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Competing interests: None declared.

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NURSES' IMPOLITENESS AS AN IMPEDIMENT TO PATIENTS' RIGHTS IN SELECTED KENYAN HOSPITALS

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ABSTRACT

The institutionalization of patients' rights is a recent phenomenon in Kenya. In 2006, Kenya's Ministry of Health initiated policy measures to improve patient satisfaction through a charter of patients' rights. The aim was to change the longstanding public perception that nurses in public hospitals routinely ignored patients' right to respectful treatment. This paper focuses on linguistic indicators of violation or promotion of patients' rights in the health care context. We examine the extent to which patients' rights to dignity, respect, and humaneness are observed or denied, and we argue that impolite utterances impede rather than promote the realization of other fundamental human rights. It appears that nurses' impoliteness does not merely constitute rudeness, but encodes a violation of dignity which, in turn, hampers the chances of enjoyment of broader human rights such as the right to autonomy, free expression, self-determination, information, personalized attention, and non-discrimination. We argue that, for patients to enjoy their rights in the hospital setting, a clear definition of roles and relationships and public education on strategies of asserting their rights without intimidation are necessary. It emerges that when patients' rights are denied, patients resort to retaliation by violating the dignity of the nurses. This jeopardizes the envisaged mutual support in the nurse-patient relationship and compromises patient satisfaction.

INTRODUCTION

Patients' rights are an integral component of human rights. They promote and sustain beneficial relationships between patients and health care providers. The role of patients' rights, therefore, is to reaffirm fundamental human rights in the health care context by according patients humane treatment. The need to protect and promote the dignity, integrity, and respect of all patients is now widely accepted. To this end, the World Health Organization (WHO) predicts that

the articulation of patient rights will in turn make people more conscious of their responsibilities when seeking and receiving or providing health care and this will ensure that patient-provider relationships are marked by mutual support and respect.¹

In an article on the ethics of "undignifying situations," David Seedhouse and Anne Gallagher found that patients are vulnerable to a loss of dignity in hospitals.² It is therefore pertinent to evaluate patients' and nurses' perceptions of dignity since, through it, we can identify strategies of either violation or promotion of human rights in health care contexts. This is driven by the awareness that human dignity is at the core of most human rights treaties.

According to WHO, patients' rights vary in different countries depending on the prevailing local cultural and social norms.³ For instance, the infor-

mative model in North America and Europe sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the health care staff mainly as providers of information. In contrast, the service provider in Kenya is still regarded as an authoritarian benefactor, while the patient is considered vulnerable and expected to be subservient. Such authoritarianism may curtail the claim to rights. Despite the debate about how to conceive of the provider-patient relationship, there is growing international consensus that all patients have a fundamental right to privacy, autonomy of decision, and access to information. Ultimately, a human rights approach calls for an accommodative provider-patient relationship. Ideally, this would guarantee the patient the right to autonomy, free expression, self-determination, information, personalized attention, and non-discrimination.

The need to recognize, guarantee, and practice patients' rights has been reaffirmed through the ratification of international documents such as the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR). Research findings, however, indicate that nurses routinely engage in acts that hamper the realization of patients' rights. This renders patients less empowered to participate actively in the nursing experiences. For instance, in Western Australia, Saras Henderson found that nurses considered patient involvement in their own care as an interference in the nurse's duties, and that the majority of nurses were unwilling to share their decision-making powers with patients.⁴ This creates a sense of exclusion, resulting in little input by patients. In an article on the "dignity of elders," Cynthia Jacelon reported that the three most violated patients' rights include miscommunication, conflicts over payments, and lack of respect for personal, spiritual, and religious values and beliefs.⁵ In a comparable study in Turkey, Nevin Kuzu, Ergin Nesrin, and Zencir Mehmet found that few patients knew about the regulations on patients' rights; on most occasions, the patients stated that they were not able to request services because they felt intimidated by the nurses' dominance in the interactions.⁶ Lesley Baillie has identified acts that would make patients feel comfortable; these included use of humor, reassurance, friendliness, and professionalism.⁷ Other similar dignity-promoting acts included explanations, giving information, offering choices, gaining consent, and promoting independence.

Similarly, Harvey Chochinov indicated that reassurance and friendliness also promote dignity.⁸

From the foregoing, it emerges that nurses' attitudes and behaviors pose an impediment to the actualization of patients' rights in many countries. For effective implementation of patients' rights, WHO suggests that patients deserve the opportunity to have their complaints examined and dealt with in a thorough, just, effective, and prompt manner.⁹

THE STATE OF THE NURSING PROFESSION IN KENYA

It has been reported that many of the most experienced and best-trained nurses emigrate from Kenya to the UK and US. According to the Kenya Nursing Workforce and Training Analysis Project, the flight of nurses contributes to a severe shortage of health workers, thereby crippling health care.¹⁰ Due to this attrition, nursing officials say Kenya is facing a nursing shortage of up to 50%. The "Nurses and Midwives" division of the Ministry of Health estimates that Kenya has 17,000 public sector nurses but requires 35,000. There are 49 nurses to 100,000 citizens compared to the WHO recommended ratio of 143 to 100,000.¹¹ This imbalanced ratio renders nurses overworked and has been cited as one cause of nurses' dissatisfaction. It may result in nurses displacing their anger and frustrations on hapless patients.

The large-scale emigration of nurses is attributed to various factors. For instance, the secretary general of the National Nurses Association of Kenya, who is also a serving nurse, states that nurses' working conditions are quite deplorable in a number of government institutions. While a basic certified nurse is supposed to be assigned to no more than six patients at a time in a hospital setting, nurses can be responsible for up to eight times that number, and sometimes must treat three patients who are sharing a single bed.¹² The secretary general says that a nurse may have the knowledge, skills, and drive, but not the necessary tools and a supportive environment. This causes a feeling of frustration and lowers performance. Nurses' strikes are therefore rampant in Kenya. The nurses' grievances often include complaints about long working hours, overload, unpaid risk allowances, uniform allowances, and delayed promotion.¹³

Patrick Mbindyo and colleagues reported that long-serving nurses in Kenya professed to have been

attracted to work within the health care sector by the altruistic nature of the service (that is, rewards associated with caring for others), while other nurses joined due to the prestige associated with medical work. According to one nurse, doctors are not at all supportive of nurses. She complained that a doctor would come, perform the reviews, and leave. The nurse is then left with the patient. During night duty, a single nurse attends to almost 60 patients. This leads to burnout among staff, which results in poor attitudes towards patients and work. This has been compounded by the negative attitude of the community towards nurses.¹⁴

ROLES AND EXPECTATIONS OF NURSES AND PATIENTS IN KENYA

Simon Makabila reported in 2006 that there was public concern in Kenya that medical practice had become more hazardous because caretakers perform most of the patient care duties due to nursing shortages. Medical practice also increasingly becoming impersonal and dehumanized.¹⁵ The Kenya Institute of Public Policy Research and Analysis report of 1994 indicated that facets of patient satisfaction range from politeness of providers to the time spent waiting for service. The report also recorded complaints that nurses in Kenya's public hospitals were rude, impolite, and offered cold reception.¹⁶ In view of this, the Kenya National Health Sector Strategic plan for 2005–2010 promises to make health service provision humane, compassionate, and dignified.¹⁷ Promotion of the patient's dignity through respect, empathy, courtesy, advocacy, and a short turn-around (response) time form the core commitments in the Kenyan charter of patients' rights.¹⁸ Similarly, the nurses' training curriculum emphasizes humaneness. This is implied by the objective that nurses should support their patients at all times, and that their care should enable those who are dying to do so with dignity.¹⁹ Despite these clear policy statements, public perception in Kenya still points to blatant violation of patients' rights through verbal abuse.²⁰ In the following section, we demonstrate the interdependence of dignity, patients' rights, and broader human rights. This relationship forms a basis upon which to ascertain the validity of the perceptions of Kenyan patients and nurses on the impact of acts that violate dignity on the chances of the realization of rights. Nurses are the gatekeepers of doctors' operations, and also serve as patients' advocates. Their actions and utterances can therefore determine the extent of

patients' access to health. The nurses' critical role of control can frustrate or facilitate the patients' access to health, which is a basic human right.

