Original Article

Discriminative nursing care: A grounded theory study

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Abstract

Background: Discriminative nursing care is one of the most important challenges in the field of ethical care and the rights of patients. Experiencing discrimination has negative impacts. **Objective:** The aim of this study was to explore the process of the development of the discriminative nursing care. **Methods:** Sampling was begun purposefully and gradually continued, according to the obtained codes and categories, using theoretical sampling until data saturation. Data collection methods included semi-structured interviews, observations, and field notes. In this study, 13 clinical nurses and 5 patients in Iran were selected from public hospitals. The inclusion criteria were willingness to participate, having adequate experience about the considered phenomenon, and being able to discuss the subject. Data analysis was performed simultaneously to data collection using the method of Corbin and Strauss 2008. **Results:** Five categories were extracted. The categories include: "context," "causal conditions," "phenomena," "strategies," and "outcomes." Each of these categories contained subcategories with specific characteristics. The context was classified into "nurse's characteristics" and "patient's characteristics. ""Complete conflict" and "hatred" were extracted from the category of causal conditions. The causal conditions and context led to "discriminative nursing care" phenomena. The two strategies were "avoiding the patients" and "robotic care." Outcomes were located in a spectrum ranging from "annoyance and discomfort" to "imposition of costs." Finally, the categories were connected together and the meaning of "care in the context of the sense of interaction with the patient" was theorized. **Conclusions:** It is important to provide nursing education on the development of discriminative nursing care and its associated complications. Nurses should understand the nature, components, and the process of discriminative care. Understanding discrimination improves the action of nurses.

Keywords: Discrimination, grounded theory, nursing care, qualitative study

Introduction

Discrimination is defined as treating a person or a particular group differently, or worse than others.[1] Nurses do not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social or marital status, gender, gender identity, gender expression, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability, socioeconomic status, or any other attribute,[2] but discriminative care of patients because of their membership in a particular demographic group (e.g.,: race, sex, class) or demographic status is not uncommon.[3]

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Experience of discrimination by patients will mainly lead to resistance, conflict, shock, damage, anxiety, depression, and disappointment. In this case patients strongly feel that they are betrayed. In fact, discrimination itself is considered as a stressor and harmful factor for health and well-being.[4] Understanding how discriminative nursing care occurred in healthcare settings is particularly important for several reasons. First, the healthcare system has a moral and legal obligation to provide equal care to all patients, regardless of their demographic status or other characteristics. Second, discrimination in healthcare settings may cultivate patient disengagement from the healthcare system, thereby negatively affecting future healthcare encounters and patient health.[5] Finally, discriminative nursing care directly lead to unqualified care. For these reasons, it is important to determine the way discriminative nursing care is formed. This

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study was conducted to explore the process of the realization of discriminative nursing care.

Methods

This qualitative study is based on Corbin and Strauss' approach to grounded theory.[6] To select the participants, the researcher contacted supervisors and head nurses to help reviewer find the best participants. Convenience sampling was therefore used. At the end of each interview, the researcher asked interviewees to introduce potentially eligible people they knew. As a result, purposive sampling replaced convenience sampling. With the progress of the research, the collection of the data, and some help from theoretical notes, the data itself began leading the researchers toward the proper choice of participants; therefore, theoretical sampling replaced purposive sampling.[7] Sampling continued until data saturation was reached.[6] In this study, 13 clinical nurses and 5 patients in Iran were selected from public hospitals. Data were collected through in-depth, semi-structured and face to face interviews with open-ended questions, observations, and field notes.[8] The main part of the interviews with nurses and patients was started with a general question and was continued based on the participants' answers. In the course of the interviews, complementary probing questions were added when needed and the researcher tried to encourage participants to delve deeper into the subject by asking questions and at times even by repeating parts of their statements or a timely pause between their answers. The interviews were recorded using an audio recorder and immediately transcribed after each session. The average interview time was 45 minutes. After a number of interviews and their coding, the researcher visited the clinical settings in person for an informal observation of the nurses' performance in patient care while looking for signs of the issues raised by the nurses in their interviews on discriminative care. The researcher closely observed the performance of nurses as healthcare providers in order to determine whether or not they were providing discriminative care to their patients. Since interviews and observations were conducted in participants' workplace, field notes were also taken in support of interviews and observations. In the present study four supporting processes of trustworthiness were applied, namely credibility, dependability, conformability, and transferability.[9] Approval for the study was obtained from the ethics committee of the Iran University of Medical Sciences (no. IR.IUMS.1395.9223493202, 28 September 2016). Written informed consent was also obtained from all participants. This study was conducted by three female researchers, but only the interviewer had contact with the participants; therefore, only the interviewer (corresponding author) knew of the real identity of the participants throughout the study.

