

Exploring the perceptions of dignity among patients and nurses in hospital and community settings: an integrative review

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Abstract

Background: Patients have a right to be treated with dignity. However, reports have continually identified concerns regarding the quality of care and dignity in hospitals. Undignified care can have unfavourable impact on the patient's recovery such as leading to depression and loss of will to live. The aim of this study was to explore dignity as perceived by patients and nurses within hospital and community environments.

Methods: An integrative review methodological approach was adopted. Nine databases including Medline, CINAHL plus with full text, Web of Science, Embase, Pubmed, Psycinfo, Scopus, Nursing and Allied Health Source, and Science Direct were systematically searched for relevant articles using a predetermined set of inclusion criteria. Articles were included if they were primary empirical studies, peer reviewed, published between 2008–2019, assessing patients' or nurses' perception of dignity outside the end-of-life context, conducted in one of the European countries and written in English. Included papers were analysed using constant comparative analysis. The preferred reporting system for systematic review and meta-analysis (Prisma) flow diagram was used for quality appraisal and review.

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Results: Fourteen relevant articles were included in this review. Four overarching themes and 10 subthemes were identified as impacting on patient dignity. Overarching themes include autonomy, healthcare delivery factors, organisational factors and the meaning of dignity, whilst subthemes include dependence/independence, choice, staff attitudes, communication, privacy, structure of services, staff shortages, physical environment, respect and person-centred care.

Conclusion: There are a wide range of factors impacting on patient dignity. Adopting evidence-based interventions supported by adequate theoretical backing can help to enhance patient dignity in hospital and community settings.

Keywords

community, dignity, hospital, nurses, patients, perceptions, setting

Introduction

Respect for human dignity is a core value of human interaction (Mann, 1998) and is desired by most people irrespective of their condition (Ebrahimi et al., 2012; Jacelon et al., 2004). The respect of human dignity constitutes the foundation on which human rights are based hence, the Universal Declaration of Human Rights states that all humans are equal in dignity and rights (United Nations War Crimes Commission, 1948). Accordingly, the World Health Organization (1994) in a declaration on the promotion of patients' rights in Europe states that 'patients have the right to be treated with dignity'. Dignity has been shown to have an important influence on the patient's care journey. For example, Williams and Irurita (2004) found that care believed to be dignified provided emotional comfort which in turn enhanced recovery. Conversely, undignified care can have an unfavourable impact on the patient's recovery such as leading to depression, loss of will to live (Chochinov et al., 2002) and feelings of worthlessness (Jacobson, 2009). This can further lead to complaints and sometimes negative media interest (Tadd et al., 2011).

The importance of dignity in nursing is highlighted by the centrality of dignity in various nursing codes of practice across the world. The International Council of Nurses' (ICN, 2012) code states that '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'. Furthermore, ICN (2012) identified maintaining human dignity as an ethical goal of nursing. In the UK, stipulations in the Nursing and Midwifery Council (NMC, 2018) code posited that nurses should act with integrity and honesty when caring for all patients, and must treat patients fairly and give them autonomy. However, it is worthy of note that codes of practice are only relevant if clearly understood. In a European wide study, Tadd et al. (2006) found that nurses had a poor understanding of their professional codes and often relied on personal values and experiences. Furthermore, despite its glaring significance, it is often unclear what dignity means or how it should be defined. Therefore, it can be argued that any requirement to uphold patient dignity is of little help if the meaning of dignity is not understood (Barclay, 2016).

Scholars have described the concept of dignity as complex (Leung, 2007; Tranvåg et al., 2015), vague (Høy et al., 2016), abstract (Guo and Jacelon, 2014) and confusing. A review of the theoretical literature suggests that dignity exists in two interdependent yet separate forms. Despite philosophical and disciplinary differences researchers conceptualise dignity as dualistic (Tranvåg et al., 2015) using various terminologies to describe it including objective dignity

versus subjective dignity (Gallagher, 2004), basic dignity versus personal dignity (Leung, 2007), dignity of stature and dignity of merit (Nordenfelt, 2004), absolute dignity versus relative dignity (Edlund et al., 2013) and human dignity versus social dignity (Jacobson, 2009). Whatever terminology is used, most authors suggest that one type of dignity is inherent/inborn and cannot be reduced or influenced while the other type of dignity is subjective and changeable often influenced by external factors (Tranvåg et al., 2015). This latter form of dignity is of most relevance in the healthcare context as the care we provide can promote or undermine dignity (Nordenfelt and Edgar, 2005). However, despite plentiful research and rich discourse about dignity in care there is no general agreement on what it means (Barclay, 2016).

Several UK reports have identified concerns regarding the quality of care and dignity in hospitals. The Parliamentary and Health Service Ombudsman (2011) identified failings in the basic standards of care such as assistance with feeding, cleaning and comfortable environment, availability of drinking water, and communication. Another report by the Care Quality Commission (2011) on dignity and nutrition of older people identified several indignities including not gaining informed consent, treating patients disrespectfully and discussing patient's personal information in open areas. Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) presented horrifying levels of indignity suffered by patients in the care of the hospital as recounted by patients and their family. It has been established that dignity is important to patient care, however evidence suggests that dignity is not always respected and is often undermined. Therefore, there is a need to investigate factors that may impact on a patient's dignity.

Method

Search method

The search process entailed a systematic approach applying clear procedures and reflective processes as suggested by Harcourt and Rumsey (2004) in identifying and reviewing articles. Articles were searched for in a systematic manner between January and March 2019. A comprehensive search of the literature was undertaken as suggested by Dixon-Woods et al. (2005) and Walsh and Downe (2005) as this enables the researcher to find every relevant piece of literature which meets the predetermined inclusion criteria, in order to avoid omitting key research whose omission can bias the study.

