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Ethical Behaviours in Clinical Practice Among Mexican Health Care Workers

Edith Valdez-Martínez,

Instituto Mexicano del Seguro Social, Mexico City, Mexico.

Pilar Lavielle,

Unidad de Investigación en Epidemiología, Mexico City, Mexico.

Miguel Bedolla, and

Pontifical University, Rome, Italy.

Allison Squires

University of Pennsylvania, Philadelphia, PA, USA.

Abstract

The objective of this study was to describe the cultural domain of ethical behaviours in clinical practice as defined by health care providers in Mexico. Structured interviews were carried out with 500 health professionals employed at the Mexican Institute of Social Security in Mexico City. The Smith Salience Index was used to evaluate the relevance of concepts gathered from the free listings of the interviewees. Cluster analysis and factor analysis facilitated construction of the conceptual categories, which the authors refer to as 'dimensions of ethical practice'. Six dimensions emerged from the analysis to define the qualities that comprise ethical clinical practice for Mexican health care providers: overall quality of clinical performance; working conditions that favour quality of care; use of ethical considerations as prerequisites for any health care intervention; values favouring teamwork in the health professional–patient relationship; patient satisfaction scores; and communication between health care providers and patients. The findings suggest that improved working conditions and management practices that promote the values identified by the study's participants would help to improve quality of care.

Keywords

cultural domain; health care ethics; Mexico; nurses; physicians; social workers

Introduction

Health care professionals are increasingly confronted by the technology explosion, changing economic forces, problems in health care delivery, bioterrorism, and globalization. The transformation of medical practice from institutions providing a service to individuals to a gigantic industry is, in part, the result of the great progress in basic and clinical investigation,

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Address for correspondence: Edith Valdez-Martínez, Coordinación de Investigación en Salud Centro Medico Nacional Siglo XXI Instituto Mexicano del Seguro Social, Avenida Cuauhtemoc # 330, Colonia Doctores, CP: 06725, México D.F, Mexico. Tel: +52 (55) 562 769 65; Fax: +52 (55) 576 109 52; E-mail: edith.valdez@imss.gob.mx evaldesmz@cis.gob.mx.

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as well as revolutions in pharmacology and surgery.^{1–4} As a result, health care professionals find it increasingly difficult to meet their responsibilities to patients and society.⁵ These professionals work in diverse cultures shaped by national traditions.

Lonergan theorized that culture is a set of skills, feelings, values and beliefs that are shared by a people in such a way that they can collaborate in the construction of what is good for the individual, for society and, in the end, for all human beings.⁶ The United Nations Educational, Scientific and Cultural Organization (UNESCO) described culture as follows:

... culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.⁷

Tradition, in contrast to culture, is a ‘living faith’ concerning what has been handed down to one generation by a previous one.⁸ Culture, however, should not simply be equated with ethnicity, but rather the concept of culture can serve as a heuristic device for various types of analysis.^{9,10}

Mexicans have a rich cultural heritage with many traditions. They call themselves ‘mestizos’ (mixed) because their present culture was shaped by the those of their Native American (called Indigenous Peoples in Mexican Spanish), European and African ancestors. Thus, Mexican culture represents a blending of centuries-old indigenous traditions together with customs and beliefs brought from Spain and Africa. At present, Mexican culture is also influenced by the USA.⁹ Central to this ‘mestizo’ culture is that the well-being of the family is valued over that of individual members.⁹ There is a strong tendency towards paternalism in addition to an asymmetry of power in the health professional–patient relationship.^{9,11}

Mexico faces two major challenges in health services delivery. First, Mexico’s epidemiological profile still has a high prevalence of the infectious diseases typical of economic underdevelopment,¹² but the country also faces an increasing incidence of chronic diseases.

The second challenge stems from the wide variation in the quality of the care patients receive within the health care system. Mexico’s complex health system includes a mix of public and private institutions. The Mexican Institute of Social Security (IMSS) provides medical care to approximately 50 million Mexicans out of the nearly 106 million person population.¹³ The IMSS’s health care units system is organized on three levels. The first level is that of family medicine, which is a user’s first contact with medical care. The second level of care comprises regional hospitals and zone general hospitals to which patients are referred from family care units for diagnostic, therapeutic and rehabilitation procedures. The third level consists of high technological medical units with the capacity to respond to the most serious of illnesses and injuries.¹⁴

Recent Mexican government policies have attempted to reform the health sector in order to make it more responsive to the needs of the population. These reforms required the system-wide decentralization of what had been a very centralized sector. The National Health Program (PRONASA) 2001–2006¹⁵ identified three challenges facing the health system as it attempts to accomplish its main objective of improving the health of Mexicans. These challenges include improved equity and quality of care, and providing health insurance for the entire population. The reforms also focused on changing the coverage provided by different insurance programmes; improving the quality of medical services by modernizing management and the norms of all health care delivery procedures; and above all, on improving the scientific–technological aspects of health care delivery.

