger-Brown, 2017:304; McIntosh & Sheppy, 2013:35). The patient-nurse ratio is much higher for professional nurses than for other categories of nurses. A study in Brazil reported a 1:13.4 ratio for professional nurses and a 1:4.2 ratio for assistant and technician nurses (Alves & Guirardello, 2016: 331), causing concern because different categories of nurses have different levels of knowledge and skills (French, et al. 2011:5).

When nurses were exposed to constant work overload it impacted negatively on their well-being. They then struggled to concentrate and maintain good interpersonal relations. They were more prone to emotional outbursts and interpersonal conflicts due to the fact that they felt tired and pressurised. They were unable to complete all their tasks and they experienced feelings of guilt. They felt stressed and even confused at times (French, et al. 2011:5).

Passion for one's work is almost a pre-requisite for being a good nurse. However, passion could contribute to burnout and emotional fatigue. Being unable to find a balance between one's work and personal life could reduce one's productivity levels. Such passion is defined as obsessive passion and could be detrimental to a person's well-being (Bushardt, Beal, Young & Khosla, 2016:16; Burke, Astakhova & Hang, 2015:457).

Participants in a recent study suggested the implementation of a so called 'haven' where they could debrief. A need for emotional intelligence training was also expressed to be able to handle their 'mood swings', frustrations and their unforeseen rudeness due to work pressure (French, et al. 2011:7). Yoga has proven to be an effective self-care method to improve and alleviate burnout in nurses. Improvement was observed in nurses' levels of self-care, mindfulness and emotional exhaustion during an eight-week yoga intervention

programme (Alexander, Rollins, Walker, Wong & Pennings, 2015:462). Nurses have been neglected as a target group for lifestyle promoting programmes. A study revealed improvement in smoking habits, weight management and fitness with the implementation of such programmes in the USA, Canada and Taiwan (Chan & Perry, 2012:2247). Participation in mindfulness training held promising results in reducing stress and improving workplace resilience (Foureur, Besley, Burton, Yu & Crisp, 2013:114).

A study explored the reasons why professional nurses remained in nursing practice despite almost unbearable workloads and unfavourable working conditions. Professional nurses were resilient and found positive ways of coping with their workplace pressures enabling nurses to continue nursing and to enjoy doing so (Cope, Jones & Hendricks, 2016:115).

4.3.7 **Valuing patient well-being**

Professional nurses are dignified when they contribute to the well-being of patients. They value patients as the number one priority in their work life and want to focus on the benefit of their patients.

Quality nursing care is perceived by nurses as the intention to provide good and kind care with respect, empathy and responsibility while protecting the well-being of patients (Burhans & Alligood, 2010:1693; Catlett & Lovan, 2011:59). They are sincere in their care promises to patients (Butts, 2013:84), making sure to deliver care to the improvement of their well-being. They are willing to sacrifice themselves in the best interest of their patients always trying to put themselves in their patients' shoes to understand their circumstances (Catlett & Lovan, 2011:60; Burhans & Alligood, 2010:1693). Nurse managers in charge of units have an "around the clock" consciousness for the well-being of their patients. They reported about personal sacrifices of coming on duty earlier and leaving later to ensure the smooth running of their units for the sake of safeguarding their patients (Athlin, et al. 2014:237-238).

Taking good care of patients is associated with small deeds of kindness and providing comfort (Catlett & Lovan, 2011:59; McCabe & Sambrook, 2014:821).

It is described as “doing things that really matter” by nurses in a recent study. Being able to hold a patient’s hand or sitting down to talk to a patient and attending to his/her emotional needs was seen as care that really mattered (Hofmeyer, et al. 2016:16). Valuing patients’ well-being is thus more than attending to a list of tasks to get a job done. Patients are worthy of more than to be treated as a mere number or an object (Sabatino, et al. 2016:285).

Nurses depend on the work outputs and abilities of other members of the nursing team. Trust becomes a challenge when certain team members do not demonstrate the required knowledge and skills to care for patients safely (McCabe & Sambrook, 2014:822). The well-being of patients might be compromised under such circumstances. Some categories of nurses might not be reliable to provide patient care. When patients were neglected due to the lack of care of colleagues it impacted on their dignity.

Professional nurses are at the patients’ bedsides 24 hours a day. Seeing patients’ well-being being compromised by other health professionals impacted on their professional dignity. Nurses might experience ethical complexity in valuing patients’ well-being in clinical practise (Rasoal, et al. 2016:825; Varcoe, et al. 2012:493). Nurses face “right versus wrong” decisions while being expected to act in the best interests of the patients (Albina, 2016:78). They are guided by their nursing code of ethics (SANC, 2013:1-9) and their clinical wisdom to take ethical decisions requiring a “calculated intellectual ability, contemplation, deliberation, and efforts to achieve a worthy goal” (Butts, 2013:89). Such wisdom is part of a person’s moral integrity to act as a patient’s advocate.

Professional nurses might not always have the autonomy to prevent disregard for a patient’s well-being (Sabatino, et al. 2016:285). A participant, in the current study, described an experience where the well-being of a patient had been compromised without a valid reason. Participants in a Swedish study also witnessed patients being treated rudely or not being valued by physicians. Rudeness, ignoring patients as if they did not exist and disrespecting end-of-life situations were mentioned. When professional nurses

were exposed to situations where they were forced to “see what they don’t want to see,” their dignity was violated (Lindwall & Von Post, 2014:335).

Some nurses also provided care disrespectful of patients’ dignity. Witnessing violation of a patient’s dignity impacted negatively on the professional dignity of nurses (Sabatino, et al. 2016:286). A participant in the current study described an experience where a patient’s privacy was not respected by a nurse which was detrimental to the participating nurse’s own professional dignity.

Patient well-being could be threatened by heavy workloads and inadequate staffing levels (Ball, et al. 2014:116; Calegari, et al. 2015:43). A South-African study reported unfavourable work circumstances in public hospitals for both nurse managers and nurses which impacted negatively on the safety and well-being of patients (Mokoka, et al. 2010:[1]). Malawian nurses experienced work circumstances which adversely affected their performance and professional well-being (Msiska, et al. 2014:97). Nurses, in a recent study, repented the perceived loss of “care as an art” being replaced by “care as a financial target” opposing nurses’ desires to value patient well-being (Harvey, Thompson, Pearson, Willis & Toffoli, 2017:1). Although most hospital boards devote time to patients’ safety issues, they did not influence the provision of safe patient care in their organisations (Mannion, Freeman, Millar & Davies, 2016:V).

It is thus crucial for all role players in healthcare to “*understand and relieve suffering in their patients, and to recognize that medical intervention sometimes fails to relieve suffering and becomes a source of suffering itself*” (Cassell, 1982:639).

4.3.8 **Being humiliated by others**

Professional standing due to one’s own and others’ percipience is experienced in interaction with patients, healthcare practitioners, colleagues, managers and the general public. Participants described experiences of being degraded not only as professionals but also as human beings. Such experiences contrast with the values unique to nursing such as kindness, gentleness, respect and

valuing patients (Rook, 2017:144). A culture of safety for healthcare users forms part of the fundamental principles in the South African code of conduct (SANC, 2013:6) which nurses are expected to uphold. However, the same culture of safety was found to be violated in the work environment of nurses (Voget, 2017:78; Kerber, Woith, Jenkins & Astroth, 2015:522; Khademi, et al. 2012:333). Participants in the current study reflected on emotionally unsafe experiences which impacted on their ability to provide optimal patient care.

Medical practitioner-nurse interactions were experienced as being negative and demotivating. Physicians employed humiliating verbal remarks, mannerisms and sarcasm towards nurses as professionals. Physicians were found to be “mean and rude” in their daily collaboration with nurses (Gotlib Conn, Kenaszchuk, Dainty, Zwarenstein & Reeves, 2014:eP1057), also during telephone encounters with physicians even when addressing concerns about critically ill patients. Physicians’ rudeness included yelling over the phone or disconnecting the phone without addressing the patients’ concerns. A lack of trust was experienced by junior professionals and they often had to hand the phone to the senior professional nurse at the request of the physician. Professional nurses reported being reprimanded in the presence of patients, questioning their clinical judgements (Kerber, et al. 2015:524). Some medical practitioners expected nurses to clean up after them, as if nurses were their servants (Stievano, et al. 2016:11). The absence of small gestures portraying good manners, such as greeting, was humiliating and impacted negatively on their professional dignity (Sabatino, et al. 2016:285).

Most participants, in the current study, described experiences of disregard for their professional autonomy, including disregard for patient care, nursing suggestions and decisions. They perceived medical practitioners as ‘looking down’ on them. Several studies confirmed a ‘physician centred’ and ‘physician superiority’ culture in healthcare facilities. The skills, knowledge and clinical inputs of professional nurses were often disregarded. When professional nurses could not be instrumental in the treatment and recovery process of patients (Sabatino, et al. 2016:285), they felt humiliated and useless (Atefi, et al. 2014:357; Farhadi, et al. 2016:21-22).

Professional nurses were not valued for their professional expertise and their unique understanding of the patient's condition being at the bedside 24 hours a day. They felt left-out and humiliated due to a lack of autonomy (Atefi, et al. 2014:356-357; Farhadi, et al. 2016:21-22). A professional nurse described an experience of disregard towards her academic standing (doctorate in nursing) as being most humiliating. Some physicians belittled the qualification while a patient underestimated the knowledge base of nursing. He could not understand the professional nurse's level of knowledge saying she knew so much he thought she was a physician (Jesus, et al. 2010:167).

While nurses valued the act of caring, some members in society perceived the act of caring as being inferior to other medical professions. They failed to acknowledge the science of nursing by associating it only with the execution of tasks to fulfil in the basic needs of patients (Jesus, et al. 2010:167; Karanikola, et al. 2011:110).

One participant in the current study mentioned being exposed to physically threatening behaviour and verbal abuse from a physician, causing her to feel like a battered woman. Another participant reported being humiliated for things which were beyond of her control. She reflected on being called an idiot in spite of having a vast amount of knowledge and clinical expertise. Other physicians' acts of incivility included yelling, screaming, throwing of instruments and slamming of charts (Kerber, et al. 2015:525).

Nurses are cornerstones in healthcare fulfilling a vital role in caring for patients (Greenwood, 2016:4). They are, however, not recognised as such. A recent study revealed nurses' perception of the public image of nurses (Braganca & Nirmala, 2017:97). Few nurses (2.7%) perceived the public as viewing nurses as being resourceful, while a mere 10% of nurses agreed on being viewed by the public as being skilled professionals (Braganca & Nirmala, 2017:99). Nurses in another study reported experiences of disrespect from patients, patients' family members and members of the public (Mokoka, et al. 2010:[4]).

Questions were raised about the views of nurses in South Africa's private healthcare sector where nurses were exposed to unprofessional expectations by members of the public (Braganca & Nirmala, 2017:100). Similar experiences were described by participants in the current study. Some patients treated nurses "*like nobody"* (Pm) and degraded them to nothing more than their personal assistants. Disregard for nurses' knowledge and skills were experienced as being degrading and humiliating. They judged, confronted and questioned the skills of professional nurses. Another study reported similar experiences with patients insisting on physicians' interventions even though nurses were able to attend to the patients' clinical issues within the nurses' scope of practice (Khademi, et al. 2012:334).

Although managers should ensure the safety of their staff members against humiliating experiences, managers were sometimes part of the problem. Professional nurses, participating in the current study, experienced abusive behaviour to continue despite having reported such behaviour. They were unaware of managers' actions following reporting of such events and they did not receive feedback. These findings correlated with the findings of Hogarth, et al. (2016:78).

Experiences of a lack of confidentiality about personal matters and a lack of trust when reporting sick added to nurses' feeling of humiliation by managers in the current study. Similar distrust situations were reported by Khademi, et al. (2012:333) when nurses had to take sick leave. The latter study also reported that hidden cameras to monitor the behaviour of nurses were regarded as a violation of nurses' dignity.

The behaviour of managers impacted on the professional dignity of nurses. When managers reprimanded nurses in the presence of patients and/or other members of the healthcare team they felt degraded and their professional dignity was violated. A young nurse reflected on being reprimanded in the presence of a patient for doing something for a patient which was apparently supposed to be the carers' responsibility. Not standing up for an act she

believed was to the benefit of the patient, left her with regret and self-disappointment (Adam & Taylor, 2014:1243).

Several participants in another study described experiences of disrespect from the nurse managers in their units. Such behaviour included yelling in front of other staff members and being accused falsely without subsequent apologies (Kerber, et al. 2015:525; Khademi, et al. 2012:334; Voget, 2017:66). Not being valued as humans (Khademi, et al. 2012:333) and being exposed to managers who humiliated staff members caused moral distress (Voget, 2017:66). When managers failed to protect staff members in dealing with unreasonable demands of patients, professional nurses felt degraded and valueless. Similar experiences were reported by Voget (2017:71) because staff members also felt disheartened and powerless due to the lack of professional support from their managers (Voget, 2017:71).

Humiliation involves emotions of anger, shame and disappointment. Victims feel powerless, small and inferior (Elshout, Nelissen & Van Beest, 2017:1581). It is also described as feeling “wiped out” or “sick in the gut”. Such experiences are remembered for many years (Klein, 1991:96). Several factors influence the humiliating experiences of nurses. Professional character and self-confidence are perceived to minimise the negative experiences of humiliation. Staying on top of medical technology and portraying clinical ‘know how’ positively influence the professional standing of nurses (Valizadeh, et al. 2016b:112). Female nurse leaders are perceived as having a weaker professional standing to protect the needs of nurses. There is a degraded professional standing in society due to the perceived lack of status of the nursing profession. Some believe it is also due to the monetary value of nurses earning less than other members of the health team. Certain expected routine tasks which nurses have to perform are perceived as being degrading by nurses (Valizadeh, et al. 2016b:113).

Being humiliated by others impacted negatively on the professional dignity of nurses and on patient care. Participants in the current study perceived the dignified moments in their work life as having the best patient care outcomes.

Exposure to undignified moments influenced nurses' ability to function efficiently and to provide compassionate care. Professional nurses in a Canadian study working in theatre described negative emotions following exposure to humiliating behaviour, feeling not "good enough", powerless, embarrassed, hopeless and doubting their own abilities (Higgins, 2009:73).

Nurses cope in different ways with degrading moments. Some react by being assertive and trying to remain positive. They re-direct their focus towards patient care. Others would cry in a private place and some would pray to just get through the day (Voget, 2017:80). A participant in the current study reflected on bouncing back by standing proud as a nursing professional. She took a conscious decision not to allow others to drag her down.

The reality of disruptive behaviour in healthcare settings thus remains a challenge for healthcare leaders to address effectively, leading nurses "from vulnerability to dignity" (Janzen, Mitchell, Renton, Currie & Nordstrom, 2016:254).

4.4 SUMMARY

In this chapter the researcher discussed the findings about the phenomenon regarding the experiences of factors impacting on preserving the professional dignity of nurses in relation to the reviewed literature. The constituents which supported the essence of 'professional standing due to one's own and others' percipience' were discussed in relation to the professional dignity of nurses which could be experienced positively or negatively.

Chapter 5 will deal with the development and refinement of the strategies to preserve the professional dignity of nurses.

CHAPTER 5

PHASE 2: DEVELOPMENT AND REFINEMENT OF STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN A DEMANDING HEALTHCARE ENVIRONMENT OF PRIVATE HEALTHCARE FACILITIES

5.1 INTRODUCTION

The experiences of nurses regarding their professional dignity in private healthcare facilities were described in phase 1 of the study. The essence of the phenomenon (experiences of factors that impact on the professional dignity of nurses) was shown as ‘professional standing due to own and other's percipience’. The following constituents of the essence were uncovered and supported the essence during this phase of the study, namely: perceiving one’s own professional dignity; having contradictory experiences; being proud to be a professional nurse; receiving support, appreciation and respect; providing care in complex situations; performing as a professional nurse; valuing patient well-being; and being humiliated by others.

In this phase draft strategies were developed and refined to preserve the professional dignity of nurses. The findings of phase 1 and an extensive literature study will serve as basis information for the development of the strategies. Experiences of factors that impacted on the professional dignity of nurses in private healthcare facilities, as described in phase 1 will be incorporated in the draft strategies for refinement through focus group interviews with nurses, hospital and nursing management and members of the health team from the two participating healthcare facilities. The process used to develop and refine the strategies is described in the following section.

5.2 DEVELOPMENT OF THE DRAFT STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN PRIVATE HEALTHCARE FACILITIES

Strategies serve as important navigational aids for companies moving into the future (Hillier, 2011:503; Martin, 2014:79) and could be used by managers to improve the healthcare work environment for nurses, based on research findings. In the current study the research findings of phase 1 are translated

into statements (constituting the draft strategies) aiming to develop a final set of strategies. Strategies are developed as a “stream of decisions” (Mintzberg, 1978:935) to assist companies towards making hard choices to ensure critical and successful outcomes (Martin, 2014:79). There are two critical choices that lead to successful outcomes; the “where-to-play” choice (in the current study it refers to the understanding of the experiences of nurses of the factors that affect their professional dignity) and the “how to win” choice which, in the current study, refers to the implementation of strategies to preserve the professional dignity of nurses (Martin, 2014:81).

The current study aims to develop and refine strategies to preserve the professional dignity of nurses in private healthcare facilities. The body of evidence, on which the strategies are based, was obtained from constituents identified from analysing data which derived from unstructured phenomenological individual interviews with 11 nurses, combined with extensively reviewed literature relevant to the eight constituents (consolidated from the constituents identified during the data analysis of the findings of phase 1 as discussed in chapter 4 of this thesis).

The researcher adopted the principles of strategic navigation, while developing the draft set of strategies, to preserve the professional dignity of nurses. Strategic navigation is a methodology to develop pathways into the future as part of a process described as strategic spatial planning.

It envisages long-term and short-term activities which include the mapping of pathways into the long-term future and adopting short-term detailed plans and campaigns (Hillier, 2011:503). The strategies in the current study provide long-term pathways to preserve the professional dignity of nurses for managers of private healthcare facilities to utilise for developing their unique individual short-term detailed plans and campaigns. Strategic navigation deals with current reality and how it emerged together with exploring opportunities which might have potential to develop into new pathways (Hillier, 2011:503).

In the current study, the researcher explored the current reality of professional nurses and their experiences regarding professional dignity. Simultaneously, future possibilities to determine strategies to identify new future pathways to preserve the professional dignity of nurses were also sought. The researcher thus focused her thought processes on strategic navigation during strategy development as illustrated in Figure 5.1.

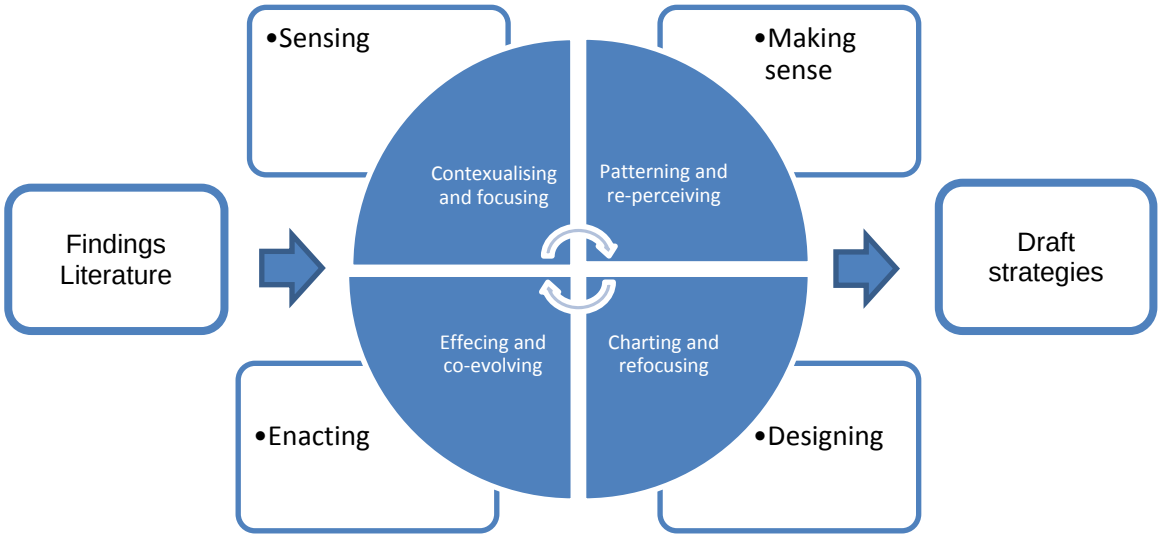

Figure 5.1: Strategic navigation in strategy development (Adapted from Hillier 2010)

Strategic navigation takes place in four stages namely sensing, making sense, designing and enacting.

5.2.1 Sensing

Sensing is about taking a retrospective view of what happened in the past through contextualising and focusing. Contextualising and focusing are required to explore "how elements and processes respond to both their own logics and to external pressures and stimuli", including the inter-dependency and associations between elements, relations and experiences (Hillier, 2010:4). Contextualising serves as a process to gain understanding by seeing things within the context where it takes place. It is the insight into how things

take place and how it happened at a certain point in time. Focusing refers to that critical moment when core issues are sensed and identified (Hillier, 2010:3).

