

Nurses' commitment to respecting patient dignity

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ABSTRACT

Background: Although respecting human dignity is a cornerstone of all nursing practices, industrialization has gradually decreased the attention paid to this subject in nursing care. Therefore, the present study aimed to investigate nurses' commitment to respecting patient dignity in hospitals of Isfahan, Iran. **Methods:** This descriptive-analytical study was conducted in hospitals of Isfahan. Overall, 401 inpatients were selected by cluster sampling and then selected simple random sampling from different wards. Data were collected through a questionnaire containing the components of patient dignity, that is, patient-nurse relationships, privacy, and independence. All items were scored based on a five-point Likert scale. The collected data were analyzed using descriptive statistics and Chi-square tests. $P < 0.05$ were considered significant in all analyses. **Findings:** Most patients (91%) scored their relationships with nurses as good. Moreover, 91.8% of the participants described privacy protection as moderate/good. Only 6.5% of the subjects rated it as excellent. The majority of the patients (84.4%) believed their independence was maintained. These subjects also approved of taking part in decision-making. **Conclusion:** According to our findings, nurses respected patient dignity to an acceptable level. However, the conditions were less favorable in public hospitals and emergency departments. Nursing authorities and policy makers are thus required to introduce appropriate measures to improve the existing conditions.

Key words: Dignity, ethical values, hospital, Isfahan, nursing staff, privacy

INTRODUCTION

Human dignity has attracted extensive attention in various academic fields including philosophy, ethics, nursing, medicine, social sciences, and politics.^[1] Due to the significance of this subject in the health care industry during the 21st century, many countries have focused on high-quality care provision simultaneous with patient dignity protection.^[2,3]

The English word "dignity" comes from Latin words "dingus" (meaning worth) and "dignitas" (meaning merit)^[4,5] and

denotes respect, decency, humanity, and status.^[6] Human dignity has long been considered in medical fields and might actually stem from Socrates's emphasis on the importance of respecting patients' dignity.^[7] Moral philosophers have also traditionally assessed morality based on human dignity.^[8] However, materialistic approaches gradually emerged following scientific developments and industrialization. Meanwhile, since recent advances in health sciences were tending to increase life expectancy at the cost of patient dignity, criticisms began to raise.^[9] As a result, studies on patient dignity initiated in 1989 in the U.S. and continued in Scandinavia, Australia, Hong Kong, Canada, and Europe.^[10]

While dignity is apparently a basic need for both healthy and ill human beings, occurrence of diseases can definitely threaten

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human dignity.^[11] Owing to their increased dependence and the need to be taken care of, patients may actually experience loss of dignity during their whole hospitalization period.^[12]

How nurses can affect patient dignity has been evaluated in numerous western studies. Respecting patient dignity has been identified as a major principle in nursing practice^[13] that promotes trust in health care services and enhances patient satisfaction.^[14] It will not only establish desirable patient-staff relationships and a feeling of security, but also lead to shorter hospitalization (by alleviating mental health problems), reduced costs, and staff motivation.^[7] On the other hand, in addition to immediate emotional responses (e.g., anger, hatred, and sadness), violation of patient dignity by nurses can provoke deep, long-lasting feelings of worthlessness, exhaustion, social isolation, and alienation and a desire to commit suicide.^[15]

Many researchers, including Henderson *et al.*,^[3] Baillie and Gallagher,^[5] Jo and Doorenbos,^[9] Pleschberger,^[11] Jackson and Irwin,^[13] and Matiti and Trorey,^[16] have indicated the risk for patients' loss of dignity in health care environments. Various Iranian studies have also examined the application of the patient's bill of rights in hospitals and measured patients' satisfaction and their awareness of their own rights. Although qualitative studies on patient needs have extracted human dignity from the participants' viewpoints,^[17,18] no research has particularly focused on this concept. Nevertheless, such studies are warranted since the meaning of dignity differs among individuals, cultures, and countries.^[12]

Therefore, the present study aimed to evaluate the behaviors of nurses regarding the protection of inpatients' dignity in hospitals of Isfahan (Iran). However, since as an abstract concept, patient dignity has largely been elucidated through three main parameters, that is, relationship, privacy, and independence,^[2,16,19,20] we also considered the same parameters in our assessments.

