Dignity in care in the clinical setting: A narrative review

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Abstract
This review aimed to explore nursing literature and research on dignity in care of inpatients and to evaluate how the care patients received in the hospital setting was related to perceived feelings of being dignified or undignified. Studies conducted between 2000 and 2010 were considered, using Cumulative Index to Nursing and Allied Health Literature and MEDLINE, and the search terms ‘patient dignity’, ‘dignity in care’, ‘human dignity and nursing’ and ‘dignity and nursing ethics’. Findings revealed, from the perspectives of nurses and patients, that dignity in care in the hospital setting is seen to be influenced by physical environment, staff attitude and behaviour, organisational culture and patient independence. This review can help nurses to better understand dignity in care, and for policy makers, there are implications about determining the physical environment, staff attitude and behaviour and organisational culture needed to promote patient dignity in nursing. By identifying the most important factors from patients’ and nurses’ perspectives that contribute to dignity in care, nursing interventions, such as campaigns and education in clinical practice, can be developed.

Keywords
Care, dignity, nurses, nursing, review

Introduction
Enhancing patients’ rights and maintaining their dignity have been affirmed as goals of the World Health Organization. A World Health Organization investigation found – in 41 countries – that most participants selected dignity as the second most important domain, behind prompt attention in care. Therefore, dignity is an important issue in the health-care system. Dignity is a core concept in nursing care. Care without dignity can adversely influence patients’ recovery because maintaining dignified care promotes emotional comfort, which enhances recovery.
All health-care team members are reminded to respect the dignity of clients and patients. Nurses are responsible for fostering human dignity through their interactions with their patients and with others in the health-care team. Internationally, different aspects of delivering nursing care with respect have been highlighted. Several nursing organisations in Western countries promote respect among nurses for basic human rights, maintenance of patient dignity and respect for differences in personality, race, culture, gender, age, economic status and lifestyle. Similarly, nurses in Taiwan are required to respect patients’ individuality, autonomy, human dignity, religion, customs, values and cultural differences.

Respect for dignity is central to professional nursing codes. The International Council of Nursing Code states the following: ‘Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect’ (p. 1). Thus, dignity is an important human need, patients have the right to receive dignified care, and nurses are responsible for dignified patient care. Recently, health-care literature on dignity has addressed the meaning and implications of dignity in a multidisciplinary field and nurse and patient populations. In general, this literature is descriptive, tending to focus on relations between health-care providers and patients and patients’ own experiences.

This review was designed to provide an overview of research on dignity in care in the hospital setting. It aims to show where knowledge is required for the education of nurses about dignity in care. Numminen et al. conducted research to review literature of the nurses’ codes of ethics in practice and in education. Moreover, we employed the data analysis followed by Numminen et al., who focused on research design, data collection and analysis method, sampling of participants and study setting assessment. We asked the following questions of the studies we reviewed: (a) What are the methodological approaches? (b) What are the main themes of interest? and (c) What are the main findings?

The study

Methods

This review considered patients whose dignity was maintained or violated during hospitalisation. The review considered any nursing literature review and study that explored patient dignity care experiences, including review articles and quantitative and qualitative studies. The research material was collected on the basis of scientific reports published between 2000 and 2010 in English and referenced in Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE, PubMed, Journals@Ovid and Education Resources Information Center (ERIC). Evidence-based reviews (Bandolier, Cochrane Library) were accessed and searched via the Health Information Resources Website. The following were used as search terms: ‘patient dignity’, ‘dignity in care’, ‘human dignity and nursing’ and ‘dignity and nursing ethics’. The database search yielded 438 reviews and studies; those that included only the inpatient setting and patients more than 18 years old numbered 233; after duplicates were removed, the total was 205 and after other areas such as paediatrics, gynaecology, critical care and terminal stage (n = 160) were excluded, the total was 45. This process yielded 45 citations after records had been screened. The remaining abstracts were screened for irrelevant studies, which were excluded (n = 8). Finally, 37 articles were selected for review. This process is summarised in Figure 1.

