

The Dignity of Burn Patients: A Qualitative Descriptive Study on Nurses, Family Caregivers, and Patients

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Abstract

Background: As an ethical principle, showing respect to human dignity is considered as a professional duty of all nurses. The aggressive nature of severe burn injuries makes it hard to respect existential values and dignity of burn patients. However, only a few studies have been conducted on the preservation of the dignity of burn patients.

Purpose: The purpose of the study was to determine the various aspects of the concept of burn patients' dignity from the perspective of nurses, family caregivers, and burn patients themselves.

Methods: The present study has a descriptive, qualitative research design. Moreover, data were collected using semi-structured, in-depth, individual interviews. Thereafter, data analysis was performed using conventional content analysis. The subjects of the present study were from nurses, family caregivers, and patients referred to the biggest burns hospital in the southeast of Iran. The participants were then selected via a purposeful sampling (n=25), which continued until reaching data saturation. This study lasted from October 2017 to August 2018.

Results: Three main themes were extracted from the information obtained in the interviews, which were as follows: Creating an intimate atmosphere, showing respect, and providing comprehensive support.

Conclusion: Burn patients need receiving appropriate care in a convivial atmosphere where they are looked after by empathetic caregivers who dedicate enough time to them as well as allowing them to express their feelings and concerns. In addition, patients' human values and beliefs should be respected and all aspects of their existence should be taken into account to preserve their dignity. In this regard, workshops designed based on the findings of the present study can help improving the quality of burn care nursing.

Background

Burn injury is known as one of the leading causes of morbidity and mortality worldwide [1]. Notably, Individuals from all age groups and various socioeconomic levels are at the risk of suffering from these kinds of burns. The clinical experiences of burn survivors suggest that suffering from burn injuries is usually accompanied with severe distress, which may lead to some emotional, psychological, and physical changes among the victims [2]. Several studies have shown that burn survivors face various physical and psychological challenges during their recovery period, which may affect all aspects of their lives [2,3].

The aggressive nature of severe burns and the heavy burden of dealing with the consequences including the impaired physical functioning, disfigurement, and psychological distress, are some threats to the victims' human dignity and to the successful return to a normal life [4]. Furthermore, being inflicted by unbearable pain, impaired performance, disfigurement, and changes in their self-image and social roles affect burn patients' existence. All the above-mentioned factors were shown to be positively associated

with burn patients' social isolation, feelings of over-dependence on others, and fear of losing their dignity [2].

A basic duty of nurses in the burns wards of hospitals is providing compassionate and respectful care to these patients [5]. According to a study by Watson et al., caring is an ethical ideal in nursing with the aim of maintaining and improving human dignity, and the goal of nursing is to help individuals achieving higher levels of mind-body-soul coordination. Accordingly, this goal can be realized through human-human caring processes and interactions, which in turn, can result in self-healing and self-controlling [6]. Confirming Watson's viewpoint, Roach stated that humanity and human dignity are inseparable. In consistent with this idea, Jacobs pointed out that the essence of nursing is not only to restore health or re-establish a holistic balance and coordination, but also to show respect to human dignity [7].

Dignity is an inalienable right of every human being [8]. Human dignity is an ultimate and irreducible entity, which is incommensurably superior to other human values. This view on dignity concept is compatible with religious points of view in this regard [9]. Correspondingly, the dominant religion in Iran is Islam, and the Islamic culture attaches great importance to show respect to the individuals' rights [10]. Moreover, in Islam, in which God is believed as the Only Creator, human dignity is the most discussed issue in its holy scripts [9]. It is noteworthy that the first patient bill of rights has released in Iran in 2002, which consists of 10 clauses similar to its international counterpart. So, it is not only specific to the Iranian culture [8].

Dignity is an important aspect of nursing care [10]. Preservation of human dignity is a core principle, which must not be applied only to patients, but also to all human beings [11]. In codes of ethics, respect for human dignity is the right of every human being, which is regarded as an ethical duty of nurses in hospitals. Human dignity is the perception of respect and competence in others, and it allows a person to feel value and respect for others and to believe that they can grow and develop [12].

Preservation of dignity is one of the most important ethical responsibilities of caregivers [13]. In addition, protection of dignity is associated with the increased patient satisfaction and self-esteem, the reduced length of hospital stay, the enhanced ability of patients to cope with their illness, and giving patients the sense that their lives are meaningful [11]. Respect for human dignity enhances caregivers' motivation to provide a high quality care, which consequently results in an effective relationship between patients and caregivers [14]. In contrast, violation of dignity leads to psychological and spiritual distresses, the reduced motivation to survive, and deterioration of patients' physical and mental health conditions [15]. In recent years, many studies have addressed patients' and caregivers' perceptions of human dignity [15]. In the literature, the nature of dignity has been previously assessed in several groups of patients and caregivers including patients with cardiovascular diseases [16-17], critically ill patients, elderly patients [20-21], hospitalized adolescents [22], autistic teenagers [13], and patients with cancer [23-25]. However, our understanding on the ethical aspects of caring for burn patients is still limited [26], and despite the serious psychological, social, cultural, and religious consequences of burn injuries; the dignity of burn patients has not been explored in any study yet. Burn injuries and the ensuing complications may cause

the affected people to have a sense of inferiority and to feel that their dignity is at risk, which also impairs their self-awareness [27].

Dignity is a concept that can be defined based on cultural contexts and physical environments [28]. Clarifying the meaning of burn patient's dignity is crucial for the purpose of fully respecting and preserving the dignity of this group. Therefore, it is necessary to establish the meaning of dignity as well as its related factors in this group of patients. Due to the abstract nature and complexity of the concept of dignity, a qualitative study is required to achieve a clear and deep knowledge on this concept [8,11]. Besides, a qualitative approach helps to discover those problems related to burns and to achieve an extensive understanding on the issues related to burn patients [2]. Notably, Research on burn patients' dignity can help determining the various dimensions of this concept, identifying the effective factors on maintaining the dignity of burn patients, and providing a high quality care. Nurses' and family caregivers' descriptions of the dignity of burn patients can yield a better understanding on the concept in questioning the context of caring for burn patients. In this regard, the present study can help healthcare administrators and caregivers in providing a supportive and empowering environment where burn patients' rights and dignity are maintained. The aim of the present study was to determine the various aspects of burn patients' dignity as perceived by nurses, family caregivers, and burn patients.

Specific objectives

1. What are the experiences of nurses, family caregivers, and patients regarding the burn patients' dignity?
2. Based on their experiences, how do nurses, family caregivers, and patients describe the burn patients' dignity?

Methods

The present study was a descriptive qualitative research performed using the content analysis approach. Qualitative content analysis as a systematic qualitative research technique was also used to code and categorize the obtained data to condense a large amount of textual information for determining patterns in words, their relationships, structures, and discourses [29]. Qualitative research is a systematic mental process with the purpose of describing human experiences and understandings about them [30]. As dignity is a concept or mental experience [11], the present study used a qualitative exploratory design. The aim of the study was to explore the meaning of the burn patients' dignity using the conventional content analysis. According to Hsieh and Shannon, conventional content analysis can be applied when literature on the phenomenon under study is limited. In this case, researchers avoid using a preconceived understanding of the topic, rather, they try to extract a definition of the topic from data [30].