METHODS

The population of this descriptive-analytical study was all inpatients in public, private, and charity hospitals of Isfahan (Iran). Based on the sample size formula (with 95% confidence interval; $z = 91.1$; and $P = 0.5$), the sample size was calculated as 384 individuals which was extended to 401 participants to allow for loss to follow-up. In order to select the subjects through cluster sampling, a list of all hospitals in Isfahan was first extracted. The hospitals were then categorized (e.g., public, private, and charity), and some of each type were randomly selected. In each hospital, some wards (emergency department, Intensive Care Units, internal medicine, and surgery) were simple random selected. Finally, the participants were randomly selected from the mentioned wards.

The inclusion criteria were age over 18 years, ability to communicate in Farsi, absence of known mental problems,

and a hospital stay of at least 24 h. Data were all collected in one stage.

Ethical considerations were observed throughout the study. Data collection started only after receiving approvals from the Ethics Committee of Isfahan University of Medical Sciences (Number 291216). The patients were explained about the nature and objectives of the study, the anonymity of the questionnaires, and voluntariness of participation. They were also reassured that participation would not, in any form, affect their course of treatment. The researchers provided their contact details so that the subjects could ask about the study results.

Following an intensive review of available literature^[20,21] and consultation with relevant experts, a two-part questionnaire was developed to assess patient dignity protection under sociocultural conditions of the Iranian society. The first part of the questionnaire comprised of two sections, first about demographic characteristics, and the existing hospitalization data such as duration of hospital stay, and history of hospitalization along with hospital name, ward, room type, and number of patients in each room. The second part included 31 questions regarding the components of patient dignity. It consisted of 10 items about the relationship, 14 about privacy, and seven about independence. All items of this part were scored based on a five-point Likert scale. Each item could be responded as not applicable, never, sometimes, often, and always. These corresponded to scores zero-four (0 = poor = 1, moderate = 2, good = 3, and excellent = 4). Items implying poor behavior in respect of patient dignity were scored reversely.

Content and face validity of the questionnaire was confirmed by eight Nursing Faculty Members of Isfahan University of Medical Sciences and Isfahan Azad University. Moreover, a Cronbach's alpha equal to 0.83 suggested the acceptable reliability of the tool.

The questionnaires were filled out after obtaining informed consent from the patients. Data were collected from 8 am to 8 pm every weekday during November, 2012 to March, 2013. Descriptive statistics (frequency, percentage, mean, and standard deviation) and Chi-square tests were then applied to analyze the collected data in SPSS for Windows 17.0 (SPSS Inc., Chicago, IL, USA). $P < 0.05$ were considered significant in all analyses.

Findings

The mean age of the patients was 51.29 (± 18.01) years (range: 18–89 years). Females and married individuals constituted 58.9% and 75.6% of the study sample. Only 11.9% of the participants held an academic degree. About one-third of the subjects (32.9%) were self-employed, and 15.5% were office workers. Most patients (71.3%) were hospitalized for 1–5 days (mean hospital stay: 5.33 days). Moreover, 60.8% of the patients had a history of hospitalization (1–5 times). The majority of the participants (80.8%) were staying in public

rooms. The subjects had the greatest frequency (43.75%) in public hospitals and the lowest (9.25%) in charity hospitals. The maximum (45.4%) and minimum (6.3%) frequency of the patients was seen in the internal medicine wards and emergency departments, respectively.

Almost all patients (91%) reported nurses to have excellent/good relationships with patients. On the other hand, 91.8% of the participants rated privacy protection as good/moderate and only 6.5% rated it as excellent. In addition, 84.4% of the subjects believed their independence was sustained. They actually agreed with taking part in decision-making [Table 1].

The relationships between commitment to respecting patient dignity and demographic characteristics are shown in Table 2. As seen, patient-nurse relationships were significantly correlated with patient's age ($\chi^2 = 13.98$; $df = 6$) and type of hospital ($\chi^2 = 19.3$; $df = 6$). In other words, older patients were more satisfied with the level of respect they received. In addition, patient-nurse relationships were more favorable in private and charity hospitals than in public hospitals. On the other hand, both patients' privacy and independence had significant relationships type of hospital and ward and number of patients in one room. In fact, these components of patient dignity had maximum and minimum scores in private and public hospitals, respectively. Intensive Care Units and internal medicine wards had the highest and lowest scores in privacy protection, respectively. However, patients' independence was not well-maintained in Intensive Care

Units, and internal medicine wards scored the highest in this regard. Finally, the participants believed that increased number of patients in one room decreased their independence and privacy. None of the other evaluated variables had significant relations with respecting patient dignity.