Patients' own attitudes also influenced their evaluation of nurses' politeness. Some patients expected to be handled rudely even before they went to the health facilities. For instance, a labor ward patient expected to be insulted because of what she had been told before she went to the facility. Such presumptions could influence the patients' linguistic behavior leading to choice of strategies aimed at countering the preconceived notion that the nurses were bound to be impolite. In such instances, the patient would be the aggressor by initiating the dignity-violating acts and failing to engage in what Gino Eelen has called strategic conflict avoidance.²¹ This retaliatory act of dignity violation is described by Calnan and colleagues as resistance, or asserting oneself in the face of threats to dignity.²² Moreover, Elizabeth Arnold and Kathleen Boggs argue that such stereotyping by patients would be a barrier to smooth interaction.²³

THE RELATIONSHIP BETWEEN DIGNITY, PATIENTS' RIGHTS, AND OTHER HUMAN RIGHTS

It should be noted that patients' rights are human rights. Language users' utterances and actions convey notions of assertion, promotion, or violation of patients' dignity. Consequently, Nora Jacobson has argued that dignity and human rights are historically and conceptually coupled in the UDHR, that actions taken by speech participants to respect, protect, and fulfill human rights promote dignity, and, conversely, that those which violate human rights violate dignity.²⁴ Since expressions of dignity promotion and violation are mediated by language, speakers should demonstrate awareness of the fact that the content of their utterances determine the addressees' perception of the observance of dignity. While polite utterances promote dignity, impolite ones inherently threaten dignity, hence are not considered the norm. Expectations of what constitutes dignity depend upon the norms and expectations of a society, and since it is socially produced, dignity is inherent in every person, and anyone deserves to be valued by virtue of being human. For an individual to determine the degree of dignified treatment that he or she is accorded, the language choices of the other party are evaluated, since words are a manifestation of the speaker's intentions and attitude towards others. Dignity entails the positive feelings that the individual

has for the self, including respect, self esteem, self worth, trust, valuing self, and honoring self. Lesley Baillie has reported that staff behavior and the hospital environment impact patients' dignity, and threats to patients' human needs can lead to loss of dignity.²⁵ It is therefore imperative to review the place and relevance of human dignity within existing local and international legally binding laws and conventions. In the next section we review the principle of respect for human dignity that is at the core of any national or international text that concerns the protection of fundamental rights. Dignity is a conceptual principle that is present throughout the proclamation of such rights. The need to guarantee and preserve human dignity remains one of the recurring themes in all major human rights treaties. Semantically related versions of the phrases, "the inherent dignity" or "human dignity," are found in the preambles of all major human rights treaties. These phrases are also articulated in various articles of national constitutions. Although these documents do not explicitly specify a "right to dignity," it is apparent that the protection of dignity is one of the most basic goals of all human rights law. Violations of an individual's human dignity should therefore be considered as violations of that person's human rights. It is apparent that the protection of human dignity is the source of the guarantee of human rights and fundamental freedoms, since it constitutes the essential objective of human rights provisions.

DIGNITY AS A PREREQUISITE FOR OTHER RIGHTS IN INTERNATIONAL COVENANTS

Examples from three international covenants illustrate how dignity is defined as basic to all human rights. First, the preamble of the UDHR states, for example, that the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world..."²⁶ Similarly, the International Covenant on Economic, Social and Cultural Rights (ICESCR) notes in its preamble that human rights derive from the inherent dignity of the human person.²⁷

The UDHR also links dignity with other fundamental rights. For instance, in Article 22, the fulfillment of "social security" and economic, social, and cultural rights is said to be an important component of dignity and the "free development of ... personality."²⁸ Moreover, Article 23 states that all people who work

shall be compensated enough to provide their families with "an existence worthy of human dignity."²⁹ Second, other human rights treaties also identify certain rights as being especially important to the preservation of dignity. For instance, the ICCPR recognizes that all human rights derive from the inherent dignity of the human person.³⁰ Article 10 of the ICCPR holds that "all persons deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person."³¹ Moreover, ICCPR Article 2.3a states that each State party to the Covenant undertakes "to ensure that any person whose rights or freedoms ... are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity"; and Article 17.1 states that "[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation."³²

Third, as Article 1 of the Charter of Fundamental Rights of the European Union states clearly, "Human dignity is inviolable. It must be respected and protected"; in an expanded "overview" on this Charter, the European Union Committee on Citizens' Freedoms and Rights, Justice and Home Affairs add, "there can be no exception, nor can any limit be imposed [to it], even where law and order is concerned."³³ This implies that human dignity takes precedence over all other considerations. Article 1 of the charter thus envisages a situation whereby all human action should strive to preserve dignity. Any law that overlooks human dignity should therefore be considered undesirable, however useful it may be for exercising control over individuals.

The principle of respect for human dignity is therefore universal — recognized equally at both the international and national levels — as a fundamental value in society and as a central component of human rights discourse. Nevertheless, its legal value and the circumstances under which redress is to be sought have not been formally defined. The question arises as to whether it is possible for human dignity to be subjected to a legal decision. It has been noted that violation of the majority of fundamental rights and freedoms also breaches the respect and protection of human dignity.³⁴ The legal approach to this idea has changed. In many areas, it is now accepted that certain situations are liable to breach human dignity, yet legal protection may not always be available to

the individuals concerned.³⁵ This is the case in areas such as health (for example, in terminal illness or where the conditions for psychiatric internment are concerned), extreme poverty (for example, the right to housing), the treatment of illegal aliens or of foreigners whose legal status has not yet been clarified, and prison conditions. Other examples may include the mother-and-child relationship, the elderly, or the mentally handicapped.³⁶

GUARANTEES OF HUMAN DIGNITY IN NATIONAL LAWS: PARALLEL EXAMPLES

In Article 19.2 of the Constitution of Kenya, it is stated that “the purpose of recognizing and protecting human rights and fundamental freedoms is to preserve the dignity of the individuals and communities and to promote social justice.”³⁷ In addition, Article 28, on human dignity, further states that “every person has inherent dignity and the right to have that dignity respected and protected.”³⁸ It is therefore clear that the Kenyan government establishes a conceptual link to the preservation of dignity as a prerequisite for the enjoyment of the rights associated with social justice, such as health and education.

Comparable national constitutions elsewhere also underline the primacy of human dignity. For instance, Article 23 of the Constitution of the Kingdom of Belgium states that “everyone has the right to lead a life in conformity with human dignity.”³⁹ And Article 1 of the Basic Law of the Federal Republic of Germany provides that “human dignity is inviolable. To respect and protect it is the duty of all state authority.”⁴⁰ Further, Article 3 of the Constitution of the Italian Republic states that all citizens possess an equal social status and are equal before the law, without distinction as to sex, race, language, religion, political opinions, and personal or social conditions.⁴¹ These examples demonstrate that various governments recognize dignity as a prerequisite for the enjoyment of other fundamental human rights. In Section 95 of the Constitution of the Republic of Latvia, the state undertakes to “protect human honor and dignity.”⁴² Similarly, the Constitution of the Republic of Lithuania, Article 21, states that “the person of a human being shall be inviolable and the dignity of the human being shall be protected by law. It shall be prohibited to torture, injure a human being, degrade his dignity, and treat him in a cruel manner.”⁴³ The notions of “human honor” and “the human person” are akin to self esteem, while

“degrading” and “cruel treatment” might compare to the impolite approaches exhibited by Kenyan nurses in our study, described below.

