# Torabizadeh-Nurses' and patients' perceptions of dignity

# Adherence to patient’s dignity: the viewpoints of patients and nurses

Camellia Torabizadeh

Associate Professor, Shiraz University of Medical Sciences, Shiraz, Iran. E-mail: torabik@sums.ac.ir

Samaneh Jafari

Master of Nursing, Shiraz University of Medical Sciences, Shiraz, Iran. E-mail: samaneh.jfri@gmail.com

Marzieh Momennasab

Assistant Professor, Shiraz University of Medical Sciences, Shiraz, Iran. E-mail: [momennasab@sums.ac.ir](mailto:momennasab@sums.ac.ir)

**Corresponding author**

Marzieh Momennasab

Zand St., Namazi Sq., School of Nursing and Midwifery, Shiraz, Iran.

Tel: +98 9173093533; Fax: +98 711647452

E-mail: [momennasab@sums.ac.ir](mailto:momennasab@sums.ac.ir); mnasab48@yahoo.com

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

The authors declare that they have no conflict of interest.

The first author of the present study has done several studies regarding ethical issues, two of which are about patient’s dignity based on a qualitative method and published in Journal of Medical Ethics and Ethics & Behavior (1, 2). The present study is her first quantitative work regarding patient’s dignity.

This original manuscript is unpublished and no part of this study HAS been submitted to another journal.

1. Torabizadeh C, Ebrahimi H, Mohammadi E, Valizadeh S. Incongruent perceptions among nurses and patients: a qualitative study of patient's dignity in Iran. *Ethics & Behavior*. 2013; 23(6):489-500. DOI: 10.1080/10508422.2013.793162

2. Ebrahimi H, Torabizadeh C, Mohammadi E, Valizadeh S. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. *Journal of Medical Ethics*. 2012; 38(12):723-8. DOI: 10.1136/medethics-2011-100396

**Acknowledgements**

The present article was extracted from the M.S. thesis of the second author. The thesis was titled “The comparison of hospitalized patients’ and nurses' perception of dignity in the selected hospitals of Shiraz University of Medical Sciences in 2017” and has been approved by the committee of ethics at Shiraz University of Medical Sciences, Shiraz, Iran (No:7665). The authors would like to thank all participants who voluntarily participated in this study. We also gratefully acknowledge the Center for Development of Clinical Research of Namazi Hospital for statistical assistance.

**Abstract**

Much of the available research on patient dignity either is qualitative in type or explores dignity in certain patient groups, e.g. elderly patients, cancer patients, terminally-ill patients, and adolescent patients. The present study addresses nurses' and adult patients' views on observance of patient dignity. 200 nurses and 200 patients from various hospital units (39 internal and surgical units) from four hospitals affiliated with Shiraz University of Medical sciences participated in the study. The results showed that the nurses' mean scores for observance of patient dignity were significantly higher than the patients' in four areas: privacy, autonomy, respect, and relationship.

In order for nurses to maintain and improve patient dignity, nurses must become better acquainted with patients' understanding of observance of their dignity. The patient dignity questionnaire developed in the present study is a reliable instrument for measuring observance of patient dignity as perceived by nurses and patients.

Keywords: dignity, privacy, autonomy, respect, communication, patient’s right

**Introduction**

Observance of patient dignity is integral to providing high-quality clinical care ([1](#_ENREF_1)). On the other hand, failure to respect patient dignity adversely affects patients' recovery. Nurses' adherence to the principles of patient dignity expedites patients' recovery and contributes to their mental peace and quiet ([2](#_ENREF_2),[3](#_ENREF_3)). Unfortunately, however, patients are often dissatisfied with medical staff's observance of their dignity in hospitals ([2](#_ENREF_2),[4](#_ENREF_4),[5](#_ENREF_5)).

Patient dignity is affected by various factors, including the attitude and behavior of the hospital staff, the environment, culture, and the manner of providing clinical care ([6](#_ENREF_6)). An identification of patients' needs and expectations with regard to dignity requires an individual analysis of patients' needs ([7](#_ENREF_7)). Raising nurses' awareness of factors influencing patient dignity is important ([8](#_ENREF_8)); however, nurses and patients have different ideas of dignity-based care ([9](#_ENREF_9),[10](#_ENREF_10)).

Studies show that patients consider the following factors, among others, to be influential in observance of patient dignity: privacy, confidentiality, patient's participation in care plans, respect, and even the manner of addressing patients ([9-12](#_ENREF_10)). Extensive literature review yields four domains for patient dignity: privacy, autonomy, respect, and relationship.

In the present study, the following databases were used for search of articles: Cochrane Library, PubMed, CINAHL, Science Direct, Scopus, ProQuest, Medline, Elsevier, Google Scholar, and Ovid. Research was performed using the search operators OR and AND. Also, the keyword control "MeSH", which is available in PubMed, was used to find words related to the subject of the study. The following keywords were used individually and in combination for the search: Nursing, Nurses, Patients, Patients dignity, dignity, Ethics, Privacy, Patient privacy, Respect, relationship, Autonomy, Patient control, Patient decision making.

**Privacy:** The concepts of privacy and dignity are interrelated (13,[14](#_ENREF_14)). Patients strongly believe that respect for their privacy is essential to observance of their dignity ([15](#_ENREF_15)). Yet, in many hospital units, patients' privacy is not properly maintained (4,6,9). Having their private information overheard, overhearing other patients' private information, being seen by strangers, not having privacy during examination by the medical staff, and lack of respect for their privacy are among factors that disrupt patient privacy ([13](#_ENREF_13)).

