Advances in Nursing Science
Vol. 42, No. 4, pp. 278–288

Analyzing Patients' Complaints
Awakening of the Ethic of Belonging

CE 1.5 Contact Hours

Yan Ming, BSN, RN; Holly Wei, PhD, RN; Hong Cheng, BSN, RN; Jie Ming, BSN, RN; Mark Beck, DNP, RN

Nursing ethics are fundamental principles to nursing practice. The purpose of this study is to analyze patients' complaints filed against nurses from a nursing ethics perspective. This is a qualitative study. The data source is the patients' complaints filed in a university-affiliated hospital in China. The complaints are categorized into 4 themes: uncompassionate attitudes, unprofessional communication, disrespect of patient rights, and unsatisfactory quality of nursing care. The ethic of belonging reflects nurse-patient relations. Patients expect to be treated with dignity. This study sends out a call for nurse leaders and educators to reevaluate the practice and education of the nursing professional identity. **Key words:** *ethic of belonging*, *human caring*, *nursing ethics*, *patient rights*, *patients' complaints*

PATIENTS' hospital experiences have gained much attention globally in recent years. The payment system in the United States, for example, has been transitioned from a fee-for-service to a pay-for-performance. This payment system ties patients' subjective experiences to hospitals' financial reimbursement. In China, on the other hand, the payment system largely operates on a fee-for-service payment system, which is partially blamed for the increase in patients' complaints in recent years. A recent mixed-methods study shows that patients' negative hospital experiences lead to the majority of patients' complaints, raising questions about the ethical nature of provider practice.[1] This study, thus, focuses on patients' complaints about nurses from a nursing ethics perspective.

Historically, nursing ethics have been an integral part of the nursing profession. Ever since the era of Florence Nightingale, nurses have taken on an ethical role to place patients in their best possible conditions for nature to act and heal.[2] The primary professional responsibility of nurses is to serve people who need nursing care.[3] Nursing is an interpersonal practice, in which building caring and trustworthy relationships is imperative for nurses to provide quality and safe patient care. Ethics are morals guiding the actions of human beings,[4] and nursing ethics are fundamental principles to nursing practice.[5] The 4 widely accepted normative ethical principles for health care professionals include respecting autonomy, beneficence, nonmaleficence, and justice.[6] Through delivering the care that is ethics-laden, nursing affects patients' health. While caring is the underlying principle of the nursing profession, the current nursing practice still encounters tensions between task-oriented instrumental care and human-centered caring.[7,8]

Author Affiliations: *The Affiliated Hospital of Qingdao University, China (Mss Ming, Cheng, and Ming); Graduate Nursing Leadership Department, College of Nursing, East Carolina University, Greenville (Dr Wei); and Samuel Merritt University, Oakland, California (Dr Beck).*

The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

We would like to acknowledge the reviewers for their constructive feedback to improve the quality of this article.

Correspondence: *Holly Wei, PhD, RN, Graduate Nurse Leadership, College of Nursing, East Carolina University, Greenville, NC 27834 (weih16@ecu.edu).*

DOI: 10.1097/ANS.0000000000000278

Statement of Significance

What is known or assumed to be true about this topic:

As economies grow, people's expectations for quality of care increase not only in clinical skills but also in humanity. The field of medicine including nursing, however, has traditionally been considered as "hard science" in China, where the training of nurses focuses more on the tangible medical knowledge and skills and less on ethical and humanistic caring.

What this article adds:

This article innovatively investigated patients' complaints from a nursing ethics perspective. As health care is facing transformational changes globally, the notions introduced in this paper, such as "the other," human-centered caring, and nurse-patient relationships, are important concepts in nursing ethics. This study sends out a call for nurse leaders and educators to reassess the education of the nursing professional identity.

