

Patient dignity in an acute hospital setting: A case study

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Abstract

Background: Nurses have a professional duty to respect patients' dignity. There is a dearth of research about patients' dignity in acute hospital settings.

Objective: The study investigated the meaning of patient dignity, threats to patients' dignity, and how patient dignity can be promoted, in acute hospital settings.

Design: A qualitative, triangulated single case study design (one acute hospital), with embedded cases (one ward and its staff, and 24 patients).

Setting: The study was based on a 22-bedded surgical ward in an acute hospital in England.

Participants: Twenty-four patients, aged 34–92 years were purposively selected. There were 15 men and 9 women of varied socio-economic backgrounds. They could all communicate verbally and speak English. Twelve patients, who had stayed in the ward at least 2 days, were interviewed following discharge. The other 12 patients were observed and interviewed on the ward. The ward-based staff (26 registered nurses and healthcare assistants) were observed in practice. 13 were interviewed following observation. Six senior nurses were purposively selected for interviews.

Methods: The data were collected during 2005. The Local Research Ethics Committee gave approval. Unstructured interviews using topic guides were conducted with the 24 patients, 13 ward-based staff and 6 senior nurses. Twelve 4-h episodes of participant observation were conducted. The data were analysed thematically using the framework approach.

Findings: Patient dignity comprised feelings (feeling comfortable, in control and valued), physical presentation and behaviour. The environment, staff behaviour and patient factors impacted on patient dignity. Lack of environmental privacy threatened dignity. A conducive physical environment, dignity-promoting culture and other patients' support promoted dignity. Staff being curt, authoritarian and breaching privacy threatened dignity. Staff promoted dignity by providing privacy and interactions which made patients feel comfortable, in control and valued. Patients' impaired health and older age rendered them vulnerable to a loss of dignity. Patients promoted their own dignity through their attitudes (rationalisation, use of humour, acceptance), developing relationships with staff and retaining ability and control.

Conclusion: Patients are vulnerable to loss of dignity in hospital. Staff behaviour and the hospital environment can influence whether patients' dignity is lost or upheld.

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Keywords: Surgical nursing; Caring; Qualitative research; Dignity; Nurse–patient relationship; Communication; Hospital

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What is already known about the topic?

- Dignity is complex and multi-faceted, relating to feelings, control, presentation of self, privacy and behaviour from others.

- Patient factors, the environment and staff behaviour can threaten or promote patients' dignity but their impact in an acute hospital setting has been little studied.

What this paper adds

- The core of patient dignity in an acute hospital setting is feeling comfortable, in control and valued; other components are physical presentation and behaviour.
- Patients are vulnerable to loss of dignity due to their impaired health, which is further threatened by lack of privacy, and curt or authoritarian staff behaviour.
- Patients' ability to rationalise their situation, other patients' support, a dignity-promoting culture, and staff interactions making patients feel comfortable, in control and valued, promote dignity when under threat.

1. Introduction

Patients in varied settings have identified the importance of dignity to them (Chochinov et al., 2002; Matiti, 2002; Joffe et al., 2003) and respecting people's rights to dignity is inherent in nursing (International Council of Nurses (ICN), 2006). However, dignity has been described as an ambiguous, vague concept (Shotton and Seedhouse, 1998; Tadd et al., 2002; Macklin, 2003). Some studies indicated that patients are vulnerable to a loss of dignity in hospital (Seedhouse and Gallagher, 2002; Matiti, 2002; Jacelon, 2003) but what threatens patients' dignity and how patients' dignity can be promoted has been little investigated, particularly in acute hospital settings. In this paper, findings from a qualitative case study are presented which provide insights into the meaning of dignity, how dignity is threatened in hospital and how dignity can be promoted.

2. Background

2.1. *The requirement for nurses to respect patients' dignity*

In the United Kingdom (UK), dignity has been on the NHS agenda for some time with health policies supporting dignified care for patients being produced by all four UK countries' health departments. In England, Department of Health (DH) documents increasingly emphasise that patients' dignity should be respected, while acknowledging that this is not always the case. In 2001 the DH published the *Essence of Care* (DH, 2001a) which included benchmarks for best practice in privacy and dignity for all patients. In the *National Service Framework for Older People* (DH, 2001b), concerns about older people's dignity were raised and the framework emphasised that older people's dignity should be respected. However, the term 'dignity' was loosely used and related to a wide range of care. In a follow-up document, the *DH* (2006a) acknowledged that older people's dignity was

not always respected and a 'Dignity in Care' campaign was launched (DH, 2006b). This campaign relates to health and social care broadly and remains on-going. Dignity is clearly an important issue within UK healthcare but the policy documents are rarely underpinned by research.

From a legal perspective, in 1948 the United Nations published the Universal Declaration of Human Rights (UDHR), which recognised the 'inherent dignity' of human beings, and provided the background to modern day human rights legislation. Although the UDHR is not legally binding, many countries incorporated the UDHR provisions into their laws and constitutions. Mann (1998) however pointed out that the UDHR did not actually define what it meant by 'dignity'. The European Convention on Human Rights was signed in 1950 but was only recently incorporated into UK law when the Human Rights Act (HRA) (Great Britain 1998) was passed. The HRA recognises that all individuals have minimal and fundamental human rights and two of the articles relate to aspects of dignity and are clearly relevant to healthcare: the absence of inhumane or degrading treatment (Article 3) and the right to privacy (Article 8). The ICN (2001) endorsed the UDHR and the ICN's Code of Ethics for Nurses includes:

Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, the right to dignity and to be treated with respect. (ICN, 2006, p. 1)

From a UK professional regulatory viewpoint, the Nursing and Midwifery Council's (NMC) Code of Professional Conduct states that nurses must:

Make the care of people your first concern, treating them as individuals and respecting their dignity. (NMC, 2008, p. 2)

It is essential therefore that nurses understand the meaning of dignity and how they can protect patients' dignity.

Nursing theorists who take a humanistic approach propose that respect for human dignity is central in nursing (Gaut, 1983; Roach, 2002; Watson, 1988). Watson (1988) wrote extensively about caring relationships between nurses and patients and she expressed the view that preserving human dignity is integral to the caring style of nursing. She recognised that health problems may threaten dignity (thereby leading to 'indignity') but she did not clarify how this might be addressed. Roach's (2002) work on caring closely reflects Watson's perspective that humanity and dignity are inextricably linked. Jacobs (2001) gave strongest support for the nurse's role in promoting patients' dignity, suggesting that respecting human dignity is not simply a role of nurses but is central to nursing and more important even than health:

The central phenomenon of nursing is not health or some sort of restoration of holistic balance and harmony but respect for human dignity. (Jacobs, 2001, p. 25)

Jacobs (2001) argued that nursing is about preventing threats to dignity and restoring dignity if it has been lost and that

nurses should ask themselves whether they are respecting the dignity of each person during every action.