Article 30 of the Constitution of the Republic of Poland is more explicit, stating that “the inherent and inalienable dignity of the person shall constitute a source of freedoms and rights of persons and citizens. The respect and protection thereof shall be the obligation of public authorities.”⁴⁴ There is a lesson here for Kenya in the sense that, for successful realization of rights, it is not enough to simply express them as a guarantee. The watchdog role of government agencies and redress mechanisms must be spelled out clearly. This is not the case in Kenya’s public hospitals, at present. Poland’s Article 41 states that “anyone deprived of liberty shall be treated in a humane manner.”⁴⁵ The hospital context represents a deprivation of the patient’s freedoms of movement, association, and self-determination. Moreover, the display of power by Kenyan nurses is counter to Article 13 of the Constitution of the Portuguese Republic, which outlines the principle of equality by stating that “all citizens have the same social rank and are equal before the law.”⁴⁶ Finally, Article 19 of the Constitution of the Slovak Republic states that “everyone shall have the right to maintain and protect his or her dignity, honor, reputation and good name.”⁴⁷ This provision implies that one has the right to reclaim dignity in settings where it may have been compromised. Such explicit statements would empower citizens to register complaints and seek redress when denied their rights.

METHODOLOGY

The data described, analyzed, and discussed below and in the sections that follow formed part of a PhD project on nurse-patient interactions that was undertaken by Dr. Ojwang and directed by Drs. Ogutu and Matu. The aim of this qualitative study was to identify patients’ and nurses’ perceptions of politeness as a parameter of patient satisfaction in view of the emerging concept of patients’ rights. Nurses and patients were interviewed using an interview guide that consisted of open-ended questions, provided in Figures 1 and 2.⁴⁸ We used simple random sampling to identify 10 patients and five nurses in each of the four government hospitals situated in Nyanza province, Kenya. The patients were approached at the hospital exit and their consent sought. We ensured that we obtained firsthand information rather than

Figure 1. Interview guide for patients

A researcher at Maseno University would like to find out how nurse-client politeness strategies impact on the realization of the charter of patients’ rights. Be assured that:

- Your identity/name will not be referred to anywhere in the final research report.
- The information you give will be used purely for academic purposes.

Please respond to the following questions:

Facility_____ Gender___ Age____
 Inpatient/ Outpatient_____

1. What aspects of the charter of patients’ rights would guarantee you positive treatment in health care contexts?
2. Narrate briefly the nature of the nurse’s communication strategies that you have experienced recently.
3. Describe the nurses’ utterances that you considered polite and dignifying.
4. Describe the nurses’ utterances that you considered impolite and dignity-threatening.
5. How could the interaction have been made more satisfactory?

rely on general public perception. Patients who could spare one hour were interviewed within the health facility, while others were interviewed at home. All interviews took place within 72 hours of discharge from the hospital in order to enhance a higher rate of recall of experiences. For our nurses’ interviews, we approached nurses in their offices during breaks and arranged appointments. Since nurses were busy, some had to be interviewed at home when they were off duty and free of work distractions. The interviews were recorded, the recording supplemented with field notes. Recorded interviews were later transcribed for analysis. The themes that we sought from the transcripts included awareness of patients’ rights, polite strategies, impolite strategies, and notions of patient satisfaction and dissatisfaction. We present first the patients’ point of view followed by the nurses’ point of view. Results are discussed in the context of international human rights conventions and the Kenyan declarations of patients’ rights.

PATIENTS’ EXPERIENCE OF VIOLATION OF RIGHTS IN KENYA

Qualitative findings exemplify patients’ perception of nurses’ impoliteness and, thus, the violation of patients’ rights (namely, the right to dignity) and other broader human rights. It is apparent that the nurses’ verbal impoliteness constituted violations of dignity and not merely rudeness. Such behavior

is ultimately a precursor to the violation of other specific human rights, and goes against the philosophy of nursing as stated in Article 1 of the National Nurses’ Association of Kenya Code of Conduct and Ethics, that nurses must adhere to the dignity, equality, and individuality of man. Such behavior also counters Article 3 of the same Code, which states that all people have a right to quality of health care regardless of race, creed, ethnic background, social status, political convictions, sex, or color.⁴⁹ The significance of these clauses is that nurses are expected to uphold human rights and focus on patients’ needs.

Politeness forms a key ingredient in Kenya’s charter of patients’ rights, and the success of all other health services depends on this aspect of interpersonal relationship.⁵⁰ In order to evaluate patients’ perceptions of the quality of nurses’ utterances that overtly encode denial of patients’ rights, we adopted Peter Grundy’s view that politeness describes the extent to which actions, including the way things are said, match addressees’ perceptions of how they should be performed.⁵¹ Polite strategies are desirable because they promote dignity and demonstrate acceptance, while impolite acts are undesirable because they cause social tensions and violate the addressee’s dignity.⁵² We also applied Joakim Ohlen’s contention that, for a social process to become an encounter about issues of dignity, “violation” requires not only

Figure 2. Interview guide for nurses

A researcher at Maseno University would like to find out how nurse-client politeness strategies impact on the realization of the charter of patients' rights. Be assured that:

- Your identity/name will not be referred to anywhere in the final research report.
- The information you give will be used purely for academic purposes.

Please respond to the following questions:

Facility_____ Gender____ Current Designation_____

Professional qualification: _____

Experience_____ (yrs)

1. What communication strategies do you find effective and relevant to patients' needs?
2. In your opinion, which communication strategies can aid the realization of the charter of patients' rights?
3. In your opinion, what communication strategies negate patients' rights?
4. In your opinion, what communication strategies promote patients' rights?
5. Specify any factors that might constrain your interaction with a patient.

the occurrence of word or deed, but also an act of interpretation. The individual or collective actors involved in the encounter, including any observers who might be implicated, must therefore perceive what transpires and attribute meaning to it.⁵³ Within such a framework, dignity encounters appear more likely to result in violation when an actor is in a position of vulnerability, that is, when sick, poor, weak, helpless, ashamed, or confused.⁵⁴ The conflict is complete if the other actor is in a position of antipathy, that is, when the actor is prejudiced, arrogant, hostile, or impatient. Additionally, violation is more common when the relationship is one of asymmetry, that is, when one actor has more power, authority, knowledge, wealth, or strength than the other. Research by Cynthia Jacelon has shown that nurses whom patients remembered best tended to be those who had uttered unpleasant statements.⁵⁵ In the sections below, we describe instances that patients in our study perceived as impolite, hence violating dignity.

Discrimination, labeling, and grouping

The verbal acts that patients perceived as impolite involved nurses seeing the patients not as unique individuals but as members of a collective group. Such parameters of exclusion or grouping were deemed undesirable because they discriminated the targeted patients on grounds of class, gender, and age. The nurses' utterances in these cases implied that

the patients were viewed as inferior, and that such inferiority was perceived as due to their social status. For example, a patient recalled that she was not told to leave her baby outside of an injection room but was sternly asked why she had entered the room with the baby and whether she had "been to school." By implying that the patient might be illiterate and attributing her ignorance of hospital procedures to this presupposition, the nurse demeaned and intimidated the client, hence damaging her self-esteem. This was a blatant violation of the right to be informed of any rules and routines that bear on patients' stay and care. This failure to inform the patient of such rules and routines denied her the right to self-determination and non-discrimination. The act of doubting the patients' literacy illustrates two forms of dignity violation: first, *diminishment*, which involves making an actor feel smaller or lessened by the form and content of the interaction, and second, *labeling*, which involves tagging an actor with a descriptive term that carries a connotation of moral deficiency or social inferiority.