**Autonomy**: One aspect of patient dignity is facilitating, supporting, and enhancing patients' right to make decisions for themselves and respecting those decisions ([16](#_ENREF_16)). From patients' viewpoint, lack of autonomy and control is synonymous with disrespect for their dignity ([17](#_ENREF_17)). Asking patients for permission prior to medical measures and invasive procedures is one of the principles of observing patients' autonomy ([18](#_ENREF_18)). Patients' participation in the decision-making process leads to their satisfaction, acceptance of the care plan, and respect for patient dignity ([19](#_ENREF_19)).

**Respect:** Dignity is synonymous with having patients feel that they are respectable ([20](#_ENREF_20), [21](#_ENREF_21)).Patients' most significant expectation of the medical personnel is respect ([22](#_ENREF_22)).Studies show that patients who are respected have greater satisfaction with their clinical care and experience a faster recovery ([23](#_ENREF_23), [24](#_ENREF_24)).Studies also show that patients' perception of respectful clinical care has not been explored sufficiently yet (4,9,[25](#_ENREF_25)).

**Relationship:** Dignity is closely connected with an individual's relations with others (4,[26](#_ENREF_26)) and depends on empathy and mutual trust ([26](#_ENREF_26), [27](#_ENREF_27)). Four different types of relationship affect dignity: verbal communication, body language, kind behavior (with emotions), and devoting adequate time ([8](#_ENREF_8)). An effective relationship can not only improve patients' physical and mental conditions, but facilities patients' adaptation to their diseases and pain ([28](#_ENREF_28)).

Dignity is a correlative of culture, thus the need for studying it in different cultures. Although most nurses believe that patient dignity is properly observed, patients remark that their dignity is often ignored ([4](#_ENREF_4),[9](#_ENREF_9)). Most of the available research on patient dignity either is qualitative in type ([8](#_ENREF_8),[29](#_ENREF_29),[30](#_ENREF_30)) or addresses dignity in certain patient groups, such as elderly patients ([29-31](#_ENREF_29)), cancer patients ([1](#_ENREF_1),[32](#_ENREF_32)), and terminally-ill patients ([28](#_ENREF_28),[33](#_ENREF_33),[34](#_ENREF_34)). Accordingly, the present study aims to compare the viewpoints of adult patients and nurses with regard to patient dignity.

**Methods**

***Study setting, participants and study design***

The present study is a descriptive, cross-sectional work conducted in the internal and surgical units of four university hospitals. 200 nurses and 200 patients from a total of 39 internal and surgical units in the aforementioned hospitals participated in the study between June 2017 and September 2017.

***Study instruments***

The data collection instruments employed in the present study were a demographics questionnaire and the patient dignity questionnaire. Developed by the researchers after a thorough literature review, the patient dignity questionnaire consists of questions about observance of patient dignity in the four domains of respect, relationship, privacy, and autonomy. The dimensions were compared on a one-on-one basis according to the calculated score for each dimension (the sum of the scores for each item divided by the number of items for that dimension) and a comparison of mean scores between the two groups. For each dimension, the scores were summed up and divided by the number of items for that dimension so that all the dimensions could be compared. A low mean score for observance of patient dignity in a domain from nurses' and patients' perspective indicates that nurses and patients consider patient dignity to be poorly observed in that domain. A high mean score for observance of patient dignity in a domain from nurses' and patients' perspective indicates that nurses and patients consider patient dignity to be highly observed in that domain.

The patient dignity questionnaire measures the "degree" to which patient dignity is observed from patients' and nurses' perspectives. The questionnaire consists of 33 items: items 1 through 6 address privacy, 7 through 12 address autonomy, 13 through 24 address respect, and 25 through 33 address relationship. The items of the patient dignity questionnaire are the same for nurses and patients, except they are addressed differently based on whether the respondent is a nurses or a patient. The degree to which each item is observed is measured on a 5-point Likert scale: Never observed (1 point); Rarely observed (2 points); Sometimes observed (3 points); Usually observed (4 points); Always observed (5 points) (Appendix 1).

The validity of the patient dignity questionnaire was assessed in the areas of quantitative and qualitative face validity and quantitative and qualitative content validity. The qualitative evaluation of the face validity of the questionnaire was based on face-to-face interviews with 10 nurses and 10 patients who were questioned about the difficulty level, relevance, and ambiguity of the items. Accordingly, 10 experts were asked to score each item on a 5-point Likert scale: (5=very importance; 4=relatively important; 3=fairly important; 2=slightly important; 1=not important at all). Next, the impact score of each item was calculated and the items whose impact scores were over 1.5 were kept for later analyses.

The content validity of the patient dignity questionnaire was assessed using qualitative and quantitative approaches. The qualitative evaluation of content validity was carried out thus: 10 professors who were familiar with the concepts of patient dignity, ethics, and psychometric instrument development were asked to give their written views on the quality of the items in terms of syntax, semantics, the placement of the items, and the scoring system. Subsequently, Content Validity Ratio (CVR) and Content Validity Index (CVI) were used for the quantitative evaluation of the content validity of the questionnaire. Accordingly, 10 experts were asked to determine the necessity of the items on a 3-point scale (Necessary, useful, but not necessary, and unnecessary). Based on Lawshe Table, to determine the least value of content validity ratio, the items whose CVR was judged to be above 0.62 by the experts were considered significant (p<0.05) ([35](#_ENREF_35)). The CVI of the questionnaire was analyzed following Waltz and Bausell's method ([36](#_ENREF_36)): 10 experts assessed the items on a 4-point Likert scale in terms of relevance, clarity, and simplicity. The items whose scores were 0.79 and above were retained and the rest were eliminated.

