A CASE STUDY OF PATIENT DIGNITY IN AN ACUTE HOSPITAL SETTING

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Table of contents

Abstract........................................................................................................................................................................ 6

Acknowledgements.......................................................................................................................................................... 7

Chapter 1 'I've lost all my dignity now - there's none left': The importance of dignity for patients and expectations of health care professionals......................................................................................... 8
  1.1 Introduction.......................................................................................................................................................... 8
  1.2 The trigger and starting point for the study........................................................................................................ 8
  1.3 The importance of dignity to patients............................................................................................................... 11
  1.4 Expectations of healthcare staff to respect patients' dignity............................................................................. 13
  1.5 The aims and structure of the thesis.................................................................................................................. 20
  1.6 Chapter summary.............................................................................................................................................. 22

Chapter 2 The meaning of patient dignity explored.................................................................................................. 23
  2.1 Introduction......................................................................................................................................................... 23
  2.2 Difficulties with defining dignity: theories and meanings................................................................................... 23
  2.3 Concept analyses of dignity............................................................................................................................. 29
  2.4 Primary research exploring the meaning of dignity........................................................................................... 36
  2.5 The nature of dignity: emerging themes.......................................................................................................... 45
  2.6 Chapter summary.............................................................................................................................................. 49

Chapter 3 Threats to patient dignity and the promotion of patient dignity in hospital.............................................. 50
  3.1 Introduction......................................................................................................................................................... 50
  3.2 Primary research studies exploring threats to patient dignity and how patient dignity can be promoted..................................................................................................................................................... 50
  3.3 How the hospital environment impacts on patient dignity............................................................................. 59
  3.4 How staff behaviour impacts on patient dignity.............................................................................................. 66
  3.5 How patient factors impact on patient dignity............................................................................................... 75
  3.6 Theoretical framework and research questions................................................................................................ 80
  3.7 Chapter summary.............................................................................................................................................. 83

Chapter 4 Methodology and data analysis.................................................................................................................... 85
  4.1 Introduction......................................................................................................................................................... 85
  4.2 Epistemology....................................................................................................................................................... 85
  4.3 Case study design.............................................................................................................................................. 86
  4.4 Selection of the case study hospital and ward and gaining access................................................................... 91
  4.5 Ethical issues....................................................................................................................................................... 92
  4.5.1 Ensuring consent........................................................................................................................................... 93
  4.5.2 Confidentiality.............................................................................................................................................. 97
  4.5.3 Balancing risks and potential benefits......................................................................................................... 97
  4.6 Preparation of Heron Ward and recruitment of staff participants................................................................... 98
  4.7 Preparation for the research............................................................................................................................. 99
  4.8 Post discharge interviews............................................................................................................................... 100
  4.9 Participant observation.................................................................................................................................... 104
  4.10 Interviews with senior nurses......................................................................................................................... 112
  4.11 Examination of Trust documents.................................................................................................................... 112
  4.12 Data analysis process.................................................................................................................................... 113
Tables

Table 1.1 Department of Health documents which emphasise that patients' dignity should be respected

Table 4.1 Overview of data collection methods and participants

Table 4.2 Profile of patients interviewed following discharge from Heron ward

Table 4.3 Profile of patients observed and interviewed on Heron ward

Table 4.4 Overview of themes and categories

Table 4.5 Summary of strategies to promote rigour, based on Lincoln and Guba's (1985) criteria

Table 5.1 Themes 1 and 2: 'The meaning of patient dignity in hospital' and 'Threats to patients' dignity in hospital'

Table 5.2: Behaviour associated with dignity

Table 6.1 Theme 3 'Promotion of patients' dignity in hospital'

Figures

Figure 3.1 Patient dignity in hospital: a theoretical framework

Figure 4.1 Layout of Heron Ward

Figure 7.1 Patients' conceptualisation of dignity in an acute hospital setting

Figure 7.2 How patients' dignity is promoted or threatened in hospital
Abstract

UK healthcare policies emphasise that patients' dignity should be respected. However, studies indicate that hospital patients are vulnerable to a loss of dignity. There is a dearth of research relating to patient dignity generally and little research has been undertaken in acute hospital settings specifically.

A qualitative case study examined the meaning of patient dignity and how patient, staff and environmental factors affect patients' dignity. The study's setting was a surgical ward, specialising in urology, and ethical approval was obtained. Data were collected from post discharge interviews with patients (n=12); four-hour periods of participant observation (n=12) with follow-up interviews with patients (n=12) and staff (n=13); observation of staff handovers (n=12); interviews with senior nurses (n=6); and examination of Trust documents. Data were analysed using Ritchie and Spencer's (1994) framework approach.

A model of patient dignity was presented to portray the definition which developed from the findings:

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

Lack of privacy in hospital threatened dignity, heightened by bodily exposure and a mixed sex environment. A conducive physical environment, a dignity-promoting culture and leadership, and other patients’ support promoted patient dignity. Staff being curt, authoritarian and breaching privacy threatened dignity. Staff promoted dignity by providing privacy and interactions which made patients feel comfortable, in control and valued. Patients' impaired health threatened dignity due to loss of function, intimate procedures and psychological impact. Patients promoted their own dignity through their attitudes and developing relationships with staff. A second model was constructed to portray how patients’ dignity is threatened or promoted by staff behaviour, the hospital environment and patient factors.

The results emphasise that staff behaviour and the hospital environment have an important impact on whether patient dignity is threatened or promoted. However, patient factors can also promote dignity.
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Chapter 1  *I've lost all my dignity now - there's none left*: The importance of dignity for patients and expectations of health care professionals

1.1 Introduction

This thesis focuses on patient's dignity in an acute hospital setting and will explain the nature of patient dignity, what threatens patients' dignity and how patients' dignity can be promoted. This first chapter starts with a personal experience, which provided the trigger for the study as it highlighted an acutely ill patient's perception of her dignity being lost and raised questions about the meaning of dignity, particularly in an acute healthcare setting. The importance of dignity to patients is then explored followed by an examination of healthcare policy, legislation and professional guidance which establish that patients' dignity should be respected. The chapter concludes with the aims of the thesis and an outline of the chapters.

Nursing is the specific focus throughout the thesis because, in acute hospital settings, nurses have a constant presence in the patients' care environment, while other healthcare professionals (HCPs) visit patients on wards with varying frequency and for limited periods of time. Nurses therefore have more control over the immediate care environment with potentially greater impact on patients' experiences of care, including their dignity. As health care assistants (HCAs) work within the nursing team, they are also of key interest in the thesis.

1.2 The trigger and starting point for the study

Box 1.1 presents a personal experience which provided the starting point and trigger for the thesis.

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1 As the focus of this thesis is acute hospital care, the term 'patient' is used throughout to refer to people undergoing healthcare.
## Box 1.1 A personal experience

In March 2001 my mother was admitted to hospital with an infected knee joint and septicaemia. Her condition rapidly deteriorated and she quickly developed pneumonia, eventually going into respiratory failure followed by multi-organ failure. While on the orthopaedic ward, a week after her admission, she looked at me one evening with an expression of profound hopelessness and despair and said as a statement of fact: ‘I’ve lost all my dignity now - there’s none left’. My mother’s condition at that time was very poor. She was extremely breathless, nauseous, could hardly eat or drink, and had pain and discomfort in her leg, despite analgesics. She had continuous oxygen therapy, an intravenous infusion, and a urinary catheter. I felt slightly irritated: how typical of her that she should be worrying about her ‘dignity’ when she could barely breathe! I said: ‘Why do you say that? Is it anything the nurses are doing that makes you feel like that?’ My mother was nursed in a side room (due to her infection), she was always well presented with a clean nightdress, and staff appeared to treat her kindly and with respect. My mother said, adamantly, though in a whisper: ‘No, no, never. They're always gentle. They never hassle me’. I guessed that she felt that she had lost her dignity because she was now so helpless, having to be helped with everything. I knew she hated that. She liked to look after other people and had only ever accepted help from anyone with a very bad grace. She herself was a nurse and I reasoned with her saying: ‘Look, for all those years you cared for people - now it’s your turn. Nearly everyone needs help at some point in their lives. You have to accept it. I’m sure you’ll be independent again soon. This is a temporary thing’. The next day she was transferred to the intensive therapy unit to be artificially ventilated, where she died three days later. I never had the chance to explore with her why she felt she had lost her dignity and whether there was anything at all that could have restored her dignity.

Reflecting on this experience, I realised that I often talked about dignity in relation to nursing but what did it really mean? It was obviously not just about privacy and ‘good’ care as my mother was in a sideroom and she was physically well cared for. I started to question further: what is dignity? Does it mean different things to different people? Are there different dimensions - maybe physical, emotional, spiritual? Is dignity inextricably linked with independence? If so, loss of dignity could be a central issue in acute hospital settings where people often need help with activities in which they are usually
independent. Exploring dictionary definitions of dignity did not give me the insights I sought (see Box 1.2) and I was not convinced that they portrayed what patients and healthcare staff actually mean when they talk about dignity.

Box 1.2 Dictionary definitions of dignity

1. a formal, stately, or grave bearing: he entered with dignity. 2. the state or quality of being worthy of honour: the dignity of manual labour. 3. relative importance; rank: he is next in dignity to the mayor. 4. sense of self-importance (often in the phrases stand (or be) on one's dignity, beneath one's dignity). 5. high rank, esp. in government or the church. 6. a person of high rank or such persons collectively. [from old French dignite, from Latin dignitãs merit, from dignus worthy]’ Collins English Dictionary (1994), p. 441

'dignity n the state of being dignified; elevation of mind or character; grandeur of bearing or appearance; elevation in rank, place etc.; degree of excellence; preferment; high office; a dignitary. - n dignitary someone in a high position or rank, esp in the church. Beneath one's dignity degrading, at least in one's own estimation; stand on one's dignity to assume a manner that asserts a claim to be treated with respect. The Chambers Dictionary (1993), p.470

'1 composed and serious manner or style. 2 the state of being worthy of honour or respect. 3 worthiness, excellence (the dignity of work). 4 high or honourable rank or position. 5 high regard or estimation'. The Concise Oxford Dictionary (1990) p.326

The Collins English Dictionary (1994) identifies the origins of the word 'dignity' from the Latin dignitãs meaning merit, and dignus meaning worthy. The dictionary definitions inferred that dignity was how one was regarded by others and that dignity was earned. These interpretations are difficult to relate to the dignity of an acutely ill hospital patient in a meaningful way. My mother was distressed (rather than 'composed') but surely in the circumstances, that was almost inevitable. Perhaps being so very ill and helpless, she felt she was no longer 'worthy of honour or respect'. But where does that leave nurses in relation to respecting patients' dignity? I wondered if there was any way in which staff caring for her could have helped her to feel she was 'worthy of respect' or engender a 'sense of self-importance' in her despite her condition. Yet she did not consider the nurses
were at fault and as a relative I could not identify any of their actions (or omissions) that were to blame. Thus the reality of promoting patients' dignity seemed more complex than I had previously considered. My reflections led me to feel that in reality I knew little about dignity: the real meaning of dignity, why patients might feel that their dignity was lost and what could prevent this from happening in an acute hospital setting. However, I felt certain that dignity was important for patients.

1.3 The importance of dignity to patients

Tadd et al. (2002) assert that dignity is central to interactions between HCPs and patients but that staff often fail to appreciate the impact of patients and/or relatives experiencing or witnessing undignified care. A number of studies in varying contexts have identified the importance of dignity for patients. In a project entitled 'Dignity and older Europeans' (reviewed in 2.4), older adults (Tadd, 2004a), middle-aged and younger adults (Tadd, 2004b) and health and social care professionals (Tadd, 2004c) across Europe agreed that people of all ages have a universal need for dignity. Patients in varied hospital settings have identified that dignity was important to them (Jacelon, 2003; Lai and Levy, 2002; Matiti, 2002). Many studies highlighting the importance of dignity have been conducted with terminally patients, their families and staff. Chochinov et al.'s (2002a) study of dignity with terminally ill patients (reviewed in 2.4) includes many quotations indicating that patients viewed loss of dignity very negatively. In a further study, Chochinov et al.'s results (2002b) indicated a link between loss of dignity and various negative effects, such as psychological and symptom distress, heightened dependency needs and loss of will to live. A number of research studies identified dignity as one of the most important issues in terminal care from patients', relatives' and/or staff perspectives (Aspinal et al., 2006; Keegan et al.; 2001; Miettinen et al., 2001; Payne et al., 1996; Touhy et al., 2005; Vohra et al., 2004; Volker et al., 2004). Critical care nurses in two studies expressed that facilitating dying with dignity is important in end-of-life-care (Beckstrand et al., 2006; Kirchhoff et al., 2000).

From a broader healthcare perspective, and indicating that dignity is not just important to in terminal care, Joffe et al. (2003) surveyed 27,414 patients following their discharge from acute care in the United States of America (USA) to identify how involvement in decisions, confidence and trust in care providers, and treatment with respect and dignity, influenced
patients’ evaluations of their hospital care. Approximately 85 per cent of patients reported
that they were always treated with respect and dignity. However, patients who have been
discharged may view their hospital admission more favourably than when they were
actually in hospital. Nevertheless, perceptions of respectful, dignified treatment correlated
most closely with high satisfaction with the hospital indicating that patients who perceive
that they are treated with dignity are happier with their overall hospital experience.

In three other studies, participants were not specifically asked about dignity but the
importance of being treated with dignity emerged from the data. These studies all used
qualitative approaches to data collection, using in-depth interviews with small samples.
Holland et al. (1997) interviewed a convenience sample of twenty-one patients about their
recollections of their stay in the intensive therapy unit (ITU). Participants stated that it was
easier to cope with the stress of ITU if nurses treated them with respect and dignity. In a
further ITU based study, Engstrom and Söderberg (2004) studied the experiences of
seven ITU patients’ partners who all stressed that it was important that staff showed
respect for the patient's dignity. Clegg (2003) used grounded theory to explore perceptions
of culturally sensitive care with older south Asian patients who were being cared for in two
community hospitals. She conducted four informal interviews in the patients’ first language
with relatives present in two cases. ‘Demonstrating respect’ emerged as a core category,
with ‘Retaining dignity’ being a subcategory. This was a very small study but few studies
have considered the care experiences of people who cannot speak English. The results
indicated that promoting dignity was necessary for cultural sensitivity and involved
preserving humanity and self-respect in the hospital setting.

Regarding nurses’ experiences of promoting patients’ dignity, Perry (2005) conducted an
internet based study, accessing a self-selected, international sample of nurses
(n=approximately 200) who were asked to share a story related to career satisfaction.
Nurses who were satisfied with their careers believed that they provided quality care;
defending patients’ dignity was one of the four core values which emerged. In Yonge and
Molzahn's (2002) Canadian study, eighteen purposefully selected registered nurses (RNs)
from varied settings gave examples of going to great lengths to preserve patients’ dignity
in situations in which they were vulnerable, demonstrating the importance these nurses
placed on dignity. Johnstone et al. (2004) surveyed Australian nurses (n=398), regarding
ethical concerns encountered in practice. Protecting patients' rights and human dignity was
a frequently cited ethical concern which could indicate high staff awareness of dignity as
an ethical issue. However, the results could also highlight the vulnerability of patients to a loss of dignity. A key limitation of this study was its low response rate (17%). Fagermoen (1997) surveyed Norwegian nurses (n=731) with varying experience about their underlying values and found that human dignity was the core value, with all other values either arising from it or being aimed at preserving it.

The studies reviewed in this section indicate the importance of patient dignity from a variety of perspectives and healthcare settings, though research with older people, terminal care and critical care dominates. The next section draws on health policy documents, legislation and professional guidance for nurses to examine the expectations of HCPs, particularly nurses, in relation to patient dignity in hospital.

1.4 Expectations of healthcare staff to respect patients' dignity

Increasingly, Department of Health (DH) documents stress that patients' dignity should be respected while acknowledging that this is not always the case. Recent documents are listed chronologically in Table 1.1 and are next discussed.

In ‘The Patient’s Charter and You’ (DH, 1995) (see Table 1.1), 'rights' are defined as aspects of care which ‘patients will receive all the time’ while ‘expectations’ are standards to be aimed for but which may be prevented in 'exceptional circumstances' (p.4). Expectations for dignity to be respected (along with privacy, religion and culture) were identified as an expectation rather than a right. While the document provides support for patients’ dignity to be respected, Montgomery (1996) argued that the Patients’ Charter was unenforceable and later DH documents indicate that expectations of dignity being respected were not fulfilled. Nevertheless it is a health policy document asserting that patients can expect the NHS to respect their dignity which predated the Labour government from which the next documents originated.
Table 1.1 Department of Health documents which emphasise that patients' dignity should be respected

<table>
<thead>
<tr>
<th>Year</th>
<th>Document</th>
<th>Content relating to dignity</th>
</tr>
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| 1995 | The Patient’s Charter | Personal consideration and respect  
‘You can expect the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places. For example, meals should suit your dietary and religious needs. Staff should ask you whether you want to be called by your first or last name and respect your preference’. (DH, 1995, p.6) |
| 2000 | The NHS Plan | ‘They [older people] are also distressed when service providers fail to respect their privacy and dignity – a problem which can occur at home or in a nursing home, as well as on a hospital ward’. (DH, 2000a, p.123) |
| 2001 | The Essence of Care | Includes ‘Privacy and Dignity’ as one of the fundamental aspects of care.  
Dignity defined as ‘Being worthy of respect’.  
Agreed patient-focused outcome: ‘Patients benefit from care that is focused upon respect for the individual’  
7 factors with benchmarks of best practice:  
Attitudes and behaviours;  
Personal world and identity;  
Personal boundaries and space;  
Communicating with staff and patients;  
Privacy of patient - confidentiality of patient information;  
Privacy, dignity and modesty;  
Availability of an area for complete privacy. (DH, 2001a) |
| 2001 | The National Service Framework (NSF) for Older People | ‘The need for an NSF for older people was triggered by concerns about widespread infringement of dignity and unfair discrimination in older people’s access to care’. (Alan Milburn, p.12)  
‘Respecting the individual’ is one of the four themes. Standard two ‘Person centred care’ specifically states that the NHS and local councils have a duty to provide services that respect dignity, individuality and privacy. (DH, 2001b) |
| 2004 | Standards for Better Health | **Domain: Patient Focus**  
C13 Health care organisations have systems in place to ensure that:  
a) staff treat patients, their relatives and carers with dignity and respect (p.14)  
**Domain: Care Environment and Amenities**  
C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being  
b) supportive of patient privacy and confidentiality. |
2006  A new ambition for old age: next steps in implementing the National Service Framework for Older People.

Liam Byrne, the Minister for Care Services, states that in the current care system (including home, hospital and care homes), the aim that older people should be 'treated with respect for their dignity and human rights' is not applied everywhere. Professor Ian Philp states that within five years, older people and their relatives can be confident that: 'Older people will be treated with respect for their dignity and their human rights'. The document details three themes, the first being 'Dignity in care'.

(DH, 2006a)

2006  'Dignity in Care' campaign

Invited providers and commissioners of services and members of the public to volunteer as 'Dignity in Care Champions' to 'take forward a dignity in care social movement' and raise the profile of dignity in care, challenge bad practice, and share experiences and expertise. Focus is on dignity for older people; targets all health and social care services that are in contact with older people.

The 'Dignity Challenge' is a ten-point plan: High quality services that respect people's dignity should:

1. Show zero tolerance towards all forms of abuse.
2. Treat people with the same respect as you would want for yourself and your family.
3. Treat each person as an individual.
4. Ensure people are able to maintain maximum levels of independence, choice and control.
5. Support people in expressing their needs.
6. Respect people's rights to privacy.
7. Ensure people can complain without fear of retribution.
8. Work with patients' families and their partners in their care.
9. Help people to maintain confidence and self-esteem.
10. Alleviate people's loneliness and isolation.

(DH, 2006c)

The NHS Plan (DH, 2000a) included a section entitled 'Dignity, security and independence in old age', exemplifying how the DH gives older people's dignity particular attention. The DH (2000a) acknowledged the existence of a lack of respect for the privacy and dignity of older people (see Table 1.1) but there is no elaboration about what the shortcomings are. In both the Patients' Charter (DH, 1995) and the NHS Plan (DH, 2000a), privacy and dignity are grouped together, implying that they are inextricably linked. The document later
promised that dignity (along with privacy and autonomy) will be respected, under the heading ‘Assuring standards’ but there is no detail about how this will be achieved. Promoting independence is considered in a separate section and includes intermediate care services and support to remain at home. Thus independence is considered separately from dignity, although in later DH documents, these two concepts are linked.

The next two documents in Table 1.1 were published following a high profile media campaign led by The Observer newspaper concerning poor standards of care for older people in hospital. The campaign (entitled 'Dignity on the Ward') initiated a DH funded enquiry (Health Advisory Service (HAS) 2000, 1998) and subsequently, the publication of the Essence of Care (DH, 2001a), later re-published by the NHS Modernisation Agency, (2003), and the NSF for Older People (DH, 2001b). Thus media pressure may have forced the DH into advocating that quality care (including dignity), particularly for older people, is fundamental in healthcare. Following the publication of Essence of Care (DH, 2001a), many hospitals appointed nurses as ‘Essence of Care’ facilitators, to work towards the benchmarks of best practice with nurses and other disciplines. The document is patient/client centred and the benchmarks are relevant to all staff. Examining the section on ‘Privacy and Dignity’, the section's best practice statements are not supported by an evidence base. The publication of the Essence of Care (DH, 2001a) provides further evidence that the DH view patient dignity as fundamental and again implies that privacy and dignity are inseparable. In the NSF for Older People (DH, 2001b), Alan Milburn (then Secretary of State for Health) acknowledged concerns about older people’s dignity in an even stronger statement than that cited in the NHS Plan (see Table 1.1). The contrast between this statement and the assurances made in the Patients' Charter (DH, 1995) six years earlier is stark. The combination of dignity with other concepts (individuality and privacy) is evident and is discussed further in Chapter 2 (2.2). Overall, the NSF emphasised that older people’s dignity should be respected but the term ‘dignity’ is loosely used and related to a wide range of care.

