# Torabizadeh-Nurses' and patients' perceptions of dignity

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

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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.

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

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## **Abstract**

The available research regarding patient’s dignity is either of the qualitative type or addresses dignity among special groups, such as elderly patients, cancer patients, end-stage patients, or teenage patients. Accordingly, the present study was conducted with the purpose of comparing the perspectives of nurses and adult patients on dignity. 200 nurses and 200 patients from multisite­­­­-39 wards from four university hospitals- participated in this study. The results showed that the mean score for the observance of each of the aspects of patient dignity (privacy, autonomy, respect and communication) were significantly higher for nurses than patients (*p*<0.001). Nurses need to be informed about patients’ perceptions regarding how their dignity is maintained in order to be able to observe and promote it. The patient dignity questionnaire designed in the present study is a valid and reliable instrument for evaluating patient’s dignity from the viewpoint of nurses and patients.

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

**Introduction**

One of the important aspects of high-quality healthcare is observing patient dignity ([1](#_ENREF_1)). Failure to observe patient dignity can adversely affect patients’ recovery. However, dignified care can enhance a patient’s pace of recovery and increase his or her emotional comfort ([2](#_ENREF_2),[3](#_ENREF_3)). Very often, patients complain about the poor observance of their dignity while they are hospitalized ([2](#_ENREF_2),[4](#_ENREF_4),[5](#_ENREF_5)).

There are several factors which can affect observance of patient dignity: the attitudes and behaviors of the hospital staff, environment, culture of care, and the performance of certain care activities ([6](#_ENREF_6)). In order to determine patient’s needs and expectations regarding their dignity, patients should be evaluated individually ([7](#_ENREF_7)). Because it should be viewed from the patient’s perspective, dignity can be an elusive concept. Patients and nurses often perceive dignity differently ([8](#_ENREF_8)-10). It is important to increase nurses’ awareness about the factors influencing patient dignity from patients’ perspectives ([11](#_ENREF_11)).

Studies show that from patients’ perspective, different factors affect their dignity: privacy, confidentiality of information, participation in the care process, respect, and even the way the patients are addressed ([9](#_ENREF_9),[12](#_ENREF_12),[13](#_ENREF_13)). An extensive literature review reveals four important factors in observance of patient dignity: privacy, autonomy, respect and communication.

***Privacy*:** The terms ‘privacy’ and ‘dignity’ are intertwined ([14](#_ENREF_14)). Patients strongly believe that privacy plays a very important part in their care. Yet, patients claim to have very little privacy in hospital wards (4,6,9). Patients refer to the following items as important factors in their perception of privacy: other people overhearing their personal information, patients overhearing other people’s personal information, being seen by irrelevant people, having a private space when being physically examined, and the nurses’ respect for patients' privacy. Nursing staff should make sure that patient dignity is maintained and promoted by paying attention to patients’ privacy and interacting with patients to help them feel comfortable, respected and valued ([15](#_ENREF_15)).

***Autonomy***: Treatment of patients with dignity can be defined as facilitating, supporting and promoting their ability and right to decide for themselves and respecting their decisions ([16](#_ENREF_16)). Lack of autonomy and control among patients is often perceived as loss of dignity ([17](#_ENREF_17)). Asking for the patient’s consent before medical interventions and treatment is an important factor in observing autonomy in the hospital ([18](#_ENREF_18)). Patient's involvement in decision-making results in patients’ higher satisfaction, adherence to their recovery procedure, and acceptance of preventive care ([19](#_ENREF_19)).

***Respect***: Dignity is defined as the person’s feeling respected ([20](#_ENREF_20),[21](#_ENREF_21)). Many patients consider respect as the most important things they would like to receive from their relatives and care givers ([22](#_ENREF_22)). Recent studies suggest that patients who report to have been treated with respect experience better clinical outcomes and higher satisfaction with their care ([23](#_ENREF_23),[24](#_ENREF_24)). Studies show that the patient’s perception of respectful care has not been identified well ([25](#_ENREF_25)).

***Communication***: Dignity is shown by a person’s presence and communication with others ([26](#_ENREF_26)). Dignity is felt only in a context of empathy and mutual confidence in humans ([26](#_ENREF_26),[27](#_ENREF_27)). The different types of communication behavior (verbal interaction, body language, compassionate behavior, and devoting enough time) all affect patient dignity ([11](#_ENREF_11)). Effective communication can improve patients’ physical and emotional state and also help patients to adjust to their illness and ease their pain ([28](#_ENREF_28)).