Participants and research settings

A total of 14 nurses, 6 family caregivers, and 5 patients were selected using purposeful sampling from the largest burn hospital in the southeast of Iran. This study lasted from October 2017 to August 2018. In

the present study, the first researcher (BT) interviewed caregivers who had rich experiences in the field of caring burn patients who were able to express their experiences eloquently, which provided much information with respect to the research question. The inclusion criteria for the nurses were as follows: having at least a bachelor's degree, a minimum of 6 months' work experience, experience of caring for a second-degree or a third-degree burn patient, not being fatigued due to work overload in the hospital, having willingness to participate in this study, being able to provide meaningful and rich information on the subject of the study, and speaking and understanding Farsi language. The inclusion criteria for the family caregivers were the followings: age of 18 years old or above; being a member of the patient's family, e.g. a spouse, child, sibling, or a friend of the patient; having no psychological or metabolic disorder to their knowledge; not being on any medication affecting the mind, not suffering from physical or psychological fatigue due to caring their patients, being mentally and physically fit to be interviewed, and experiencing caring a second-degree or a third-degree burn patient. Furthermore, to be included in this study, the family caregivers should be willing to participate in the study, be able to provide meaningful and rich information on the subject of the study, and be able to speak and understand Farsi language. The inclusion criteria for the patients were as follows: age over 18 years old; having second or third degree burns; at least three weeks passed from their burn injuries; being burned by accident; visiting the burn hospital for replacement of the bandages of their burn wounds; having no confirmed psychological disorder or mental retardation; not being addicted to LSDs, drugs, or alcoholic drinks before or after receiving burn injuries; speaking Persian; being able to provide rich information on the concept under study; and having willingness to participate in the study.

On the introduction of the research team, the first three authors had a Ph.D. in nursing, and the second and third authors had previously conducted research in the area of patient dignity [8,13]. The present study was conducted to fill the gap in the existing literature on the dignity of burn patients. All the researchers were trained and also skilled in qualitative research. The research context was Amirmomenin Burn and Plastic Surgery Hospital, which is the largest burns facility in Shiraz located in the southeast of Iran. Accordingly, this hospital offers all kinds of medical services related to burn injuries in the south of Iran. All the wards of this educational hospital provide specialized care in the burns, rehabilitation, and plastic surgery fields. This medical center consists of several specialized care departments as follows: general surgery, plastic surgery, endocrinology, rehabilitation, ophthalmology, traditional medicine, dental care, radiology, sonography, internal medicine, and psychology. Moreover, the special services offered by this facility are the followings: pain-free dressing, laser therapy, dressing with amnion, and dressing with skin graft. This hospital also houses a burn and wound healing research center.

The research setting comprised of all the above-mentioned sections of this hospital including the male surgical ward, the female surgical ward, the emergency department, and ICU. Data were collected using face-to-face, semi-structured interviews with 14 nurses, 6 family caregivers, and 5 burn patients.

Data collection

Due to lack of a specific protocol for recognizing the dignity of burn patients (in hospitals) in Iran, a comparative approach was adopted in the present study to identify appropriate participants. In this regard, the first author/interviewer selected the potential participants from different wards and work shifts based on her experience, informed judgment, and the inclusion criteria of the research. Notably, only the subjects who had enough knowledge and experience in the area of burn patients' dignity, were interviewed.

Informed consent was obtained from all the participants included. The interviews were conducted by the first researcher (BT) in the nurses' break room or at the conference hall of the hospital, with the permission of the ward's head nurse. During these interviews, none of the other staff members were allowed to enter the room/ conference hall without permission.

In order to focus on the dimensions of the burn patients' dignity, the first author (BT) has initially interviewed a nurse, a family caregiver and a burn patient (not actual participants) in terms of the final interview guideline. Correspondingly, this interview guideline was oriented around the subjects' perceptions and definitions of burn patients' dignity, as well as their past and present experiences. Afterward, in order to encourage the participants to answer her questions openly and sincerely, the first author (BT) informed the participants that she is a university faculty member, all information would remain confidential and anonymous, and participation is on a voluntary basis. Before conducting each interview, the objectives and method of the study were explained to the participants as well as the fact that the sponsorship was non-commercial.

The interviews were started with a general question-"what does the concept of burn patients' dignity mean to you?"-to allow the participants to describe their understanding and experiences completely. Thereafter, based on the participants' responses, more specific questions were asked to gather information related to the objectives of the study more directly including "What experiences have you had related to the dignity of burn patients?" and "How do you feel after respecting or ignoring a patient's dignity?". These questions were specifically designed for the burn patients included: "What are your experiences on preserving your dignity during your stay time in hospital?" "What conditions would threaten your dignity?" and "How did you feel when your dignity was maintained or ignored?"

To obtain more clear answers, the interviewer used open-ended questions, such as "What do you mean by that?", "Can you explain further?", and "Can you give an example?".

All the interviews were conducted and then recorded by the first author (BT). Accordingly, the participants' voices were recorded using a Sony Voice Recorder ICD-TX650.

The duration of the interviews varied from 45 to 70 minutes. During the interviews, the participants' nonverbal communication was also noted. Notably, these participants were selected using the purposeful sampling, which continued until reaching data saturation. Correspondingly, data saturation has been reached when no new categories were extracted from the obtained data and all the categories were saturated in terms of feature and dimension. In the present study, data saturation was reached after

performing 22 interviews, and three further interviews were done to ensure that no new information could be extracted from the data.

Data Analysis

As data were being collected, they were then analyzed using Graneheim and Lundman's (2004) approach to perform qualitative content analysis. This approach consists of the following steps: immediately transcribing the interviews after completion, reading the transcripts to reach a general understanding of their contents, identifying units of meaning and the initial codes, classifying the initial codes into broader categories based on their similarities and differences, and determining the hidden content of the obtained data [31].

Accordingly, immediately after conducting each interview, the first author (BT) transcribed the interview, read, and re-read the transcript. Subsequently, after obtaining a general understanding on the content, she executed an inductive analysis of the information.

At the reading stage, important paragraphs were carefully read line by line. Words, sentences, or paragraphs that were significant regarding the burn patients' dignity were designated as semantic units. Thereafter, a code was assigned to each key paragraph or phrase.

Subsequently, the second author (MR) reviewed the transcripts and then verified the semantic units and open codes. It is noteworthy that disagreements on the semantic units and codes were resolved in a meeting attended by all the four researchers (BT, MR, CT and MF).

All the categories were then classified based on the similarities and differences among the codes. To ensure the maximum strength of the codes, all the categories were revised and then compared with the obtained data. Next, in several meetings, the research team members (BT, MR, CT and MF) have extracted the themes by careful and in-depth contemplation and comparing the categories with each other.

During the data collection and analysis processes, the researchers have attempted to apply bracketing. Accordingly, bracketing is a method commonly used in the qualitative research, in order to mitigate the potentially undesirable effects of preconceptions that may cause bias in research [31]. Hence, the researchers in this study attempted to ignore their own knowledge, beliefs, values, and experiences to describe the participants' points of view on the concept of burn patients' dignity accurately. The researchers did not form any judgment on the data and accepted them as they were. Data analysis was conducted using MAXQDA 2007.

Study Rigor

The accuracy and trustworthiness of the data were tested using Lincoln and Guba's criteria [32]. To ensure the credibility of the data, the researchers applied prolonged engagement, member checking, and peer debriefing. Before conducting the present study, the researcher (BT) was present in the wards as a nursing instructor and had regular interactions with the participants during the course of the study.

Afterward, the collected data were reviewed with the participants (nurses, family caregivers, and patients) and then examined via triangulation (nurses, family caregivers, and patients from different genders and age groups) and maximum variation sampling based on contrasting evidence. Furthermore, in order to confirm the dependability and conformability of the obtained data, the researchers had a panel of experts for examining the transcripts, the extracted codes, and categories.