In another example of labeling, when a patient inquired as to why, when he had paid fees, service was not forthcoming, the nurse told him to shut up since he was not better than the others who were quiet. The patient was further told to go to a private hospital, and asked why he was queuing in a government

hospital if he thought he had enough money. Here labeling occurred in the reference to socioeconomic capability. By obliquely suggesting that a patient might have come to the public hospital because he could not afford the more expensive private facilities, the nurse was labeling the patient as socioeconomically inferior. The nurse's suggestion further implied that she lacked confidence in the health care system in which she worked. This reinforced the public perception that services in the public facilities might be inferior to those in private facilities.

Lastly, discrimination based on gender was witnessed in a situation where a male patient reported that a female nurse spoke well to his son but repeatedly spoke spitefully to his wife. This exposed how personal biases can constrain the interactions in nursing contexts.

In the foregoing illustrations of discrimination, the nurses acted contrary to Geoffrey Leech's recommendation that in any interaction each party should avoid disruption and maintain the social equilibrium and friendly relations.⁵⁶ Nora Jacobson described discrimination as the tendency to treat an actor poorly based on achieved or ascribed status or apparent membership in a lower-status group.⁵⁷ Moreover, the nurses' inclination to label the patients as vulnerable due to their perceived deficiencies confirms the observation that a speaker may use what is known as a "face-threatening act" to manipulate the addressee's behavior for the sake of one's personal goals.⁵⁸ The nurses' acts contravened the right of the patient to be treated equally and with dignity without discrimination based on gender, race, creed, or socioeconomic status. The tendency to discriminate and label patients causes degradation, that is, a feeling of worthlessness and humiliation, that is, shame and guilt, as well as anger associated with resentment and hostility. Ultimately, it denies patients a sense of belonging by making them feel different.

Nurses' unsatisfactory communication strategies

Nurses also engaged in acts of exclusion, sometimes withheld information, and failed to explain requirements to patients. Most cases of unsatisfactory reception and denial of the right to respectful and humane treatment were reported by patients in the maternal-child health, maternity, and labor wards. The most recurrent complaints by patients indicated that nurses in charge did not bother to explain pro-

cedures but were quick to blame any deviant acts on the uninformed patients. This violated the patient's right to be informed unconditionally as promised in the Kenyan charter of patients' rights.⁵⁹

A further unsatisfactory strategy was cited by a patient who commented that her nurse was a bit forceful and too determined, not caring whether the former was ready for the process of dressing or not. This violated the patient's right to self-determination. Similarly, another patient reported a direct accusation by a nurse who quarreled with him and said that he lacked respect, instead of clarifying the procedures to him.

In the experience of another patient, the nurse was a poor communicator because she carelessly told the patient's relatives that his condition (tuberculosis) was contagious, hence it was up to them whether they approached his isolation room. This ignored the patient's right to preserve self esteem. Here, the patient's experience illustrates the violation known as objectification, in which an actor is treated like a thing and not a person. It also exemplifies *abjection*, which entails forcing an actor to humble oneself by compromising closely held beliefs or by forced association with material or practices considered unclean (in this case related to the contagion of tuberculosis). This was a contravention of the stated right to be treated with dignity in relation to diagnosis, treatment, and care which ought to be rendered with respect for one's culture and values. By uttering the word "contagious" in the hearing of the patient and his relatives, the nurse denied the patient the right to dignified treatment and this encoded loss of hope for the patient's recovery. This form of violation also exemplified revulsion, in which the patient was treated as though he was disgusting or tainted. It also implied exclusion, by making the patient feel unwelcome in or left out of the social setting.

Ignoring and dismissing patients' concerns

Patients reported nurses' dominance and control of the interactions as another undesirable situation. This is confirmed by a patient's report that the nurses were harsh and did not want to listen to her explanation. All they wanted was a "yes" or "no." The act of dismissing, ignoring, or discounting the patients' perceptions, concerns, needs, and feelings violated the right to express opinions freely on matters related to the course of their treatment, which is also specified

in the Kenyan charter of patients' rights. Through this approach of prevarication, the nurse did not opt for the desirable skills that would have encouraged elaboration. Another patient reported that the nurse arrived late, but when they complained, she told them to shut up since they were not her employer. This tendency illustrates authoritarian approaches similar to those identified by Gillian Woolhead.⁶⁰ ICCPR Article 19(1) states that "everyone shall have the right to hold opinions without interference" while 19(2) provides that "everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, either orally ... or through any other media of his choice."⁶¹ It is therefore counter-productive to fail to listen to patients' views; if they are rendered passive participants, they may withhold vital information that would have been useful, for example, in aiding the diagnosis of their ailments.

Gratuitous impoliteness and generalized disrespect

When asked to state the nurses' most undesirable strategies, the majority of patients expressed their dissatisfaction with interactions in which the nurse turned out to be overtly impolite. Impoliteness is conceptualized here as being gratuitously nasty or showing generalized disrespect. The most overt attacks on the dignity of patients entailed embarrassment, harassment, and disrespect that appeared obvious even to the bystander by causing derision. For instance, patients detested open criticism by nurses. This perspective is in tandem with our conclusion that in contexts where there were bystanders or third parties present, the damage to dignity was more discernible. This fact is corroborated by the encounter of a patient who said that the nurse shamed her in front of her fellow mothers by speaking spitefully to her. This experience illustrates the form of dignity violation described by Alicia Huckstadt as condescension, which involves talking down to someone like a child regardless of their adult age.⁶² A similar experience was reported by an inpatient who, when she asked for clean bed sheets, was told by nurse that a hospital was not a hotel. In this instance, the nurse's response violated the patient's right to be heard.

Another incidence of violating dignity through rude language was reported by a first-time patient who said that the nurse quarreled and shouted at her instead of explaining the procedures. In that instance, the

patient felt that the nurse diminished her dignity since, according to the patient, the nurse should have known that shouting never solves a problem. Indeed, Eelen reported that shouting can increase stress, especially in patients with cardiovascular ailments.⁶³

Even when obliquely communicated, patients could still detect nurses' impolite utterances and adjudged them as violating dignity. For instance, in a case reported by a 60-year-old inpatient, the verbal attacks were aimed at his wife, who was told to mind her own business when she complained that the patient had missed drugs. This vilification denied the patient the right to information.

In a more direct case, a patient complained that the nurses could harass and embarrass them so that they looked like fools. For instance, one nurse summoned patients like outcasts by referring to them as "those TB people." In such an approach, the nurse engaged in an act of *grouping* which involves seeing an actor not as a unique individual but only as a member of a collective group. This approach represents lack of personalized attention, yet such attention is included in customer rights in Kenya's health service charter.⁶⁴ One patient in our study who detested this approach complained that

[w]hen you have been addressed like that, you don't feel good within you. For some nurses, even if you greet her, she does not respond. She just looks at you coldly. A nurse may also tell a patient to wait until she finishes what she is doing before she can talk to you. You may also be told to go and wait outside indefinitely and that you are not a better patient than the others.