To determine the reliability of the patient dignity questionnaire, the researchers measured the internal consistency of the scale. Following a pilot study of 35 nurses and 35 patients, Cronbach's alpha was calculated to determine the internal consistency of the questionnaire. The overall reliability of the completed questionnaires (nurses and patients) was found to be 0.968; it was 0.979 for the group of patients and 0.949 for the group of nurses.

***Data collection***

### Of the hospitals affiliated with the University of Medical Sciences, four hospitals were selected according to the simple random sampling approach (Lottery Method). Based on the comments of a statistical counselor after a pilot study of two groups of nurses and patients, each consisting of 35 subjects, sample size was set at 200 nurses and 200 patients. Overall, the selected hospitals consisted of 21 surgical units and 18 internal units. After acquiring the approval of the research department and ethics committee of the university, the researchers visited the internal and surgical units of the selected hospitals in different working shifts and explained the objectives of the study to the subjects and asked for their informed consent.

Sampling was carried out in two stages: in the first stage, four university hospitals were randomly selected. In the second stage, the stratified sampling method was used to select nurses and patients from each unit in proportion to the number of nurses and patients in the units. To select subjects, one of the researchers visited the internal and surgical units of the hospitals in the morning, afternoon, and night shifts and made lists of the nurses and patients. Subsequently, the simple random sampling method was used to select subjects from among those individuals who met the criteria of the study. The study subjects were handed the questionnaire and were given enough time to complete it. A total of 500 nurses and patients were invited to participate and 400 consented to enroll in the study (acceptance rate=80%). Only the patients and nurses who signed the informed consent form participated in the study.

The inclusion criteria for the patients were: willingness to participate, having had at least a one-day length of stay, absence of cognitive disorders, being literate, and being aged between 18 and 64 years. The inclusion criteria for the nurses were having at least one month's experience of professional practice and having at least a bachelor's degree in nursing.

***Ethical considerations***

The present study had been approved by the ethical committee of the University of Medical Sciences. After being informed about the objectives of the study, the participants filled out an informed consent form. The participants were assured of the voluntary nature of participation, anonymity of the questionnaires, and confidentiality of their information.

***Data Analysis***

The normality condition of the quantitative variables was investigated using the Shapiro-Wilks test. The collected data were analyzed using descriptive tests (mean and standard deviation), t-test, one-way ANOVA, and Pearson's correlation coefficient. P-values of less than 0.05 were considered as significant. Data were analyzed using SPSS v. 23.0.

**Results**

The average age of the patients was 45.6±15.40; 59.5% of the patients were male; 71.5% were married; 61% were semi-literate, and an unexpected illness was the cause of hospitalization of many of them (62%). 77% of the nurses were aged between 25 and 44 years; the average age of the nurses was 28.83±6.32; 79.4% were female; 53% were single; 93.5% had a bachelor's degree in nursing; 65% had attended ethics workshops, and the work experience of half of the nurses (50%) was less than 5 years. The average work experience of the nurses was found to be 6.15±5.12 years (Table 1).

- - - - - - - - - - - - - - - - - - - - - - - - - - -  
PLEASE INSERT TABLE 1 ABOUT HERE  
- - - - - - - - - - - - - - - - - - - - - - - - - - -

The nurses' mean scores for patient dignity in each of the domains of privacy, autonomy, respect, and relationship, as well as all the domains combined, were found to be significantly higher than the patients'. The lowest mean score of the nurses was 3.82 and was in the domain of autonomy. The lowest means of the patients' scores were 3.49 and 3.54 and were for the domains of autonomy and relationship respectively (Table 2)

- - - - - - - - - - - - - - - - - - - - - - - - - - -  
PLEASE INSERT TABLE 2 ABOUT HERE  
- - - - - - - - - - - - - - - - - - - - - - - - - - -

The results of Pearson correlation coefficient showed that there was not a statistically significant relationship between the average ages of the nurses and patients and the work experience of the nurses on one hand and the observance of patient dignity on the other (Table 3).

- - - - - - - - - - - - - - - - - - - - - - - - - - -  
PLEASE INSERT TABLE 3 ABOUT HERE  
- - - - - - - - - - - - - - - - - - - - - - - - - - -

The results of the student's t-test showed that there was not a statistically significant relationship between the nurses' gender, marital status, level of education, and attendance in ethics workshops on one hand and observance of patient dignity on the other (Table 4).

- - - - - - - - - - - - - - - - - - - - - - - - - - -  
PLEASE INSERT TABLE 4 ABOUT HERE  
- - - - - - - - - - - - - - - - - - - - - - - - - - -

The results of statistical tests (student's t-test and ANOVA) showed that there was not a statistically significant relationship between the patients' gender, marital status, level of education, and cause of hospitalization on one hand and observance of patient dignity on the other (Table 5).