To test the transferability of the findings to other similar groups and settings, the researchers had included several burn care nurses, family caregivers of burn patients, and burn patients who had not participated in the study, to evaluate the degree to which the results reflected their own experiences. The researchers also requested feedbacks from the experts and the participants (including peer review and revision of the manuscripts by the participants and professors and colleagues who were familiar with qualitative research). The collected information had not only confirmed the reliability of the findings of the study, but also provided the researchers with further rich experiences and complementary views, which were considered in the data analysis.

Results

25 subjects (14 nurses, 6 family caregivers, and 5 burn patients) were included in the present study. The age ranges of the nurses, family caregivers, and patients were 28-54, 22-41, and 24-48 years old, respectively. The work experience of the nurses ranged from 2 to 28 years, with the average of 13.71 ± 9.78 years. The demographic characteristics of the participants enrolled are presented in Table 1.

Table 1 The themes and categories of this study

Themes	Category
Creating an intimate atmosphere	Empathy
	Effective communication
	Dedicating time to the patients
Showing respect	Respect for human equality
	Respect for patient autonomy
	Respect for beliefs and values
	Avoidance of pity
Comprehensive support	Pain relief
	Psychological support
	Social support

Data analysis yielded three main themes as follows: creating an intimate atmosphere, showing respect, and providing comprehensive support. In this regard, these themes and their categories are shown in Table 2.

Table 2 The demographic characteristics of the participants

No	Participant	Position	Marital Status	Education Level
P1	Nurse	Staff nurse	Married	Bachelor
P2	Nurse	Staff nurse	Single	Bachelor
P3	Nurse	Matron	Single	Bachelor
P4	Nurse	Head nurse	Married	Bachelor
P5	Nurse	Staff nurse	Married	Bachelor
P6	Nurse	Supervisor	Single	Master
P7	Nurse	Staff nurse	Single	Bachelor
P8	Nurse	Supervisor	Married	Master
P9	Nurse	Staff nurse	Single	Bachelor
P10	Nurse	Staff nurse	Single	Bachelor
P11	Nurse	Staff nurse	Married	Bachelor
P12	Nurse	Staff nurse	Married	Bachelor
P13	Nurse	Staff nurse	Married	Bachelor
P14	Nurse	Staff nurse	Single	Bachelor
P15	Family Caregivers	Housewife	Single	Diploma
P16	Family Caregivers	Housewife	Single	Diploma
P17	Family Caregivers	Employee	Married	Bachelor
P18	Family Caregivers	Self-employed	Married	Illiterate
P19	Family Caregivers	Self-employed	Single	Diploma
P20	Family Caregivers	Housewife	Married	Illiterate
P21	Patients	Employee	Married	Bachelor
P22	Patients	Housewife	Single	Diploma
P23	Patients	Self-employed	Married	Diploma
P24	Patients	Housewife	Married	Illiterate
P25	Patients	Self-employed	Single	Diploma

Creating an intimate atmosphere

One of the most important findings of the study, which was referred by all the participants, was creating an intimate atmosphere. From the participants' perspective, providing a high-quality care to patients while maintaining their dignity requires a cordial atmosphere for nurses, patients, and patients' families. By

kindly behaving patients and dedicating time to them, nurses can build emotional intimacy with patients and also impart a sense of comfort, trust, and respect to them. Moreover, from the participants' perspective, intimacy with patients is the key to be sympathizing with them, which allows patients to discuss their problems with their nurses easily. This theme is comprised of 3 categories as follows: empathy, effective communication, and dedicating time to patients.

Empathy

From the viewpoint of the caregivers, empathy is of great importance in burns departments due to the special nature of burn injuries and the conditions under which the patients are. Since burn patients' health and quality of life are usually affected by their injuries very seriously and they are hospitalized for longer periods, nurses have more time to be empathetic to the patients. Correspondingly, this type of relationship helps nurses understanding patients better and then supporting them more effectively. Every burn patient needs physical and psychosocial cares due to his/her specific needs. Regarding showing empathy for burn patients, one participant stated that:

"A burn patient needs a lot of empathy and emotional closeness; in fact, empathy is complementary to our treatment process. No matter how good the care we provide is, it is not going to work without empathy..."(P1)

From the nurses' point of view, burn patients are less likely to complain from pain when they realize that nurses empathize with them, so nurses can help the patients more effectively.

"When I imagine myself in his [a burn patient's] position, it helps me a lot in understanding his issues and concerns, and then I can help him more ..." (P6)

Effective communication

From the participants' point of view, good communication skills, including clearly speaking, using facial expressions, making eye contact, and attentively listening, play major roles in healing burn patients as well as reducing their suffering and increasing their satisfaction. According to the patients who participated in this study, the dignified care is possible through a proper and effective communication. It was indicated that only when nurses talk to patients and use body language, patients are encouraged to ask their questions and express their concerns and requests. From the participants' point of view, the dignified care is a function of nurses' use of verbal and nonverbal communications to identify the best strategy for each patient for the purpose of managing their pain and other issues as well as coping with their current situation. Most of the participants stated that the dignified care is influenced by caregivers' communication skills and intimacy.

The patients believed that caregivers' use of kind words during caring, addressing the patients by such terms as "dear," and appreciation of the patients' patience at the end of painful procedures are among the communication skills, which help preserving patient dignity during caring them.

"There was a nurse here who had always used kind words like "dear" and "sweetheart to address the patients whenever she wanted to talk to them ... Her kind words showed that she cared about the patients ..." (P21)

According to the participants included, nonverbal forms of communication are considered as an indispensable part of dignified care, which reflect the nurses' feelings and perceptions of patients. Listening well and making eye contact with patients are signs of giving value to patients and making an effort to understand their concerns. With respect to nonverbal communication skills, one patient stated:

"My nurse listened to me well ... she made eye contact with me every time she wanted to talk with me ... her behavior made me feel valuable ..." (P22)

The nurses believed that burn patients can express their concerns more freely when nurses establish an effective non-verbal communication with them.

"I hold my patients' hands, sit next to them, listen to them, and smile at them, all of which will raise their spirits and allow them to talk about their worries ..." (P8)

According to the conducted interviews, burn patients need care combined with kindness and compassion. This kind of care makes the patients feel valued and believe that their dignity is being maintained.

"I start a friendly relationship with my patients and try to make them feel emotionally close with me. This makes them to feel valuable..." (P2)

The participants stated that, due to burn patients' prolonged length of stay, they feel more comfortable with the caregivers who call them by their first names, laugh with them, and treat them just like a friend.

"I am very friendly to them and speak gently with them. I call them by their first names, and they consequently become happy and a friendly atmosphere is created as a result..." (P14)

Dedicating time to the patients

According to the interviews with the studied participants, burn patients feel more intimate and talk more freely when caregivers spend time with them. Accordingly, this also motivates patients to cooperate in their treatment process. On the other hand, nurses' failure to spend quality time with their patients creates feelings of worthlessness and indignity in them.

"Sometimes, I talk to my patients for a long time about their problems as well as my own experiences When the patients realize how much time I spend with them, they feel valued..." (P10)

Showing respect

From the caregivers' viewpoints, the traumatic experience of suffering a burn, painful hospital treatments, body dysfunctions, and expressions of pity from others cause burn patients feeling that they are not

treated with dignity. Therefore, nurses can preserve the dignity of burn patients during caring them by showing respect for their identity and autonomy and by involving the patients in their treatment plans. The theme of showing respect consists of the categories of respecting human equality, respecting autonomy, respecting beliefs and values, and avoidance of pity.