Such sentiments, coming from a disgruntled patient, portray the nurses as insensitive to the communicative impact of their words. Impolite utterances therefore impede the accommodative interaction and mutual respect entrenched in international rights documents and envisaged by the Kenyan charter of patients' rights. As Catherine Berglund and Deborah Saltman have observed, therapeutic relationships need the human touch to bring them alive and to develop a rapport with clients.⁶⁵ Similarly, Graham Dexter and Michael Wash have proposed that nurses should appreciate the needs, values, and wishes of

clients. This calls for polite language use that preserves dignity.⁶⁶

The foregoing reports have revealed that violation of patients' rights manifest primarily as nurses' dominance and control, authoritarian approaches, and unwillingness to bridge the social and power frontiers that set the limits for their interactions. Nurses' utterances also exhibited a tendency to disrupt the social equilibrium. Through these interactions, patients were denied certain broader rights, such as the right to information, fair treatment, respect, and non-discrimination. It has emerged that the general consequences of dignity violation include patients' distrust, dread, disempowerment, apathy, depression, and loss of hope. The Kenyan situation is consonant with Ohlen's conclusion that dignity violation may cause loss of self-esteem, loss of status, loss of confidence, and loss of self-determination.⁶⁷ Although patients find themselves in confinement due to their health conditions, acts that humiliate them and limit their fundamental rights are undesirable. By using their positions of authority to curtail the patients' rights, nurses contravene the provisions of ICCPR Article 10.1, which states that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.⁶⁸

PATIENTS' EXPERIENCE OF PROMOTION OF RIGHTS IN KENYA

For comparative purposes, patients were interviewed on experiences that they considered relevant to aspects of the charter of patients' rights that would guarantee them acceptable treatment and thus uphold their dignity. They were further asked to narrate the nature of the nurses' communication strategies that they had experienced recently, and their degree of satisfaction with it. It emerged that patients preferred friendly, personalized, and humane approaches that showed genuine concern, and that cared for their problems by focusing attention on their interests. The manifestations of such desirable treatment are outlined below.

Acknowledgement of humanity, right to respect, and personalized treatment

In the first category of desirable nurses' behavior, patients identified as promoting dignity nurses' expressions of solidarity or inclusion of the patients. This was characterized by nurses' reciprocity, rap-

port, empathy, and trust towards patients. Patients also reported that dignity-promoting settings are those that feature humane habits such as acceptability, transparency, friendliness, and calm. These reports reaffirm Cynthia Jacelon's argument that actors may at times experience an enhancement in their dignity when they are treated with respect by others.⁶⁹

To further illustrate the humane nature of some nurses, a labor ward patient reported that her nurse was mindful because she encouraged her to push and told her that the baby would come through quickly. Moreover, patients indicated a preference for nurses who gave elaborate explanations to their questions and addressed their worries. They also reported that they liked nurses who addressed them slowly, repeated names at least twice, talked without spite, and had a friendly tone. According to Ken Walsh and Ige Kowanko, these strategies represent recognition which entails acknowledging the humanity of others by paying attention and showing appreciation.⁷⁰ The foregoing reports further exemplify strategies that reduce stress in the patient and give a positive outlook to the patients' medical condition as envisaged in the work of Penny Mares, Alix Henley, and Carol Baxter.⁷¹

In the words of one patient, a sick person should be handled kindly and advised on exactly what to do in situations of confusion. One should also be handled cautiously in order to know his or her mind. These sentiments echo David Hyland's expectations of the nurse as caregiver, advocate, and parent surrogate.⁷² Nora Jacobson also cited advocacy on behalf of patients, and characterized it as standing up for or beside those who are oppressed.⁷³ Moreover, a patient noted that a sick person may come to the hospital while bad tempered, and hence not willing to disclose his or her health condition unless handled with patience. These views underscore Cheryl Forchuk's contention that the needs, experiences, and ideas of the patient should be the primary goal of the therapeutic relationship.⁷⁴

Listening

Listening and probing skills were introduced by a patient who suggested that a good nurse would be one who listens to the patient's case and investigates his complaints while paying attention to the patient's words before acting. Such an approach would agree with the stance by Arnold and Boggs, that the capacity to listen empathetically to a patient's concerns is a powerful therapeutic intervention because, by

active listening, the nurse is able to demonstrate care and genuine interest in sharing information with the patient.⁷⁵ Such listening would facilitate mutual understanding and enable the patient for active participation.

Kindness

It also emerged that some patients expected emotional support from nurses. For instance, one patient indicated that the nurse he encountered was kind, encouraging, and convincing. The nurse had made him feel at ease and comfortable, and assured him that he would not feel much pain during a treatment procedure. Jacobson described such attitudes as those that involve keeping others company in difficult situations.⁷⁶ In her taxonomy of dignity, such attitudes represent instances of love because they encode acts of honoring and esteeming others.⁷⁷

Polite friendliness

This category of desirable approaches entails accommodating the other party by treating them as likable. It also involves showing them that they have needs similar to one's own. Results revealed that, for patients, the notion of good reception entailed expectations of polite friendliness. Dignity promotion is more likely to occur when an actor is in a position of confidence, that is, has a sense of self assurance, hope, and feels deserving of good things, while the other individual in the relational exchange is in a position of compassion, that is, is kind, open-minded, honest, and has good intentions. In this regard, patients had expected greetings, exchange of pleasantries, getting clear directions, and being addressed by name as some of the approaches that would make them feel at ease around nurses. The patients' expectations here agree with the opinion of Yueguo Gu, that in unequal encounters (such as the nurse-patient one), the actor in a superior position (in this case, the nurse) would be expected to speak first and to accommodate the other party by making them at ease.⁷⁸ If the nurse did not practice these traits of expected polite friendliness, then the right to be treated with dignity and respect would have been violated. Polite friendliness would enhance patients' self-disclosure because they would feel uninhibited, hence less apprehensive.

Empowerment

Provision of information to patients and clarification of issues and procedures also emerged as empow-

ering, hence promoting dignity. For example, one patient reported that she was satisfied by the reception because the nurse explained that patients had to wait for their names to be called before they could see the doctor. This demonstrated empowerment, in which the nurse equipped patients with pertinent information, thereby enabling them to navigate the hospital environment confidently without looking lost or confused. Such an approach by the nurse would ameliorate the threat to dignity because the nurse had clearly spelled out the procedures without leaving the patients uninformed. In this instance, the patient's right to accurate and prompt information was granted in conformity with the customer rights in Kenya's charter of patients' rights.⁷⁹

Respect for individual differences and cultural diversity

Patients tended to value nurses whose utterances exhibited a non-subjective disposition. This approach granted the patients equality of status and was hence a sign of unconditional acceptance. For instance, a Voluntary Counselling and Testing (VCT) patient reported that the nurse did not show signs of a "holier-than-thou" attitude towards him. Instead, the nurse encouraged him by stating that HIV was a challenge to everyone in the society. This implied that the nurse showed acceptance and was non-judgmental of the patient's health status.

Age difference featured as a socio-cultural factor in patients' expectations of dignity promotion by nurses. For instance, a patient expected the nurses she encountered to talk to her "properly" because they were like grandchildren to her. This patient's ageist attitude introduces a cultural constraint because, in the Kenyan context, the elderly usually expect to get unconditional respect from those younger than they are, regardless of any professional differences. This illustrates the expectations of the need to accord patients the right to respect of cultural diversity, as provided in the Kenyan charter of patients' rights.⁸⁰

Gender also emerged as a determinant of patients' personal desires. A female patient expressed preference for a male nurse because the latter showed greater concern and talked to her nicely when she was in labor. This gender perspective confirms Thomas Holtgraves' contention, that language users are social beings who bring to any particular verbal interaction a variety of social beliefs, motives, and goals.⁸¹

Another patient noted that nurses should also engage in dignity-promoting acts by demonstrating behavioral or emotional restraint and concealment, by covering up embarrassing situations. Since it is a social desire to avoid embarrassment, nurses ought to grant the right to respect the diversity of patients' social backgrounds.