The following keywords were used in the search: 'dignity', 'perception', 'nurse', 'patient', 'community' and 'hospital'. Words were then first entered individually into specified databases relevant to the topic of study to identify any synonymous words and phrases, alternative terminology, related terms, plurals and variations in word spelling (Cronin et al., 2008). The search was done using the following nine databases: Medline, CINAHL plus with full text, Web of Science, Embase, Pubmed, Psycinfo, Scopus, Nursing and Allied Health Source, and Science Direct. In the first step, the search was carried out according to the purpose of the research and using the selected keywords. While searching, Boolean logical operators such as 'AND' and 'OR' were used to restrict the search.

Inclusion/exclusion criteria

To be included in the final review, each article was screened for the following inclusion criteria: written in English; published between 2008 and 2019; published in peer reviewed

journals; conducted in European countries; studies considering perceptions of dignity from patients and nurses in any context except end of life. Only studies conducted in European countries were included in the study because they have similar geographical and cultural features, and it is believed that the perceptions of dignity in these areas may be more alike.

The reason for excluding studies at end of life is because dignity at end of life has been extensively researched and systematic reviews conducted (Ostlund et al., 2012; Pringle et al., 2015; Johnston et al., 2015; Rodriguez-Prat et al., 2016). While there is a substantial body of evidence exploring patients' and nurses' perceptions of dignity outside the context of palliative/end-of-life care, there is a lack of an integrated review of literature analysing and synthesizing this evidence. This study intends to close this gap as it explores this issue in order to advance understanding about this issue and inform practice.

Studies were included if there were more than 50% adults aged over 18 years. One of the inclusion criteria for articles in this study was that at least 50% of their participants were nurses or patients. All primary studies (quantitative, qualitative and mixed methods) were included as they could offer insight into the phenomena under study. Studies not meeting the inclusion criteria were excluded. See Figure 1 for the process of screening the articles to be included in the review.

Data management and strategy

Critical appraisal. In the current study, all included articles were critically appraised using the Critical Appraisal Skills Programme (CASP) qualitative checklist (Critical Appraisal Skills Programme, 2018) for qualitative studies and Long et al.'s (2002) tool for quantitative studies.

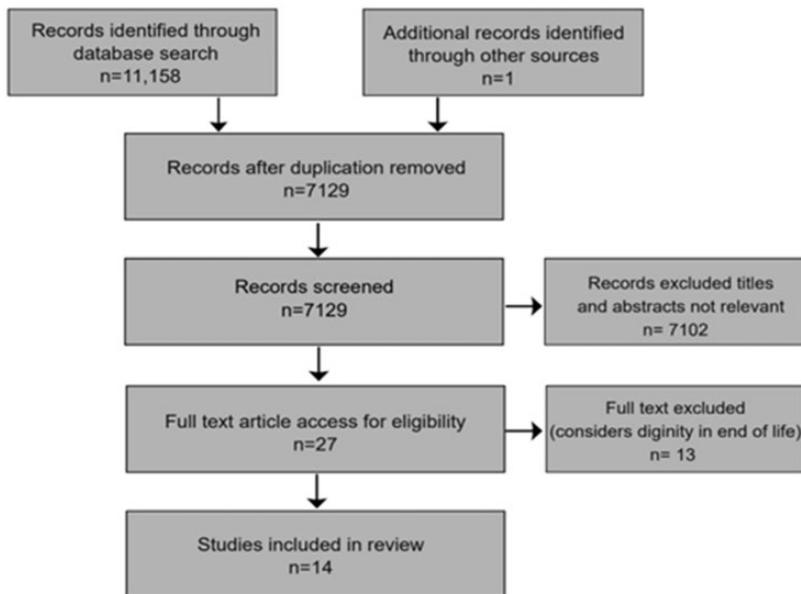


Figure 1. Prisma flow diagram.

Data extraction and analysis. Two reviewers (EMS & CO) performed the data extraction. Relevant data such as aims, findings and methods were extracted to a table (see Table 1 for data extraction summary). Data were analysed using constant comparative analysis (Keenan et al., 2005). Using this method all studies identified in the search were read thoroughly and initial codes given to subsets of data (Thomas and Harden, 2008). A coding strategy involving descriptive and evaluation coding was adopted. The descriptive strategy involved assigning codes which best described a passage of data while the evaluation coding involved assigning codes based on judgement of the presence of a concept (Miles et al., 2014).

Characteristics of included studies. A total of 14 studies met the inclusion criteria and were thus included in this study. The majority (9) of included studies were conducted in the UK, one in Sweden, one in the Netherlands, one in Italy, one in Norway and one conducted across three countries (Sweden, Norway and Denmark). Seven studies considered dignity solely from the patient's perspective, while five considered dignity from the perspective of both the patient and the healthcare professional, mainly nurses. A further three considered dignity solely from the perspectives of healthcare professionals, mainly nurses. Most studies (10) were hospital-based and hence considered perspectives of dignity within hospital environments, while four studies considered the perceptions of dignity within community settings. The majority of studies which considered dignity from the perspectives of patients had mainly older participants over the age of 60, even though the intention was to include eligible participants over the age of 18. All studies included female and male participants, and this was mostly balanced in included studies. Where studies considered the perceptions of healthcare professionals, nurses made up at least 50% of their study population.

The majority (12) of studies were qualitative in nature while two studies were quantitative. The sample sizes in most of the qualitative studies were small, the smallest (Moen and Nåden, 2015) being seven and the largest (Baillie et al., 2009) 1,110. However, this does not detract from the quality of the studies, as traditional qualitative research does not require a large sample size as the aim is not to generalise but to explore in-depth the nature of a given phenomenon (Bajwah, et al, 2013). Most studies (Baillie et al., 2009; Calnan et al., 2013; Chambers et al., 2014; Høy et al., 2016; Oosterveld-Vlug et al., 2014; Tauber-Gilmore et al., 2018; Webster and Bryan, 2009; Williams et al., 2016) adopted purposive or convenience sampling (Hall et al., 2014; Matiti and Trorey, 2008). Where a purposive sample was used, three studies (Calnan et al., 2013; Oosterveld-Vlug et al., 2014; Williams et al., 2016) attempted to achieve maximum variation by including participants or facilities of various characteristics within the sampled population. Data collection methods used in all the included studies include one or a combination of semi-structured interviews, non-participant observation and self-report text and questionnaires. Most studies used a variation of thematic content analysis for data analysis.