Results

Methodological approaches

The analysis followed Numminen et al. and focused on research design, data collection and analysis method, sampling of participants and study setting assessment. Nearly all the studies used qualitative
methods to approach patient dignity. Only two studies used quantitative methods as well to understand why patients have higher satisfaction with care when they are treated with dignity. For data collection, qualitative studies used semi-structured interview guides and audio-taped interviews that were transcribed verbatim and transcripts that were coded and analysed by content analysis; field notes and participant observations were also used. In quantitative studies, the researchers used self-developed questionnaires or established instruments.

This narrative review found that the research on dignity in care has four trends, which are as follows: (a) from mid-2000, the number of studies has steadily increased; (b) in recent years, qualitative studies are the
majority; (c) research has become more international and (d) the research has discussed factors that influence patient dignity.

**Main themes of interest**

The review focused on the following themes: definition of dignity in care, dignity in care from nurses’ and patients’ perspectives and factors that influence dignity in care. The definition of dignity in care is essential to the process of nursing care. Dignity in care encompasses basic ethical principles in caring and comprises regard and respect for human dignity and the will to do well. In addition, the domains of interest were dignity in care from nurses’ and patients’ perspectives and included studies that directly focused on patient dignity in the clinical setting. Moreover, studies focused on factors that influence dignity in care, showing that patients are vulnerable to losing dignity in hospital.

**Main findings within themes of interest**

**Definition of dignity in care.** When nurses safeguard and protect patients’ dignity, this becomes evident in the nurses’ demeanour and attitude, in the way they treat patients, in the atmosphere on the ward and in the regulations and procedures followed.21 Jacobson19 developed a general theory of dignity, concluding that the word ‘dignity’ describes two phenomena: human dignity and social dignity. Human dignity is common to all human beings due to being human and social dignity is bestowed or earned. Jacobson19 also asserted that social dignity is divided into ‘dignity-of-self’ and ‘dignity-in-relation’. It is experienced by interaction, and it can be lost, gained, threatened and promoted in health-care systems. Jacelon22 conducted a grounded theory study to explore older people’s dignity in an acute hospital. The results showed that dignity comprises internal dignity and interpersonal dignity. Internal dignity is self-dignity, based on the sense of self-worth of individuals; interpersonal dignity is based on older people being respected by others within interactions. Hofmann23 also asserted that dignity is to respect patients, meeting them as whole persons in the health-care system. Widäng and Fridlund24 conducted qualitative research that used a phenomenological approach to determine how patients perceive dignity, and their findings were summarised into three description categories: self-respect, dignity and confidence. Matiti and Trorey25 conducted a phenomenological hermeneutic approach to determine how patients considered that their dignity was compromised, selecting 102 patients in three hospitals in the United Kingdom over 18 months. The results were six key themes that contribute to the preservation of patient dignity, which were identified as privacy; confidentiality; communication and the need for information; choice, control and involvement in care; respect and decency and forms of address. The patients provided details of their expectations with respect to these factors. They also asserted that dignity is a cultural concept. Individual attitudes, values and perceptions are related to the maintenance of dignity; when patients have the ability to respond to changing situations and to potentially undignifying circumstances, their dignity should henceforward be maintained. There are two kinds of dignity: ‘other-regarding’, which is achieved by respecting the dignity of others, and ‘self-regarding’, which is achieved by respecting one’s own dignity.26 Nordenfelt27 proposed that the meaning of dignity is ‘grounded in the rationality of human beings and their ability to achieve a moral status’ (p. 100), and that dignity is categorised into the following four types: human value, merit, moral stature and personal identity. The Royal College of Nursing (RCN) of the United Kingdom28 asserted that the definition of dignity is concerned with patients’ feelings of worth and value and that nurses should maintain patients’ dignity in nursing care. The RCN28 also proposed that maintaining patient dignity should emphasise four factors during hospitalisation: the physical environment; the organisational culture and during the implementation of care, the attitudes and the behaviour of nurses and others. Gallagher and Seedhouse29 indicated that dignity in nursing practice can be considered as two fundamental professional values: a ‘human right’ and a ‘nursing core value’.
Nurses must also realise that respect is an important human trait that they can demonstrate by being sensitive to patients’ needs. These needs include environmental privacy and dignity during care, which must be delivered by professional nurses. Thus, dignity is an important human need, patients have the right to be cared for with dignity and nurses are responsible for delivering dignified patient care.