DISCUSSION

Respect to dignity is a human right and a responsibility, that is, nurses are responsible to promote their patients' interests and dignity. Patient-nurse relationships were rated as excellent, good, and moderate by 59.1%, 31.9%, and 9.0% of our participants, respectively. Eshkevari *et al.* reported the relationships between health personnel and patients to be mostly (60%) desirable.^[22] Similarly, Hasanian suggested respectful behavior in 85% of the cases.^[23] Most Indonesian patients (88.4%) were also satisfied or very satisfied with nurses' behaviors.^[24] However, in a study on 122 patients in Pakistan, Khan *et al.* described communication skills of the nurses as poor (below 60%) and identified negligence of nursing managers to be the main reason for such a shortcoming.^[25] Likewise, Sangestani *et al.* found 29.9%, 40.6%, and 29.5% of the patients in emergency departments to be highly, moderately, and poorly satisfied with the behavior of nurses. The researchers emphasized on unfavorable communication skills of Iranian nurses in emergency departments and justified the problem by lack of time, stressful environment, and nurses' inattention to the significance of communication in treatment.^[26] Jackson and Irwin^[13] and Galloway^[27] confirmed the absence of appropriate patient-nurse interactions. They indicated that although desirable communication with patients is essential for respecting their dignity, nurses' inadequate knowledge leads to poor relationships.

In the current study, privacy protection was good and moderate in the opinion of 46.4% and 45.4% of the patients, respectively. Meanwhile, a mere 6.5% of the subjects considered it as

Table 1: Frequency distribution of nurses' commitment to respecting patient dignity

Nurses' commitment to respecting patient dignity	Frequency (%)			
	Poor	Moderate	Good	Excellent
Patient-nurse relationships	0 (0)	36 (9)	128 (31.9)	237 (59.1)
Patient privacy protection	7 (1.7)	182 (45.4)	186 (46.4)	26 (6.5)
Maintaining patients' independence	3 (0.7)	58 (14.5)	212 (52.9)	128 (31.9)

Table 2: Relations between demographic characteristics and nurses' commitment to respecting patient dignity

Characteristic	Patient-nurse relationships		Patient privacy protection		Maintaining patients' independence	
	P	df	P	df	P	df
Patient characteristics						
Age	0.03	6	0.27	9	0.37	9
Gender	0.20	2	0.11	3	0.38	3
Marital status	0.35	6	0.90	9	0.79	9
Education	0.63	10	0.99	15	0.89	15
Occupation	0.41	4	0.12	6	0.23	6
Hospital stay duration	0.66	4	0.88	6	0.20	6
Number of hospitalizations	0.91	6	0.23	9	0.31	9
Hospital's characteristics						
Hospital's name	0.004	6	0.000	9	0.000	9
Ward type	0.053	6	0.001	9	0.001	9
Room type	0.45	4	0.72	6	0.82	6
Number of patients in each room	0.23	4	0.01	6	0.00	6

excellent. Despite the importance of the right to privacy in maintaining patient dignity,^[17] the existing conditions are alarming. In fact, Malekshahi concluded that only 10% of the subjects enjoyed complete privacy protection.^[28] Likewise, a qualitative study by Heidari *et al.* in Hamadan (Iran) showed that while nurses had to deal with various cultural demands of the patients, the inefficiency of the health system prevented them from protecting patient privacy.^[29] Comparable results were also reported by Whitehead and Wheeler.^[30] Baillie reported frequent patient complaints regarding the violation of privacy, e.g., entering the room without permission and not respecting patients' information privacy.^[10] According to Lin and Tsai, privacy protection was commonly ignored during clinical practices. They suggested that underestimating the importance of covering the patients' bodies could seriously damage their privacy and thus threaten their dignity.^[2]

Most patients (52.9%) in the present study ranked respect to their independence as good. While others ranked it mainly as excellent (31.9%) and moderate (14.5%), only 0.7% reported poor independence. Previous studies have also indicated that patients' independence is generally maintained in hospitals. Farsinejad *et al.* reported 59% of their patients to have the freedom to make decisions.^[31] In a study on cancer patients, 43% of the subjects believed they had the right to reject treatment. Moreover, the patients typically approved of their own participation in decision-making.^[32] Conversely, Baba Mahmoodi *et al.* found only 14.15% of the patients in Mazandaran Province (Iran) to benefit from the right to make decisions about medical treatments. Nevertheless, since the majority of their 200 participants were rural residents with education levels lower than a high school diploma, they might have had difficulty understanding the medical explanations. They could thus feel they were not taking part in decision-making.^[33] Parsapoor *et al.* compared educational, private, and public health centers. They concluded that the level of patients' participation in making a medical decision was substantially lower in educational settings than in public and private health centers. Of course, the nature of an educational therapeutic center can partly justify this finding.^[34]

According to our participants, increasing age was associated with better patient-nurse relations and hence higher level of respect for patient dignity. Farsinejad *et al.*,^[31] Arefi and Talaei,^[35] Gahramanian *et al.*,^[36] and Arab *et al.*^[37] reported comparable findings and explained them by greater demands of younger patients as a result of their awareness of their own rights.