Since dignity is a culture-specific concept, it should be studied in different cultures. Although most nurses believe that patient dignity is respected, patients believe that their dignity is not respected (2,[4](#_ENREF_4),5,[8](#_ENREF_8)). Despite extensive search, the researchers could not find any descriptive studies comparing the perspectives of nurses and adult patients regarding dignity in the medical and surgical wards. The available research in this field is either of the qualitative type ([8](#_ENREF_8),[29](#_ENREF_29),[30](#_ENREF_30)) or addresses dignity among special groups such as, elderly patients ([31-33](#_ENREF_31)), cancer patients ([1](#_ENREF_1),[34](#_ENREF_34)), end stage patients ([35-37](#_ENREF_35)), or teenage patients ([38](#_ENREF_38)). Therefore, the present study was conducted with the purpose of comparing the perspectives of nurses and adult patients on dignity.

**Methods**

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

This cross-sectional study was conducted in the internal and surgical units of hospitals in the south of Iran. 200 nurses and 200 patients from multisite­­­­-39 medical and surgical wards from four university hospitals- participated in this study between June 2017 and September 2017.

***Study instruments***

The data collection instruments used in the study were a demographics questionnaire and the patient dignity questionnaire. The demographics questionnaire included questions related to demographic and professional details of the nurses and the demographics of the hospitalized patients. The patient dignity questionnaire was devised after an extensive review of the available literature by the researchers and contained questions about the four aspects of dignity, i.e. respect, communication, privacy, and autonomy. This questionnaire addressed “observance status” from the perspectives of nurses and hospitalized patients. The observance of the items was based on a 5-point Likert scale: “never observed” (1) to “always observed” (5). In order to confirm the face and content validity of the patient dignity questionnaire, qualitative and quantitative methods were used. In order to validate the qualitative face validity, face-to-face interviews were conducted with 10 nurses and 10 patients and the items were evaluated based on difficulty level, appropriateness, ambiguity or unclearness. Next, the researchers assessed the quantitative impact of the items. To do so, 10 specialists were asked to score each item in the questionnaire on a 5-point Likert scale: (5 = very important, 4 = important, 3= fairly important, 2 = not very important, 1 =not important). The items which had an impact score of above 1.5 were saved for subsequent analysis. In order to examine the quality validity of the content, 10 university professors who were familiar with the concept of patient dignity, professors of ethical studies, or professors with experience in designing questionnaires were asked to provide a written copy of their views on the content of the instrument based on grammar, appropriateness of the words or terms, accuracy, and appropriate scoring. The next step to determine the quantitative validity of the content was measuring the content validity ratio (CVR) and content validity index (CVI) of the items. CVR was calculated in order to make sure that, statistically speaking, the best and the most important content was included. 10 experts rated the importance of each item using a 3-point Likert scale ("necessary", "useful but not necessary", "not necessary at all"). According to Lawshe Table, for identifying the least value of content validity ratio, the items which had a CVR of above 0.62 were considered significant (*p*<0.05) and were retained ([39](#_ENREF_39)).

The CVI was calculated to make sure that the items of the instrument were effective and accurate enough to assess the content. The CVI of the questionnaires were evaluated according to Waltz and Bausell’s method ([40](#_ENREF_40)). 10 experts examined the items of the instrument based on a 4- point Likert scale based on the three criteria of relevancy, clarity and simplicity. The items with a score of 0.79 and above were retained and the other items were removed.

The internal consistency method was used to determine the reliability of the patient dignity questionnaire: Cronbach's alpha was calculated after the pilot study had been conducted on 35 nurses and 35 patients. The overall reliability of the questionnaire (nurses and patients) was 0.968: for the patients, it was 0.979; for the nurses, it was 0.949. The Patient Dignity Questionnaire contained 33 questions. Questions 1 to 6 addressed privacy, 7 to 12 addressed autonomy, 13 to 24 addressed respect and 25 to 33 addressed communication. The items of the patient dignity questionnaire were the same for the patients and the nurses; however, the verbs of the statements were different based on the addressee (patients or nurses). The score range of the patient dignity questionnaire for "observance" was between 33 and 165 (Appendix 1).

***Data collection***

Among the hospitals affiliated with the university, four hospitals were selected using random sampling. First, a pilot study was conducted on two groups of nurses and patients with 35 subjects in each; based on the results of the pilot trial, the number of participants was set at 200 for patients and 200 for nurses. These four hospitals had 21 surgery sections and 18 internal sections. The sample size of nurses and patients from each section were selected based on stratified sampling with appropriate allocation. One of the researchers visited the internal and surgical sections of these four hospitals during the morning, afternoon and night shifts. After the list of the nurses and patients was completed, a number of them who met the criteria of the study were selected based on the simple random sampling method. The inclusion criteria for patients were willingness to participate in the study, at least one day of hospitalization, not having any cognitive disorders, literacy level of reading and writing, and being aged between 18 and 64. The exclusion criterion for the patients was that they be one of the professional healthcare personnel. The inclusion criteria for the nurses were willingness to participate, having at least one month's work experience, and having a bachelor's degree or above in nursing.