In the Mexican health care system's reform programmes, the 'quality' concept involves two dimensions: technical and interpersonal. The former looks for achieving better results through the conduct and application of health care and scientific research. The latter comes from concerted efforts to increase respect for patients as human beings and improve their satisfaction with the health care services they receive.

Finally, a third challenge lies in the lack of health insurance for about 50 million Mexicans. Mexico has the physical infrastructure and personnel capacity to address most health care problems faced by the population, but a high percentage of people cannot afford the costs of that care.

These reforms, however, have not focused on how to integrate ethics into health care delivery.^{11,16,17} Since the late 1990s, Mexican health care leaders and managers have developed a heightened awareness of the importance of the moral dimension of health care service provision. This has resulted in a rapid proliferation of professional codes of ethics, codes of conduct for health professionals and patients' rights documents.¹⁶ The codes were, in part, elaborated on the bases of codes developed by international organizations such as the American Medical Association and the International Council of Nurses. Even though the Mexican codes reveal a great deal about the formal working ideology of the Mexican health professionals and the way they wish to be perceived externally,^{18,19} there is still work to be done to adapt them to the Mexican context. The use or neglect of the stipulations of these codes by Mexican health care providers also throws considerable light on the relationship between their individual values, professional practice and the Mexican legal system.^{18,19}

At the same time, however, codes of ethics have some limitations. For instance, there are many aspects of health care, such as compassion, which are not wholly reducible to rules. Additionally, ethics cannot be limited to a series of 'do's' and 'don'ts'.¹⁸ In truth, ethics is of such profound importance in health care that it is impossible to understand the nature and purpose of health work without also understanding its ethics and the very nature of ethical reflection.²⁰ In order to make health care decisions that are based on ethics, the values captured by codes of ethics need to shift from the periphery of professional life towards its centre.^{18–20}

As it is not possible to teach ethical concepts or generate a cultural shift among health care professionals simply by asking students to memorize a code of professional ethics, we deemed it necessary to define the content and limits of ethical behaviours among Mexican health care professionals. The purpose of this study, therefore, was to describe health care provider-defined ethical behaviours in order to guide the development of workplace policies that foster ethical behaviour in Mexican health care providers' clinical practice. Criteria guiding these behaviours would be derived by using the language, concepts and categories that reflect their skills, feelings, values and beliefs.^{10,21}

Method

Study design

A descriptive, cross-sectional study was performed with a purposive convenience sample of 500 health care professionals selected from nine IMSS health care facilities in Mexico City. To ensure maximum sample variation, the sampling of study participants was proportional to the number of workers in each area or service and included all three levels of medical care.

This study was approved by the National Commission of Scientific Research of the IMSS (approval #2005785162).

Study sites

The health professionals interviewed were tenured at three types of medical care unit: two first level care units; two second level care units; and five third level care units.

Study population

The interviewees were men and women who worked full time morning or night shifts who volunteered to participate in the study. They were recruited via internal advertisements using flyers and were employed as nurses, nurses' aides, physicians and social workers. Nurses' aides pay attention to and apprise patients of their rights, duties and institutional programmes, among other tasks. At hospital care units, nurses' aides help patients and their relatives with the process of admission, information, hospitalization and discharge, as well as supporting physicians administratively. Administrative and housekeeping personnel were excluded from the study population because they do not participate directly in patient care.

Data collection

The researchers conducted structured interviews at each interviewee's workplace, using free-listing techniques.¹⁰ 'Free listing' is derived from cognitive anthropology and isolates or defines cultural domains organized into words, concepts, or phrases that refer to a predetermined conceptual sphere.¹⁰ The assumption with these predetermined domains is that there is something common to all people's understanding of that domain, not just common to health professionals.^{10,22} Free listing is a good way to explore common understandings in ethics.^{10,22} All respondents participated voluntarily in the study. They were asked about their understanding of the nature of health care ethics and were asked to describe the concepts in their own words.