In 2004, the Department of Health published ‘Standards for Better Health’ which was implemented in 2005. The document sets out a level of quality for all organisations providing NHS care in England. There are seven domains with core standards, which must be complied with, and developmental standards, which must be worked towards. As shown in Table 1.1, there are two domains (Patient Focus, and Care Environment and Amenities) which include core standards specifying that staff must treat patients and
relatives with dignity and respect and that the care environment must support privacy and confidentiality. Thus there is unequivocal support from the DH that privacy and dignity are not optional and the expectation of staff is clearly stated.

More recently, the DH (2006a) published 'A new ambition for old age: next steps in implementing the National Service Framework for Older People'. The document acknowledged again that older people’s dignity is not always respected but promised that this will be rectified within five years (see Table 1.1). The document includes the theme 'Dignity in care' which refers to wide-ranging activities including attention to nutrition and the physical environment. The document's proposal for the appointment of named practice-based nursing leaders, accountable for ensuring older people's dignity, was the main aspect reported in the media, indicating that older people's dignity is still a high profile media issue. While leadership is important in promoting dignity in healthcare, such initiatives should not detract from the responsibility of all staff to promote patients’ dignity and due to similar comments from healthcare staff, this idea was later withdrawn.

In November 2006, following an on-line 'Dignity in Care' survey (DH, 2006b), the DH launched a 'Dignity in Care' campaign (DH, 2006c) (see Table 1.1). The 'Dignity in Care' survey, which received over 400 responses from professionals and public about experiences of dignity in care, identified a number of issues including uncertainty about what dignity is, what minimum standards should be and key areas of concern. The 'Dignity in Care' campaign focuses on dignity for older people predominantly and relates to health and social care broadly. The ten points in the 'Dignity Challenge' (see Table 1.1) can be applied to any sector and they include privacy and treating people with respect and as individuals, which were areas of concern in the on-line survey. The campaign is described as 'the first ever dignity in care campaign' which 'aims to stimulate a national debate about dignity' (DH, 2006c). Clearly, dignity in care remains an important issue within healthcare from a DH perspective.

Having reviewed health policy, legislation is next considered in relation to patient dignity. The background to modern day human rights legislation is that in 1948 the United Nations (established in 1945 at the end of the Second World War) published the Universal Declaration of Human Rights (UDHR), which recognized the ‘inherent dignity’ of human beings and included the statement:

'all human beings are born free and equal in dignity and rights'. (Article 1)
Although the UDHR is not legally binding, many countries have incorporated the UDHR provisions into their laws and constitutions. The European Convention on Human Rights was signed in 1950 but was only recently incorporated into UK law when the Human Rights Act (HRA) (1998) was passed. The HRA recognises that all individuals have minimal and fundamental human rights and two of the articles relate to aspects of dignity. Article 3 'Prohibition of torture' states that:

‘No one should be subjected to torture or to inhuman or degrading treatment or punishment’. (Great Britain, 1998)

Given the nature of healthcare investigations and treatment, some patients might view their experience as inhuman or degrading, which could be further affected by the care environment. Article 8 ‘Right to respect for private and family life’ states that:

‘Everyone has the right to respect for his private and family life, his home and his correspondence’. (Great Britain, 1998)

Threats to confidentiality and mixed sex wards are examples where patients may feel their privacy, and thus their dignity, is threatened (see 3.3). When people are unwell they could be particularly vulnerable to a loss of dignity (see 3.5) and as discussed earlier, the emphasis on dignity in DH documents implies that older people are particularly vulnerable to their dignity being threatened. Woogara (2001) identifies that under the HRA, patients can seek redress in law should their dignity not be respected and thus HCPs have a legal obligation to respect patients' dignity.

Health policy and legislation are key frameworks for healthcare practice but professional regulations and guidance are also important in nursing and are next reviewed. Examination of relevant documents confirmed that respect for patients' dignity is considered essential for professional nursing practice, both nationally and internationally. A position statement from the International Council of Nurses (ICN) (2001a) endorsed the UDHR and asserted that all individuals undergoing healthcare have the 'right to dignity, including the right to die with dignity' (p.272). The ICN's Code of Ethics for Nurses includes:

‘Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect’. (ICN, 2001b, p. 375)

From a professional regulatory viewpoint, UK nurses have an unarguable duty to respect patients' dignity and could be held to account for their actions should they not do so, as the Nursing and Midwifery Council's (NMC) Code of Professional Conduct states:

‘You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs’. (NMC, 2004, clause 2.2)
The NMC's (2004) guidance implies an active approach from nurses is expected, using the terms 'protect' and 'promote' in relation to the dignity of patients, rather than the more passive 'respect' for dignity. In 2003, the Royal College of Nursing (RCN), the main professional body representing United Kingdom (UK) nurses, released a document attempting to define nursing. A wide range of sources was used, drawing on both published literature and the views of nurses in practice today. The definition presented is followed by six defining characteristics, the fifth of which states that nursing has:

'a particular value base: nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings'. (RCN, 2003, p3)

The RCN (2003) further states that these values are included in codes of ethics and are professionally regulated. Thus, the RCN also endorses the view that respecting patients' dignity is integral to nursing.

Professional guidance for nurses can also be sought from nursing theorists' work who articulated the nature of nursing and the role of nurses. An analysis of nursing theories found wide variation with some making explicit reference to nurses promoting dignity (e.g. Jacobs, 2001; Watson, 1988), others implicit reference (e.g. Orem, 1995), while others did not refer to patient dignity at all (e.g. King, 1981; Neuman, 1995). From a historical viewpoint, Florence Nightingale and Virginia Henderson deserve particular attention. Florence Nightingale, usually considered to be the first nursing theorist, wrote about what nurses do in 'Notes on Nursing', first published in 1859 (Nightingale, 1952). There is no specific reference to patient dignity but some relevant issues are addressed, for example, Nightingale advises that nurses should give patients time and consideration and not appear rushed. These suggestions could be considered to respect dignity; similar suggestions are reviewed in Chapter 3 (see 3.4). Virginia Henderson's (1960) definition of nursing is widely quoted and was adopted by the ICN in 1960 but her description of 'the unique function of the nurse' does not refer to promoting dignity. However, in her more recent work (Henderson, 1991), dignity is mentioned on several pages but always in relation to caring for people who are dying.

Nursing theorists who take a humanistic approach (one which emphasises patients as humans) propose that respect for human dignity is central in nursing (Gaut, 1983; Halldirsdottir, 1991; Nåden and Eriksson, 2004; Roach, 1992, 2002; Sherwood and Starck, 1991; Watson, 1988). Watson (1988) wrote extensively about caring relationships between nurses and patients in which she believed human dignity is paramount. She asserted that
preserving human dignity (linked with humanity) is integral to the caring style of nursing. However, she does not explain her understanding of what dignity actually is, nor how it can be promoted. She recognised that health problems may threaten dignity (thereby leading to ‘indignity’) but she does not clarify how this might be addressed. Roach’s (1992, 2002) work on caring closely reflects Watson’s perspective that humanity and dignity are inextricably linked. Her work has a strong ethical and Christian theme and she expresses that all humans are bestowed with dignity as they are ‘created in God’s image’.

Among the nursing theorists, Jacobs (2000, 2001) gave the strongest support for the nurse's role in promoting patients' dignity. Jacobs' work is much more recent, perhaps indicating that the term 'dignity' has only recently been applied to patient care and nursing; as noted previously, Florence Nightingale's (1859) work and Henderson's (1960) text do not refer to dignity at all. Jacobs (2001) suggested that respecting human dignity is not simply a role of nurses but is central to nursing and more important even than health: ‘The central phenomenon of nursing is not health or some sort of restoration of holistic balance and harmony but respect for human dignity’. (Jacobs, 2001, p.25) Jacobs (2001) argued that nursing is about preventing threats to dignity and restoring dignity if it has been lost and that nurses should ask themselves whether they are respecting the dignity of each person during every action.

In summary, the DH documents reviewed emphasised that patients' dignity should be respected by HCPs across all sectors but they acknowledge that this has not always occurred in reality. There has been particular concern about older people being vulnerable to a loss of dignity and minimal recognition in the DH's recent documents that adults of other ages might also be concerned about their dignity in hospital. Legislation and professional nursing guidance provide strong support for the importance of patient dignity and an expectation that nurses will respect and promote dignity.

1.5 The aims and structure of the thesis

This chapter has established the importance of dignity to patients, and nurses' professional responsibilities to respect patients' dignity. It is not clear however what is really meant by the term dignity; the dictionary definitions were not helpful and the DH documents indicated varying interpretations and associated concepts. For nurses in acute care settings to be able to protect and promote patients' dignity (NMC, 2004), they need to
understand how patients perceive their dignity, what threatens patients' dignity and what nurses and the care environment can do to promote patients' dignity. Therefore, the broad aims of this thesis, all related specifically to patients in an acute hospital setting, are to:

1. Explore the meaning of patient dignity;
2. Examine how patients' dignity is threatened;
3. Investigate how patients' dignity can be promoted.

The thesis will address the aims in the following way:

- Chapter 2 explores the meaning of patient dignity, by reviewing scholarly and philosophical viewpoints, concept analyses and primary research. These indicate that interpretations and meanings of dignity are diverse and little explored from patients’ perspectives, particularly in acute hospital settings. Four themes about the meaning of dignity for patients are then presented, which emerged from the review.
- Chapter 3 reviews primary research concerning how patients’ dignity is threatened in hospital and how dignity can be promoted; again there was found to be a dearth of research conducted in acute hospital settings. The chapter then presents a theoretical framework derived from the literature review in Chapters 2 and 3 and identifies specific research questions.
- Chapter 4 explains the research design, data collection and data analysis methods and includes the ethical considerations and the steps to enhance rigour.
- Chapter 5 presents the research findings about the meaning of patient dignity in an acute hospital setting and how patients' dignity is threatened in hospital; these findings are discussed in relation to previous research and areas of new knowledge are highlighted.
- Chapter 6 presents the findings explaining how patients' dignity is promoted in hospital and again the results are discussed in relation to previous research and areas of new knowledge are highlighted.
- Chapter 7 presents the conclusions about the meaning of patient dignity in an acute hospital setting, and how the hospital environment, staff behaviour and patient factors threaten or promote patients' dignity. Patients' conceptualisations of dignity are portrayed in a model and a definition of patient dignity is provided. A model representing how patient dignity is threatened or promoted in hospital is presented. The implications for management, clinical practice and education are
considered in the light of the research findings. The strengths and limitations of the study and areas for future research are also included.

1.6 Chapter summary

This chapter started with a personal experience which illustrated that patient dignity is a complex issue and promoting patients' dignity is not necessarily straightforward. It has been established that there is an expectation that patients' dignity will be respected but that there is concern in the UK about threats to patients' dignity, particularly for older people. For nurses, there is clearly a professional duty to respect patients' dignity and the importance of dignity to patients has also been indicated. In the next chapter, the meaning of patient dignity is explored.
Chapter 2 The meaning of patient dignity explored

2.1 Introduction

Chapter 1 presented the context for the thesis and reviewed the importance of dignity for patients and the expectation for HCPs, particularly nurses, to respect patients' dignity. It has already been eluded to that the meaning of dignity could be more complex in nature than it first appears and this chapter starts by examining difficulties in defining dignity and some theories about the meaning of dignity drawn from scholarly and philosophical papers and texts. Concept analyses of dignity and patient dignity are then examined, followed by a review of relevant primary research studies, explaining their methodologies and comparing their key results. Themes about patient dignity emerging from the literature review are then presented. Appendix 1 outlines the literature searching strategies used throughout the development of this thesis.

2.2 Difficulties with defining dignity: theories and meanings

Although the term ‘dignity’ is embedded in many documents and papers, it is rarely defined and as discussed, dictionary definitions (Box 1.2) are not insightful in relation to acute hospital care (see 1.2). Shotton and Seedhouse (1998) suggest that dignity is a vague and poorly defined concept, warning that unless dignity’s meaning is clear, it can disappear beneath more tangible priorities. These might include measurable elements like waiting times for treatments or length of stay in hospital. Indeed, the Member of Parliament who launched the 'Dignity in Care' campaign (see 1.4), explained the rationale as being that the increased throughput in the health service had at times ‘been at the expense of the quality of care provided’ (Lewis, 2006). Belanger et al. (2003) also highlight that although the health care literature constantly refers to ‘nursing with dignity’ the construct is not explained. Tadd (2005a) asserted that dignity is a complex concept but without clarifying what it entails, respecting dignity could become a futile objective. Thus a number of authors highlight that dignity is not clearly or universally defined.

Other writers who refer to the difficulty of defining dignity include the French philosopher Marcel:
‘It is my own profound belief that we cannot succeed in preserving the mysterious principle at the heart of human dignity unless we succeed in making explicit the properly sacred quality peculiar to it’. (Marcel, 1963, p.128)

Marcel was discussing dignity in general, but he articulated the problem of how dignity can be promoted if it is not understood. More recently, Kass (2002) referred to the elusiveness of dignity and asserted that consequently, in the field of bioethics, it is treated by many as having only symbolic rather than actual value. Similarly, Pullman (2004) described dignity as an ‘enigma’ and suggested that its precise nature is elusive. Nevertheless, Seedhouse (2000) asserted that to say we will promote dignity without understanding it or how to do this is not enough. He therefore suggested that dignity and how it can be promoted should be clearly defined and based on best evidence. An evidence-based approach to practice is expected throughout healthcare today; it is not acceptable for practice to be based on rituals or solely on individuals' views about practice. Marmot (2004) questioned how dignity can be measured if it is not defined precisely, a valid point if measuring quality in healthcare is considered important.

Although the above authors indicated that there is no simple definition of dignity, the term is often used as though there is a common understanding. Tadd et al. (2002) noted that phrases including the word ‘dignity’ have become increasingly commonplace, for example, ‘respect for human dignity’, ‘treatment with dignity’, ‘death with dignity’, ‘right to dignity’. They argued that such phrases have almost become clichés, especially in the care of older people. However, they suggested that while the term is often used in mission statements, HCPs may in reality undervalue this ‘fundamental aspect of care’ (p.1). Similarly, in an editorial in the British Medical Journal, entitled ‘Dignity is a useless concept’, Macklin (2003) argued that the term ‘dignity’ has become merely a slogan, being used in circumstances (for example practising intubation on newly dead bodies) which are not really about dignity at all. Macklin (2003) asserted that in many documents, the term ‘dignity’ actually means respect, voluntary informed consent, confidentiality and the need to avoid discrimination and abusive practices. The article provoked considerable debate with most respondents emphatically rejecting Macklin’s viewpoint (Baker, 2003; Bastian, 2003; Ford, 2003; Gallagher, 2004a; Giannet, 2003; Konarzewski, 2003; Limentani, 2003; Rapoport, 2003; Woods, 2003) and arguing that the concept of dignity is fundamental in good practice. However, some agreed with Macklin (2003) that the term is abused and ill defined and that the meaning of dignity needs further exploration (Caplan, 2003; Koch, 2003; Mylene, 2003; Notcutt, 2003). Many respondents offered their own views of the meaning of dignity and there were considerable variations which could support Macklin's
(2003) stance that the term ‘dignity’ is meaningless because it means different things to different people. The response to Macklin’s (2003) editorial indicated that there are strong views about the importance of dignity in healthcare despite the many interpretations of what dignity means. In a later paper, Macklin (2004) applauded the scrutiny that the concept of dignity was now being subjected to but questioned whether there is a universal conception of dignity. She concluded that further debates are needed to clarify what dignity means so that it becomes more than ‘mere slogans’.

Ashcroft (2005) examined the debate about the nature of dignity and concluded that scholars divide into four main groups: those, like Macklin (2003) above, who consider ‘dignity-talk’ is unhelpful, another group who relate dignity to autonomy (e.g. Beyleveld and Brownsend, 2001), a third group who consider dignity to be about capability and functionality (e.g. Seedhouse, 2000; Marmot, 2004) and the fourth group consider dignity to be possessed by all and only human beings (e.g. Kass, 2002; Nordenfelt, 2003a). As regards the relationship between dignity and autonomy, the German philosopher Immanuel Kant is often cited. Kant defined dignity as intrinsic worth which he argued should be accorded on the basis of ability to reason and that as humans are able to reason, they possess dignity (Kant, 1909). He related rationality with autonomy: ‘Autonomy then is the basis of the dignity of human and of every rational nature’ (p.54). However, Beauchamp (2001) asserted that Kant’s (1909) philosophy failed to acknowledge the dignity of those who lack the capacity for autonomy; this could include people who are acutely ill. Similarly, Sandman (2002) argued that if autonomy is an attribute of dignity, then what about children or people who are mentally impaired? These seem logical objections to Kant's views on the links between autonomy and dignity. From the viewpoint of a person with a disability, Toombs (2004) expressed concern that the emphasis on autonomy and capability in relation to dignity threatens the self-worth of those, like herself, who have impaired physical ability.

However, a theoretical framework of autonomy developed for long-term care suggested a broader concept of autonomy with different levels (Collopy, 1988). Collopy (1988) argued that people who are physically incapacitated can exercise decisional autonomy even though they may not be able to instigate these decisions themselves (‘executional autonomy’). Collopy (1988) also suggested that in some situations people delegate autonomy to others, freely accepting choices made by others. Such a situation, he argued, should be seen as a valid form of autonomy rather than a surrender of autonomy. In both
these levels, although the situation may be long-term, it can also be short-term, for example following major surgery. Thus although Collopy's (1988) focus was on older people's autonomy in long-term care, the framework offers a perspective of autonomy applicable throughout healthcare. The framework highlighted that these different levels of autonomy carry inherent risks, for example, staff might deny opportunity to exercise decisional autonomy to those without executional autonomy. Therefore, staff caring for people with physical impairment in any settings, need to recognise and resist such situations.

Representing Ashcroft's (2005) third group of theorists, Seedhouse suggested that dignity can generally be defined as:

'A person will have dignity if he is in a situation where his capabilities can be effectively applied'. (Seedhouse, 2000, p.52)

Seedhouse (2000) suggested that promoting dignity requires a match between capability and circumstances which is problematic in acute care settings, where patients' capabilities may be constrained due to their physical health condition. It should also be acknowledged that the hospital setting may further hinder people's capability being exercised. Ashcroft's (2005) fourth group of theorists, who assert that dignity is inherent in human beings, is a viewpoint established by the UDHR and is now encompassed within UK law under the HRA (see 1.4). Mann (1998) however pointed out that the UDHR does not actually define what is meant by dignity. Nordenfelt (2003a) explained that 'menschenwürde', a German word meaning the dignity of human beings, is something we all have because we are human and equal and therefore have the same minimal human rights: the provision of the necessary means of existence, freedom from strong and continued pain, minimal liberty and self respect. Thus nobody can be treated with less respect than anyone else with regard to human rights and ‘menschenwürde’ cannot be taken from anyone while they are alive (Nordenfelt, 2003a). This could imply that humanness (and thus dignity) ceases on death yet it is a widely held view in healthcare and the media that people's bodies should be treated in a dignified way after death. Sandman (2002) explained that as well as the notion of human dignity that all humans have, there is also contingent dignity which is the uniqueness which distinguishes one human being from another.

If dignity is inherent with being human, this implies that it is a quality that cannot be lost. Nordenfelt (2003a) however infers that it is possible to lose dignity but that this has a profound effect on the individual:
‘To lose one’s dignity is to lose one’s sense of being human, and this entails total despair’. (Nordenfelt, 2003a, p.99)

It is apparent that some patients do feel that it is possible to lose their dignity and staff also express this view. Dillon (1995), too, argued that whereas human rights can only be disregarded, negated, insulted, violated or suppressed, human dignity can actually be impaired or destroyed temporarily or irreversibly like any real quality. In Chochinov et al.’s (2002a) study of terminally ill patients, outpatients were more likely to feel that dignity could not be lost, but two thirds of inpatients believed that it could be taken away, particularly by their care and treatment. Perhaps outside hospital, where patients feel that they have control and their illness is still well controlled, they do not feel that they can lose their dignity. However, patients are likely to be more unwell and feel less in control once admitted to hospital. Chochinov et al.’s (2002a) findings imply that regardless of philosophical views, many patients perceive that it is possible to lose their dignity. There is debate too over whether dignity is only aligned with human beings; Kolnai (1995) acknowledged that while dignity is related mainly to human beings, it can also apply to the cat, the bull, elephants, trees, landscapes and works of art. Sandman (2002) argued that it is difficult to identify features of humans that are sufficiently inclusive or exclusive to justify the stance that they have dignity just because they are human.

Recently, an analysis by Jacobson (2007) identified two distinct meanings of dignity: human dignity (menschenwürde) and social dignity. Johnson (2007) explained that social dignity is experienced through interaction and, while human dignity cannot be removed, social dignity can be 'lost or gained, threatened, violated, or promoted' (p.295). Jacobson (2007) explained that social dignity always arises in a social context and comprises two linked elements: ‘dignity-of-self’ (includes self confidence, self-respect) which is created through interaction, and ‘dignity-in-relation’, which concerns the conveyance of worth to others and is situated in time and place. Jacobson (2007) also asserted that traditional definitions of dignity relating to status and merit are included in social dignity, thus this broad category of social dignity encompasses various interpretations. Jacobson (2007) suggested that being clear about whether human or social dignity is being discussed, may help reduce some of the vagueness associated with dignity. Jacobson (2007) then explored the various arenas in which dignity is referred to: in human rights, law, social justice, bioethics, care and health. She identified that most empirical work concerning dignity in health relates to social dignity and that further explanatory empirical work is required in this area. She asserted that the concept of human dignity can be used to argue
for the right to health and that dignity should be prominent in debates about health equity.