Thematic analysis

Themes and overarching themes for this study were generated following careful analysis of the included studies. Four overarching themes and 10 sub themes were developed from the study. Table 2 shows articles from which themes were generated.

Table 1. Data Extraction Table.

Author/date of publication/ Country of study	Research aim/ setting	Method	Participants and sample size	Key findings	Critical Appraisal
Calnan <i>et al.</i> (2013). Country of study: UK	To identify characteristics of the ward environment including processes and organization which maintain and challenge dignity in the care of older people. Study Setting: Hospital Ward	Design: Qualitative ethnographic approach Data collection: Non-participant observation and semi structured interviews. In-depth interviews. Data analysis: Thematic analysis using constant comparison Sampling: purposive sampling.	40 Recently discharged patients aged above 65, 32 Trust managers responsible for patient experience, 79 Ward staff directly involved in the care of older people includes nurses, OT's, doctors. Total sample size = 151	A lack of consistency in the provision of dignified care which appears to be explained by the dominance of priorities of the system and organisation tied together with the interests of ward staff and clinicians. The emphasis on clinical specialism meant that staff often lacked the knowledge and skills to care for older patients whose acute illness is often compounded by physical and mental co-morbidities. The physical environment of acute wards were often poorly designed, confusing and inaccessible, and might be seen as 'not fit for purpose' to treat their main users, those over 65 years, with dignity	Strengths Triangulation of data collection improving quality. Maximum variation sampling to ensure inclusion of all-important elements of the population. Unstructured observations overcoming Apparent bias inherent in individual accounts of actions. Good audit trail: handwritten notes of observations, audio recorded interviews. Limitations No consideration of the influence of the Hawthorne effect on staff behaviour Funded research which may influence findings in favour of funding organization
Oosterveld-Vlug <i>et al.</i> (2014) Country of study: Netherlands	To explore how Dutch nursing home residents, experience personal dignity and the factors preserving or undermining it Study Setting: Nursing home	Design: qualitative descriptive Methodology Data collection: In-depth interviews Data analysis: Thematic constant comparison analysis Sampling: Purposive	30 Dutch nursing home residents recently admitted to selected homes long term	Living in a nursing home was not a reason to feel less self-worth, but rather seen as a consequence of functional incapacity. Nevertheless, many residents felt discarded by society and not taken seriously, simply because of their age or illness. Waiting for help, being dictated to by nurses and not receiving enough attention could undermine personal dignity, whereas aspects of good professional care (e.g. being treated with respect), a supportive social network and adequate coping capacities could protect it	Strengths Purposive sampling of homes and participants to achieve maximum variation in terms of nature of home, rural and urban, age, gender, religion. Informed consent gotten thus ethically sound. Interviews recorded and transcribed and field notes kept hence having a good audit trail. Data collection and analysis done concurrently until data saturation was reached. Limitations The use of a structured framework to analyse and describe findings could limit researcher

(continued)

Table 1. Continued.

Author/date of publication/ Country of study	Research aim/ setting	Method	Participants and sample size	Key findings	Critical Appraisal
Moen and Naden (2015) Country of study: Norway	The aim of the study was to acquire knowledge of what contributes to maintaining and promoting the dignity of intensive care patients Setting: Intensive care unit of a hospital	Design: Qualitative phenomenological approach Data collection: qualitative interviews Data analysis: Giorgi's phenomenological analysis strategy	7 former intensive care patients previously admitted on the unit for at least 5 days in the last year	Being seen and heard and having one's wishes, and needs attended to are parts of dignified care. Personal and individual nursing was essential, as well as the extra involvement beyond what was expected. Being helpless and having to be cared for was unpleasant and degrading. The experience of being unable to speak could cause demeaning situations. Being met with respect was the essence of having one's dignity maintained and promoted. The sense of being treated as an object was the essence of experiences that inhibited dignity	such that any new themes not included in the framework are missed. Strengths Clear and detailed description of analysis process. Discussion between authors until a consensus was reached about themes. Limitations Interviews carried out on same day as appointment. Patients may be tired. No information on sampling methods used for facility and participants. No caveat to say that information may be shared if harmful information shared. The thematic conversation guide used for the interview appeared to be leading the patients towards a set of answers
Williams, Kinnear and Victor (2016). Country of study: UK	To explore healthcare professionals' perspectives of dignified care and experiences of providing care. Setting: 4 UK NHS trust	Design: Qualitative Data collection: in-depth interviews Data analysis: Thematic analysis	48 health care professionals including nurses = 16	Dignity is enacted by focusing on the 'little' things that matter to both professionals and patients; and improving care by making poor care 'visible'.	Strengths Purposive maximum variation sampling. Audio recorded where consent is given and handwritten where consent is not given. Double coding by two authors Audit trail of coding frameworks Researchers maintaining reflexivity through out Strengths Combination of random and convenience sampling as unable to achieve maximum variation sampling. Detailed notes taken for
Hall, Dodd and Higginson (2014). Country of study: UK	To explore and compare the views of residents in care homes for older people, their families and care providers on maintaining dignity.	Design: Qualitative descriptive method Data collection: Semi structured interviews Data analysis: Framework approach	33 for managers, 29 care assistants, 18 nurses employed by the homes, 10 community nurses, 16 residents, 15	The most prevalent themes were: "independence," and "privacy"; followed by "comfort and care," "individuality," "respect," "communication," "physical	

(continued)

Table 1. Continued.