The discipline of nursing, within a unitary caring science practice framework, values the wholeness of a person and caring human relations. Unitary caring science, drawing on the European philosopher Emmanuel Levinas' notions of the human-universe-oneness and the infinite love in the universal field,[9] emphasizes the universal love, a transpersonal caring relationship, and the ethic of belonging.[10] Levinas asserts that the "ethic of belonging" is the first principle of science, and is a priori of the ontology of separateness of being.[10] We all belong to the universal field of love before we are separate beings; wholeness and connection come before separation and division, thus establishing unitary caring science as an ethical-epistemic-ontological worldview.[10] Based on this worldview, ethics, the caring relational ontology and an awareness of belonging become the ethical foundation for the discipline of nursing. This universal love and transpersonal caring relationship are the essences of how one treats "the other." "The other," according to Levinas, is "not me," someone else other than oneself.[9] The ethic of belonging is the interconnectedness with the infinite universe and the consciousness of the spirit and energy source.[10]

In health care, the ethic of belonging describes the relationships between health care professionals and patients.[11] Patient-provider relationships are largely influenced by 2 factors, the inescapability of getting sick and providers' power to heal. Upon coming to hospitals to seek care, patients and families become "the other" who depends on health care providers to restore their health. In the provider-patient interactions, if not careful, health care providers may enact their powers in negative ways. The negative ways of power over patients may include coercion, manipulation, and hierarchy,[12] which can lead to intimidation and fear and violate the spirit and intention of belonging. When providers show the power over patients (the other), the expectations between patients and providers may depart and thus lead to negative patients' experiences and feelings.[1]

In China, as economies grow, people's expectations for quality of care increase as do patients' complaints. With advanced understandings of the law, individuals become more aware of the regulations and their rights.[13,14] When discrepancies or incongruencies occur between patients' expectations and health care professionals' actions, patients become dissatisfied, and complaints ensue.[1,14] While the increase in patients' complaints is multifactorial, little research, however, has examined patients' complaints from a caring relation and an ethical perspective.

Understanding patients' complaints against nurses from an ethical point of view may provide insights and guidance in improving the education and performance of ethical nursing practice. A major medical center in China has been collecting patients' complaints about nurses for the last several years. To fully understand patients' expectations and experiences, hospital leaders are required to examine patients' complaints to guide quality

improvements and nursing education. Therefore, the purpose of this study is to analyze patients' complaints filed against nurses through the lens of human relations and nursing ethics.

STUDY METHODS

Ethical approval

The hospital had deidentified the data for research purposes. The use of the deidentified data was approved by the Research Management Department of the hospital in China.

Study design

This is a qualitative study evaluating patients' complaints filed against nurses. A qualitative summative content analysis[15] is used to conduct the data analysis. There are 3 approaches to qualitative content analysis—conventional, directed, and summative.[15] A major difference between the 3 approaches is coding schemes. The coding categories for conventional content analysis are derived inductively from the data. In a directed content analysis approach, an existing theory or related research findings are used as a guide for initial codes. A summative content analysis comprises counting and comparing relevant keywords or content and interpreting core context. We used the summative content analysis approach to count and compare patients' complaints and understand the underlying meaning of the text data. This methodology was chosen for this study because it helped us examine the central facet of the social interactions between patients and nurses and summarize the occurrence of the complaints quantitatively as descriptive statistics.

Data source and study setting

The data of the study were the complaints that patients or families filed in a major academic affiliated hospital in China between January 2015 and December 2017. This hospital is a 4000-bed tertiary medical center with average outpatient visits around 4.7 million a year and inpatients about 180 000 a year. Patients' complaints were filed via phone, in-person, or mailed letters. In this hospital, a specific department was set up to receive patients' complaints across disciplines. To fulfill the purpose of this study to strengthen the discipline of nursing, we focused on the complaints against nurses.

Data analysis

A qualitative summative content analysis approach[15] was used to compare and interpret the frequencies and characteristics of patients' complaints against nurses. Based on the suggestions by Hsieh and Shannon,[15] the process of data analysis was as follows: (*a*) the deidentified data were uploaded and managed by Microsoft Excel, (*b*) the first and second authors/researchers (Y.M. and H.W.) coded the data independently, (*c*) to ensure coding consistency, these 2 researchers/authors (Y.M. and H.W.) first conducted a few cases together to ensure interrater reliability, (*d*) the authors met regularly to discuss the coding progress, and (*e*) when disagreements occurred with coding, the authors refound meanings from the original documents together to reach understanding and coding congruency.

The rigor of the study

The rigor of the study was achieved according to the recommendations by Sandelowski,[16] including credibility, fittingness, auditability, and confirmability. For credibility, the first 2 authors/researchers (Y.M. and H.W.) made sure that the codes selected were true to the meaning of patients' complaints. To ensure the fittingness, complaints that reflect the experience of patients and families interacting with nurses were examined. The authors kept a clear audit trail during the coding process to uphold auditability. To achieve confirmability, another 2 authors/researchers conducted an independent check to make sure that the codes represented patients' complaints.