Ashcroft (2005) suggested that an alternative to trying to define dignity is to view dignity as a 'thick' concept which includes both descriptive and evaluative dimensions and he concluded that the meaning of dignity requires further debate. However, from a different perspective, Toombs (2004) asserted that, as a person with a significant disability, while there may be philosophical debate about the meaning of dignity, in everyday life dignity means self-worth, which is similar to some dictionary definitions (see Box 1.2). At the request of the Department of Health, the Social Care Institute for Excellence (SCIE) (2006) produced a practice guide for 'Dignity in Care', which stated that:

'While dignity may be difficult to define, what is clear is that people know when they have not been treated with dignity and respect'. (SCIE, 2006)

Nevertheless, for HCPs to consistently and universally treat people with dignity, a clear understanding of the nature of dignity is necessary. SCIE (2006) suggested that dignity comprises many overlapping aspects such as respect, privacy, autonomy and self-worth and offers a 'provisional' meaning of dignity based on a standard dictionary definition:

'a state, quality or manner worthy of esteem or respect; and (by extension) self-respect'.

However, as previously discussed, dictionary definitions have limited usefulness, particularly in an acute care context. Dillon (1995) suggested that dignity belongs to a family of concepts including respect, esteem, regard, honour and worth. These concepts mainly relate to feelings about self and in healthcare, could be affected by HCPs’ attitudes and behaviour towards patients.

Like some dictionary definitions (see Box 1.2), Nordenfelt (2003a) identified that merit is one meaning of dignity and similarly Kass (2002) connected dignity with worthy behaviour, for example demonstrating courage and generosity. While initially this interpretation of dignity appears to have little relevance in a hospital setting, some patients may feel that they should appear brave when they are ill. Kolnai (1995) regarded dignity as being typified by behaviours such as composure, calmness, restraint, reserve, and emotions or passions which are subdued or securely controlled. It is commonplace for the media to use the term 'dignity' when describing someone who behaves calmly and courageously in difficult circumstances.

The various scholarly and philosophical writings discussed indicate a range of different views about the meaning of dignity and some of these ideas are not necessarily applicable.
or relevant to patients in an acute care setting. Increasing the lack of clarity about the nature of dignity, the word ‘dignity’ is often combined with other terms, for example with comfort and autonomy (Johnson, 1998; Lothian and Philp, 2001), privacy (DH, 1995; DH, 2000a; DH, 2001a) and respect (Belanger et al., 2003; DH, 2000b) but the relationship between these concepts is not clarified. There are also many verbs attached to dignity:

- restoring dignity, which implies dignity can be lost but regained;
- maintaining, upholding, respecting, fostering, preserving and protecting dignity - these all indicate a similar meaning, that the person possesses dignity and steps are taken to retain this;
- promoting dignity, which could imply restoring dignity if lost, maintaining dignity or taking active steps to enhance dignity.

Any of the above could apply to individuals themselves, in relation to restoring, maintaining or promoting their own dignity. However, healthcare literature emphasises HCPs’ role in relation to patients’ dignity, presumably when patients cannot do this for themselves. There is an implication that dignity is internally held by patients but that external forces (such as behaviour of healthcare staff) can enable patients to retain or enhance their dignity. In this thesis, ‘promoting’ dignity will be used to encompass all the other verbs referred to above, as the NMC states that nurses should promote patients’ dignity (NMC, 2004). Measures to promote dignity might help restore a feeling of dignity to patients who feel that their dignity has been lost, support patients to retain their dignity, and enhance patients’ experiences of dignity in the healthcare setting.

Several authors have conducted concept analyses of dignity and these will next be presented to continue the exploration of the meaning of dignity, and their application to acute hospital settings will be considered.

### 2.3 Concept analyses of dignity

Nine concept analyses of ‘dignity’ were identified, some applied to specific care settings, and each will be reviewed, in chronological order, as these analyses have built upon each other.

Mairis (1994) carried out a concept analysis, applying Walker and Avant's (1988) model for concept clarification, and accessing nursing students’ personal definitions of dignity, a literature review and discussion with other professionals. The range of literature reviewed
is limited and the respondents were chosen because of their accessibility, but this is not uncommon in concept analyses. Mairis (1994) identified critical attributes of dignity as being maintenance of self-respect, self-esteem and appreciation of individual standards. She proposed that dignity may be demonstrated by appearance and behaviour. Mairis provided a theoretical definition of dignity:

‘Dignity may be said to exist when an individual is capable of exerting control or choice over his or her behaviour, surroundings and the way in which he or she is treated by others. He or she should be capable of understanding information and making decisions. He or she should feel comfortable with his or her physical and psychosocial status quo’. (Mairis, 1994, p.952)

People who are acutely ill may not be able to exert control or choice, or be capable of understanding information and Mairis’ (1994) definition implied that dignity is not then possible while later acknowledging that people are particularly vulnerable to loss of dignity in such situations. Mairis’ (1994) definition therefore has limited application to HCPs aiming to promote dignity as it infers that dignity is not achievable if control and choice are diminished. However, her statement that dignity entails feeling comfortable indicates that helping patients to feel comfortable might promote dignity, which is more useful for nursing practice. Notably, Mairis (1994) did not draw on patients' views about dignity when developing her theoretical definition.

Haddock (1996) built on Mairis' analysis, using Chinn and Kramer’s (1991) process for concept analysis. She used dictionaries, professional literature, views from fifteen colleagues, friends and family, poetry and popular literature, music and visual images. Haddock (1996) suggested that patients may have personal interpretations of dignity, which would pose challenges for HCPs who may not be aware of these interpretations, particularly if patients, because of their illness, are unable to express them. Haddock (1996) identified that there are distinctions between possessing dignity, as an aspect of self, being treated as if one has dignity and actively giving dignity as if it is a commodity. Haddock (1996) does not discuss whether it is possible to confer dignity to a person who feels that they have lost their dignity.

Haddock (1996) presented the definitions she obtained from the fifteen individuals as four components: the dignified self, another person (who respects another human) and the undignified self, with communication (including speech, behaviour, appearance and surroundings) mediating between all three. The dignified self comprised: self respect, self confidence, self control, control of environment, pride of self, being trustworthy, happy with
self, humorous, autonomous, independent, private, positive self identity, striving to keep
boundary, integrity and identity of self when under attack. This long list of attributes
highlights the multifaceted nature of dignity, illuminating the challenges of applying
interpretations of dignity in patient care. It is unclear whether Haddock (1996) was
suggesting that a patient would require all of these attributes to have dignity or whether
only some would apply, depending on the individual's interpretation of dignity. Haddock
(1996) offered an operational definition of dignity, which she referred to as tentative:

'Dignity is the ability to feel important and valuable in relation to others, communicate this to others, and be treated as such by others, in contexts which are viewed as threatening. Dignity is a dynamic subjective belief but also has a shared meaning among humanity. Dignity is striven for and its maintenance depends on one's ability to keep intact the boundary containing beliefs about oneself and the extent of the threat. Context and possession of dignity within oneself affects one's ability to maintain or promote the dignity of others'. (Haddock, 1996, p.930)

This lengthy definition indicates the complexity of dignity and the difficulty of developing a
succinct definition of dignity. Haddock (1996) only incorporated some of the attributes of
the 'dignified self' arising from her analysis into the definition, in particular those related to
control (self control, autonomous, independence) are not evident in her definition. Acutely
ill patients may not be able to communicate with their carers, which Haddock's (1996)
definition asserts is a necessity for dignity. Haddock (1996) introduced the view that a
person's ability to promote others' dignity is affected by whether they themselves have
dignity; clearly this would have implications for HCPs. Although Haddock (1996) built on
Mairis' (1994) concept analysis, there is little similarity between their definitions and both
are problematic when applied to acutely ill patients.

Both Mairis (1994) and Haddock (1996) are from the UK; the next two concept analyses
examined are North American. The origins of writers are relevant as interpretations of
dignity may have cultural influences but the USA and Canada, as westernised countries,
have similar values to Britain. Johnson's (1998) analysis focused on dignity in relation to
dying. He asserted that the concept of dignity is used ambiguously and vaguely but that
the phrase 'dying with dignity' is often used to mean dying well. His analysis relied solely
on reviewing literature and he identified that dignity is often coupled with terms such as
peace, comfort, autonomy, control and quality-of-life; the linking of dignity with other terms
was noted in 2.2. Johnson (1998) suggested that analysing the humanness of dignity may
help in understanding dignity. He identified that 'human' relates to possessing qualities of
people and individuality while 'humaneness' entails possessing the best qualities of
people, for example kindness. He highlighted that individuals might have different interpretations of what constitutes dying with dignity. Johnson (1998) does not offer any definition of dignity thus doing little to reduce the ambiguity he earlier discussed. He emphasised the importance of communication with those who are dying so that their individual needs can be met, a suggestion that could equally apply to any hospital patient.

The Canadian theorist Jacobs' (2000, 2001) theory about nursing was discussed in 1.4, but her first paper included a concept analysis. Jacobs (2000) examined moral philosophy, dictionary definitions, current literature and, like Mairis (1994), surveyed students on nursing programmes. Presumably it was due to convenience that both Mairis (1994) and Jacobs (2000) accessed students’ views but gaining experienced nurses or patients' views would have been more appropriate. Students’ meanings of dignity included: pride, self-confidence, self-esteem, self-respect, values, what makes one human, part of inner being, worth and uniqueness, trustworthiness, being solemn, earnest, reverent, and being respectful of others (including protecting privacy). Jacobs (2000) referred to Mairis’ (1994) work in her paper, but not Haddock’s (1996) analysis, indicating her literature review was incomplete. Jacobs (2000) suggested that the concept of dignity is underdeveloped if only investigated scientifically, as it has no physical properties. However, as discussed later in this chapter (2.5), some interpretations of dignity relate to physical dimensions such as personal presentation. Jacobs (2000) argued that dignity requires considerable research to understand its meaning and that the concept should be explored from an artistic and ethical perspective too. In her conclusion Jacobs stated that:

‘Dignity appears to be a conceptual something that all persons have and therefore can lose. Dignity is a conceptual something that persons are born with and want to die with’. (Jacobs, 2000, p.31)

Describing dignity as a ‘something’ implies that dignity is too complex a concept to define with one word but Jacobs (2000) inferred that people view dignity as a desirable attribute which can be lost.

UK authors Fenton and Mitchell's (2002) concept analysis is focused on older people. Like Johnson (1998) these authors’ analysis relied solely on reviewing literature including Mairis' (1994) and Haddock's (1996) papers but Jacobs' (2000) work is not referenced. The authors do not approach their analysis in a systematic manner and often focus more on how dignity is, in their view, diminished, rather than the concept of dignity. Despite their paper's title, the literature reviewed related to dignity generally, not specifically to older people, with the exception of two papers. They concluded with this operational definition:
‘Dignity is a state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated. Dignity is promoted when individuals are enabled to do their best within their capabilities, exercise control, make choices and feel involved in the decision-making that underpins their care’. (Fenton and Mitchell, 2002, p.21)

Their definition implied that dignity is an internal state, related to being valued as an individual and they included suggestions about how dignity is promoted in their definition too. Their definition is not clearly based on their paper's analysis however and could certainly apply to any patient, not just older people.

A USA team (Jacelon et al., 2004) also conducted a concept analysis related specifically to older adults. Like Mairis (1994), the authors used Walker and Avant's (1995) concept analysis model and reviewed literature from nursing, medicine, philosophy, sociology and social work. Concurrently, they appropriately conducted five focus groups with older adults (65 years or above). As the team wished to remain focused on work related to older adults, their review excluded literature relating to children and younger adults but some of the literature included (e.g. Jacobs, 2001; Mairis, 1994) does not specify a particular age group so how stringently the 'older age' criterion was applied is questionable. Jacelon et al. (2004) described 'philosophical dignity' as being dignity held by virtue of being a unique human being, supporting literature reviewed in 2.2. Similarly to Haddock's (1996) representation of 'The dignified self' and 'The other (respects another human)', Jacelon et al. (2004) identified 'Dignity as an attribute of the self and related concepts' and 'Behavioural dignity'. Dignity's attributes included self-worth, self-respect and pride. 'Behavioural dignity' was the most frequently used way of defining dignity in both the focus groups and the literature and related to both the behaviour of the individual and other people. The focus group participants expressed that dignified behaviour included being polite, not-complaining, being self-directing and accepting help 'gracefully' and they considered that such behaviour was learned. The review concluded that older people may experience dignity through giving love and support to others and the reciprocal nature of dignity is identified. However, it is questionable whether such a statement applies only to older people. Jacelon et al. proposed the following conceptual definition of dignity:

‘Dignity is an inherent characteristic of being human, it can be felt as an attribute of the self, and is made manifest through behaviour that demonstrates respect for self and others’. (Jacelon et al., 2004, p.81)

They state that their concept analysis does not support the dictionary definition of dignity as being worthy. The Essence of Care (DH, 2001a) however, and more recently the SCIE (2006), used a similar definition of dignity as being worthy of respect. Interestingly, in an
earlier study (see 2.4), Jacelon (2003) defined dignity as being an individual's self-worth and composed of individual and interpersonal attributes. Clearly, Jacelon et al.'s (2004) later concept analysis provided an alternative viewpoint as they concluded that the most frequently held view was that dignity was about behaviour.

Like Haddock (1996), Marley's (2005) concept analysis used Chinn and Kramer's (1991) framework. As with previous authors, he examined dictionary definitions and reviewed professional literature including primary research but he also surveyed opinions about dignity from ten people from nursing and non-nursing backgrounds. He did not provide any details about these participants and there is no indication about whether they drew on healthcare experiences. Following the same model as Haddock (1996), he then grouped their responses into 'the dignified self' (self-pride, self-respect, is understood, in control of one's own privacy, in control, uniqueness, autonomous, appearance, hopeful), the undignified self (lack of control, embarrassment, feeling exposed in body, lack of privacy) and characteristics of other people who can confer dignity (e.g. respect for uniqueness and wholeness). Marley (2005) noted that participants repeatedly suggested that dignity can be conferred, or removed, by another, such as a HCP. He described dignity as being 'a quality that existed both in and for people; that it is both possession and gift' (p.84) and emphasised the uniqueness of individuals in relation to dignity. Marley's (2005) concept analysis is well applied to an acute care setting with a case study presented to illustrate dignity being promoted by staff and a contrary case. The strength of Marley's (2005) analysis is its clarity concerning the internal qualities of dignity and how dignity can be conveyed by others. His analysis appears to support both Haddock (1996) and Jacelon et al.'s (2004) concept analyses in this respect although the latter place greater emphasis on the role of the individual's behaviour in relation to their own dignity.

Griffin-Heslin (2005) used Walker and Avant's (1995) concept analysis framework to analyse dignity and she made particular application to dignity in the Accident and Emergency (A&E) Department. She briefly reviewed philosophical considerations, with reference to Jacobs (2001) and Kant and then reviewed primary research concerning the maintenance of dignity in a nursing context. She also considered dictionary definitions and dignity in a non-nursing context (e.g. in art, music, literature). Based on the literature review, Griffin-Heslin (2005) then identified four defining attributes of dignity: respect (including self-respect and respect for others and privacy), autonomy, empowerment and communication. The examples provided (e.g. modesty) in the category of 'empowerment'
were not clearly congruent with this attribute. The theme of communication included ways of communicating, inferring that this attribute related to how dignity would be promoted by others, in a similar way to that portrayed by Haddock (1996). However, the distinction between dignity internally held, and dignity conferred by others, is not clearly stated, as it was in Marley's (2005) analysis.

The final concept analysis is of care with dignity (Coventry, 2006), which is a subtly different focus from the others reviewed. The paper is published in the Journal of Gerontological Nursing but is not overtly focused on older people alone. Although the analysis is presented in a structured manner, there is no concept analysis framework used. Surprisingly none of the concept analyses presented in this section are included in her analysis, which would have been relevant even though her focus, being on 'care with dignity', was slightly different. In addition, there is minimal inclusion of any of the empirical work relating to patient dignity thus the analysis is not comprehensive. Coventry (2006) explored the philosophical background to dignity and then reviewed definitions of dignity from the literature from which she concluded, in line with dictionary definitions, that 'to have dignity, one must feel worthy' (p.43), yet Jacelon et al. (2004) concluded otherwise from their more systematic review. She emphasised that dignity is an inner force but that caregivers should as part of their role help to preserve patients' dignity through their actions. Coventry (2006) identified dignity as being an inner feeling of well-being, personal worth and self-respect and like other authors (e.g. Haddock, 1996; Marley, 2005) she recognised that interactions with others will affect dignity. She asserted that care with dignity is underpinned by embedded values: autonomy, truth, justice and responsibility to human rights but that the medical system remains authoritarian and hierarchical, which threatens dignity.

In summary, there are a number of published concept analyses of dignity and most of the authors used recognised concept analysis frameworks, thus adopting a systematic approach. Some concept analyses had a broad context but others focused on a particular client group. The concept analyses of dignity highlight the multi-dimensional nature of dignity and that it is not easily defined or explained. These authors' work together draws on a fair range of literature but a rather unsystematic collection of people’s views. Some of the concept analyses concluded with definitions and most identified a number of concepts and attributes related to dignity. When comparing their findings there are common elements, but further exploration is needed.
To examine the nature of patient dignity further, the next section reviews relevant primary research.

2.4 Primary research exploring the meaning of dignity

There are few primary research studies investigating the meaning of patient dignity; most studies undertaken are more concerned with how dignity is threatened or promoted and these are reviewed in Chapter 3. The studies identified related predominantly to either terminal/palliative care or care of older people, indicating the concerns about the dignity of these client groups. In addition there was one study based in critical care, one on a children's ward and one in an acute hospital setting for adults. Most studies included results about how dignity can be threatened and promoted too, which are presented in Chapter 3.

In Pokorny's (1989) qualitative study, nine patients who had had cardiovascular bypass surgery were interviewed about their perceptions of dignity, following their ITU experiences. Attributes of dignity were identified as privacy, control, independence, competence and caring. This was a small study based in a specialist critical care area but indicated some possible meanings of dignity to patients. Matiti's (2002) UK-based phenomenological study (selected results published in Matiti and Trorey, 2004) was particularly relevant to this thesis as it was the only one identified which explored perceptions of dignity of adults of all age groups based in an acute hospital. Matiti (2002) conducted taped, semi-structured interviews with a convenience sample of patients (n=102) and a purposive sample of staff (n=94) in a variety of acute wards. Patients were still in hospital at the time which could have made them reluctant to express negative views but Matiti (2002) used various strategies to increase patients' openness. The advantage was that the patients were still undergoing the experience of hospitalization, increasing the likelihood of accurate descriptions. Both patients and staff had difficulty defining dignity, supporting views discussed in 2.2. Patients described dignity as being something everyone has, that it is about self worth and personal standards, how they present themselves and are perceived by others, reflecting notions previously reviewed in this chapter. Matiti (2002) categorised what patients described as their dignity into eleven categories: privacy, confidentiality, need for information, choice, involvement in care, independence, form of address, decency, control, respect and nurse-patient
communication. Patients set standards or expectations relating to each of these categories, taking into account the hospital situation, and the maintenance of each of these together led to the patient feeling in control and dignified. Nurses identified similar categories as patients, except for 'control', indicating that nurses did not link control with dignity. Patients' privacy was highly rated by all participants as the main attribute of patient dignity, emphasising its importance in maintaining patients' dignity.

Patients expressed that they had to adjust how they maintained their dignity in hospital, implying that the patients took an active role. Matiti (2002) used the term 'Perceptual adjustment level' (PAL) to portray the stages patients go through in adjusting their perceptions of their dignity following admission to hospital; a model is presented representing this process. Matiti's (2002) definition of patient dignity is based on the PAL theory:

*'Patient dignity is the fulfilment of patients' expectations in terms of values within each patient's perceptual adjustment level, taking into account the hospital environment'. (Matiti, 2002)

The definition indicates the individuality of dignity to patients, implying that the meaning of dignity varies according to what the patient expects, how they have adjusted to being in hospital, and the impact of the hospital setting. The findings suggested that staff approach to patients and the environment impact on patients' experiences of dignity and the adjustments they make in hospital but the data collection methods did not enable direct study of these influences. In summary, Matiti's (2002) findings are highly relevant to this thesis and offer insights into the meaning of dignity that were not provided by the concept analyses explored in 2.3.

Chapter 1, section 1.3, indicated the importance of dignity to patients in terminal/palliative care settings and accordingly several researchers have explored the meaning of dignity from this perspective. These studies are reviewed next but it must be recognised that their context differs from that of this thesis. Gamlin (1998) used internet newsgroups and email mailing lists to elicit patients', relatives' and staff's thoughts and experiences about the meaning of dignity for people with advanced illness. He provided little detail about the respondents (n=45) but mentioned Australian, North American and UK responses. Gamlin (1998) recognised the limitations of his methodology, as respondents were self-selected. He found that dignity was described in various ways and that it was considered to be a dynamic concept which may change once illness develops. His description bears similarity to Matiti's (2002) finding that patients in hospital make perceptual adjustments. Gamlin's
(1998) findings included choice, respect and retaining control, all of which were identified by Matiti (2002) too.

Three other studies have explored the meaning of dignity in terminal care since Gamlin’s (1998) research. Street (2001) conducted a study concerning portrayals of dignity at end of life, using discourse analysis, drawing on literature, internet sites, media reports, legislation, policy statements and interviews with patients and family members. She offered no details regarding the number of participants or the format of the interviews so her contribution is difficult to evaluate due to the lack of methodological detail. The individuality of dignity is once again identified. Themes included autonomy and self-determination (including control), personhood or self-worth, embodiment, and dignity as relational - a process of relationships. Thus, while her research was based in a different setting to Matiti’s (2002) later study, there are a few common elements, and control in relation to dignity is further supported.