Author/date of publication/ Country of study	Research aim/ sample setting	Method	Participants and sample size	Key findings	Critical Appraisal
Hoy <i>et al.</i> (2016). Country of study: Sweden, Norway, and Denmark	Setting: care homes within two areas of London	to qualitative Analysis Sampling: convenience and random sample	residents' family members Total sample size: 121	appearance" and "being seen as human."	participants unwilling to be audio recorded forwarded to them for validation. Data analysed independently by 2 authors Limitations Resident participation dependent on home managers determining them as able to take part. (managers may only select residents that will give positive experiences of dignity) Strengths Aim stated. Type of purposive sampling not stated. No attempts to achieve maximum variation. Sample mostly female (21 females- 7males). Only participants with mental capacity involved. Ethical approval gotten. Participants allowed to speak freely Audio recorded interviews Limitation Interviews carried out by different researchers which may affect results as each person has different interviewing styles. One collector promotes a consistent approach to data collection Strengths Large sample size. Focuses exclusively on the perception of nurses Limitations Research design very unclear Use of survey style questionnaires (continued)
Ballie <i>et al.</i> (2009). (RCN survey) Country of study: UK	To understand the perspectives of nurses, healthcare assistants and students regarding the maintenance and promotion of dignity	Design: Survey Data Collection: questionnaire containing open free text and closed questions Data analysis: Excel sample	1,110 participants comprising nurses, nursing students and health care assistants who were members of the Royal College of Nursing (RCN).	Respondents perceived that the physical environment and organisation influenced the provision of dignified care Dignity is promoted through thoughtful planning, sensitive	

Table 1. Continued.

Author/date of publication/ Country of study	Research aim/ setting	Method	Participants and sample size	Key findings	Critical Appraisal
Baillie (2009). Country of study: UK	in everyday practice Setting: emailed questionnaire to current RCN members To understand the meaning of patient dignity, threats to patients' dignity, and how patient dignity can be promoted, in acute hospital settings Setting: acute general hospital	spreadsheet package and thematic analysis Design: qualitative triangulated single case study design Data collection: Unstructured interviews and participant observation Data Analysis: Thematic framework approach Sampling: purposive sampling	24 patients who had stayed on the ward for at least 2 days were interviewed. 13 Nurses were interviewed 6 senior nurses were interviewed. 26 nurses and health care assistants were observed.	communication, preserving privacy and promoting choice. 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	despite qualitative approach. No note on ethics. Lack of detailed explanation of how free text data was analysed. Strengths Data collection methods were pilot tested. Reflective diaries were kept to ensure researcher aware of on biases Limitations One researcher collected all the data and did the coding and analysis which may have been influenced by own biases. No variation in sample. All participants white. Interviews in hospital not audio recorded but written up. The researcher may have missed important points. Use of observations but no attempt to mitigate the Hawthorne effect.
Webster and Bryan (2009). Country of study: UK	To investigate the lived experiences of older patients who had been in hospital, to explore their views on dignity and the factors which promote dignity Setting: District general hospital	Design: Qualitative descriptive phenomenological approach Data collection: Semi structured interviews Data analysis: Colaizzi's framework of analysis Sampling: Purposive sampling	10 older patients aged 73–83 who recently had an unplanned admission lasting longer than 72 hours.	Respondents report that factors that promote dignity include privacy for the body, cleanliness, independence and being able to exert control, sufficient time from staff, attitudes to older people and communication.	Strengths Manen's approach was used to identify researcher's potential bias. More than 72 hours stay to be able to have gained insight into hospital Use of an interview guide which was appropriate for the research question. Close interview dates upon discharge to allow fresh memory. Clear eligibility criteria. Detailed explanation of data analysis

(continued)

Table 1. Continued.

Author/date of publication/ Country of study	Research aim/ setting	Method	Participants and sample size	Key findings	Critical Appraisal
Mairi and Trorey (2008). Country of study: UK	To explore patients' expectations regarding the factors that contribute to the maintenance of their dignity while in hospital. Setting: 3 Acute hospitals in the east midlands	Design: Qualitative phenomenological hermeneutic approach Data collection: in-depth interviews Data analysis: Content analysis using a phenomenological approach Sampling: Convenience sampling	102 patients admitted to sampled wards.	Six key themes that contribute to the preservation of their dignity were identified – privacy; confidentiality; communication and the need for information; choice; control and involvement in care; respect and decency and forms of address.	Limitations No explanation on how decisions regarding design were made. No caveat about full confidentiality Strengths Ethical approval gotten. Clear aims Limitations Use of convenience sampling did not ensure information rich sources No idea when interviews occurred before or after admission. Length of interviews quite short. Data analysis process unclear as method used not stated
Ferri, Muzzalupo, and Di Lorenzo (2015). Country of study: Italy	To explore inpatients' perception of dignity in an Italian General Hospital setting Setting: Italian General Hospital	Design: Descriptive cross-sectional design Data collection: questionnaire Data Analysis: statistical analysis using STATA program. Sampling: Purposive sampling	100 patients hospitalized for more than 3 days	The frequency of positive or negative answers was statistically significantly related to the preservation of dignity according to the following questions ($p < 0.005$, multivariate logistic regression): "privacy to use the bathroom" and "respectful interaction", as protective factors and "maintaining of body privacy", "involvement in the care process", "correct communication" as risk factors	Strengths Adopted a measureable approach to assessing dignity Clear aims Limitations Sample size small. Approach to sampling unclear. Methods of data analysis unclear
Heijlenskjö Id, Ekstedt and Lindwall (2010) Country of study: Sweden	To understand how nurses experience patients' dignity in Swedish medical wards Setting: 3 medical units in central Sweden	Design: qualitative hermeneutic approach Data collection: Flanagan's critical incident technique Data Analysis: Hermeneutic text interpretation	12 nurses working in medical units in Sweden	The findings show that the nurses who wanted to preserve patients' dignity by seeing them as fellow beings protected the patients by stopping other nurses from performing unethical acts. They regard patients as fellow human beings, friends, and unique persons with their own history, and have the courage to see when patients' dignity is violated.	Strengths Acknowledging authors' preconceptions prior to analysis, detailed analysis process Limitations No double coding, self-report text hence respondents may only report what they believe the researcher wants to hear

(continued)

Table 1. Continued.