2.2. The meaning of dignity

Although the term ‘dignity’ is embedded in many documents and papers, it is rarely defined. Shotton and Seedhouse (1998) suggest that dignity is a vague and poorly defined concept, warning that unless dignity’s meaning is clear, it can disappear beneath more tangible and measurable priorities such as waiting times for treatments. Other writers have referred to the elusiveness of dignity (Kass, 2002; Pullman, 2004) and Tadd (2005) asserted that without clarifying what dignity entails, respecting dignity could become a futile objective. Seedhouse (2000) suggested that dignity and how it can be promoted should be clearly defined and based on best evidence. Tadd et al. (2002) noted that phrases including the word ‘dignity’ have become increasingly commonplace, for example, ‘treatment with dignity’, ‘death with dignity’, ‘right to dignity’. They argued that such phrases have almost become clichés, especially in the care of older people but that, in reality, health care professionals undervalue this ‘fundamental aspect of care’ (p. 1). In a *British Medical Journal* editorial, Macklin (2003) argued that the term ‘dignity’ has become merely a slogan and that in many documents, the term ‘dignity’ actually means respect, voluntary informed consent, confidentiality and the need to avoid discrimination and abusive practices. The article provoked considerable debate with many respondents emphatically rejecting Macklin’s (2003) viewpoint and arguing for the value of dignity as a concept (Baker, 2003; Bastian, 2003; Ford, 2003). However, others agreed that dignity is ill defined and that the meaning of dignity needs further exploration (Mylene, 2003; Notcutt, 2003).

Nordenfelt (2003) identified four concepts of dignity: *menschenwürde* (dignity that all humans have equally), merit (due to position in society or earned through achievements), moral stature (dignity due to moral deeds—a virtue), and dignity of identity (integrity of body and mind). In a later paper, Nordenfelt and Edgar (2005) acknowledged that dignity of identity is most relevant in the context of illness as disability restricts autonomy and threatens personal identity. The themes ‘dignity as merit’ and ‘dignity as moral stature’ are of questionable relevance to healthcare because nurses should treat all patients with respect for dignity, regardless of perceived merit or moral status. Nordenfelt and Edgar (2005) emphasised that while *menschenwürde* cannot be diminished or lost while a person is alive, the presence and degree of the other three types of dignity varies in each individual.

More recently Jacobson’s (2007) analysis identified two distinct meanings of dignity: human dignity (*menschenwürde*) (as previously discussed) and social dignity. Jacobson (2007) asserted that social dignity is experienced through interaction and can be ‘lost or gained, threatened,

violated, or promoted’ (p. 295). Jacobson (2007) proposed that social dignity always arises in a social context and comprises two linked elements: ‘dignity-of-self’ (includes self confidence, self respect) which is created through interaction, and ‘dignity-in-relation’, which concerns the conveyance of worth to others and is situated in time and place. Jacobson (2007) suggested that being clear about whether human or social dignity is being discussed, may help reduce some of the vagueness associated with dignity. She identified that most empirical work concerning dignity in health relates to social dignity and that further explanatory empirical work is required in this area.

For nurses to consistently and universally treat people with dignity, a clear understanding of the nature of dignity is necessary. Views about the meaning of dignity have rarely been derived from patients’ perspectives. Concept analyses of dignity mostly comprised literature reviews (Johnson, 1998; Fenton and Mitchell, 2002; Griffin-Heslin, 2005; Coventry, 2006) but a few included views from convenience samples of students (Mairis, 1994; Jacobs, 2000) or friends, colleagues and family (Haddock, 1996; Marley, 2005). One United States (US)-based concept analysis of dignity in older people appropriately included older people’s views (Jacelon et al., 2004). The concept analyses highlighted the fact that dignity is complex and multi-dimensional.

2.3. Patient dignity

Primary research about patient dignity has been conducted in the US (Pokorny, 1989; Jacelon, 2003; Matthews and Callister, 2004), the UK (Matiti and Sharman, 1999; Street, 2001; Turnock and Kelleher, 2001; Gallagher and Seedhouse, 2002; Matiti, 2002; Enes, 2003) and Scandinavia (Söderberg et al., 1997; Widäng and Fridlund, 2003; Öhlén, 2004; Randers and Mattiasson, 2004; Stabell and Nåden, 2006). There have also been studies based in Australia (Walsh and Kowanko, 2002), Hong Kong (Lai and Levy, 2002), Canada (Chochinov et al., 2002) and Europe (Bayer et al., 2005; Stratton and Tadd, 2005; Ariño-Blasco et al., 2005). Thus dignity is of universal concern to nurses.

However, only a few studies of patient dignity have been conducted in acute hospital settings. Two small phenomenological studies both highlighted how staff behaviour influences patients’ dignity in acute hospital settings (Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). In a more comprehensive study, Matiti (2002) explored perceptions of dignity by conducting semi-structured interviews with 102 adult patients and 94 staff in acute wards. Patients associated dignity with self worth and personal standards, their presentation and perceptions of others. Matiti (2002) proposed 11 categories which together maintained dignity, thus highlighting the multi-factorial nature of dignity: privacy, confidentiality, need for information, choice, involvement

in care, independence, form of address, decency, control, respect and nurse–patient communication. Matiti (2002) identified patients' own roles in maintaining their dignity, finding that patients adjusted their perceptions of their dignity in hospital, reaching their own 'perceptual adjustment level'.

Studies of dignity based in intensive therapy units (ITUs) have been small in nature but provide useful insights. Pokorny (1989) identified privacy, control, independence, competence and caring as attributes of dignity from patients' perspectives. In Söderberg et al.'s (1997) study, ITU nurses identified that patients' dignity was compromised when treatment was inhumane, excessive or unfair. A further ITU-based study highlighted patients' vulnerability to bodily exposure and the importance of staff providing privacy (Turnock and Kelleher, 2001).

Several researchers have focused on terminally ill people's dignity (Street, 2001; Chochinov et al., 2002; Enes, 2003; Öhlén, 2004) but their findings may not necessarily transfer to acute hospital patients who have diverse health conditions. Enes's (2003) hospice-based phenomenological study identified control as important for dignity and poor resources and organisation affected dignity negatively. Patients adjusted their views of dignity because of their condition, supporting Matiti's (2002) perceptual adjustment level theory. As in other settings, Öhlén's (2004) phenomenological study highlighted how staff behaviour could threaten dignity.