The most major work relating to dignity in terminal care is from a Canadian team of researchers who conducted a series of studies concerning how terminally ill patients' dignity can be conserved (Chochinov, 2002; Chochinov et al., 2002a; Chochinov et al., 2002b; Chochinov et al., 2004; Hack et al., 2004; McClement et al., 2004) and their early research investigated patients' interpretations of dignity. Chochinov et al. (2002a) conducted interviews with fifty patients (27 out-patients and 23 in-patients) with advanced terminal cancer, at a specialised palliative care unit. In semi-structured interviews, respondents were asked for their definitions of dignity and what supports or undermines this. The interview schedule was developed by a multi-disciplinary expert panel and researchers familiar with the topic. This should have resulted in a valid tool but there is no mention of it being piloted, which would enhance confidence in its validity.

Chochinov et al. (2002a) suggested that there are a number of terms (pride, self-respect, quality of life, well-being, hope and self-esteem) which overlap conceptually with ‘dignity’, thus supporting results from the concept analyses reviewed and, like Matiti (2002), the authors stress the individuality of dignity to patients. They presented a model which aimed to promote an understanding of dignity for those nearing death which included: illness-related issues (level of independence, cognitive acuity, functional capacity, symptom distress, physical distress and psychological distress), dignity conserving repertoire comprising perspectives (continuity of self, role preservation, generativity/legacy,
maintenance of pride, hopefulness, autonomy/control, acceptance, resilience/fighting spirit) and practices (living in the moment, maintaining normalcy and seeking spiritual comfort), and a social dignity inventory: (privacy boundaries, social support, care tenor, burden to others and aftermath concerns). Chochinov et al.’s (2002a) theme of illness-related issues bears similarity to Street's (2001) theme of embodiment, as that too was linked to the physical effects of terminal disease. Clearly much of Chochinov et al.’s (2002a) model is specific to terminal care but there are still some commonalities with Matiti’s (2002) findings and Pokorny's (1989) earlier work, such as privacy, independence and control. Chochinov et al. (2002a) acknowledged that the results may not be generalizable to patients with other types of life-threatening conditions (e.g. advanced cardiac illness). In addition, the majority of the study's participants were older individuals; younger people with terminal illness may have different views about dignity.

Enes' (2003) study, based in a UK hospice, used a phenomenological approach to explore the meanings, feelings and experiences of dignity, conducting in-depth interviews with a purposive sample of eight patients, five relatives and seven HCPs. There were a broad range of responses confirming the complex nature of dignity but four main themes emerged: relationship and belonging (including feelings, self and others' perceptions), having control (over decisions, body, behaviour and what is happening), being human (being worthy of respect, esteem, having rights) and maintaining the individual self (included individuality, independence, privacy and appearance). In a similar way to the PAL described by Matiti (2002), patients adjusted their view of dignity because of their condition so some aspects became less important. As with the studies previously reviewed, Enes' (2003) results included independence, control and privacy. Her theme of relationship and belonging bears similarities to Chochinov et al.’s (2002a) social dignity inventory and supports Street's (2001) relational dimension of dignity. Respect (in the theme 'being human') is a category within Matiti's (2002) work too.

Having reviewed studies examining the meaning of dignity in a terminal/palliative care context, studies based in care of older people are next reviewed. Gallagher and Seedhouse (2000) conducted a multi-method quasi-experimental pilot study in the UK (selected results published in: Gallagher and Seedhouse, 2002; Seedhouse and Gallagher, 2002) to test the hypothesis that practice will improve if health workers understand and apply a clearly defined concept of dignity, which was based on capability (Shotton and Seedhouse, 1998). The study took place on three UK wards: a rehabilitation
ward for older people, a ward for older people with mental health problems, and a medical ward, which catered mainly for older people but with some patients under 65 years. The researchers used quantitative tools to measure differences in staff attitudes pre and post intervention (a teaching session about dignity) and carried out observation of practice. The observation tools had been used in previous studies but were not designed specifically to study dignity and the appropriateness of their application is questionable. On each ward, a convenience sample of six staff (qualified and unqualified) and six patients and/or relatives were interviewed and asked for their views about dignity. The interview schedules were highly structured and included vignettes but the basis for the questions and the source of the vignettes is not explained. The researchers concluded that the hypothesis was neither verified nor refuted and they acknowledged that the tools used were probably not appropriate for this study.

However, the interview results are useful as there is a paucity of research accessing patients’, relatives’ and staff’s views about dignity. Dignity as respect featured strongly in the interviews and privacy as an attribute of dignity emerged from both staff and patient interviews, supporting research from other settings already reviewed. Staff considered the concept of dignity was subjective and was about not making patients feel awkward. Other themes from patients included confidence, pride, being treated as a competent adult and independence. Relatives’ perceptions of dignity included aspects of physical appearance, such as cleanliness and being groomed. Although Gallagher and Seedhouse’s (2000) study has limitations (some acknowledged by the authors), a strength was that data was collected from a range of participants.

Jacelon (2003) used grounded theory to study older people (75 years and above) going through the process of hospitalization in an acute hospital in the USA. Two other publications (Jacelon, 2002; 2004) present findings from her study too. Jacelon also co-authored a concept analysis of dignity in older people (Jacelon et al., 2004, see 2.3). Five participants were interviewed on admission, on discharge and following discharge, and observed for at least two hours on each day of their admission. Jacelon (2003) also interviewed five relatives and six staff members. Although the sample sizes seem small, Jacelon (2003) asserted that sampling continued until saturation was reached. Like several studies in other settings (Gamlin, 1998; Matiti, 2002; Enes, 2003) Jacelon (2003) identified the dynamic nature of patient dignity and her methodology enabled her to examine in depth how patients adjusted.
Jacelon (2003) found that the older people entered hospital with their self-dignity already established, which helped sustain their dignity during their acute illness. Initially patients focused on their health but as that stabilised they became more concerned about their dignity, which was affected by hospital procedures and staff interactions with them. Concepts of dignity emerged as self dignity and interpersonal dignity; privacy was defined as the interface between these. Self dignity entailed dignity as being an internal concept, based on past achievements and evidenced by patients’ own behaviour, while interpersonal dignity was described as being treated with respect by others, particularly hospital staff, which could enhance self dignity. These findings bear similarity to Marley’s (2005) concept analysis, discussed earlier. Like some participants in Matiti’s (2002) study, some patients described dignity as behaving according to the standards they had been brought up to. Patients’ dignity was diminished by relinquishing control to hospital staff. Several of these concepts support previous research about the nature of dignity, in particular privacy and control. Jacelon (2003) concluded that while dignity is a dynamic state, a strong sense of dignity can help sustain patients through hospitalization. However, she found dignity was continually threatened in hospital. As the study was conducted in an acute hospital setting, it is particularly relevant to this thesis but only older people were included thus limiting the findings’ applicability.

The largest study concerning the dignity of older people was the 'Dignity and Older Europeans' project, a multi-site study over six European countries (England, Sweden, Spain, France, Ireland and Slovakia). The study aimed to investigate views about dignity and older people in society; Calnan and Tadd (2005) provide an overview of the methodology. The project did not study hospital patients’ dignity but the results still have relevance to this thesis, particularly in understanding the meaning of dignity, and some participants drew on healthcare experiences. Prior to the study’s commencement, a theoretical model of dignity was developed by analysing the literature (Nordenfelt, 2003a; Nordenfelt, 2003b). The model identified four concepts of dignity: *menschenwürde* (dignity that all humans have equally - discussed in 2.2), merit (due to position in society or earned through achievements), moral stature (dignity due to moral deeds - a virtue), and dignity of identity (integrity of body and mind). In a later paper, Nordenfelt and Edgar (2005) acknowledged that dignity of identity is most relevant in the context of illness as disability restricts autonomy and threatens personal identity. The themes 'dignity as merit' and 'dignity as moral stature' are of questionable relevance to healthcare because, as
established in 1.4, HCPs should treat all patients with respect for dignity anyway, regardless of perceived merit or moral status. The theme of *menschenwürde* implies only that human beings have dignity but does not assist with understanding what this actually means. Nordenfelt and Edgar (2005) emphasised that while *menschenwürde* cannot be diminished or lost while a person is alive, the presence and degree of the other three types of dignity varies in each individual. This model formed the theoretical framework for the research and the findings were all analysed in relation to the model.

The project investigated views about dignity of older people through conducting focus groups of older people, young and middle-aged adults, and health and social care professionals, using semi-structured interviews. Some questions were related to general attitudes and views about older people thus only the findings relating to the meaning of dignity are considered here. All researchers received common training in conducting focus groups and qualitative analysis, enhancing reliability. Purposive sampling was used to recruit a broad mix of people within each category. The project first published reports on the project website for the combined results from all the countries: for the older people's focus groups (Tadd, 2004a, also published in Bayer *et al.*, 2005), the younger adults (Tadd, 2004b) and the professionals (Tadd, 2004c, also published in Ariño-Blasco *et al.*, 2005). Reports for the UK alone were also published on the website: for UK older people (Dieppe, 2005a, also published in Woolhead *et al.*, 2005), younger adults (Tadd, 2005b) and UK professionals (Dieppe, 2005b, also published in Calnan *et al.*, 2005). There have been extensive further publications arising from this project (e.g. Stratton and Tadd, 2005; Woolhead *et al.*, 2006). Only the results from the UK focus groups are discussed in this section as they are most applicable to this UK-based thesis.

There were similar findings from the three types of focus groups held, each of which will be summarised. Woolhead *et al.* (2005) reported that from the UK older people’s focus groups (n=72; 15 focus groups), three major categories emerged: dignity of identity (self-respect, self-esteem, pride, integrity, trust, appearance), human rights (equality, human entitlement to dignity) and autonomy (independence, control, choice). Similarly, in the UK focus groups with health and social care professionals (n=52; 12 focus groups), the meaning of dignity related to dignity of identity (respect, self-respect, self-esteem, exposure, intrusion, communication, personal appearance, treat as an individual, privacy, emotional care), rights (choice, equality, consent, confidentiality, innate dignity) and autonomy (independence, control) (Calnan *et al.*, 2005). Some of these meanings presumably
applied to indignity rather than dignity (e.g., intrusion, exposure) but this was not clarified. Tadd (2005b) reported on the UK focus groups with young adults and middle-aged adults (n=87; 18 focus groups). Participants viewed dignity as having two main components: relationship with self (innate, self-respect, self-esteem, self-worth, pride) and relationship with others (interactions and mutual respect). These are similar to the self dignity and interpersonal dignity, described by Jacelon (2003). The importance of identity to dignity (including appearance) and dignity of merit (the view that dignity should be earned) were also expressed, though participants recognised that if dignity was related to merit, this was potentially discriminatory. The participants identified aspects of dignity as being appearance, autonomy and choice (feeling in control), independence and struggle, privacy (particularly in relation to healthcare), financial security (to enable a comfortable existence), and happiness and health (as illness was seen to lead to dependency). Overall, the project's findings generally supported the philosophical theoretical framework and there was much commonality between the three types of participants' views.

The main limitation of the Dignity and Older Europeans project relates to its methodology, as data was collected through only one method. Focus groups are a useful method of accessing views from a large number of people, but the data reflects only people's views, not their actions. In relation to dignity in acute hospital settings, the project's results have limited applicability as the focus group participants were not actually based in this setting. Many had some experience of hospitals, either as patients, relatives or professionals, but their views were based on general experience. Nevertheless, meanings of dignity such as independence, control, autonomy and respect support the healthcare-based studies already reviewed.

In Sweden, Randers and Mattiasson (2004) used participant observation to evaluate the effects of teaching ethics to HCPs working in rehabilitation wards for older people. Their study assumed that dignity is comprised of two integrated concepts: autonomy and integrity, and that if these are achieved then dignity will be upheld. This assumption was based on the ethos of the Swedish health care system; two Swedish philosophical textbooks were cited to support this view. Randers and Mattiasson (2004) explained integrity as being related to privacy and personal space while autonomy is defined as making significant decisions about one's own life. There is no mention of any pre-intervention data being obtained in the study and thus comparisons before and after the teaching intervention are impossible. Neither patients' nor the HCPs' views about the care
observed were sought; the observation data was recorded and then analysed using two theoretical frameworks relating to integrity and autonomy. The model used to analyse autonomy had been developed for long-term care, which was therefore appropriate. This study has limited usefulness, as only two dimensions of dignity were considered (autonomy and integrity - privacy) and though these have been identified in previous studies, they present a narrow basis from which to study dignity.

Based on a different age-group, Reed *et al.* (2003) conducted an ethnographic pilot study to explore the dignity of children in two acute children's wards in a UK district general hospital (DGH). Although the study has limited application to this thesis, which is focused on adults, children's wards are based in an acute hospital setting so there may be relevance. The researcher carried out participant observation and informal interviews with a range of staff (nurses, students, HCAs, home care team, play and education staff) and parents to explore the concept of dignity. The number of participants is not stated and the paper reporting this study only included results from the nurses' interviews, thus the methodology is difficult to evaluate. The respondents typically equated dignity with privacy. Some respondents considered that dignity was the same regardless of age, while others specified different ages at which dignity became important, for example adolescence. Reed *et al.* (2003) identified two levels of dignity: macro and micro dignity. Macro dignity, they proposed, is shared and common to all humanity, a description equating to *menschenwürde*, as discussed earlier. Micro dignity is about maintaining individual and social norms and capabilities, for example body functions such as continence. Micro-dignity appears to be a broad category which could encompass appearance and independence as well as self identity. Reed *et al.* (2003) considered that the notion of control is central to dignity, which is well supported by research in a range of other settings already reviewed here. They suggested that dignity becomes a major concern in hospital as it is a public place, indicating how the care environment impacts on patients' dignity and why patients need to adjust, as discussed in Matiti (2002).

In summary, only Matiti's (2002) and Jacelon's (2003) studies were based in acute adult care hospital settings and Jacelon's (2003) study focused on patients over 75 years only. These studies are, however, the only empirical work identified that has investigated the meaning of dignity from patients' and nurses' perspectives, and many of the other studies were small scale or pilot studies. A variety of research designs and methods has been used: phenomenology, internet survey, discourse analysis, quasi-experiment, grounded
theory and ethnography. Despite the variability in the settings (acute care, terminal care, older people and children) there were some common themes to emerge, many of which supported the concept analyses already reviewed. The next section presents emerging themes about the meaning of dignity which were developed from the literature review conducted.

2.5 The nature of dignity: emerging themes

The literature reviewed identified ambiguity and uncertainty about the nature of dignity - its meanings and qualities - with many different views, definitions and models suggested. Very little of this literature has been directly derived from patients' perspectives however. That dignity is inherent in human beings is established in law (Great Britain, 1998), from some philosophical perspectives (Nordenfelt, 2003a) and was supported in some of the research reviewed (Matiti, 2002; Jacelon, 2003; Woolhead et al., 2005; Calnan et al., 2005; Reed et al., 2003) and concept analyses (Griffin-Heslin, 2005; Jacelon et al., 2004; Marley, 2005). However this premise does not actually assist in understanding the meaning of dignity. Several of the research studies conveyed that dignity is dynamic: patients adjusted their perceptions during hospitalisation (Matiti, 2002; Jacelon, 2003) and as illness progressed (Enes, 2003; Gamlin, 1998). Individuality of interpretations of dignity has also been identified (Fenton and Mitchell, 2002; Haddock, 1996; Mairis, 1994; Matiti, 2002; Street, 2001).

Gallagher (2004b) suggested that dignity can be considered as two values: respect towards the dignity of others and respecting one's own dignity. Similarly, there is a distinction in some of the literature regarding dignity as an internal quality and dignity as a quality associated with behaviour. Dignity as an internal quality has been described as an aspect of self (Haddock, 1996), self dignity (Jacelon, 2003), dignity-of-self (Jacobson, 2007), an attribute of the self (Jacelon et al., 2004) or a possession (Marley, 2005). However, dignity is also related to behaviour, described as interpersonal dignity (Jacelon, 2003), behavioural dignity (Jacelon et al, 2004), dignity-in-relation (Jacobson, 2007) and as a gift (Marley, 2005). The themes about the meaning of dignity which are next explored are individuality and feelings, control, presentation of self, and attitude and behaviour from others. The relationship between privacy and dignity will also be discussed.

Dignity as an internal quality has been closely linked to each patient's individuality and
feelings, and the uniqueness of each individual has been identified as a dimension of
dignity (Fenton and Mitchell, 2002; Mairis, 1994; Marley, 2005; Sandman, 2002). Feelings
associated with dignity are: self esteem (Chochinov et al., 2002a; Enes, 2003; Haddock,
1996; Jacobs, 2000; Mairis, 1994; Matiti, 2002; Sandman, 2002), self-worth (Coventry,
2006; Enes, 2003; Jacelon et al., 2004; Jacobs 2000; Mairis, 1994; Matiti and Trored,
2004; SCIE, 2006; Woolhead et al., 2005), pride (Chochinov et al., 2002a; Gallagher and
Seedhouse, 2000; Griffin-Heslin, 2005; Haddock, 1996; Jacelon et al., 2004; Jacobs,
2000; Mairis, 1994; Marley, 2005; Matiti, 2002; Woolhead et al., 2005), confidence
(Haddock, 1996; Jacobs, 2000; Gallagher and Seedhouse, 2000), self-respect (Chochinov
et al., 2002a; Coventry, 2006; Gallagher and Seedhouse, 2000; Griffin-Heslin, 2005;
Haddock, 1996; Jacelon et al., 2004; Jacobs, 2000; Jacobson, 2007; Mairis, 1994; Marley,
2005; Matiti, 2002; Nordenfelt, 2003a; Tadd, 2004a, 2004b, 2004c), achievement (Marley,
2005; Nordenfelt, 2003a) and feeling important and valuable (Griffin-Heslin, 2005;
Haddock, 1996; Mairis, 1994). Other feelings related to dignity are: being happy with self
(Haddock, 1996), well-being (Chochinov et al., 2002a; Coventry, 2006), hope (Chochinov
et al., 2002a; Marley, 2005) and feeling comfortable (Fenton and Mitchell, 2002; Mairis,
1994). Thus a range of feelings and attributes have been associated with internal dignity.

All three studies from acute hospital settings identified control as an important component
of dignity (Jacelon, 2003; Matiti, 2002; Reed et al., 2003) indicating the relevance of
control to dignity within this environment, perhaps because patients experience a lack of
control, especially when acutely ill. While control relates to feelings, it is also closely
associated with behaviour - of patients themselves and others, particularly staff. There are
various dimensions of control, including control over choices, decisions and behaviour
(Calnan et al., 2005; Chochinov et al., 2002a; Enes, 2003; Fenton and Mitchell, 2002;
Gamlin, 1998; Griffin-Heslin, 2005; Haddock, 1996; Mairis, 1994; Marmot, 2004; Matiti,
2002; Randers and Mattiasson, 2004; Reed et al., 2003; Woolhead et al., 2005).
Autonomy also relates to control and was found to be frequently related to dignity (Calnan
et al., 2005; Chochinov et al., 2002a; Coventry, 2006; Griffin-Heslin, 2005; Haddock, 1996;
Jacobs, 2001; Kant, 1909; Marley, 2005; Marmot, 2004; Nordenfelt, 2003a; Randers and
Mattiasson, 2004; SCIE, 2006; Street, 2001; Woolhead et al., 2005). Some writers refer to
capability in definitions of dignity (Mairis, 1994; Shotton and Seedhouse, 1998;
Seedhouse, 2000) which is linked with control because people who can do things
themselves are likely to have greater control over their activities. The closely related
concept of independence is also relevant to control and links between independence and
dignity are well supported in the literature (Calnan et al., 2005; Chochinov et al., 2002a; Enes, 2003; Gallagher and Seedhouse, 2000; Griffin-Heslin, 2005; Haddock, 1996; Matiti, 2002; Pokorny, 1989; Woolhead et al., 2005). Unfortunately physical independence is often reduced in both long-term impaired health and during acute illness, presenting HCPs with the challenge of promoting dignity for people who may feel that they have lost their dignity due to loss of independence.

Some interpretations of dignity concern presentation of self in public through physical appearance (Chochinov et al., 2002a; Gallagher and Seedhouse, 2000; Enes, 2003; Mairis, 1994; Matiti, 2002; Tadd, 2004a). Turnock and Kelleher's (2001) study (see 3.2) was based on the assumption that dignity equates with the body being kept covered up. Although an association between dignity with modesty and decency has been identified (Griffin-Heslin, 2005; Matiti, 2002), there were few other references supporting such a link with dignity, although the converse (the body being inappropriately exposed) is frequently considered a threat to dignity (see 3.3). Presentation of self is also through personal behaviour and Jacelon (2003) identified that self dignity is portrayed through one's behaviour. Specific types of behaviour include courage and generosity (Kass, 2002), composure and restraint (Jacelon et al., 2004; Kolnai, 1995), courteousness (Jacelon et al., 2004), trustworthiness and solemnity (Jacobs, 2000) and giving love and support to others (Jacelon et al., 2004). Patients in two studies expressed that dignity is behaving according to their personal standards (Jacelon, 2003; Matiti, 2002).

The meaning of dignity as being about the attitude and behaviour from others is portrayed in a wide range of literature in relation to the nature of dignity but such behaviour also relates to how dignity is promoted (see Chapter 3, 3.4). Jacelon's (2003) study explained interpersonal dignity as being how staff behaviour towards patients conveyed a sense of worth. Thus communication is important (Coventry, 2006; Griffin-Heslin, 2005; Haddock, 1996; Marley, 2005), including form of address (Calnan et al., 2005; Matiti, 2002) and relationships, which involve reciprocal behaviour (Enes, 2003; Jacelon, 2003; Street, 2001). Later, in Jacelon et al.'s (2004) concept analysis, they described 'behavioural dignity' as including both the behaviour of individuals themselves and that of others towards them, thus a slightly different interpretation.