STUDY FINDINGS

General descriptions of the complaints against nurses

A total of 1214 patients' complaints were received in this hospital from January 2015 to December 2017. These complaints were filed against individuals across health care professions including physicians, technicians, desk clerks, and nurses. Among the total of 1214 complains, 127 (10.5%) were filed against nurses, which was the focus of this study. Table 1 shows the demographics of the patients and families who filed the complaints.

As shown in Table 1, complaints were filed about equally by males (49.6%) and females (45.7%). More than half of the complaints were filed by family members (55.9%). Nurses who were complained about the most were those working in outpatient clinics (48.8%), followed by inpatient units (26.0%), emergency department (11.8%), and diagnostic departments (8.7%).

Categories of the complaints

The complaints were categorized into 4 themes. In the order of the amounts filed from the most to the least, the 4 categories were nurses' uncompassionate attitudes, unprofessional communication, disrespect of patient rights, and unsatisfactory quality of nursing care. Most of the patients' complaints, however, were filed due to multiple reasons. For example, patients indicated in their complaints that when they were not happy about the quality of nurse care, they initially did not plan to file the complaints. However, what triggered the complaints was nurses' uncompassionate attitudes or unprofessional communication skills. Because patients' complaints were often due to multiple reasons, we chose to categorize patients' complaints based on the primary and secondary reasons for the complaints.

Table 1. Demographics of Patients' Complaints (n = 127)

Characteristic	n (%)
Gender	
Male	63 (49.6)
Female	58 (45.7)
Unsure	6 (4.7)
Person filing complaints	
Patients	42 (33.1)
Family members	71 (55.9)
Unsure	14 (11.0)
Units that were complained	
Inpatient units	33 (26.0)
Outpatient clinics	62 (48.8)
Emergency departments	15 (11.8)
Diagnostic departments	11 (8.7)
Unsure	6 (4.7)

We first classified a patient's complaint based on its primary reason and then categorized it according to its secondary reason. For example, one family member complained that his mother was 80 years old. He was afraid that his mother could not understand her doctor's questions and wanted to attend his mother to see the doctor, but he was not allowed to accompany his mother due to a hospital visitation policy. After the family member begged the nurse at the desk for permission a few times, the nurse became angry and talked back using unprofessional language. In this situation, the primary reason for the complaint was the disrespect of patient rights, and the second category was unprofessional communication. Table 2 shows the frequencies of the primary and secondary complaints and patients' perceptions of nurses' actions that led to their complaints.

Uncompassionate attitudes

Uncompassionate attitudes were categorized when patients/families did not feel that nurses showed empathy or concerns for patients, or when patients/families felt that nurses treated them in a way that was negative, destructive, or aggressive. Some complaints reported that patients felt that nurses were indifferent about what patients were going through. Others indicated that when patients or families asked nurses questions or

Table 2. Categories of Patients' Complaints

Categories	n (%)	Patients' Perceptions About Nurses' Actions That Led to Patients' Complaints	Implications for Practice
Uncompassionate attitudes	Primary complaint: 44 (34.65)	Nurse did not show empathy or concerns about patient experience	Promote humanistic caring Maintain a positive and compassionate attitude
	Secondary complaint: 58 (45.66)	Nurses became defensive or aggressive toward patients/families	Show empathy and loving-kindness
Unprofessional communication	Primary complaint: 36 (28.35)	Nurses used improper language tone or expressions when talking to patients/families	Treat patients with courtesy and support Build trusting and caring relationships with patients
	Secondary complaint: 50 (39.37)	Nurses used poor facial/body language when interacting with patients/families	Deliver information with kindness and clarity
Disrespect of patient rights	Primary complaint: 25 (19.69)	Nurses did not clearly deliver information to patients/families	Be advocates for patient rights Revisit hospital/unit policies and rules to ensure flexibility
	Secondary complaint: 10 (7.87)	Nurses failed to protect patient autonomy in decision-making	Respect patient autonomy in decision-making
Unsatisfactory nursing care quality	Primary complaint: 23 (18.11)	Nurses did not perform sufficient examinations or clinical observations that resulted in poor patient outcomes	Improve care competency Enhance caring attitudes and communication skills
	Secondary complaint: 8 (6.3)	Nurses conducted substandard technical skills	Decrease/eliminate power-gradience to promote nurse-patient ethical relations

requested nurses to help, they felt that nurses were not constructive or helpful.