Strategic navigation takes place in four stages namely sensing, making sense, designing and enacting. Contextualising the eight concepts consolidated from the constituents created an understanding of the context and relations in which they exist and how they came about. The researcher considered the unique dynamics between role players which surfaced in the findings and literature with the potential possibilities during strategy formation. Focusing enabled the researcher to identify the issues which mattered most and to formulate strategies comprising the very core of the professional dignity of nurses.

5.2.2 **Making sense**

Making sense takes place through patterning and re-perceiving. Patterning is a process of bringing together. It consolidates different viewpoints, understandings and new insights towards the here and now and also towards a projected future seeking for knowledge gaps and ways to supplement current knowing (Hillier, 2010:4). Re-perceiving entails deeper sensitivity and understanding by giving what is known a fresh look. The aim is to conclude with diverse perspectives on future options and opportunities (Hillier, 2010:5). Patterning aided the researcher to make sense of newly discovered findings and of discoveries reported in the relevant literature. It structured her thought processes to direct strategies towards the current and the foreseen future. She followed a process of re-perceiving in gaining deeper understanding of the factors impacting on the professional dignity of nurses through seeing things in a new way with fresh eyes. Strategies were visualised while considering multiple future possibilities.

5.2.3 **Designing**

During the designing phase, beacons for strategy formation are uncovered. It serves as a useful resource to visualise going forward. It is a process of potential creativity by re-focusing and charting. Re-focusing serves as a strainer to establish “what might happen if” in order to separate more

important from less important aspects. It thus looks at different elements and influencing forces as a process of anticipation (Hillier, 2010:5). Charting is a process of "strategically navigate towards" the anticipated future by the formulation of the strategy plans. During this stage critical consideration of possible risk, consequences and opportunities takes place (Hillier, 2010:6). Re-focusing filtered the researcher's attention towards the most important strategic intent. The researcher re-focused her thought patterns in formulating a concise rationale and in directing her attention to the specific factors critical in preserving the professional dignity of nurses (Hillier, 2011:519). The process of charting enabled the actual determining of strategies. Practicality, ability to execute, implications, risks and opportunities were considered. The strategies were derived within the boundaries of the findings and incorporated relevant literature.

5.2.4 **Enacting**

During the stage of enacting, the actual plans are implemented and adapted through the processes of effecting and co-evolving. Effecting involves the actual implementation of the strategic plans. Several considerations are necessary during the implementation stage. Each strategic plan is evaluated for the possibility of enablement and its effect on organisational systems. Measuring of future successes are considered as well as anticipated future challenges and problems. Strategic plans are not cast in stone. During the process of co-evolving, when implementation takes place, it might be necessary to adapt plans according to surfacing change dynamics.

Critical unintended consequences might require a change in thinking patterns or future pathways thus requiring sensitivity in identifying such consequences accordingly. (Hillier, 2010:6). Although the researcher would not be involved directly during the proses of implementation, the process of effecting was considered as an action of anticipation. Strategies were formulated which were concise and realistic for potential future use by managers of private healthcare facilities.

Co-evolving enabled the researcher to prepare her thought processes towards possible changes which could evolve during the refinement process. It opened her mind towards acceptance of new suggestions and changes to be made, based on the inputs of participants in the focus group interviews.

5.3 DRAFT STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES

Experiences of factors impacting on the professional dignity of nurses in private healthcare facilities, which should be explored to preserve the professional dignity of nurses, were identified and addressed in the draft strategies. It included perceiving one's own professional dignity; having contradictory experiences; being proud to be a professional nurse; receiving support, appreciation and respect; providing care in complex situations; performing as a professional nurse; valuing patient well-being; and being humiliated by others. The constituents represent the experiences identified during the analysis and description regarding factors impacting on the professional dignity of nurses.

These eight concepts were discussed in chapter 4 to elucidate their manifestations and consequences. In formulating the discussion, literature relating to the concepts was extensively reviewed. The conclusions, derived from the discussion, were used to develop the draft strategies to preserve the professional dignity of nurses in a demanding private healthcare environment. It also provided the conceptual framework for formulating the rationale underlying each draft strategy. The findings and discussion provided the input information for the development of the draft strategies as illustrated in figure 5.1.

The following process was adopted to develop the strategies:

- Experiences regarding factors impacting on the professional dignity of nurses were explored and described using a descriptive phenomenological research approach.

- Essence and constituents of the experiences of the participants, concerning factors impacting on the professional dignity of nurses, were identified and presented based on the findings.
- An extensive literature review was conducted to develop a more comprehensive and deeper understanding of the constituents as discussed in chapter 4.
- Draft strategies were developed following the principles of strategic navigation, based on the discussion presented in chapter 4, in accordance with the findings and the extensive literature review.

5.4 PROCESS OF REFINEMENT OF THE DRAFT STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES

Research during this phase of the current study was conducted within a constructivist paradigm. It was thus assumed that multiple realities of the phenomenon (professional dignity of nurses) existed (Denzin & Lincoln, 2008:32) and that truth derives from multiple realities "mentally constructed by individuals" (Polit & Beck, 2017:10). Constructivist researchers gain information in the natural setting from participants through flexible emerging research methods. By going back to the field more than once, researchers gain more insight as the findings emerge (Polit & Beck, 2017:12) while knowledge is constructed in interaction with the participants (Guba & Lincoln, 1994:111).

The researcher included people who were involved in preserving the professional dignity of nurses for the refinement of the strategies. It was assumed that the selected professional nurses, hospital and nursing management and members of the health team of the two participating private healthcare facilities could contribute to the refinement of strategies to enhance the professional dignity of nurses. The researcher assumed that when professional nurses hold themselves in high esteem and is supported by hospital and nursing management and members of the health team; their autonomous practice would be respected; and the professional dignity of nurses could be enhanced.

Two focus group interviews were conducted to gain rich inputs from selected healthcare professionals to refine the draft strategies to preserve the professional dignity of nurses. Focus group interviews were described comprehensively in chapter 2 section 2.5.6.1 of the research methodology.

Limited opportunities existed for the generation of new data during the focus group interviews. Developed draft strategies were presented to the focus group participants based on the findings of phase 1 of the current study and on the reviewed literature. Focus group participants had to contribute to the refinement of the draft set of strategies presented to them. The draft strategies were presented as a list of statements to focus group participants to discuss and debate each strategy one-by-one. Opinions and comments were encouraged about each strategy's applicability and suitability to preserve the professional dignity of nurses.

Focus group participants were requested to reformulate, add or remove statements from the draft set of strategies. The comments during focus group interview 1 were used to refine the draft set of strategies as developed by the researcher. The comments during focus group 2 were used to further refine the set of strategies as refined during focus group 1. The end result was a refined set of strategies to preserve the professional dignity of nurses. In consultation with the research supervisor it was determined that there was no need for conducting further focus groups for further refinements.

5.5 INTRODUCTION TO THE DRAFT STRATEGIES

The title of the strategies is **'Strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities'**.

The strategies aimed to assist managers of private healthcare facilities to make hard choices to ensure critical and successful outcomes in preserving the professional dignity of nurses in private healthcare facilities. Nurses, hospital and nursing management and members the health team are target users of the strategies while nurses are the target recipients. Each strategy

has an accompanying rationale included and also actions to be taken by the target users.

The draft set of strategies to preserve the professional dignity of nurses namely, perceived professional dignity, contradictory experiences, pride, support/appreciation and respect, complex and demanding situations, nurses' professional role, patient well-being and degrading experiences and the refinement findings obtained through two focus group interviews, will be discussed in the following section.

5.6 DESCRIPTION OF THE DRAFT STRATEGIES AND THE RECOMMENDED IMPROVEMENTS AS OUTCOMES OF THE FOCUS GROUP INTERVIEWS

The following strategies are applicable to preserving the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities. In the first column of the table actions are presented and in the second column the suggested changes that the researcher obtained from the participants of the focus group interviews are listed.

Strategy 1: Hospital and nursing management, members of the health team and nurses are to value nurses' professional dignity.

Rationale

Although nurses, as part of the health team, might not think about their professional dignity while they are on duty (Sabatino, et al. 2014:659) it is determined by the way they view themselves and it is reinforced by the way other members of the team react to them (Sabatino, et al. 2014:663). Nurses' perceptions are influenced by their beliefs and professional values of 'being good nurses' (Aydin Er, et al. 2017:238; Kaya, et al. 2017:716). Professional nurses use their knowledge and skills to contribute to teamwork and to the well-being of their patients (Sabatino, et al. 2016:284). Their professional dignity gets jeopardised when nurses do not value their own capabilities and/or when other members of the health team do not value nurses' inputs in teamwork (Stievano, et al. 2012:346; Stievano, et al. 2009:97). Nurses' perceptions of their capabilities and of their contributions to teamwork could be influenced negatively or positively by themselves, other members of the health

team and hospital and nursing management (Adam & Taylor, 2014:1243; Khademi, et al. 2012:332).

Table 5.1: Strategies to value nurses' professional dignity

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management, the health team and the nurses should acknowledge and support nurses' strive to:	
• Render prompt and accurate care according to clinical standards.	Add 'as well as clinical data' at the end of the sentence (FG1).
• Gather and provide clinical information to support the coding and administration of various medical insurance models for payment and length of stay.	Change action to 'Support the coding and administration of various medical insurance models for payment and length of stay' (FG2).
• Participate in universal 'Best Care Always' and accreditation programs in support of the best clinical outcomes for patients.	Add as additional action 'Gather and provide patient clinical information in collaboration with members of the health' (FG2).
• Mentor newly qualified nurses in clinical practice and professional conduct.	
• Oversee sub-category nurses to uphold and support clinical care within scope of practice.	
• Utilise team work output to monitor, record and report clinical and emotional parameters of patients.	Replace 'team work output' with 'team work' (FG1).
• Utilise team work output to execute planned multidisciplinary care regimes safely to patients.	Replace 'team work output' with 'team work' (FG1).
• Advocate changes and new suggestions in clinical care to the betterment of patients.	Replace 'betterment' with 'improvement' (FG2).
• Participate in client satisfaction and patient safety initiatives to the	

betterment of service to clients.	
• Participate in driving cost down in private healthcare.	
• Contribute to a realistic operational and staffing budget.	

Strategy 2: Hospital and nursing management are to curtail work experiences which are contradictory to nurses' desire to prioritise patient care

Rationale

Nurses want to be person-centred, kind and caring in looking after their patients (Lyneham & Levett-Jones, 2016:86). When they experience circumstances contradicting their desire to truly care (Catlett & Lovan, 2011:60), it impacts on their professional dignity. Being questioned or judged while being knowledgeable and skilled (Jesus, et al. 2010:164), knowing the right thing to do but not having the power to do it (Shirey, et al. 2010:84) and wanting to care but being caught up in patient-less nursing actions (Eley, et al. 2012:1550) could be detrimental to the professional standing of nurses. Facing the financial side of business, being a patient's advocate without support (Striley & Field-Springer, 2016:86) and having practice issues with no voice (Kay, et al. 2015:66) could make it difficult for nurses to stay motivated and compassionate in fulfilling the role of being a 'good nurse'. Nurses also experience circumstances which could be detrimental to their own well-being because they are taught to give and to sacrifice their own needs for the sake of their patients' well-being (Steege & Rainbow, 2017:24). Nurses' ability to express and retain their own professional dignity might be jeopardised. Nursing unit managers might experience frustration striving to balance corporate expectations and administration with their clinical responsibilities for patient care in their units (Udod & Care, 2012:74). They often experience circumstances having "more responsibility than authority" (Athlin, et al. 2014:234).

Table 5.2: Strategies to curtail work experiences contradictory to nurses' desire to prioritise patient care

Actions	Suggested improvements from nurses, hospital and nursing management and members of the health team
Hospital and nursing management should:	
• Reduce excessive administration and paperwork expected of nurses.	Add additional action 'Introduce digital technology for nursing notes, billing and stock replenishment' (FG 2)
• Align the role of nurses with patient-centred care.	
• Empower unit managers to take decisions in the best interest of their units.	
• Consider a reasonable workload for nurses to experience satisfaction in caring for their patients.	
• Promote self-care principles to nurses.	Add 'physical and emotional' before self-care (FG1).
• Introduce forums where nurses are comfortable to voice their clinical practice challenges.	
• Provide administrative support structures to mitigate the impact of profit as a business goal on nurses.	Change wording to 'Provide insight and administrative support to nurses into company strategy to ensure financial sustainability of the business' (FG1).

Strategy 3: Hospital and nursing management, members of the health team and nurses are to champion nurses in the keeping of their pride in themselves and their profession

Suggested improvements from nurses, hospital and nursing management and members of the health team (Replace 'champion' with 'encourage and mentor' FG1).

Rationale

Nurses are dignified when they are proud. People who experience pride feel good about themselves (Tracy, et al. 2010:168). Nurses take pride in who they are and want to honour their profession. They are proud of a job well done and of their contribution to enhance the standards of their profession (Rauen, et al. 2015:71). They experience feelings of pride when they are able to resolve workplace conflicts and problems independently. They take pride in their knowledge and skills (Hintistan & Topcuoglu, 2017:49) and a good academic standing earns them the respect to take an equal stand with other health team members (Farhadi, et al. 2016:22; Jesus, Marques, et al. 2010:169). Some nurses find themselves vulnerable in their pride as professionals. They might be too hard on themselves trying to perform perfectly (Melrose, 2011:1), and making a nursing error could be detrimental to their professional dignity and pride (Courvoisier, et al. 2011:e23138). Others (especially newly qualified nurses), might lack pride, professionalism and commitment towards their work and their profession. These individuals need guidance into their professional role as a matter of priority to strengthen their pride and commitment (Sneltvedt, et al. 2012:13).

Table 5.3: Strategies to enable professional nurses to remain proud of themselves and their profession

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management, the health team and the nurses should enable nurses to:	
• Carry the name of the nursing profession with pride.	
• Promote the academic standing of well-educated nurses in the workplace.	
• Contribute to the betterment of nursing standards in the profession.	Replace 'betterment' with 'enhancement' (FG2).

• Own and solve their problems and conflict independently.	
• Portray a good professional image.	
• Carry their duties in a respectful and professional manner.	
• Stand up for themselves in an assertive manner.	
• Earn respect in being competent, knowledgeable, skilled and well educated.	
• Engage in equal collaboration with other members of the health team as autonomous nursing professionals.	
• Guide and uplift team members who are vulnerable in their pride.	Replace ‘vulnerable’ with ‘not so confident’ (FG1).
• Provide opportunity and encourage nurses to engage in higher education.	Replace ‘not so confident in their pride’ with ‘not so self-assured in their confidence’ (FG2).
• Be supportive and understanding towards nurses when a nursing error occurs.	Add additional action ‘Debrief after a nursing error has occurred (FG2).

Strategy 4: Hospital and nursing management are to adopt a supportive management style to support, appreciate and respect nurses

Suggested improvements from nurses, hospital and nursing management and members of the health team (Replace ‘supportive management style’ with ‘management style’ FG2).

Rationale

Nurses feel dignified when they are supported and appreciated. They discover their worth as professionals through favourable feedback from patients (Tseng, et al. 2013:163; Seitovirta, et al. 2017:1048) and managers. When they experience sincere interest in the problems they encounter, are listened to and thanked, they feel supported and appreciated (Atefi, et al. 2014:357). Most nurse managers take good care of nurses (Eneh, et al. 2012:163). They act as advocates and shields for nurses during difficult encounters (Gustafsson & Stenberg, 2017:419; Loveridge, 2017:25). However, nurses are

not always supported, appreciated and/or respected. A lack of trust in nurses to do their jobs (Loveridge, 2017:24), a lack of support when workplace violence occurs (Kitaneh & Hamdan, 2012:469; Taylor & Rew, 2011:1072) and inadequate numbers of staff (Atefi, et al. 2014:356; Voget, 2017:52) might cause nurses to feel despondent and not good enough (Loveridge, 2017:25). Feeling unappreciated and unworthy (Karanikola, et al. 2011:110) could be detrimental to the professional dignity of nurses.

Table 5.4: Strategies for adopting a supportive management style to support, appreciate and respect nurses

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management should:	
• Give feedback and maintain open communication.	
• Show gratitude towards nurses' hard work and contribution.	Replace 'contribution' with 'commitment'
• Show sincere regard in finding solutions to nurses' problems.	Change wording to 'Show sincere regard in nurses' personal and work related problems' (FG1). Replace 'in' to 'towards' and 'problems' to 'challenges' (FG2).
• Respect decisions taken on ground floor.	Replace 'decisions' with 'suggestions' (FG1). Replace 'ground floor' to 'ground level' (FG2).
• Recognise nurses for a job well done.	
• Support nurses in client service encounters regarding patients' complaints.	
• Set achievable standards and deadlines.	
• Staff units adequately.	Replace 'adequately' with 'to capacity considering company financial viability and guidelines' (FG1). Replace 'to

	capacity' to 'according to level of care' (FG2). Or change wording to 'Staff units optimally to promote safe patient care while considering company financial viability and guidelines' (FG2).
• Gain input from nurses in determining staffing budgets.	
• Gain insight in unique nursing circumstances before judging nurses' mistakes.	
• Provide opportunities for nurses to soundboard.	Replace 'soundboard' with 'express their feelings' (FG2).
• Respect 'off-duty' times and work life balance of nurses.	
• Re-look workplace violence policies and provide simplistic reporting and feedback procedures for nurses and management.	

Strategy 5: Hospital and nursing management and members of the health team are to support nurses to function optimally in complex and demanding situations

Rationale

Nurses are exposed to a different kind of nursing in private healthcare facilities. Rendering care in a volumes-driven work environment, to the satisfaction of private paying and medical insured patients under strict financial control, places high demands on nurses as professionals. They have to plan their work activities according to a fast work pace and a high turnover rate of patients (Udod & Care, 2012:73; Rasoal, et al. 2016:830). They find themselves in circumstances where they have to rush to complete their tasks on time (Valizadeh, et al. 2016a:6) implying a risk for safe patient care (Rasoal, et al. 2016:829). Comprehensive nursing care, and adhering to the values taught during training, pose challenges under such circumstances (Walsh & Buchanan, 2011:357). Nurses experience pressure at times to compromise nursing standards and might face moral risks when not acting according their knowledge of the 'right' requirements (Striley & Field-Springer,

2016:86). Nurses might also experience difficulties to break through diversity barriers in their encounters with colleagues, patients, public and members of the health team working in a diverse work environment (Kuwano, et al. 2016:567). Dissatisfied patients, nursing errors and care left undone could become possibilities (Valizadeh, et al. 2016b:112; Mokoka et al. 2010:[5]; Ball, et al. 2014:116) impacting negatively on the professional dignity of nurses.

Table 5.5: Strategies for supporting nurses to function optimally in complex and demanding situations

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management and the health team should:	
• Consider current corporate expectations of nurses.	Replace 'consider' with 're-consider' (FG2).
• Consider staffing models and work processes which promote person-centred patient care.	Replace 'person-centred patient care' with 'patient-centred care'.
• Promote a holistic approach towards patient care between all members of the health team.	Add 'and integrated' following 'holistic' (FG1).
• Orientate and in service new staff in diversity principles.	Change wording to 'Orientate and provide in service training to new staff in diversity principles' (FG1).
• Lobby for the teaching of diversity as part of the nursing curriculum in basic training.	
• Understand the uniqueness of each generational group and actively engage with each group and adapt leadership and work environment accordingly.	Change wording to 'Actively engage and understand the uniqueness of each generational group' (FG2). Add additional action 'Adapt leadership and work environment to benefit each generational group' (FG2).
• Support nurses in dealing with financial confrontations with family and patients	Change wording to 'Provide structures to support nurses in dealing with financial confrontations from patients and their families' (FG1). Change

	wording to 'Support nurses with structures to deal with financial discussions/queries from patients and their families (FG2).
• Support nurses in dealing with emotional outbursts of clients.	Replace 'clients' with 'patients, their families and members of the health team' (FG1).
• Provide ethical safety for nurses to work according to standard regardless of pressure from external sources.	Replace 'for nurses to work according to standard' with 'standards' (FG1). Replace 'external sources' with 'the health team and hospital management' (FG2).

Strategy 6: Hospital and nursing management, members of the health team and nurses are to support professional nurses in fulfilling their role

Suggested improvements from nurses, hospital and nursing management and members of the health team (Replace 'professional nurses' with 'nurses' and replace 'role' with 'expected professional role within the health team FG1; replace strategy statement with 'Hospital and nursing management and members of the health team should support nurses in fulfilling their expected professional role FG2).

Rationale

Professional nurses practise within the boundaries of their code of ethics and are responsible and accountable for their nursing actions and ultimately for patient care (SANC, 2013:4). While carrying out their responsibilities, nurses also set high standards for themselves for providing excellent care to patients (Burhans & Alligood, 2010:1693; Catlett & Lovan, 2011:59). Some patients might rely on more experienced and competent professional nurses to fulfil their needs. Managers also expect additional inputs from senior nurses to mentor less competent and inexperienced nurses even though senior professional nurses might not have the capacity to do so (Drury, et al. 2014:522). A lack of adequate numbers of staff who are competent and motivated to support professional nurses (French, et al. 2011:6) adds to their workload and it becomes a challenge to fulfil the extended and diverse roles expected of them (Atefi, et al. 2014:356). Professional nurses might also carry emotional burdens. They might find it hard

to defuse incidents of disruptive behaviour in the presence of other staff members and patients (Higgins & MacIntosh, 2009:56). Performing as a professional nurse under demanding circumstances might lead to fatigue and burnout (French, et al. 2011:5; Bushardt, et al. 2016:16; Burke, et al. 2015:457) which might adversely influence their patient care (Sagherian, et al. 2017:304; McIntosh & Sheppy, 2013:35), impacting negatively on their professional dignity.