While self-respect has been identified in relation to dignity as an internal quality, conveying respect for others is frequently identified as behaviour associated with dignity. Jacobs
(2001) suggested that respect and dignity are separate, but closely linked concepts. Gallagher (2004b) explored how dignity and respect are linked and highlighted that the term respect is used in itself, as in to show respect for people but is also combined with other terms as in respect for dignity (or other attributes e.g. privacy). Respect is a term particularly likely to be used in succinct definitions of dignity (see Box 1.1; DH, 2001a; SCIE, 2006). The association of dignity with behaviour conveying respect emerged from concept analyses (Griffin-Heslin, 2005; Haddock, 1996; Jacobs, 2000; Jacelon et al., 2004; Johnson, 1998; Marley, 2005), in research with older people (Calnan et al., 2005; Gallagher and Seedhouse, 2002; Jacelon, 2003; Woolhead et al., 2005), in terminal care (Enes, 2003; Gamlin, 1998) and acute care (Matiti, 2002). Reciprocal respect was reported in focus groups with older people (Jacelon et al., 2004; Woolhead et al., 2005). Being treated as an individual (Calnan et al., 2005; Enes, 2003), as a competent adult (Gallagher and Seedhouse, 2000), valued for one's individuality (Fenton and Mitchell, 2002) and treated as important and valuable (Haddock, 1996) are other behaviours associated with dignity.

As identified in Chapter 1, privacy has been closely linked to dignity and in some contexts as if they are inseparable particularly in health policy documents. Privacy was identified in some of the concept analyses in various forms, for example, being private and able to keep one's boundaries as an attribute of the dignified self (Haddock, 1996), protecting privacy to convey respect (Griffin-Heslin, 2005; Jacobs, 2000) and being in control of one's own privacy (Marley, 2005). The literature implied that privacy, sometimes linked with personal space, related to keeping aspects of oneself (physical or emotional) hidden from others. Privacy was associated with dignity in most of the research studies reviewed (Calnan et al., 2005; Chochinov et al., 2002a; Enes, 2003; Gallagher and Seedhouse, 2000; Jacelon, 2003; Matti, 2002; Pokorny, 1989; Randers and Mattiasson, 2004; Reed et al. 2003). Overall though, privacy emerged relevant as a factor that either promoted dignity, if present, or threatened dignity, if it did not meet the person's desired level. Jacelon (2003) exemplified this by explaining that being afforded privacy can convey respect to a person and that therefore privacy is important to dignity regarding respect and personal space. From reviewing the literature, a feeling that privacy was maintained to one's desired level helped to promote dignity and the behaviour of others had a major impact on whether privacy was experienced. Therefore privacy is discussed in more detail in Chapter 3 as a factor that could threaten dignity (if lacking) or promote dignity.
2.6 Chapter summary

This chapter has highlighted that dignity has a range of meanings and that the term is used in varying contexts. From a healthcare perspective, the literature review indicated that dignity is held internally, experienced through feelings, expressed externally through physical appearance and personal behaviour, and influenced by the attitude and behaviour of others. Feeling in control is a major attribute which relates both to personal feelings and the behaviour of others. The meaning of dignity has not been extensively explored through primary research, particularly in acute care settings, and patients’ views have rarely been sought. In the next chapter, the literature is reviewed concerning what threatens patients’ dignity and how dignity can be promoted, and a theoretical framework is presented.
Chapter 3 Threats to patient dignity and the promotion of patient dignity in hospital

3.1 Introduction

Chapter 2 examined the meaning of dignity, reviewing concept analyses, primary research studies and other scholarly papers and texts. This chapter first presents an overview of primary research studies which have explored threats to patient dignity and how dignity is promoted in hospital, drawing on some studies reviewed in Chapter 2 (2.4) and a range of other studies. The chapter then discusses the literature relating to how the themes of hospital environment, staff behaviour and patient factors threaten or promote dignity. The theoretical framework derived from this review and the specific research questions conclude the chapter.

3.2 Primary research studies exploring threats to patient dignity and how patient dignity can be promoted

Primary research focusing on how dignity is threatened or promoted has been conducted in a range of settings using various methodologies. Studies based in acute hospital settings will first be reviewed.

Matiti and Sharman (1999) suggested that pre-operative care involves potential threats to dignity mainly because of issues around body image. They surveyed 250 adult patients to evaluate whether they felt that their dignity had been maintained, and addressed communication, privacy and body image, which a literature review identified as relevant to dignity. The questionnaire was piloted thus enhancing internal validity. The patients completed the questionnaires during the post-operative period, while still on the ward. As the questionnaires were completed anonymously, this should have encouraged honesty. The results indicated that most patients were satisfied with the level of dignity maintained pre-operatively but a lack of auditory privacy and inadequate explanations were highlighted. The patients’ responses were framed by the questions, and the authors acknowledged that only asking about communication, body image and privacy prevented a more comprehensive picture being obtained.

Matiti’s (2002) phenomenological study based in acute medical and surgical wards
(reviewed in 2.4) identified threats to dignity and how dignity was promoted as well as exploring patients’ and staff perceptions of dignity. The study design enabled participants to express their own perceptions, rather than being constrained by a quantitative survey approach as in Matiti and Sharman (1999). The perceptual adjustment level (PAL) theory (see 2.4) portrayed how patients adjusted their perceptions of their dignity in hospital, taking into account the new environment. As considered in 2.4, Matiti (2002) identified eleven categories (privacy, confidentiality, need for information, choice, involvement in care, independence, form of address, decency, control, respect and nurse-patient communication), the sum of which led to dignity being maintained. Developing a trusting nurse-patient relationship enabled patients to reach an acceptable PAL in relation to these factors, leading to patients feeling dignified and in control. Nurses stated that they maintained dignity according to how they would like to be treated but Matiti (2002) pointed out that there may have been different expectations between nurses and patients, and patients’ perceptions of their dignity were not assessed. In summary, Matiti’s (2002) findings provided valuable insights into how patients and staff perceived dignity was threatened or promoted in an acute hospital environment.

In a much smaller, Australian study, Walsh and Kowanko (2002) also used a phenomenological design, conducting taped unstructured interviews with a volunteer sample of five patients and four nurses. Ideally, participants for such a small study should have been selected purposively to ensure quality rich data were gained. There is no detail about the participants, although the data infers an acute care setting. The participants were asked to describe experiences of how dignity had been maintained or compromised. There was close similarity between the themes which emerged from the patients' interviews (being exposed, having time, being rushed, time to decide, being seen as a person, the body as object, being acknowledged, consideration, discretion - including use of humour to reduce embarrassment), and those from the nurses' interviews (privacy of the body, private space, consideration of emotions, giving time, the patient as a person, the body as object, showing respect, giving control, advocacy). Most themes related to staff behaviour, and some related to how staff promoted dignity (e.g. giving control) while others related to how dignity was threatened (e.g. patients being exposed). Findings relating to privacy included issues such as prevention of exposure and personal space. The study provided an in-depth account of the participants' views but the sample was very small.
In a Swedish study, Widäng and Fridlund (2003) interviewed seventeen male patients from medical or surgical wards, the aim being to describe how male patients conceived integrity. The authors state that integrity is a complex concept linked to wholeness, although in Randers and Mattiasson's (2004) study (see 2.4), also based in Sweden, their explanation of integrity equates it with privacy. Once again, according to the researchers this was a phenomenological study, although the questions asked were quite structured, which appears incongruent with the research design. The authors stated that participants were invited to be interviewed which implies a purposive sampling technique although this was not explicit. The interview questions concerned integrity and three categories emerged from the data: self respect, dignity and confidence. The category, 'dignity', related to how caregivers treat patients and was about being seen as a whole person, being respected (included providing privacy and listening) and being seen as trustworthy.

Woogara (2004) (selected results published in Woogara, 2005a; 2005b) conducted an ethnographic study in three acute medical and surgical wards. His main focus was privacy, which has already been identified as important for dignity in this thesis and Woogara's model of privacy proposed that dignity is a component of privacy. He also examined levels of intrusion against the Essence of Care Privacy and Dignity benchmark (DH, 2001a) and the HRA (Great Britain, 1998), finding that they were poorly adhered to. His methods comprised non-participant observation, unstructured interviews with patients (n=55) and staff (n=12), and semi-structured interviews with patients (n=18) and staff (n=22). As the patients' interviews were conducted while they were still in hospital, there was a risk that patients may not have revealed their true feelings. Woogara (2004) did not provide information about how he ensured that he did not intrude on patients' and relatives' privacy while conducting non-participant observation, which gives concern from an ethical perspective. Wainwright (1994) asserts that the presence of a non-participant observer threatens patients' dignity and privacy. Furthermore, it is more usual to conduct participant observation in an ethnographic study so that the researcher can become immersed in the culture (Streubert, 1999a). Woogara (2004) found that nearly all staff and patients considered privacy to be important but not as important as other aspects of care such as medicine administration, indicating a hierarchy of care. The majority of patients and staff expressed acceptance that patients had little privacy in NHS wards and Woogara (2004) observed that privacy was continually breached. He identified that patients had little control or choice in hospital, for example they were moved round the ward without their consent, disrupting the relationships they had formed with other patients. Overall, Woogara's (2004)
findings portray a bleak picture of privacy in an NHS hospital, and if privacy is disregarded, dignity will be threatened.

The next two studies reviewed were both based in ITUs. Clearly, although these were based in an acute hospital setting, ITUs differ from medical and surgical wards, where most acutely unwell patients are cared for. The main aim of Söderberg et al.’s (1997) phenomenological hermeneutic study was to explore ethical dilemmas arising with ITU patients in Sweden. The interviews asked twenty RNs from ITUs in six different hospitals to narrate episodes of ethical difficulty. There is no information about how the sample was obtained. Dignity emerged as a core theme as situations posing ethical dilemmas often involved instances where the nurses felt patients’ dignity and/or integrity were compromised because treatment was inhumane, excessive or unfair. There is an absence of patients’ and relatives’ perspectives in this study and little practical insight offered into ways in which nurses can promote dignity.

In the UK, Turnock and Kelleher (2001) studied the maintenance of ITU patients’ dignity using an action research approach. They stated that non-exposure of certain areas of the body (e.g. genitalia) is a social norm within the UK but that it is common practice in ITU for patients to be nursed naked, for the convenience of clinical procedures. Bodily exposure has been identified as a threat to patients’ dignity (Matiti, 2002; Walsh and Kowanko, 2002) but Turnock and Kelleher (2001) assumed that maintenance of dignity is synonymous with prevention of bodily exposure without recognising that other factors (e.g. staff interactions) might affect patients’ dignity too. They used non-participant observation to record incidents involving exposure; most occurred during clinical procedures. Full screening of patients occurred in only a third of exposure incidents. A focus group of eight staff discussed the results and planned how maintenance of patient dignity (prevention of bodily exposure) could be improved. Staff identified that the need for observation and equipment hindered full screening but also acknowledged that dignity was not always a high priority. They identified ways of preventing bodily exposure, such as greater vigilance about screening and clothing, and protocols were developed. A subsequent audit of clothing found 42 per cent of patients were now clothed in comparison with 22 per cent prior to the intervention. The use of screens however was not re-examined. The study's findings highlighted the vulnerability of critically ill patients to bodily exposure and the important role of staff in providing privacy. The action research design enabled accepted practices to be challenged and a new staff-led protocol to be implemented and partially
evaluated. The main limitation of the study is that only one aspect related to patient dignity was examined.

Other studies of how patient dignity is threatened and promoted in an acute hospital setting include two studies based in children's wards. Although this thesis is focused on adults, these studies are relevant as many acute care practices are hospital-wide, regardless of age. Using structured questionnaires, Rylance (1999) interviewed the parents of 300 in-patient children about privacy, dignity and confidentiality during their children's stay in a UK hospital. The study is reported briefly and there is no information about how the questionnaire was developed and tested. Furthermore the sample was opportunistic and no response rate is stated. These issues all limit how the study's results can be interpreted and in addition the author acknowledged that the survey made assumptions that the issues on the questionnaire were important to parents. Although the age of the children was from three months to sixteen years the views of the older children were not sought. The findings indicated that privacy, dignity and confidentiality were poorly respected in children's wards. Reed et al.'s (2003) pilot study (reviewed in 2.4) identified 'micro dignity' as being concerned with individual and social norms and thus loss of control over bodily functions threatened dignity. They suggested that the nurse-patient relationship is key to enabling patients to feel valued as a human being (macro dignity), while attending to issues relating to micro dignity. Like other researchers, Reed et al. (2003) highlighted the lack of privacy in hospital and the risk of exposure (physical and personal) in front of others.

USA researchers, Matthews and Callister (2004), conducted a descriptive qualitative study to investigate women's perceptions of how their dignity was maintained during childbirth. Although the setting and client group were very different to the population of interest to this thesis there could be applicability as women in childbirth have only a short stay in the healthcare environment and their experience, like many patients in acute care settings, is acute and intense. The volunteer sample comprised twenty women who had given birth in the past three months. The women's recollections of their childbirth may have faded over this timespan. Semi-structured interviews were conducted in their homes, using an interview guide based on previous research and clinical experience. Follow-up interviews were conducted with five women to verify the results of the analysis, thus enhancing validity. The findings emphasised that nurses played a central role in promoting the
women's dignity and that the women appreciated feeling valued and respected and being assisted to achieve their preferred level of control.

With a similar client group in a different culture, Lai and Levy (2002) report on a Chinese phenomenological study with a purposeful sample of eight women, focusing on their experiences of vaginal examinations during labour. The taped unstructured interviews were conducted in a private room on the postnatal ward at least 24 hours post delivery so the women were rested but their memories of their experiences should have remained clear. The results included that the women needed to be able to trust in the examiner's respect for them as individuals and that they would maintain their dignity. However, as in other studies, privacy was not always maintained during this intimate procedure. The examiner being kind, considerate, experienced and skilful was more important than their gender. The women felt some control over the situation when the examiner was sincere and supportive. Both Matthews and Callister's (2004) and Lai and Levy's (2002) studies confirmed the importance of healthcare staff's attitudes and behaviour and could be applicable to other healthcare environments.

A number of other studies have focused on how older people's dignity is threatened or promoted. The HAS 2000 (1998) reported on an inquiry into the care of older people in acute hospitals in the UK. As discussed in 1.4, the study was triggered by The Observer campaign 'Dignity on the Ward'. The Observer had highlighted the need for 'basic dignified nursing care: personalised care, promoting autonomy, personal hygiene and access to food and drink' (HAS 2000, 1998, p. 4), as well as other issues relating to healthcare for older people. The study was undertaken in sixteen acute wards in eight general hospitals across England. Structured interviews aiming to cover all aspects of the hospital experience were conducted with patients over 70 years old (n=71) and some of their relatives (n=59) after discharge. While conducting the interviews following discharge might have increased honesty, the interviewees' recollections of their hospital experiences may not have been accurate. Staff (n=305), of whom 73 per cent were nurses, returned a questionnaire. Ten focus groups were held with staff volunteers followed by individual staff interviews (n=10) to check the validity of the focus group findings. Four trained researchers observed 68 patients over 75 years on fifteen wards, observing physical environment, quality of care and interactions, and the managers of these wards were also interviewed. Staff and patients were told that interactions were being observed but not that quality of care was being judged, thus whether informed consent was obtained is questionable. The
observation method was developed for judging quality of care in in-patient settings for people with dementia yet the patients observed were all on acute medical and surgical wards; the authors do not discuss the transferability of the research instrument to this setting. The observers were trained to use the tool and satisfactory inter-rater reliability was achieved, thus enhancing the study's validity.

The HAS 2000's (1998) extensive results indicated that preserving dignity and individuality, when meeting essential needs, was not always achieved and although this sometimes related to a poor physical environment it was more often to do with staff attitudes. There was inadequate provision of essential personal care, and staff interactions which threatened dignity were evident, while reassurance and information-giving promoted dignity. The HAS 2000 (1998) found that some wards had a culture of respect for patients. As discussed in 1.4, this study provided the basis for health policies such as Essence of Care (DH, 2001a) and the NSF for Older People (DH, 2001b) which aimed to address the issues identified.

Gallagher and Seedhouse's (2000) study of older people's dignity (reviewed in 2.4) identified both threats to dignity and ways in which dignity could be promoted. Staff approach to patients was a dominant theme and ensuring comfort and cleanliness promoted dignity. Patients' conditions increased their vulnerability to a loss of dignity, for example, incontinence or confusion. As in the other studies reviewed in this section, participants highlighted the importance of privacy, not being exposed and caring interactions. A clean, pleasant environment promoted dignity but an inadequate environment with poor resources undermined dignity. In the light of this, Seedhouse and Gallagher (2002) emphasised that the better the resources, the more likely that patients will be dignified.

The previous two UK studies portray how poor environments and staff attitudes in older people's care threatened dignity and Jacelon's (2003) USA study revealed undignifying care too. However, she also presented how older people promoted their own dignity in hospital in a variety of ways. The study, conducted with older people in an acute hospital setting (reviewed in 2.4), indicated that patient's self dignity was threatened on admission as they were expected to undress, lie on stretchers and be subjected to examinations which breached privacy and diminished dignity. Once the acute phase of illness was over, patients became more uncomfortable about their dignity and they told stories about
themselves (e.g. their accomplishments) to portray their dignity. Patients identified that if they treated staff respectfully, they would reciprocate and staff whose interactions demonstrated respect, promoted patients' dignity. As in other studies, lack of privacy threatened dignity but patients coped by adjusting their attitude. Jacelon's (2003) study, like Matiti's (2002), emphasised patients' own role in sustaining their dignity by making adjustments.

The 'Dignity and Older Europeans' project reviewed in 2.4 focused mainly on views about older people and dignity in society as a whole but some of the focus group findings related to how dignity was promoted or threatened in hospital, drawn from participants' experiences. Older people and professionals in the UK identified that dignity was threatened in healthcare when there was a lack of attention to patients' appearance, there was a lack of privacy and inappropriate forms of address were used (Calnan et al., 2005; Woolhead et al., 2005). UK professionals identified many organisational and resource issues that threatened the dignity of older people but considered that promoting independence and interactions that conveyed respect promoted dignity (Calnan et al., 2005).

In Norway, Stabell and Nåden (2006) conducted four qualitative focus groups with nurses, regarding the challenges they faced on a rehabilitation ward in a nursing home and how these affected patients' feelings of dignity. A limitation, therefore, is that the results were based on nurses' perceptions of these effects, not patients'. Stabell and Nåden (2006) developed a theoretical framework which drew on Seedhouse's (2000) philosophy and thus the results were interpreted in relation to capability and independence. Nurses discussed situations where patients' disabilities prevented them from doing what they wanted to do; there were strong links made between dignity and independence. Some staff discussed how heavy workload impinged on their ability to promote dignity. Nurses expressed that treating patients as individuals was important for dignity but found it challenging trying to meet patients' varying needs.

The next studies to be discussed relate to dignity in terminal care. As presented in 2.4, a Canadian team of researchers have studied how terminally ill patients' dignity can be conserved (Chochinov, 2002; Chochinov et al., 2002a; Chochinov et al., 2002b; Chochinov et al., 2004; Hack et al., 2004; McClement et al., 2004). Their dignity-conserving model (see 2.4) incorporates both concepts of dignity and factors affecting dignity. Thus physical
or psychological distress (e.g. fear of dying) and reduced independence are factors that can threaten dignity while patients engaged in various dignity-conserving perspectives and practices to conserve dignity. McClement et al. (2004) identified how HCPs can assist with illness-related concerns and suggested ways to support patients with their dignity-conserving perspectives and practices. Hack et al. (2004) continued the work of Chochinov et al. (2002a, 2002b) with 213 cancer patients completing rating scales concerning their overall sense of dignity, symptom distress, pain, functional dependency, quality of life, social support, desire for death, anxiety, hopelessness, will to live and burden to others. All the instruments used had been previously validated. Nearly half of the patients reported some dignity concerns, if only occasional ones. Factor analysis indicated that patients who felt depressed, and whose physical health had deteriorated to the extent that they needed help with personal care, were more vulnerable to a loss of dignity. The findings and recommendations may have limited application to an acute hospital setting.

Enes’ (2003) study of dignity in terminal care which explored the meaning of dignity (reviewed in 2.4), also identified the negative impact of illness and treatment, and care which promoted dignity. Some participants expressed that treatment impacted on body image (e.g. weight gain due to steroids) but patients’ ability to adapt and alter their perceptions of dignity was evident. All participants identified that lack of resources and poor organisation had a negative impact on dignity. Staff attitudes, including empathy and conveying respect, could promote dignity. Gamlin’s (1998) internet-based study of dignity in palliative care (reviewed in 2.4) identified that offering choices and enabling control and conveying respect were staff actions promoting dignity.

In a Swedish study, Öhlén (2004) explored care which threatened the dignity of patients undergoing palliative care, using a phenomenological approach to interview sixteen men and women in-depth about their care experiences. They were not specifically asked about violation or dissatisfaction with care but examples they gave were of receiving bad news (about diagnosis) in a ‘brusque and brutal way’ and fundamental care needs being denied. Öhlén (2004) concluded that people who are life-threateningly ill are highly vulnerable to care-related violations and that caregivers must prevent such occurrences. The study’s findings could be applicable to acute hospital settings too, where patients are also vulnerable.

In summary, the primary research studies reviewed in this section all make contributions to
understanding how patient dignity can be threatened or promoted but only five (Matiti and Sharman, 1999; Matiti, 2002; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003; Woogara, 2004) were conducted in acute hospital settings with adults across the age range. Of these, Widäng and Fridlund's (2003) and Woogara's (2004) studies included findings related to dignity but were not focused on dignity as a main theme. Nevertheless, as indicated during the review there were some common themes and it became clear that the study of how patient dignity is threatened or promoted in an acute hospital setting should focus on three areas: the hospital environment, staff behaviour and patient factors. Therefore the next three sections review how these factors threaten or promote patients' dignity, drawing predominantly from studies previously reviewed as well as other research and scholarly papers relevant to the identified areas.

3.3 How the hospital environment impacts on patient dignity

This section will first consider the factors in a hospital environment which threaten patients' dignity. The negative impact of the unfamiliar hospital environment and surrounding people has long been identified (Foucault, 1973) with the unfamiliarity increasing patients' vulnerability (Sundin et al., 2001). The physical environment (in particular, lack of privacy), inadequate resources (physical and human) and a dehumanizing ward culture and organisation have all been found to threaten dignity and the literature relating to each will be presented.