Data analysis

Univariate techniques were employed to describe the customary sociodemographic characteristics of the study population, the number of concepts registered, the frequency of their appearance, and their order of appearance. The content and its relevance were determined by means of the Smith Salience Index,^{22,23} which is based on the frequency of mentioning and order of appearance of each concept. The Smith Index assumes that the concepts mentioned first and with the greatest frequency are those of greatest importance to the interviewee.^{22,23}

To identify differences in concepts and variation among professionals of different sex, work category and medical care level, the chi-squared test was employed²⁴ using pairs of variables and the 16 most relevant concepts.

Based on the study's objective and the type of data generated, a multivariate analysis that included all concepts that were mentioned at least 10 times ($n = 56$) was performed. To obtain a better representation of the information and greater reliability of the results, two methods were employed: conglomerate (cluster) analysis by means of the Jaccard coefficient for dichotomous data^{25,26} and factor analysis.^{24,25}

Results

Table 1 shows the sociodemographic characteristics of the 500 interviewees. Free listing identified a total of 675 concepts, of which 435 (64%) were mentioned only once per person. All concepts with the same general meaning were combined. For example, respect for co-workers, respect for the patient, respect for the other's rights, and respect for the worker, were reduced to a single concept: mutual respect, which was also registered. This process yielded 160 items (Table 2). The regrouping of concepts was independently reviewed by two researchers to reduce threats to validity. Fifty per cent of the interviewees mentioned four or

less concepts, while the remainder noted more than four. They mentioned between one and 15 concepts in the interviews.

A scree plot did not reveal clear cut-off points that reflected a true division between concepts belonging to cultural domains and idiosyncratic concepts (i.e. concepts referred to by one person). A total of 56 concepts with frequencies of 10 or more comprised the final core concept groups. According to the analysis guided by the Smith Salience Index, the concepts of mutual respect, confidentiality and privacy, work responsibility, and acting with honesty dominated the health care workers' concepts of ethical behaviours (Table 3).

Further review of the data did show sex differences in the frequencies of responses for different concepts. For example, for female health care providers, the response frequencies suggest that ethical behaviours among health care professionals have more to do with 'mutual respect', 'confidentiality and privacy', and 'work responsibility'. Male health care workers, on the other hand, related their ability to behave ethically with their access to 'precise and effective information', 'professional updating', and 'telling the patient the truth'. Despite the qualitative distinctions between the sexes about how they defined ethical behaviours, there were no statistically significant differences in the response frequencies ($\chi^2 = 21.09$; $P = 0.134$) (Table 4).

By work category, other differences emerged. For social workers, concepts related to 'mutual respect', 'confidentiality', and 'privacy' dominated their perceptions of ethical behaviours. 'Kindness', 'precise and effective information', and 'dignified treatment of the patient' prevailed among nurses' aides. Nurses consistently identified the most important ethical behaviour as 'offering trust to the patient'. Finally, physicians indicated 'professional updating' as the most important factor in ensuring ethical behaviour among their professional group. The analysis revealed statistically significant differences in these perceptions ($\chi^2 = 103.69$; $P = 0.000$) among the different job categories (Table 4).

The search for relationships among content items by conglomerate (cluster) analysis demonstrated that the cultural domain of ethical behaviours among Mexican health care professionals could be condensed into six dimensions: determinants of clinical performance quality; elements favouring the ethical dimension of health care quality; ethical considerations for any health care intervention; values favouring teamwork and the health professional–patient relationship; patient satisfaction markers; and communication (Figure 1). To validate the dimensional groupings, a factor analysis was performed, the results of which are presented in Table 5. Factors six to nine do not appear in Table 5 because: (1) the concepts contained in them were found in frequencies of only one or two per factor; or (2) they were not interpretable concepts; or (3) they were duplicated.

Discussion

The results of this study suggest that a culture of professional ethics exists among Mexican health care providers and that they share some common values that shape the nature of this ethical culture through the six dimensions that define it. Variation in the responses was explained by both sex and profession.