Author/date of publication/ Country of study	Research aim/ setting	Method	Participants and sample size	Key findings	Critical Appraisal
Tauber-Gilmore et al. (2018) UK	To explore inpatient and staff views on dignity Setting: The larger dignity study ran on 17 wards at a large London acute healthcare organisation across three hospital sites. Six wards were medical specialty wards, three were acute admission wards, four wards were surgical, three were older person wards (two medical and one surgical), and one was oncology ward.	Design: Qualitative Data collection: Recorded semi-structured interviews Data Analysis: Pragmatic thematic analysis Sampling: purposive and snowball sampling method	13 patients and 38 healthcare professionals 13 nurses, 9 doctors, ⁴ occupational therapists, 3 pharmacists, 3 physiotherapists, 3 student nurses, 2 healthcare assistants, 1 ward administrator Total sample size: 51	The meaning of dignity was broadly agreed on by patients and staff. Three broad themes were identified: the meaning of dignity, staffing level and its impact on dignity, and organisational culture and dignity. Registered staff of all healthcare discipline and student nurses report very little training on dignity or care of the older person.	Strengths Attempt to ensure maximum variation of participants by selecting wards of different specialities. Detailed inclusion and exclusion criteria, use of an interview guide, confidentiality caveat well understood and acted on by research team where bad care was reported. Limitations Attempts to ensure comfort by conducting interview where participants felt most comfortable however this risked their confidentiality as some were conducted in the bay
Chambers et al. (2014) UK	To explore the service user experience of detained care in particular relation to dignity and respect whilst sectioned. Setting: 3 mental health trusts	Design: Qualitative Data collection: recorded semi-structured interviews Data Analysis: inductive thematic approach Sampling: purposive sampling technique	19 sectioned service users	The service users considered their dignity and respect compromised by 1) not being 'heard' by staff members, 2) a lack of involvement in decision-making regarding their care, 3) a lack of information about their treatment plans particularly medication, 4) lack of access to more talking therapies and therapeutic engagement, and 5) the physical setting/environment and lack of daily activities to alleviate their boredom	Strengths Aim clear, adequate interview guide used, an assuring confidentiality, the caveat about needing to escalate if harmful information was shared was added Limitations No allusion to what sort of research design was being used, audio recorded, and no triangulation

Table 2. Articles from which themes were generated.

Themes Generated	Articles
Independence/dependence	4, 26, 37, 40, 43
Choice	4, 9, 21, 24, 26, 37, 40, 49, 55
Staff attitudes	2, 4, 21, 24, 43, 49, 55, 59
Communication	4, 21, 24, 26, 40, 43, 49, 55
Privacy	2, 16, 21, 26, 37, 40, 55
Structure of services	2, 4, 7, 49
Staff shortages	2, 7, 9, 43
Physical environment	2, 4, 7, 9, 26, 37, 43
Respect	4, 9, 16, 21, 24, 37, 49
Person-centred care	4, 9, 21, 24, 26

Results

Autonomy

Dependence/independence. Independence was overwhelmingly described as impacting on patient's dignity in included papers. Studies by Oosterveld-Vlug et al. (2013), Hoy et al. (2016), Moen and Naden (2015), Baillie (2009) and Matiti and Trorey (2008) suggest that the more dependent a patient, the more vulnerable they are to a loss of dignity, whilst independence was a protector of patient dignity. Hoy et al.'s (2016) study of dignity in nursing homes found a contradictory opinion by patients, with some reporting that being dependent did not threaten their dignity but instead gave them the help needed to improve their quality of life and, hence, their dignity. Dependence with intimate care was the aspect of care most reported as undignifying. In various studies (Baillie et al., 2009; Tauber-Gilmore et al., 2018), it was reported that being admitted to the hospital was associated with being susceptible to a loss of dignity as a result of complexity of care provided. The indignity of certain required procedures and the hospital environment were also mentioned as some of the factors contributing to undignified care (Baillie et al., 2009). In contrast, Oosterveld-Vlug et al.'s (2014) study on dignity and factors that influence dignity amongst nursing home residents found that admission to a nursing home did not in itself impact on dignity, but the associated increased dependence did affect dignity. Old age and being fragile were some of the reasons given. In the same vein, Calnan et al. (2013) in their study referred to older age as one stage of the life course where dignity may be threatened due to the vulnerability created by increased incapacity, frailty and cognitive decline.

Choice. Feeling powerless due to having no control or choice was reported by patients in several studies (Chambers et al., 2014; Matiti and Trorey, 2008; Tauber-Gilmore et al., 2018; Webster and Bryan, 2009) as impacting on their dignity, while nurses in other studies (Heijkenskjöld et al., 2010; Høy et al., 2016; Tauber-Gilmore et al., 2018) report promoting dignity by increasing choice and giving patients control wherever possible. Choice and control were commonly promoted in areas of personal care, involvement of family, meals, leisure activities and cultural and religious practices (Baillie 2009; Hall et al., 2014; Heijkenskjöld et al., 2010). Two studies (Matiti and Trorey, 2008; Moen and

Nåden, 2015) showed how lack of involvement and choice threatened patient dignity as some patients reported feeling powerless and devalued because of this. Interestingly, whilst most nurses alluded to promoting choice and involvement with their patients, patients in some studies (Calnan et al., 2013; Chambers et al., 2014; Hall et al., 2014) reported having their choices or preferences ignored due to a variety of factors such as staff shortages, staff attitudes, wanting to reduce work load and environmental or policy constraints.