Table 5.6: Strategies enabling professional nurses to fulfil their role

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management, members of the health team and nurses should:	Delete 'nurses' (FG2).
• Identify and support professional nurses who are exposed to workload imbalance.	Replace 'professional nurses' with 'nurses' in all actions.
• Implement structures to deal with disrespect and sub ordinance issues towards professional nurses.	Replace 'disrespect' with 'disrespectful' and replace 'sub ordinance' with 'insubordinate behaviour' (FG2).
• Lobby for formal training and regulation of care workers.	Add 'to support nurses' following 'care workers' (FG1).
• Re-look, understand and support the diverse role and expectations towards professional nurses.	Replace 're-look, understand and support' with 'Understand, support and revise' (FG2) and towards to 'of' (FG).
• Re-look, understand and support senior and more experienced professional nurses carrying heavy work load.	Replace 're-look, understand and support' with 'Understand and support' (FG2) and replace 'heavy' with 'heavier' (FG2).
• Identify professional nurses with symptoms of fatigue and burnout.	
• Create 'haven' hubs where professional nurses can soundboard and get stressful situations of their chest.	Change wording to 'Create support forums where nurses can confide and discuss their stressful situations in confidentiality' (FG2).
• Implement stress reducing programmes such as yoga classes.	
• Implement lifestyle and resilience	

promoting programmes.	
	Add additional action ‘Provide a skilled and competent sub category nursing complement’ (FG1).

Strategy 7: Hospital and nursing management, members of the health team and nurses should honour nurses strive to value patient well-being as their first priority

Suggested improvements from nurses, hospital and nursing management and members of the health team (Replace ‘strive’ with ‘striving’ FG2)

Rationale

Professional nurses have the well-being of their patients at heart (Burhans & Alligood, 2010:1693; Catlett & Lovan, 2011:59) and want to provide care that ‘really matters’ in a gentle and kind manner (Hofmeyer, et al. 2016:16). They function in a team and depend on the work output of all team members in caring for their patients (McCabe & Sambrook, 2014:822). When nurses face challenges in providing care to patients, or when the well-being of patients is compromised, it impacts negatively on their professional dignity (Sabatino, et al. 2016:286). When nurses witness compromised patient well-being, they experience ethical complexity in their valuing of patient well-being in clinical practice (Rasoal, et al. 2016:825; Varcoe, et al. 2012:493). Nurses then face ‘right versus wrong’ decisions where they are expected to act in the best interest of the patient (Albina, 2016:78). Professional nurses might not have the courage to act because they might not perceive themselves as being sufficiently autonomous to prevent disregard of a patient’s well-being (Sabatino, et al. 2016:285).

Table 5.7: Strategies to honour nurses' striving to value patient well-being as their first priority

Actions	Suggested improvements from nurses, hospital and nursing management and members the health team
Members of the health team and nurses should enable nurses to:	
• Care for patients as their number one priority.	
• Care for patients in a gentle and kind manner.	
• Provide in the comfort and emotional needs of patients.	Replace 'in' with 'for' (FG2).
• Keep their care promises to patients.	
• Provide accurate up to standard care to patients.	
• Plan their work routine towards care that really matter.	Replace 'matter' with 'matters' (FG2).
• Be reliable and competent team players in valuing patient well-being.	
Hospital and nursing management should:	
• Provide work environment where professional nurses can render care that really matter.	Replace 'matter' with 'matters' (FG2).
• Support teamwork and ensure that all team members are competent and committed to patient well-being.	
• Empower nurses to step up in the best interest of patients as patient advocates or whistle blowers without being judged.	

Strategy 8: Hospital and nursing management and members of the health team are to support and equip nurses to cope with degrading experiences in their work environment

Suggested improvements from nurses, hospital and nursing management and members of the health team (Replace 'degrading' with 'humiliating' FG2).

Rationale

Nurses are kind, gentle and respectful (Rook, 2017:144) when they care for their patients (Rook, 2017:145). Nurses expect the same kindness from the people with whom they interact. When people are unkind and disrespectful towards them, nurses encounter challenges to retain their professional dignity. Medical practitioner-nurse interactions might sometimes be discourteous and inconsiderate (Sabatino, et al. 2016:285). Nurses might also experience disregard towards nurses' patient care suggestions (Atefi, et al. 2014:357; Farhadi, et al. 2016:22). Medical practitioners' conduct could even be obnoxious (Gotlib Conn, et al. 2014:eP1057; Kerber, et al. 2015:524-525). Although most nurse managers treated their staff well (Eneh, et al. 2012:163), some misused their power and treated nurses in an inhuman and unfair manner (Khademi, et al. 2012:333; Voget, 2017:66). These nurses might then feel disheartened and powerless (Voget, 2017:71). Some patients did not value the contributions of nurses (Khademi, et al. 2012:334). When professional nurses cannot be instrumental in the treatment and recovery process of patients, they feel valueless, impacting negatively on their professional dignity (Atefi, et al. 2014:356; Farhadi, et al. 2016:21; Sabatino, et al. 2016:285).

Table 5.8: Strategies to support and equip nurses to cope with degrading experiences in their work environment

Actions	**Suggested improvements from nurses, hospital and nursing management and members of the health team**
Hospital and nursing management and members of the health team should enable nurses to:	Replace 'professional nurses' with 'nurses' in all actions (FG2).
• Actively engage with medical practitioners to discuss their collaboration.	
• Establish strategy to deal with family and patients being disrespectful towards professional nurses.	Replace 'family and patients' with 'patients, their families and other health team members' (FG2).

• Encourage professional nurses to deliberately take a stand towards their clinical competence and autonomy.	Replace statement with 'Encourage nurses to take a deliberate stand towards their clinical competence and autonomy' (FG2).
• Educate public with regards to nurse academic standing.	
• Ensure prompt feedback following reported events of disruptive behaviour.	
• Enable professional nurses to sharpen their clinical skills and competencies.	Replace 'professional nurses' with 'nurses' and replace 'sharpen' with 'continually improve' (FG2).
• Initiate training in assertiveness.	
• Openly disapprove of media's portraying of nurses' image in a sexual context.	Change wording to 'Actively disapprove of the sexual context of nurses' image portrayed by the media (FG2).
• Enable professional nurses to adapt coping mechanisms to counteract degrading behaviour.	Replace 'adapt' with 'develop' and replace 'degrading' with 'humiliating' (FG2).

The researcher incorporated most of the suggested changes from the focus group participants as these changes added value to refining the strategies. It included replacing some words with others or rephrasing an action in totality, to enhance the comprehensibility of the actions. Some actions were beneficial, enhancing the completeness of the strategies.

A sequence of the activities performed in the development and refinement of the strategies to preserve the professional dignity of nurses has been summarised as follows:

- Findings were determined from the data analysis of the unstructured phenomenological individual interviews conducted during phase 1 of the current study.
- Literature was reviewed extensively and integrated with the findings to form part of a discussion.
- Draft strategies were developed.
- Focus group participants were selected to refine the proposed strategies

- Focus group interview 1 was conducted to refine the draft strategies.
- Strategies were refined according to suggested comments.
- Focus group interview 2 was conducted to further refine the strategies already refined by the participants in focus group 1.
- Strategies were iteratively refined according to suggested comments.
- Final strategies to preserve the professional dignity of nurses were compiled and are presented in chapter 6 of this thesis.

5.7 SUMMARY

Phase 2 of the study was described in this chapter. The steps followed to develop and refine strategies to preserve the professional dignity of nurses in demanding private healthcare facilities were discussed. The use of focus group interviews as a method to refine the strategies with inputs from focus group participants was described. In chapter 6, which is the final chapter of this thesis, the refined set of strategies, conclusions of the study, implications and recommendations will be addressed.

CHAPTER 6

THE GUIDELINES, RECOMMENDATIONS, IMPLICATIONS AND CONCLUSIONS

6.1 INTRODUCTION

The research to develop strategies to preserve the professional dignity of nurses in a demanding healthcare environment was conducted in two phases which have been presented in five chapters. Chapter 1 introduced the study and provided background information, reflecting on the need to explore strategies to preserve the professional dignity of the nurses in a demanding private healthcare environment. In chapter 2, the research paradigm and the philosophical underpinning that grounded the study were discussed. In the third chapter, the findings of phase 1 of the study which explored the factors impacting on the professional dignity of nurses were presented. In chapter 4, a discussion of the findings of phase 1, contextualised within relevant literature, was presented to provide a deeper understanding of the studied phenomenon's essence and constituents. Chapter 5, addressing phase 2 of the study, outlined the processes that followed to develop and refine the strategies, based on the eight constituents identified in chapter 3 contextualised within relevant literature (refer to chapter 4). In chapter 6, the researcher presents the strategies and the recommendations, implications, limitations and conclusions of the study.

6.2 SUMMARY OF THE STUDY

The objectives of the study included: 1) exploring and describing how nurses in private healthcare facilities experience factors that impact on their professional dignity and 2) the development of strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities.

Unstructured phenomenological individual interviews with nurses, from specialised and general units in two private healthcare facilities, provided rich descriptions of their experiences of the factors impacting on nurses' professional dignity. Engagement with 11 nurses in their natural setting while

staying close to the phenomenon with a phenomenological attitude ensured true reflection of the phenomenon without contamination with the researcher's preconceptions and knowledge. Participants reflected on the main question of how they experienced factors that impacted on their professional dignity in open dialogues (unstructured phenomenological individual interviews) confidentially. They were prompted to elaborate further with probing questions as and when needed. Following an in-depth phenomenological analysis from the verbatim transcribed interviews and field notes, data were presented with an essence and its constituents.

The essence of the phenomenon (experiences of factors that impact on the professional dignity of nurses) was shown as 'professional standing due to own and others' percipience'.

The following constituents supporting the essence were uncovered:

- Perceiving one's own professional dignity
- Having contradictory experiences
- Being proud to be a professional nurse
- Receiving support, appreciation and respect
- Providing care in complex situations
- Performing as a professional nurse
- Valuing patient well-being
- Being humiliated by others

Descriptions of the essence and its constituents were presented as findings followed by a literature contextualisation. Draft strategies to preserve the professional dignity of nurses were developed by the researcher from the findings of phase 1 of the study and from the extensive literature review, which was conducted to obtain a deeper understanding of the essence and its constituents. Thereafter, the strategies were refined from the inputs obtained from participants during two focus group interviews. Sixteen private healthcare role players participated in two focus group interviews in two private healthcare facilities. Draft strategies were reviewed and updated after each

focus group interview through an iterative process. Two focus group interviews were found to be sufficient for obtaining rich group inputs to draft a final set of strategies for potential use by different private healthcare facilities.

The strategies are:

- Hospital and nursing management, members of the health team and nurses should value nurses' professional dignity.
- Hospital and nursing management should curtail work experiences which are contradictory to nurses' desire to prioritise patient care.
- Hospital and nursing management, members of the health team and nurses should encourage and mentor nurses to remain proud of themselves and their profession.
- Hospital and nursing management should adopt a management style to support, appreciate and respect nurses.
- Hospital and nursing management and members of the health team should support nurses to function optimally in complex and demanding situations.
- Hospital and nursing management and members of the health team should support nurses in fulfilling their expected professional roles.
- Hospital and nursing management, members of the health team and nurses should honour nurses' desiring to value patient well-being as their first priority.
- Hospital and nursing management and members of the health team should support and equip nurses to cope with humiliating experiences in their work environment.

6.3 DESCRIPTION OF THE STRATEGIES

The strategies to preserve the professional dignity of nurses is described within the contextual framework of the findings and literature, considering the unique dynamics between prominent role players and the identified issues that mattered most to the professional dignity of nurses. The description brings to light multiple future possibilities to preserve the professional dignity of nurses for consideration, and includes a rationale presenting the most critical experiences of factors impacting on the professional dignity of nurses in concise summaries. The inputs of healthcare professionals in the two selected

private healthcare facilities ensured the delineation of practical and realistic strategies and actions for future use. A description of the strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare facilities is presented in the following section.

STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN THE DEMANDING HEALTHCARE ENVIRONMENT OF PRIVATE HEALTHCARE FACILITIES

Pre-amble

The professional dignity of nurses refers to the dignity nurses experience in their work life (Stievano, et al. 2012:351). It is determined by their perspectives of themselves as professional persons and the way others view their knowledge and skills (Sabatino, et al. 2014:663). It also refers to their ability to function as autonomous professional people (Sabatino, et al. 2016:284-285) and it is confirmed by their professional status in the health team and in society (Stievano, et al. 2012:347-347). When nurses are respected for their knowledge, skills and contribution to patient care they feel valued (Stievano, et al. 2012:350) and they can better address the health needs of patients (Stievano, et al. 2013:120). Their professional dignity is enhanced when they are respected by their colleagues and members of hospital management (Stievano, et al. 2009:97) in a supportive work environment (Sabatino, et al. 2016:287).

Nurses find themselves in a demanding work environment in private healthcare. They face high demands concerning cost containment, the implementation of state of the art technology, the provision of specialised care and dealing with declining staff per patient ratios (Messenger & Vidal, 2015:6; Aiken, et al. 2012:e1717; Chan, et al. 2013:1386-1387). Principles of ‘time is money’ and ‘value for money’ drive high volumes with a fast work pace while great emphasis is placed on patient satisfaction (Del Vecchio, et al. 2015:356; Dasgupta, 2012:528). It results in pressure on nurses to ensure the shortest duration of hospitalisation and strict control over cost (Dasgupta, 2012:528).

At the same time consumers (patients and their family members) of private healthcare services demand high quality care that includes some luxuries as they pay high fees (Chan, et al. 2013:1386). A demanding environment for nurses in private healthcare becomes inevitable under such circumstances (Dasgupta, 2012:528). The need to explore strategies to preserve the professional dignity of nurses was identified following an extensive literature search. While much research has been done on the dignity of patients, only a few studies were found on the professional dignity of nurses (Lawless & Moss, 2007:234).

To determine the factors that impacted on the professional dignity of nurses, the researcher conducted unstructured phenomenological individual interviews with 11 professional nurses from two private healthcare facilities. The participants were asked how they experienced factors that impacted on their professional dignity followed by probing questions when necessary. Raw data were analysed and grouped into themes. The deep and comprehensive understanding of the factors that impacted on the professional dignity of nurses was used to compile strategies and actions to preserve the professional dignity of nurses. The refinement of the strategies involved the inputs of nurses, hospital and nursing management and members of the health team during two focus groups interviews, one conducted at each participating private healthcare facility.

Strategy 1: Hospital and nursing management, members of the health team and nurses should value nurses' professional dignity.

Rationale

Although nurses, as part of the healthcare team, might not think about their professional dignity while they are on duty (Sabatino, et al. 2014:659) it is determined by the way they view themselves and it is reinforced by the way other members of the team react towards them (Sabatino, et al. 2014:663). Their perception is influenced by their beliefs and professional values of being good nurses (Aydin Er, 2017:238; Kaya, et al. 2017:716). Professional nurses use their knowledge and skills to contribute to teamwork and the well-being of

patients (Sabatino, et al. 2016:284). Their professional dignity gets jeopardised when nurses do not value their own capabilities and/or the other members of the health team do not value their input in teamwork (Stievano, et al. 2012:346; Stievano, et al. 2009:97). Nurses' perceptions of their capabilities and of their contributions to teamwork could be influenced negatively or positively by themselves, other members of the health team and hospital and nursing management (Adam & Taylor, 2014:1243; Khademi, et al. 2012:332).

Actions

Hospital and nursing management, members of the health team and the nurses should acknowledge and support nurses' desires to:

- Render prompt and accurate care according to clinical standards.
- Gather and provide patients' clinical information in collaboration with members of the health team.
- Support the coding and administration of various medical insurance models for payment and duration of hospitalisation.
- Participate in universal 'Best Care Always' and accreditation programs in support of the best clinical outcomes for patients.
- Mentor newly qualified nurses in clinical practice and professional conduct.
- Supervise different categories of nurses to uphold and support clinical care within their scope of practice.
- Utilise team work to monitor, record and report clinical and emotional parameters of patients.
- Utilise team work to implement planned multidisciplinary care regimes safely to patients.
- Advocate changes and new suggestions in clinical care for the enhancement of patients' care.
- Participate in satisfaction and patient safety initiatives to improve service to patients.
- Participate in driving cost down in private healthcare.
- Contribute to compiling and operating within a realistic operational and staff allocation budget.

Strategy 2: Hospital and nursing management should curtail work experiences which are contradictory to nurses' desire to prioritise patient care.

Rationale

Nurses want to be person-centred, kind and caring in looking after their patients (Lyneham & Levett-Jones, 2016:86). When they experience circumstances in contradiction to their desire to truly care (Catlett & Lovan, 2011:60), it impacts on their professional dignity. Being questioned or judged while being knowledgeable and skilled (Jesus, et al. 2010:164), knowing the right thing to do but not having the power doing it (Shirey, et al. 2010:84) and wanting to care but being caught up in patient-less nursing actions (Eley, et al. 2012:1550) could be detrimental to the professional standing of nurses. Facing the financial side of business, being a patient's advocate without support (Striley & Field-Springer, 2016:86) and having practice issues with no voice (Kay, et al. 2015:66) make it difficult for nurses to stay motivated and compassionate in fulfilling the role of being a good nurse. Nurses also experience circumstances which could be contradictory towards their own well-being because they were taught to give and to sacrifice their own needs for the sake of their patients (Steege & Rainbow, 2017:24). Their ability to express and to take a stand for their own professional dignity might be jeopardised. Nursing unit managers face frustration in their ability to balance corporate expectations and administration with their clinical responsibilities towards patient care in their units (Udod & Care, 2012:74). They might often experience circumstances having "more responsibility than authority" (Athlin, et al. 2014:234).

Actions

Hospital and nursing management should:

- Reduce excessive administration and paperwork expected of nurses.
- Introduce digital technology for nursing notes, billing and stock replenishments.
- Align the role of nurses with patient-centred care.
- Empower unit managers to take decisions in the best interest of their units.

- Consider a reasonable workload for nurses to experience satisfaction in caring for their patients.
- Promote physical and emotional self-care principles to contribute to nurses' well-being.
- Introduce forums where nurses are comfortable to voice their clinical practice challenges.
- Provide insight and administrative support to nurses about company strategies to ensure financial sustainability of the business.

Strategy 3: Hospital and nursing management, members of the health team and nurses should encourage and mentor nurses to remain proud of themselves and their profession.

Rationale

Nurses are dignified when they are proud. People who experience pride feel good about themselves (Tracy, et al. 2010:168). Nurses are proud of who they are and want to maintain the good the name of their profession. They are proud of a job well done and of their contribution to improve the standards of their profession (Rauen, et al. 2015:71). They experience feelings of pride when they are able to resolve workplace conflicts and problems independently. They take pride in their knowledge and skills (Hintistan & Topcuoglu, 2017:49) and a good academic standing earns them the respect to take an equal stand in the health team (Farhadi, et al. 2016:22; Jesus, et al. 2010:169). Some nurses find themselves vulnerable in their pride as professionals. They may be too hard on themselves in performing to perfection (Melrose, 2011:1), and making a nursing error might be detrimental to their professional dignity and pride (Courvoisier, et al. 2011:e23138). Others (especially newly qualified nurses), might lack pride, professionalism and commitment towards their work and their profession. These individuals need guidance into their professional role as a matter of priority to strengthen their pride and commitment (Sneltvedt, et al. 2012:13).

Actions

Hospital and nursing management, members of the health team and the nurses should enable nurses to:

- Carry the name of the nursing profession with pride.
- Promote the academic standing of well-educated nurses in the workplace.
- Contribute to the enhancement of nursing standards in the profession.
- Own and solve their problems and conflicts independently.
- Portray a good professional image.
- Perform their duties in a respectful and professional manner.
- Stand up for themselves in an assertive manner.
- Earn respect in being competent, knowledgeable, skilled and well educated.
- Engage in equal collaboration with other members of the health team as autonomous professional nurses.
- Guide and uplift team members who are not so self-assured in their confidence.
- Provide opportunities and encourage nurses to engage in higher education endeavours.
- Be supportive and understanding towards nurses when a nursing error occurs.
- Debrief after a nursing error has occurred.

Strategy 4: Hospital and nursing management should adopt a management style to support, appreciate and respect nurses.

Rationale

Nurses feel dignified when they are supported and appreciated. They discover their worth as professionals through the favourable feedback from patients (Tseng, et al. 2013:163; Seitovirta, et al. 2017:1048) and managers. When they experience sincere interest in the problems they encounter, are listened to and thanked, they feel supported and appreciated (Atefi, et al. 2014:357). Most nurse managers take good care of nurses (Eneh, et al. 2012:163). They act as advocates and shields in the difficult encounters faced by nurses in their work life (Gustafsson & Stenberg, 2017:419; Loveridge, 2017:25). However, nurses are not always supported, appreciated and respected. A lack of trust in nurses to do their jobs (Loveridge, 2017:24), a lack of support during the

occurrence of workplace violence incidents (Kitaneh & Hamdan, 2012:469; Taylor & Rew, 2011:1072) and a lack of adequate staffing (Atefi, et al. 2014:356; Voget, 2017:52) might cause nurses to feel despondent and not good enough (Loveridge, 2017:25). Feeling unappreciated and unworthy (Karanikola, et al. 2011:110) could be detrimental to the professional dignity of nurses.