The participants' concepts of ethics frequently appeared to be related to professional goals and aspirations. These are sometimes known as 'aspirational values' and incorporate professional ideals, goals and visions.¹⁹ This means that they are aspects of a professional's vision of the future, which helps to motivate him or her towards an ideal and, subsequently, give meaning to the present. Professionals' aspirational values tend to be conscious; if they espouse them at all, individuals often have overt emotional investment in them.¹⁹ They are freely chosen by individuals and groups from other alternatives, are often prized and proclaimed as core

components of a professional's culture, and consciously transfer into an individual's private life and professional practice. To act on aspirational values, a professional requires personal awareness, relevant knowledge, understanding, commitment, courage and appropriate skills to realize them.¹⁹

The association between participants' job category and their responses is a significant finding in this study. Chambliss²⁷ says that 'even if all nurses were men and all doctors women, the current system would impel them to act as nurses and doctors now act' (p. 83).²⁷ This suggests that role socialization plays a part in how individuals develop their perceptions of what are professionally acceptable ethical behaviours. At the same time, even though sex factors did not have statistically significant associations with the responses, the predominance of women nurses, nurses' aides, and social workers suggests that sex still has an effect. Additional studies in this area could examine this question in greater depth.

Our findings also indicate that enhancing health care workers' ability to practice their roles in a more ethical way may help to confront the previously mentioned problems identified by the National Health Program.¹⁵ To confront problems effectively and to meet the health system's goals, health care leaders will need to promote equity, quality of care and universal health insurance, while at the same time recognizing the limitations on the amount of administrators' and health care professionals' time, funding and skills available for this task. In the past, health system reforms in Mexico (like decentralization) did not focus on building the capacity of health care workers or the leadership. As a result, these reforms were not as effective as they could have been had the workers and leaders possessed the necessary skills to implement them. Ethically grounded professional values are one such core skill.

Do Mexican health care professionals have the values that are necessary for them to make a commitment to accomplish the task? It would seem that the group of professionals in the study had at least a set of core professional values that could be further developed to assist the realization of health system goals. The results, however, do not imply that all members of the Mexican health care worker community possess the same core values. Notwithstanding this, the study provides a first vision of the culture of professional ethics among Mexican health care workers and identifies areas and worker groups where these values could be enhanced.

The combination of qualitative and quantitative research methods provided a richer description of the dimensions of professional ethics than a single method could provide. The mixed methods showed ways to understand the worldview of members of the 'culture' being studied (an *emic* perspective). The diversity in professional and educational background, work experience, and personal background provided a good foundation for developing a better understanding of how Mexican health care workers define ethical behaviours in clinical practice.

Limitations

From a methodological point of view it must be stated that this study was performed using non-probability sampling, which will have reduced its external validity. Thus, the extent to which these results would apply to health care workers in other geographical areas of the country or in another cultural context, such as in a predominantly indigenous region, need to be explored.

According to Pattison and Pill,¹⁹ the basic virtues of strength, temperance, justice and prudence are required if the practice and values of health care professionals are to be promoted. The results of this study suggest that a commitment to competent role performance, high quality performance, acting with honesty, and peer performance evaluation may also be necessary for promoting ethical behaviour in the workplace. External factors such as the increasing influence

of the pharmaceutical industry on the practice of health care workers constantly challenge their ability to adhere to ethical behaviours. Assisting them to maintain their core values will help to combat these influences. A greater understanding of the nature of what defines ethical behaviours in relation to role performance may also help to foster a more humanitarian perspective in the delivery of health care. Keeping humanitarianism in the forefront of health care workers' consciousness by fostering ethical behaviours may help the workers themselves to develop a greater sense of control in the face of increasingly specialized knowledge, depersonalization and the effects of globalization.

More empirical work must be carried out to find out how particular values, either professional or personal, manifest themselves in clinical practice and in encounters with patients. Investigating the relationship between individual and organizational ethical values would also help to explore the question in greater depth. Here again, interpersonal comparative empirical research could reveal much about the similarities and differences between organizations and individual practice, and how these values interact in positive and negative ways.