**Dignity in care from nurses’ and patients’ perspectives.** The issue of patient dignity in the clinical setting has been conducted in the following countries: the United States, the United Kingdom, Canada, Finland, Australia, across Europe and in Asia. The results show that maintaining dignified patient care includes protecting patients’ privacy, respecting patients and allowing them to have autonomy. Dignified care also offers choices to patients and emotional support while telling them the truth about their disease, and involves communicating with patients, maintaining their body image and honouring their privacy. Webster and Bryan asserted that older people perceived care as dignified when they were clean, had feelings of being in control, had independence, were given sufficient time by their nurses and were communicated with. Lin et al. conducted a qualitative descriptive study to explore dignity in care from patients’ perspectives in Taiwan. The results showed that many hospitalised patients were satisfied with the maintenance of their dignity. Six themes contributing to the preservation of their dignity were identified: sense of control and autonomy, being respected as a person, avoidance of body exposure, caring from the nursing staff, confidentiality of disease information and prompt response to needs. In addition, Jo and Doorenbos proposed that patients perceived that fullness of dignity comprises seven themes, expressed as introspection, rightness, satisfaction, confidence, patience, a sense of justice and transcendence. The patients’ perceived loss of dignity was categorised into seven themes, expressed as a sense of disparagement, a feeling of low social rank, wretchedness, a sense of betrayal, a feeling of helplessness, inferiority and a sense of deprivation.

Heijkenskjoëld et al. concluded that, from the nurses’ perspective, dignity revealed two main themes: nurses maintaining patients’ dignity and violating patients’ dignity. Maintaining patient dignity meant allowing patients to speak about their lives and participate in their own care processes and included nurses dedicating sufficient time to patients and nurses stopping other nurses from violating patients’ dignity. By contrast, nurses violate patient dignity when they see patients as objects, for example, when nurses do not respect the will of the patient, and if it is not possible for the patient to call a nurse for assistance in cases where they rely on the nurses because of their illness, the patient will feel abandoned by the nurse.

Baillie’s qualitative study investigated the meaning of patient dignity, and its promotion on a surgical ward in urology showed that patients identified the following feelings as central: feeling comfortable, in control and valued. Feeling comfortable meant feeling safe, happy, relaxed, not worried, not embarrassed and having a sense of well-being. Dignity in care is influenced by a patient’s ability to control his or her relationship with the nurses, by private space provided by the nurses and by the general physical environment of the hospital. Recently, Baillie also proposed that patients’ dignity can be divided into three domains: patient, nurse and the hospital environment. Gallagher et al. identified that dignity-promoting care could be organised into four themes: first, the physical environment of care, including space, privacy and access to facilities, such as the bathroom; second, staff attitudes and behaviour, that is, how individuals respond to patients, lack of privacy, lack of respect and inappropriate language; third, the culture of care, related to the hospital philosophy, and the values and moral climate of the organisation — with a positive culture of care, the staff respecting cultural differences rather than focusing on therapeutic goals only and fourth, specific care activities required during hospitalisation, such as bathing, toileting and dressing, be carried out in a private place so that patients are not vulnerable to losing dignity. In addition, Lin and Tsai conducted a qualitative descriptive study to explore dignity in care from nurses’ perspectives in Taiwan. The results showed that nurses’ measures to maintain dignity in patient care were captured in five themes: respect, protecting privacy, emotional support, treating all patients alike and maintaining body image.
Factors influencing dignity in care. Studies showing that patients are vulnerable to losing dignity in hospital include those by Matiti, Gallagher and Seedhouse, Jacelon and Baillie. Recently, some studies also asserted that patient dignity was violated or promoted by factors, such as physical environment, staff attitude and behaviour, other health providers involved in care activities, organisational culture, specific care activities and patient factors. The physical care environment significantly influences patient dignity.