A lack of privacy in hospital has emerged as a central factor that leads to a loss of dignity and while staff behaviour is an important factor (considered in 3.4) the physical structure can be at fault. As considered in 1.4, the DH (2004) clearly states that NHS hospitals in England must provide a care environment that supports patient privacy and confidentiality. Patients have been found to dislike wards that allow inadequate privacy and personal space (Douglas and Douglas, 2004; HAS 2000, 1998) and small bedspaces leading to close proximity of beds threaten dignity (Seedhouse and Gallagher, 2002; Woogara, 2004). Rylance (1999) too identified that the physical structure of wards negatively impacted on patients' dignity in children's wards. Woogara (2004) highlighted the open nature of wards which are designed for observation not privacy and Johnson (2005) suggested such designs provide unacceptable levels of privacy by today's standards while acknowledging the tension between promoting privacy and observing patients. In healthcare settings, patients are generally expected to share their bedroom with complete
strangers, which would not usually happen at home (Jacelon, 2003; Kirk, 2002; Woogara, 2004) and is perceived by some patients as a loss of privacy. Two studies in terminal care found a preference for single room accommodation (Kirk, 2002; Street and Love, 2005) and participants in some acute care studies also expressed that single rooms offered greater privacy (Matiti, 2002; Woogara, 2004).

The public nature of hospitals puts privacy at risk (Reed et al. (2003), threatening privacy of the body and privacy of patients' personal information. As regards the body's privacy, healthcare experiences can lead to bodily exposure, for example, during childbirth (Lai and Levy, 2002; Matthews and Callister, 2004). Patients' perceptions of bodily exposure can vary, for example, Matiti (2002) identified that older patients were more self conscious about exposure and she highlighted societal acceptance towards most of the male body being exposed publicly. Several studies have found that hospital gowns or nightclothes put privacy of the body at risk as they are ill-fitting and expose the back (Bauer, 1994; Denner, 2004; Matiti, 2002; Matiti and Sharman, 1999; Maxwell, 2000; Tadd, 2005b; Walsh and Kowanko, 2002; Woogara, 2005). In addition, Matiti (2002) identified that as gowns are done up at the back they render patients helpless. Bodily exposure also extends to exposure of body products with publicly displayed urine bags being considered a loss of dignity (Volker et al., 2004) and privacy (Bauer, 1994; Woogara, 2004). Thus there are a variety of ways in which hospital experiences result in bodily exposure.

The use of curtains to screen patients is the key method of preventing bodily exposure in hospital wards and Burden (1998) found that curtains are also used to signify privacy needs. However, several studies have highlighted the inadequacy of curtains in protecting privacy as they are often poor fitting and not fully closed (Barron, 1990; Gallagher and Seedhouse, 2000; Jacelon, 2003; Matiti, 2002; Turnock and Kelleher, 2001; Woogara, 2004) and they do not provide a barrier against sound. Inadequate auditory privacy in hospitals has been identified in several studies (Barlos et al., 2001; Bauer, 1994; Hooper, 1995; Jacelon, 2003; Matiti, 2002; Matiti and Sharman, 1999; Maxwell, 2000; Pattison and Robertson, 1996; Rylance, 1999; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003; Woogara, 2004). In Barlos et al.'s (2001) emergency department study, four patients expressed that the lack of auditory privacy led them to withhold some details of their medical history, a worrying finding which could have safety implications. With good reason, therefore, Johnson (2005) asserts that no patients should be asked to provide personal information behind curtains. A lack of privacy when talking to hospital staff (Pattison and
Robertson, 1996), and during ward rounds, has been highlighted (Matiti, 2002; Rylance, 1999; Woogara, 2004). A Swedish study identified the importance patients placed on being able to talk to doctors privately (Bäck and Wikblad, 1998) and Matiti (2002) found a lack of facilities for discussing private matters. Interestingly, Woogara (2004) found that privacy of information, though considered relevant by some patients, was emphasised more by staff.

Mixed sex wards have been found to further threaten the privacy and thus the dignity of patients. In some wards, patients are cared for in same sex bays with separate bathroom facilities but in other wards there has been no segregation or separate facilities and patients are cared for in a mixed sex environment (MSE). In 1995 the DH, in The Patients' Charter, assured patients of certain rights and expectations regarding admission to mixed sex wards, later acknowledging that mixed sex wards are a threat to patients' dignity (DH, 1997). However studies, particularly with older people, have continued to identify mixed sex wards as a threat to dignity because of lack of privacy (Gallagher and Seedhouse, 2000; The HAS 2000, 1998) and the risk of bodily exposure (Woolhead et al., 2005). Page (1995) found strongly opposed views of mixed sex wards in a survey of patients, relatives and staff in an acute hospital. The overwhelming majority expressed concern, with patients being worried about potential bodily exposure and embarrassment. Respondents considered that mixed sex wards were only acceptable if patients were not in a mixed sex bay and had separate washing and toilet facilities. More recently, Rhodes et al. (2003) surveyed thirty patients admitted to a UK acute stroke unit about their experiences of being in a MSE. About a third of the patients considered that the MSE was unacceptable due to a lack of single sex toilet and washing facilities and insufficient information about the MSE. Generally, however, relatives and friends appeared more concerned than patients about the MSE. Johnson (2005) argued that while MSEs may improve patient throughput, shared facilities between sexes infringe privacy. Recently, the DH (2005a) published a statement giving a commitment to eliminating mixed sex accommodation for patients, identifying three objectives to deliver single sex accommodation, which were defined as separate sleeping areas, bathroom and toilet facilities for men and women and NHS Trusts are being monitored against these objectives.

Shotton and Seedhouse (1998) suggested that when resources are scarce, and there are obvious technical problems to deal with, it is easy to neglect patient dignity. Several studies identified that inadequate resources (e.g. linen) threatened dignity (Enes, 2003;
HAS 2000, 1998; Matiti, 2002; Seedhouse and Gallagher, 2002) and that they led to
depersonalisation (Calnan et al., 2005; Woolhead et al., 2005) and routinisation of care
(Calnan et al., 2005). A poor physical environment which threatens dignity includes
inadequate bathrooms and toilet facilities (Gallagher and Seedhouse, 2000; HAS 2000,
1998; Matiti, 2002). Several studies identified that staff shortages adversely affected
dignity (Calnan et al., 2005; HAS 2000, 1998; Matiti, 2002; Reed et al., 2003; Seedhouse
and Gallagher, 2002; Tadd, 2004a; Woogara, 2004). The resulting use of agency staff led
to loss of continuity and increased likelihood of dignity being violated in some studies
(Calnan et al., 2005; Gallagher and Seedhouse, 2000; Matiti, 2002; Reed et al., 2003).
Staff shortages made patients feel rushed and less valued as human beings and they
experienced a loss of individuality (Matiti, 2002; Walsh and Kowanko, 2002). UK young
and middle-aged adults expressed that the healthcare system resembled a production line,
with patients treated as objects (Tadd, 2005b) and A&E nurses described how high
workload prohibited an individualised, holistic approach to patients (Byrne, 1997). Patients
have been found to perceive busy staff as detached and dehumanizing (Kralik et al.,
1997), abrupt (Matiti, 2002) and felt inhibited from asking staff questions (Coyle and
Williams, 2001; Matiti, 2002). Busy staff were also less likely to promote independence
(Matiti, 2002; Stabell and Nåden, 2006) and privacy (Woogara, 2004) and staff caring for
older people admitted that high workload prevented them being able to provide quality
personal care (Calnan et al., 2005). Overall, there is much evidence to suggest that
inadequate human resources have a negative impact on patients’ dignity. However, Reed
et al. (2003) proposed that nurses hold power through busyness, communicating it to
patients by avoiding eye contact, indicating that while high workload may impact on staff
approach, individual behaviour also plays a part.

The environmental culture is also pertinent and includes the social norms of staff and the
policies, systems and accepted practices within the setting. Poor ward leadership and a
lack of good role models (Woogara, 2004) and a dehumanising hospital culture (Walsh
and Kowanko, 2002) have been reported. UK professionals identified organisational and
resource issues that threatened the dignity of older people as being a lack of staff training
and organisational issues, such as task-orientated culture, high pressure work, NHS
priorities, managerial targets and lack of guidelines (Calnan et al., 2005). Gallagher and
Seedhouse’s (2000) study highlighted that institutions have their own cultures and hospital
culture could have a positive or a negative effect. Traditional practice and ward culture
were considered to have a negative impact on patient dignity in children's wards (Rylance,
1999). Older people in focus groups stated that the care environment diminished individuality leading to loss of dignity (Tadd, 2004a). Furthermore, a number of studies identified that loss of control and disempowerment accompanied hospitalisation (Bauer, 1994; Douglas and Douglas, 2004; Jacelon, 2003; Matiti, 2002; Reed et al., 2003; Schuster, 1976; Woogara, 2004). The expectation that patients will routinely undress on admission has been noted in several studies (Jacelon, 2003; Maxwell, 2000; Woogara, 2004) thus removing identities. From a managerial perspective, Woogara (2004) reported that DH deadlines, for example, waiting list targets, took a greater priority than privacy. Thus a number of studies have identified ways in which hospital culture and organisation can threaten patients' dignity.

Ways in which the hospital environment can promote patients' dignity will now be considered. A number of studies identified that a physical environment which provides privacy will promote dignity (Ariño-Blasco et al., 2005; Clegg, 2003; Enes, 2003; Gallagher and Seedhouse, 2000; Jacelon, 2004; Jacobs, 2000; Randers and Mattiasson, 2004; Reed et al., 2003; Turnock and Kelleher, 2001; Walsh and Kowanko, 2002) but the type of environment necessary to promote privacy, and thus dignity, is rarely specified. Street and Love (2005), in a palliative care-based study, identified that staff equated privacy solely with physical space. Pattison and Robertson (1996) found that patients overwhelmingly preferred wards with bays to Nightingale2 wards, although patients felt the latter promoted better visibility of them by nurses. Lawson and Phiri (2003) found that patients in single rooms were generally more satisfied with their environment than patients in multiple-bed spaces. Patients have also been found to like a ward layout which engenders feelings of security and comfort (Douglas and Douglas, 2004). While these latter studies indicated patients' preferences for the environmental layout in hospital, they made no specific links with dignity.

Gallagher and Seedhouse (2000) found that a clean, pleasant environment promoted dignity but few other writers studying patient dignity have referred to these aspects. However, the impact of the physical environment on patients' well-being and satisfaction has been studied, and ward cleanliness was found to be important (Douglas and Douglas, 2004; Lawson and Phiri, 2003). Indicators of a patient-friendly environment included personal space and ownership, privacy and dignity, and accessible facilities, such as

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2 Nightingale wards are traditional UK wards, established in Florence Nightingale's hospital design, comprising one long ward with beds on either side.
bathrooms (Douglas and Douglas, 2004). In Bauer's (1994) study of privacy in hospital, accessibility to bathrooms was also considered important. Lawson and Phiri (2003) found that patients in newer, purpose-built wards expressed more satisfaction with the overall design, appearance and layout, than patients in older wards. They suggested that patients' concerns about the appearance of wards have a symbolic element as patients' impressions of the ward's appearance link to their confidence about their care in that environment. Patients in newer wards stated that the environment helped them to feel better, their recovery times were improved and they expressed greater satisfaction with other aspects of their hospital stay including their treatment and the staff (Lawson and Phiri, 2003). Lawson and Phiri (2003) concluded that patients who are happier in their environment transfer these feelings to their assessment of other aspects of their experience. In addition, staff may feel more positive in a better environment and portray this to patients in their behaviour. Chapter 2 established the link between dignity and having control and several authors argue for a hospital environment which gives patients some level of control, for example over the lighting and use of the television (Douglas and Douglas, 2004; Lawson and Phiri, 2003; Ulrich, 1997). In a study of how personhood is maintained in a hospice, Kabel and Roberts (2003) found that patients personalized their space with photos and items from home, which could be a way of patients exerting some control over their surroundings, as well as reducing unfamiliarity.

As previously identified hospital culture can have a positive or negative impact on dignity (Gallagher and Seedhouse, 2000). Few other studies have linked ward culture and promotion of dignity but the HAS 2000 (1998) study found that some wards had a culture of respect for patients and sensitivity to privacy and dignity which was highly dependent on the ward manager's leadership. Holland et al. (1997) identified the importance of a professional, caring work culture in the critical care environment which they studied. They suggested that the unit culture was influenced by the managerial style, philosophy and the collection of individuals working there. They also asserted that formal and informal leaders are responsible for fostering a professional caring attitude amongst new and existing staff. Although their findings are relevant in relation to how a caring culture is promoted, no direct links were made to patient dignity. The DH (2004) stated that hospitals must have systems in place to ensure that staff treat patients and relatives with dignity and respect. Such systems would require written policies relating to dignity but a lack of written guidance has been reported (Calnan et al., 2005; Woogara, 2004). There are some examples of hospital based approaches to promote good practice in patient dignity, for
example Essence of Care benchmarking with follow-up action plans (Denner, 2004) and staff workshops (Matiti and Cotrel-Gibbons, 2006).

Chochinov et al. (2004) identified the role of social support in promoting dignity for terminally ill patients. Other studies have not explicitly linked this dimension with the promotion of dignity though several studies in varying settings indicated that patients appreciate the company and support of other patients (Applegate and Morse, 1994; Douglas and Douglas, 2004; Kralik et al., 1997; Lawson and Phiri, 2003; Pattison and Robertson, 1996; Söderberg et al., 1999; Street and Love, 2005). For example, some staff in Street and Love’s (2005) study reported that palliative care patients appreciated the social support of other patients and their families. Lawson and Phiri (2003) found that, despite the impact on privacy, some patients preferred to have the company of others in a multi-bed space than being in a single room and there were no apparent gender or age differences related to this view. Pattison and Robertson (1996) found that most surgical patients described a ‘group spirit’ on the wards studied but ward design had no significant effect on the development of personal relationships between patients. However, in Douglas and Douglas’s (2004) study, ward layout was influential in promoting social interaction and support of other patients. The HAS 2000 (1998) observed that while female patients were often supportive to each other, male patients were much less likely to interact and be interested in each other’s well-being. However, no links to dignity were made.

Two authors identified explicit benefits that patients gain from being with patients with similar conditions: the enhancement of their privacy (Woogara, 2004) and feeling understood (Söderberg et al., 1999). In an early study on patient privacy, Schuster (1976) described camaraderie between patients which had a positive impact on how they perceived privacy. Patients themselves decreased the distance between each other and shared personal information. Schuster (1976) identified a ‘levelling out’ effect, whereby patients accepted a different degree of privacy in hospital as they were all in the same situation. Bauer (1994) too described the role of the ‘patient community’ in relation to privacy, with patients expressing the need to be mutually considerate to each other and that good relationships between patients had a positive effect on privacy. In a care home for older people Applegate and Morse (1994) found that some residents behaved as friends to others, helped and advocated for each other and in these situations there was warmth, sharing, humour and reciprocity with a respect for privacy. Overall, there is
evidence that patients can have a beneficial effect on each other but explicit links to dignity are not made in most studies although effects on privacy are sometimes noted.

The studies reviewed in this section were conducted in a wide range of settings but relatively few in acute hospital settings for adults of all ages. Research studies have identified various factors in the hospital environment which threaten patients’ dignity: the ward’s physical structure, lack of bodily and auditory privacy, mixed sex wards, poor resources, a controlling ward culture and organisation, and lack of written guidance. Conversely, environmental privacy has been found to promote dignity in studies set in a range of healthcare settings but other environmental factors that might promote dignity are rarely identified and poorly supported in the current literature. There is research supporting how a conducive physical environment and the company of other patients can have a positive impact on patients’ experiences but explicit links to their dignity are weak and need further exploration. Staff behaviour has already been alluded to in relation to ward culture but is more specifically examined in the next section.

### 3.4 How staff behaviour impacts on patient dignity

Staff have been found to threaten dignity by breaching patients’ privacy and through their interactions with patients. Research relating to both these aspects is next considered, and the staff behaviour which promotes dignity will then be discussed.

While patients’ bodily privacy can be breached because of environmental factors (discussed in 3.3), staff behaviour can also play a major part. Staff exposing people’s bodies and being inattentive to their privacy has been found to threaten patients’ dignity in the care of older people (Applegate and Morse, 1994; Gallagher and Seedhouse, 2000; Jacelon, 2002; Woolhead et al., 2005), on general wards (Matiti, 2002; Walsh and Kowanko, 2002), in ITU (Turnock and Kelleher, 2001) and with women in labour (Lai and Levy, 2002). Staff intrusion behind curtains during intimate procedures involving bodily exposure has been reported in maternity units (Lai and Levy, 2002), by older people (Ariño-Blasco, 2005) and in acute wards (Bauer, 1994; Matiti, 2002; Woogara, 2004). Patients’ personal territory (their bedspace and locker - referred to by Matiti (2002) as the patient's 'micro-environment') was not respected by staff either (Matiti, 2002; Woogara, 2004). Matiti (2002) found that while staff expressed that privacy was important, they did not see themselves as ‘intruders’. Overall, previous research from various settings indicates that
staff do not always uphold patients' privacy, despite patients' vulnerability and dependence in the healthcare setting. However, Bauer (1994) found patients were often accepting towards nurses intruding behind doors or curtains when they were undressed. Apart from lack of attention to privacy of the body, there are other forms of behaviour towards people's bodies that can threaten dignity. These include treating people's bodies like objects (Tadd, 2004a, 2004b, 2004c; Walsh and Kowanko, 2002) and not treating a person's body after death with respect (Söderberg et al., 1997).

Various types of staff interactions, comprising verbal communication and their attitude, can threaten patients' dignity. An authoritarian approach, including disempowerment and denying choice, was identified in care of older people (HAS 2000, 1998; Hewison, 1995; Huckstadt, 2002; Jacelon, 2002, 2004; Randers and Mattiasson, 2004; Woolhead et al., 2005), in palliative care (Martin, 1998; Öhlén, 2004) and children's wards (Reed et al., 2003). Authoritarian behaviour includes excluding patients from involvement in decisions about their lives and deaths (Tadd, 2004a) and overprotecting patients (Nay, 2002; Tadd, 2004a). In situations where people have physical incapacity there is a risk that autonomy in decision-making is not upheld by caregivers (Collopy, 1988). Nay (2002) argued that all physical risk is removed from older people in the health care system, and that removing the right to take risks removes autonomy and control. However, HCPs expressed dilemmas in trying to balance risk and freedom in the care of older people (Tadd, 2004c) but this concern was not raised by the focus groups with non-HCPs (Tadd, 2004b); perhaps they were unaware of the HCPs' dilemmas. In the UK, the Code of Professional Conduct requires nurses to both protect patients from risk and promote dignity, hence the potential dilemma (NMC, 2004).

In a study based in rehabilitation wards, nurses admitted using power frequently but considered their approach was essential for rehabilitation programmes to succeed and stated that choices were given in some activities (Giaquinto, 2005). Hewison (1995) identified that language is a key aspect of control and that nurses use several different types of power: overt power, as when patients are ordered to do something, persuasion, controlling patients' activities, and terms of endearment where patients were spoken to like children, which appeared to be caring but was combined with control. Forms of address that threaten dignity have been identified as: patients not being asked how they would like to be called so first or second names assumed (Calnan et al., 2005; Matiti, 2002; Woogara, 2004; Woolhead et al., 2005), patients being addressed by endearments (HAS
2000, 1998; Matiti, 2002; Woogara, 2004; Woolhead et al., 2005) and older people reported being spoken to as if they were deaf, unintelligent or children (Tadd, 2004a). Matiti (2002) found that there were varying preferences expressed by patients and some patients adjusted to how they were addressed even though they would have preferred a different form. Matiti and Sharman (1999) found that the majority of patients preferred being addressed by their first names but 15 per cent preferred their surnames, and patients were generally addressed by their preferred name.

Other types of interactions found to threaten dignity are not treating patients with respect (Gallagher and Seedhouse, 2000; Lai and Levy, 2002; Randers et al., 2002; Tadd, 2004a, 2004c), ignoring patients (Enes, 2003; HAS 2000, 1998; Matiti, 2002; Tadd, 2004a, 2004c; Walsh and Kowanko, 2002), brusqueness (HAS 2000, 1998; Öhlén, 2004), harshness (Calnan et al., 2005), not treating patients as though they are credible (Söderberg et al., 1999; Werner and Malterud, 2003), not attending to patients promptly (Matiti, 2002), treating patients like children (Matiti, 2002), being patronizing (Calnan et al., 2005) and humiliating patients (Tadd, 2004a). As regards lack of respect, Woogara (2004) reported a general lack of courtesy towards patients, for example, doctors rarely introduced themselves to patients and patients were frequently interrupted by staff while they were eating. Matiti (2002) identified that nurses did not recognise the need for respect to be integral to all procedures, only associating it with personal care. More extreme staff behaviour that threatens dignity is inhumane treatment and care (Nordenfelt, 2003a). Some older people in Tadd's (2004a) study reported verbal abuse from hospital staff and in some instances care verging on physical abuse; the older people considered this was caused partly by the impoverished and under-resourced care environment. However, while working in such an environment may be demoralising for staff, abusive behaviour is clearly unacceptable and breaks the Code of Professional Conduct for nurses in the UK (NMC, 2004).