One patient's complaint stated, "When I tripped in the waiting area, the nurse on duty glanced at me, but did not help or even show any empathy." One person reported that because of the urgency of his wife's threatened abortion, he had to register an emergency department number because the obstetric outpatient clinic did not have any openings that day. However, when his pregnant wife was transferred to the obstetric clinic, she got reprimanded loudly because she did not have the registration number for the obstetric clinic, which made his wife cry. When the husband went inside to talk to the nurse, the nurse was unconcerned about the situation and even called the hospital security staff to escort him out. The husband felt that the hospital was supposed to be a place where humanity resided. He filed the complaint because he did not think that the nurse's rude and uncaring attitudes were appropriate for the circumstance. The complaint indicated that the nurse's action did not show respect for humanity or ethics.

Nurses are commonly the frontline staff of a health care facility. Their attitude and demeanor directly affect patients' perceptions of the quality of patient care and the kindness—benevolence—of the organization. Patients come to a hospital at their vulnerable times due to their illnesses, and this is the time that they need help, compassion, and

loving-kindness. Nurses are recommended to maintain a positive and compassionate attitude and respect patient humanity.

Unprofessional communication

Unprofessional communication was characterized when patients/families perceived that nurses lacked the use of proper language, tone, choice of words, or facial/body expressions when talking to patents and families. Patients filed their complaints when they felt that nurses treated or spoke to them rudely without professional considerations. Complaints of poor communication also indicated that communications among health care professionals were lacking.

Patients filed their complaints against nurses when they felt that nurses talked rudely to patients and families and used improper—unprofessional—facial expressions and body languages. One complaint stated that when a nurse at the front desk spoke to him, she did not even lift her head. While talking, the nurse had an unprofessional attitude and spoke to him rudely. He tried to learn this nurse's name, but no one on the unit would tell him. Another example was that a nurse was eating while replying to patients' questions. She had a shallow voice and did not even look at patients. When the patient who later filed the complaint did not hear what the nurse said and asked her to repeat, the nurse not only did not explain but also reprimanded him.

One patient complained about the lack of communications between nurses and physicians. The patient reported that his physician told him that the result of the pathological examination would be out in a week. At that time, the patient would receive a call from a nurse to let him know the results. When the patient did not receive the phone call from a nurse as he had expected, he called the clinic. The complainant said that the language of the nurse on the phone was coarse and told him that she did not see any report, and, besides, no one had told her that she needed to call him. The nurse then hung up the phone.

Patients have certain expectations of nursing as a profession. In the eyes of the public, nursing as a profession has an image that is to serve and help people in need of nursing care. Nurses as professionals provide patients with loving-kindness and humanistic care. When coming to a hospital, patients need medical help and advice and depend on nurses to provide them with clear and understandable information and guidance. Patients have the right to be treated with humanity, courtesy, and support and to feel a sense of belonging. Ethically, it is nurses' responsibility to be fair to all patients, respect human dignity, and explain information understandably and respectfully.

Disrespect of patient rights

Concerns about the disrespect of patient rights were categorized when patients perceived that their rights were violated. Under these situations, patients did not feel that nurses had provided adequate information for them to understand treatment procedures and make an informed decision or felt that their safety was compromised. Patients' complaints indicated that, at times, hospital policies could have been the barriers to endorse patient rights.

Patients felt that being able to understand a procedure and make an informed decision was a critical patient right. However, one complaint was that the patient was asked by a nurse to sign a consent form for a diagnostic procedure. He said that the nurse did not explain the procedure or the medication before he was asked to sign. That patient, after the procedure, developed a rash. When he went back to the hospital and asked what medication he was given, he told the nurse that he had a known history to be allergic to that medication.

Some hospital rules and policies were considered by patients to be inappropriate to protect patient rights. One complaint was that a nurse denied a mother's request to accompany her 17-year-old daughter when her daughter was to have a breast examination by a male physician. The mother felt

it was her right to be with her underage child. Another complaint was about an elder patient. The son of the elder patient was afraid that his mother might not be able to comprehend what her physician would say to her during the examination and wanted to accompany her to the examination room. This family member's request was denied because of a hospital visiting policy, which the patient did not feel was appropriate and filed the complaint. Another complaint was that a husband accompanied his wife to a surgical clinic to receive information about the wife's surgery. Since his wife had heart disease, he wanted to go in with her in case she needed help to process the procedural information. However, a nurse at the front desk refused to allow him to go in with his wife even after he had explained the situation and requested multiple times. The complainant thought that the nurse lacked human caring.