Several studies focused on older people's dignity. Gallagher and Seedhouse's (2002) findings indicated that staff behaviour, the environment and resources affect patients' dignity. In Jacelon's (2003) study of older people's acute hospitalisation, concepts of dignity were self dignity (an internal concept) and interpersonal dignity (being treated with respect). Relinquishing control to staff and lack of privacy threatened dignity but, as in other studies (Matiti, 2002; Enes, 2003), patients coped by adjusting their attitude. In the 'Dignity and Older Europeans' project, the importance of staff behaviour was again highlighted (Bayer et al., 2005; Stratton and Tadd, 2005; Ariño-Blasco et al., 2005). Two qualitative studies of dignity in childbirth indicated the importance of feeling in control, privacy and respect (Lai and Levy, 2002; Matthews and Callister, 2004).

To summarise, common themes about the meaning of dignity were feelings, control, privacy, presentation of self, and behaviour from others. Few studies have been conducted in acute hospital settings with adults across the age range. Studies were mainly small scale and commonly used surveys and phenomenology. Staff behaviour and the hospital environment were identified as affecting dignity but were rarely studied directly through observation. Thus overall, the few studies of patient dignity in acute hospital settings have used a narrow range of methodologies and as patient dignity is of central concern to nurses and health policy makers, further research is needed.

3. Method

The aims of the study were to investigate in an acute hospital setting:

- (1) The meaning of patient dignity;
- (2) 'How patients' dignity is threatened;
- (3) 'How patients' dignity is promoted.

A multi-method qualitative case study design was used. No previous studies were identified which used this approach. Case studies are suitable for developing an understanding of a phenomenon in its real-life context and any appropriate range of data collection methods can be used (Yin, 2003). Using Yin's (2003) framework, the design was a single case (one hospital) with embedded cases: one ward (including staff) and 24 patients.

The setting was an acute public hospital in rural England. The ward 'Heron' (fictitious name) was a 22-bedded surgical ward specializing in urology, although patients with other conditions were regularly admitted. The 24 patients, aged 34–92 years (mean = 64) were purposively selected. There were 15 men and 9 women of varied socio-economic backgrounds; all were white British. Except for two medical patients, all had urological conditions; 20 had surgery during their admission. The inclusion criteria required patients to communicate verbally and speak English, so they could express their experiences. Twelve patients were interviewed post-discharge and they had to have stayed in Heron ward for at least 2 days so they would have adequate experience of the ward. The other 12 patients were observed and interviewed on the ward, immediately following observation. They had to require assistance from staff and be sufficiently orientated to give informed consent for observation and interview. All permanent ward-based staff (26 registered nurses and health-care assistants) were observed in practice and 13 ward staff, who were most involved with observed patients' care, were interviewed immediately following observation. Six senior nurses (three ward-based and three hospital-based) were purposively selected for interviews, as they could offer insight into factors influencing dignity from a wider hospital perspective.

The Local Research Ethics Committee gave ethical approval and the study was registered with the hospital's Research and Development Office, thus fulfilling research governance requirements (DH, 2005). Meetings were held with ward staff prior to the study commencing. Ward staff made the initial approach to patients, so that they could decline more easily than if they were approached directly by the researcher. All participants were given written information about the study and time to decide whether they wished to take part and they all gave written consent. Patients were assured that there was no obligation to take part and that their care would not be affected should they decline. All data were anonymised and kept securely in locked filing cabinets and password protected computers.

All data were collected during 2005 by one researcher, thus promoting a consistent approach to data collection. Topic guides with open questions and probes were used for conducting interviews (see Table 1). The post-discharge interviews were taped and conducted in patients' own homes within 2 weeks of discharge. Participants could thus express their views in the security of their own environment, promoting an open response. Twelve 4-h episodes of participant observation were conducted either in the morning or the first part of the night shift, thus avoiding visiting times when observation could have been intrusive. To increase the likelihood of participants' behaviour being natural and therefore valid data being collected, the participant observer aimed to integrate into the ward environment. This was achieved by participating in care wearing a nurse's uniform and developing a relationship with the staff through working shifts

with them prior to data collection commencing. However, the observer's presence could have affected the situations observed and interpretation of events could have been affected by the researcher's own beliefs and values. A research diary with reflective notes was therefore maintained, as the use of reflexivity assists in managing the researcher's influence on the situation studied (Byrne, 2000). These reflective notes helped to promote rigour during data collection and analysis but were not analysed as data.

During observation fieldnotes were written about the patient's condition, the environment and each event (e.g. care, interaction) occurring (see observation guide, Box 1). Following observation, each patient, and the main staff member(s) involved, were interviewed separately about the patient's dignity on the ward. These interviews were

Table 1
Interview topic guides for groups of participants

Participants	Topic guides
Patients interviewed post-discharge from ward ($n = 12$)	<p>Dignity is often mentioned as being important in healthcare.</p> <p>What does the term dignity mean to you?</p> <p>The researcher will use the patient's own expressed understanding of what dignity is to explore their thoughts and feelings about the following topics:</p> <p>Whether, before being admitted, they had any thoughts about their dignity being affected in hospital.</p> <p>If so, what these thoughts were and where they came from.</p> <p>Whether the hospital setting affected their dignity, and if so how.</p> <p>Whether staff affected their dignity during their hospital stay, and if so how.</p> <p>Whether there were any particular situations while in the ward when they felt they lost, or could have lost, their dignity. If yes, explore:</p> <ul style="list-style-type: none"> what the situation was, whether/how it related to their condition, treatment or care, their feelings at the time, anything they did to try to keep their dignity, how staff affected the situation (did they make the situation better or worse), anything else they would have liked staff to do in this situation. <p>Anything else they would like to say about their dignity as a patient on Heron ward.</p>
In-patients interviewed following observation episode ($n = 12$)	<p>Opening question:</p> <p>Dignity is often mentioned as being important in healthcare.</p> <p>What does the term dignity mean to you?</p> <p>The researcher will use the patient's own expressed understanding of what dignity is to explore their thoughts and feelings about the following topics:</p> <p>Any occasions during the observation period when they felt they lost, or could have lost their dignity.</p> <p>If so, when this happened.</p> <p>What they felt caused it.</p> <p>What effect staff had on the situation—whether they made the situation better or worse, and if so how.</p> <p>Whether there was anything else staff could have done in this situation to help promote their dignity.</p> <p>If there were no occasions when the patient felt they lost or nearly lost their dignity:</p> <p>What they feel helped promote their dignity during the observation period.</p> <p>Whether there was anything staff did which helped to promote their dignity.</p> <p>What effect, if any, they feel the ward environment has on their dignity.</p> <p>Whether there is anything more that could be done to the ward environment to promote patient dignity.</p> <p>Anything else they would like to say about their dignity as a patient on Heron ward.</p>