In the current study, none of the components of dignity were significantly related with the patients' education level or occupation. Likewise, in a study on 404 Palestinian refugees, Khatib and Armenian could not establish significant relationships between dignity and either education or occupation.^[38] However, Arab *et al.*^[37] and Javadi *et al.*^[39] found significant relations between patients' education level and their expectations and demands, that is, less educated

individuals had lower knowledge about care provision and thus placed fewer demands on the health personnel.

Similarly, Arefi and Talaei highlighted an inverse relationship between the patients' satisfaction and education levels. They suggested that individuals with higher social status had greater demands and were hence less satisfied.^[35] Although our findings showed a reduction in satisfaction as patients education levels increased, the observed difference was not significant. Therefore, better clarification of this relationship requires further research.

We detected a significant relation between the type of hospital and respecting patient dignity. In other words, patient dignity was more respected in private and charity hospitals. Similarly, Farsinejad *et al.* found private and public hospitals of Tehran (Iran) to have significant differences in terms of appropriate care provision and patient privacy and confidentiality protection. They introduced the presence of various groups of students to be responsible for these differences.^[31] As stated by Baba Mahmoodi *et al.*, many services in educational hospitals are provided by medical and paramedical students who may have insufficient knowledge about and inappropriate attitudes toward patient rights. Under such circumstances, the patients may feel their rights are abused.^[33] Nurses, on the other hand, have commonly justified their inappropriate behaviors toward patients by the existing problems in public hospitals. In fact, high number of patients and lack of coordination among the nursing, security, and service staff can negatively (although sometimes indirectly) affect patient satisfaction.^[40]

Our findings revealed a significant relation between the type of ward and patients' privacy protection and independence. The highest and lowest scores of privacy protection belonged to Intensive Care Units and internal medicine wards, respectively. In contrast, Intensive Care Units, where patients are severely ill, scored considerably lower than other wards when maintaining patients' independence was involved. The subjects in internal medicine wards were the most satisfied with their level of independence. Consistent with our findings, Kalroozi *et al.* reported higher respect for patient dignity in Intensive Care Units. They explained that while all patients require careful scientific care, their needs may not be completely fulfilled in any wards except subspecialty wards.^[41] A similar relationship between the type of ward and patient right protection was also discovered by Biranvand *et al.* who reported emergency, internal medicine, and surgery wards to have the lowest scores in this regard.^[42]

In the present study, although room type and components of patient dignity were not significantly related, number of patients in each room had inverse relationships with patient privacy and independence. As asserted by Whitehead and Wheeler^[30] and Bagheri *et al.*,^[43] constant presence of other patients in shared rooms cause various problems (e.g., not being able to have a private phone call and issues such as exposing body parts during diagnosis and treatment) can negatively affect patient dignity. On the contrary, Baillie believed that

having a roommate helps patients communicate with and be supported by other individuals with similar conditions. They will, therefore, feel better during the course of treatment. However, depending on their personal characteristics, some patients may prefer to stay in private rooms.^[10] Obviously, more research in this field is warranted.

The present study had a number of limitations. First, completing and collecting the questionnaires was time-consuming. Moreover, due to the special conditions of the patients, it was often necessary for the researchers to help them fill out the questionnaires.

CONCLUSION

Our findings indicated that nurses mostly respected patient dignity. However, relatively poor performance was detected in some aspects. For instance, 9% of the participants scored patient-nurse relationships as moderate. Moreover, 91.8% of the patients believed that their privacy was moderately/well protected. Independence was scored as moderate by 14.5% of the patients and as poor by 0.7%. Therefore, measures have to be taken to promote patient dignity in health centers. Specific systematic courses and workshops are also essential to familiarize nursing students with the subject of patient dignity. In addition, the presence of eager authorities who facilitate, monitor, and follow the implementation of patient dignity-related regulations would be invaluable. Finally, it is crucial to consider patient dignity while designing and equipping health centers.

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Conflicts of interest

There are no conflicts of interest.

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