The collected data were analyzed using SPSS software v. 23, and descriptive and inferential statistics. The significance level was set at *P*<0.05.

***Ethical considerations***

This study was approved by the research ethics committee at Shiraz University of Medical Sciences. All the participants were informed about the purpose of the study, and gave their informed consent to participate.

**Results**

The average age of the patients was found to be 45.6±15.43; 59.5% were male and 71.5% were married; 61% of the patients had primary education; the reason for the hospitalization of the majority was acute illness (62%). The average age of the nurses was 28.83±6.32. Most of the nurses were female (79.4%) and 53% were single; 65% of nurses had participated in in-service ethical courses and half of the nurses (50%) had a work experience of less than five years with an average of 6.15±5.12 years (Table 1).

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The mean score for the observance of each of the aspects of patient dignity (privacy, autonomy, respect and communication) and the overall score of the observance of patient dignity were significantly higher for nurses than patients. The lowest mean scores for the nurses' and patients’ perception of observance of patient dignity were in the dimension of autonomy: respectively 3.82 and 3.49 (Table 2).

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In order to examine the relationship between the different dimensions of the patient dignity questionnaire in nurses and patients participating in the study, Pearson correlation coefficient was used. The dimensions of the patient dignity questionnaire had a significant positive relationship between each other for nurses and patients. As for nurses, there was a significant positive relationship between the observance status of communication and respect with a correlation coefficient of 0.829; as for the patients, there was a significant positive relationship between the observance status of communication and respect with correlation coefficients of 0.804, which showed a significant relationship (Table 3).

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**Discussion**

The comparison of the nurses' and patients’ perceptions showed that nurses attain higher scores in the observance status of privacy, autonomy, respect, communication and the overall dimensions of dignity. The nurses’ perception of observance of patient dignity was higher than the patients', which shows that nurses believe that patient dignity is observed well, while patients do not think so. Therefore, nurses need to become familiar with patients’ perceptions. The results of most previous studies in this area are consistent with those of the present study and show that there is a significant difference between nurses’ and patients’ perceptions of patient dignity. The results of a study by Torabizadeh et al. (2013) in Iran show that nurses' and patients’ perceptions of patient dignity are different ([8](#_ENREF_8)). A study comparing Iranian nurses’ and hospitalized teenagers’ perceptions of patient dignity shows a significant difference between teenagers’ and nurses’ perspectives on the observance of patients' privacy and nurse-patient interaction; however, the study does not report a significant difference in the dimension of respect for teenagers’ decisions between the two groups ([38](#_ENREF_38)). The results of a study in six European countries show that there is a difference between nurses' and patients’ perceptions regarding respect ([10](#_ENREF_10)). In Walsh and Kowanko’s study (2002) in Australia, nurses refer to privacy, respect, control, support, and dedicating time to patients as factors that contribute to observance of patient dignity; the patients, on the other hand, consider respect, privacy, control, choice, humor and honesty as important. The finding of the Australian study show similarities between the perceptions of nurses and patients which is not consistent with the results of the present study ([29](#_ENREF_29)); however, in their study, Walsh and Kowanko address perception of the contributing factors in patient dignity, while the present study addresses perception of the observance of the dimensions of patient dignity.

Based on the findings of the present study, nurses’ perception score for patient dignity is higher than patients’, which indicates that nurses need to become acquainted with patients’ expectations regarding observance of patient dignity in its different aspects. Nurses play an important role in satisfying patients’ expectations regarding patient dignity, thus there is a need for introducing nurses to patients’ perspectives on patient dignity ([2](#_ENREF_2)).

Nurses and patients reported lower observance regarding patient autonomy compared with other dimensions of patient dignity. In healthcare centers, there is a paternalistic approach, meaning that the care providing staff makes decisions about patients' care and patients’ autonomy is not respected. Although in recent years there has been some emphasis on the importance of respecting patients’ legal right to decision-making in the care process, this issue is not observed in Iranian hospitals ([41-43](#_ENREF_41)). The results of a study conducted by Zirak et al. (2017) in Iran show that most patients are not familiar with their rights regarding patient dignity; in order to improve observance of patient dignity, there should be extensive educational programs for care providers, patients and their families ([44](#_ENREF_44)). The findings of a systematic review reveal that patients want to have control over and make decisions about their treatments; yet, because care providers do not consider patients’ autonomy, their dignity is not respected ([35](#_ENREF_35)). The results of a study in England show that patients are forced to agree with the treatment procedures in different hospital sections: patients are not practically asked for their informed consent ([45](#_ENREF_45)). A study in Azerbaijan reports that there is need for fundamental changes to reform the patients’ informed consent forms to promote their awareness ([46](#_ENREF_46)). In addition, Holm and Severinsson (2014) report that patients’ lack of participation in control over their treatment results in negligence of patients’ autonomy and, therefore, their dignity ([47](#_ENREF_47)). Attention to social backgrounds, individual characteristics, and mutual trust between patients and nurses can contribute to the decision-making process and patients’ autonomy. Increasing patients' decision-making powers regarding their care and daily activities can give patients a greater sense of dignity ([48](#_ENREF_48)).