Table 1 (Continued)

Participants	Topic guides
Staff interviewed following observation episode ($n = 13$)	<p>What does the term dignity mean to you?</p> <p>The following topics will then be explored in relation to the observed patient and their care/treatment of him/her:</p> <p>Threats to dignity:</p> <p>Whether they felt [patient's name] dignity was lost, or threatened at any point during the observation period.</p> <p>If so what they feel caused this to happen.</p> <p>What effect they feel they had on the situation—whether they feel they improved or worsened the situation, and how.</p> <p>How they feel other staff improved or worsened the situation, and how.</p> <p>Whether they feel they or any other staff could have done anything else to promote [patient name]'s dignity in this situation, and if so, what.</p> <p>Promotion of dignity:</p> <p>If they feel the patient kept their dignity during their care/treatment:</p> <p>What they feel helped promote the patient's dignity.</p> <p>What their role was in promoting the patient's dignity.</p> <p>Effect of the ward environment:</p> <p>How they feel the ward environment affected [patient name]'s dignity.</p> <p>Whether there is anything more that could be done to the ward environment to promote patient dignity.</p> <p>Anything else they would like to say about patient dignity on Heron ward.</p>
Senior nurses interviewed ($n = 6$)	<p>What does the term 'dignity' mean to you?</p> <p>Do you feel there are any characteristics of the patient group on Heron ward that could threaten or promote their dignity? If yes, what are these?</p> <p>In your experience, how do staff, and their approach to patients, affect patient dignity?</p> <p>How do you feel the environment on Heron ward affects the patients' dignity?</p> <p>As a senior member of staff, what do you feel your role is in relation to patient dignity on Heron ward?</p> <p>Do you feel there are any factors outside the immediate ward environment which affect patient dignity, positively or negatively? (e.g. hospital, government, society)</p> <p>If yes, could you tell me about these?</p> <p>Are there any ward/hospital policies that specifically relate to patient dignity?</p> <p>If yes, which are they? What effect do you feel these have on patient dignity in practice?</p> <p>Is there anything else you would like to say about patient dignity on Heron ward?</p>

not taped so that they would appear less formal and potentially anxiety provoking. Detailed notes were written using the researcher's own shorthand and some verbatim speech was recorded in the notes. The observation fieldnotes and

Box 1. Observation guide

Description of patient's general condition and appearance

Description of physical environment of care

Events during observation period:

For each event:

- time of occurrence;
- description of staff (discipline, grade) involved;
- actions taken by staff and patient, and their responses;
- verbal and non-verbal interactions between staff and patient, and their responses.

interview notes were written up in full on the same day, so events could be recalled as fully as possible. Although patients could have been reluctant to voice concerns while still in the ward, due to the rapport developed during the observation period, they appeared to speak freely. All participants were assured of confidentiality. The interviews with senior nurses were taped. All taped interviews were transcribed within 24 h. Hospital and ward documents were scrutinized for references to dignity and either copied (with permission) or notes were taken; the senior nurses provided some electronically.

To pilot the main data collection methods, two post-discharge interviews and two participant observation episodes were conducted and critically reviewed with the researcher's doctoral supervisors. Together they considered that the data collection methods elicited rich data and so these data were analysed with data subsequently collected.

Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability guided attention to rigour. Credibility was promoted by using steps to

enhance the quality of the data collected, for example, a research diary was maintained to promote reflexivity and early findings were discussed with participants who confirmed the findings were credible. The description of the case should enable readers to assess transferability of the findings to their own settings. One researcher collected all the data using topic guides and an audit trail of decision-making was maintained, thus maintaining dependability. The audit trail also assisted confirmability and the steps to achieve credibility, transferability and dependability also promoted confirmability.

The data were analysed manually using the framework approach (Ritchie and Spencer, 1994), which entailed combining themes from the theoretical framework with themes from the data to develop a coding framework. Applying this tested and systematic approach promoted rigour, which was further enhanced by critical review throughout the analysis process with the researcher's doctoral supervisors. The data were first reduced to 'significant statements'—phrases or sentences relating to dignity. Each statement was coded using the coding framework and then categorised under themes. Charts relating to each theme and its categories were developed and data were mapped onto the charts. These charts illuminated how widespread different views were, whether age or gender affected responses and whether observational data supported or contrasted with interview data, thus promoting data triangulation. Early findings were presented and discussed with the ward staff who confirmed their credibility.

4. Findings

The themes presented are: the meaning of patient dignity, patient factors affecting dignity, the impact of the hospital environment on dignity and how staff behaviour affects dignity.

4.1. *The meaning of patient dignity*

As Table 1 indicates, all staff and patients were asked about their interpretation of dignity, which they expressed as being feelings, physical presentation of self, and behaviour—of self and/or others. Patients' and staff views were closely related. Both patients and staff identified feelings as being central: feeling comfortable, in control and valued. Patients expressed feeling comfortable if they felt safe, happy, relaxed, not worried, did not feel embarrassed and had a sense of well-being. For example, Mr. A expressed dignity as:

Feeling sort of generally happy with your surroundings and where you are and who you're with and not feeling embarrassed by whatever. (Mr. A)

Dignity was also described as feeling valued: feeling of consequence, feeling cared for, self respect and self esteem. Four patients and two staff members particularly emphasised dignity as feeling in control, for example:

Feeling that you have some being of your own and that you're not under pressure to do things. (Mr. B)

About half the patients and over half the staff associated dignity with appearance: being dressed appropriately and not having their bodies exposed, for example:

Just not showing your body to other people I think. Just keeping it covered all the time. (Mrs. Z)

Physical presentation was closely linked with feelings, influencing how comfortable patients felt. Three quarters of the patients, all the senior nurses and half the ward staff referred to behaviour in relation to the meaning of dignity, for example:

If you're treated well - not just like on a conveyor belt - just another one coming in - but as a person. (Mrs. Y)

Respect was the most commonly used term relating to behaviour associated with dignity, widely expressed by staff and patients, for example:

Respect from other people isn't it? Respect and people treating you as you treat them, and not making you feel small. (Mrs. X)

About a third of the patients and a smaller number of staff expressed the view that dignity entailed mutually respectful behaviour.