Studies in varied settings reported staff using a 'cold' approach in their interactions with patients which, although not explicitly identified as a threat to dignity, could be interpreted as a lack of respect. Applegate and Morse (1994) found that some care home staff treated patients as objects, gave no explanations and did not demonstrate compassion, understanding or kindness nor respect individuality. In Holland et al. (1997)'s study, critical care patients remembered some staff being cold and distant which increased their stress. Kralik et al. (1997), in a study of women's experiences of post-operative nursing care,
found that patients described some nurses as being 'detached' from them. 'Detached' nurses treated patients as a number or object, were sharp or cold in their approach and behaved as if their work was just a job. They also identified nurses who were too efficient and busy as being 'detached'. On a similar vein, in Walsh and Kowanko's (2002) study, patients considered that staff rushing them threatened their dignity. Patients in Kralik et al.'s (1997) study also described 'detached' nurses as being dehumanizing and authoritarian and they performed care with minimal verbal communication and information. Similarly, in their study of older patients' experiences of comfort, Tutton and Seers (2004) described staff who did not provide comfort as being disengaged and using a harsh approach, showing no sympathy, being irritable and an attitude implying that they 'could not be bothered'. Tutton and Seers (2004) concluded that for patients to have a positive outcome there needs to be some emotional connection between staff and patients. Again, although their study does not make links with dignity, the approach of nurses who did not provide comfort appears similar to that which has been identified as threatening dignity. Studies relating to the 'popular/unpopular patient' suggested that in some instances nurses' behaviour changes according to whether they 'like' a patient (Johnson and Webb, 1995; Stockwell, 1972) and a detached approach, which threatens dignity, is likely where patients are unpopular.

A few studies identified staff provision of poor quality care as threatening patients' dignity. The HAS 2000 (1998) reported inadequate provision of essential care such as personal hygiene and assistance with elimination. Similarly, Woolhead et al. (2005) identified a lack of attention to older people's appearance as threatening their dignity. In Öhlén's (2004) study too patients reported that their dignity was violated by lack of fundamental care, for example not being assisted to wash following vomiting. More recently, respondents in the DH (2006b) survey identified lack of assistance with eating, hygiene and elimination and inattention to patients' appearance as threats to dignity.

While studies have identified various types of staff behaviour that threaten dignity, the potential of staff behaviour to promote patients' dignity is strongly supported in a wide range of literature. Emphasising the role of staff, Widäng and Fridlund (2003) argued that promoting dignity is dependent on how patients are treated by their caregivers. Some studies suggest that underlying staff attitudes and values are crucial if staff behaviour is to promote dignity. For example, Nåden and Eriksson (2004) identified that nurses who promoted dignity had a strong moral attitude underpinned by values such as respect,
honesty and responsibility; such nurses had a *genuine interest and desire to help patients* (p.90). Similarly Bayer et al. (2005) found older people considered that attitudes of caregivers were central to dignified care, portraying that the person is valued. Applegate and Morse (1994) asserted that privacy-promoting actions such as pulling curtains are of little value if not accompanied by respect for personhood. They observed that staff whose attitude towards nursing home residents was that of a friend, respected their privacy. Walsh and Kowanko (2002) concluded that while privacy was important it was not enough to promote dignity; patients also needed to feel like unique human beings. Thus the underlying staff attitude has emerged as paramount in several studies.

As discussed earlier, staff breaching privacy has been found to threaten patients' dignity. Thus the provision of privacy by staff has emerged as important for patients' dignity from studies in diverse settings: terminal care (Kabel and Roberts, 2003; McClement et al., 2004), critical care (Holland et al., 1997), care of older people (Ariño-Blasco et al., 2005; Bayer et al., 2005; Gallagher and Seedhouse, 2000; Jacelon, 2003), maternity care (Matthews and Callister, 2004) and acute hospital care (Matiti, 2002; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). The use of curtains has been identified as important for promoting privacy (Jacelon, 2003; Matiti, 2002) although as discussed earlier, curtains are sometimes ill-fitting. Staff applying signs or clips to curtains to prevent staff intrusion has been reported (Denner, 2004; Wright, 2006). The importance of privacy of the body through prevention of exposure has been explicitly identified (Gallagher and Seedhouse, 2000; Jacobs, 2000; Matiti, 2002; Tadd, 2004a, 2004c; Turnock and Kelleher, 2001; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003) and Matiti (2002) highlighted the importance of explanations prior to exposure. Maintaining privacy of information (confidentiality) is another staff factor which can promote dignity (Calnan et al., 2005; Matiti, 2002). Overall, provision of privacy by staff is a key factor which helps to promote dignity and it includes environmental privacy, privacy of the body and informational privacy.

There is much literature suggesting that humanistic caring approaches promote dignity: treating patients as human beings (Enes, 2003; Halldirsdottir, 1991; Tadd, 2004c, Walsh and Kowanko, 2002), holistically (Tadd, 2004c; Widäng and Fridlund, 2003) and conveying a caring attitude (McClement et al., 2004). The Essence of Care (DH, 2001a) asserts that staff-patient communication which respects individuality promotes dignity, which is well supported in research from a variety of settings: terminal care (Enes, 2003; Kabel and
Roberts, 2003; McClement et al., 2004), women in labour (Lai and Levy, 2002), care of older people (Ariño-Basco et al., 2005; Gallagher and Seedhouse, 2002; Randers and Mattiasson, 2004; Stabell and Nåden, 2006), care of patients with stroke and aphasia (Sundin et al., 2001), children's wards (Reed et al., 2003) and acute hospital care (Matiti, 2002; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). In several studies, nurses emphasised the need to treat patients as people, no matter what their condition - conscious, unconscious or dead (Gallagher and Seedhouse, 2000; HAS 2000, 1998; Jacobs, 2000; Nordenfelt, 2003b; Söderberg et al. 1997; Walsh and Kowanko, 2002). Walsh and Kowanko (2002) identified that patients stated that they wanted to be acknowledged as a 'living, thinking and experiencing human being not just an object' (p.149). Johnson (1998) specifically referred to acknowledging humanity being necessary to promote the dignity of people who are dying. It is concerning that patients do not always feel that they are treated as human beings, prompting the question of whether when people become patients, there is a risk that their humanity is diminished.

In an acute hospital setting, the importance of a trusting nurse-patient relationship to promote dignity was identified in both adult (Matiti, 2002) and children's wards (Reed et al., 2003). Reciprocity in relationships has been highlighted where patients' dignity was promoted: mutual valuing between staff and patients (Matiti, 2002) and mutual respect (Jacelon, 2003). Though other authors have not specifically referred to staff-patient relationships, the interactions identified as promoting dignity portray a caring approach which would promote a relationship. In Holland et al.'s (1997) study in critical care, patients identified that caring, professional attitudes of nurses made them feel safe and a warm, caring approach was associated with being treated with dignity. Treating people with respect is closely linked to meanings of dignity (see 2.5) but is also a means to promote dignity (Ariño-Basco et al., 2005; Clegg, 2003; DH, 2006b; Enes, 2003; Gallagher and Seedhouse, 2000; Gamlin, 1998; Lai and Levy, 2002; Matiti, 2002; Randers and Mattiasson, 2004; Tadd, 2004a, 2004c; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). A few studies and health policy documents have more explicitly identified how respect can be conveyed by staff: showing respect for personal space (DH, 2001a; Widäng and Fridlund, 2003), believing people and respecting their wishes (DH, 2001a; Matthews and Callister, 2002; Widäng and Fridlund 2003), adopting a discreet manner (Calnan et al., 2005) and respecting patients' culture and religion (DH, 2001b; Jacobs, 2000; McClement et al., 2004). Other interactions portraying respect are courteousness, politeness and addressing people by their preferred name (DH, 2001b; Gallagher and
Treating patients with respect may help them to feel valued which is important in promoting patients’ dignity too (Chochinov et al., 2002; Hagerty and Patusky, 2003).

Previous research has identified a wide range of other staff approaches which promote dignity: fostering hope (Hack et al., 2004), treating patients with empathy (Enes, 2003; Matthews and Callister, 2002; Tadd, 2004c), compassion, kindness, patience and consideration (Gallagher and Seedhouse, 2000; Halldirsdottir, 1991; Lai and Levy, 2002; Tadd, 2004a; Walsh and Kowanko, 2002), giving patients and relatives time (Halldirsdottir, 1991; Söderberg et al., 1997; Walsh and Kowanko, 2002), listening (Gallagher and Seedhouse, 2000; Jacobs 2000; Tadd, 2004a, 2004b, 2004c; Widäng and Fridlund, 2003), cheerfulness (Halldirsdottir, 1991), reassurance and encouragement (HAS 2000, 1998; Matthews and Callister, 2004), friendliness (Jacelon, 2003) and helpfulness (Gallagher and Seedhouse, 2000; Jacelon, 2003; Sundin et al., 2001). Tutton and Seers (2004) found staff approach had a powerful impact on patient comfort for older people and that patients sought out nurses who were kind, gentle and friendly as they made them feel comfortable. As identified in 2.5, dignity is associated with feelings in some of the literature, including feelings of comfort, so Tutton and Seers’ (2004) work is relevant although not explicitly linked to dignity.

Gaining patients' confidence has been found to promote dignity in a few studies, for example, Sundin et al. (2001) reported that gaining patients’ confidence and trust helped to restore their dignity. Widäng and Fridlund (2003) found that patients trusted staff when they appeared knowledgeable and had good communication skills and empathy. Studies have also indicated that staff acting in a professional manner reassured patients (McClement et al., 2004; Widäng and Fridlund, 2003). Two studies of women in maternity units identified that their dignity was promoted when they felt confident in the staff (Matthews and Callister, 2004; Lai and Levy, 2002). Intimate procedures can potentially cause embarrassment (which may result in loss of dignity) and there is some evidence that nurses adopting a discreet, matter-of-fact manner in such situations promoted dignity (Gallagher and Seedhouse, 2000; Walsh and Kowanko, 2002). Similarly, Matiti (2002) found that patients’ embarrassment during intimate procedures was reduced if patients felt nurses were doing an everyday professional activity and were sensitive.

Two studies in terminal care explicitly linked humour with promoting dignity. McClement et
al. (2004) suggested that sensitive use of humour can help conserve dignity in terminally ill people, helping them to live for the moment. Dean (2003) studied the use of humour and laughter in palliative care and found that it had a number of functions including protection of patients’ dignity. Staff participants explained using intuition for when and how to use humour in their interactions. These were the only studies identified explicitly linking staff use of humour with promotion of dignity but several other studies identified staff use of humour to reduce embarrassment (Maxwell, 2000; Seed, 1995; Skogstad, 2000; Walsh and Kowanko, 2002) and patients may perceive embarrassment as a loss of dignity. Other studies indicated that staff use of humour with patients had beneficial effects, although promoting dignity was not explicitly identified. Psychological benefits of humour include the reduction of anxiety, depression and loneliness, improvement of self-esteem, restoration of hope and energy and a feeling of empowerment and control (Berk, 2001). Use of humour has been found to reduce stress (Bennett et al., 2003; Berk, 2001; Bottorff et al., 1995; Sumners 1990), convey kindness (Sumners, 1990), relax patients (Sundin et al., 2001) and create closeness (Olsson et al., 2002). Olsson et al. (2002) considered that although humour has an important role in effective interpersonal communication, empathy and sensitivity are necessary in its use.

Helping patients to feel in control (through information-giving and explanations, offering choices, seeking consent and promoting independence) is well supported in the literature. However few of the studies referring to this dimension of dignity were based in acute hospital settings with adults, the exceptions being Matiti (2002) and Walsh and Kowanko (2002); Matiti (2002) suggested that control impacts on all other aspects of dignity. Gaining consent before carrying out procedures emerged as important in the ‘Dignity in Older Europeans’ study (Tadd, 2004a, 2004c). Promoting independence (Calnan et al., 2005; Clegg, 2003; Hack et al., 2004; McClement et al., 2004; Matiti, 2002; Woolhead et al., 2005) and maintaining patients’ abilities (Walsh and Kowanko, 2002; Hack et al., 2004) have been identified as promoting dignity. Facilitating choices and decisions to promote dignity is prominent in the literature (Calnan et al., 2005; Doutrich et al., 2001; Enes, 2003; Gamlin, 1998; Jacobs, 2000; Johnson, 1998; Kabel and Roberts, 2003; Matiti, 2002; Matthews and Callister, 2004; McClement et al., 2004; Nåden and Eriksson, 2003; Nordenfelt, 2003b; Perry, 2005; Randers and Mattiasson, 2004; Walsh and Kowanko, 2002; Widång and Fridlund, 2003; Woolhead et al., 2005). Information and explanations promoted a feeling of being in control for women with fibromyalgia (Söderberg et al., 1999), women in labour (Lai and Levy, 2002; Matthews and Callister, 2002), patients with
terminal illness (Enes, 2003), older people (Bayer et al., 2005; HAS 2000, 1998; Jacelon, 2002), in critical care (Holland et al., 1997), and reduced unfamiliarity and promoted informed choice in acute care wards (Matiti, 2002). Patients' self esteem and thus their dignity can be promoted by staff involving patients in their care (Cahill, 1998; Matiti, 2002) and promoting their autonomy (Tadd, 2004a).

The literature cited so far has mainly considered the attitude and interpersonal behaviour of caregivers. Perhaps because providing quality care could infer respect and that the person is of value, the provision of quality health care has been considered to promote dignity. For example, in ‘A new ambition for older age’ (see Chapter 1, 1.4), the DH (2006a) included the following aims in its section on ‘Dignity in Care’: the improvement of the physical environment, assistance with eating and drinking and best practice end-of-life care. However, all of these measures should apply to people of all ages, not only older people. Examples of quality care that have been associated with dignity include: ensuring good standards of hygiene and dress (Bayer et al., 2005; Clegg, 2003; Gallagher and Seedhouse, 2000; HAS 2000, 1998; Woolhead et al., 2005), assisting with elimination needs (Calnan et al., 2005), assessing symptoms (McClement et al., 2004) and providing comfort and pain relief (Jacobs, 2000). The DH (2001b) stated that enabling patients to wear their own clothes promotes their dignity and Wilson (2006), in a small project based on a ward for older people, successfully implemented a new system to enable patients, where possible, to wear their own day clothes. Promoting dignity through quality care is particularly likely to be associated with terminal care, for example achieving good pain control (Bayer et al., 2005; Chochinov et al., 2002; DH, 2001b; Jacobs, 2000), maintaining good hygiene and verbal communication (Woolhead et al., 2005) and respect for the body and person at the time of death (Jacobs, 2000; Söderberg et al., 1997; Tadd, 2004c). The NSF for Older People (DH, 2001b) included a wide range of measures to promote quality of care for older people who are dying, under the heading ‘Dignity in end-of-life care’.

In summary, the literature review has identified staff behaviour as a major dimension relating to patient dignity with three broad areas of staff behaviour: breaching or providing privacy, staff interactions and the quality of care provided. Many of the research findings presented have arisen from settings outside the acute hospital environment however; few studies have examined the impact of staff behaviour in acute care settings for adults across the age range. Some of the interactions which may promote patients' dignity, for
example humour, are only weakly supported in the current literature. The next section examines literature relating to the impact of patient factors on dignity.

3.5 How patient factors impact on patient dignity

Previous research identified that hospital patients are vulnerable to a loss of dignity (Gallagher and Seedhouse, 2000; Jacelon 2003) and reasons for this are explored next. Specific patient factors that can threaten dignity and may accompany hospitalisation are: altered body image (Enes, 2003; Matiti and Sharman, 1999), physical impairment (Hack et al., 2004; Tadd, 2004a, 2004c); depression (Hack et al., 2004); dementia (Tadd, 2004a, 2004c), confusion (Gallagher and Seedhouse, 2000), dependency and loss of function (Chochinov et al., 2002a; Gallagher and Seedhouse, 2000; Hack et al., 2004; Huckstadt, 2002; Jumisko et al., 2005; Matiti, 2002; Söderberg et al., 1999; Sundin et al., 2001; Volker et al., 2004), incontinence (Reed et al., 2003), physical and psychological distress (Chochinov et al., 2002a); and pain and suffering (Chochinov et al., 2002a; Woolhead et al., 2005).

In acute care settings people who can usually physically care for themselves may be unable to do so because of the reasons for their hospitalisation. Several studies have described the impact of dependence on patients' feelings, though not all make links with dignity. For example, Holland et al. (1997) found that critical care patients identified that their loss of function and dependence was stressful and Schuster's (1976) study of privacy in hospital found that impaired mobility or consciousness prevented patients from influencing their personal boundaries. Some studies have reported patients' embarrassment at being dependent on others (Bauer, 1994; Matiti, 2002) and Matiti (2002) identified that some patients could not adjust to their dependency while incapacitated. Matiti (2002) highlighted that patients still needed to feel that their dignity was maintained when they were very ill, particularly when looking back on it afterwards. The intimate care resulting from dependency, such as washing, dressing, toileting and catheterisation, can invade privacy and cause embarrassment (Bauer, 1994; Matiti, 2002; Woogara, 2001). The gender of the care-giver in such situations can further influence patients' feelings (Chur-Hansen, 2002; Matiti, 2002). Hack et al. (2004) found that when terminally ill patients' physical health deteriorated to the extent that they needed assistance with personal care, they experienced an associated loss of dignity. Woogara (2005) highlighted how patients who were dependent on staff had very limited control and choice over their
activities, such as elimination. Several examples from different studies illustrate this point: Jacelon (2003) reported that older people described how their dignity was negated by performing intimate activities, such as going to the toilet, in front of others, and older people identified that using bedpans and commodes, because of loss of ability to independently go to the toilet, was a threat to their dignity (Sacco-Peterson and Borell, 2004). Bauer's (1994) study found that the majority of patients agreed that using a bedpan or commode was 'one of the most dreadful things' in relation to privacy. In a study of seven people with advanced cancer, Volker et al. (2004) found participants expressed concern about losing control over bodily functions and not being able to care for themselves. Similarly, Rozmovits and Ziebland (2004) reported on the embarrassment of colorectal cancer, being associated with disruption of bodily functions and invasive and sometimes distressing procedures.

The above review relates mainly to physical factors threatening patients' dignity; psychological factors are less apparent in the literature. However, Tadd (2004a) reported that loneliness, boredom, apathy, desperation and suffering, led to a loss of dignity for older people. Any of these factors can accompany hospitalisation, particularly where it is long-term. The psychological impact of living with fear and uncertainty, which can accompany both acute and long-term illness, has also been identified (Råholm and Lindholm, 1999) and Chochinov et al. (2002a) reported that fear of dying impacted on dignity. Nordenfelt (2003b) elaborated on how illness threatens dignity, suggesting that illness itself leads to loss of a person's self image of having integrity, strength and autonomy. Thus the loss of dignity relates to the loss of an intact and functioning body. Pearson et al. (2004) found that illness led to a loss of identity and role for some hospitalized patients and, as identified in 2.5, feelings about self are associated with dignity.

Some literature indicates that older people are more susceptible to loss of dignity. The emphasis on dignity in DH documents relating to older people implies that this is the case (DH, 2001b; DH, 2006a; DH, 2006c). In the DH (2006b) survey, many respondents' comments related to older people's dignity being threatened. Some research on dignity has focused on older people only (Gallagher and Seedhouse, 2000; HAS 2000, 1998; Jacelon, 2003; Tadd, 2004a, 2004b, 2004c) which could indicate that the authors consider older people to be more vulnerable to a loss of dignity but as they made no comparisons with younger age groups, no conclusions about this can be drawn. Matiti and Trorey
(2004) cited two patients of differing ages who expressed that dignity is more at risk in older people. Redman and Fry (2003) found that nurses in leadership roles identified protecting patients' rights and human dignity as their most frequently experienced ethical issue. The authors considered this might have been partly because many respondents worked with older people who, Redman and Fry (2003) considered, are particularly vulnerable to loss of their human rights and dignity. Supporting this view, Scott et al. (2003) highlighted the vulnerability of older people in long-term care and their powerlessness in their relationships with staff. They found that the older people reported never being involved in decisions and low levels of consent to procedures were also found. Tadd (2004c) found that HCPs considered older people to be more at risk of loss of dignity due to frailty and vulnerability, leading to the need for intimate care. In perhaps the strongest evidence for older people's greater susceptibility to loss of dignity in hospital, Woolhead et al. (2005) report that UK older people themselves considered that they were more vulnerable to loss of dignity than younger people, as they considered that younger people are more able to assert their rights while older people take on a more passive role in healthcare settings.

While, as discussed earlier, patients in hospital can encounter many threats to their dignity, several studies' findings indicated that patients use a variety of mainly psychological approaches to deal with the potential loss of dignity arising in healthcare, thus promoting their own dignity. Chochinov et al.'s (2004) model of dignity in terminally ill people identified strategies to conserve dignity as living in the moment, maintaining normalcy and seeking spiritual comfort but these were specifically related to dignity in terminal illness. Jacelon (2003) reported that older patients described 'self-dignity' as their own inner sense of their worth based on their achievements during their lives. Patients told stories about themselves (such as when they had helped others or accomplished something) to remind themselves and staff about their dignity and life outside hospital. Towards the end of their admission, they drew on their memories to help sustain their self dignity. Similarly, research with terminally ill patients identified that drawing on their life experience helped them to conserve their dignity (Chochinov, 2002).

While previous sections highlighted how the physical environment and staff behaviour impact on patients' privacy in hospital, Schuster's (1976) study of privacy in hospitalised adults recognised how patients' attitudes affect their privacy. She makes no links to dignity but her findings could have relevance, as links between privacy and dignity have emerged
in this literature review. Schuster (1976) identified three aspects of privacy: life style, event and personality. Privacy of life style referred to individual's preferences for privacy in their everyday life. Privacy of event was when privacy was required in a certain situation, such as an intimate care procedure. Privacy of personality related to privacy as part of self. Schuster (1976) identified that maintaining a boundary was a crucial issue and in hospital four factors affected patients' control over their boundary: mobility, level of consciousness, the relationships between patients, and their perceptions of the role of patients and staff. Patients rationalised that they were all in the same position as regards privacy and they perceived that staff had legitimate access to patients and could cross their boundary. Although this study is old, the findings still appear applicable today and are supported by more recent studies. For example, Bauer (1994) found that some patients accepted personal information being overheard by others as the situation was reciprocal so it 'levelled out'. Similarly, Woogara (2004) reported one patient adopting the attitude that privacy was not an issue as patients all had the same condition. Like Schuster (1976), Bauer (1994) found that patients had individual perceptions of what constituted privacy and that relationships between patients affected views of privacy.