Results

Data were presented using the framework proposed by Corbin and Strauss for the development of categories and subcategories. The categories include: causal conditions, context, strategies, phenomena, and outcomes. Finally, the categories were connected together and the meaning of "care in the context of the sense of interaction with the patient" was theorized.

Causal conditions

Two subcategories were extracted from the category of causal conditions (contributing to the discriminative nursing care), with them providing an explanation about how the phenomenon of discrimination in nursing care was experienced by the participants. Causal factors for this consisted of "complete conflict" and "hatred."

- Complete conflict: Based on the participants' experiences, the nurse assesses the patient's characteristics (including moral, behavioral, facial, economic, social, cultural, belief, educational, and disease type). If, all of the patient's characteristics are considered as negative based on this assessment, the nurse will feel a complete conflict between him/herself and the patient. In other words, the nurse will not feel close to the patient whose characteristics are considered to be negative based on his/her point of view. One of the participants (nurse no. 9) stated that: "when the patient entered the emergency department, based on the history I took, I realized that he had just been released from the prison and had ethical and behavioral problems. I do not like patients with ethical and behavioral problems and I do not like to take care of them either. I cannot get close to them because I'm not like them."
- Hatred: Participants believed that when the patient's characteristics were considered negative from the nurse's point of view, the nurse will have feeling of hatred toward the patient. While describing his feelings, one participant (nurse no. 8) said that: "the patient had taken fifty pills as a suicidal attempt, but failed to commit suicide. I hate this patient because he has committed suicide and does not believe in God. I am a believer in God, so I hated this patient and did not take care of him."

Context

The context in which discriminative nursing care emerged was classified into the following two categories: "nurse's characteristics" and "patient's characteristics."

- Nurse's characteristics: According to participants' statements, weak conscience, weak religious beliefs, inhuman beliefs, belief in futile care, and negative nurses' professional characteristics could be grounds for discriminative nursing care. One of the participating nurses (nurse no. 11) said that: "caring for a patient with schizophrenia is a futile care because the disease is not curable. Nurses who care for a patient with schizophrenia waste their energy and time. I will never do this."
- Patient's characteristics: It could be deduced from the interview texts that the patient's characteristics are the grounds for discriminative nursing care. So, if characteristics are different from nurses' values and beliefs, discriminative nursing care will be practiced. In other words, when

the nurse adopts negative attitudes toward the patient's characteristics, there is a risk for discriminative care. One of the participants (nurse no. 4) stated that: "I took care of the patient properly on the first day of admission in the ward. However, when I realized that he was bad-tempered and bad-mouth, I did not take good care of him. His temper and behavior led me to avoid him and not to take care of him in a timely manner."

Strategies

Strategies were affected by causal conditions and the phenomenon. Nurses also developed their strategies as a result of the context in which discriminative nursing care occurred and the conditions surrounding this. The two major strategies used by them were: "avoiding the patients" and "robotic care."

- Avoiding the patients: Strategies such as avoiding patients, lack of physical contact, or communication with them were adopted by the nurses. One of the participants (nurse no. 1) explained about this strategy that: "I absolutely hate to take care of patients with AIDS or hepatitis or addicts and homeless individuals. I hate these patients; so, I try not to get close to them and not have any physical contact with them. I try to avoid these patients."
- Robotic care: Robotic care is another strategy used by nurses. In other words, the nurse tries to provide routine care like a robot, regardless of the patient's need. In this strategy, the nurse thinks of him/herself as a robot that has to provide routine services and has no verbal communication with the patient. One of the participating nurses (nurse no. 13) said that: "I hated illiterate patients with a low cultural level because they have a low understanding of care and disease. I become a machine or a robot while taking care of these patients. I only do the physician's orders and routine tasks like a robot, but I do not pay attention to other needs of the patients and I do not talk to them."

Phenomena

The causal conditions and context led to "discriminative nursing care" phenomena. In this kind of care, the nurse refuses to take care of the patient or provide care at in an inappropriate time and manner. Also, the nurse does not interact with the patient, does not care about the patient's needs, and does not respond to the patient. In other words, the nurse does not observe the ethics of the nursing profession and even become immoral. One of the participating nurses (nurse no. 12) stated that: "it is futile task to take care of brain death patients. I do not take care of these patients, I do not even change their position." Another participant (patient no. 2) also stated that: "this nurse doesn't like me. She does not talk to me. Whenever I ask a question or want something, she treats me very badly and does not answer my question."

Outcomes

The participants used strategies to overcome causal conditions, leading to subsequent consequences. These consequences were located in a spectrum ranging from "annoyance and discomfort" to "imposition of costs."