- - - - - - - - - - - - - - - - - - - - - - - - - - -  
PLEASE INSERT TABLE 5 ABOUT HERE  
- - - - - - - - - - - - - - - - - - - - - - - - - - -

**Discussion**

The results of the present study show that, overall, the nurses' mean scores for observance of patient dignity in the domains of privacy, autonomy, respect, and relationship, as well as all their total score, are higher than the patients'. This is consistent with the findings of many other similar studies and confirms the difference between nurses' and patients' perceptions of patient dignity. The qualitative study of Torabizadeh et al. conducted in Iran reports that the dignity of the participating patients was not properly observed and patients and nurses had different understandings of dignity ([9](#_ENREF_9)). In a study comparing the perspectives of Iranian nurses and adolescent patients on patient dignity, the results showed a statistically significant difference between the nurses' and patients' perceptions of privacy and interaction between nurses and patients; however, the difference between the two groups' understanding of respect for patients' rights to decision-making was not statistically significant ([37](#_ENREF_37)). According to the result of a study which was conducted in six European countries, nurses' and patients' perceptions of respect are significantly different ([38](#_ENREF_38)). In their Australian study, Walsh and Kowanko report that nurses consider respect, privacy, control, support, and time devotion as influential factors in patient dignity; similarly, patients believe respect, privacy, control, the right to decide, humor, and honesty to be crucial ([39](#_ENREF_39)). This finding is not consistent with the results of the present study where nurses' and patients' views were found to be different. The former study, however, does not address the extent to which the factors which influence patient dignity are observed.

The results of the present study show that there is not a significant relationship between the nurses' demographic and professional characteristics and the patients' demographic characteristics on one hand and their perspectives on observance of patient dignity in various domains and all the domains combined on the other. According to a study in Iran, men and women have similar perceptions of observance of dignity ([40](#_ENREF_40)), which is consistent with the findings of the present study. Likewise, the results of the study of Borhani et al. show that the mean scores of men and women for patient dignity are similar ([41](#_ENREF_41)). On the other hand, according to the study of Albers et al., patients' gender, age, and marital status correlates with their understanding of the factors affecting patient dignity, which is inconsistent with the findings of the present study ([42](#_ENREF_42)).

In the present study, the nurses were found to believe that patient dignity was observed to a greater degree than the patients did, thus the need for nurses' better familiarity with patients' expectations regarding their dignity in various domains. By identifying factors that are influential in observance of patient dignity from patients' perspective, nurses can better meet patients' expectations ([2](#_ENREF_2)).

According to the results of the present study, the relationship between nurses' attendance in ethics workshops and their mean score for observance of patient dignity is not significant. It appears that nursing ethics workshops have not been very effective in introducing Iranian nurses to the concept of patient dignity and ways of observing it, thus the necessity of a reconsideration of the educational content of the workshops. The medical staff and nursing students interviewed in a study in England reported that they had not received any education on patient dignity ([29](#_ENREF_29)). It seems that to have a better awareness of patient dignity, nurses and nursing students should be taught the concept of dignity in clinical care through empirical approaches ([43](#_ENREF_43)).

The nurses and patients were found to perceive the observance of patient dignity to be the lowest in the domain of autonomy. The items that pertained to this domain included questions about providing patients with enough information to enable them to make informed decisions prior to medical measures, the right to decide about procedures and therapies, the right to participate in care plan, and respect for patient's choice. The results of other studies also show that patients' autonomy and dignity are not properly respected. According to the study of Rodriguez et al., patients want to have more control and make decisions about their care plan, but due to not having their autonomy properly noted, they believe their dignity is not observed ([33](#_ENREF_33)). In their study in England, Redley et al. report that patients are forced to consent to medical procedures and that they are not actually asked for their informed consent in hospital units ([44](#_ENREF_44)). A study in Azerbaijan concludes that there is need for decisive measures toward development of an informed consent form and higher respect for patients' informed consent ([45](#_ENREF_45)). Similarly, the studies of Holm and Severinsson show that neglecting patients' right to participate in their care and have control results in their lack of autonomy and not having their dignity respected ([46](#_ENREF_46)). Attention to social values and personal traits and stressing mutual trust between patients and nurses can enhance respect for patients' right to decide and have dignity ([47](#_ENREF_47)).

The results of the present study show that from patients' perspective, patient dignity is not properly observed in the domain of relationship. Likewise, Woolhead et al. report that medical staff is not capable of establishing a dignity-based relationship with patients. They refer to lack of resources, in-laws, personnel, and time as barriers to effective relationship between nurses and patients ([48](#_ENREF_48)). Webster et al. also report nurses' failure to observe patient dignity in the domain of relationship. Unacceptable verbal communication and delays in the implementation of clinical procedures were among factors Webster et al. found to threaten patient dignity ([49](#_ENREF_49)). Similarly, the study of Janglad et al. shows that patients are not satisfied with the relationship of the medical staff with them: patients complain about not receiving adequate information or being given incomplete information, nurses' lack of sympathy with patients, inadequate support for patients on the part of nurses, and unprofessional behavior of the medical staff, among others ([50](#_ENREF_50)). Lohne et al. report that patients consider sympathy, devoting time to patients, and mutual trust as the most important aspects of a medical relationship and respect for patient dignity ([27](#_ENREF_27)). The study of Beach et al. shows that according to patients, honesty, providing information, modesty, and giving attention are key factors in the relationship of nurses with patients and contribute to observance of patient dignity ([24](#_ENREF_24)). In the present study, listening to patients, giving clear answers to their questions, providing information sufficiently, and a friendly rapport with patients were among the issues which were addressed in the domain of relationship.