The complexity of promoting choice whilst ensuring patient safety especially for patients with cognitive impairments was identified by nurses and home managers in two studies (Hall et al., 2014; Heijkenskjöld et al., 2010). Hall et al. (2014) note that nurses can find themselves in a dilemma when a patient's choice is deemed unreasonable or unsafe and attempts to negotiate safer choices are refused. Again, Baillie's (2009) study found that more dependent patients had less control and choice irrespective of their age, hence making them more vulnerable to a loss of dignity. This is further reiterated by Chamber et al. (2014) who found that sectioned patients reported feeling undignified where physical or chemical restraint was used.

Healthcare delivery factors

Staff attitudes. Promoting choice and control is closely related to staff attitudes. Where staff were dedicated to promoting choice and control, they exhibited positive attitudes such as listening to patients and taking them seriously (Oosterveld-Vlug et al., 2014), giving patients required attention and being kind (Webster and Bryan 2009). The majority of the included studies (Baillie, 2009; Baillie et al., 2009; Hall et al., 2014; Heijkenskjöld et al., 2010; Oosterveld-Vlug et al., 2014; Webster and Bryan, 2009; Williams et al., 2016; Tauber-Gilmore et al., 2018) reported staff attitude as impacting on patient dignity. Across studies, attitudes perceived as rude, inattentive, disrespectful, uncompassionate and insensitive were reported by patients as negatively affecting their dignity.

Specific episodes where nurses' attitudes made patients feel devalued were described by patients and include offering a bed pan instead of the toilet when asked, peeping through drawn curtains, taking away buzzers to prevent patients from using them, telling patients to open bowels in pads, being bossy, speaking in an abrupt manner and refusing to answer buzzers (Baillie, 2009; Tauber-Gilmore et al., 2018). Conversely, staff attitudes such as being treated with respect, acting in a sensitive and compassionate manner with regards to continence and personal care, being present and listening to patients were found to positively impact on patient dignity (Heijkenskjöld et al., 2010). Consequently, Oosterveld-Vlug et al. (2014) and Høy et al. (2016) concluded that good professional care was a protector of patient dignity. Staff acknowledged that procedures carried out with the best intentions can become potentially undignifying if carried out without seeking adequate consent from the patient (Baillie et al., 2009).

Communication. Communication was a key feature of patient and staff descriptions of dignity. For example, in Moen and Naden's (2015) study, patients described feelings of indignity related to their inability to communicate due to serious illness, which was overcome once able to communicate. Another aspect of communication identified in other studies was the way and manner in which staff communicated with patients. When staff took their time to listen, provided sufficient information, made appropriate use of humour and used the right body language and tone, patients felt more dignified (Hall et al., 2014; Moen and Naden,

2015; Webster and Bryan 2009). Conversely, poor and inappropriate communication such as talking over and ignoring patients detracted from the maintenance of patient dignity (Baillie, 2009). Among staff, lack of time to adequately communicate with patients or an inability to communicate effectively was identified as infringing on patient dignity (Heijkenskjöld et al., 2010; Tauber-Gilmore et al., 2018).

Privacy. Patients and professionals in the included studies related privacy to dignity. Privacy of body was most referred to by patients when discussing dignity (Baillie et al., 2009; Høy et al., 2016; Moen and Naden, 2015). Patients in one study (Webster and Bryan, 2009) acknowledged that some bodily exposure and embarrassment were expected in hospital, however nurses' attitudes were important in enhancing dignity. Staff preserved patients' privacy by respecting personal space, knocking before entering rooms (Hall et al., 2014) and drawing curtains prior to procedures requiring bodily exposure (Baillie et al., 2009). Conversely, nurses failed to preserve dignity in terms of privacy when they failed to empathise with patients' embarrassment during bodily exposure and failed to cover up exposed patients (Ferri et al., 2015). A lack of auditory privacy was also identified in two studies (Baillie, 2009; Matiti and Trorey, 2008) as threatening dignity.

Organisational factors

Structure of services. The management and organisation of hospitals and care homes had a huge influence on patient dignity. Working in an organisation which prioritises dignity and dignity-promoting activities was identified by staff as paramount to delivering dignified care; however, where organisations were focused on meeting targets and staying financially afloat, patient care was often relegated to the back burner, in turn negatively influencing patient dignity (Baillie, 2009; Baillie et al., 2009; Calnan et al., 2013; Tauber-Gilmore et al., 2018). Ward staff in two of the studies (Baillie et al., 2009; Calnan et al., 2013) described the relentless pressure from management to move patients as quickly as possible in an effort to create beds to meet set targets, without regard to the impact this might have on the patient and their dignity. Patients in another study (Baillie, 2009) recounted how being constantly moved about made them feel less human and just a number on the board.

Good leadership at all levels was also reported as positively impacting on patient dignity (Baillie et al., 2009; Tauber-Gilmore et al., 2018). Baillie (2009) described the influence of good leadership on staff behaviours in relation to dignity on the ward since the ward manager was dedicated to ensuring dignified care, and led by example, this becoming evident in the behaviour of all staff. Additionally, nurses reported that an organisational focus on measureable aspects of care can detract them from aspects of care which are immeasurable, such as the maintenance of patient dignity. This can, therefore, lead staff to focus on those aspects of care which are measureable, again impacting on patient dignity. Additionally, this can also lead to a focus on excessive documentation as opposed to providing actual dignified care (Calnan et al., 2013).

The impact of organisation policies or ward culture can have unintentional consequences for patient dignity. This was highlighted by patients who described instances where choices were restricted and preferences ignored in a bid to follow organisational policies or structures. Such policies could in themselves independently impact on patient dignity as described by Calnan et al. (2013) where patients with infections are isolated in single rooms leaving them feeling dejected and abandoned.