Patients' dignity was affected by patient factors, the hospital environment and staff behaviour. These are each discussed next.

4.2. *Patient factors affecting dignity*

Patient factors which made patients vulnerable to a loss of dignity related to their impaired health and, to some extent, older age.

Both patients and staff described how patients' impaired health led to dependence in personal care, which threatened dignity. Also, many patients experienced intimate diagnosis-associated procedures, particularly as most had urological conditions:

The very fact that you have a catheter and you were having your urine bag changed every so often - it's not dignified. (Mr. C)

From a psychological perspective, a serious illness, or uncertainty about their diagnosis, led to patients feeling out of control.

There were some references to older age rendering patients more vulnerable to a loss of dignity. However, although 11 patient participants were over 65 years old, only a few referred to their age regarding dignity. Younger patients seemed as concerned about their dignity as older patients. Some younger patients perceived older patients were physically frailer, thus needing greater assistance but health status was more influential. For example Mrs. Y (in

her 40s) was highly dependent post-operatively, as the nurse caring for her identified:

Not being able to do much for herself at the moment leaves her a bit vulnerable. (Nurse 1)

However, Mr. D (in his 90s) was independently mobilising in the ward and able to attend to his own personal care. Attitudes towards bodily exposure were linked with age by a few patients (of varying ages), for example:

I'm a man who was brought up in the innocent age and your body being touched and played with by women and that kind of thing is a bit difficult. (Mr. E, in his 70s)

One ward nurse similarly expressed that older people may feel more uncomfortable about bodily exposure.

Senior nurse 1, who had a hospital-wide role, expressed that hospital culture negatively affected older patients' dignity:

I think older people are more at risk and I think it's because of our culture. . . particularly in a hospital environment.

She gave examples of endearments being used to address older people and their independence being diminished in hospital. However, no patients interviewed identified a negative culture towards older people on Heron ward.

Although the patient factors discussed could make patients vulnerable to a loss of dignity, many patients expressed how they actively promoted their own dignity. Two-thirds of the patients identified that their attitude towards potentially undignifying situations helped either to promote their dignity or to accept a loss of dignity, thus feeling more comfortable. However, only two staff members (a senior nurse and a health care assistant) referred to patients' attitudes as a factor affecting dignity. Patients rationalised that bodily exposure to staff, and intimate procedures, were necessary in hospital:

Encroaching on the body's modesty when undergoing treatment is a necessity – it's just part of their [staff's] job. (Mr. G)

Some patients described using humour to counteract threats to dignity. Two patients considered that a loss of dignity was inevitable in certain situations: Mrs. U considered that having her 'bottom wiped' was a loss of dignity which staff could not prevent and Mr. C felt similarly about having a urethral catheter. These patients thus adopted an attitude of acceptance which seemed to make them feel more comfortable:

In some ways I suppose I've lost my dignity but I've accepted it. (Mrs. U)

Six patients (five men and one woman) explicitly referred to developing good relationships with staff to promote their dignity and patients were often observed taking the initiative to build relationships. Staff, however, did not refer to this patient strategy at all. Attaining good relationships with staff

increased patients' social support, helped them to feel more comfortable in the hospital environment and would also, patients reasoned, have a positive impact on how staff related to them, for example:

If you don't set off on the right foot and treat them with respect, then they're not going to do the same to you. (Mr. H)

Patients related not complaining about upsetting incidents to avoid jeopardising relationships:

I didn't do anything about it. I didn't want to upset anybody because I don't want anybody taking it out on me. (Mr. A)

While patients related these comments as being how they promoted their dignity, such statements clearly indicate patients' vulnerability in healthcare settings and a power imbalance between patients and staff.

Five patients expressed that their physical ability helped to promote dignity but no staff explicitly referred to this factor. These were patients who were less incapacitated and could be more independent in their personal care. Patients also described, and were observed, trying to keep control over their situation.

4.3. *The impact of the hospital environment on dignity*

The hospital environment affected dignity in various ways, positively and negatively. The physical layout was one aspect. Two patients considered that the ward's layout (five-bedded bays with bathrooms) breached privacy and thus dignity; they would have preferred to have been in single rooms. However, other patients and staff considered the layout as promoting privacy, and therefore dignity, for patients. Just three staff members and one patient, identified that a lack of auditory privacy threatened dignity. Mrs. X stated that when her surgeon visited her post-operatively:

Everybody in the ward could hear what he'd done and what he'd found . . . you can't help it can you - if you're laying in the next bed. . . I just thought 'Don't speak too loud' - I'm not exactly proud of what's going on. (Mrs. X)

Bodily exposure was a lack of privacy of the body, which a third of patients and the majority of staff identified as a threat to dignity. Due to invasive devices being attached (e.g. catheters, intravenous infusions), patients were not fully dressed, generally wearing hospital gowns which exposed them:

How dignity's compromised is these gowns you wear are wide open at the back aren't they. (Mr. F)

However, patients wearing hospital gowns seemed ingrained as a ward 'norm' and only two staff members (one nurse and one health care assistant) identified them as a threat to dignity.

Due to hospital bed shortages, Heron ward's single sex bays were sometimes mixed, exacerbating concerns about bodily exposure. Both patients and staff were uncomfortable

about this situation. Mrs. W related how while getting out of bed, a male patient opposite her ‘instead of averting his eyes’ stared at her. Even when bays were single sex, male patients sometimes entered the female bay, while female patients stayed in their own bay. Staff commented on the difficulty of trying to prevent male bodily exposure on the ward:

We try to keep them [genitals] under cover but they persistently expose themselves - being a mixed ward this could be a problem. (Nurse 2)

Hospital systems threatened dignity, mainly due to bed management issues. Due to bed shortages patients were frequently moved between wards:

I went in three different beds before I ended up on this ward because they didn’t have room anywhere - being trundled around like that - you feel a bit helpless. (Mr. C)

The subsequent large number of patient admissions and transfers increased workload, which staff and patients perceived affected dignity adversely. However, there were examples observed of staff working under great pressure but, from patients’ perspectives, they still promoted dignity.