The above sub-themes illustrate the desired act of leveling, or reducing asymmetry between patient and nurse. Such views reveal the socio-emotional needs of patients, and promote what Ide Sachiko described as smooth communication because, through such interactions, the speech participants were able to establish a common ground upon which the interaction proceeded.⁸² Two patients indicated that in their rating of nurses' politeness strategies, they not only considered their personal treatment but were also concerned with the nurses' interaction with other patients, since patients consider themselves as constituting an "in-group" with shared values and expectations. This alludes to Jacobson's notion of courtesy, conceptualized as giving common respect.⁸³

From the above experiences of rights promotion, it emerges that patients were in agreement as to what constitutes acceptable communication in the nursing context. Polite friendliness or the desire to be noticed emerged as the preferred strategy in the patients' perceptions of acts that would promote their dignity. Patients also agreed that conferring the right to respect and personalized treatment also determined dignity-promoting behavior. Leveling or reducing asymmetry between nurse and patient, smooth nurse-patient communication, and sharing a common ground also featured as key to dignity promotion. These sub-themes imply that there is need for nurses to adopt polite friendliness strategies to ensure patient satisfaction and support the enjoyment of the broader rights that complement the right to health care. In future, the policy makers should promote approaches that consider patients as partners in the health system. A framework for registering patients' views and complaints while ensuring confidentiality should be instituted. This would ensure that patients pursue rights they have been denied without antagonizing the nurses on whom they depend for service. This could be done by establishing public relations desks from which patients could receive clear instructions on hospital procedures that would enable them to approach the nurses from an informed position.

NURSES' PERSPECTIVES ON PATIENTS' RIGHTS VIS-À-VIS PATIENTS' BEHAVIOR, NURSES' BEHAVIOR, AND OTHER VARIABLES

Nurses were asked to state the communication strategies that they found relevant to patients' needs. In response, they cited aspects of their own behavior coupled with patient behavior that would both impede or promote the realization of patients' rights. They also cited other factors, like class differences, that might strain the nurse-patient interaction process. Although nurses expressed a tacit awareness of the ongoing reforms towards client-centered approaches and the existence of the Kenyan charter of patients' rights, some of their views did not seem to recognize patients' rights. For instance, one nurse said that she knew that there were changes in policy towards patient-centeredness, but she went on to complain that some patients are just difficult, and that a nurse needed to be tough to withstand such patients. The nurse concluded that dealing with patients was "stress." This attitude is in contrast to that of patients, who explicitly expressed the desire to experience respect, dignity, and acceptance. Whereas nurses emphasized professional ethics as the guiding principle in discharging their duties, patients expected a humanistic approach to nursing. Only two nurses explicitly mentioned respect for patients' views and feelings as a prerequisite to productive interactions. This discrepancy between patient values and nurses' values might suggest that nurses have had a slow uptake of the requirement to recognize, respect, and uphold patient rights.

Nurses' behavior and strategies that uphold realization of patients' rights

Nurses were asked to outline strategies that could aid the realization of the provisions of the charter of patients' rights. Their responses embodied nurses' expectations of how patients should approach them. This was a crucial factor in establishing polite exchange, because the patients' approach would determine the direction of the verbal interaction, its chances of success, and the politeness strategies adopted. In response, some nurses mentioned the need to treat patients equally, act without prejudice, help patients psychologically, physically, and emotionally, and prioritize patients' needs. To these nurses, aspects of polite friendliness included such behaviors as reassuring patients to allay anxiety, being sympathetic, empathic, and having a personal touch.

Other desirable traits included being non-judgmental, honest, confidential, and understanding.

Nurses also mentioned as desirable traits greeting and welcoming patients warmly, building rapport, and listening to patients' views. They further noted that greeting the client is a positive strategy because it accords self-esteem to the individual. In their view, greeting should ideally be followed by asking the patient about the problem, helping to solve it, and guiding patients to choose the best solution. Nurses also emphasized skills that promote patients' active role in decision making and creating rapport. This represents an awareness of the positive politeness strategy of accommodating the addressee as a member of the "in-group." It emerged that a cadre of nurses who had worked for less than five years recognized patients' rights and favored socio-emotional exchanges in contrast to their longer-serving colleagues. When probed further about positive communication strategies that would guarantee patients' rights, nurses mentioned patience, reassuring the patient, and empathizing. These sub-skills agree with the Kenyan Ministry of Health's objective of granting patients the right to dignifying and respectful treatment.⁸⁴ Nurses also alluded to the significance of cooperative turn-taking and co-construction of the interactions.

Nurses' behavior and strategies that impede realization of patients' rights

Nurses were also asked to evaluate their own colleagues and identify the communication approaches that might negate the provisions of the charter of patients' rights. They identified insulting language targeting patients, inattentiveness, poor non-verbal communication, and non-confidentiality as undesirable strategies that constituted impoliteness by fellow nurses. Arrogance and intolerance were reported as originating from both nurses and patients, especially when patients were directed to pay for items prescribed for treatment against their will. Another set of undesirable communication strategies nurses mentioned included instances where the nurse ignored or failed to listen to what the patients said. Moreover, nurses reported, the nurse could fail to cultivate trust and establish rapport, show bias in handling issues, and be judgmental. These would heighten the potential for conflict and confrontation inherent in all human interaction.⁸⁵

Distorted or incomplete information from the nurses also featured as an undesirable strategy. Asking closed-ended questions and speaking to patients unhappily were also identified as bad strategies in nurse-patient interactions. Moreover, some nurses asked patients questions that they were unable to answer. By doing this, the nurses imposed roadblocks, which Matthew McKay and colleagues have described as communication behaviors that stop or temporarily halt a meaningful dialogue; these authors argue that roadblocks can deprive the client of autonomy and dignity.⁸⁶

The relationship between physical exhaustion, attitude, and interaction patterns also featured in the nurses' responses. One nurse averred that when they were strained with too much work, their attitude changed and some bits of negative verbal and non-verbal acts might manifest in their utterances, thereby constraining the interactions. Similarly, it was stated that most nurses experienced burn-out in the course of the day and by the end of the day are impatient with patients. A nurse pointed to impolite strategies whereby some fellow nurses shouted at patients to speak up, even if the patient was in pain. In addition, poor nurse strategies included poor interpersonal relations by showing superior attitude to patients. Conveying superiority would jeopardize the success of the interaction and account for the perceptions of loss of dignity and violation of rights attributed to either party. The nurses' demonstration of absolute power in their professional sphere of influence is faulted by Sik Ng and James Bradac, who argue that the notion of power is understood not as static and unchanging but as constantly negotiable.⁸⁷ This implies that to enhance dignity promotion, patients should be regarded as partners in the process of seeking and giving of health care. Such partnership can narrow the social and professional gap between the two parties and cultivate preference for utterances that do not encode outright denial of rights that are clearly spelled out in the statutes.

Patients' behavior that promotes realization of rights

Nurses were able to specify the positive behavior that they expected from patients in order for the latter to be accorded their rights. One nurse expected the patient to observe the norms of territoriality by keeping a distance from bystanders when presenting a problem. Although this approach might look

conspiratorial in a context where other patients also wait for service, it would guarantee the right to confidentiality and personalized attention in case of embarrassing or taboo topics. Despite the overriding formality nurses expected, a degree of liberalism was seen in the response of two nurses who stated that the patient was free to approach them in any way as long as the point was made.