Respect for human equality

One of the major challenges of preserving the dignity of burn patients while providing care to them, is cultural differences. The population of Iran is comprised of different races and ethnic groups. The majority of the population in Iran are Fars, but caregivers are likely to meet burn patients from Baloch, Azeri, Turk, Kurd, Lur, or Arab minorities. Patients' cultural, ethnical, and social backgrounds can affect the sense of value of the patients as well as their families.

The participants of the present study stated that all patients are equal. Accordingly, caregivers must preserve the dignity of all patients, regardless of their gender, religion, race, ethnicity, economic status, and social class. One of the nurses stated that:

"Most of the patients in this hospital are from the poor classes of the society, but we give them all the services they need, regardless of their ethnicity or social class ..." (P9)

A family caregiver said:

"When a nurse fairly provides care to all burn patients, no matter what the cause of their injuries, self-immolation or an accident, this reflects the preservation of human dignity..." (P15)

Respect for patient autonomy

Another gesture that demonstrates respect for the dignity of burn patients is maintaining patient autonomy. From the participants' points of view, patients should be free to choose their doctors and to reject or accept any recommended medical procedure. It is also important that patients must be given the chance of making their informed decisions. By providing patients with the necessary information on the different types of treatments and their possible side effects, nurses can facilitate patients' informed interactive participation in the decisions making process around their care. The participants regarded showing respect for patients' freedom of choice and the right to participate in their care as a sign of respecting patients' autonomy and, by expansion, their dignity.

"It is the worst kind of disrespect to give no explanation to a burn patient. I involve my patients in their treatment plans, which encourages them to cooperate with me..." (P5)

In the present study, the nurses provided their patients with educational tools, informed them about their role in their own care process, and provided cooperative follow-up to help their patients performing their daily activities and regaining their kinesthetic abilities, which inspired patients with a sense of value. To maintain the dignity of burn patients, the participating caregivers tried to inform their patients on their

treatment and showed them pictures of some healed burn injuries to help them in making better decisions.

"Some patients resist skin graft. I usually use educational pamphlets to explain their situation to them and some photos of burn injuries, which have healed after skin graft ... I talk to them ... In fact, by informing the patients, I help them deciding on how they want to continue their treatment ... " (P1)

The patients' experiences showed that the members of treatment teams try to encourage patients to play an active role in making decisions related to their treatment process.

"My nurses explained the purpose of everything they performed for me, like replacement of the dressing of my wounds, my medication, and its side effects ... they informed me of the possible side effects of my surgery and by raising my awareness, they gave me freedom of choice ... all of which made me feel valued ..." (P23)

Respect for beliefs and values

According to the participants, burn patients more tend to become interested in mystical, spiritual, and religious practices after suffering from burn injuries. By providing prayer services, arranging meetings with a priest for them, and providing access to prayer books, caregivers can show respect for the patients' dignity. In this regard, one participant said:

"Many patients here believe in praying. To respect the dignity of these patients, we've provided them with a bookshelf full of prayer books and this had really helped their recovery process ..." (P5)

Avoidance of pity

The family caregivers were found to experience pitying looks and words directed at their patients, which had undermined the dignity of their patients as they believed.

The caregivers in the present study mentioned that, although burn injuries can cause serious changes in burn patients' physical functions and appearances, the patients should be treated as ordinary people and the treatment team should avoid pitying behaviors. However, the experiences of the interviewed family caregivers showed that they could detect pity in other people's behaviors and expressions of emotions, which made it harder for their patients to tolerate their special conditions. The patients had not only forced to tolerate the pain and physical problems caused by their injuries, but also had to bear the pitying attitude of the people around them. Correspondingly, this was regarded as disrespect for patients' dignity.

"Burns patients do not need pities, and yet some nurses pity them. For instance, they say stuffs like "Oh, poor thing!"... This can make the patient feel disrespected ..." (P5)

The family caregivers declared that they expected more professional and systematic behaviors from the treatment teams compared to others. They expected the members of treatment teams, who had received

education and training in this regard, to have good communication skills and to be able to express empathy with no expression of undue pity, which could add to patients' psychological concerns. The family caregivers' experiences underlined the importance of avoiding pitying behaviors to maintain patient dignity.

"Patients with burn injuries need to be treated with respect ... They [nurses] should not give the impression that our patients would never recover ... Being pitied by others is a sign of disrespect for these patients ..."
(P18)

Comprehensive support

The findings of the study indicated that comprehensive support is an important contributory factor in maintaining burn patients' dignity. It is notable that a comprehensive support consists of the following categories: pain relief, psychological support, and social support.

Pain relief

The majority of the interviewed nurses defined pain as the most important physical cause of complaint amongst burn patients. In this regard, it was shown that any slight movement or even the implementation of various treatment procedures can increase patients' pain. The participants stated that, since burn patients may suffer from multiple injuries and functional disabilities, relieving the intensity of their pain using different methods and regular evaluation of the efficacy of the measures taken into account for managing their pain, demonstrate respect for the dignity of the patients. According to a nurse:

"We have lots of patients with sustained severe injuries to their organs or those suffering from spinal cord injuries due to electrocution, and most of them are constantly complaining of pain. Having their wound dressings replaced is a really painful experience. We use partial anesthesia when we want to replace a patient's dressing. After performing the procedure, if the patient is still in pain, painkillers are administered for them. We may use non-pharmacological interventions, too ..." (P12)

Psychological support

From the perspective of this study participants, burn injuries could not only affect the patients' bodies, but also affect the psychological health of the patients and their families. Burn patients desperately need the support of the people around them, because the treatment procedures are relatively long, so they are implemented at several stages, which can be very painful, and the patients may suffer depression, isolation, anxiety, humiliation, and loss of dignity. One of the most important aspects of nursing burn patients is providing them with the emotional and psychological supports required to preserve their dignity and to facilitate their recovery.

"Once, we had a patient who was seriously ill and her husband did not allow her family to visit her. I did my best to convince her husband to change his mind The patient saw her family members, and afterward she just felt very valued and then recovered more quickly..." (P1)

Based on the patients' experiences, paying attention to the emotional and psychological needs of burn patients signifies respect for their dignity. According to a patient:

"I missed my son so much during my treatment process ... my nurse made arrangements with my family ... they brought my child to the entrance of the hospital ... my nurse put me in a wheelchair and took me to the entrance so I could see my child ..." (P24)

Based on the experiences of the caregivers of burn patients, it is important to consider the origin of the patients' mental distress and then make an effort to resolve it toward maintaining their dignity.

"Herein, we have patients who are scared of death. Family visits can help them a lot to cope with this fear. For these patients, we usually assign a round-the-clock companion..." (P4)

Other measures, which can help preserving burn patients' dignity are the followings: evaluating their mental and emotional well-being, providing them with counseling services, and ensuring collaboration among the members of the burn care team and the patients' families.

"Drug Addiction, family problems, and fear of alienation from the family and society are known as the leading psychological problems in burn patients. So, we should attempt to reduce the patients' psychological distress by raising their awareness, arranging counseling sessions for the patients and their families, removing the gaps between the patients and their family members, and facilitating cooperation between the treatment team and the patients' families ..." (P11)

Another nurse stated:

"After discharging a patient, we introduce him or her to a counseling center where they and their families can receive counseling services ..." (P13)

Social support

According to the participants' experiences, burn patients encounter various social issues like social stigma, which can cause them to quit their studies or jobs, and divorce. These problems pose a threat to the social dignity of burn patients. In this regard, the theme of social support consists of two categories named as avoidance of stigma and financial support from family and charity.