These complaints are filled with requests to respect patients' autonomy for treatment, ensure flexibility, and protect patient rights and humanity. The examples here are indicative of 2 aspects—patient safety and rights. Depending on the culture of patients, it is a patient's right to be fully informed about his or her treatment plans and the medications and procedures given and undergoing.

Unsatisfactory quality of nursing care

Complaints about the quality of nursing care were those related to the concerns about nurses' lower-than-standard performance. The issues related to the quality of care were raised when patients felt that nurses performed insufficient examinations or had poor technical skills. Patients' complaints about nurses' quality of care were often aroused by nurses' uncompassionate attitudes and communication instead of underperformed skills.

Patients complained about nurses' quality of care when they perceived that nurses had below-the-standard technical skills. However, more than half of the complaints about the quality of nursing care were aroused by nurses' noncaring demeanors. One complainant indicated that 3 nurses tried to place his intravenous injection, but all failed. When he talked to nurses about their performance, he said that nurses became offensive and were rude in replying. It is because of their ignorant attitudes that he decided to file the complaint. Another complaint showed that a skin test was performed, but nurses did not read the result in time as required. When the patient came to ask a nurse to read the skin test, the nurse told him that it was too late, and the test had to be redone. When he asked the nurse why she did not read it as scheduled, he said that the nurse became very offensive, angry, and rude, which was why he submitted the complaint.

Another example was that a patient did not feel well after a kidney procedure. He rang the call bell to get a nurse. Because no one came after he rang the call bell once, he rang it a second and third time. A nurse finally came after he rang the call bell 4 times. When the nurse arrived, the patient described that the nurse was angry, and her attitude was blunt and punitive.

Patients and families expect that it is nurses' ethical and professional duty and obligation to provide high-quality care. When incongruency occurs between patients' expectations for care and the care that they receive, patients are dissatisfied, and patients' complaints may occur. However, most of the times patients' complaints are not triggered by their perceptions of substandard care, but by nurses' uncompassionate attitudes or unprofessional communication skills. To provide the best care to patients and families requires nurses to be not only competent in clinical knowledge but also empathetic in nursing care.

DISCUSSION

This study gives insight into patient dissatisfaction with the nursing practice at a hospital in China. The findings for primary and secondary reasons for patient complaints indicate the complexity of patient experiences in health care. When patients come to health care settings to seek care, they not only look for "sick" care that is disease-specific

but also desire for human care, the battle of instrumental care, and human-centered caring. Instrumental care is considered as ways in which nurses treat their nursing practice as tasks. Human-centered caring emphasizes the whole nurse being with the whole patient as a person in building a healing nurse-patient relationship.[8] A fundamental difference between instrumental care and human-centered caring is how nurses treat "the other"—patients. The primary and secondary complaints indicate that, most often, patients file complaints because they do not feel that they are treated with human caring. This finding indicates that nurses' caring behaviors may alleviate patients' negative experiences and complaints.

In the development of a human-centered caring relationship, Halldorsdottir[17] postulates 5 stages of being with "the other." These stages include biocidic (depersonalizes "the other"), biostatic (insensitive to "the other"), biopassive (detachment from "the other"), bioactive (recognizes the personhood of "the other"), and biogenic (affirms the personhood of "the other").[17(p650)] The findings of the study indicate that patients' complaints occur when the nurse-patient relationships are at the biocidic and biostatic stages. The care at these 2 stages is insensitive and indifferent to patients' subjective feelings and experiences. To promote the relational caring and reach the biogenic stage, nurses, in addition to focusing on the diagnostic labeling or technical solutions to patients' issues, need to emphasize patients' health, personhood, and nurse-patient relationships.[18] Relational ontology at its core is about establishing a healing environment, where the possibility of a human-to-human connection is the goal, not the byproduct of the delivery of health care. The foundation of this relational ontology is the ethic of belonging.

In health care, nursing ethics should be the foundation to guide nursing as a profession and practice. Great nurses should not only possess competencies in nursing skills, but also be altruistic, responsible, and empathetic.[19] This study shows that nurses' behaviors, verbal and nonverbal, affect patients' experiences and perceptions of care. As shown in Table 2, the findings demonstrate that more than 80% of the complaints were stimulated primarily and/or secondarily by uncompassionate attitude and unprofessional communication skills. How nurses theorize their nurse-patient relationships influences their behaviors in their care delivery.[20,21] If nurses see themselves as a part of the task-driven delivery system, their focus may be on task-completion and process-fulfillment, instead of using love-kindness and humanity to create an environment and a culture to make patients feel a sense of belonging.