Actions

Hospital and nursing management should:

- Give feedback and maintain open communication.
- Show gratitude towards nurses' hard work and commitment.
- Show sincere regard towards nurses' personal and work-related challenges.
- Respect suggestions at ground level.
- Recognise nurses for a job well done.
- Support nurses in client service encounters regarding patients' complaints.
- Set achievable standards and deadlines.
- Staff units according to level of care, considering the company's financial viability guidelines.
- Gain inputs from nurses in determining staffing budgets.
- Gain insight in unique nursing circumstances before judging nurses' mistakes.
- Provide opportunities for nurses to express their feelings.
- Respect 'off-duty' times and work life balance of nurses.
- Provide an environment of psychological safety for nurses.
- Implement a process of follow up and feedback to nurses regarding workplace violence.

Strategy 5: Hospital and nursing management and members of the health team should support nurses to function optimally in complex and demanding situations.

Rationale

Nurses are exposed to a different kind of nursing in private healthcare facilities. Rendering care in a volumes-driven work environment to the

satisfaction of private paying and medically insured patients, under strict financial control, places high demands on them as professionals. They have to plan their work activities according to a fast work pace and high turnover rates of patients (Udod & Care, 2012:73; Rasoal, et al. 2016:830). They find themselves in circumstances where they have to rush to complete their tasks on time (Valizadeh, et al. 2016a:6) which imposes a risk to safe patient care (Rasoal, et al. 2016:829). Comprehensive nursing care and staying true to the values which were taught during training, becomes a challenge under such circumstances (Walsh & Buchanan, 2011:357). Nurses might experience pressure at times to compromise nursing standards and may face moral risk of acting against what they know to be right (Striley & Field-Springer, 2016:86). They might also experience difficulties to break through diversity barriers in their encounters with colleagues, patients, public and members of the healthcare team working in a diverse work environment (Kuwano, et al. 2016:567). Dissatisfied patients, nursing errors and care left undone become possibilities (Valizadeh, et al. 2016b:112; Mokoka, et al. 2010:[5]; Ball, et al. 2014:116) and might impact negatively on the professional dignity of nurses.

Actions

Hospital and nursing management and members of the health team should:

- Reconsider current corporate expectations of nurses.
- Consider staffing models and work processes which promote patient-centred care.
- Promote a holistic and integrated approach towards patient care between all members of the health team.
- Orientate and provide in-service training to new staff in diversity principles.
- Lobby for the teaching of diversity as part of the nursing curriculum in basic training.
- Actively engage and understand the uniqueness of each generational group.
- Adapt leadership and work environment to benefit each generational group.
- Support nurses with structures to deal with financial discussions/queries from patients and their families.

- Support nurses in dealing with emotional outbursts of patients, their families and members of the health team.
- Provide ethical safety standards regardless of pressure from the health team and hospital management.

Strategy 6: Hospital and nursing management and members of the health team should support nurses in fulfilling their expected professional roles.

Rationale

Professional nurses practise within the boundaries of their code of ethics and are responsible and accountable for their nursing actions and ultimately for patient care (SANC, 2013:4). While carrying huge responsibility they also set high standards for themselves in providing excellent care to patients (Burhans, et al. 2010:1693; Catlett & Lovan, 2011:59). Some patients rely heavily on more experienced and competent professional nurses to fulfil their needs. Managers also expect additional input from them to mentor less competent and inexperienced staff even though they do not have the capacity (Drury, et al. 2014:522). Inadequate numbers of staff, who are competent and motivated to support professional nurses (French, et al. 2011:6), further adds burden to their workload and it becomes a challenge to fulfil the extended and diverse role which are expected from them (Atefi, et al. 2014:356). Professional nurses also carry an emotional burden. They find the responsibility to defuse incidents of disruptive behaviour in the presence of other staff members and patients extremely hard to cope with (Higgins & MacIntosh, 2009:56). Performing as a professional nurse under demanding circumstances may eventually lead to fatigue and burnout (French, et al. 2011:5; Bushardt, et al. 2016:16; Burke, et al. 2015:457) which might adversely influence their care towards patients (Sagherian, et al. 2017:304; McIntosh & Sheppy, 2013:35) and impact negatively on their professional dignity.

Actions

Hospital and nursing management and members of the health team should:

- Identify and support nurses who are exposed to workload imbalance.

- Implement structures to deal with disrespectful and insubordinate behaviour towards nurses.
- Lobby for formal training and regulation of care workers to support nurses.
- Understand, support and revise the diverse role and expectations of nurses.
- Understand and support senior and more experienced nurses carrying heavier work load.
- Identify nurses with symptoms of fatigue and burnout.
- Create support forums where nurses can confide and discuss their stressful situations in confidentiality.
- Implement stress reducing programmes such as yoga classes.
- Implement lifestyle and resilience promoting programmes.
- Provide a skilled and competent sub category nursing complement.

Strategy 7: Hospital and nursing management, members of the health team and nurses should honour nurses' desiring to value patient well-being as their first priority.

Rationale

Professional nurses have the wellbeing of their patients at heart (Burhans & Alligood, 2010:1693; Catlett & Lovan, 2011:59) and want to provide care that 'really matters' in a gentle and kind manner (Hofmeyer, et al. 2016:16). They function in a team and depend on the work outputs of all team members in looking after the well-being of their patients (McCabe & Sambrook, 2014:822). When nurses are hindered in providing care to their patients, or when the well-being of patients is compromised, it impacts negatively on their dignity (Sabatino, et al. 2016:286). When nurses are witness of compromised patient well-being, they are exposed to ethical complexity in their valuing of patient well-being in clinical practise (Rasoal, et al. 2016:825; Varcoe, et al. 2012:493). They face 'right versus wrong' decisions where they are expected to act in the best interest of the patient (Albina, 2016:78). Professional nurses may, however, not have the courage to act because they do not always perceive themselves as having the autonomy to step up to prevent disregard to a patient's well-being (Sabatino, et al. 2016:285).

Actions

Members of the health team and nurses should enable nurses to:

- Care for patients as their number one priority.
- Care for patients in a gentle and kind manner.
- Provide for the comfort and emotional needs of patients.
- Keep their care promises to patients.
- Provide accurate up to standard care to patients.
- Plan their work routine towards care that really matters.
- Be reliable and competent team players in valuing patient well-being.

Hospital and nursing management should:

- Provide a work environment where nurses can render care that really matters.
- Support teamwork and ensure that all team members are competent and committed to patient well-being.
- Empower nurses to step up in the best interest of patients, as patient advocates, without being judged.

Strategy 8: Hospital and nursing management and members of the health team should support and equip nurses to cope with humiliating experiences in their work environment.

Rationale

Nurses are kind, gentle and respectful (Rook, 2017:144) when they care for their patients (Rook, 2017:145). They expect the same kindness from the people with whom they interact. When people are unkind and disrespectful towards them they find it a challenge to uphold their professional dignity. Medical practitioner-nurse interaction, in particular, might be discourteous and inconsiderate (Sabatino, et al. 2016:285) and the suggestions of nurses towards the care of patients might at times not be acknowledged (Atefi, et al. 2014:357; Farhadi, et al. 2016:22). Medical practitioners' conduct might even be obnoxious at times (Gotlib Conn, et al. 2014:eP1057; Kerber, et al. 2015:524-525). Although most nurse managers treat their staff well (Eneh, et al. 2012:163), some might misuse their power of authority and treat nurses in

an inhuman and unfair manner (Khademi, et al. 2012:333; Voget, 2017:66). They might then feel disheartened and powerless (Voget, 2017:71). Some patients might not always value the contribution of nurses towards patients' health (Khademi, et al. 2012:334). When professional nurses cannot be instrumental in the treatment and recovery process of patients, they feel of less value and it impacts on their professional dignity (Atefi, et al. 2014:356; Farhadi, et al. 2016:21; Sabatino, et al. 2016:285).

Actions

Hospital and nursing management and members of the health team should enable nurses to:

- Actively engage with medical practitioners to discuss their collaboration.
- Establish strategies to deal with patients, their families and other health team members being disrespectful towards nurses.
- Encourage nurses to take a deliberate stand towards their clinical competence and autonomy.
- Educate public with regards to nurses' academic standing.
- Ensure prompt feedback following reported events of disruptive behaviour.
- Enable nurses to continually improve their clinical skills and competencies
- Initiate assertiveness training.
- Enable nurses to develop coping mechanisms to counteract humiliating behaviour.

6.4 RECOMMENDATIONS FOR PRACTICE AND RESEARCH

The recommendations made from the study are based on the strategies that have been developed. It brings to light the aspects for consideration to preserve the professional dignity of nurses. The strategies should be used in the endeavour to find ways to preserve the professional dignity of nurses. The strategies can be used in any sequence and should be used as a complete set or as individual entities to be gradually introduced.

6.5 IMPLICATIONS FOR NURSING

The implications of the current study for nursing in terms of practice and future research are discussed next.

Practice

The findings of the study revealed the current reality of professional nurses and their experiences regarding their professional dignity and may in future sensitise managers, members of the health team and nurses towards the preserving of their professional dignity. Future possibilities and pathways in the form of strategies can be utilised by healthcare facilities to preserve the professional dignity of nurses.

The strategies provide a concise rationale of the experiences of the factors impacting on nurses' professional dignity and serve to direct the thought processes of managers towards the preserving of professional dignity of nurses in their strategic intent during their strategy planning sessions. Eight strategy statements, with realistic and practical actions, provide an easy to use tool to assist managers to determine their own strategy regarding preserving the professional dignity of their nurses.

The use of the strategies to preserve the professional dignity of nurses may facilitate the initiatives of healthcare facilities to address factors, impacting on the professional dignity of nurses such as a complex and demanding work environment, which will indirectly impact on improving nursing practice. Strategies provide a pathway to follow which is research-based. In this way it contributes to the improvement of the practice of nursing.

Continuous awareness should be fostered in healthcare facilities about the concept of preserving the professional dignity of nurses, and about nurses' experiences of factors impacting on their professional dignity.

Professional nurses should be made aware of their professional dignity and their professional standing in preserving their professional dignity. The

strategies to preserve the professional dignity of nurses can be used in other countries, or it could be adapted for use in other countries.

Research

Further studies and replication of the current study should be considered in other private healthcare facilities. Similar studies should be conducted in the public sector, considering the unique difference in work environment and client base between private and public sector. Future research could be considered to determine the use and impact of the strategies for preserving the professional dignity of nurses. Future standardisation of the strategies is also recommended.

6.6 LIMITATIONS OF THE STUDY

Despite the insightful findings, the following limitation needs to be mentioned. The findings derived from unstructured phenomenological individual interviews conducted with 11 nurses. These nurses' experiences might differ from the experiences of professional nurses working in other healthcare facilities. The description of the factors impacting on the professional dignity of nurses was taken as a reflection of their experiences; hence the researcher took this limitation into account when the study was concluded.

6.7 CONCLUSION

The purpose of the study was to develop strategies to preserve the professional dignity of nurses in a demanding healthcare environment of private healthcare facilities. The study findings confirmed that the factors impacting on preserving the professional dignity of nurses, negatively or positively, were: perceived professional dignity, contradictory experiences, pride, support/appreciation and respect, complex situations, expected professional role, patient well-being and being humiliated. To preserve the professional dignity of nurses is crucial for nurses in nursing practice in private healthcare.

Strategies that can aid healthcare facilities to preserve the professional dignity of nurses have been developed and presented.

REFERENCES

Abelsson, A. & Lindwall, L. 2017. What is dignity in prehospital emergency care? *Nursing ethics,* 24(3):268-278.

Adam, D. & Taylor, R. 2014. Compassionate care: empowering students through nurse education. *Nurse education today,* 34(9):1242-1245.

Adams, R. 2016. Dignity: impact in human interactions. (Paper presented at the 2016 IPFW Student Research and Creative Endeavor Symposium. Book 53.)

Ahmad, M. 2017. Nursing practice and era challenges. (Paper presented the First International Conference of the Faculty of Nursing Assiut University. International Conference, January 30.)

Aiken, L.H., Sermeus, W., Van den Heede, K., Sloane, D.M., Busse, R., McKee, M., *et al.* 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British medical journal* (BMJ), 344:e1717.

Albina, J.K. 2016. Patient abuse in the health care setting: the nurse as patient advocate. *AORN Association of Operating Room Nurses journal,* 103(1):73-81.

Alexander, G.K., Rollins, K., Walker, D., Wong, L. & Pennings, J. 2015. Yoga for self-care and burnout prevention among nurses. *Workplace health & safety,* 63(10):462-470.

Alves, D.F.S. & Guirardello, E.B. 2016. Safety climate, emotional exhaustion and job satisfaction among Brazilian paediatric professional nurses. *International nursing review,* 63(3):328-335.

Anderberg, P., Lepp, M., Berglund, A. & Segesten, K. 2007. Preserving dignity in caring for older adults: a concept analysis. *Journal of advanced nursing,* 59(6):635-643.

Andorno, R. 2014. Human dignity and human rights. (*In* Andorno, R. Handbook of global bioethics. Dordrecht: Springer Science Business Media. p. 45-57.)

Andrews, D.R., Burr, J. & Bushy, A. 2011. Nurses' self-concept and perceived quality of care: a narrative analysis. *Journal of nursing care quality,* 26(1):69-77.

Anney, V.N. 2014. Ensuring the quality of the findings of qualitative research: looking at trustworthiness criteria. *Journal of emerging trends in educational research and policy studies (JETERAPS),* 5(2):272-281.

Antoniazzi, C.D. 2011. Respect as experienced by registered nurses. *Western journal of nursing research,* 33(6):745-766.

Appleton, J.V. & King, L. 1997. Constructivism: a naturalistic methodology for nursing inquiry. *Advances in nursing science,* 20(2):13-22.

Arroliga, A.C., Huber, C., Myers, J.D., Dieckert, J.P. & Wesson, D. 2014. Leadership in health care for the 21st century: challenges and opportunities. *American journal of medicine,* 127(3):246-249.

Atefi, N., Abdullah, K., Wong, L. & Mazlom, R. 2014. Factors influencing registered nurses' perception of their overall job satisfaction: a qualitative study. *International nursing review,* 61(3):352-360.

Athlin, E., Hov, R., Petzäll, K. & Hedelin, B. 2014. Being a nurse leader in bedside nursing in hospital and community care contexts in Norway and Sweden. *Journal of nursing education and practice,* 4(3):234-244.

Aydin Er, R., Sehiralti, M. & Akpinar, A. 2017. Attributes of a good nurse: the opinions of nursing students. *Nursing ethics,* 24(2):238-250.

Aylward, L.A., Crowley, T. & Stellenberg, E.L. 2017. The role of patient care workers in private hospitals in the Cape Metropole, South Africa. *Curationis,* 40(1):1-8.

Badcott, D. & Leget, C. 2013. In pursuit of human dignity. *Medical health care and philosophy*, 16(4):933-936.

Baertschi, B. 2014. Human dignity as a component of a long-lasting and widespread conceptual construct. *Journal of bioethical inquiry*, 11(2):201-211.

Baillie, L. & Gallagher, A. 2011. Respecting dignity in care in diverse care settings: strategies of UK nurses. *International journal of nursing practice,* 17(4):336-341.

Baillie, L. & Gallagher, A. 2012. Raising awareness of patient dignity. *Nursing standard,* 27(5):44-49.

Baillie, L., Ford, P., Gallagher, A. & Wainwright, P. 2009. Nurses' views on dignity in care. *Nursing older people*, 21(8):22-29.

Ball, J.E., Murrells, T., Rafferty, A.M., Morrow, E. & Griffiths, P. 2014. 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. *British medical journal quality & safety*, 23(2):116-125.

Baltzell, K., McLemore, M., Shattell, M. & Rankin, S. 2017. Impacts on global health from nursing research. *American journal of tropical medicine and hygiene,* 96(4):765-766.

Barclay, L. 2016. In sickness and in dignity: a philosophical account of the meaning of dignity in health care. *International journal of nursing studies,* 61:136-141.

Barkway, P. 2001. Michael Crotty and nursing phenomenology: criticism or critique? *Nursing inquiry,* 8(3):191-195.

Basch, C.E. 1987. Focus group interview: an underutilized research technique for improving theory and practice in health education. *Health education quarterly,* 14(4):411-448.

Beck, C.T., Keddy, B.A. & Cohen, M.Z. 1994. Reliability and validity issues in phenomenological research. *Western journal of nursing research*, 16(3):254-267.

Berger, R. 2015. Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative research,* 15(2):219-234.

Berwick, D.M. 2003. Improvement, trust, and the healthcare workforce. *Quality & safety in health care,* 12(6):448-452.

Blignaut, A.J., Coetzee, S.K. & Klopper, H.C. 2014. Nurse qualifications and perceptions of patient safety and quality of care in South Africa. *Nursing & health sciences,* 16(2):224-231.

Blumenthal, D. & Hsiao, W. 2005. Privatization and its discontents - the evolving Chinese health care system. *New England journal of medicine,* 353(11):1165-1170.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in Health Sciences. Cape Town: Heinemann.

Bournes, D.A. & Milton, C.L. 2009. Nurses' experiences of feeling respected - not respected. *Nursing science quarterly*, 22(1):47-56.

Braganca, A. & Nirmala, R. 2017. Nurses' perception about the public image of a nurse: an exploratory study. *International journal of innovative and applied research*, 5(5):97-104.

Burhans, L.M. & Alligood, M.R. 2010. Quality nursing care in the words of nurses. *Journal of advanced nursing,* 66(8):1689-1697.

Burke, R.J., Astakhova, M.N. & Hang, H. 2015. Work passion through the lens of culture: harmonious work passion, obsessive work passion, and work outcomes in Russia and China. *Journal of business and psychology*, 30(3):457-471.

Bushardt, S.C., Beal, B.D., Young, M. & Khosla, S. 2016. Professional nurses and the dark side of work passion. *Nursing made incredibly easy,* 14(4):16-21.

Butts, J.B. 2013. Ethics in professional nursing practice. 3rd ed. Burlington, Mass.: Jones and Bartlett Learning.

Calegari, R. de C., Massarollo, M.C.K.B. & Dos Santos, M.J. 2015. Humanization of health care in the perception of nurses and physicians of a private hospital. *Revista Da Escola De Enfermagem Da USP,* 49(Esp2):41-46.

Carey, M.A. 2016. Focus groups - what is the same, what is new, what is next? *Qualitative health research*, 26(6):731-733.

Cassel, E.J. 1982. The nature of suffering and the goals of medicine. *New England journal of medicine*, 306(11):639-645.

Catlett, S. & Lovan, S.R. 2011. Being a good nurse and doing the right thing: a replication study. *Nursing ethics,* 18(1):54-63.

Chan, C.W. & Perry, L. 2012. Lifestyle health promotion interventions for the nursing workforce: a systematic review. *Journal of clinical nursing,* 21(15-16):2247-2261.

Chan, Z.C., Tam, W., Lung, M.K., Wong, W. & Chau, C. 2013. On nurses moving from public to private hospitals in Hong Kong. *Journal of clinical nursing, 22*(9-10):1382-1390.

Chen, J., Davis, K.G., Daraiseh, N.M., Pan, W. & Davis, L.S. 2014. Fatigue and recovery in 12-hour dayshift hospital nurses. *Journal of nursing management,* 22(5):593-603.

Cheraghi, M.A., Manookian, A. & Nasrabadi, A.N. 2014. Human dignity in religion-embedded cross-cultural nursing. *Nursing ethics*, 21(8):916-928.

Chochinov, H.M. 2004. Dignity and the eye of the beholder. *Journal of clinical oncology, 22*(7):1336-1340.

Clavelle, J.T., Goodwin, M. & Tivis, L.J. 2013. Nursing professional attire: probing patient preferences to inform implementation. *Journal of nursing administration,* 43(3):172-177.

Coetzee, S.K., Klopper, H.C., Ellis, S.M. & Aiken, L.H. 2013. A tale of two systems - nurses practice environment, well-being, perceived quality of care and patient safety in private and public hospitals in South Africa: a questionnaire survey. *International journal of nursing studies,* 50(2):162-173.

Cogswell, D. 2008. Existentialism for beginners. Danbury, USA: For Beginners LLC.

Converse, M. 2012. Philosophy of phenomenology: how understanding aids research. *Nurse researcher,* 20(1):28-32.

Cope, V., Jones, B. & Hendricks, J. 2016. Resilience as resistance to the new managerialism: portraits that reframe nursing through quotes from the field. *Journal of nursing management,* 24(1):115-122.

Corley, M.C., Minick, P., Elswick, R.K. & Jacobs, M. 2005. Nurse moral distress and ethical work environment. *Nursing ethics,* 12(4):381-390.

Courvoisier, D.S., Agoritsas, T., Perneger, T.V., Schmidt, R.E. & Cullati, S. 2011. Regrets associated with providing healthcare: qualitative study of experiences of hospital-based physicians and nurses. *PLoS One,* 6(8):e23138.