Avoidance of stigma

This sub-theme concerns people's wrong beliefs, criticism, and being ostracized. The participants' experiences showed that most families believe that their patients with burn injuries had lost many of their former capabilities. Moreover, some individuals had misunderstandings on the causes of burn victims' injuries who considered self-immolation or punishment by the patients' parents as the cause, which resulted in their spreading false rumors about the patients' source of injuries. According to one of the family caregivers:

“Many of our relatives thought that my sister had lost her fertility and could never have a baby ...” (P20)

The patients have mentioned that they were criticized by their families and friends and also blamed for what had happened to them. In some cases, the patients’ families, especially spouses, were criticized for their manner in dealing with the patients. Some of the victims stated that they were treated as outcasts by their families and other people and consequently received less attention than they did before.

According to one of the patients:

“On the subway, for example, the seat next to me is vacant and still no one takes it. It is as if they are avoiding me or do not want to sit next to me ...” (P25)

Financial support from family and charity

Based on the participants’ experiences, the treatment of burn patients is often a lengthy process accompanied with anxiety and pain, which causes financial distress in addition to health complications and physical problems. The treatment of and follow-up care for burn injuries is very costly and patients often have to ask their families or relatives for financial help. Thereafter, when such requests are met, patients feel valued and dignified.

“Financially speaking, my family has helped me a great deal. Right now, they have already paid for my surgery and medication ... they say they would do anything to see me completely recovered Well, it makes me feel valued to know that I am important to my family ...” (P22)

According to the participants enrolled in this study, another issue that is a threat to the dignity of burn patients is the social problem, which rises after the event. Divorce, disintegration of the family, and stigmatization, which often cause patients to quit their studies or resign from their jobs, also are among the social harms that adversely affect the social dignity of burn patients. One of the participating nurses pointed out:

“I know many patients who decided to quit their jobs due to the inappropriate behavior of the people around them ...” (P12)

From the viewpoints of the caregivers interviewed in the present study, the financial support provided by insurance companies, charity institutes, and social welfare organizations is quite limited, so burn patients view their nurses and family caregivers as their main sources of support. Therefore, nurses and social workers seek to preserve the patients’ social dignity by helping them learning job skills and find new jobs and by referring them to charity centers to help them paying their treatments’ costs.

“We had a patient here whose spouse separated from her because of her facial burn marks and then she had no source of income and came to us. Herein, the personnel try to help these people in any way they can such as introducing them to charities, finding jobs for them, and buying their medications” (P10)

Discussion

The results of the present study show that nurses', family caregivers, and burn patients' perceptions of burn patients' dignity fall into three main themes as follows: creating an intimate atmosphere, showing respect, and providing comprehensive support. According to the results obtained from the interviews, empathizing with burn patients in a convivial relationship and dedicating time to them could create an intimate atmosphere. In such a context, nurses can preserve the dignity of the patients by showing respect to the patients' intrinsic values and autonomy and also by attempting to meet their emotional, psychological, and social needs.

In the present study, the theme of creating an intimate atmosphere is comprised of the following categories: empathy, effective communication, and dedicating time to patients. Nurses mostly attempt to form a deep human and spiritual connection with their patients, so that they can imagine themselves in their situation to preserve their dignity. Martins et al. (2014) in their study have performed a continuous assessment of nurses' emotions when facing the patients' pain and distress. Accordingly, they have reported that nurses often identify with the pain and distress of patients and their family members [33]. In a study by Badger and Royse (2012), nurses were found to attempt to empathize with patients and their family members by attentively listening to them and trying to understand their experiences and concerns [34]. The results of another study demonstrated that, if patients find caregivers unapproachable and unfriendly, they feel insecure and consider their behaviors as disrespectful [19]. Gallagher et al. (2008) reported that failure to dedicate adequate time to talk to patients, lack of eye contact, and negligence make patients feel worthless and humiliated as well [35].

According to Watson, a human is a being who deserves to be cared for, respected, nourished, understood, and helped. Moreover, Watson believes that an ethical interpersonal relationship in a clinical environment indicates respect for human dignity [36].

The results of a study of Henderson et al. (2009) in Australia showed that most nurses do not invest enough time to have conversation with their patients, or when they are conversing with them, they are engaged in doing their other tasks or looking at the equipment and not making proper eye contact with the patients. As a result, in this situation, patients feel worthless and neglected. Also, nurses speak in loud voices, which is a sign of disregard for patients' dignity [37]. Likewise, Ebrahimi et al. (2012) reported that nurses' poor verbal and nonverbal communication skills weaken the emotional connection between nurses and patients, which consequently creates feelings of humiliation and neglect in these patients [8]. Failure to establish an effective relationship with patients gives patients the impression that their caregivers do not value them and have no respect for their dignity [38]. Thus, one of the major factors in maintaining patient dignity is the quality of the relationship of the medical staff, including nurses, with them [39]. Patients' care and treatment do not occur in a vacuum and are immediately affected by the environment; interactions; and social, political, and financial factors [8].

Based on the experiences of the studied participants, respect plays a significant role in maintaining the dignity of burn patients. The theme of showing respect consists of the following categories: respecting human equality, respecting autonomy, respecting beliefs and values, and avoidance of pity. From the

participants' points of view, in order to preserve the dignity of burn patients, the patients must be provided with fair and unbiased care in combination with respect for their beliefs and their autonomy.

Similarly, several studies have emphasized the necessity of showing respect for the intrinsic value of humanity and the fact that dignity should not be a function of such factors as age, wealth, education, and severity of a patient's illness [40-41]. According to Baillie (2009), all human beings have equal rights to dignity, which should be acquired and cannot be taken away [42]. Matiti and Trorey (2008) in their study mentioned that patients expect nurses to maintain their dignity, regardless of their social classes or health conditions [38]. The results of a study by Bagherian et al. (2019) in Iran showed that cancer patients' demand is that their values should be respected. Patients' experiences demonstrated that maintaining patient autonomy and equality in care are essential to respect patients' ethical values and to preserve their dignity [25].

The participants of the present study have also stated that, due to their prolonged treatment processes and various complications associated with their injuries, burn patients and their family members feel more valued if they can participate in the decision-making processes and treatment plans organized for them. Pepastaro et al. (2016) reported that patients' dignity is maintained when patients are involved in the medical decisions making related to them [43]. Likewise, Baillie and Matiti (2013) concluded that observance of patient autonomy is a fundamental principle of patient-centered care, resulting in the preservation of patients' dignity [44]. In most Asian cultures, collectivism lies at the core of the common social belief system, and in a collectivist culture, an individual's world view is mostly affected by the society, so individuals perceive themselves as entities attached to the society. However, in general, in North American and Western cultures, individualism prevails. In an individualistic culture, independence is preserved through every individual's discovery and expression of his/her unique characteristics, while a collectivist culture more emphasizes on the presence of every one, complying, and having a coordinated relationship with other [45-46]. Furthermore, in collectivist societies, including Iran, families should be involved in the decision-making processes of their patients. Though patients are at the center of the consultation meetings about their treatment plans, their families should also be allowed to participate in the making of decisions, according to the patients' preferences.