The means scores for the patients' perception of observance of patient dignity in the domains of privacy, autonomy, respect, and relationship showed that in nearly half of the cases, the patients believed that patient dignity was observed to a certain extent; this finding indicates that patient dignity should not only be observed, but the manner of observance should be improved. According to studies of the understanding of Iranian patients of patient dignity, patients are not satisfied with the observance of their dignity in hospitals and nurses must be informed about the factors that are influential in observance of patient dignity from patients' perspective ([4](#_ENREF_4),[9](#_ENREF_9),[32](#_ENREF_32)). The study of Ferri et al. in Italy, however, reports that patients believe that patient dignity is observed to high degrees, which is not consistent with the findings of the present study. Yet, they found that patient dignity was better observed in the domains of personal space and respect than in the domains of relationship and communication of information ([51](#_ENREF_51)).

The present study is the first descriptive work of research in Iran which compares nurses' and adult patients' perceptions of patient dignity. The questionnaire developed possesses acceptable psychometric properties and can be employed in evaluations of nurses' and patients' perspectives on patient dignity. The simplicity and clarity of the items of the present questionnaire make it an easy one for nurses and patients to complete.

**Limitations and suggestions**

One of the limitations of the present study is that patient dignity was studied in various internal and surgical units as a whole. It is possible that in certain units, like general surgery units or general internal units, where the number of in-patients is larger, nurses have less time for interacting with and caring for patients, which can affect patients' and nurses' perspectives. Accordingly, it is suggested that future studies address patients' perceptions in different units separately.

**Conclusion**

The results of the present study show that nurses and patients have different understandings of the observance of patient dignity: nurses believe that patient dignity is observed to a higher degree than patients do. Thus, for a more satisfactory observance of patient dignity, nurses need to be familiarized with patients' views on how to observe patient dignity. In hospitals, patient dignity should be observed according to patients' expectations and needs. According to the results of the present study, patient dignity is not properly observed in the domains of autonomy and relationship. Therefore, nurses should be educated about strategies to improve their observance of patient dignity in the domain of autonomy which includes respecting patients' right to decide, allowing patients to participate in their care plan, and acquiring patients' informed consent before any clinical measures. Furthermore, nurses should improve respect for patient dignity in the domain of relationship by listening to patients, sympathizing, meeting patients' needs, dedicating time to patients, providing sufficient information, and creating mutual trust.

**Table 1**

Demographic characteristics of the nurses and patients

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Status | Number (Percentage) | |
| Patients | Nurses |
| Age | Between 18 and 24 years | 20 (10.0) | 40 (20.0) |
| Between 25 and 44 years | 72 (36.0) | 154 (77.0) |
| Above 45 years | 108 (54.0) | 6 (3.0) |
| Gender | Male | 119 (59.5) | 41 (20.6) |
| Female | 81 (40.5) | 158 (79.4) |
| Marital status | Married | 143 (71.5) | 94 (47.0) |
| Single | 57 (28.5) | 106 (53.0) |
| Level of Education | Primary education | 122 (61.0) | - |
| High schools diploma | 46 (23.0) | - |
| Bachelor's | 27 (13.5) | 187 (93.5) |
| Master's | 5 (2.5) | 13 (6.5) |
| Reason for hospitalization | Acute illness | 124 (62.0%) | - |
| Chronic disease | 76 (38.0) | - |
| Attendance in ethics workshops | Yes | - | 130 (65.0) |
| No | - | 70 (35.0) |
| Work experience | Less than 5 year | 100(50,0) | - |
| Between 5 to 10 year | 60(30,0) | - |
| More than 10 years | 40(20,0) | - |

**Table 2**

Distribution of the nurses' and patients' mean scores for observance of patient dignity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dimension | Subjects | N | Mean**±**(SD) | P-value |
| Privacy | Patient | 200 | 3.72 **±** (0.99) | <0.001 |
| Nurse | 200 | 4.2**±**(0.74) |
| Total | 400 | 3.96**±**(0.9) |
| Autonomy | Patient | 200 | 3.49**±**(0.98) | <0.001 |
| Nurse | 200 | 3.82**±**(0.83) |
| Total | 400 | 3.65**±**(0.92) |
| Respect | Patient | 200 | 3.87**±**(0.83) | <0.001 |
| Nurse | 200 | 4.19**±**(0.67) |
| Total | 400 | 4.03**±**(0.77) |
| Relationship | Patient | 200 | 3.54**±**(0.97) | <0.001 |
| Nurse | 200 | 4.18**±**(0.73) |
| Total | 400 | 3.86**±**(0.92) |
| Total dignity score | Patient | 200 | 3.65**±**(0.84) | <0.001 |
| Nurse | 200 | 4.1**±**(0.63) |
| Total | 400 | 3.87**±**(0.78) |

**Table 3**

The relationship between the participants' average ages and nurses' professional experience on one hand and dimensions of patient dignity on the other

|  |  |  |  |
| --- | --- | --- | --- |
| Patients |  | Age | work experience |
| Privacy | -0.04 (0.55) | - |
| Autonomy | -0.08 (0.28) | - |
| Respect | -0.13 (0.08) | - |
| Communication | -0.09 (0.22) | - |
| Nurses | Privacy | -0.09 (0.2) | -0.004 (0.957) |
| Autonomy | -0.07 (0.3) | -0.009 (0.895) |
| Respect | -0.04 (0.56) | 0.036 (0.610) |
| Communication | -0.02 (0.75) | 0.063 (0.376) |