In another dynamic view, a nurse reported that a patient should be allowed to exhaust and express feelings and be given time to make decisions. We considered these views progressive because they respect the patients' rights to free will and self-determination. Such interactions would fulfill the policy intention of humaneness and client-centered service, whereby the patient is considered as a rational being who may hold valuable health opinions.⁸⁸ This is a departure from the traditional stance of nurses who had preconceived ideas and made unilateral decisions regardless of the patient's own experience and preferences. In order for this humane strategy to work, the patient was expected to be open and willing to cooperate with the nurse. Nurses also suggested that patients should relate their problems openly and exhaustively, listen before responding, and give feedback. In addition, another nurse reported that respect for the nurse and the patient's ability to open up were desirable traits. This would lead to uninhibited self-initiated disclosure and a sustained two-way interaction.

Other variables that may constrain the interaction process

The interviews also revealed other factors beyond nurses' and patients' control but which, nonetheless, are pertinent to our characterization of nurses' impoliteness and patients' rights and dignity. For instance, nurses invariably mentioned language barrier from the broad perspective of lack of mutual intelligibility, and for which they used interpreters. Other factors mentioned included literacy level of the patient, age gap, and class differences between nurses and patients. These might also hinder effective communication and interfere with efforts to promote dignity. The consciousness of these background differences and clashes of interest arising from social tensions could set the scene for conflict in subsequent interactions with the patient. Cultural beliefs also featured as a constraint to effective nurse-patient interaction since some patients were said to harbor divergent

opinions emanating from their cultures. This led to a clash of values, since nurses sometimes failed to embrace diversity. The fact that nurses were aware that patients had preconceived ideas suggests that the two groups sometimes came into the interaction as adversaries.⁸⁹

Structural weaknesses in the health system could also constrain the interactions. For instance, patients mentioned the fact that lack of confidentiality due to ward overcrowding might have aggravated the violation of their rights. Moreover, the large number of patients and little time to attend to them was seen by nurses as a threat to efficient and satisfactory service. This suggests that nurses were prone to attention shifts with many patients competing for attention.

A further determinant of the quality of interactions was the duration of stay in the hospital. Outpatients reported more instances of violation of rights than inpatients. From the patients' perceptions, we inferred that inpatients were more likely to have their rights respected by the nurses due to the rapport resulting from a longer stay. Many outpatients who had come on repeat visits also reported less strained interactions, primarily because they knew the procedures and thus, in the words of one nurse, "did not waste time asking questions like their first-time counterparts."

CONCLUSION

The results of our survey show that the policy measure in 2006 by Kenya's Ministry of Health, intended to make health service provision humane, compassionate, and dignified, still faces implementation challenges. The reports discussed above, based on Kenyan patients' and nurses' perspectives, indicate that the attitudes of both nurses and patients pose a challenge to the realization of the charter of patients' rights. It is evident that nurses bear the greater blame for the impediments in the implementation of rights as they are spelled out in the patients' charter. It is apparent that nurses still perceive their role as that of the all-knowing benefactor and are still not receptive of patients' input. Public perception has also not changed, because nurses in the public hospitals are still regarded as aloof and unresponsive to patients' needs. We found that patients expected to experience interaction strategies that promoted dignity and reduced the professional gap, while nurses expected patients to maintain a degree of formality that ren-

dered patients as passive recipients of care. Violations of the dignity of patients reflect the nurses' unwillingness to bridge the social and power frontiers that set the limits for their interactions. This inclination to protect professional space compromises patient satisfaction by emphasizing their "out-group" status. This tendency violates the patients' fundamental right to non-discrimination.

In order for the Kenyan patients' service charter to have practical meaning for both patients and nurses, better training in advocacy skills for the nurses is pertinent. Patients should also be sensitized on desirable strategies for asserting their rights in a manner that does not threaten the dignity of nurses nor impinge upon official nursing duties. Accordingly, to promote the active participation of patients, we suggest that they should be supported in their attempts to access service by applying humane approaches that minimize conflict between patients and health care providers while facilitating the uninhibited enjoyment of rights. This could be achieved by introducing a clear system for lodging complaints and getting feedback without antagonizing the nurses. The customer care staff could be mandated to play the role of patient advocates to clarify procedures. Public awareness campaigns could also be enhanced through posters and leaflets to define patients' rights and obligations in the hospital setting. Moreover, as Henderson argued, contemporary nursing practice envisages that nurses should work in partnership with patients and share power with them by giving information and support.⁹⁰ Mutual cooperation is required, therefore, in order to maintain patients' dignity in nurse-patient interactions and guarantee the practice of fundamental human rights. Since individuals and collectives usually act to create, maintain, defend, and reclaim their own dignity and that of others, the nurses whose approaches were reportedly undesirable should be sensitized to be aware of the impact that their impolite strategies have on patient satisfaction. This would create mutual rapport and enhance patient satisfaction and remove some of the hurdles that impede access to health care.

REFERENCES

1. World Health Organization Regional Office for Europe, *A declaration on the promotion of patients' rights in Europe* (Copenhagen: WHO Regional Office for Europe, 1994). Available at http://www.who.int/genomics/public/eu_declaration1994.pdf.
2. D. Seedhouse and A. Gallagher, "Undignifying situations," *Journal of Medical Ethics* 28/6 (2002), pp. 368–372.
3. World Health Organization, "Patients' rights" (2005). Available at <http://www.who.int/genomics/public/patientrights/en/>.
4. S. Henderson, "Power imbalance between nurses and patients: A potential inhibitor of partnership in care," *Journal of Clinical Nursing* 12/4 (2003), pp. 501–508.
5. C. S. Jacelon, "The dignity of elders in an acute care hospital," *Qualitative Health Research* 13 (2003), pp. 543–556.
6. N. Kuzu, A. Ergin, and M. Zencir, "Patients' awareness of their rights in a developing country," *Public Health* 120/4 (2006), p. 290–296.
7. L. Bailie, "The impact of staff behaviour on patient dignity in acute hospitals," *Nursing Times* 103/34 (2007), p. 30.
8. H. M. Chochinov, "Dignity in the terminally ill: A developing empirical model," *Social Science and Medicine* 54/3 (2002), pp. 433–443.
9. World Health Organization Regional Office for Europe (see note 1).
10. S. Chankova, S. Muchiri, and G. Kombe, "Health workforce attrition in the public sector in Kenya: A look at the reasons," *Human Health Resource* 7/58 (2009), p. 58.
11. B. Singer, "Kenyan nurses in brain-drain," *The East African* (April 14, 2008). Available at <http://www.afrika.no/Detailed/11048.html>.
12. Chankova et al. (see note 10).
13. P. Mbinyo, L. Gilson, B. Lucy, et al., "Contextual influences on health worker motivation in district hospitals in Kenya," *Implementation Science* 4/43 (2009), p. 43.
14. Ibid., p. 44.
15. S. Makabila, "Kenya losing specially trained nurses," *The Kenya Nurse* 10/2 (2006), pp. 6–9.
16. Kenya Institute of Public Policy Research and Analysis, *An evaluation of the health sector and client satisfaction in Kenya* (Nairobi: Claripress, 1994).
17. Kenya Ministry of Health, *The second national*