Based on the experience of the studied participants, attention to and respect for the beliefs and wishes of burn patients in Iran stand for respecting the dignity of these patients. Similarly, in other studies, showing respect to the patients' values is considered as an essential task to preserve their dignity. In some studies, respecting the patients' values and beliefs has been reported as a component of professional patient-centered care [25, 47]. According to one study, paying attention to patients' beliefs and thoughts is closely connected with patient dignity [48]. Notably, the concept of human dignity is dependent on cultural context. In all areas of healthcare, caregivers should respect the patients' values, be aware of their cultural orientations, and learn about their cultural perspectives on health and sickness [49]. Cultural and religious values influence individuals' beliefs on human dignity; therefore, they have an impact on patients' understanding of dignity in healthcare [48]. The participants' stressing the importance of showing respect to the patients' values can be attributed to the religious beliefs of the patients and their

families, because all of whom were Shia Muslims. In this regard, Islam dictates that all humans deserve to be respected. In other words, the tradition of respecting others in Iran may be rooted in the collectivism and cultural values of the Iranian people.

According to the experiences of the caregivers, the dignity of burn patients may be undermined by expressions of undue pity stated by the members of treatment teams or other people nearby. The results of the conducted interviews showed that, sometimes, the members of treatment teams or burn patients' companions unintentionally lead to more pain and suffering to the patients, rather than soothing them, by pitying behaviors. Similarly, Bagherian et al. (2019) in their studies have reported that the dignity of patients is preserved when they are not pitied [25]. So, it seems that some caregivers are not familiar with communication skills, which convey empathy and only show that they are sorry for patients with suggesting no practical solutions. Therefore, this behavior is interpreted as expressions of pity by patients and their companions.

Comprehensive support, as another theme of burn patients' dignity, is comprised of the categories of pain relief, psychological support, and social support. The caregivers interviewed in the present study have emphasized the importance of comprehensive support in preserving the burn patients' dignity in Iran. From the participants' points of view, the destructive and traumatic effects of burn injuries affect all aspects of the patients' existence. Notably, most of the caregivers reported pain as the most serious physical problem experienced by burn patients. Similarly, the results of another study showed that all burn patients suffer from daily pains [50] and these experiences remain in their memories forever [51]. In this situation, alleviating the patients' pain and meeting their other needs are the main responsibilities of nurses, which are considered as the signs of respect for patients' rights. Burn patients often need nurses to support them by applying some proper pain management techniques [52]. Pain management is an ethical responsibility of caregivers, which is known as an essential element in nurses' professional codes of ethics [53]. In a study, burn survivors are found to view pain and anxiety managements as crucial, especially at the first replacement of their dressings [54]. However, the experiences of most burn patients indicate poor pain management of caregivers [55].

According to the results of the interviews with the caregivers, burn injuries could not only affect the patients' bodies, but also affect their mental health, family members, family relationships, and social activities (e.g. participation in social activities, employment, and education). In some cases, divorce and other catastrophic life changes happened due to burn patients' hospitalization because of their injuries. According to the experiences of the caregivers, the devastating nature of burn injuries and the ensuing complications damage the ego of burn victims. The results of a study conducted in Iran showed that burn survivors experience threats to all dimensions of their "self" in the form of disturbances in their feelings, cognition, sense of identity, and behaviors. Correspondingly, all these emotional-cognitive disturbances cause burn survivors experiencing "self-disruption." In addition, most of the participants in that study have reported that they were able to overcome their hopelessness through their belief in God and receiving support from the people around them [56]. Several studies conducted in different countries also

suggested that family support can facilitate burn patients' adaptation, improve their quality of life, promote their mental rehabilitation, and help them coping their depression [4,57].

In a study by Li et al. (2020), dignity therapy was found to alleviate the psychological distress of end-stage cancer patients and satisfy their spiritual needs [58]. It was indicated that, the dignity of the hospitalized patients can be threatened by some certain factors, including patients' inability to play important parts in life, lack of support from friends and the medical personnel, and uncertainty about the future [11]. In a study by Bagheri et al. (2018), disregarding patient participation and failure to support patients were reported to cause patients' loss of dignity [59]. Sideli et al. (2010) reported that people who get less social support are more likely to endure higher levels of stress and pain [27]. By studying the stigma of having burn injuries from the perspectives of burn victims' families at the time of hospital discharge, Rossi et al. (2005) concluded that burn patients' families are worried and ashamed about the society's attitude to their injured family member [60]. However, not much research is currently available on the role of families and their support in the preservation of patients' dignity [49].

In the Iranian culture, the family is the main source of emotional support for patients; therefore, the presence of family members and relatives at the side of their patients is known as a part of patients' regular care and their families' social and religious values. In this culture, a holistic healthcare system dictates that in the hospital environment, professional caregivers should tend to the needs of patients as well as their families [61]. Holistic care acknowledges human dignity; regards patients as one with their environment; and considers the body, mind, and soul of patients. Furthermore, recognizing the role of patients in the treatment process, allowing patients to participate in their care, and encouraging patients to practice self-care are some of the other aspects of holistic care, which consequently result in the preservation of patients' dignity and autonomy [62].

In conclusion, the findings of the present study showed that the dignity of burn patients is a multi-faceted phenomenon, which mostly depends on the cultural context of patients and can be preserved in an intimate atmosphere where patients are respected and given a comprehensive support. In addition, it appears that an intimate atmosphere can lay the foundation for providing a comprehensive support, and showing respect can also guarantee the continuation of the intimate atmosphere and the comprehensive support.

One of the limitations of the present study was that a limited number of family caregivers and burn patients were interviewed for at the data collection stage. Also, the viewpoints of other members of treatment teams were not taken into account and the data were exclusively collected through individual interviews in the context of an educational burn hospital in southeast of Iran. Therefore, the researchers suggest that, to collect richer data, future studies should use larger samples of family caregivers and burn patients selected from various environments and then include the experiences of other members of treatment teams including doctors, physiotherapists, psychologists, and social workers.

Another limitation concerns the data collection method. Accordingly, herein, the data were collected through conducting semi-structured, individual interviews, while other methods of data collection may

provide richer information on the dignity of burn patients. Therefore, it is suggested that future studies employ other methods of data collection as well, including observation and focus group interviews.

Conclusion

Showing respect to the patients' rights and dignity has been emphasized as one of the ethical responsibilities of professional caregivers. The dignity of burn patients is potentially at risk due to numerous physical, psychological, and social factors. In this regard, the results of the present study confirm that preserving the dignity of burn patients produces positive outcomes. In order to preserve the dignity of burn patients, the patients should be respected and then provided with comprehensive care in an intimate atmosphere. The results of this study can also help healthcare managers and policy-makers to create a supportive environment in which the burn patients' dignity is effectively preserved. Notably, in the present study, an empathetic relationship, dedicating time to listening to patients' words, showing respect for patients' beliefs and values, providing care free of discrimination, and giving comprehensive support were found to be effective on maintaining the dignity of burn patients.

Abbreviations

Ph.D: Doctor of Philosophy; ICU: Intensive Care Unit

Declarations

Ethics approval and consent to participate

The present study has been approved by the Research Ethics Committee of Shiraz University of Medical Sciences, Shiraz, Iran (Code: IR.SUMS.REC. 1396.S197). Before being interviewed, the participants were informed about the objectives of the study, the confidentiality of their information, why the interviews had to be recorded, and the researcher's role. The nurses were assured that none of the information recorded during the interviews would be disclosed to their employers. Written and oral informed consent was obtained from all the participants. The participants were also informed that they were free to withdraw at any stage of the study. The time and location of the interviews were selected at the participants' convenience.

Consent for publication

Not applicable.