**Table 4**

The relationship between nurses' understanding of observance of patient dignity and their personal and professional characteristics

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Variable | | N | Mean | SD | t | p-value |
| Gender | Female | 158 | 4.14 | 0.58 | 1.906 | 0.062 |
| Male | 41 | 3.9 | 0.77 |
| Marital Status | Single | 94 | 4.1 | 0.63 | 0.145 | 0.885 |
| Married | 106 | 4.09 | 0.63 |
| Level of Education | Bachelor's | 187 | 4.09 | 0.62 | 0.139 | 0.889 |
| M.S.; Ph.D. | 13 | 4.12 | 0.82 |
| Attendance in ethics  Workshops | Yes | 130 | 4.09 | 0.61 | 0.183 | 0.855 |
| No | 70 | 4.11 | 0.67 |

**Table 5**

The relationship between patients' understanding of observance of patient dignity and their personal characteristics

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Variable |  | N | Mean | SD | t | (p-value) |
| Gender | Female | 81 | 3.55 | 0.85 | 1.443 | (0.151) |
| Male | 119 | 3.72 | 0.84 |
| Marital Status | Single | 143 | 3.68 | 0.85 | 0.674 | (0.501) |
| Married | 57 | 3.59 | 0.84 |
| Level of Education | Under-diploma | 122 | 3.7 | 0.88 | 1.377 | (0.251) |
| Diploma | 46 | 3.71 | 0.77 |
| Bachelor's | 27 | 3.44 | 0.81 |
| Master's | 5 | 3.16 | 0.51 |
| Cause of hospitalization | Acute illness | 124 | 3.65 | 0.87 | 0.162 | (0.872) |
| Chronic illness | 76 | 3.67 | 0.81 |

**Appendix 1**

The 33-item Patient Dignity Questionnaire

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Items** | **Never observed**  **(1)** | | **Rarely observed**  **(2)** | | **Sometimes observed**  **(3)** | | **Usually observed**  **(4)** | | | | **Always observed**  **(5)** |
| **Privacy** |
| 1. Before clinical and nursing procedures are performed, patients' informed consent should be acquired. |  | |  | |  | |  | | | |  |
| 2. Nurses should knock before entering patients' rooms. |  | |  | |  | |  | | | |  |
| 3. Before any clinical or nursing acts, nurses should ensure patient's privacy (e.g. closing doors, drawing curtains). |  | |  | |  | |  | | | |  |
| 4. Care providers should not share patient's information with others. |  | |  | |  | |  | | | |  |
| 5. While discussing personal matters, patient's privacy should be respected. |  | |  | |  | |  | | | |  |
| 6. Irrelevant areas of patient's body should be covered during medical acts (e.g. bandaging, examination). |  | |  | |  | |  | | | |  |
| **Autonomy** |
| 7. Patients should be informed about their treatment plans to make informed decisions. |  |  | |  | | | |  | |  | |
| 8. Patients have the right to make decisions about the clinical and nursing acts they are judged to require. |  |  | |  | | | |  | |  | |
| 9. Patients should be allowed to participate in clinical and nursing acts. |  |  | | | |  | | |  |  | |
| 10. Patients should be allowed to perform their daily activities (e.g. getting dressed, walking) alone if they can. |  |  | | | |  | | |  |  | |
| 11. Patients' opinions should be taken into consideration. |  |  | | | |  | | |  |  | |
| 12. Patients should be effectively supported to care for themselves independently. |  |  | | | |  | | |  |  | |
| **Respect** |
| 13. Patients should be spoken to respectfully. |  |  | | | |  | | |  |  | |
| 14. Nursing cares should be provided according to patients' individual needs. |  |  | | | |  | | |  |  | |
| 15. Nurses should address patients with their last names. |  |  | | | |  | | |  |  | |
| 16. If a patient needs help, action should be taken immediately. |  |  | | | |  | | |  |  | |
| 17. A quiet environment should be provided for patients to rest and sleep. |  |  | | | |  | | |  |  | |
| 18. Patients should have access to hygienic hospital facilities and equipment. |  |  | | | |  | | |  |  | |
| 19. Patients' ethnicities, dialects, accents, and religious beliefs should be respected. |  |  | | | |  | | |  |  | |
| 20. Patients should be respected regardless of their financial, social, and cultural status. |  |  | | | |  | | |  |  | |
| 21. At the time of admittance, patients should be provided with proper clothing. |  |  | | | |  | | |  |  | |
| 22. The members of the medical team should be coordinated to prevent any delays in the provision of care. |  |  | | | |  | | |  |  | |
| 23. There should be adequate facilities for the patients' companions to rest and make themselves comfortable. |  |  | | | |  | | |  |  | |
| 24. Patients' requests should be granted as far as possible. |  |  | | | |  | | |  |  | |
| **Communication** |
| 25. Nurses should introduce themselves upon first meeting patients. |  |  | | | |  | | |  |  | |
| 26. At the time of admittance, patients should be introduced to their care providers and the environment. |  |  | | | |  | | |  |  | |
| 27. Nurses should communicate with patients according to patients' individual personality types. |  |  | | | |  | | |  |  | |
| 28. Nurses should be friendly and kind to patients. |  |  | | | |  | | |  |  | |
| 29. Nurses should listen to patients patiently. |  |  | | | |  | | |  |  | |
| 30. Unequivocal answers should be given to patients' question. |  |  | | | |  | | |  |  | |
| 31. Nurses should inform patients adequately about their condition, care plan, medication, etc. |  |  | | | |  | | |  |  | |
| 32. Nurses should explain the purpose of every care procedure to patients before it is performed. |  |  | | | |  | | |  |  | |
| 33. Nurses should establish an effective relationship with patients' companions. |  |  | | | |  | | |  |  | |