Staff shortages. Nurses identified staffing levels as being of fundamental importance in maintaining patient dignity. Where there were staff shortages and heavy workloads nurses reported feeling unable to provide dignified care due to having to rush care in the limited time available in order to be able to meet the needs of all patients (Baillie et al., 2009; Chambers et al., 2014; Calnan et al., 2013). Conversely, adequately staffed wards allowed nurses more time with the patients which improved patient dignity. Managers in Oosterveld-Vlug et al.'s (2014) study report having limited funds to employ permanent staff hence a reliance on temporary staff. Sadly, patients in the same study described how being cared for by different individuals threatened their dignity.

Physical environment. Factors related to the environment where care is provided were identified in eight studies (Baillie, 2009; Baillie et al., 2009; Calnan et al., 2013; Chambers et al., 2014; Høy et al., 2016; Matiti and Trorey 2008; Oosterveld-Vlug et al., 2014; Webster and Bryan 2009) as influencing patient dignity. Observational findings by Calnan et al. (2013) depicted acute hospitals as confusing, poorly designed and inadequately signed such that patients, especially older patients, found it difficult finding their way which threatened their dignity. This was further corroborated by patients in semi-structured interviews who stated that similar looking wards made them feel confused and lost which took away any semblance of control they had.

Additionally, acute hospitals in included articles were characterised by limited space with care revolving around the patient's bed space; such limited space can make care episodes, especially personal care, potentially undignifying for patients. Calnan et al. (2013) identified an interesting point with regards to the unavailability of spaces such as day rooms where patients can go for diversionary activities to pass time. Hospital stays with care revolving around the bed can leave patients bored or depressed and slow down recovery therefore threatening their dignity. On the other hand, Chambers et al. (2014) found that well designed wards with the right decoration can have a positive impact on patient dignity since patients reported feeling more relaxed in newly designed wards with better spaces.

Sharing a room or bay with other patients or service user was also identified as impacting on patient dignity, however findings were contradictory. Some studies (Oosterveld-Vlug et al., 2014) found that sharing a room negatively impacted on patient dignity as it limited their privacy while other studies (Baillie, 2009) found a positive influence on their dignity as they got to enjoy meaningful conversations with other patients, enabling solidarity amongst patients who felt comfortable being with other patients in similar conditions.

The meaning of dignity

Respect. Staff and patients in seven studies (Baillie, 2009; Chamber et al., 2014; Ferri et al., 2015; Hall et al., 2014; Heijkenskjöld et al., 2010; Matiti and Trorey, 2008; Tauber-Gilmore et al., 2018) conceptualised dignity as being treated with respect. Dignity was mostly described by patients in terms of feelings. For example, feeling respected featured predominantly in patient descriptions of dignity and was frequently associated with being treated as human. Interestingly, only one study associated dignity to an inherent human right (Baillie, 2009). Other terms such as being treated as worthy as opposed to insignificant were also used in their descriptions.

Person-centred care. Receiving care tailored to their specific needs was an essential feature of patient descriptions of dignity (Tauber-Gilmore et al., 2018) however, this was more

prominent in staff descriptions with many promoting choice as a way of tailoring care to meet patient needs (Hall et al., 2014; Heijkenskjöld et al., 2010). The importance of paying attention to patient's individual preferences is most highlighted by a patient in Høy et al.'s (2016) study who, despite being an ardent baker in her youth, refuses to continue baking despite opportunities to do so. Prominent amongst patient descriptions is the need to continue to present themselves in a way that preserves their body-image or identity (Baillie, 2009; Hall et al., 2014; Høy et al., 2016); hair styling, shaving, make up and putting on their own clothes were identified as ways of doing this. Helping patients to look well-groomed was also identified by nurses as a method of promoting dignity. Wearing hospital gowns, even though identified as a necessity when attached to certain devices by patients, was identified as negatively influencing dignity. Baillie (2009) in her observations comments on the lack of awareness by nurses on the potential for hospital gowns which are readily put-on patients to threaten their dignity, especially with regards to their design which often leaves patients' buttocks exposed.

Forms of address were also identified by some patients and nurses as influencing dignity. The use of endearments which made patients feel like children was reported as undignifying (Chambers et al., 2014; Heijkenskjöld et al., 2010). Another study (Baillie, 2009) reported that being referred to by their first name was perceived as undignifying by a patient.

Discussion

The study aimed to explore dignity as perceived by patients and nurses within hospital and community environments. A key finding of this review was that patients and nurses related dignity to respect or being treated as human. Consequently, findings suggest that when patients were treated with respect and treated others including other patients with respect, dignity was perceived as maintained. This finding has been replicated in other studies (Lothian and Philp, 2001; Šaňáková and Čáp, 2019). With regards to being treated as human, nurse and patient perspectives indicate that this was an important component of human dignity. As has been popularly reported in the literature, this aspect of dignity is closely related to the intrinsic dignity inherent in every human by mere belonging to the human race (Jacobson, 2009; Edlund et al., 2013).

The three overarching themes generated suggest that factors such as autonomy, healthcare delivery factors and organisational factors impacted on patient dignity. It established that autonomy was essential to the maintenance of patient dignity. Individuals have a right to be informed and make decisions for themselves which must not be violated unless it is determined the individual lacks the capacity to make the decision in question (MCA, 2005). Patients highlighted respecting their choices and providing information to enable choice as important to protecting their dignity.

Earlier studies, such as those of Hall et al. (2014) and Lothian and Philp (2001) have also identified the influence of autonomy on patient dignity. Additionally, this study showed that increased dependence due to impaired health negatively influenced patient autonomy and ultimately their dignity. However, Edlund et al. (2013) have argued that to reinstate damaged dignity one must accept the offer of help, accept and adjust to a new situation and allow oneself to be reliant on others through which a new form of dignity can be developed. Despite its importance to the maintenance of patient dignity Barclay (2016) notes that respect for patient autonomy is not synonymous with dignity.