Availability of data and material

The interview data will not be shared since the participants have been guaranteed full anonymity.

Competing interests

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Authors' contributions

BT made a substantial contribution to the acquisition of data, analysis, and interpretation of the data. MR and CT made a substantial contribution to the examination of the concept and design, data analysis, interpretation of the data, and revising the article critically before announcing it to be fit for publication. MF has made a substantial contribution to the study design and revising the article critically. MG has reviewed the article critically. All the authors have read and approved the final version of the manuscript.

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References

1. Shirkhoda M, Kaviani Far K, Narouie B, et al. Epidemiology and evaluation of 1073 burn patients in the southeast of Iran. *SEMJ* 2011; 12: 11-21, <http://emedicalj.com/en/articles/78475.html>
2. Zamanzadeh V, Valizadeh L, Lotfi M, et al. Preserving self-concept in the burn survivors: a qualitative study. *Indian J. Palliat. Care* 2015; 21: 182. doi: 10.4103/0973-1075.156492.
3. Outwater AH, Ismail H, Mgalilwa L, et al. Burns in Tanzania: morbidity and mortality, causes and risk factors: a review. *Int J Burns Trauma* 2013; 3: 18. PMID: 23386982, PMCID: PMC3560491
4. Moi AL, Vindenes HA and Gjengedal E. The experience of life after burn injury: a new bodily awareness. *J Adv Nurs* 2008; 64: 278-86. doi: 10.1111/j.1365-2648.2008.04807. x.
5. Smeltzer SC, Bare BG, Hinkle JL, et al. *Brunner& Suddarth's Textbook of Medical-Surgical Nursing*. 12th ed. Philadelphia: Lippincott, Williams and Wilkins, 2010: 1719.
6. Watson Jean. *Human caring science: a theory of nursing*, 2nd ed. 2011; Jones & Bartlett Learning co.
7. Simões Â, Sapeta P. The concept of dignity in nursing care: a theoretical analysis of the ethics of care. *Revista Bioética*. 2019 Jun;27(2):244-52. <https://doi.org/10.1590/1983-80422019272306>
8. Ebrahimi H, Torabizadeh C, Mohammadi E, et al. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. *J Med Ethics* 2012; 38: 723-8. doi: 10.1136/medethics-2011-100396

9. Cheraghi MA, Manookian A, Nasrabadi AN. Human dignity in religion-embedded cross-cultural nursing. *Nurs Ethics*. 2014 ;21(8):916-28. doi: 10.1177/0969733014521095
10. Manookian A, Cheraghi MA and Nasrabadi AN. Factors influencing patients' dignity: a qualitative study. *Nurs Ethics* 2014; 21: 323-34. doi: 10.1177/0969733013498526.
11. Kadivar M, Mardani-Hamooleh M and Kouhnavard M. Concept analysis of human dignity in patient care: Rodgers' evolutionary approach. *J Med Ethics Hist Med* 2018; 11. PMID: 30258554, PMCID: PMC6150922
12. Parandeh A, Khaghanizade M, Mohammadi E, et al. Nurses' human dignity in education and practice: An integrated literature review. *IJNMR* 2016; 21: 1. doi: 10.4103/1735-9066.174750
13. Mohammadi F, Rakhshan M, Molazem Z, et al. Caregivers' perception of dignity in teenagers with autism spectrum disorder. *Nurs Ethics* 2019; 26: 2035-46. doi: 10.1177/0969733018796679.
14. Berglund B, Anne-Cathrine M and Randers I. Dignity not fully upheld when seeking health care: Experiences expressed by individuals suffering from Ehlers–Danlos syndrome. *Disabil Rehabil* 2010; 32: 1-7. doi: 10.3109/09638280903178407
15. Hall S, Goddard C, Speck PW, et al. "It makes you feel that somebody is out there caring": a qualitative study of intervention and control participants' perceptions of the benefits of taking part in an evaluation of dignity therapy for people with advanced cancer. *J Pain Symptom Manage* 2013; 45: 712-25. doi: 10.1016/j.jpainsymman.2012.03.009.
16. Bagheri H, Yaghmaei F, Ashktorab T, et al. Patient dignity and its related factors in heart failure patients. *Nurs Ethics* 2012; 19: 316-27. <https://doi.org/10.1177/0969733011425970>
17. Borhani F, Abbaszadeh A and Rabori RM. Facilitators and threats to the patient dignity in hospitalized patients with heart diseases: a qualitative study. *IJCBNM* 2016; 4: 36. PMID: 26793729, PMCID: PMC4709810
18. Fernández-Sola C, Cortés MMD, Hernández-Padilla JM, Torres CJA, Terrón JMM and Granero-Molina J. Defining dignity in end-of-life care in the emergency department. *Nurs Ethics* 2017; 24: 20-32. doi: 10.1177/0969733015604685
19. Hosseini A, Rezaei M, Bahrami M, et al. The relationship between dignity status and quality of life in Iranian terminally ill patients with cancer. *IJNMR* 2017; 22: 178. doi: 10.4103/1735-9066.208157
20. Šaňáková Š and Čáp J. Dignity from the nurses' and older patients' perspective: a qualitative literature review. *Nurs Ethics* 2019; 26: 1292-309. doi: 10.1177/0969733017747960
21. Webster C and Bryan K. Older people's views of dignity and how it can be promoted in a hospital environment. *J Clin Nurs* 2009; 18: 1784-92. doi: 10.1111/j.1365-2702.2008.02674.x
22. Jamalimoghadam N, Yektatalab S, Momennasab M, et al. Hospitalized adolescents' perception of dignity: a qualitative study. *Nurs Ethics* 2019; 26: 728-37. doi: 10.1177/0969733017720828
23. Kostopoulou S, Parpa E, Tsilika E, et al. Advanced cancer patients' perceptions of dignity: the impact of psychologically distressing symptoms and preparatory grief. *J Palliat Care* 2018; 33: 88-94. doi: 10.1177/0825859718759882