Nurses' cold and indifferent attitudes and communication toward patients and families pose barriers to building a caring-healing nurse-patient relationship. This study finds that patients and families often complain about nurses' cold facial expressions and dismissive verbal communications. As Levinas points out, "The face formulates the first word: the signifier arising at the thrust of his sign as eyes that look at you."[9(p178)] The findings of this study show that nurses' facial expressions and language signify their first words to patients and families. When nurses talk without lifting their faces or having eye contacts, the first words of nurses, then, do not contain a compassionate or welcome message, and nurses do not show a willingness to connect with "the other." The ethic of belonging is an ethical worldview signifying that all lives are connected, which in health care provides an ethical base to guide nurse-client relationships and nurses' roles and duties to the other.[10,22] When patients come to health care settings, they should not be disregarded, but rather should be wholly and fully engaged in an experience of human belonging.

Nurses have a privilege to care for patients and families at their vulnerable times in life. As a result of this study, nurses are encouraged to respect humanity and treat patients with a caring consciousness. When nurses care for patients and families with a caring consciousness, they consider their nursing practice as sacred acts and treat patients as one of their own. Patients need to know that they have the autonomy and the right to receive clear

and respectful instructions to help them make informed decisions about their care. Ethics are how people behave when they belong together as human beings.[4] Nursing ethics determine how nurses act as a profession.[3,5] Nursing education should educate nurses on how to ethically behave—to care for others and make "the other" feel he/she belongs.

The quality of care is directly related to the quality of relationships within the health care delivery system. Viewing nursing as the sacredness of being in the face of "the other" engages nurses to meet their ethical obligation.[23] The nurses' intentionality of being authentically present with patients/families creates the environment of healing.[24] Nurses constitute a healing environment by being authentically present, seeking to understand patients' stories with genuine listening, and demonstrating compassion and equanimity in the encounter. Patients and their families are vulnerable due to their illnesses.[25] Health care by its very nature is a process that treats patients and families in their vulnerable states. Engaging with patients and families in their vulnerability establishes the relationship and creates an environment of safety. Nursing, in its essence, is a relational discipline that encounters "the other" in their state of defenselessness.[7]

Caring actions make people feel loved and respected.[3,5] Findings of the study show that nurses at times may face paradoxes during their daily work routines. It is imperative for nurses to become proficient in balancing their hospital policies and patient care obligations, and advocate for patient rights while still engaging in a caring human relationship. Professional nurses have a choice when choosing the rhythmic patterns of their daily practice—how they create a nurturing environment and relate to others.[26,27] Nurses also can select ways in which they make meaning of their interactions with patients, "the other."

Human beings are holistic who have biological, social, psychological, and spiritual needs and cannot be reduced to certain medical cases, illnesses, or diagnoses. Nursing science is sacred with mighty healing power and should not be reduced to just task-performing.[28] Nurses have the ability to transform what they do from tasks to caring moments and have the responsibility to be skill-competent and treat others with compassion. Patients receiving care from a health care system expect kindness, compassion, and honoring them as a human being with dignity. This expectation can be summed up in the "ethic of belonging," whereby nurses encounter patients (the other) through the portal of the face, establishing the connection or belonging with "the other" as the essential obligation of all human beingness. This obligation comes before acknowledging and acting upon the separateness of being. The intentionality of the actions of the nurse often translates into being "acted upon" rather than "acted with." When nurses see "the other" as sharing the same humanity as themselves, the ethic of belonging is operational.

Limitation

This study is conducted based on an existing data source of patient complaints. The characteristics of the data may have limited the understanding of the patients' complaints in depth. Nonetheless, the data have provided a solid foundation to apprehend patients' experiences and expectations. The research is framed by ethical theories that challenge normative ethics that most commonly underpin Nursing Codes of Ethics and Conduct. For the country in which this original exploration is conducted, the findings have created new nursing knowledge. Future research may investigate nurses' perceptions of caring in the study site and develop appropriate interventions to improve patient care quality.