Cowman, S., Cert, P. & Dip, N. 2016. Translating nursing research - bedside to bench. *Bahrain medical bulletin*, 38(2):73.

Cox, G. 2009. How to be an existentialist or how to get real, get a grip and stop making excuses. London: Continuum.

Cruz, J.P., Alquwez, N., Cruz, C.P., Felicilda-Reynaldo, R., Vitorino, L.M. & Islam, S.M.S. 2017. Cultural competence among nursing students in Saudi Arabia: a cross-sectional study. *International nursing review,* 64(2):215-223.

Dahlberg, K. 2006. The essence of essences - the search for meaning structures in phenomenological analysis of lifeworld phenomena. *International journal of qualitative studies on health and well-being,* 1(1):11-19.

Dahlberg, K., Dahlberg, H. & Nyström, M. 2008. Reflective lifeworld research. 2nd ed. Lund, Sweden: Studentlitteratur AB.

Darbyshire, P. & McKenna, L. 2013. Nursing's crisis of care: what part does nursing education own? *Nurse education today,* 33(4):305-307.

Dasgupta, P. 2012. Effect of role ambiguity, conflict and overload in private hospitals' nurses' burnout and mediation through self-efficacy. *Journal of health management,* 14(4):513-534.

Dawson, A.J., Stasa, H., Roche, M.A., Homer, C.S. & Duffield, C. 2014. Nursing churn and turnover in Australian hospitals: nurses' perceptions and suggestions for supportive strategies. *BMC nursing*, 13(1):1-10.

Day, C. & Gray, A. 2016. Health and related indicators. (*In* Padarath, A. & English, R., *eds*. South African health review. Durban: Health Systems Trust. p.243-347.)

De Azevedo Amorim, L.K., De Oliveira Souza, N.V.D., Da Silva Pires, A., Ferreira, E.S., De Souza, M.B. & Vonk, A.C.R.P. 2017. The nurse's role: recognition and professional appreciation in the user's view. *Journal of Nursing Universidade Federal de Pernambuco (UFPE),* 11(5):1918-1925.

DeFelice, D. & Janesick, V.J. 2015. Understanding the marriage of technology and phenomenological research: from design to analysis. *Qualitative report,* 20(10):1576-1593.

Del Vecchio, M., Fenech, L. & Prenestini, A. 2015. Private health care expenditure and quality in Beveridge systems: cross-regional differences in the Italian NHS. *Health policy,* 119(3):356-366.

Denzin, N.K. & Lincoln, Y.S. 2008. The landscape of qualitative research. 3rd ed. Thousand Oaks, Calif.: Sage.

Dikmen, Y., Karataş, H., Arslan, G.G. & Ak, B. 2016. The level of professionalism of nurses working in a hospital in Turkey. *Journal of caring sciences,* 5(2):95-102.

Dinmohammadi, M., Peyrovi, H. & Mehrdad, N. 2013. Concept analysis of professional socialization in nursing. *Nursing forum,* 48(1):26-34.

Doody, O., Slevin, E. & Taggart, L. 2013. Preparing for and conducting focus groups in nursing research, part 2. *British journal of nursing*, 22(3):170-173.

Dowling, M. 2007. From Husserl to van Manen: a review of different phenomenological approaches. *International journal of nursing studies*, 44(1):131-142.

Drury, V., Craigie, M., Francis, K., Aoun, S. & Hegney, D.G. 2014. Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: phase 2 results. *Journal of nursing management,* 22(4):519-531.

Duarte, C.G., Lunardi, V.L., Silveira, R.S.D., Barlem, E.L.D. & Dalmolin, G.D.L. 2017. Moral suffering among nurse educators of technical courses in nursing. *Revista brasileira de enfermagem,* 70(2):301-307.

Duhan, L. 1987. Ambiguity of time, self, and philosophical explanation in Merleau Ponty, Husserl and Hume. *Auslegung*, 13(2):126-138.

Dwyer, L., Andershed, B., Nordenfelt, L. & Ternestedt, B. 2009. Dignity as experienced by nursing home staff. *International journal of older people nursing,* 4(3):185-193.

Eaton, S.E. & Brown, B. 2017. Graduate student research manual: focus groups and interviews. Calgary, Canada: University of Calgary.

Edlund, M., Lindwall, L., Post, I.V. & Lindström, U.Å. 2013. Concept determination of human dignity. *Nursing ethics,* 20(8):851-860.

Edward, K., Ousey, K., Warelow, P. & Lui, S. 2014. Nursing and aggression in the workplace: a systematic review. *British journal of nursing,* 23(12):653-659.

Eley, D., Eley, R., Bertello, M. & Rogers-Clark, C. 2012. Why did I become a nurse? Personality traits and reasons for entering nursing. *Journal of advanced nursing,* 68(7):1546-1555.

Elshout, M., Nelissen, R.M. & Van Beest, I. 2017. Conceptualising humiliation. *Cognition and emotion*, 31(8):1581-1594.

Emeghebo, L. 2012. The image of nursing as perceived by nurses. *Nurse education today,* 32(6):e49-e53.

Eneh, V.O., Vehviläinen-Julkunen, K. & Kvist, T. 2012. Nursing leadership practices as perceived by Finnish nursing staff: high ethics, less feedback and rewards. *Journal of nursing management,* 20(2):159-169.

Englander, M. 2012. The interview: data collection in descriptive phenomenological human scientific research. *Journal of phenomenological psychology*, 43(1):13-35.

Esmaeilpour, M., Salsali, M. & Ahmadi, F. 2011. Workplace violence against Iranian nurses working in emergency departments. *International nursing review,* 58(1):130-137.

Farhadi, A., Elahi, N. & Jalali, R. 2016. The effect of professionalism on the professional communication between nurses and physicians: a phenomenological study. *Journal of nursing and midwifery sciences,* 3(3):8-26.

Feather, R.A., Ebright, P. & Bakas, T. 2015. Nurse manager behaviors that RNs perceive to affect their job satisfaction. *Nursing forum,* 50(2):125-136.

Filstead, W.J. 1979. Qualitative methods: a needed perspective in evaluation research. (*In* Cook, T.D. & Reichardt, C.S., *eds*. Qualitative and quantitative methods in evaluation research. Beverly Hills: Sage. p.33-48.)

Finlay, L. 2002. "Outing" the researcher: the provenance, process, and practice of reflexivity. *Qualitative health research,* 12(4):531-545.

Finlay, L. 2012. Unfolding the phenomenological research process: Iterative stages of “seeing afresh”. *Journal of humanistic psychology,* 53(2):172-201.

Finlay, L. 2014. Engaging phenomenological analysis. *Qualitative research in psychology*, 11(2):121-141.

Flick, U. 2009. An introduction to qualitative research. 4th ed. Thousand Oaks, Calif.: Sage.

Forozeiya, D. 2017. Critical care nurses’ experiences of coping with moral distress. Ottawa, Canada: Université d'Ottawa / University of Ottawa. (Thesis - Ph.D.)

Foureur, M., Besley, K., Burton, G., Yu, N. & Crisp, J. 2013. Enhancing the resilience of nurses and midwives: pilot of a mindfulness-based program for increased health, sense of coherence and decreased depression, anxiety and stress. *Contemporary nurse,* 45(1):114-125.

French, H., Du Plessis, E. & Scrooby, B. 2011. The emotional well-being of the nurse within the multi-skill setting. *Health SA Gesondheid,* 16(1):1-9.

Gallagher, A. 2004. Dignity and respect for dignity - two key health professional values: implications for nursing practice. *Nursing ethics,* 11(6):587-599.

Gallagher, A. 2007. The respectful nurse. *Nursing ethics*, 14(3):360-371.

Gallagher, A. 2011. Editorial: What do we know about dignity in care? *Nursing ethics,* 18(4):471-473.

Gastmans, C. 2013. Dignity-enhancing nursing care: a foundational ethical framework. *Nursing ethics,* 20(2):142-149.

Gearing, R.E. 2004. Bracketing in research: a typology. *Qualitative health research,* 14(10):1429-1452.

Gill, P., Stewart, K., Treasure, E. & Chadwick, B. 2008. Methods of data collection in qualitative research: interviews and focus groups. *British dental journal,* 204(6):291-295.

Gilson, D. 2017. Why I am proud to be a nurse. *Wyoming nurse*, 30(2):1-1.

Giorgi, A. 1997. The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of phenomenological psychology,* 28(2):235-260.

Giorgi, A. 2005. The phenomenological movement and research in the human sciences. *Nursing science quarterly,* 18(1):75-82.

Giorgi, A. 2012. The descriptive phenomenological psychological method. *Journal of phenomenological psychology,* 43(1):3-12.

Goldman, A. & Tabak, N. 2010. Perception of ethical climate and its relationship to nurses' demographic characteristics and job satisfaction. *Nursing ethics,* 17(2):233-246.

Gotlib Conn, L.G., Kenaszchuk, C., Dainty, K., Zwarenstein, M. & Reeves, S. 2014. Nurse-physician collaboration in general internal medicine: a synthesis of survey and ethnographic techniques. *Health and interprofessional practice, 2*(2):eP1057.

Gray, D.E. 2014. Doing research in the real world. 3rd ed. Thousand Oaks, Calif.: Sage.

Greenwood, A. 2016. Value of nursing project: phase I. Oakland, Calif.: Health Impact.

Guba, E.G. & Lincoln, Y.S. 1994. Competing paradigms in qualitative research. (*In* Denzin, N.K. & Lincoln, S., *eds*. Handbook of qualitative research. Thousand Oaks, Calif.: Sage. p.105-117.)

Gustafsson, L. & Stenberg, M. 2017. Crucial contextual attributes of nursing leadership towards a care ethics. *Nursing ethics,* 24(4):419-429.

Hall, J. 2015. Proud to be. *SRNA news bulletin,* 17(6):5-5.

Harvey, C., Thompson, S., Pearson, M., Willis, E. & Toffoli, L. 2017. Missed nursing care as an 'art form': the contradictions of nurses as carers. *Nursing inquiry,* 24(3):e12180:1-8.

Higgins, B.L. 2009. Operating room nurses' perceptions of the effects of physician-perpetrated abuse. Fredericton, N.B., Canada: University of New Brunswick. (Dissertation - MA.)

Hillier, J. 2010. Managing change by strategic navigation. (*In* Workshop Paper, "Managing Structural Change in Partnered Governance", Session 11. Paper presented at Our Common Future, Essen, November 6th.)

Hillier, J. 2011. Strategic navigation across multiple planes: towards a Deleuzean-inspired methodology for strategic spatial planning. *Town planning review,* 82(5):503-527.

Hintistan, S. & Topcuoglu, B. 2017. Professionalism characteristics of nurses working in internal medicine clinics. *Universal journal of public health,* 5(1):46-53.

Hodgetts, S. 2011. Being assertive benefits everyone. *Nursing times*, 107(47):41-41.

Hofmeyer, A., Toffoli, L. & Vernon, R. 2016. Making compassion explicit in undergraduate nursing curricula: teaching the next generation. Adelaide: University of South Australia. (Technical Report, School of Nursing and Midwifery.)

Hogarth, K.M., Beattie, J. & Morphet, J. 2016. Nurses' attitudes towards the reporting of violence in the emergency department. *Australasian emergency nursing journal,* 19(2):75-81.

Houghton, C.E. 2014. 'Newcomer adaptation': a lens through which to understand how nursing students fit in with the real world of practice. *Journal of clinical nursing,* 23(15-16):2367-2375.

Hovland, O.J. & Johannessen, B. 2015. What characterizes Norwegian nursing students' reflective journals during clinical placement in an African country? *International journal of Africa nursing sciences,* 2*:*47-52.

Iacobucci, T.A., Daly, B.J., Lindell, D. & Griffin, M.Q. 2012. Professional values, self-esteem, and ethical conenfidence of baccalaureate nursing students. *Nursing ethics,* 20(4):479-490.

Islam, G. 2011. Recognizing employees: reification and dignity in management. Sao Paulo: Insper Instituto de Ensino e Pesquisa. (Insper Working Paper No. wpe_266.)

Jacobson, N. 2007. Dignity and health: a review. *Social science & medicine,* 64(2):292-302.

Jacobson, N. 2009. A taxonomy of dignity: a grounded theory study. *BMC international health and human rights*, 9(1):3[1-9].

Jacobson, N. & Silva, D.S. 2010. Dignity promotion and beneficence. *Journal of bioethical inquiry,* 7(4):365-372.

James, S. & Miza, T.M. 2015. Perceptions of professional nurses regarding introduction of the Batho Pele principles in state hospitals. *Curationis,* 38(1):1-9.

Janzen, K.J., Mitchell, M., Renton, L.J., Currie, G. & Nordstrom, P.M. 2016. From vulnerability to dignity: the RN Declaration of Self-Esteem. *Nursing forum,* 51(4):254-260.

Jayasekara, R.S. 2012. Focus groups in nursing research: methodological perspectives. *Nursing outlook*, 60(6):411-416.

Jesus, E.D.S., Marques, L.R., Assis, L.C.F., Alves, T.B., Freitas, G.F.D. & Oguisso, T. 2010. Prejudice in nursing: perception of nurses educated in different decades. *Revista da Escola de Enfermagem Da USP,* 44(1):164-170.

Jiménez-López, F.R., Roales-Nieto, J., Seco, G.V. & Preciado, J. 2016. Values in nursing students and professionals. *Nursing ethics,* 23(1):79-91.

Jordan, J. & Haines, M. 2017. Focus groups: how feedback from employees can impact the decision-making process. *Pennsylvania libraries: research & practice,* 5(2):117-126.

Kalafati, M. & Paikopoulou, D. 2011. Nursing care of culturally diverse patients in the intensive care unit. *Nosileftiki,* 50(1):49-62.

Kalipeni, E., Semu, L.L. & Mbilizi, M.A. 2012. The brain drain of health care professionals from sub-Saharan Africa: a geographic perspective. *Progress in development studies,* 12(2-3):153-171.

Kalisch, B.J. & Lee, K.H. 2010. The impact of teamwork on missed nursing care. *Nursing outlook,* 58(5):233-241.

Kalisch, B.J. & Xie, B. 2014. Errors of omission: missed nursing care. *Western journal of nursing research,* 36(7):875-890.

Kamberelis, G. & Dimitriadis, G. 2013. Focus groups. Abingdon: Routledge.

Karanikola, M.N.K., Papathanassoglou, E.D.E., Nicolaou, C., Koutroubas, A. & Lemonidou, C. 2011. Greek intensive and emergency care nurses' perception of their public image. *Dimensions of critical care nursing,* 30(2):108-116.

Kay, K., Evans, A. & Glass, N. 2015. Moments of speaking and silencing: nurses share their experiences of manual handling in healthcare. *Collegian,* 22(1):61-70.

Kaya, H., Işik, B., Şenyuva, E. & Kaya, N. 2017. Personal and professional values held by baccalaureate nursing students. *Nursing ethics*, 24(6):716-731.

Kenner, C.A. 2017. Trends in US nursing research: links to global healthcare issues. *Journal of Korean Academy of Nursing Administration,* 23(1):1-7.

Kerber, C., Woith, W.M., Jenkins, S.H. & Astroth, K.S. 2015. Perceptions of new nurses concerning incivility in the workplace. *Journal of continuing education in nursing,* 46(11):522-527.

Khademi, M., Mohammadi, E. & Vanaki, Z. 2012. Nurses' experiences of violation of their dignity. *Nursing ethics*, 19(3):328-340.

Kitaneh, M. & Hamdan, M. 2012. Workplace violence against physicians and nurses in Palestinian public hospitals: a cross-sectional study. *BMC health services research,* 12(1):469-477.

Kitzinger, J. 1995. Qualitative research: introducing focus groups. *BMJ British medical journal,* 311(7000):299-302.

Kleiman, S. 2004. Phenomenology: to wonder and search for meanings. *Nurse researcher,* 11(4):7-19.

Klein, D.C. 1991. The humiliation dynamic: an overview. *Journal of primary prevention*, 12(2):93-121.

Kothari, C.R. 2004. Research methodology: methods and techniques. New Delhi: New Age International.

Krauss, S.E. 2005. Research paradigms and meaning making: a primer. *Qualitative report,* 10(4):758-770.

Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *American journal of occupational therapy,* 45(3):214-222.

Krueger, R.A. & Casey, M.A. 2015. Focus groups: a practical guide for applied research. 5th ed. Thousand Oaks, Calif.: Sage.

Kuwano, N., Fukuda, H. & Murashima, S. 2016. Factors affecting professional autonomy of Japanese nurses caring for culturally and linguistically diverse patients in a hospital setting in Japan. *Journal of transcultural nursing,* 27(6):567-573.

Lawless, J. & Moss, C. 2007. Exploring the value of dignity in the work-life of nurses. *Contemporary nurse: a journal for the Australian nursing profession*, 24(2):225-236.

Leider, R. 2015. The power of purpose: creating meaning in your life and work. 3rd ed. Oakland, Calif.: Berrett-Koehler.

Lincoln, Y. & Guba, E. 1985. Naturalistic inquiry. New Delhi: Sage.

Lindwall, L. & Von Post, I. 2014. Preserved and violated dignity in surgical practice - nurses' experiences. *Nursing ethics,* 21(3):335-346.

Lopez, K.A. & Willis, D.G. 2004. Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qualitative health research,* 14(5):726-735.

Loveridge, S. 2017. Straight talk: nurse manager role stress. *Nursing management,* 48(4):20-27.

Luigi, D., Iuliana, C., Alma, P. & Bilan, Y. 2014. Directly estimating the private healthcare services demand in Romania. *Journal of international studies,* 7(3):55-69.

Lyneham, J. 2010. Is there harm in silence? *Journal of medical ethics*, 36(11):642-643.

Lyneham, J. & Levett-Jones, T. 2016. Insights into registered nurses' professional values through the eyes of graduating students. *Nurse education in practice,* 17:86-90.

Macklin, R. 2003. Dignity is a useless concept. *BMJ British medical journal, 327*(7429):1419-1420.

Malloy, D.C., Hadjistavropoulos, T., McCarthy, E.F., Evans, R.J., Zakus, D.H., Park, I., Lee, Y. & Williams, J. 2009. Culture and organizational climate: nurses' insights into their relationship with physicians. *Nursing ethics*, 16(6):719-733.

Manning, K. 1997. Authenticity in constructivist inquiry: methodological considerations without prescription. *Qualitative inquiry*, 3(1):93-115.

Mannion, R., Freeman, T., Millar, R. & Davies, H. 2016. Effective board governance of safe care: a (theoretically underpinned) cross-sectioned examination of the breadth and depth of relationships through national quantitative surveys and in-depth qualitative case studies. *Health services and delivery research,* 4(4):1-165.

Martela, F. & Steger, M.F. 2016. The three meanings of meaning in life: distinguishing coherence, purpose, and significance. *Journal of positive psychology,* 11(5):531-545.

Marten, R., McIntyre, D., Travassos, C., Shishkin, S., Longde, W., Reddy, S. & Vega, J. 2014. An assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS). *The Lancet,* 384(9960):2164-2171.

Martin, R.L. 2014. The big lie of strategic planning. *Harvard business review,* 92(1):78-84.

Matney, S.A., Staggers, N. & Clark, L. 2016. Nurses' wisdom in action in the emergency department. *Global qualitative nursing research*, 3:1-10.

Maxwell, J.A. 2012. The importance of qualitative research for causal explanation in education. *Qualitative inquiry,* 18(8):655-661.

Mayosi, B.M. & Benatar, S.R. 2014. Health and health care in South Africa - 20 years after Mandela. *New England journal of medicine,* 371(14):1344-1353.

McCabe, T. & Sambrook, S. 2014. The antecedents, attributes and consequences of trust among nurses and nurse managers: a concept analysis. *International journal of nursing studies,* 51(5):815-827.

McIntosh, B. & Sheppy, B. 2013. Effects of stress on nursing integrity. *Nursing standard,* 27(25):35-39.

McNamara, M.S. 2005. Knowing and doing phenomenology: the implications of the critique of 'nursing phenomenology' for a phenomenological inquiry. A discussion paper. *International journal of nursing studies,* 42(6):695-704.

Mediclinic. 2017. Mediclinic clinical services intranet data base. (See Annexure I: Mediclinic's granting of permission to use this information).

Meherali, S.M., Paul, P. & Profetto-McGrath, J. 2017. Use of research by undergraduate nursing students: a qualitative descriptive study. *The Qualitative report,* 22(2):634-654.

Meiring, A. & Van Wyk, N.C. 2013. The image of nurses and nursing as perceived by the South African public. *Africa journal of nursing and midwifery,* 15(2):3-15.

Melrose, S. 2011. Perfectionism and depression: vulnerabilities nurses need to understand. *Nursing research and practice*, 2011:1-7.

Messenger, J.C. & Vidal, P. 2015. The organization of working time and its effects in the health services sector: a comparative analysis of Brazil, South Africa and the Republic of Korea. Geneva: International Labour Organization.

Milton, C.L. 2008. The ethics of human dignity: a nursing theoretical perspective. *Nursing science quarterly,* 21(3):207-210.

Mintzberg, H. 1978. Patterns in strategy formation. *Management science,* 24(9):934-948.

Misztal, B.A. 2013. The idea of dignity its modern significance. *European journal of social theory*, 16(1):101-121.