Recommendations

Based on the results of this study and their interpretation, we make the following recommendations:

- That a core ethics curriculum be designed, developed, implemented and evaluated for all health-related educational programmes that build on the existing foundation of the ethical culture already present. This seems to be the most appropriate way to develop that culture in the direction of ever more appropriate ethical principles, doctrines and professional behaviours. This core curriculum should be implemented using a participative method to promote the appropriation of these values by all health care workers. Given that an identifiable set of ethical principles that truly determine behaviour is a hallmark of a true profession, promoting ethics among health care workers would enhance professionalism and, in turn, the quality of patient care.
- That in this core ethics curriculum, health professional ethics be examined as an *emic* concept alongside relevant *emic* constructs in other organizations and societies. The reason for this is that health professional ethics impinges on the performance of other professions. More than anything else, however, it determines the quality of the care provided to patients who must put their trust, well-being and life in the hands of professionals.
- That more studies similar to this one, designed to understand further the culture from which the ethics of health care professionals emerges, be devised, developed, implemented and published, in order to develop from their results (similar to as stated in the previous section) ever more appropriate doctrines and principles for promoting ethics education for health professionals.
- That professional codes of ethics be given an enlarged and more positive role in the education and character formation of future health professionals. Codes should be used to nurture and encourage the expression of virtues rather than simply as texts to be recited during a promotion or a graduation ceremony, or being used in an *ad hoc* fashion to police specific practices.

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Figure 1.
Dendrogram of the 56 most common concepts noted by the interviewees ($n = 500$)
Previously presented as part of a poster: Yale School of Nursing International Conference,
February 2008 (modified).

Table 1Interviewees' sociodemographic characteristics (*n* = 500)

Variable	Category	No.	%
Sex	Men	118	23.6
	Women	382	76.4
Age (years)	20–29	39	7.8
	30–39	145	29.0
	40–49	255	51.0
	50–59	57	11.4
	≥60	4	0.8
Civil status	Single	109	21.8
	Married	326	65.2
	Widowed	11	2.2
	Divorced	33	6.6
	Common-law relationship	21	4.2
Work category	Physician	130	26.0
	Nurse	273	54.6
	Social worker	24	4.8
	Nurses' aide	73	14.6
Health care level	First	136	27.2
	Second	115	23.0
	Third	249	49.8
Work shift	Morning	340	68.0
	Night	160	32.0

Previously presented as part of a poster: Yale School of Nursing International Conference, February 2008 (modified).

Table 2
Concepts ($n = 160$) mentioned by the interviewees ($n = 500$)

Concept	No.	Concept	No.	Concept	No.
Mutual respect	256	Work availability	9	Accessibility	2
Confidentiality and privacy	148	Life	9	Constancy	2
Work responsibility	131	Initiative	8	Innovator	2
Acting honestly	129	Self-knowledge	8	Investigation	2
Professional competence	99	Affection toward the patient	8	Gratitude	2
Quality and warmth in patient care	94	Integral conduct	8	Contraception	2
Kindness	82	Conscience	7	Coherence	2
Precise and effective information	67	Euthanasia	7	Consideration	2
Professional updating	59	No maleficence	7	Culture	2
Tolerance	56	Satisfaction	7	Human development	2
Offering trust to the patient	55	Time	7	Discrimination	2
Teamwork	50	Adequate treatment	7	Family	2
Dignified patient treatment	50	Love of oneself	6	Generosity	2
Empathy with patients and co-workers	42	Supply	6	Independence	2
Telling the patient the truth	41	Prudence	6	Leadership	2
Punctuality	40	Simplicity	6	Goals	2
Humanity	40	Good cheer	5	Perseverance	2
Being professional	40	Criterion	5	Planning	2
Love for my work	37	Optimism	5	Productivity	2
Patient autonomy	37	Respect for the authorities	5	Seriousness	2
Adequate and timely patient care	37	Organ transplantation	4	Congeniality	2
Communication	34	Alleviate suffering	4	Show health providers respect	2
Worker's personal appearance	30	Integral patient care	4	Transfusions	1
Interpersonal relationship	28	Right to medical care	4	Abstraction	1
Ability to commit to work	28	Faith and hope	4	Analysis	1
Patient and work individuality	26	Being honourable	4	Appropriate	1
Honesty	25	Creativity	4	Audacity	1
Respect for the patient's physical integrity	22	Formality	4	Caution	1
Equity at work and toward the patient	21	Objectivity	4	Community	1
Cleanliness of the work area	20	Personality	4	Concentration	1