**References**

1. Sautier LP, Vehling S, Mehnert A. Assessment of patients' dignity in cancer care: preliminary psychometrics of the German version of the Patient Dignity Inventory (PDI-G). Journal of pain and symptom management. 2014;47(1):181-8.

2. Matiti MR, Trorey GM. Patients' expectations of the maintenance of their dignity. Journal of clinical nursing. 2008;17(20):2709-17.

3. Nortvedt L, Kumar BN, Lohne V. A qualitative study of immigrant women on long-term sick leave and their experience of dignity. Disability and rehabilitation. 2017:1-8.

4. Ebrahimi H, Torabizadeh C, Mohammadi E, Valizadeh S. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. Journal of medical ethics. 2012;38(12):723-8.

5. Akin Korhan E, Ustun C, Uzelli Yilmaz D. Practices in Human Dignity in Palliative Care: A Qualitative Study. Holistic nursing practice. 2018;32(2):71-80.

6. Gallagher A, Li S, Wainwright P, Jones IR, Lee D. Dignity in the care of older people - a review of the theoretical and empirical literature. BMC nursing. 2008;7:11.

7. Bagheri H, Yaghmaei F, Ashktorab T, Zayeri F. Relationship between illness-related worries and social dignity in patients with heart failure. Nursing ethics. 2016.

8. Manookian A, Cheraghi MA, Nasrabadi AN. Factors influencing patients' dignity: A qualitative study. Nursing ethics. 2014;21(3):323-34.

9. Torabizadeh C, Ebrahimi H, Mohammadi E, Valizadeh S. Incongruent Perceptions Among Nurses and Patients: A Qualitative Study of Patient's Dignity in Iran. Ethics & Behavior. 2013;23(6):489-500.

10. Sanakova S, Cap J. Dignity from the nurses' and older patients' perspective: A qualitative literature review. Nursing ethics. 2018:969733017747960.

11. Lachman VD. Practical use of the nursing code of ethics: part I. Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses. 2009;18(1):55-7.

12. Shahriari M, Mohammadi E, Abbaszadeh A, Bahrami M. Nursing ethical values and definitions: A literature review. Iranian journal of nursing and midwifery research. 2013;18(1):1-8.

13. Lin YK, Lin CJ. Factors predicting patients' perception of privacy and satisfaction for emergency care. Emergency medicine journal : EMJ. 2011;28(7):604-8.

14. Hasan Tehrani T, Seyed Bagher Maddah S, Fallahi-Khoshknab M, Ebadi A, Mohammadi Shahboulaghi F, Gillespie M. Respecting the privacy of hospitalized patients: An integrative review. Nursing ethics. 2018:969733018759832.

15. Hosseini FA, Momennasab M, Yektatalab S, Zareiyan A. Patients' perception of dignity in Iranian general hospital settings. Nursing ethics. 2018:969733018772078.

16. Enzo A, Okita T, Asai A. What deserves our respect? Reexamination of respect for autonomy in the context of the management of chronic conditions. Medicine, health care, and philosophy. 2018.

17. Hosseini A, Rezaei M, Bahrami M, Abbasi M, Hariri H. The Relationship between Dignity Status and Quality of Life in Iranian Terminally Ill Patients with Cancer. Iranian journal of nursing and midwifery research. 2017;22(3):178-83.

18. Ursin LO. Personal autonomy and informed consent. Medicine, health care, and philosophy. 2009;12(1):17-24.

19. Beach MC, Sugarman J, Johnson RL, Arbelaez JJ, Duggan PS, Cooper LA. Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventive care? Annals of family medicine. 2005;3(4):331-8.

20. Khaledi S, Moridi G, Valiee S. Iranian patients' perspective of patients' rights: a qualitative study. Indian journal of medical ethics. 2016;1(1):16-22.

21. Brown SM, Azoulay E, Benoit D, Butler TP, Folcarelli P, Geller G, et al. The Practice of Respect in the Intensive Care Unit. American journal of respiratory and critical care medicine. 2018.

22. Chochinov HM. Dignity-conserving care--a new model for palliative care: helping the patient feel valued. Jama. 2002;287(17):2253-60.

23. Dickert NW, Kass NE. Understanding respect: learning from patients. Journal of medical ethics. 2009;35(7):419-23.

24. Beach MC, Forbes L, Branyon E, Aboumatar H, Carrese J, Sugarman J, et al. Patient and family perspectives on respect and dignity in the intensive care unit. Narrative inquiry in bioethics. 2015;5(1a):15a-25a.

25. Sugarman J. Toward treatment with respect and dignity in the intensive care unit. Narrative inquiry in bioethics. 2015;5(1a):1a-4a.