Implications

This study draws attention to and sends out a call for ethical practice and education in nurses. With more than 80% of the complaints filed against nurses related to nurses' uncompassionate attitudes primarily (34.65%) and secondarily (45.66%), it is necessary to revisit the nurse-patient relationships and more importantly the ethical root of the bonds. The information presented could inform nursing practice, education, and professional conduct.

In China, the field of medicine and nursing has traditionally been considered as "hard science." The training of physicians and nurses focuses more on the tangible medical knowledge and skills that can be objectively measured and less on humanistic caring.[1,29] The criteria of "great" nurses are based on their clinical skills. "Great" nurses are those who can perform nursing skills perfectly. Health care organizations in China frequently hold nursing performance exhibition matches where nurses compete in the performance of nursing skills. The best performers are recognized as "great" nurses.

This study, however, indicates that if nurses' professional actions are reduced to just nursing performance, the ethical principles of nursing would be compromised. To improve the performance of nursing as a profession, the nursing education and recognition systems need to focus not only on the "hard science" (the skill performance) but also on the "soft science"(the ethical and caring practice).[30] Specific recommendations are provided from nursing education and nursing clinical practice perspectives.

Nursing education

Nursing education, including prelicensure and postgraduate education, needs to create space in the curriculum and continuing education to experientially educate and reinforce how to encounter and care for "the other." Understanding "the other" as Levinas defines the moral/ethical obligation is the foundation of how nursing creates a healing environment. By utilizing nursing ethics, nurses inform the empirical as well as personal ways of knowing. Seeing "the other" as a self-reflection is key to the empathic way of connection that conveys caring and compassion.[10,23]

Clinical practice

Clinically, nurses need to know effective ways to communicate with patients and families. Academic institutions and continuing education providers need to educate nurses in nursing's lingua franca, the language of nursing, for nurses to maintain a disciplinary focus.[31] Caring is the context within which the empirical, ethical, personal, and esthetic nursing care can be delivered to patients and families. Empirical policies and procedures are mute without the context of caring. Ethics will be devoid of meaning without caring. Nurses, when they cannot speak "nursing," which is the delivery of nursing care with the language of nursing that is caring, will be perceived not to "care" for their patients. Knowing how to speak "nursing" and communicate with patients is key to raising nurses' awareness at a conscious level of caring, compassion, and connection.[31-33]

CONCLUSION

This study sends out a call for nurses and educators both in China and internationally to reconsider the education of the nursing professional identity. One's worldview and beliefs shape his/her ethical and moral actions. The scientific models of nursing determine nurses' ethical and moral underpinnings. The awakening of the ethic of belonging—creating a culture of belonging—is an imperative duty and obligation for nurses in the current health care system. Nurses can contribute to the ethic of belonging by forming a respectful alliance with patients and families and by advocating and appreciating patient rights. The ethic of belonging and the high quality of care are a perfect match to promote nurse-patient relations and patient experiences.

REFERENCES

1. Wei H, Ming Y, Cheng H, Bian H, Ming J, Wei TL. A mixed method analysis of patients' complaints: underpinnings of theory-guided strategies to improve quality of care. *Int J Nurs Sci*. 2018;5:377-382. doi:10.1016/j.ijnss.2018.06.006.