The complexity of respecting patient autonomy whilst ensuring patient safety was identified by nurses in this study. This presents a dilemma where a patient can make autonomous decisions, it therefore becomes a balancing act between managing patient risk and respecting their autonomous wishes (Jakobsen and Sørli, 2010; Ryan, 2003). This is made worse by the increasingly litigious culture propelling staff to ignore patient autonomy in a bid to minimise risk (Dimond, 2016). Mattiasson et al. (2005) have commented on the vulnerability to paternalism experienced by dependent patients even though beneficially meant but harmful to patient autonomy hence dignity. However, nurses have a legal, professional and ethical duty to respect patient autonomy hence, once a patient has the mental capacity to make a decision this must then be respected, since a failure to do so could lead to professional and legal sanctions (MCA 2005; Griffith and Tengah, 2017; NMC 2018). The link between dignity and staff behaviour has been widely reported. This highlights the notion of interpersonal dignity whereby behaviours from others convey feelings of worth (Jacelon, 2003).

This finding has been echoed in the findings of previous studies about dignity with consistency (Ebrahimi et al 2012; Hanson, 2014). For example, Koppelman (2002) found that when nurses did not treat patients as human or referred to them in terms of their primary illness or condition, this amounted to objectifying the patient thus violating their dignity. Lothian and Philp (2001) and Mullen (2019) found that when staff leave patients in a vulnerable position such as incorrect assumptions about patients' continence, being slow to answer call buzzers and making rude comments when toileting was requested, patients felt devalued. Failings in this most basic of needs were highlighted in the Francis Report (2013) but recent studies continue to show that lessons have not been fully learnt. In other studies, findings indicated that prompt and skilled care earned patient trust in both the professional and their sense of security (Efraimsson et al., 2001; Widäng and Fridlund, 2003).

In this study patients' and nurses' accounts of dignity enhancing communication were similar, both featuring descriptions of instances where the nurse took time to explain treatment, listen to and address patient concerns, and involved the patient where possible. These are all characteristics of effective communication according to Bramhall (2014). Likewise, earlier studies highlighted the significance of effective communication in the maintenance of patient dignity, for instance Kirk et al. (2004) and Thorne et al. (2013) found that patients and their families expected healthcare professionals to be expert communicators with the ability to initiate conversations and share important information. A patient-centred communication style has been proposed to improve patient understanding of their care (Robinson et al., 2008). Communication styles which use open-ended questions, pay attention to patient concerns and allow time for patients to express themselves have been identified as patient centred (Howie et al., 2004).

The influence of staff shortages on patient dignity was identified by both patients and nurses in this study. Due to poor staffing, nurses reported having heavier workloads and less time to appropriately interact with patients which detracted from their dignity. This supports findings from a previous study by Baillie (2008) where nurses report experiencing moral distress due to an inability to provide dignified care because of heavy workloads and time constraints.

This review found more similarity than differences in patient and nurse perceptions of dignity. A striking difference was the importance of confidentiality in the maintenance of dignity which was mostly prominent in staff descriptions but rarely present in patient descriptions. This may be due to nurses' awareness of the legal, ethical and professional

implications of a breach in confidentiality which may be lost to the patient. Another important difference was in patient and nurse descriptions of care. Even though patients identified and described poor care, nurses rarely described any episodes of poor care. It can only be speculated as to why this was the case; possibly because these incidents were more noticeable to patients or because nurses were unwilling to report such events. The importance of healthcare professionals and patients having a shared understanding of what dignity means is important for ensuring dignified care (Barclay, 2016). Cronican (2017) has also reported how a lack of awareness of dignity-compromising situations or what is perceived as dignified can influence patient dignity via nurse–patient interactions.

Strengths and limitations

No research is flawless (Harvard, 2007). We have systematically undertaken all steps required to review the literature. The researchers acknowledge that this study has various strengths and limitations. Firstly, the study was limited by the methods of literature searching. The search was only conducted using official electronic scientific databases accessible from the authors' institution. It is possible that some significant articles are indexed in other databases to which the authors had no access. While the study might have been limited by the search strategy applied, this does not diminish the relevance of our findings and the value added to knowledge. The researchers made efforts to ensure all published articles relevant to the study were identified and included. Additional search strategies such as chain referencing were also adopted in order to identify all studies which may have been missed due to the above issues. An additional limitation, relating to identifying all relevant studies, was the fact that no effort was made to identify unpublished studies relevant to the study; this is particularly important as the impact of publication bias is well documented (Moher et al., 2009). It is therefore possible that relevant unpublished work which may have reported contradictory findings was missed. Future studies should therefore endeavour to contact key scholars in the area of study as they may have other studies which are relevant for inclusion.

Secondly, this review was limited to studies conducted in European countries and it is possible that including studies published elsewhere could have resulted in different findings and further illuminated the concept of dignity from other cultural perspectives. Despite these limitations the study has several strengths since much of the literature around dignity has focused on dignity in an end-of-life context.

Conclusion

This study has synthesised knowledge around perceptions of dignity amongst patients and nurses, outside of the context of end of life. Dignity has been shown to have an important influence on the patients care journey. Various factors impact on patient dignity and how it is perceived. This review provides information on dignity from patients' and nurses' perspectives in a healthcare setting. The adoption of a person-centred approach may affect positive changes on patient dignity in hospitals. Furthermore, this review provides information for healthcare professionals, especially nurses, on what dignity in care is and how best to promote patient dignity. Preserving dignity is especially important in care for older patients because of their vulnerability. Educational materials should be developed based on the themes and subthemes synthesised in this study.

Key points for policy, practice and/or research

- Independence enhanced dignity and confidence.
- Choice is key to empowerment of patients and preservation of dignity.
- Communication is an essential feature in enhancing a positive and dignified relationship between nurses and patients.
- There is a strong relationship between privacy and dignity for both nurses and patients.
- Receiving care tailored to specific needs is an essential feature of patient dignity.
- The physical environment can impact on care and dignity.

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