It was clear that a conducive physical environment and facilities promoted patients’ dignity:

This ward has more open space - it’s clean and new - it makes you feel better. (Mr. I)

The ward’s small bays enabled camaraderie between patients who felt comfortable being with other patients with similar conditions: ‘all in the same boat’. They felt less embarrassed when undergoing intimate procedures:

Everybody realises there’s something going on behind those curtains but - so what - they’re all in the same boat. (Mr. C)

Patients commented on the caring and respectful attitude of other patients:

Everyone [other patients] seems to root for everyone else. (Mrs. T)

Only two nurses identified that other patients in the environment promoted patients’ dignity, indicating this was an aspect not generally recognised by staff.

When asked about the ward environment’s effect, almost half the patients referred to aspects of ward culture and leadership which promoted their dignity.

There’s a very caring, respectful approach. The ward is friendly - there’s a nice feel about the place. People on this ward are sensitive to making you feel dignity is promoted all the time. (Mr. J)

Just three ward staff interviewed commented on ward culture in relation to the environment. In contrast, all the senior nurses discussed aspects of ward culture and leadership indicating a greater awareness of the effect of culture on dignity at their level. The hospital-based senior nurses

commented on the importance of ward leadership in relation to dignity on the ward and spoke highly of Heron ward’s manager in that respect:

We’ve got a very good sister in Heron ward who comes from the older school of thought and in fact does know how people should be treated - every patient should be treated with dignity, irrespective of age. (Senior nurse 2)

One patient (Mr. K) also specifically commented on the ward manager’s leadership in relation to dignity.

The senior nurses’ comments suggested that promoting dignity was very important in the hospital and comments from ward-based staff and patients indicated a dignity-promoting ward culture. Yet there were few written documents, either ward or hospital-based, which explicitly related to patient dignity, apart from the *Essence of Care* (DH, 2001a) documentation. However, although the ward philosophy did not actually refer to dignity, it described relevant staff behaviour, for example that individual differences will be respected.

4.4. *How staff behaviour affects dignity?*

Staff behaviour had an important effect on patients’ dignity and related to interactions with patients and provision of privacy. A few patients and one nurse identified that authoritarian interactions could threaten dignity:

It’s like you’re a thing in a bed and I’m coming round. You have to have all these tablets whether you want them or not. (Mrs. V)

Half the patients interviewed described observing a staff member behaving in a curt manner, otherwise termed ‘brusque’, ‘off-hand’, or ‘stand-offish’. Mr. D elaborated that such behaviour entailed:

Having a lack of conversation, doing a job in a matter-of-fact way and not bothering much about it. (Mr. D)

Only a few ward staff identified that interactions might threaten dignity; staff concerns about dignity were more often about privacy issues. However, one senior nurse described the potentially negative effect of staff approach:

If you’re abrupt with the patient and [do] not approach them calmly or what ever they can react. If your approach is not good and the patient feels threatened then you won’t get the same reaction from patients. (Senior nurse 2)

Some staff did acknowledge that their behaviour could breach privacy, for example, ‘people come and peep round the curtains’ (Nurse 3). In an isolated example, Mr. A explained how during a bladder washout, a staff member intruded and chatted to the nurse carrying out his procedure, which caused ‘a certain loss of dignity’. However, there was generally a high level of awareness about privacy in the ward. All ward staff interviewed, five of the six senior nurses, and half the patients

identified that staff promoted their dignity by providing privacy. Patients commented that nurses were attentive to pulling round curtains, whenever bodily exposure might occur, which observation confirmed. Staff explained how they ensured patients' bodies were covered:

You should never expose any more of the body than absolutely necessary when carrying out care. (Nurse 4)

Mrs. Y expressed gratitude that when she 'couldn't be bothered' to maintain her own dignity (due to her poor physical condition), 'staff stepped in and straightened me up'.

Most patients and staff interviewed identified interactions that they felt were therapeutic as they promoted patients' dignity. Such interactions were frequently observed in practice. Generally, patients discussed more extensively about staff interactions while staff put a greater emphasis on providing privacy. Staff helped patients to feel comfortable by using humour, reassurance and friendliness. Professionalism was also referred to:

They like to feel safe - that you are professional and the patient feels safe in your hands, when you're dealing with their problems. (Senior nurse 2)

To promote dignity, staff need to combine being businesslike and professional with sensitivity and caring. (Mr. J)

Staff behaviour during dignity-threatening procedures could prevent dignity being lost. For example, Mr. E commented that removal of his catheter could have threatened his dignity but the nurse's approach prevented this as 'she did it very nicely without any bother or fuss or anything'. Six of the patients, but just two ward staff, commented that staff use of humour promoted dignity. Reassurance and friendliness were identified by over half the patients as promoting their dignity and these attributes were often observed, but only two nurses referred to these specific interactions. Interactions that made patients feel in control included: explanations and information giving, offering choices, gaining consent and promoting independence. The subtle phrasing of interactions could affect whether patients felt control was retained:

She [Nurse] said 'Would you like your paracetamol now?' not 'Here's your paracetamol' or 'Here's your tablets' without telling me what they are. (Mrs. V)

Over half the patients but fewer staff identified that interactions that made patients feel valued promoted their dignity. Courteousness (including politeness, how patients were addressed, greetings and using a respectful approach) was particularly highlighted, for example:

From the cleaner to the sister, I got the same respect, which was nice. (Mrs. W)

While just over half the patients identified helpfulness and consideration from staff promoted their dignity, only one

ward nurse and one senior nurse did so. Yet many such examples were observed in practice and thus it seemed that staff did not recognise that helpfulness and consideration to patients promoted dignity.

5. Discussion

The study involved only one English hospital and specifically one ward's staff and patients, although three senior nurses had hospital-wide roles and hospital documents were examined. Ideally, a multiple case study design would have been used with other acute hospitals involved but these require extensive resources and are often beyond the resources of a single researcher (Yin, 2003). The data collection sources focused on patients and staff but relatives' views might have provided a different perspective and could be included in future research. A further limitation is that participants, particularly staff, might have changed their behaviour when the researcher was observing, for example paying more attention to dignity (according to their interpretation of its meaning) than they do usually. Data from interviews with patients following discharge, when they should have felt able to be entirely honest about their experiences, enabled monitoring of whether there were differences between observed practice and practice described at interview. Conversely, there was a risk that these interviewees may have provided answers which they believed were desirable or that their views may have changed since discharge. However, the observational data and in-patient interviews enabled any such contrasts to be identified. There was actually close consistency between the findings derived from the different data sources. Some findings supported those from previous studies, mainly from different settings, but also identified new perspectives about patient dignity in acute hospitals.