Mokoka, E., Oosthuizen, M.J. & Ehlers, V.J. 2010. Retaining professional nurses in South Africa: nurse managers' perspectives. *Health SA Gesondheid*, 15(1):1-9.

Moran, D. 2000. Introduction to phenomenology. London: Routledge.

Moran, D. 2005. Edmund Husserl: founder of phenomenology. Cambridge, UK: Polity Press.

Moreira, A.C. & Silva, P.M. 2015. The trust-commitment challenge in service quality-loyalty relationships. *International journal of health care quality assurance,* 28(3):253-266.

Morrison-Beedy, D., Côté-Arsenault, D. & Feinstein, N.F. 2001. Maximizing results with focus groups: moderator and analysis issues. *Applied nursing research,* 14(1):48-53.

Morrow, S.L. 2005. Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology*, 52(2):250-260.

Msiska, G., Smith, P. & Fawcett, T. 2014. Emotive responses to ethical challenges in caring: a Malawian perspective. *Nursing ethics,* 21(1):97-107.

Nguyen, D.T., Teo, S.T., Grover, S.L. & Nguyen, N.P. 2017. Psychological safety climate and workplace bullying in Vietnam's public sector. *Public management review*, 19(10):1415-1436.

Offredy, M. & Vickers, P. 2010. Developing a healthcare research proposal: an interactive student guide. Chichester, West Sussex: Wiley.

Ogle, K.R. & Glass, N. 2014. Nurses' experiences of managing and management in a critical care unit. *Global qualitative nursing research*, 1:1-12.

O'Reilly, M. & Kiyimba, N. 2015. Advanced qualitative research: a guide to using theory. Thousand Oaks, Calif.: Sage.

Parse, R.R. 2010. Imagine! *Nursing science quarterly,* 23(2):97.

Patton, M.Q. 1990. Qualitative evaluation and research methods. Thousand Oaks, Calif.: Sage.

Pillay, R. 2009. Work satisfaction of professional nurses in South Africa: a comparative analysis of the public and private sectors. *Human resources for health*, 7(15):1-15.

Plummer, P. 2017a. Focus group methodology, part 1: Design considerations. *International journal of therapy and rehabilitation,* 24(7):297-301.

Plummer, P. 2017b. Focus group methodology, part 2: Considerations for analysis. *International journal of therapy & rehabilitation,* 24(8):345-351.

Polit, D.F. & Beck, C.T. 2017. Nursing research: generating and assessing evidence for nursing practice. Philadelphia, Pa.: Wolters Kluwer.

Polkinghorne, D.E. 2005. Language and meaning: data collection in qualitative research. *Journal of counseling psychology*, 52(2):137-145.

Pompeii, L.A., Schoenfisch, A., Lipscomb, H.J., Dement, J.M., Smith, C.D. & Conway, S.H. 2016. Hospital workers bypass traditional occupational injury reporting systems when reporting patient and visitor perpetrated (type II) violence. *American journal of industrial medicine,* 59(10):853-865.

Ponterotto, J.G. 2005. Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *Journal of counseling psychology*, 52(2):126-136.

Porr, C., Dawe, D., Lewis, N., Meadus, R.J., Snow, N. & Didham, P. 2014. Patient perception of contemporary nurse attire: a pilot study. *International journal of nursing practice,* 20(2):149-155.

Raftopoulos, V., Charalambous, A. & Talias, M. 2012. The factors associated with the burnout syndrome and fatigue in Cypriot nurses: a census report. *BMC public health*, 12(1):1-13.

Ranchod, S., Adams, C., Burger, R., Carvounes, A., Dreyer, K., Smith, A., Stewart, J. & Van Biljon, C. 2017. South Africa's hospital sector: old divisions and new developments. *South African health review*, 2017(1):101-110.

Rapport, F. & Wainwright, P. 2006. Phenomenology as a paradigm of movement. *Nursing inquiry,* 13(3):228-236.

Rasoal, D., Kihlgren, A., James, I. & Svantesson, M. 2016. What healthcare teams find ethically difficult. *Nursing ethics,* 23(8):825-837.

Rauen, C., Ceballos, K. & Risch, S. 2015. Celebrate and be proud! *Critical care nurse,* 35(1):71-74.

Republic of South Africa. 2005. Nursing Act (Act 33 of 2005). *Government Gazette 592, Regulation* 38047. Pretoria: Government Printer.

Rezaei-Adaryani, M., Salsali, M. & Mohammadi, E. 2012. Nursing image: an evolutionary concept analysis. *Contemporary nurse,* 43(1):81-89.

Ritchie, J., Lewis, J., Nicholls, C.M. & Ormston, R. 2003. Qualitative research practice: a guide for social science students and researchers. Thousand Oaks, Calif.: Sage.

Rook, H. 2017. Living nursing values: a collective case study. Wellington: Victoria University. (Thesis - Ph.D.)

Rothwell, E., Anderson, R. & Botkin, J.R. 2016. Deliberative discussion focus groups. *Qualitative health research,* 26(6):734-740.

Sabatino, L., Kangasniemi, M.K., Rocco, G., Alvaro, R. & Stievano, A. 2016. Nurses' perceptions of professional dignity in hospital settings. *Nursing ethics*, 23(3)277-293.

Sabatino, L., Stievano, A., Rocco, G., Kallio, H., Pietila, A. & Kangasniemi, M.K. 2014. The dignity of the nursing profession: a meta-synthesis of qualitative research. *Nursing ethics*, 21(6):659-672.

Sadala, M.L.A. & Adorno, R.D.C.F. 2002. Phenomenology as a method to investigate the experience lived: a perspective from Husserl and Merleau Ponty's thought. *Journal of advanced nursing*, 37(3):282-293.

Sagherian, K., Clinton, M.E., Abu-Saad Huijer, H. & Geiger-Brown, J. 2017. Fatigue, work schedules, and perceived performance in bedside care nurses. *Workplace health & safety,* 65(7):304-312.

Sandelowski, M. 2000. Focus on research methods-whatever happened to qualitative description? *Research in nursing and health,* 23(4):334-340.

Sandelowski, M. 2010. What's in a name? Qualitative description revisited. *Research in nursing & health,* 33(1):77-84.

Sayer, A. 2007. Dignity at work: broadening the agenda. *Organization,* 14(4):565-581.

Schroeder, D. 2010. Dignity: one, two, three, four, five, still counting. *Cambridge quarterly of healthcare ethics,* 19(1):118-125.

Scott, P.A. 2017. Ethical principles in healthcare research. (*In* Scott, P.A., *ed*. Key concepts and issues in nursing ethics. Cham, Switzerland: Springer. p. 191-205.)

Seitovirta, J., Vehviläinen-Julkunen, K., Mitronen, L., De Gieter, S. & Kvist, T. 2017. Attention to nurses' rewarding - an interview study of registered nurses working in primary and private healthcare in Finland. *Journal of clinical nursing,* 26(7):1042-1052.

Shaw, K., Timmons, S. & PGCAP, B.A. 2010. Exploring how nursing uniforms influence self-image and professional identity. *Nursing times,* 106(10):21-23.

Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22(2):63-75.

Shirey, M.R., McDaniel, A.M., Ebright, P.R., Fisher, M.L. & Doebbeling, B.N. 2010. Understanding nurse manager stress and work complexity: factors that make a difference. *Journal of nursing administration*, 40(2):82-91.

Siles-González, J. & Solano-Ruiz, C. 2016. Sublimity and beauty. *Nursing ethics,* 23(2):154-166.

Skår, R. 2009. The meaning of autonomy in nursing practice. *Journal of clinical nursing,* 19(15-16):2226-2234.

Smith, J.A., *ed*. 2015. Qualitative psychology: a practical guide to research methods. Thousand Oaks, Calif.: Sage.

Smith-Trudeau, P. 2017. What would you do if you knew you wouldn't fail? Discovering your purpose. *Vermont nurse connection,* 20(3):3-4.

Sneltvedt, T. & Sørlie, V. 2012. Valuing professional pride and compensating for lack of experience: challenges for leaders and colleagues based on recently graduated nurses' narratives. *Home health care management & practice,* 24(1):13-20.

Sobh, R. & Perry, C. 2006. Research design and data analysis in realism research. *European journal of marketing,* 40(11/12):1194-1209.

Solomon, R.C. & Higgens, K.M. 1996. A short history of philosophy. New York: Oxford University Press.

South African Nursing Council. 2013. Code of ethics for nursing practitioners in South Africa. Pretoria: SANC.

Speziale, H.S., Streubert, H.J. & Carpenter, D.R. 2011. Qualitative research in nursing: advancing the humanistic imperative. Philadelphia, Pa.: Lippincott Williams & Wilkins.

Stanley, D. 2010. Multigenerational workforce issues and their implications for leadership in nursing. *Journal of nursing management,* 18(7):846-852.

Starks, H. & Trinidad, S.B. 2007. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative health research,* 17(10):1372-1380.

Steege, L.M. & Rainbow, J.G. 2017. Fatigue in hospital nurses 'Supernurse' culture is a barrier to addressing problems: a qualitative interview study. *International journal of nursing studies*, 67:20-28.

Stellenberg, E.L. & Dorse, A.J. 2014. Ethical issues that confront nurses in private hospitals in the Western Cape Metropolitan area. *Curationis*, 37(1):01-09.

Stievano, A., Alvaro, R. & Russo, M.T. 2009. The value of nursing professional dignity [Italian]. *International nursing perspectives*, 9(3):97-105.

Stievano, A., Bellass, S., Rocco, G., Olsen, D., Sabatino, L. & Johnson, M. 2016. Nursing's professional respect as experienced by hospital and community nurses. *Nursing ethics*: 1-19.

Stievano, A., Marinis, M.G.D., Russo, M.T., Rocco, G. & Alvaro, R. 2012. Professional dignity in nursing in clinical and community workplaces. *Nursing ethics,* 19(3):341-356.

Stievano, A., Rocco, G., Sabatino, L. & Alvaro, R. 2013. Dignity in professional nursing: guaranteeing better patient care. *Journal of radiology nursing,* 32(3):120-123.

Stratton, M. 2016a. The power of professional pride. *Association of operating room nurses journal*, 104(5):381-382.

Stratton, M. 2016b. The power of respect. *Association of operating room nurses journal,* 104(4):279-280.

Striley, K. & Field-Springer, K. 2016. When it's good to be a bad nurse: expanding risk orders theory to explore nurses' experiences of moral, social and identity risks in obstetrics units. *Health, risk & society,* 18(1-2):77-96.

Sturm, B.A. & Dellert, J.C. 2016. Exploring nurses' personal dignity, global self-esteem and work satisfaction. *Nursing ethics,* 23(4):384-400.

Sull, D., Homkes, R. & Sull, C. 2015. Why strategy execution unravels - and what to do about it. *Harvard business review*, 93(3):57-66.

Sutton, J. & Austin, Z. 2015. Qualitative research: data collection, analysis, and management. *Canadian journal of hospital pharmacy,* 68(3):226-231.

Taylor, J.L. & Rew, L. 2011. A systematic review of the literature: workplace violence in the emergency department. *Journal of clinical nursing,* 20(7-8):1072-1085.

Taylor, S.J., Bogdan, R. & DeVault, M. 2016. Introduction to qualitative research methods: a guidebook and resource. 4th ed. Hoboken, N.J.: Wiley.

Ten Hoeve, Y., Jansen, G. & Roodbol, P. 2014. The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of advanced nursing,* 70(2):295-309.

Todres, L. & Wheeler, S. 2001. The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *International journal of nursing studies*, 38(1):1-8.

Tracy, J.L., Shariff, A.F. & Cheng, J.T. 2010. A naturalist's view of pride. *Emotion review,* 2(2):163-177.

Trafford, V. & Leshem, S. 2008. Stepping stones to achieving your doctorate: focusing on your viva from the start. London: McGraw-Hill Education.

Truong, M., Gibbs, L., Paradies, Y. & Priest, N. 2017. "Just treat everybody with respect": health service providers' perspectives on the role of cultural competence in community health service provision. *Association of Black Nursing Faculty journal,* 28(2):34-43.

Tseng, H., Wang, H. & Weng, W. 2013. Nursing students' perceptions toward the nursing profession from clinical practicum in a baccalaureate nursing program - a qualitative study. *Kaohsiung journal of medical sciences,* 29(3):161-168.

Tuckman, B.W. & Jensen, M.A.C. 1977. Stages of small-group development revisited. *Group & organization studies,* 2(4):419-427.

Udod, S.A. & Care, W.D. 2012. 'Walking a tight rope': an investigation of nurse managers' work stressors and coping experiences. *Journal of research in nursing,* 18(1):67-79.

Valizadeh, L., Zamanzadeh, V., Habibzadeh, H., Alilu, L., Gillespie, M. & Shakibi, A. 2016a. Threats to nurses' dignity and intent to leave the profession. *Nursing ethics,* 1:1-12.

Valizadeh, S., Khoshknab, M.F., Mohammadi, E., Ebrahimi, H. & Bostanabad, M.A. 2016b. Dignity and respect are the missing link of nurses' empowerment. *International journal of medical research & health sciences,* 5(3):110-115.

Van Bogaert, P., Adriaenssens, J., Dilles, T., Martens, D., Van Rompaey, B. & Timmermans, O. 2014. Impact of role-, job-and organizational characteristics on nursing unit managers' work-related stress and well-being. *Journal of advanced nursing,* 70(11):2622-2633.

Van den Heede, K. & Aiken, L.H. 2013. Nursing workforce a global priority area for health policy and health services research: a special issue. *International journal of nursing studies,* 50(2):141-142.

Van der Graaf, R. & Van Delden, J.J.M. 2009. Clarifying appeals to dignity in medical ethics from an historical perspective. *Bioethics,* 23(3):151-160.

Van Eckert, S., Gaidys, U. & Martin, C. 2012. Self-esteem among German nurses: does academic education make a difference? *Journal of psychiatric and mental health nursing,* 19(10):903-910.

Varcoe, C., Pauly, B., Storch, J., Newton, L. & Makaroff, K. 2012. Nurses' perceptions of and responses to morally distressing situations. *Nursing ethics,* 19(4):488-500.

Varjus, S., Leino-Kilpi, H. & Suominen, T. 2011. Professional autonomy of nurses in hospital settings - a review of the literature. *Scandinavian journal of caring sciences,* 25(1):201-207.

Voget, U. 2017. Professional nurses' lived experiences of moral distress at a district hospital. Stellenbosch: Stellenbosch University. (Thesis - Ph.D.)

Wainwright, P. & Gallagher, A. 2008. On different types of dignity in nursing care: a critique of Nordenfelt. *Nursing philosophy*, 9(1):46-54.

Walker, L., Clendon, J. & Walton, J. 2015. What nurses think about professionalism. *Nursing New Zealand,* 21(1):12-13.

Walliman, N. 2011. Research methods: the basics. London: Routledge.

Walsh, M. & Buchanan, M.J. 2011. The experience of witnessing patients' trauma and suffering among acute care nurses / L'expérience de témoin des traumatismes et de la souffrance des patients chez les professionnels en soins infirmiers actifs. *Canadian journal of counselling and psychotherapy (Online),* 45(4):349-364

Watt, D. 2007. On becoming a qualitative researcher: the value of reflexivity. *Qualitative report*, 12(1):82-101.

Weaver, K. & Olson, J.K. 2006. Understanding paradigms used for nursing research. *Journal of advanced nursing,* 53(4):459-469.

Welford, C., Murphy, K. & Casey, D. 2012. Demystifying nursing research terminology: part 2. *Nurse researcher,* 19(2):29-35.

Wertz, F.J. 2005. Phenomenological research methods for counseling psychology. *Journal of counseling psychology,* 52(2):167-177.

Williams, J.K., Katapodi, M.C., Starkweather, A., Badzek, L., Cashion, A.K., Coleman, B., Fu, M.R., Lyon, D., Weaver, M.T. & Hickey, K.T. 2016. Advanced nursing practice and research contributions to precision medicine. *Nursing outlook,* 64(2):117-123.

Willis, P. 2001. The “things themselves” in phenomenology. *Indo-Pacific journal of phenomenology*, 1(1):1-12.

Wimpenny, P. & Gass, J. 2000. Interviewing in phenomenology and grounded theory: is there a difference? *Journal of advanced nursing*, 31(6):1485-1492.

Wojnar, D.M. & Swanson, K.M. 2007. Phenomenology: an exploration. *Journal of holistic nursing*, 25(3):172-180.

World Health Organization. 2006. The world health report 2006: working together for health. Geneva: World Health Organization.

Wright, P.R. 2011. Care of culturally diverse patients undergoing ophthalmic surgery. *Insight: Journal of the American Society of Ophthalmic Registered Nurses,* 36(1):7-11.

Yalden, B.J. & McCormack, B. 2010. Constructions of dignity: a pre-requisite for flourishing in the workplace? *International journal of older people nursing*, 5(2):137-147.

Yip, W. & Mahal, A. 2008. The health care systems of China and India: performance and future challenges. *Health affairs,* 27(4):921-932.

Zahavi, D. 2003. Husserl's phenomenology. Stanford, Calif.: Stanford University Press.

Zumla, A., George, A., Sharma, V., Herbert, N. & Masham, B. 2013. WHO's 2013 global report on tuberculosis: Successes, threats, and opportunities. *The Lancet*, 382(9907):1765-1767.

ANNEXURE A

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

22/09/2016

Approval Certificate
New Application

Ethics Reference No.: 260/2016

Title: Strategies to preserve the professional dignity of nurses in a demanding healthcare environment [PhD - Nursing]

Dear Mrs Yvonne Combrinck

The **New Application** as supported by documents specified in your cover letter dated 22/08/2016 for your research received on the 24/08/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 21/09/2016.

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years
- Please remember to use your protocol number (**260/2016**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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ANNEXURE B

MEDICLINIC

RESEARCH APPLICATION – Y COMBRINCK

Date: 3 November 2016

FOR APPROVAL

G VAN WYK
HR Executive

NOTES

• Locality	:	Mediclinic Pietermaritzburg and Bloemfontein
• Employee	:	Yes
• Value of Study	:	Confirmed
• Topic	:	Strategies to preserve the professional dignity of nurses in a demanding healthcare environment
• Impact	:	Two hospitals – Interviews and focus group discussions (FGD): Professional nurses (10), FGDs (5-10 participants per group; nursing managers, hospital managers PNs and members of healthcare group)
• Supported by Hospital	:	Supported by L. Zeelie and L. Louw (Nursing Managers)

ANNEXURE C

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

Title of the Study: "Strategies to preserve the professional dignity of nurses in a demanding health care environment".

Dear Participant,

1. INTRODUCTION

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to participate. It is important to understand what the study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

2. THE NATURE AND PURPOSE OF THIS STUDY

The purpose of the study is to explore and describe how nurses in private health care services experience factors that impact on their professional dignity. You are considered as a very important source of information and are thus approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The participants in this study will comprise of professional nurses employed in private health care services in 2 selected hospitals. Individual interviews will be conducted in a private venue and will not last longer than 30 minutes. The participants will be asked questions about the way they experienced factors that impacted on their professional dignity. The interviews will be conducted in English by the researcher. Interviews will be voice recorded, and later typed to be studied. Participation is voluntary. If you wish to withdraw from the study at any time, or wish to withhold information, you can do so without explanation.

4. RISK AND DISCOMFORT INVOLVED

Possible risks for participants are emotional discomfort from talking about their experiences. You will be free to stop the interview at any time should you find it difficult to talk about the experiences.

5. POSSIBLE BENEFITS OF THIS STUDY

A possible benefit of participating could be an opportunity to talk to somebody who is interested in your experiences.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the MEDICLINIC management. Copies of the approval letters are available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Yvonne Combrinck. If you have any questions about the study please contact her at 082 802 0459. Alternatively, you may contact her supervisor Prof Neltjie van Wyk at cell 082 776 1649 or co-supervisor Dr Shirley Mogale at 012 354 2125.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once the information has been analysed no one will be able to identify you.

Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.
I have received a signed copy of this informed consent agreement.

Participant's name ……..... (Please print)

Participant's signature ..... Date.....

Investigator's name .....……... (Please print)

Investigator's signature .....…… Date….....

Witness's Name .....……..... (Please print)

Witness's signature .....…… Date….....

ANNEXURE D

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

Title of the Study:

"Strategies to preserve the professional dignity of nurses in a demanding health care environment".

Dear Participant,

1. INTRODUCTION

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to participate. It is important to understand what the study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

2. THE NATURE AND PURPOSE OF THIS STUDY

The purpose of the study is to develop strategies to preserve the professional dignity of nurses in the demanding healthcare environment of private healthcare services. You are considered as a very important source of information and are thus approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The participants in this study will comprise of managers, professional nurses and members of the health team working in private healthcare services in 2 selected hospitals. Focus groups will be conducted in a private venue and will not last longer than 2 hours. Focus group participants will be asked questions about draft strategies as developed in phase 1 of the study to reflect on ways to preserve the professional dignity of nurses in private healthcare services. The focus group sessions will be conducted in English by the researcher, assisted by a co-researcher. Participation is voluntary. If you wish to withdraw

from the study at any time, or wish to withhold information, you can do so without explanation.

4. RISK AND DISCOMFORT INVOLVED

Possible risks for participants are emotional discomfort from taking part in a group. Personal opinions may be challenged and group dynamics may be experienced as intimidating. You will be free to stop the group session at any time should you find it difficult to further participate in the discussion.