- health sector strategic plan* (Nairobi: Government Press, 2004), pp. 3–5.
18. Kenya Ministry of Health, *Patients' service charter* (Nairobi: Government Press, 2006).
 19. Kenya Medical Training College, *Curriculum for the diploma in Kenya registered community health nursing* (Nairobi: Kenya Medical Training College, 2005).
 20. Makabila (See note 15).
 21. G. Eelen, *A critique of politeness theories* (Manchester: Jerome Publishing, 2001).
 22. M. Calnan, G. Woolhead, P. Dieppe, and W. Tadd, "Views on dignity in providing health care for older people," *Nursing Times* 101/33 (2005), pp. 38–41.
 23. E. Arnold and K. U. Boggs, *Interpersonal relationships and professional communication skills for nurses* (Sydney: W. B. Saunders Company, 1989).
 24. Universal Declaration of Human Rights (UDHR), G.A. Res. 217A (III) (1948). Available at <http://www.un.org/Overview/rights.html>.
 25. Baillie (see note 7), p. 31.
 26. UDHR (see note 24), preamble.
 27. International Covenant on Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI), Art. 1(1). (1996). Available at <http://www2.ohchr.org/English/law/ccpr.htm>.
 28. UDHR (see note 24), Article 22.
 29. *Ibid.*, Article 23.
 30. International Covenant on Civil and Political Rights (ICCPR), G.A. Res. 2200A (XXI) (1996), preamble. Available at <http://www2.ohchr.org/english/law/ccpr.htm>.
 31. *Ibid.*, Article 21.
 32. *Ibid.*, Articles 2(3a) and 17(1).
 33. Charter of the Fundamental Rights of the European Union (2000/C 364/01), Article 1. Available at http://www.europarl.europa.eu/charter/pdf/text_en.pdf. The expanded "Overview" cited here, as well as the English-language text of the constitutions of other members of the European Union is at European Commission Committee on Citizens' Freedom and Rights, Justice and Home Affairs, *Freedom, security and justice: An agenda for Europe*. Available at http://www.europarl.europa.eu/comparl/libe/elsj/charter/art01/default_en.htm.
 34. *Ibid.*
 35. *Ibid.*
 36. *Ibid.*
 37. Constitution of Kenya, Article 19. Available at <http://www.kenyalaw.org>.
 38. *Ibid.*, Article 28.
 39. European Commission Committee on Citizens' Freedom and Rights (see note 33), Constitution of Belgium, Article 23.
 40. *Ibid.*, The Basic Law of Germany, Article 1.
 41. *Ibid.*, Constitution of the Republic of Italy, Article 3.
 42. *Ibid.*, Constitution of Latvia, Chapter VIII, on fundamental rights, section 95.
 43. *Ibid.*, Constitution of Lithuania Article 21.
 44. Charter of the Fundamental Rights of the European Union (see note 33).
 45. European Commission Committee on Citizens' Freedom and Rights (see note 33), Constitution of Poland, Article 41.
 46. *Ibid.*, Constitution of the Portuguese Republic, Article 13.
 47. *Ibid.*, Constitution of the Slovak Republic, Article 21.
 48. Benson Ojwang conducted the interviews and discussed the analysis and identification of themes with the co-authors, who acted as thesis supervisors.
 49. National Nurses' Association of Kenya, *Code of Conduct and Ethics* (2009), p. 12. Available at <http://www.kacc.go.ke/docs/NNAK-CODE.pdf>.
 50. Kenya Ministry of Health (see note 18).
 51. P. Grundy, *Doing pragmatics* (London: Edward Arnold, 2008), p. 41.
 52. *Ibid.* p. 43.
 53. J. Ohlen, "Violation of dignity in care-related situations," *International Journal of Research and Theory for Nursing Practice* 18/4 (2004), pp. 371–385.
 54. K. Tracy, "Reasonable hostility": Situation-

- appropriate face-attack," *Journal of Politeness Research* 4 (2008), pp. 169–191.
55. C. S. Jacelon, "Attitudes and behaviours of hospital staff towards elders in an acute care setting," *Applied Nursing Research* 15 (2002), pp. 227–234.
56. G. Leech, *Principles of pragmatics* (London: Longman, 1983), p. 66.
57. N. Jacobson, "A taxonomy of dignity: A grounded theory study," *BioMed Central* 9/3 (2007). Available at <http://www.biomedcentral.com/1472-698X/9/3>.
58. See, for example, T.-S. Lim, "Facework and interpersonal relationships," in S. Ting-Toomey (ed), *The challenge of facework: Cross-cultural and interpersonal issues* (New York: State University of New York, 1994), pp. 209–229. On this topic, see also P. Backhaus, "Politeness in institutional elderly care in Japan," *Journal of Politeness Research* 5 (2009), pp. 54–71.
59. Kenya Ministry of Health (see note 18).
60. G. Woolhead, M. Calnan, P. Dieppe, and W. Tadd, "Dignity in older age: What do older people in the United Kingdom think?" *Age and Ageing* 33/2 (2002), pp. 165–170.
61. ICCPR (see note 30), Articles 19(1), 19(2).
62. A. Huckstadt, "The experience of hospitalized elderly patients," *Journal of Gerontological Nursing* 28/9 (2002), pp. 24–29.
63. Eelen (see note 21), p. 16.
64. Kenya Ministry of Health (see note 18).
65. A. Berglund and C. Saltman, "Re-examining linguistic power: Strategic uses of directives by Japanese women in positions of authority and leadership," *Journal of Pragmatics* 37/5 (2002), pp. 633–666.
66. G. Dexter and M. Wash, *Psychiatric nursing skills: A patient-centered approach* (London: Stanley Thornes Limited, 1997).
67. Ohlen (see note 53).
68. ICCPR (see note 30), Article 10.1.
69. Jacelon (see note 5).
70. K. Walsh and I. Kowanko, "Nurses' and patients' perceptions of dignity," *International Journal of Nursing Practice* 8/3 (2002), pp. 143–151.
71. P. Mares, A. Henley, and C. Baxter, *Health care in multicultural Britain* (London: Health Education Council, 1985).
72. D. Hyland, "An exploration of the relationship between patient autonomy and patient advocacy: Implications for nursing practice," *Nursing Ethics* 9/5 (2002), pp. 472–482.
73. Jacobson (see note 57).
74. C. Forchuk, "The developing nurse-client relationship: Nurses' perspectives," *Journal of the American Nurses' Psychiatric Association* 6/1 (2000), pp. 3–10.
75. Arnold and Boggs (see note 23).
76. Jacobson (see note 57).
77. Ibid.
78. Y. Gu, "Politeness phenomena in Chinese," *Journal of Pragmatics* 14/2 (1990), pp. 237–257.
79. Kenya Ministry of Health (see note 18).
80. Ibid.
81. T. M. Holtgraves, "Social psychology, cognitive psychology and linguistic politeness," *Journal of Politeness Research* 1/1 (2005), pp. 73–93.
82. S. Ide, "Formal forms and discernment: Two neglected aspects of linguistic politeness," *Multilingua* 8/2–3, pp. 223–248.
83. Jacobson (see note 57).
84. Kenya Ministry of Health (see note 18).
85. Jacobson (see note 57).
86. M. McKay, M. Davis, and P. Fanning, *Messages: The communication skills book* (Oakland: New Harbinger Publishers, 1995), p. 56.
87. S. H. Ng and J. J. Bradac, *Power in Language: Verbal communication and social influence* (Newbury Park: Sage Publishers, 2004), p. 3.
88. Forchuk (see note 74), p. 8.
89. M. Locher, *Power and politeness in action* (Berlin: Mouton de Gruyter, 2004), p. 23.
90. Henderson (see note 4), p. 504.