Previous research has indicated that dignity is an internal quality which was well supported by the findings as many participants expressed that the meaning of dignity was about feelings. Some feelings identified in this study's findings supported previous research, in particular: self esteem and self respect (Matiti, 2002). However, feeling comfortable was specified in two of the concept analyses (Mairis, 1994; Fenton and Mitchell, 2002) but in none of the primary research studies. For some Heron ward patients, feeling in control was closely associated with dignity, but this specific interpretation of dignity was not so widely expressed as in some other studies (Chochinov et al., 2002; Matiti, 2002). Thus, for most of this study's participants, other feelings relating to dignity were more prominent.

The meaning of dignity relating to physical presentation supports previous research with older people (Gallagher and Seedhouse, 2002), in terminal care (Chochinov et al., 2002) and acute care (Matiti, 2002). Supporting Matiti's (2002) category of 'decency', some participants expressed that dignity was keeping the body covered. However, although

Turnock and Kelleher's (2001) ITU-based study assumed dignity solely concerns modesty of the body, this study's findings indicate that few people consider this to be the only meaning of dignity. The study supported the link between behaviour and dignity which is prominent in the literature, reflecting the notion of 'interpersonal dignity', whereby behaviour from others conveys feelings of worth (Jacelon, 2003). The association between dignity and respect in previous research (Matiti, 2002) was confirmed in this study's findings too.

The definition of the meaning of patient dignity which emerged from the study's findings was:

Patient dignity is feeling valued and comfortable psychologically with one's physical presentation and behaviour, level of control over the situation, and the behaviour of other people in the environment.

This definition was developed from patients' data so their interpretations remained central but staff perceptions supported this definition too. The definition of dignity aimed to be relevant to patients and staff working in acute hospital settings and builds on previous research findings.

Fig. 1 portrays how the hospital environment, staff behaviour and patient factors affect patients' dignity. The patient has centre place in the model, surrounded by the environment and staff behaviour which threaten or promote dignity. The model's upper half portrays why patients are

vulnerable to loss of dignity in hospital. Patients' impaired health results in loss of function and older age may increase vulnerability. The potential loss of dignity is compounded by staff behaviour and the hospital environment. The model's lower half identifies how patient factors, the hospital environment and staff behaviour can promote dignity, despite patients' vulnerability.

The findings supported previous research that impaired health negatively impacts on patients' dignity (Matiti, 2002; Enes, 2003). Having a urological condition increased the likelihood of patients undergoing intimate care which threatens dignity (Lai and Levy, 2002; Matiti, 2002; Jacelon, 2003). This study's specific findings about how urological conditions affect patients' dignity has been previously published (Baillie, 2007). The psychological impact of illness on dignity was identified in research with terminally ill patients (Chochinov et al., 2004) and older people (Jacelon, 2004) but Heron ward patients expressing this view were of varied ages and conditions. Some younger patients considered that older people were more vulnerable because of greater physical dependency, also expressed by European professionals (Calnan et al., 2005). The view that older people were more vulnerable for psycho-social reasons has not been previously reported. One senior nurse expressed the view that hospital culture made older patients more at risk of losing their dignity. Some UK health policies have particularly focused on older people's dignity (DH, 2001b, 2006a) which could

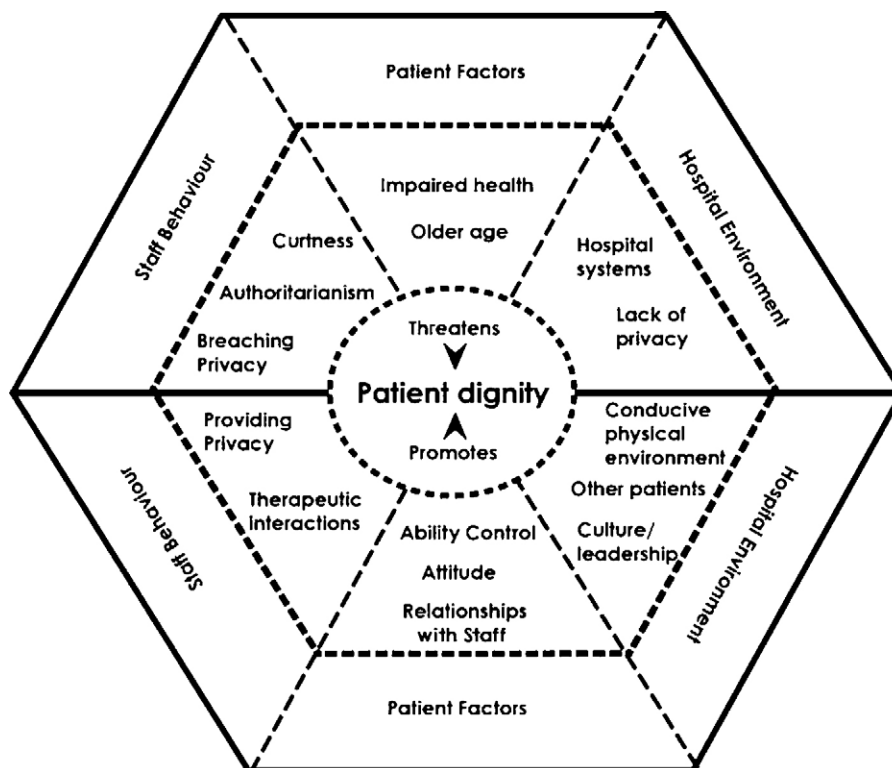


Fig. 1. How patients' dignity is promoted or threatened in hospital.

indicate that from a government perspective, they are considered a group at greater risk.

Despite their vulnerability, patients adjusted their perception of their dignity in hospital, supporting Matiti's (2002) perceptual adjustment level theory. However, staff seemed unaware of the efforts patients put in to adjust their attitude, using rationalisation and acceptance. An attitude of acceptance was previously reported regarding dignity in chronic and terminal disease (Chochinov et al., 2004; Campbell, 2005) but has not been highlighted previously in acute care. Patients' use of humour to reduce embarrassment supports other findings from acute care (Matiti, 2002; Walsh and Kowanko, 2002). As previously reported (Matiti, 2002; Jacelon, 2004), patients discussed developing and maintaining relationships with staff to promote their dignity. Such comments highlighted the powerful position of staff in hospital settings; no staff participants identified that patients used this strategy. Disempowerment of older people in hospital has been previously suggested (DH, 2001b, 2006a; Woolhead et al., 2004) but in this study, younger patients also expressed these views, highlighting the vulnerability of acutely ill patients of all ages when in hospital. A few participants associated ability and control with dignity; similarly independence has been associated with dignity (Jacelon, 2004; Matiti, 2002).