5. POSSIBLE BENEFITS OF THIS STUDY

A possible benefit of participating could be an opportunity to contribute to the betterment of the professional dignity of nurses which may indirectly lead to improved quality care of patients.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the focus group session without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Mediclinic management. Copies of the approval letters are available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Yvonne Combrinck. If you have any questions about the study, please contact her at 082 802 0459. Alternatively you may contact her supervisor Prof Neltjie van Wyk at cell 082 776 1649 or co-supervisor Dr Shirley Mogale at 012 354 2125.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once the information has been analysed no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.
I have received a signed copy of this informed consent agreement.

Participant's Name :……..……(Please print)
Participant's Signature ……...Date:……..

Investigator's Name :……..(Please print)
Investigator's Signature:……...Date:…….....

Witness's Name :…….(Please print)
Witness's Signature:……..Date:…….

ANNEXURE E

DEMOGRAPHIC INFORMATION

Age: .....

Employed in the hospital since: …….....

Employed as professional nurse in ……..ward/unit

Academic qualifications:

……

……

Professional qualifications:

……

……

……

Main question

How do you experience **factors that impact** on your professional dignity?

Probing questions

How do you **perceive your dignity** as professional nurse?

How do you **experience** the **behaviour of other members** of the health team towards you as a professional nurse?

How do you **experience** the **behaviour of nursing management** towards you as a professional nurse?

How do you **experience** the **behaviour of hospital management** towards you as a professional nurse?

ANNEXURE F

Interview 012 (Pb)

Y: Thank you very much for your willingness to participate. The emergency unit is for me a very important workplace that I don't want to miss . . . so that is why I'm really glad we can talk. If we can start off, if you can share with me how do you experience factors that impact on your professional dignity, what are those experiences that you have encountered or encounter that you would say are impacting on your professional dignity.

P: There's quite a few factors, I think being in the emergency centre. It's both from public and then it's from your doctor group as well.

Y: Hmm...

P: Umm, one of the big things that impacts on my professional dignity from the public or from the patient sector is their ability to complain.

Y: Ok.

P: and umm and most time the complaints (yes, some are valid) are because of finance, and it puts me in a very difficult position as both the nurse and the manager in the unit umm having too separate your care for that patient and having that care for your patient impact on the financial aspect so it makes it very difficult because in my professional I'm there to care as a professional, but I also have to think of the finance, we are private entity, so it has a huge impact umm and it also gives the public a misconception of the nurse, so most times what happens you're getting called to the front, your waiting are, and you getting told, patients triaged a yellow, or something like that, and they don't have money to pay, and you know, your heart is to care, so you end up upgrading your patients to a colour where they can come in, like an orange, where they not ask for the money upfront, which is, it's a very difficult situation to be in, because you don't want them to see the entity, the hospital, as a money making organisation and not a caring organisation because we say we're caring, expertise you can trust, and they have the perception that all we want is their money.

So it makes, ja, it does impact on my professional dignity a bit because it is taking me straight out of my comfort zone as a carer.

Umm, the other aspects also is under the doctor point of view. Is their behaviour in the workplace, umm, where doctors, umm, I come from a line of schooling when there was that professionalism between colleagues, you knew you addressed the other as doctor and I was sister or nurse and so on and so on.

That has moved away. So now you find more familiarity and it also, that really and truly does impact, umm, I come from and I think my home upbringing as well is that I will always say mam, sir, uncle aunt, and there is none of that in our youth and with the new doctors that are coming in so you not getting that level of separating your ranking with be it superior or not, you just are levelled to separate and it does, it impacts quite significantly so, ja.

Y: If you think of, umm, private health specifically, what are those factors unique to private health care services that impacts on professional dignity of nurses.

P: Umm, I think the big thing as I mentioned is just finances and unfortunately our doctors are also financially driven. If their patients is not able to pay, we would swore to save a life and the Geneva Convention is that you would do what you can do and then transfer out, umm, and you get some doctors that will not come out, as soon as they hear the patient is private paying, already “who’s going to pay my account”.

So it leaves you in a situation where you are almost stuck because you don’t know what to do, except to do your best for that patient, but you do need to take the level of care up a bit more, so the finance is a huge impact in private healthcare. I’ve never really worked in government except for my training so I can’t really make a comparison except for what you hear, and sometimes what you hear is not always the truth but umm it’s……..patient expectations in private has also grown with media which also has an impact. They the Google generation. So everything is googled before they come through to the emergency centre, most patients at least 90%. So they came in dictating treatment umm they came in they’ve researched your hospital, they have a right to do that, so they’ll come in telling you about your press gayney and and it does, it has an effect,

because you you, my professional dignity is that I'm gonna treat you with respect, I'm gonna be non-biased as much as I can, but then it makes you become biased

Y. Ok. Because it influence your care

P. Yes because you thinking you've already done X, Y & Z and then you come and you dictating, so where does it put me as your carer, someone you need to trust, so where's your trust relationship with me, it hasn't been build. The other thing is that because of the high expectation and the high demand on nurses, umm, what I'm find with me is that one on one, you know the professionalism that you were taught where you engage with your patient, that's also lost. Because the expectation in private is that you must meet all the expectations of the patient but the one thing which is your most basic thing is we miss that, is that communication, that one on one, there's too much pressure to deliver, deliver, deliver

Y. Is it because of busy-ness?

P. It's the busy-ness. Private healthcare has picked up. When I started in as umm we were quiet, I think we saw like 30-80 patients a month, and you were able to engage with your patients or your clients, even with your doctors. There was training at the bedside, you became more involved with the diagnosis, you knew what was going on, but when you look at it now it's almost like an abattoir

Y. Ok

P. Patients come in, you triage this colour, you expected to be in this time, you expected to do XYZ for that triage colour so that you know you've given the quality care that they deserve, but is quality actually quality. You got to question yourself, or is it because there's an expectation. So you just doing, umm I don't know if you understand what I'm saying

Y. I hear,ja

P. It's a frustrating system umm in private. I'm not sure what happens in government, but in private, it is. It's this thing, you come in you triaged into the emergency centre, doctor sees you, nurse carries out instruction, doctor moves to next patient, next nurse, and then we, in my training at XXX, we were very

privileged in that when you're a student, you were able to do rounds with doctors and learn. In private you can't do that. There's so much disjointed care which also impacts on your professional dignity because when you look at it like you, we use to have, a consultant's round, as you had your surgeon, your gynae, your orthopaedic caring for that patient, the three of them grouped and they discussed the patient as a whole and in private healthcare it's very disjointed. So you've got a patient coming in example poly-trauma and your poly-trauma has got multiple fractures but also have a blunt abdomen and also has a head injury. So you have the one coming in and give his orders and move away… so this patient is segmented in care, and it does, it impacts, it really does an impact, it's a frustrating impact because there's not, there's no one voice.

Y. Ok

P. And I'm sure that carriers through to the wards. I'm not sure how they deal with it umm. So for me I think this are the 3 things. I've mentioned now it's the finance, the pressure of our new generation that are on Google and the expectations when they come in because they have rights to information and then it is the doctors. The disjointed care, the lack of professionalism in the way they conduct themselves and speak to the staff and staff back to doctors

Y. Tell me more about that

P. A bit more on that is is just umm the perception that the nurses are literally like hand maids, so you, the level of respect is not there. So, you get the shouting, uhmm, the verbal abuse towards patients where you as a nurse now has to think, "Gosh, where do I stand here. Am I siding with the doctor, am I taking my patient part as the advocate?" And when you the advocate, then you get yelled at... uhmm… I can give you an example. I had an incident where an aneathetist came to see a WCA patient to a Zulu speaking, and his English, and he was asking the patient in English about his medical condition so the patient is Zulu speaking cannot answer back. So I had to asked, can I get you and interpreter, and he wasn't happy. He brushed me off like I didn't exist, and then shouted at this poor patient and really, he used vulgar language on him, and I had to step in and I said, "If you unhappy to treat this patient, I offered you an interpreter then perhaps you should leave and get someone else to." So it does, it questions your

professional dignity. Because I mean to respect this doctor he's my senior, I mean to be the patients advocate and then I'm in the middle of being sworn, and then who's there for me?

Y: Who's there for you, that's an important part? While we talking on that part, if incidents like that happen, what support is available, what support do you get?

P: We write an event.

Y: You can keep quiet.

P: No, Yvonne. I think no it's nice to chat. So, I'm being honest. You write your events where you feed you information you take it up. And I think there's such sensitivity where it comes to the doctors, because you need them in private health.

Y: Ok.

P: You know in government you can go to the doctor and I've seen where they get called to the Superintendent's office and things are dealt with. I haven't really witnessed that in private health care. Uhm, you see the behaviour continue unless the doctor feels extremely guilty for what he's done, where he can't give you eye contact, and let's say maybe a month later he start warming up towards you, because that's his way of saying sorry. But has he apologised to the patient? I don't know if he's been spoken to. So, I think even that feedback we don't get, it is in the form of an event, it goes up, it follows its channels. Uhm, so it's not always, I've heard of events where it has been sorted, but there are events that you think to yourself, what are they actually gonna do about this?

Y: Ok, I hear. It's an important part.

P: Uhm, no, I think that in private health care, I know in state, that go straight up to the superintendent. So, and I know it's very difficult, because you need them, you needing your doctors here.

Y: So, it's almost like there is a conflicting situation where you need support, but the people that have to five the support also has to be sensitive to the business.

P: Yes, it's… it's… it's hard. I can't. I will not slaughter management or in lines of that, because it's very difficult, it's not an easy thing to deal with and you just hope that everybody when they come to work has professional dignity… has the professional sense to think when I come to work it's not about me, it's about that patient, it's about working together as a team and I think that's where the problem is in. Private is not much team work. I think in the emergency centre you look at the doctor groups that are working with the staff you can say there's teamwork there, because there's a nice degree of mutual trust and respect… but when you start calling other disciplines to work, you can see such a disjointed approach to patient care. You get the frustration, because I get frustrated, I think gee whiz, if you as a physician are coming in and they calling a psychiatrist, or a psychologist, you need to be there together, have interviews together with the patient, so the patient doesn't tell you one story or him/her one story. It…it, ja, for me it's just, and then their referral, I don't know how they communicate to each other. There's various specialists, do they just looking after what they looking after? I'm looking after what I'm looking after, and the poor patient has a split appointment and they see this one and that one. So, ja, it's very frustrating in private.

Y: So, it's almost like you feel the patient is not getting the best possible care and that are influencing you profession dignity as well.

P: It does. I mean, I've got a mom, she's what 65, 66 this year. I even tell her, energy to state, it's a holistic approach to patient care. No, I'm being serious. My mother says she's got joint pain, she's got this or that, I know that the multi-disciplinary team is going to discuss her. I don't, I have not, I get to see it in private. Where they will sit around the table and discuss for the interest or the better outcomes of the patient. Unfortunately it comes across as if it's a financial gain in private to get this patient and hog onto this patient. That's how it apparat and the, this poor patient, and it's…ja. I'm not sure that I'm answering your questions.

Y: You are, you doing perfectly, really, you doing perfectly.

Y: If you think back in your nursing career, what was that moment that you can recall where you really felt dignified as a nurse?

P: I've had lots of moments like that. Uhm… I and I'll speak about private health care. Uhm… let me start with my training. In my training, I cannot fault, every day was a wow experience for me with professional dignity and I think as I mentioned earlier it was the opportunity to engage with my patients, and I got to know them and I got to know their families. It just gave you such a sense of professional dignity. And the pride that went with it and when you walking away from you shift you were able to say I've nurse 15 patients today and you know everything about those patients. You don't see it today. When in private, uhm… my wow experience with professional dignity is when I did the trauma course. It was working on the road. And it just gave me such a sense of professional dignity. We had responded to a case where a 3 year old child had fallen into a put privy and it was in the heart on winter. And they lived in this little shacks, so we managed to retrieve the child together with search and rescue and we have to warm the child up. Now the ambulance couldn't get down to where the location was, so search and rescue were there by 4x4, but we had to warm this child up and using I think it's called a "bomer" which was like a, it was a big metal drum that they would put their wood in and warm their home up in, but I mean you're looking at other risks, because it's all enclosed, your carbon dioxide poisoning and whatever, but you so desperate for this life and the child was lifeless, and to bring her back to life was, I don't know her quality of life, because we're taken her to state hospital. We had to leave, but that for me, spoke such professional dignity, made me feel like what I've been trained and taught, through my ethos, through social science and just my general anatomy and physiology put everything into perspective when it comes to patient care and made it seem like this is an effortless job, something that you could. It still stays with me, it's the most heart-warming feeling, and for me I think that has spoken such volumes in the way I even care for patients today, is that is that there's no-one that is without hope.

Y: That is a very heart-warming story.

Y: If you think of the opposite, that most undignified moment, I'm sure there also lots of these moments.

P: I'm not perfect in my field, I can tell you that much, but I'm trying remain professional. That's why I'm probably in my company for the length that I'm in I had one incident which was so undignified. Uhm… it was a surgeon in my unit Iran the endoscopy unit and so I had a busy emergency centre plus I had a busy, a fairly busy, endoscopy unit. And to manage both departments is no easy. And think also in nursing we all know you get certain personality types that are attracted to emergency nursing or your various nursing, uhm… and I've got a doctor that is… difficult to say the least, but he doesn't know his hearts in the right place, so I think he's very confused about who he is, so he project very funny. He's got a very nasty way of projecting if there's something that made him unhappy, or he doesn't know how to communicate. Also, religion wise, it's a Muslim doctor so he's, I don't know if he's advanced past the years of before Christ, but you know the respect for women is not validated almost I think in the Muslim community. They, not that they don't respect the women, but you're not as important so it's very difficult when you work with all women, and you're a Muslim male. And also if you don't know who you are as a person and him and the staff in the endoscopy unit had quite an altercation and it was over patient care and she had every right to stand up for her patient, because he was rude and he swore at the patient and he smack the patient and she insisted that she will not be a part of it. And he didn't tell me the full story, she didn't come out and inform me, but he came and he… I was in my office so I was finishing of paperwork for management it was month end and he approached me with such arrogance.

Y: Hmmmm.

P: Ja, it was the most un-dignifying experience I've ever had where I was insulted as a professional. Uhm… I was told that I must leave if I can't run my department. I was told that I am nothing. Uhm, that I should have never been given the position. So it was very demoralising as well, and he literally had me up against my chair in the corner of my office, because he was physically… challenging…and I had to stand up and I said that if you do, and I'm not a screamer, so I stood up and I shouted and it was un-dignifying for me. My office door was open, I've got my staff, I've got patients and I just stand up well I stood up on the chair, because of his invading my privacy and if you cannot respect me

get out my office. And that's not me. I would never; I would smile at you and listen to you, but because of his body language and the fact that he was physically challenging me I had to make that stand. I had to stand there and…for me, that was very un-dignifying and I went home and felt like I was a bruised woman, like I've been battered, as a professional to stand in front of my staff and say don't ever raise your voice. Try and be as kind as possible, you know those skills you taught, those soft skills, I let them all go that day. So it was absolutely un-dignifying for me. It was, that incident was addressed with management, but I'm not too sure what the outcome was with regard to him. But he's the type of person which a week later will come and call you by your first name and then he'll bring you a little something like a kind gesture so say I'm sorry but never ever say sorry.

Y: I hear.

Y: So, if you think of these undignified moments and also the dignified moments, what would you say, what are the effect of these experiences on patient care?

P: I think the dignified moments have the best outcomes for patient care, the undignified moments unfortunately is either biased care on your patients or a lack of proper care or quality care for patients. I mean the incidents that I told you about, even the conscious sedation, was smacked on sworn at, she may not remember that, but for you, you gonna live with that forever. For that sister, she must have seen the patient in the passage or review the patient with perhaps another doctor, so it will forever lives here, this is how she was treated, do I go back and tell the patient that this is what happened and have I got a right to do that, even though I stood up as the advocate while she was under conscious sedation…for me…the undignified moment for me was the behaviour in which the doctor approached me was totally uncalled for and if he is professional enough he would have realised what he had done was wrong and there apologised… and never brought it to my office and made it my problem. So… I think it impacts, I think it impacts negatively on your patient care, I'll give you an example of today. There's a patient we received in the emergency care, she's been here in and out I should say for about 5 years plus. She came in initially with drug addiction, she used to take opioids and that, and she's come a long

way over 5 years and I don't think she's doing her opioids anymore, but she subsequently had an underlying disease as well. So all that was found out and she presents in our unit she had a terrible well she felt she had a terrible stay in the hospital about 3 weeks ago where she was in a room, the aircon was stuck 28 and it was a hot day outside. She complained and it hadn't been sorted she went out she does smoke a lot she had gone out she suffers with depression as well she had gone out and you must know if you have a mental illness or you you if there is a habit you gonna take to your habit. So she had gone out and when she was smoking and she must have gone out longer that she was suppose to they didn't give her she says she didn't get her medication and anyway her event just rolled on and she RHT from the hospital. Presented today and we phoned her physician who was in a frenzy, because why did she bother coming back, and she came here with severe abdominal pain, she had a tachycardia, she had a low grade pyrexia, and refuse to see her, he says if we admit her, he doesn't know who's going to look after her, so it falls in the hands of our doctors to now make a decision that wasn't in their best interest to discharge the patient, left the mum and the patient totally dissatisfied, so it does have…uhm…it does have a negative effect. And I went to her doctor and said, I, my heart is sore, because we must make a decision like this, based on the doctor, not on the patient presenting, so it's something that we need to look at as professionals in the work place……so unfortunately it does, and they've left with a very bitter taste. In their minds they never come back to the facility, they'll never come back to….. And she's got five years of history with this doctor that refused for her to be admitted, because she discharged herself without authorization 3 weeks ago. But her reasons, the room, the medication was not given on time, she had a whole lot…for her, was valid points.

Y: Ja, Ja, I hear. So, it's almost if there's a scenario where you feel you failed the patient that it really impacts on you as a professional.

P: This as well, ja.

Y: We've spoken a bit of the medical practitioners as being members of the health care team. How do you experience their behaviour towards you as a professional?

P: I've hardly. In the emergency nursing we very seldom, uhm…work alongside like you'll physio therapists. As for your occupational therapists, we very rarely see them. But I must say for those that do come to the unit I think there's an excellent working relationship. They do have the patient's conditions at interest and they have a good report with the patients and the multi-disciplinary team. Uhm… they also take you back to humility I think when you look at your, your reason for why you trained and that was to care, it's a caring profession, and you see it and I, for me very few times that I've seen a physio therapist come in, I've never seen arrogance, I've never see boasting, I've never seen rudeness. I've seen someone who approaches and say where's patient so and so. It's not where's the leg. Whereas I think when you at the hospital setting like the doctors and the nurses you identify your patient as the presenting complaint and yet if you get the guys from the multi-disciplinary team like your physio and your occs that come through they don't come addressing "Where's the leg", where's that, they will come and say, "I'm here for patient X and patient Y, please can I see them, can you direct me?" And it just makes you realise how we take what we have for granted, ja, by almost grouping our patient by the presentation and not by their names, so that dignity, we also loose. And they do, they bring you back to the caring, their approach, their dress…some of them may not wear name badges but when they go to their patient they introduce themselves, you know. So their dignity is maintained in their provision. It's so nice. It's so evident and it's like an effortless job for them, but I had beautiful relationships with them, the very few times I've encountered the external but from our, from our doctor based group I think there's a lot of work, there's a lot of room for improvement there.

Y: I hear.

Y: If you think of nursing management how do you experience their behaviour towards you as a professional?

P: ……Uhm……..I do think they respect us, I've had change of line managers. I think with this whole change in organisation, there's been change in line managers, so I've had change in line managers. I was under a line manager that was extremely hard on me, uhm…and maybe because of her being so hard I always felt myself being pushed into a corner and never been good

enough, uhm…in the workplace. So having to prove myself constantly which impacted on my family life, where I would stay longer than I needed to, because I needed to make sure deadlines were done, I needed to make sure that everything was perfect before I left. Uhm, it had its bad and it's good. The good was it shaped me into the person I am today. The bad is that the effect it had on my family I can't change. Uhm, I've got a new line manager who I think is quite approachable. I haven't had much encounter with my new line manager. Uhm, she'll come and do round "how's things", ja, not really, done pdp's with her. She's happy with my work so I can't… When it comes to my nursing manager, uhm…I think I'm blessed. She does respect me as a professional. Uhm…she respects my work environment. Uhm…she's very professional in the way she approaches me which allows me to be professional back. Uhm…ja, ja.

Y: If you think of general management outside of nursing management now, you've got your hospital manager, HR, the financial manager, all these.

P: Uhm…I've hardly encounters, I've got with my patients admin manager. Uhm…

Y: Ja, normally with the casualty.