24. Avestan Z, Pakpour V, Rahmani A, et al. The correlation between respecting the dignity of cancer patients and the quality of nurse-patient communication. *Indian J Palliat Care* 2019; 25: 190. doi: 10.4103/IJPC.IJPC_46_18.
25. Bagherian S, Sharif F, Zarshenas L, et al. Cancer patients' perspectives on dignity in care. *Nurs Ethics* 2019. doi: 10.1177/0969733019845126
26. Gerrek M, Behmer Hansen R and Khandelwal A. 440 Ethics in Burn Care: A Review. *J Burn Care Res* 2018; 39, Suppl (1): S192–S193. <https://doi.org/10.1093/jbcr/iry006.362>
27. Sideli L, Prestifilippo A, Di Benedetto B, et al. Quality of life, body image, and psychiatric complications in patients with a burn trauma: preliminary study of the Italian version of the Burn Specific Health Scale-Brief. *Ann Burns Fire Disasters* 2010; 23 (4): 171-176. PMID: 21991220, PMCID: PMC3188270
28. Baillie L, Gallagher A and Wainwright P. *Defending dignity-challenges and opportunities for nursing*. London: The Royal College of Nursing, 20 Cavendish Square, W1G 0RN. 2008: Page: 20. https://www.dignityincare.org.uk/_assets/RCN_Dignity_at_the_heart_of_everything_we_do.pdf
29. Elo S and Kyngäs H. The qualitative content analysis process. *J Adv Nurs* 2008; 62: 107-15. doi: 10.1111/j.1365-2648.2007.04569.x.
30. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qualitative health research*. 2005;15(9):1277-88. doi: 10.1177/1049732305276687
31. Graneheim UH and Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004; 24: 105-12. doi: 10.1016/j.nedt.2003.10.001
32. Lincoln YS and Guba EG. *Naturalist inquiry*. Newbury Park, CA: Sage, 1985, p. 289.
33. Martins JT, Bobroff MCC, Ribeiro RP, et al. Feelings experienced by the nursing team at a burns treatment center. *Escola Anna Nery* 2014; 18: 522-6. <http://dx.doi.org/10.5935/1414-8145.20140074>
34. Badger K and Royse D. Describing compassionate care: The burn survivor's perspective. *J Burn Care Res* 2012; 33: 772-80. doi:10.1097/BCR.0b013e318254d30b
35. Gallagher A, Li S, Wainwright P, et al. Dignity in the care of older people—a review of the theoretical and empirical literature. *BMC Nurs* 2008; 7: 11. doi: 10.1186/1472-6955-7-11
36. Khademi M, Mohammadi E, Vanaki Z. Appraisal of the applicability of humanism based nursing theories. *ijme*. 2012; 5 (3):33-46. <http://ijme.tums.ac.ir/article-1-116-en.html>
37. Henderson A, Van Eps MA, Pearson K, James C, Henderson P, Osborne Y. Maintenance of patients' dignity during hospitalization: Comparison of staff–patient observations and patient feedback through interviews. *Int J Nurs Pract*. 2009;15(4):227-30. <https://doi.org/10.1111/j.1440-172X.2009.01764.x>
38. Matiti MR and Trorey GM. Patients' expectations of the maintenance of their dignity. *J Clin Nurs* 2008; 17: 2709-17. doi: 10.1111/j.1365-2702.2008.02365.x

39. Avestan Z, Pakpour V, Rahmani A, Mohammadian R, Soheili A. The correlation between respecting the dignity of cancer patients and the quality of nurse-patient communication. *Indian J. Palliat. Care.* 2019;25(2):190. <http://www.jpalliativecare.com/text.asp?2019/25/2/190/256291>
40. Lin YP, Tsai YF and Chen. Dignity in care in the hospital setting from patients' perspectives in Taiwan: a descriptive qualitative study. *J Clin Nurs* 2011; 20: 794-801. doi: 10.1111/j.1365-2702.2010.03499.x
41. Shahriari M, Mohammadi E, Abbaszadeh A, et al. Perceived ethical values by Iranian nurses. *Nurs Ethics* 2012; 19: 30-44. doi: 10.1177/0969733011408169
42. Baillie L. Patient dignity in an acute hospital setting: a case study. *Int J Nurs Stud* 2009; 46: 23-37. doi: 10.1016/j.ijnurstu.2008.08.003
43. Papastavrou E, Efstathiou G and Andreou C. Nursing students' perceptions of patient dignity. *Nurs Ethics* 2016; 23: 92-103. doi: 10.1177/0969733014557136
44. Baillie L and Matiti M. Dignity, equality and diversity: an exploration of how discriminatory behaviour of healthcare workers affects patient dignity. *Divers Equal Health Care* 2013; 10. <http://www.scopus.com/inward/record.url?>
45. Ong-Flaherty C. Critical cultural awareness and diversity in nursing: a minority perspective. *Nurse Leader.* 2015 Oct 1;13(5):58-62. <http://dx.doi.org/10.1016/j.mnl.2015.03.012>.
46. Dai Q. Cross-Cultural Comparison of Self-Esteem among Mainland Chinese, Hong Kong Chinese, British-Born Chinese and White Scottish Children 2016; *Social Science Asia*, 2016 2(1): 1-12, doi: 10.14456/ssa.2016.3
47. Mohammadi F, Tabatabaei Hs, Mozafari F, et al. Caregivers' perception of women's dignity in the delivery room: A qualitative study. *Nurs Ethics* 2019: 0969733019834975. doi: 10.1177/0969733019834975
48. Cheraghi MA, Manookian A and Nasrabadi AN. Human dignity in religion-embedded cross-cultural nursing. *Nurs Ethics* 2014; 21: 916-28. <https://doi.org/10.1177/0969733014521095>
49. Hosseini FA, Momennasab M, Yektatalab S, et al. Patients' perception of dignity in Iranian general hospital settings. *Nurs Ethics* 2019; 26: 1777-90. doi: 10.1177/0969733018772078
50. Bayuo J, Agbenorku P and Amankwa R. Study on acute burn injury survivors and the associated issues *J Acute Dis* 2016; 5: 206-9. DOI: 10.1016/j.joad.2016.03.006
51. Shepherd L and Begum R. Helping burn patients to look at their injuries: How confident are burn care staff and how often do they help? *Burns* 2014; 40: 1602-8. doi: 10.1016/j.burns.2014.02.017
52. Birdsall C and Weinberg K. Adult patients looking at their burn injuries for the first time. *J Burn Care Rehabil* 2001; 22: 360-4. doi: 10.1097/00004630-200109000-00015
53. Nogario ACD, Barlem ELD, Tomaschewski-Barlem JG, et al. Nursing Actions in practicing inpatient advocacy in a Burn Unit. *Rev Esc Enferm USP* 2015; 49: 0580-8. doi: 10.1590/S0080-623420150000400007

54. Yuxiang L, Lingjun Z, Lu T, et al. Burn patients' experience of pain management: a qualitative study. *Burns* 2012; 38: 180-6. doi: 10.1016/j.burns.2011.09.006
55. Blakeney PE, Rosenberg L, Rosenberg M, et al. Psychosocial care of persons with severe burns. *Burns* 2008; 34: 433-40. doi: 10.1016/j.burns.2007.08.008
56. Zamanzadeh V, Valizadeh L, Lotfi M, et al. Self-disruption: Experiences of burn survivors. *J Qual Res Health Sci* 2014; 3: 269-80. file:///C:/Users/BlueSky/Downloads/Documents/jqr.ir-v3n3p269-en.pdf
57. Rossi LA, Costa MCS, Dantas RS, et al. Cultural meaning of quality of life: perspectives of Brazilian burn patients *Disabil Rehabil* 2009; 31: 712-9. doi: 10.1080/09638280802306257.
58. Li YC, Feng YH, Chiang HY, Ma SC, Wang HH. The Effectiveness of Dignity Therapy as Applied to End-of-Life Cancer Patients in Taiwan: A Quasi-Experimental Study. *Asian Nurs Res*. 2020. doi: 10.1016/j.anr.2020.04.003.
59. Bagheri H, Yaghmaei F, Ashktorab T, Zayeri F. Test of a Dignity Model in patients with heart failure. *Nurs Ethics*. 2018 Jun;25(4):532-46. doi: 10.1177/0969733016658793
60. Rossi LA, da SC Vila V, Zago MM, Ferreira E. The stigma of burns: perceptions of burned patients' relatives when facing discharge from hospital. *Burns*. 2005; 1;31(1):37-44. doi: 10.1016/j.burns.2004.07.006
61. Tabandeh S, Dehghan Nayeri N, Abbaszadeh A. Iranian Families' Experience of Receiving Support During Their Patients' Surgical Process: Qualitative Study. *J NURS RES* 2014; 22 (4): 268-27. 49 doi: 10.1097/jnr.0000000000000055
62. Zamanzadeh V, Jasemi M, Valizadeh L, Keogh B, Taleghani F. Effective factors in providing holistic care: a qualitative study. *Indian J. Palliat. Care*. 2015;21(2):214.

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