Concept	No.	Concept	No.	Concept	No.
Interest in the worker and the patient	19	Rapidity	4	Democracy	1
Order	18	Will	4	Ability to direct	1
Following the norms	18	Enthusiasm	3	Educators	1
Obliging attitude	17	Thanatology	3	Focusing on the problem	1
Agreeable work environment	17	Financial equilibrium	3	Evaluation	1
Ethics	17	Infrastructure	3	Feasibility	1
Values	16	Accept and correct my errors	3	Flexible	1
Human dignity	15	Aptitude	3	Imaginative	1
Motivation	15	Social well-being	3	Impersonality	1
Understanding	15	Quality of life	3	Non-conformity	1
Self-discipline	14	Compassion	3	Indemnization	1
Helping the patient	14	Giving priority to the weakest	3	Moderate	1
Morale	14	Work performance	3	Mutuality	1
Opportunities for the user	14	Intelligence	3	Nobility	1
Loyalty	13	Judgment	3	Observant	1
Humanity and sensitivity	13	Maturity	3	Pride	1
Cordiality with patients and co-workers	12	Genetic manipulation	3	Originality	1
Welfare	12	Medicine	3	Passivity	1
Safety	12	Opinion	3	Services supplier	1
Justice	11	Health	3	Testing with optimal devices	1
Bioethics	11	Patient follow-up	3	Selection	1
Listening skills	11			Common sense	1
Physician–patient relationship	11			To be	1
Human rights	10				
Decision	10				
Solidarity	10				

Previously presented as part of a poster: Yale School of Nursing International Conference, February 2008 (modified).

Table 3Average score and Smith Index of the 56 most common concepts ($n = 500$ interviewees)

Concept	Frequency	%	Average score	Smith Index
Mutual respect	256	51.20	2.23	0.44
Confidentiality and privacy	148	29.60	3.16	0.20
Work responsibility	131	26.20	2.69	0.19
Acting honestly	129	25.80	2.9	0.18
Professional competence	99	19.80	3.71	0.12
Quality and warmth in patient care	94	18.80	3.32	0.11
Kindness	82	16.40	3.57	0.10
Precise and effective information	67	13.40	3.91	0.07
Offering trust to the patient	55	11.00	3.49	0.07
Professional updating	59	11.80	4.51	0.06
Tolerance	56	11.20	4.41	0.06
Dignified patient treatment	50	10.00	3.00	0.06
Teamwork	50	10.00	4.8	0.05
Telling the patient the truth	41	8.20	3.66	0.05
Punctuality	40	8.00	3.75	0.05
Being professional	40	8.00	4.2	0.05
Patient autonomy	37	7.40	2.54	0.05
Adequate and timely patient care	37	7.40	2.38	0.05
Empathy with patients and co-workers	42	8.40	4.57	0.04
Humanity	40	8.00	3.98	0.04
Love for my work	37	7.40	4.08	0.04
Communication	34	6.80	4.53	0.03
Worker's personal appearance	30	6.00	4.63	0.03
Interpersonal relationship	28	5.60	4.00	0.03
Ability to commit to work	28	5.60	4.07	0.03
Patient and work individuality	26	5.20	3.27	0.03
Honesty	25	5.00	3.00	0.03
Respect for the patient's physical integrity	22	4.40	3.23	0.03
Equity at work and toward the patient	21	4.20	3.86	0.02
Cleanliness of the work area	20	4.00	3.9	0.02
Interest in the worker and the patient	19	3.80	3.74	0.02
Order	18	3.60	5.33	0.02
Following the norms	18	3.60	3.17	0.02
Obliging attitude	17	3.40	4.24	0.02
Agreeable work environment	17	3.40	3.88	0.02
Ethics	17	3.40	4.12	0.02
Values	16	3.20	5.00	0.02
Human dignity	15	3.00	3.33	0.02
Understanding	15	3.00	3.87	0.02
Morale	14	2.80	2.5	0.02
Loyalty	13	2.60	3.23	0.02

Concept	Frequency	%	Average score	Smith Index
Welfare	12	2.40	2.75	0.02
Bioethics	11	2.20	2.64	0.02
Human rights	10	2.00	2.4	0.02
Motivation	15	3.00	5.27	0.01
Self-discipline	14	2.80	4.71	0.01
Helping the patient	14	2.80	3.43	0.01
Opportunities for the user	14	2.80	4.36	0.01
Humanity and sensitivity	13	2.60	5.31	0.01
Cordiality with patients and co-workers	12	2.40	4.5	0.01
Safety	12	2.40	4.75	0.01
Justice	11	2.20	3.45	0.01
Listening skills	11	2.20	4.55	0.01
Physician-patient relationship	11	2.20	5.00	0.01
Decision	10	2.00	6.1	0.01
Solidarity	10	2.00	6.1	0.01