As in other studies (Turnock and Kelleher, 2001; Gallagher and Seedhouse, 2002; Enes, 2003; Randers and Mattiasson, 2004; Ariño-Blasco et al., 2005), privacy was important for dignity. However, only two patients viewed being in a five-bedded bay negatively; most patients' dignity was instead enhanced by the camaraderie of other patients. It was important to many patients however that other patients in the bay were of the same sex and had similar conditions. Two studies of terminally ill patients have associated social support/relationships with dignity (Enes, 2003; Chochinov et al., 2004) but otherwise, the dignity-enhancing impact of other patients has not been reported.

A lack of auditory privacy in hospitals is well recognised (Matiti, 2002; Walsh and Kowanko, 2002; Woogara, 2004) but only a few participants expressed that inadequate auditory privacy threatened dignity. Thus either most participants did not perceive a lack of auditory privacy or they did not associate it with a loss of dignity. However, lack of privacy of the body (bodily exposure) clearly threatened patients' dignity, supporting previous findings (Matthews and Callister, 2004; Turnock and Kelleher, 2001; Walsh and Kowanko, 2002). As in other studies (Matiti, 2002; Walsh and Kowanko, 2002; Woogara, 2004), wearing hospital gowns increased vulnerability due to potential bodily exposure but staff were largely unaware of how seriously these affected patients' dignity.

Due to bed shortages, a mixed sex environment regularly occurred, threatening dignity due to risk of bodily exposure to patients of the opposite sex. UK studies have highlighted that mixed sex wards threaten older people's dignity (Health Advisory Service 2000, 1998; Gallagher and Seedhouse,

2002; Woolhead et al., 2004) but Heron ward patients across the age range expressed discomfort. A few patients commented that high staff workload threatened dignity through its negative impact on staff interactions, supporting previous findings (Matiti, 2002; Walsh and Kowanko, 2002; Enes, 2003).

Staff behaviour strongly influenced whether patients' dignity was threatened or promoted. However, it should also be recognised that the care environment impacts on behaviour (Moos, 1987) so behaviour cannot be considered in isolation. There were a few examples of staff breaching privacy, a situation highlighted previously (Lai and Levy, 2002; Ariño-Blasco et al., 2005; Woogara, 2004). However, all data sources indicated that staff were mainly attentive to patients' privacy. As other studies found that staff frequently breached patients' privacy (Turnock and Kelleher, 2001; Woogara, 2004) the dignity-promoting ward culture could be influential. Only a few other studies have highlighted the role of a dignity-promoting culture (Gallagher and Seedhouse, 2002; Health Advisory Service 2000, 1998).

Provision of privacy alone was not enough to promote dignity; therapeutic interactions were also required. However, patients emphasised the role of staff communication more strongly than staff who were more focused on privacy aspects. Staff professionalism, use of humour, reassurance and friendliness made patients feel comfortable. Several other studies identified that staff professionalism promoted dignity (Lai and Levy, 2002; Widäng and Fridlund, 2003; Matthews and Callister, 2004). Staff use of humour has only been explicitly linked with promoting dignity in terminal care (Dean, 2003; McClement et al., 2004). References to reassurance and friendliness were reported in only a few studies (Jacelon, 2002; Matthews and Callister, 2004); thus the dignity-promoting role of these interactions has been little recognised. The research findings confirmed that giving explanations promotes dignity (Lai and Levy, 2002; Enes, 2003; Matiti, 2002; Bayer et al., 2005). Previous research indicated that feeling valued is important for patients' dignity (Chochinov et al., 2002; Jacelon, 2002; Matiti, 2002) but the explicit interactions necessary to achieve this (helpfulness, consideration, courteousness, and conveying concern for patients as individuals) have not been previously elaborated.

Rather than promoting dignity, staff interactions can threaten dignity instead, by displaying curtness—similar to brusqueness (Óhlén, 2004) and harshness (Calnan et al., 2005) identified previously. An authoritarian approach was found to threaten dignity too, supporting several earlier studies (Jacelon, 2002; Óhlén, 2004; Woolhead et al., 2004). Few staff acknowledged that staff interactions could have a detrimental impact on dignity.

6. Conclusion

Promoting dignity is central to humanistic nursing theory and nurses have a professional duty to promote patients'

dignity. Increasingly, UK health policies have emphasised the importance of patient dignity. As little research about patient dignity has been conducted in acute hospital settings, this study's findings have contributed to this limited body of knowledge.

Patient dignity in hospital was found to comprise feelings, physical presentation and behaviour and can be promoted or threatened by the hospital environment, staff behaviour and patient factors. While some findings supported research conducted in other settings, their impact on dignity has been explained more specifically. The findings highlighted patients' abilities to adjust their attitudes to dignity in hospital. The important role of non-physical environmental dimensions – ward culture and leadership, and other patients – contributes new perspectives.

There are implications for clinical practice relating to managerial, educational and practice perspectives. From a managerial perspective, the study confirms the importance of a conducive physical environment: cleanliness, provision for privacy and adequate resources. Wards need to be adequately staffed, as high workload affects staff interactions, and have strong leaders who are committed to patient dignity. Bed management policies have an important role, as a single sex environment with patients with similar conditions grouped together, enhances dignity.

While environment and resources are important factors, all staff working in practice should take individual responsibility for promoting patients' dignity as just one individual's behaviour in a team can lead to a distressing experience for patients. Staff in this study were often unaware of how interactions affect dignity and there was some lack of attention to privacy. Therefore, staff education at all levels should emphasise the impact of their interactions and patients' vulnerability. All staff should reflect on their own behaviour with patients and take action if they consider a patient's dignity is at risk due to the environment or staff behaviour. Staff must recognise patients' vulnerability to their dignity being threatened in hospital and be extra vigilant in situations where a loss of dignity is more likely, for example intimate procedures and when patients are unable to take steps to promote their own dignity. Staff should also be aware of potential power imbalances between patients and themselves.

Conducting further case studies in different acute settings is recommended, in particular, a city hospital with a multi-cultural population would contrast with the rural setting studied here. Action research could enable study of how practice might be changed, incorporating the study of dignity-promoting cultures. The impact of other patients on dignity has been little studied and further research of this dimension should be considered.

To conclude, while the hospital environment should provide the physical and managerial structure for promoting patient dignity, each individual staff member must promote dignity in their behaviour with patients and be aware of their impact on vulnerable patients' dignity during each and every encounter.

Conflict of interest

There is no conflict of interest relating to this paper.

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Ethical approval

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