- Annoyance and discomfort: According to participants' statements and experiences, discriminative nursing care causes annoyance, discomfort, sadness, heartbreak, grief, and crying among the patient being discriminated against. One of the patients (patient no. 3) who participated in the research and was discriminated, said about her feelings: "When I was discriminated, I was very upset and sad. I cried at night under the bed sheet, because my heart was broken and I was very sad."
- Lack of/delayed recovery: Discrimination practiced by nurses lead to lack of/delayed recovery and elimination of disease of patients who had experienced discrimination. This has caused numerous physical injuries to patients. One of the participants (patient no. 5) stated: "the nurse's behavior hurt my body and failure to provide proper and timely nurse care services did not help improve my diabetes-induced leg ulcers, and the infection and ulcers spread, and eventually the doctor cut off my leg from the ankle."
- Prolonged hospital stay: Lack of/delayed recovery of the patients being discriminated resulted in prolonged hospital stay. One patient in the present study (patient no. 4) said that: "the nurse had a discriminatory treatment with me. I developed pneumonia due to his discriminative care behaviors, such as the lack of antibiotic therapy at the right time and the lack of timely attention to the signs and symptoms of infection spread, which is why I was hospitalized for more days and more nights."
- Imposition of costs: Lack of/delayed recovery caused due to discriminative nursing care and, subsequent prolonged hospital stay would impose financial costs to the patient. In other words, the patient should pay more for his or her recovery, treatment and care procedures, and longer hospital stay. One of the participants (patient no. 1) stated: "I am a poor person and that is why my nurse did not like me and did not take care of me. I felt that he would discriminate between me and the other patients. I didn't recover on the right time and inevitably stayed longer in the hospital; as a result, I had to spend more due to this prolonged hospital stay. This increase and imposition of costs on me who did not have a good economic situation, was very uncomfortable and stressful."

After all the categories emerged, they were organized around the core category according to Corbin and Strauss 2008 approach. In this study, "care in the context of the sense of interaction with the patient" was a concept that was related to other concepts.

Discussion

The present study showed that nurse's attitude and feeling toward the patient was a key factor in practicing discriminatory nursing care. The nurses examined and evaluated their patient's characteristics. If they adopt a negative attitude toward all of the patient's characteristics, they would hate and disgust the

patient, which in turn leads to a complete conflict between the nurse and the patient. The sense of hatred and disgust and the sense of complete conflict with the patient led the nurse to provide care in a discriminatory manner. The results of FitzGerald and Hurst's research (2017) showed that the attitude and feeling of nurses toward their patients' characteristics may lead to nurse–patient conflict and mismatch, which in turn affect the interaction with the patient, diagnosis, care, and treatment processes.[10] The results of the present study showed that patients with lower economic, social, cultural, or educational levels as compared to the average levels at the society are more likely to be discriminated against as compared to other patients, by nurses. Also, patients who do not have an appropriate and acceptable morality, behavior, and appearance may also experience discriminative nursing care more frequently than other patients. Therefore, patient's characteristics were also a major contributor to the development of discriminative nursing care.[11] Providing discriminative nursing care leads to adverse consequences for patients. Most of these patients develop mental and emotional problems, such as annoyance and discomfort. Findings of Leary's study (2015) revealed that hurt feeling, jealousy, loneliness, shame, guilt, social anxiety, sadness, anger, and embarrassment occur when patients are discriminated against and feel less worthy than other patient.[12] In addition, inadequate quality of care services will lead to lack of/delayed recovery among patients. The patient may even suffer from other serious, common disorders and conditions, including pneumonia and sepsis.[13] The patient's length of stay in hospital is prolonged due to a lack of/delayed recovery and, in some cases, a new disease. The findings of George, Long, and Vincent research (2013) showed that discriminative nursing care could undermine the safety and security of patients and even expose them to serious and new harm and thus prolong their length of stay in the hospital.[14] All of these factors impose more financial costs on the patient. The results of Evans-Lacko *et al.* (2015) research also confirmed that the healthcare cost of patients being discriminated against are approximately twice that of those who are not discriminated against.[15]

Conclusion

The findings of this study revealed different aspects of the discriminative nursing care. It is possible to prevent the development of discriminative nursing care by taking into account its development process and increasing the awareness of nurses in different levels and ranks of its negative consequences and achieve success in providing fair, proper and ethical nursing care. Hence, it is important to provide nursing education on the development of discriminative nursing care and its associated complications.

Limitations

Some participating nurses and patients demanded that tape recorder should be switched off during interviews and disclosed information that they did not want reflected in the study. Thus, in keeping with the assured confidentiality, the researcher did not include such information, which may be considered as a limitation. However, any of the participants did not say unethical practice. In fact, participants asked researcher to turn off the recorder when they wanted to say the name of their officials or managers and criticize them. So in respecting their request for nondisclosure of this information some data were not analyzed.

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Conflicts of interest

There are no conflicts of interest.

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