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Table 4
Comparison of the 16 most relevant concepts by sex, work category and health care level

Concept	Sex (%) ^a		Work category (%) ^b				Health care level (%) ^c		
	Men	Women	Physicians	Nurses	Social workers	Nurses' aides	1	2	3
Mutual respect	41.5	52.4	45.4	50.2	75.0	47.9	58.1	43.5	48.2
Confidentiality and privacy	27.1	30.4	33.1	28.2	45.8	23.3	48.5	24.3	21.7
Work responsibility	22.0	27.5	22.3	28.9	29.2	21.9	22.8	21.7	30.1
Acting honestly	28.0	25.1	19.2	27.8	12.5	17.8	25.0	27.8	25.3
Professional competence	18.6	20.2	9.2	17.2	20.8	21.9	20.6	18.3	20.1
Quality and warmth in care	16.1	19.6	20.0	16.5	25.0	24.7	25.7	14.8	16.9
Kindness	7.6	19.1	18.5	17.9	8.3	26.0	13.2	15.7	18.5
Precise and effective information	16.1	12.6	13.1	5.9	25.0	26.0	18.4	9.6	12.4
Professional updating	16.1	10.5	9.2	11.0	8.3	4.1	11.0	8.7	13.7
Tolerance	9.3	11.8	6.9	8.1	25.0	15.1	13.2	7.8	11.6
Offering trust to the patient	5.9	12.6	7.7	13.9	8.3	4.1	11.8	10.4	10.8
Teamwork	10.2	9.9	11.5	10.6	20.8	9.6	11.0	4.3	12.0
Dignified patient treatment	6.8	11.0		7.7	12.5	21.9	12.5	9.6	8.8
Empathy with patients and co-workers	7.6	8.6		7.0	20.8	4.1	7.4	6.1	10.0
Telling the patient the truth	11.9	7.1	13.1	7.3	12.5	1.4	6.6	7.0	9.6
Punctuality	6.8	8.4	5.4	8.4	4.2	12.3	4.4	8.7	9.6

Health care level 1: family medicine; user's first contact with care.

Health care level 2: regional hospitals and zone general hospitals, to which patients are referred from family care units for diagnostic, therapeutic and rehabilitation procedures.

Health care level 3: high-technology medical units with maximum capability for diagnosis, therapy, cure.

^a $\chi^2 = 21.09$; $P = 0.134$

^b $\chi^2 = 103.69$; $P = 0.000$

^c $\chi^2 = 41.89$; $P = 0.073$

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Table 5

Representation of concepts and factors

Factor	Factor loading	Concept
Factor 1: Determinants of clinical performance quality	0.51	Work responsibility
	0.36	Professional competence
	0.38	Professional updating
	0.37	Teamwork
	0.40	Punctuality
	0.26	Humanity
	0.38	Being professional
	0.27	Love for my work
	0.33	Worker's personal appearance
	0.28	Ability to commit to work
	0.40	Order
	0.34	Obliging attitude
	0.23	Values
	0.27	Motivation
	0.22	Self-discipline
	0.27	Loyalty
Factor 2: Elements favouring the patient ethical dimension of health care quality	0.28	Offering trust to the patient
	0.33	Patient autonomy
	0.50	Equity at work and toward the patient
	0.36	Welfare
	0.27	Safety
	0.50	Justice
Factor 3: Ethical considerations for any health care intervention	0.43	Bioethics
	0.39	Quality and warmth in patient care
	0.30	Interpersonal relationship
	0.29	Human dignity
Factor 4: Values favouring teamwork and the health professional–patient relationship	0.34	Physician–patient relationship
	0.46	Mutual respect
	0.24	Acting honestly
	0.25	Kindness
	0.38	Tolerance
	0.23	Empathy with patients and co-workers
	0.29	Communication
	0.42	Understanding
Factor 5: Patient satisfaction markers	0.39	Confidentiality and privacy
	0.27	Dignified patient treatment
	0.26	Patient and work individuality
	0.20	Helping the patient
	0.25	Opportunities for the user
	0.34	Solidarity
	0.38	Precise and effective information

Factor	Factor loading	Concept
Factor 10: Communication	0.22	Telling the patient the truth
	0.24	Honesty
	0.39	Humanity and sensitivity

Only concepts with factor loadings >0.20 were included; these factors explained 20.95% of the total.

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