Dignity is also lost when personal boundaries are crossed. Maintaining privacy for patients is very important during physical examination. Birrell et al. proposed that patient information should be discussed in a private place where the conversation cannot be overheard. As to spatial privacy, nurses have been reported to recognise the importance of patients’ body privacy. In addition, rooms that cannot be locked and mixed-sex bed arrangements in the ward due to bed shortage also threaten patient dignity. Staff attitude and behaviour can threaten patient dignity leading to loss of dignity. Baillie studied how staff behaviour in acute care has an impact on patient dignity. When staff provide privacy and make patients feel comfortable, the patient feels in control and valued, and patient dignity is thus promoted.

Baillie emphasised that staff behaviour towards patients should be such that their dignity is promoted during all interactions. There is increasing emphasis in the United Kingdom on patients’ rights to be treated with dignity, and the International Council of Nurses states that nurses have a professional duty to respect patients’ dignity. Moreover, dignity violation occurs when patients have a feeling of generalised disrespect by their health provider. For example, this includes health-care providers who do not introduce themselves or who use the patients’ first names without permission. Language can turn people into objects, for example, referring to people by their disease category, the procedure they have had or their number and not by their name.

Dignity is threatened because patients are forced to rely on others for their basic care. The literature includes reports on the harm to dignity caused by having to ask for help with eating or dressing, tooth brushing and using the toilet. In addition, in some circumstances, health providers were allowed to use chemical or physical restraints. These methods limited the freedom of movement of patients. Organisational culture was an important theme in patient dignity care. The hospital philosophy and culture can be supported or influenced by staff attitude and behaviour and by the environmental setting.

Promoting dignity in care is reported in two ways in the literature: the design of a campaign of dignity in care in the clinical setting and material for education on dignity in care. Gallagher et al. proposed that promoting dignity in care is complex and challenging. Nurses always have a strong commitment to enhancing patient dignity in care; therefore, they need more knowledge and skills to provide it. Promoting dignity campaigns can create a positive atmosphere so that nurses can learn how to maintain patient dignity. Baillie and Gallagher carried out an evaluation of the RCN dignity campaign. Their major findings indicated that the main factors that enabled the dignity campaign were how receptive and how creative the staff were, the support from the organisation and their leadership and campaign materials. Dignity campaign objectives also pointed to the importance of the nurses in role modellng. There was senior support in their organisations, highlighting how important effective leadership was. How leadership enhanced and diminished dignity in care was a key finding in the RCN survey. The development of educational materials on dignity in care is an essential element in the promotion of patient dignity. The RCN of the United Kingdom provided educational materials, including a practice support pack, and all the resources were downloadable from the RCN website. These materials were developed collaboratively with practitioners, and it is likely that this influenced the accessibility and utility of their campaign resources.

Discussion

This review offers important insights that are relevant to dignity in the care of patients, which is widely considered to be one of the fundamental principles of nursing; however, the review had an important limitation. It included only the inpatient setting and patients more than 18 years old; other areas were excluded.
This narrative review shows that the defining components of dignity are human dignity and social
dignity, interpersonal dignity and internal dignity. Matiti and Trorey asserted that there are two kinds of
dignity: other-regarding and self-regarding. Throughout this review, we found that the definition of dig-
nity can be categorised into two domains: social dignity and self-dignity. The domain of social dignity
includes three elements: interpersonal dignity, dignity in relation and other-regarding dignity. Social dignity
is experienced by interaction with others. Then, the self-dignity domain includes internal dignity, dignity of
self, self-regard and self-respect. Even so, the definitions of dignity will differ slightly according to clinical
situations and patients.