2. Nightingale F, 1820-1910. *Notes on Nursing: What It Is, and What It Is Not*. Commemorative ed. Philadelphia, PA: Lippincott; 1992.
3. International Council of Nurses. *The ICN Code of Ethics for Nurses*. Geneva, Switzerland: International Council of Nurses; 2012.
4. Wheatley MJ. *Who Do We Choose to Be?* Oakland, CA: Berret-Koehler Publishers, Inc; 2017.
5. American Nurses Association. Center for ethics and human rights: 2017 annual report. https://www.nursingworld.org/~496198/globalassets/practiceandpolicy/nursing-excellence/center-for-ethics-and-human-rights-2017-annual-report-5.compressed.pdf. Published 2018.
6. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York, NY: Oxford University Press; 2012.
7. Watson J. *Unitary Caring Science: The Philosophy and Praxis of Nursing*. Louisville, CO: University Press of Colorado; 2018.
8. Bradley P, Falk-Rafael A. Instrumental care and human-centered caring: rhetoric and lived reality. *Adv Nurs Sci*. 2011;34(4):297-314.
9. Lévinas E. *Totality and Infinity: An Essay on Exteriority*. Vol 24. Pittsburgh, PA: Duquesne University Press; 1969.
10. Watson J. Caring science: belonging before being as ethical cosmology. *Nurs Sci Q*. 2005;18(4):304-305.
11. Burns L. What does the patient say? Levinas and medical ethics. *J Med Philos*. 2017;42(2):214-235.
12. Chinn PL. Dialogue on peace and power. *Nurs Sci Q*. 2016;29(3):208-210.
13. Zhang P, Wang F, Cheng Y, et al. Impact of organizational and individual factors on patient-provider relationships: a national survey of doctors, nurses and patients in China. *PLoS One*. 2017;12(7):e0181396. doi:10.1371/journal.pone.0181396.
14. Jiang Y, Ying X, Zhang Q, et al. Managing patient complaints in China: a qualitative study in shanghai. *BMJ open*. 2014;4(8):e005131. doi:10.1136/bmjopen-2014-005131.
15. Hsieh H, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277-1288.
16. Sandelowski M. Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Adv Nurs Sci*. 1993;16(2):1-8.
17. Halldorsdottir S. The dynamics of the nurse-patient relationship: introduction of a synthesized theory from the patient's perspective. *Scand J Caring Sci*. 2008;22(4):643-652.
18. Hall BA. An essay on an authentic meaning of medicalization: the patient's perspective. *Adv Nurs Sci*. 2003;26(1):53-62.
19. Wei H, Wei T, Brown KJ, Buck SH, Mill MR. Parents' perceptions of caring characteristics of physicians and nurses. *Int J Hum Caring*. 2018;22(1):49-55. doi:10.20467/1091-5710.HumanCaring-D-17-00047.
20. Halldorsdottir S. Nursing as compassionate competence: a theory on professional nursing care based on the patient's perspective. *Int J Hum Caring*. 2012;16(2):7-19.
21. Hood K, Cant R, Leech M, Baulch J, Gilbee A. Trying on the professional self: nursing students' perceptions of learning about roles, identity and teamwork in an interprofessional clinical placement. *Appl Nurs Res*. 2014;27(2):109-114.
22. Watson J. Love and caring. Ethics of face and hand–an invitation to return to the heart and soul of nursing and our deep humanity. *Nurs Adm Q*. 2003;27(3):197-202.
23. Watson J, Porter-O'Grady T, Horton-Deutsch S, Malloch K. Quantum caring leadership: integrating quantum leadership with caring science. *Nurs Sci Q*. 2018;31(3):253-258.
24. Watson J. Intentionality and caring-healing consciousness: a practice of transpersonal nursing. *Holist Nurs Pract*. 2002;16(4):12-19.
25. Wei H, Roscigno CI, Swanson KM, Black BP, Hudson-Barr D, Hanson CC. Parents' experiences of having a child undergoing congenital heart surgery: an emotional rollercoaster from shocking to blessing. *Heart Lung*. 2016;45(2):154-160.
26. Wei H, Sewell KA, Woody G, Rose MA. The state of the science of nurse work environments in the United States: a systematic review. *Int J Nurs Sci*. 2018;5:287-300.
27. Wei H, Roscigno CI, Swanson KM. Healthcare providers' caring: nothing is too small for a child hospitalized for heart surgery. *Heart Lung*. 2017;46(3):166-171.
28. Watson J. *Caring Science as Sacred Science*. Philadelphia, PA: F.A. Davis Co; 2005.
29. Hou J, Michaud C, Li Z, et al. Transformation of the education of health professionals in China: progress and challenges. *Lancet*. 2014;384(9945):819-827. doi:10.1016/S0140-6736(14)61307-6.
30. Guo Y. Implement a healthy Chinese strategy and promote the development of nursing. *Chinese J Nurs*. 2018;53(1):5.
31. Beck M. Fostering metamorphosis through caritas literacy in an RN-to-BSN program. In: Rosa W, Horton-Deutsch S, Watson J, eds. *A Handbook for Caring Science: Expanding the Paradigm*. New York, NY: Springer Publishing; 2019.
32. Beck M. My quest for caritas literacy. In: Horton-Deutsch S, Anderson J, eds. *Caritas Coaching: Journey Toward Transpersonal Caring for Informed Moral Action in Healthcare*. Indianapolis, IN: Sigma Theta Tau International Publishing; 2018.
33. Clark C. Watson's human caring theory: pertinent transpersonal and humanities concepts for educators. *Humanities*. 2016;5(2):21.