The average score of patients’ perception of observance of patient dignity and its different dimensions of privacy, autonomy, respect and communication revealed that in many cases patient dignity was believed to be partially observed, which shows that patient dignity should be more carefully considered and promoted. The results of the studies on Iranian patients’ perception of their dignity show that patients are not satisfied with the observance of their dignity in hospitals, and nurses need to be informed about the factors affecting patient dignity ([4](#_ENREF_4),[8](#_ENREF_8),[34](#_ENREF_34)). Unlike the findings of the present study, the results of a study in Italy show that patients believe that their dignity is maintained to a high standard. However, patient dignity and the dimensions of physical privacy, physical territory and respect were found to be observed more than communication and information ([49](#_ENREF_49)).

There was a significant relationship between the dimensions of communication and respect, which shows that communication based on dignity results in maintaining respect. Similar to the results of the present study, the results of a study in England show that paying attention and having emotional sensitivity when communicating with patients are important factors in maintaining patient respect and dignity ([50](#_ENREF_50)).

**Limitations and Future Development**

One of the limitations of the present study was that there was no question in the patient dignity questionnaire to determine the hospital section in which the patients were hospitalized. Therefore, observance of patient dignity in surgical and internal sections was examined together. There is a possibility that in some sections, such as general surgical sections or the general internal sections in which there are more hospitalized patients, nurses have less time to interact and care for patients, which can affect patients' and nurses’ perceptions of dignity. Thus, it is recommended that future studies examine patients’ perceptions in different sections.

**Conclusion**

The results of the present study show that nurses’ and patients’ perceptions of observance of patient dignity are different: the nurses reported higher levels of perceived patient dignity compared to the patients. As a result, nurses need to be informed about patients’ perceptions regarding how their dignity is maintained in order to be able to observe and promote it. In fact, maintenance of patient dignity in the hospital should be based on the patients’ expectations and needs. Based on the findings of the present study, the dimension of autonomy is not observed well. Thus, nurses should be educated about strategies to promote patients’ autonomy, such as creating an opportunity for patients to make decisions, participate in their own care, and consent before their treatment plan is set. The questionnaire used in the present study, has an appropriate level of validity and reliability and, therefore, can be used to evaluate the nurses' and patients’ perspectives on dignity in future studies.

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**Table 1**

**Frequency distribution of demographic characteristics of the participants**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Status** | **Number (%)** | |
| **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 only | 122 (61.0) | - |
| Diploma | 46 (23.0) | - |
| Bachelor | 27 (13.5) | 187 (93.5) |
| Master | 5 (2.5) | 13 (6.5) |
| **Reason of hospitalization** | Acute illness | 124 (62.0%) | - |
| Chronic disease | 76 (38.0) | - |
| **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**

**Comparison between the nurses’ and patients’ mean scores for the different domains of patient dignity questionnaire.**

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

**Table 3**

**Pearson’s correlation between the dimensions of patient dignity questionnaire for nurses**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nurses** | **Dimensions** | **(1)** | **(2)** | **(3)** |
| Privacy (1) | - |  |  |
| Autonomy (2) | 0.591\* | - |  |
| Respect (3) | 0.554\* | 0.568\* | - |
| Communication (4) | 0.575\* | 0.587\* | 0.829\* |
| **Patients** | Privacy (1) | - |  |  |
| Autonomy (2) | 0.773\* | - |  |
| Respect (3) | 0.762\* | 0.693\* | - |
| Communication (4) | 0.687\* | 0.704\* | 0.804\* |

\*Significance level: 0.001

**Appendix 1**

**Patient dignity questionnaire**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Items** | Never observed | Rarely observed | Sometimes observed | Usually observed | Always observed |
| **Privacy** |
| 1. Before clinical and nursing procedures are performed, patients should give their informed consent. |  |  |  |  |  |
| 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 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. Patient's opinions should be taken into consideration. |  |  |  |  |  |
| 12. Patients should be supported to care for themselves effectively and alone. |  |  |  |  |  |
| **Respect** |
| 13. Patients should be spoken to respectfully. |  |  |  |  |  |
| 14. Nursing cares should be provided according to patients' individual needs. |  |  |  |  |  |
| 15. Nurses should refer to 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 much as possible. |  |  |  |  |  |
| **Communication** |
| 25. Nurses should introduce themselves attheir first meeting with 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. |  |  |  |  |  |