This review provides information to clinicians about what dignity in care is and how to make patients feel
dignified. Most studies asserted that maintaining patient dignity emphasised respect and protecting
privacy. Respecting patients in clinical practice includes allowing them to make autonomous
decisions, treating them as complete individuals, honouring their beliefs and culture and describing and
explaining care so that they can give informed consent. In addition, respecting people includes
empathy, care, autonomy, providing information, recognising individuality, dignity and attention to
patients’ needs. With regard to protecting privacy, emphasis should be on maintaining privacy of the
patient’s body, space and condition. Privacy of the body can be achieved by drawing curtains to prevent
exposure and helping patients to wear neat clothes. As to spatial privacy, nurses have been said to recognise
the importance of patients’ body privacy. However, serious spatial privacy problems can be encountered in
many hospital rooms. Under Taiwan’s National Health Insurance, three- to five-person hospital rooms are
free of charge. Most patients, because of economic constraints, select these no-pay beds. Therefore,
although spatial privacy is often insufficient, nurses have provided adequate auditory privacy by using a
low voice to prevent others from overhearing conversations with patients about confidential disease
information. Moreover, nurses have tried to maintain single-sex bays but, due to bed shortages, are under
constant pressure to mix bays, thereby making patients feel undignified.

Furthermore, Lin et al. pointed out that dignity in care includes emotional care from the nursing staff,
giving psychological support and comfort to patients so that they feel the experience of dignity. When the
nursing staff provided care for those needs promptly, patients felt dignified during their hospitalisation.
Maintaining the patient’s body image was important to dignity in care to help patients save face, an impor-
tant value for Chinese people, and to feel more like their usual selves.

A positive care culture supports patient and staff dignity, but dignity can be compromised when manage-
mental values and financial targets are prioritised. Some recent research has explored the promotion or viola-
tion of patient dignity. Although maintaining patient dignity is an important element in nursing care,
dignity is sometimes diminished by the nursing staff. Nurses have heavy workloads, which can have an
impact on patient dignity, and staff shortages adversely affect dignity in care. Jacek found that nurses who could be remembered by patients were often those who were unpleasant. This supported
research showing how staff behaviour threatens patients’ dignity. Although staff are committed to
minimising exposure of the body, privacy is sometimes breached. Staff entering curtains unannounced has
already been reported. Staff behaviour towards patients should be such that their dignity is pro-
moted during all interactions. In the United Kingdom, patients’ rights to be treated with dignity are increas-
ingly emphasised, and nurses have a professional duty to respect patients’ dignity. In addition, the
organisational culture can influence patient dignity.

Baillie and Gallagher asserted that after working with campaign materials, staff sometimes identified
developments that required financial investment to promote dignity. Staff wishing to enhance dignity for
patients should be supported if they want to implement changes that might have resource implications. For
instance, Matiti indicated that nurses should have in-service education that relates to patients’ dignity;
enhances self-awareness and better prepares nurses with professional knowledge, appropriate attitudes and
communication skills that support dignity in care. In addition, nurses must recognise patients’ values and
staff actions in clinical practice that may invade patients’ dignity. Matiti et al.\textsuperscript{61} summarised patients’ expectations for dignity in the health-care system with regard to ending unnecessary invasions of privacy. Moreover, they indicated that nurses should discuss measures that enhance dignity in care and the reasons they do not implement dignity-promoting measures.

**Conclusions**

This narrative review will help nurses understand most factors from the patients’ and nurses’ perspectives that contribute to dignity in care in the clinical setting. Promoting the dignity of the patient in the hospital setting is important. Currently, clinical practice education in the United Kingdom does indicate dignity in care; therefore, a patient dignity care campaign and teaching materials can be developed based on this review. First to develop an in-service education course, the RCN\textsuperscript{28} and Matiti\textsuperscript{44} suggest that the course would emphasise the definition of dignity and dignity in care, such as respecting patient rights, protecting their privacy and how to not threaten patient dignity in care within the nursing process, especially through communication skills and attitudes. In addition, this review also found that giving patients emotional support, promptly responding to their needs and maintaining their body image were vital elements in patient dignity. Second, designing the dignity care campaign could be focused on the hospital organisation, leadership and environment\textsuperscript{28,39} Moreover, we also emphasise that the physical examination environment and the single-sex bed arrangement be maintained in hospital. Finally, the findings of this review can be helpful to nurses in understanding dignity in care, and, for policy makers, there are implications about determining the environment and organisational culture needed to promote patient dignity in nursing.

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**Conflict of interest**

The authors declare that there is no conflict of interest.

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