P: You know, uhm……it's very difficult to say and and……I'm trying to think. Each one has their own goals and objectives and I think that's where it comes. It's very frustrating. It's that's a PAM your goals and objectives is your finance, your finance, your finance, you know. Mine is is multi. It's not just one goal. I've got multiple goals, so to build a good relationship I think we need to understand both our worlds. It's coming there. We're getting there. Initially it wasn't, with my PAM and I. We didn't have the best relationship. Is used to wanna pull my hair out. I'm sure he felt the same about me, because my passion is different, and my goals were different. I won't say he disrespected me, I don't think he understood my world very well. Uhm… I don't know what he had done prior, which also made it a bit difficult. Uhm…and I'd been here already, so I had already been build a foundation and I've seen change come along and then there was new change, and then I'm like, Ok now I must go this way. But ja, I think we slowly getting to learn each other's worlds. Uhm…uhm…ja. I can't really comment much on that…uhm….from my hospital manager. I think his heart's in

the right place so he's very supportive. Uhm…I do think he listens. I haven't really encountered much with the clinical hospital manager, he's new in his position. But our engagement, we engaged a lot more so he feels the heartbeat of the unit. He respects my decisions. I can discuss certain issues with him and he'll tell. Sometimes he will be very honest. He will say this I can't do anything about. I'm being real with you and which is nice to know.

Y: Ja, ja.

P: So it's not like I'm left in the, I'm just hanging there waiting for his responses, things I know Ok Charlene I (use x y2) don't worry I will blank out when I transcribe. But uhm…ja, he would say, you know I can't do this. This is really, I'm uncomfortable in this as a person, so I will hand this over to whomever. Maybe I won't get feedback I don't know, but I know I did feed it to him and he came back to me and said he was uncomfortable to deal with it, but supportive, absolutely. Uhm… in my decision making I'm my idea sharing in my goals for the unit and my objectives, his very passionate when it comes to what we share, well what I've share with him on a professional level. For the unit and where I see it and how I'd like it to be. So that is so wonderful to have. So I think I can count my blessings there.

Y: That is, that is wonderful.

Y: If you must think of your professional dignity, what is it for you? How do you perceive your dignity as a professional nurse?

P: As you mentioned in the beginning, it's such an integrated one with your work and then your profession. Uhm…for me it is…….I can't separate the two.

Y: It's right, just give it to me as you see it.

P: For me my professional dignity is the honesty, the transparency, uhh…the ability to vocalise how you feel, uhh…my patient.

Y: Ok.

P: My patient. I think just that whole approach to patient care. It's it's my heartbeat, uhmm…it's, you can write all the QIP's in the world, and if you not, if

your hearts not there with care, it's a pointless effort. So for me it's very much the patient, as I mentioned, uhm… it's the pride in the job that I do…….and going beyond what I'm actually called to do, and that I love doing……the engaging with the patient and their family, and to see the outcomes……uhm…..I think with even within my scope of practise, I don't really have a problem with that that's, I think when you born to care, and it makes a world of difference, nothing is too much for you. Uhm…ja.

Y: We coming to the end of our interview. Uhm…as closure, if you think of your work environment, if you think of the concept again, is there anything else you would like to add or would like to share?

P: ……..For me……..I think that multidisciplinary teamwork within the private health care needs to be looked at. Especially for patient outcomes.

Y: Ok.

P: And your well obviously the professional dignity plays an important role in your professional outcome. Either you're negative or you're positive. And the respect….between individuals within the multidisciplinary team….Uhm….I think if there a common ground that we all here for the patient, and for the patient's outcome and not for our own gains. Uhh…I think it will change…..the way private health care actually works. Patients are, they very clued up now as to what their rights are, what their treatment should be, they they not fools when they inside our facility, and they shouldn't be treated like that, and so just…….and to remain non-biased at the workplace…I think is very essential on all, on all platforms. Patients with staff, staff with staff and staff with doctors and doctors with doctors and the transparency is important.

Y: Anything else?

P: …..Get rid of workplace violence.

Y: Workplace violence?

P: Yes.

Y: Tell me, describe that to me.

P: ….Uhmmm…I mentioned earlier, you get the verbal with the doctor, you get the nurse on nurse now, it just seems to be growing, I don't know if it's all the social stresses.

Y: Hmmm.

P: That is causing it, uhh, patients with nursing staff or admin staff, because of the financials it's, it's, there a huge burden on our communities and it's evident now when patients come to the hospital, I'm talking from their side.

Y: Yes.

P: As if they come in and is told to open up a file to see a doctor and they must pay money. Already you can see nostrils flaring. And then the language starts that this facility only wants money, that's all we after, and then it's blurted in the waiting area and that impacts on the next patient and the next patient and by the time they come in their perceived care is that you only caring for them, because they've paid. You know it is, the workplace violence is real. The other is the workplace violence with regards to the drug abuse and whatever we see, we see quite an increase in that now. Uhm…where you're getting the youngsters, uhm… I'm not too sure if you've heard of the Bronclear grouping in Maritzburg with coke and they come in aggressive, and quite abusive. So you getting that verbal and physical violence in the waiting areas….so, ja…it's…and I think that's also what pushes nurses away and you know you become aggressive in you treatment and you not even realising how aggressive your attitude is when you treating a patient, because you feel you feel you need to defend yourself or protect yourself. And then on the nurse to nurse that also seems to be an increase. And that's mainly ranking and the way we speak to each other. So, uhm…many of the new generation, the younger nurses don't like to be informed or told what to do. They….your approach to them must be a subtle approach, you know. You must just soften things down and when you from an older school you were allowed to go and say, but obviously not in front of the patient, listen what you have done is not right. In future this is how you must do it. And it was taken. But unfortunately with the newer generation you gotta watch your approach, watch your tone, watch your body language. It's, it's having quite an effect in how you communicate now. So, you so afraid to go and talk to the junior nurses, because

you feel, the new, the newer generation, because already you see their back's up against the wall and the standard then, I think it's one of the things that impacts on standard of care. Because you're so afraid to go and communicate to them, because it's gonna turn out to be I mean you've actually had incidents where they actually abuse, nurse on nurse fighting and stuff like that which is so unnecessary in our professional world. Uhmm…and then the doctor, I think I've gone on you with the doctor violence. And I sometimes also thinks it's a projection. And I don't know if they have any outlet. We still ok as nurses. We've got INCON to help you. I don't know if they have any of that where they can sit, like what you're doing now, is also therapeutic. But do they have something like that, for the volumes of patients they see, they also get abuse from patients and from nurses and from relatives, but do they have an outlet.

Y: Ok.

P: Or are we their outlet.

Y: Ja, I hear.

Y: Anything else?

Y: Thank you so so much.

P: It's a pleasure, Yvonne.

Y: I know why I had to wait for you. So I really appreciate it. I'm just gonna put this sound off.

ANNEXURE G

FIELD NOTES (FOCUS GROUP INTERVIEWS)

STRATEGY 1: **Hospital and nursing management, members of the health team and nurses are to value nurses' professional dignity.**	
Hospital and nursing management, the health team and the nurses should acknowledge and support nurses' strive to:	
Render prompt and accurate care according to clinical standards.	
Gather and provide clinical information to support the coding and administration of various medical insurance models for payment and length of stay as well as clinical data.	P1 replace gather with collaborate, replace clinical data with patient clinical information; P2 replace gather with collaborate with doctors and health team; P4 add strategy 'Include multidisciplinary team in gathering/obtaining clinical data; P6 add strategy 'Strive to collaborate with the multidisciplinary team to extract clinical diagnosis to the patient;
Participate in universal 'Best Care Always' and accreditation programs in support of the best clinical outcomes for patients.	
Mentor newly qualified nurses in clinical practice and professional conduct.	
Oversee sub-category nurses to uphold and support clinical care within scope of practice.	
Utilize team work to monitor, record and report clinical and emotional parameters of patients.	
Utilize team work to execute planned multidisciplinary care regimes safely to patients.	
Advocate changes and new suggestions in clinical care to the betterment of patients.	Cf replace betterment with improvement; P2 same; P3 same; P4 same
Participate in client satisfaction and patient safety initiatives to the betterment of service to clients.	
Participate in driving cost down in private healthcare.	
Contribute to a realistic operational and staffing budget.	

STRATEGY 2: **Hospital and nursing management are to curtail work experiences which are contradictory to nurses' desire to prioritize patient care.**	
Hospital and nursing management should:	
Reduce excessive administration and paperwork expected of nurses.	Cf digital stock and nursing notes; P1 use of technology to improve admin processes; P2 'digitalization of processes, use of technology; P4 'future use of technology'; P6 'Introduce elusive technology for nursing notes' 'Introduce a barcode scanning system for surgical stock, medication used for patient, instead of writing and charging, this will reduce workload on the nurses'; P7 'Electronic patient records and electronic billing and digitalization' P8 'Use of technology to streamline paperwork'
Align the role of nurses with patient-centred care.	
Empower unit managers to take decisions in the best interest of their units.	
Consider a reasonable workload for nurses to experience satisfaction in caring for their patients.	
Promote physical and emotional self-care principles to nurses.	Cf change to 'Promote physical and emotional self-care principles to nurses'
Introduce forums where nurses are comfortable to voice their clinical practice challenges.	P2 'Develop responsibility of nurses to be the voice at forums in their own private capacity' P7 'psychological safety
Provide insight and administrative support to nurses into company strategy to ensure financial sustainability of the business.	
STRATEGY 3: **Hospital and nursing management, members of the health team and nurses are to encourage and mentor nurses in the keeping of their pride in themselves and their profession**	**Replace champion with encourage and mentor**
Hospital and nursing management, the health team and the nurses should enable nurses to:	
Carry the name of the nursing profession with pride.	P1 'National strategy to change image of nursing profession'
Promote the academic standing of well-educated nurses in the workplace.	
Contribute to the betterment of nursing standards in the profession.	Cf replace betterment with enhancement; P1 same; P2 same; P3 same; P4 same; P5 same; P6 same; p8 same

Own and solve their problems and conflict independently.	P4 'Teach reflection'
Portray a good professional image.	
Carry their duties in a respectful and professional manner.	
Stand up for themselves in an assertive manner.	
Earn respect in being competent, knowledgeable, skilled and well educated.	
Engage in equal collaboration with other members of the health team as autonomous nursing professionals.	
Guide and uplift team members who are not so confident (vulnerable) in their pride.	Cf 'Provide opportunity and encourage nurses who are not so self-assured in their confidence'; P1 same; P2 same; P3 same; P4 same; P5 same; P7 same; P8 same
Provide opportunity and encourage nurses to engage in higher education.	
Be supportive and understanding towards nurses when a nursing error occurs.	
	P2 debriefing post events; P4 Debriefing, reflection post errors; P6 Do a debriefing, system analysis with the nurse when a nursing error occurs; P7 Debrief and system analysis/less punitive measures; P8 follow up with person to debrief
STRATEGY 4: **Hospital and nursing management are to adapt a supportive management style to support, appreciate and respect nurses**	**Cf replace supportive management style with management style; P1 same; P2 same; P4 same; P5 same**
Hospital and nursing management should:	
Give feedback and maintain open communication.	
Show gratitude towards nurses' hard work and contribution.	Cf replace contribution with commitment; P1 same; P2 same; P3 same; P4 same; P5 same; P7 same
Show sincere regard in nurses' personal and work related problems.	Cf replace in with towards and problems with challenges; P1 same; P2 same; P3 same; P4 same; P5 same; P7 same; P6 Acknowledge sincerely towards nurses personal and work related challenges
Respect suggestions (decisions) on ground floor.	Cf delete decisions/replace ground flour with ground level; P1 same; P2 same; P3 same; P4 same; P5 same; P6 same; P7 same
Recognise nurses for a job well done.	
Support nurses in client service encounters regarding patients complaints.	Cf unrealistic expectations
Set achievable standards and deadlines.	P7 set realistic standards and deadlines;

Staff units to capacity considering company financial viability and guidelines.	Cf according to occupancy, acuity, level of care/ optimal staffing of units to promote safe patient care while taking into account company financial viability and guidelines; P7 same; P2 Staff units according to occupancy/optimum staffing; P3 same; P4 same;P6 same; P5 according to occupancy/ budget guidelines
Gain input from nurses in determining staffing budgets.	
Gain insight in unique nursing circumstances before judgement of nursing mistakes.	Cf replace nursing mistakes with nursing errors; P1 same; P2 same; P3 same; P4 same; P7 same; P7 same;
Provide opportunities for nurses to soundboard.	Cf replace soundboard with express their feelings; P1 same; P2 same; P3 same; P5 same; P6 same
Respect 'off-duty' times and work life balance of nurses.	
Provide an environment of emotional safety for nurses.	Cf replace emotional safety with psychological safety/ provide a psychologically safe environment for nurses; P7 same; P1 psychological safety; P2 same; P4 same; P5 same; P6 same
Implement a process of follow up and reporting back to nurses regarding workplace violence.	P1 replace reporting back with feedback; P2 same; P3 same; P4 same; P5 same; P6 same; P7 same; P8 workplace unethical violence
STRATEGY 5: **Hospital and nursing management and members of the health team are to support nurses to function optimally in complex and demanding situations.**	
Hospital and nursing management and the health team should:	
Consider current corporate expectations of nurses.	Cf replace consider with reconsider; P1 same; P2 same; P5 same; P6 same; P8 same
Consider staffing models and work processes which promote person centred patient care.	CF replace person centred patient care with individualised patient care; P1 same; P3 same; P5 same; P8 same; P2 individualised patient centred care; P5 patient centred care;
Promote an holistic and integrated approach towards patient care between all members of the health team.	Cf 'Promote a holistic and integrated approach between all members of the health team towards patient care; P2 replace an with a; P3 same; P5 same; P8 same
Orientate and provide in service training to new staff in diversity principles.	
Lobby for the teaching of diversity as part of the nursing curriculum in basic training.	

Understand the uniqueness of each generational group and actively engage with each group and adapt leadership and work environment accordingly.	Cf 'Actively engage and understand the uniqueness of each generational group'; Add strategy 'Adapt leadership and work environment accordingly to benefit each group; P2 same; P3 same; P5 same; P6 same;
Provide structures to support nurses in dealing with financial confrontations from patients and their families.	Cf 'Support nurses with structures to deal with financial discussions from patients and their family'; P3 same; P4 same;
Support nurses in dealing with emotional outbursts of patients, their families and members of the health team.	
Provide ethical safety standards regardless of pressure from external sources.	P1 replace external sources with multidisciplinary team and management; P2 same; P3 same; P4 same; P7 same; P8 same;
STRATEGY 6: **Hospital and nursing management, members of the health team and nurses are to support nurses in fulfilling their expected professional role within the health team.**	**Fc 'Hospital, nursing management, members of the health team and nurses are to support each other in fulfilling their expected professional role'; P3 same; P4 same; P6 same; P1 delete 'within the health team'; P2 same; P7 same P8 same.**
Hospital and nursing management, members of the health team and nurses should:	
Identify and support professional nurses who are exposed to workload imbalance.	
Implement structures to deal with disrespect and sub ordinance issues towards professional nurses.	Fc 'Implement structures to deal with disrespectful and insubordinate behaviour towards professional nurses'; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
Lobby for formal training and regulation of care workers to support nurses.	
Re-look, understand and support the diverse role and expectations towards professional nurses.	Fc 'Understand, support and revise the diverse role and expectations of nurses; P2 same; P3 same; P4 same; P6 same; P7 same
Re-look, understand and support senior and more experienced professional nurses carrying heavy work load.	Fc delete re-look, replace heavy with heavier; P2 same; P6 same; P7 same; P8 same;
Identify professional nurses with symptoms of fatigue and burnout.	
Create ‘haven’ hubs where professional nurses can soundboard and get stressful situations off their chest.	Fc 'Create support groups/listening forums where nurses can discuss stressful situations confidentially'; P3 same; P4 same; P6 same; P2 Listening forums/support groups to confide in each other; P7 'Create forums where nurses can confide and discuss their stressful situations confidentially; P8 same;
Implement stress reducing programmes	

such as yoga classes.	
Implement lifestyle and resilience promoting programmes.	
Provide a skilled and competent sub category nursing compliment.	
STRATEGY 7: **Hospital and nursing management, members of the health team and nurses should honour nurses' strive to value patient well-being as their first priority**	**Cf Replace strive with striving; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;**
Members of the health team and nurses should enable nurses to:	
Care for patients as their number one priority.	
Care for patients in a gentle and kind manner.	
Provide in the comfort and emotional needs of patients.	Cf replace 'in' with 'for'; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
Keep their care promises to patients.	
Provide accurate up to standard care to patients.	
Plan their work routine towards care that really matter.	
Be reliable and competent team players in valuing patient well-being.	
Hospital and nursing management should:	
Provide work environment where professional nurses can render care that really matter.	Cf add 'a' before work environment; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
Support teamwork and ensure that all team members are competent and committed to patient well-being.	
Empower nurses to step up in the best interest of patients as patient advocates or whistle blowers without being judged.	
STRATEGY 8: **Hospital and nursing management and members of the health team are to support and equip nurses to cope with degrading experiences in their work environment.**	**Cf replace degrading with humiliating; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;**
Hospital and nursing management and members of the health team should enable nurses to:	
Actively engage with medical practitioners to discuss their collaboration.	

Establish strategy to deal with family and patients being disrespectful towards professional nurses	Cf 'Establish strategy to deal with family, patients and other healthcare members, being disrespectful towards nurses'; P1 same; P3 same; P4 same; P6 same; P8 same; P2 replace professional nurses with nurses; P7 same;
Encourage professional nurses to deliberately take a stand towards their clinical competence and autonomy.	Cf 'Encourage nurses to take a deliberate stand towards their clinical competence and autonomy'; P1 same; P2 same; P3 same; P4 same; P7 same; P8 same;
Educate public with regards to nurses' academic standing.	
Ensure prompt feedback following reported events of disruptive behaviour.	
Enable professional nurses to sharpen their clinical skills and competencies.	Cf 'Enable nurses to continually improve their clinical skills and competencies'; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
Initiate training in assertiveness.	
Openly disapprove of media's portraying of nurses' image in a sexual context.	Cf 'Actively disapprove of the sexual context of nurses image portrayed by the media'; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
Enable professional nurses to adapt coping mechanisms to counteract degrading behaviour.	Cf 'Enable nurses to develop coping mechanisms to counteract humiliating behaviour'; P1 same; P2 same; P3 same; P4 same; P6 same; P7 same; P8 same;
ADDITIONAL FIELD NOTES	Focus group interview participants showed a sincere interest in the phenomenon and actively participated in the refinement of the strategies. There were good debate amongst participants and members portrayed professionalism and respect for the opinions of each other. One focus group participant was side-tracked by her own unit operational challenges and had to be facilitated back to the topic under discussion at times. All participants gave input. While some participants gave input with every strategy others focussed on those strategies which they were more involved with.

ANNEXURE H

REFLECTIVE NOTES

[Factors of the experiences of nurses impacting on their professional dignity]

The researcher's 'knowing, feelings and priori perception' suspended outside the bracketed phenomenon:

- I understand the professional dignity of nurses as nurses' professional autonomy and their own and other's view of nurses' knowledge and skills.
- I see the concept as inseparable with my own human dignity.
- I experienced enhancement and violation of professional dignity as a professional myself in the workplace. One specific incident comes to mind very clearly which I am deeply affected by.
- As a nursing leader in private healthcare for more than 21 years I have witnessed the enhancement but also the violation of the professional dignity of nurses.
- I know that the lack of insight from general management affects the professional dignity of nurses negatively.
- I also know of the violation of the professional dignity of nurses with specific reference to medical practitioner collaboration,
- I gained insight into the concept from several studies of which the main factors highlighted to affect the professional dignity of nurses are inter and intra relations in the work environment.
- Nurses are also affected by the conduct of their colleagues.
- Nurses' ability to care for patients is influenced by the enhancement and or violation of their professional dignity.

I acknowledge that my priori knowledge and perceptions of the professional dignity of nurses and the factors having an impact on it can influence my research and the findings of my research.

I therefore now bracket all my knowing, feelings and priori perception of the phenomenon and I suspend it outside of the bracketed phenomenon of the factors of the experiences of nurses impacting on their professional dignity. I am sincere to allow myself to look upon the phenomenon with clear eyes and to seek the truth from the experiences from the selected participants with an open mind with a clear and pure consciousness. I will revisit and apply bracketing towards my knowing, feelings and priori perception continuously to ensure a clear and open mind throughout the research process.

ANNEXURE I

MEDICLINIC

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21 December 2017

Mrs Y Combrinck
Mediclinic Newcastle
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Dear Mrs Combrinck

PERMISSION TO ACCESS CLINICAL DATA

The approval by Mediclinic (letter of 3 November 2016) to conduct your research titled *"Strategies to preserve the professional dignity of nurses"* at Mediclinic Bloemfontein and Mediclinic Pietermaritzburg refers.

It is in order for you to access the necessary clinical data for your research from the Mediclinic Clinical Services database, and I wish you success with this project.

Yours sincerely

Estelle Coustas

DR ESTELLE COUSTAS
Nursing Executive

Valerie Janet Ehlers

Nurse Consultant and Researcher

Emeritus Professor and Research Fellow: University of South Africa

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(B Soc Sc, Honours B Soc Sc, BA Cur, Honours BA Cur, MA Cur, D Lit et Phil, TAALKU-F for Diploma in Translation)

CONFIRMATION OF HAVING EDITED A DOCUMENT

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5 April 2018	**I hereby certify that I have done the language editing of Ms Yvonne Combrinck's doctoral thesis titled: STRATEGIES TO PRESERVE THE PROFESSIONAL DIGNITY OF NURSES IN A DEMANDING HEALTHCARE ENVIRONMENT**

Thank you

Prof VJ Ehlers