26. Zahran Z, Tauber M, Watson HH, Coghlan P, White S, Procter S, et al. Systematic review: what interventions improve dignity for older patients in hospital? Journal of clinical nursing. 2016;25(3-4):311-21.

27. Lohne V, Aasgaard T, Caspari S, Slettebo A, Naden D. The lonely battle for dignity: individuals struggling with multiple sclerosis. Nursing ethics. 2010;17(3):301-11.

28. McIlfatrick S, Connolly M, Collins R, Murphy T, Johnston B, Larkin P. Evaluating a dignity care intervention for palliative care in the community setting: community nurses' perspectives. Journal of clinical nursing. 2017.

29. Tauber-Gilmore M, Addis G, Zahran Z, Black S, Baillie L, Procter S, et al. The views of older people and health professionals about dignity in acute hospital care. Journal of clinical nursing. 2017.

30. Borhani F, Abbaszadeh A, Moosavi S. Status of human dignity of adult patients admitted to hospitals of Tehran. Journal of medical ethics and history of medicine. 2014;7:20.

31. Cairns D, Williams V, Victor C, Richards S, Le May A, Martin W, et al. The meaning and importance of dignified care: findings from a survey of health and social care professionals. BMC geriatrics. 2013;13:28.

32. Avestan Z, Rahmani A, Heshmati-Nabavi F, Mogadasian S, Faghani S, Azadi A, et al. Perceptions of Iranian Cancer Patients Regarding Respecting their Dignity in Hospital Settings. Asian Pacific journal of cancer prevention : APJCP. 2015;16(13):5453-8.

33. Rodriguez-Prat A, Monforte-Royo C, Porta-Sales J, Escribano X, Balaguer A. Patient Perspectives of Dignity, Autonomy and Control at the End of Life: Systematic Review and Meta-Ethnography. PloS one. 2016;11(3):e0151435.

34. Chochinov HM, Hack T, McClement S, Kristjanson L, Harlos M. Dignity in the terminally ill: a developing empirical model. Social science & medicine (1982). 2002;54(3):433-43.

35. Lawshe CH. A quantitative approach to content validity. Personnel psychology. 1975;28(4):563-75.

36. Waltz CF, Bausell BR. Nursing research: design statistics and computer analysis: Davis FA; 1981.

37. Dehghan-Nayeri N, Karimi R, Sadeghee T. Iranian nurses and hospitalized teenagers views of dignity. Nursing ethics. 2011;18(4):474-84.

38. Papastavrou E, Efstathiou G, Tsangari H, Suhonen R, Leino-Kilpi H, Patiraki E, et al. Patients' and nurses' perceptions of respect and human presence through caring behaviours: a comparative study. Nursing ethics. 2012;19(3):369-79.

39. Walsh K, Kowanko I. Nurses' and patients' perceptions of dignity. International journal of nursing practice. 2002;8(3):143-51.

40. Zirak M, Ghafourifard M, Mamaghani EA. Patients’ Dignity and Its Relationship with Contextual Variables: A Cross-Sectional Study. Journal of caring sciences. 2017;6(1):49.

41. Borhani F, Abbaszadeh A, Rabori RM. New Vision for the Dignity: Understanding the Meaning of Patient Dignity in Iran. British Journal of Medicine and Medical Research. 2015.

42. Albers G, Pasman HR, Deliens L, de Vet HC, Onwuteaka-Philipsen BD. Does health status affect perceptions of factors influencing dignity at the end of life? Journal of pain and symptom management. 2013;45(6):1030-8.

43. Kyle RG, Medford W, Blundell J, Webster E, Munoz SA, Macaden L. Learning and unlearning dignity in care: Experiential and experimental educational approaches. Nurse education in practice. 2017;25:50-6.

44. Redley M, Keeley H, Clare I, Hinds D, Luke L, Holland A. Respecting patient autonomy: understanding the impact on NHS hospital in-patients of legislation and guidance relating to patient capacity and consent. Journal of health services research & policy. 2011;16(1):13-20.

45. Rustamova FA, Mammadov VG, Munir KM. Realization of informed consent as one of patient's rights: current situation in azerbaijan. Bioetika. 2016;1(17):24-9.

46. Holm AL, Severinsson E. Reflections on the ethical dilemmas involved in promoting self-management. Nursing ethics. 2014;21(4):402-13.

47. Wilson F, Ingleton C, Gott M, Gardiner C. Autonomy and choice in palliative care: time for a new model? Journal of advanced nursing. 2014;70(5):1020-9.

48. Woolhead G, Tadd W, Boix-Ferrer JA, Krajcik S, Schmid-Pfahler B, Spjuth B, et al. “Tu” or “Vous?”: A European qualitative study of dignity and communication with older people in health and social care settings. Patient Education and Counseling. 2006;61(3):363-71.

49. Webster C, Bryan K. Older people's views of dignity and how it can be promoted in a hospital environment. Journal of clinical nursing. 2009;18(12):1784-92.

50. Jangland E, Gunningberg L, Carlsson M. Patients’ and relatives’ complaints about encounters and communication in health care: evidence for quality improvement. Patient education and counseling. 2009;75(2):199-204.

51. Ferri P, Muzzalupo J, Di Lorenzo R. Patients' perception of dignity in an Italian general hospital: a cross-sectional analysis. BMC health services research. 2015;15(1):41.