Matiti’s (2002) PAL theory (explained in 2.4) portrayed how patients adjusted their perceptions of their dignity in hospital, rationalizing about the need to be in hospital to get better and that any loss of dignity accompanying hospitalization was worthwhile. Likewise, Jacelon (2003) described older patients' adjusting their attitudes during hospitalisation and Enes (2003) identified that terminally ill patients were able to adapt and alter their perceptions of dignity. Matiti (2002) found however that some patients 'suspended' their dignity while they were in hospital and not all patients were able to make perceptual adjustments and these patients coped by distancing themselves although this led to feelings of stress, embarrassment and vulnerability. Several other studies found that patients used rationalisation to cope with threats to their dignity such as having vaginal examinations during labour (Lai and Levy, 2002) and having personal care carried out by staff (Bauer, 1994; Chochinov, 2002; Schuster, 1976). Woogara (2004) found that patients dealt with the lack of privacy in hospital by adapting to the situation, viewing it as a 'trade-off' for their treatment and adopting a culture of acceptance.

Acceptance has been identified as promoting dignity for people with chronic disease (Campbell, 2005) and in Chochinov et al.'s (2004) model of dignity in terminally ill people. Bauer (1994) theorised that patients have a hierarchy of acceptance of degrees of
intimacy and accepted a degree of closeness from staff that would not be acceptable in other circumstances. She proposed that patients will accept a similar degree of closeness with other patients as with family members, which enables patients to feel more comfortable about sharing accommodation. In relation to attitudes towards bodily exposure, Walsh and Kowanko (2002) cite an example of a patient who was unconcerned about bodily exposure. Few other such attitudes have been reported but Woogara (2004) found that some patients expressed a lack of concern and acceptance about wearing hospital gowns which caused bodily exposure.

A further patient factor identified in Chochinov et al.'s (2004) model of dignity in terminally ill people was retaining control. In a study of how women live with life-threatening disease, Lumby (1997) found that retaining control (both at home and when in hospital) was a central issue and actively strived for. However, Lumby (1997) makes no links with dignity. Earlier sections examined environmental (3.3) and staff factors (3.4) which help patients have control but ways of patients taking control to promote their dignity are little explored. However, Matiti (2002) found that patients felt a sense of control by making a 'perceptual adjustment' to their notion of dignity. As discussed earlier, Schuster (1976) identified that patients' control of their personal boundary is an integral part of their privacy. Patients' dignity was promoted if they regained or retained their independence (Jacelon, 2004; Mattti, 2002); specifically it reduced embarrassment regarding personal care (Mattti, 2002). Independence could also lead to patients feeling more control over their bodies and personal activities. In Enes' (2003) study based in a hospice some patients described continuing to maintain their appearance (e.g. applying make-up) as promoting their dignity, which would enable some control over their bodies. Use of humour by patients about certain situations has also been identified as a means of feeling in control (Mahony et al., 2002) and such situations could be those which threaten dignity by being embarrassing. Several studies reported that patients used humour, possibly as a defence mechanism, to reduce embarrassment (Matiti, 2002; Maxwell, 2000; Seed, 1995; Skogstad, 2000; Walsh and Kowanko, 2002) and anxiety (Olsson et al., 2002). Campbell (2005) suggests that people with chronic disease, who maintain their self-respect and can counter threats to their dignity, have a sense of humour and courage.

A few studies have identified that patients sought relationships with staff as a means of promoting their own dignity. Chochinov et al.'s (2004) model suggested social support, including relationships with staff, as a way of restoring terminally ill patients' dignity.
Jacelon’s (2003) study of older people in hospital found several strategies used: treating staff respectfully hoping that this would lead to staff reciprocating, trying not to bother staff and, particularly as patients felt better, they would try to form relationships with staff, by talking to them about their families for example, which reduced the inequality in the relationship. Applegate and Morse (1994) found that some residents approached staff in a friendly manner, greeted them by name and offered compliments and sweets, but their findings were not specifically linked to dignity. These latter studies though, both with older people, highlight the inequality in relationships and power imbalance between staff and patients, with patients feeling that they had to make these efforts.

In summary the patient factors threatening dignity most prominent in the literature relate to physical impairment which increases dependence. Psychological factors and older age have also been identified in some studies. A few studies, two of which were set in acute hospital settings, have provided evidence of how patients adjust their attitudes to their dignity in hospital. Patients in a few studies actively developed relationships with staff, and regaining their independence also promoted dignity. All these patient strategies can be linked with patients gaining control over themselves and their situation. However, it was evident that most studies have focused mainly on staff approach and to some extent the environment when considering how dignity can be promoted; patients’ own roles have been little considered.

3.6 Theoretical framework and research questions

A range of potential threats to patients’ dignity and ways in which dignity can be promoted have been presented, related to the hospital environment, staff behaviour and patient factors. The review of previous and current work relating to dignity indicates that patient dignity is considered an important topic, but few studies focused specifically on patient dignity in an acute hospital setting therefore the literature review drew on a wide range of sources: research about patient dignity conducted in other settings and research about related areas. Of the studies focused specifically on the dignity of adults of all ages in an acute hospital setting, the impact of the environment and staff behaviour has not been explored through methods such as observation. There has been a particular emphasis on older people’s dignity but while the majority of the patients in general acute care wards (medical and surgical) are older, these wards do admit younger adults and there is no evidence to suggest that their dignity is not important too.
Drawing on the wide range of literature reviewed in this chapter and Chapter 2, a theoretical framework was developed (see Figure 3.1), and this will be explained next.

**Figure 3.1 Patient dignity in hospital: a theoretical framework**
The figure portrays patient dignity in central place, being threatened or promoted by patient factors, staff behaviour and the hospital environment. These factors interact and their combined effect has a greater impact on patient dignity than each factor in isolation.

**Patient dignity**
Patient dignity entails each person's individuality and their feelings, and having control, particularly over decisions and behaviour. Dignity also comprises the presentation of self to others in terms of physical appearance and personal behaviour. The final component is that dignity is reflected by the attitudes and behaviour from others.

**Patient factors**
Patient factors are those which are intrinsic to the patient. Health status affects dignity, as impaired health may lead to loss of function, hospitalisation and invasive treatment. Age too may be a factor; older age can tentatively be considered to render dignity more vulnerable. Positive health status with good functional ability can promote dignity as patients are more independent and in control of their actions. Psychological factors, in particular patients' attitudes and feelings about themselves, their hospitalisation and health status, and their ability to adjust to hospitalisation, can threaten or promote their dignity. Relationships with others in the environment also impacts on patients' dignity.

**The hospital environment**
The hospital environment comprises the physical environment, with its impact on privacy particularly, and the available resources (physical and human). The systems and culture also impact on patients' dignity and influence the working practices of staff. Other patients in the hospital environment affect patients' dignity as the majority of patients in NHS hospitals are cared for with other patients.

**Staff behaviour**
Staff behaviour affects patients' dignity through their interactions, which are underpinned by their attitudes. Their physical actions, in particular the provision of privacy and the quality of care they provide, also impact on patients' dignity.

**Interactions between the factors affecting patient dignity**
Patient factors, staff behaviour and the hospital environment interact and the example presented next illustrates this proposition. A patient's impaired health and lack of function threaten their dignity. However, the actual impact of this intrinsic factor is affected by staff behaviour and the hospital environment and each of these interacts too. For example, a patient's lack of function leads to the need for staff to assist with intimate care, during which their interactions with the patient and standard of privacy provided impacts on the patient's feelings. The hospital environment may or may not provide the structure for a
high standard of privacy while the intimate care is carried out, being affected for example, by whether the bay is mixed sex and curtains pull adequately. The ward culture and workload impacts on staff behaviour while carrying out the care, for example whether the staff member appears rushed and whether other staff intrude behind the curtains. The hospital environment may affect the patient’s functional ability, for example, an accessible bathroom could increase independence in hygiene. The physical appearance of the ward and the facilities may affect the patient’s attitude towards their hospitalisation. Other patients in the environment may offer social support to the patient and the patient may develop relationships with staff and other patients. This example illustrates how while impaired health status constitutes a threat to patients’ dignity, staff behaviour and the environment can affect whether dignity is promoted or further threatened in this situation.

The theoretical framework explained above led to the following research questions being identified:

In an acute hospital setting:

1. How is dignity perceived by patients and staff?
2. How do intrinsic factors affect patients’ dignity?
3. How does staff behaviour influence patients’ dignity?
4. How does the environment impact on patients’ dignity?
5. Taking into account patient factors, staff behaviour and the environment, how can patients’ dignity be promoted?

To answer the research questions it was necessary to select a study design that enabled all the relevant dimensions - patient factors, staff behaviour and the environment - to be examined in context so that their interactions and influences on each other could be ascertained.

3.7 Chapter summary

This chapter reviewed primary research relating to how patient dignity is threatened or promoted in hospital and it was identified that there is a paucity of relevant research which has investigated the dignity of adults of all ages in hospital and limited methodologies have been used to date. The hospital environment, staff behaviour and patient factors were identified as either threatening or promoting dignity and a theoretical framework was developed to portray how these factors interact with each other and affect patient dignity.
The research questions arising from the theoretical framework were specified. In the next chapter the research design, a qualitative case study, is explained, including the data collection methods, how the ethical issues were addressed and the data analysis process.
Chapter 4 Methodology and data analysis

4.1 Introduction

This chapter will first discuss the epistemology and research design, explaining the rationale for selecting a qualitative case study approach, and presenting an overview of data collection methods and participant characteristics. Ethical issues will then be discussed with reference to consent, confidentiality and balancing risks and potential benefits. Access, selection of the case study ward and recruitment of staff participants will be explained. Preparation for the study including piloting of the main data collection methods is then discussed, followed by a detailed examination of each of the data collection methods including sampling techniques and patient recruitment procedures. The data analysis process is explained and finally, the factors contributing to promoting rigour of the research are presented.

4.2 Epistemology

The literature review indicated that patient dignity is complex and subjective in nature and factors affecting dignity are inter-related and not easily, or appropriately, reduced to measurable components. In addition, there was a dearth of research exploring patient dignity within an acute hospital setting and focusing explicitly on the impact on dignity of patient factors, staff behaviour and the environment. Therefore a positivist approach would not have been congruent with the aims of this study, as researchers working from a positivist perspective adopt an objective and reductionist stance to collect quantitative data to test existing theory. Furthermore, it is argued that positivism does not enable human beings and their behaviour to be studied in depth (Crossan, 2003), which was essential to address this study's research questions in an insightful and valid manner. In the interpretivist paradigm, however, phenomena are studied from a holistic perspective in their natural setting and qualitative data are collected to gain in-depth insights to develop knowledge. The interpretivist paradigm was therefore an appropriate perspective from which to address this study's research questions.

Within the interpretivist paradigm various research designs can be used. Studies of patient dignity within an acute hospital setting have mainly used phenomenology, thus
appropriately gaining patients' and nurses' subjective perspectives of dignity through in-depth interviews. However, while patients' and staff's perceptions of dignity were important to this study's aims, the role of staff behaviour and the environment were other key considerations for which using a wider range of data collection methods, including observation, were necessary. After careful consideration of possible methodologies, a qualitative case study was considered most congruent with the study's research questions. No previous studies of patient dignity identified had used such an approach and it was considered that this methodology would provide the structure needed to develop this topic's study further. The next section explains in more detail the rationale for selecting case study design and how it was applied in this study.

4.3 Case study design

Chapter 3 established that context was highly relevant to the topic of patient dignity so it was important that the research design enabled the study to take place in an actual clinical setting. A case study design is especially suitable for developing understanding of the significance of particular factors within the context of the whole case (De Vaus, 2001). Case studies can be used within the positivist or interpretivist paradigm but because of the emphasis in case studies on in-depth and holistic study, they are often associated with qualitative research. This study was based within the interpretivist paradigm and thus the case study design developed was qualitative.

Texts on case study research were examined and Yin's (2003) structure was found to be highly informative and provided a systematic approach to the research design. Stake (1995, 1998) offers useful insights into case studies too and will be referred to when explaining the research design. Yin (2003) is an authority on case study design and defines a case study as:

>'An empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident'. (Yin, 2003, p.13).

As explained in Chapter 3 (3.6), factors affecting patient dignity are inter-related and there is a lack of clear boundaries surrounding patient dignity, with patient factors, staff behaviour and the environment all involved. Yin (2003) recommends a case study approach when 'how' or 'why' questions are being asked about:

>'a contemporary set of events over which the investigator has no control'. (Yin, 2003, p9)
All five research questions (see 3.6) begin with ‘How?’ and patient dignity is clearly a contemporary issue as evidenced by its increasing inclusion in health policy (see 1.4). The phenomenon of patient dignity in an acute care setting cannot be controlled by the researcher, as patients, staff and the environment change constantly. Thus the identified topic fulfilled Yin's (2003) criteria for suitability and the case study design was appropriate. Other researchers have successfully used case study designs to study topics within context. For example, Wilson-Barnett and Macleod Clark (1993) used a case study to study health promotion in practice rather than as reported by practitioners.

Stake (1995; 1998) suggests that there are three different types of case studies: intrinsic, instrumental and collective (see Box 4.1).

<table>
<thead>
<tr>
<th>Box 4.1 Different types of case study (Stake, 1995; 1998)</th>
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<tr>
<td><strong>Intrinsic case study</strong>: aims to develop a better understanding of a particular case but does not test abstract theory or develop new theoretical explanations.</td>
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<tr>
<td><strong>Instrumental case study</strong>: provides insight into an issue or refines a theoretical explanation and may or may not be typical of other cases.</td>
</tr>
<tr>
<td><strong>Collective case study</strong>: is the extensive study of several instrumental case studies to allow a better understanding and possible theorizing in a broader context.</td>
</tr>
</tbody>
</table>

An instrumental case study was developed with the expectation that studying one ward in one acute hospital in-depth would promote insight into patient dignity in an acute hospital setting. Any acute hospital has similarities with others and their functioning is increasingly driven by nationally set health policies and targets (contextual factors). An instrumental case study entails an in-depth investigation with all aspects and details to enable a better understanding of a theoretical problem. The particular case is selected to gain understanding of the topic studied rather than the case itself. Yin (2003) identifies that case studies can be exploratory, descriptive or explanatory, stating that ‘How’ questions are more explanatory in nature. The case study aimed to be predominantly descriptive, but also to explain how dignity can be promoted in acute healthcare settings.

Yin (2003) describes four main types of case study design. Case studies may comprise single or multiple cases and designs may be holistic, where the case (or cases) is studied
as a whole as one unit, or embedded, where there are multiple units of analysis within the case. In each of these four designs the context of the case or cases is studied too. The design for this case study was a single case (one acute hospital) with embedded cases: one ward (including its staff) and, as patients' experiences were central to this study's research questions, twenty-four patients. Yin (2003) identifies that a single case study design is appropriate in certain circumstances which include the single case selected being representative or typical of other cases. The single case (see 4.4) was a typical DGH and fulfilled the criteria for a single case design. By studying this case the propositions about patient dignity identified from the literature review could be examined in depth. However, Yin (2003) warns that a single case study design is vulnerable should the case turn out not to be what it was thought to be and therefore the selected case was kept under review.

Yin (2003) identifies five components of a research design which are important for case studies (see Box 4.2) and these are discussed next.

Box 4.2 Five components of a research design (Yin, 2003, p.21)

1. A study's questions;
2. Its propositions, if any;
3. Its unit(s) of analysis;
4. The logic linking the data to the propositions; and
5. The criteria for interpreting the findings.

The study's research questions were developed from the theoretical framework (3.6). The study's propositions were essentially tentative hypotheses, arising from the literature review, and indicated more specifically what should be examined within the case study. Yin (2003) argues that theory development is an essential part of a case study research design. The propositions were: that people may have different interpretations of the meaning of dignity and that patient dignity may be affected by the hospital environment, patient factors and staff behaviour. These propositions directly affected the research design and selection of data collection methods and participants. The third component of a case study design is identification of the units of analysis, which were the hospital, ward and patients. Yin (2003) acknowledges that the fourth and fifth components, how the data
will be interpreted and analysed, have been the least well developed for case studies. However, the data collection methods lay the foundation for examining the data in relation to the study's propositions and interpreting the findings within the theoretical framework. In this way, the research should proceed in a clearly focused manner.

Case study design offers a holistic form of inquiry (Gangeness and Yurkovich, 2006) and Topping (2006) asserts that case studies have wide application in nursing research. De Vaus (2001) considers that a case study which develops a 'full, well-rounded causal account' (p.234) can indicate how the causal factors interrelate, for example how the environment and staff behaviour together impact on patient dignity, rather than as individual and separate influencing factors. However, as with any research design, there are possible disadvantages and there are acknowledged criticisms of the case study approach (Yin, 2003). A common criticism is a lack of rigour, but Yin (2003) argues that this relates to how particular investigators have used the approach rather than being inherent in case study design. In addition, Yin (2003) points out that any research design can lack rigour. Section 4.14 explains how rigour was promoted within this study. Pegram (1999) suggests that case study research is often strongly aligned with qualitative research which may be similarly criticized for lack of rigour. Objectivity in case study research is also raised as an issue but Berg (2001) argues that case studies are as objective as any other approach and analysis strategy used by social scientists. In addition, qualitative researchers recognize and value the subjective nature of reality and its study, rather than insisting that objectivity is essential, as in positivism (Streubert, 1999b).

Critics also question the generalizability of case studies but Yin (2003) argues that case studies, like experiments, are generalizable to theoretical propositions rather than populations. The case study researcher aims for analytical generalization rather than statistical generalization. Yin (2003) argues that theory development is an essential part of a case study research design. The new insights and knowledge gained from this case study of patient dignity in an acute hospital setting could apply to patient dignity in any acute care setting. Presenting a detailed description of the case study ward will enable healthcare staff to judge the transferability of the findings to their own practice settings. Berg (2001) asserts that properly undertaken case studies should provide an understanding about similar individuals, groups and events as few human behaviours are unique. Case study research, having been conducted in the real situation, promotes believability (Pegram, 1999), thus increasing credibility (see 4.14).
Potentially case studies can comprise any combination of qualitative and quantitative data (Yin, 2003). However, as previously discussed, there is a dearth of research about patient dignity in the acute hospital setting, so collecting in-depth qualitative data was appropriate to provide a rich and holistic description of patient dignity. De Vaus (2001) asserts that a well-designed case study takes into account information from varying sources which together, give greater insight than each source alone. Commonly used methods of data collection in case studies are documentation, archival records, interviews, direct observations, participant-observation and physical artefacts (Yin, 2003). De Vaus (2001) suggests that any data collection method can be used within a case study design as long as it is *practical and ethical* (p.231) and that a multi-method approach is a distinctive feature of case study design. Collecting data from multiple sources (data triangulation) enables corroboration of the same phenomenon thus strengthening the evidence for a particular conclusion (Yin, 2003). Using a range of data collection methods should enable the study of patient dignity to include all possible influencing factors, including the context and external influences resulting in a rich, detailed description of how patients, staff and the care environment influence dignity in practice.

Table 4.1 summarises the data collection methods which were used in the case study, all of which are explained in detail later in this chapter: interviews with patients following discharge (see 4.8), participant observation (of ward handovers and patient care) (4.9), interviews with patients and staff following observation and examination of patients’ care records (see 4.9), interviews with senior nurses (see 4.10) and examination of Trust documents (see 4.11). Appendix 2 provides a timeline for the development of the thesis, indicating when each stage of the research process and data collection was conducted.
Table 4.1 Overview of data collection methods and participants

<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Participants</th>
<th>Sample size</th>
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<tbody>
<tr>
<td>Interviews</td>
<td>Patients recently discharged from the case study ward</td>
<td>12</td>
</tr>
<tr>
<td>Participant observation</td>
<td>In-patients, Ward staff, Visiting staff</td>
<td>12, 26, 16</td>
</tr>
<tr>
<td>Record examination</td>
<td>Care records of above in-patients observed</td>
<td>12</td>
</tr>
<tr>
<td>Follow-up interviews</td>
<td>In-patients observed</td>
<td>12</td>
</tr>
<tr>
<td>Follow-up interviews</td>
<td>Staff with key involvement in observed patients' care</td>
<td>13</td>
</tr>
<tr>
<td>Observation of staff handover</td>
<td>Ward staff</td>
<td>12 occasions (22 ward staff)</td>
</tr>
<tr>
<td>Interviews</td>
<td>Senior nurses (ward and Trust based)</td>
<td>6</td>
</tr>
<tr>
<td>Document examination</td>
<td>Ward/Trust policy documents</td>
<td>10</td>
</tr>
</tbody>
</table>

4.4 Selection of the case study hospital and ward and gaining access

De Vaus (2001) explains the benefits (in relation to external validity) of cases being selected strategically because of their specific characteristics. However, although the nature of the embedded case (an acute hospital ward) was purposefully selected, the particular case was chosen following negotiation with the hospital management and the specific ward. The researcher works part-time as an RN at one of two DGHs in an acute NHS Trust and in June 2004 she wrote to the Director of Nursing (DN) at the second DGH about conducting the research there and accessing a case study ward. The letter was forwarded to the Head Nurse for Practice Development (HNPD) who had a remit for liaison regarding research activity in the hospital. The crucial role of gatekeepers in facilitating a researcher’s access to a setting and recruiting research participants has been identified (Gray, 2004; Lee, 2005). There were a number of gatekeepers encountered at different stages of the study but the HNPD played a key role in facilitating access. Researchers require sound interpersonal skills in order to develop rapport with gatekeepers (Lee, 2005) and the researcher endeavoured to develop friendly relationships with the various gatekeepers encountered.

Bonner and Tollhurst (2002) examined the advantages and disadvantages of being an insider or an outsider participant observer. Being a Trust employee with knowledge of
Trust wide policies assisted in gaining access to the research setting, acceptance by staff and achieving registration with the Trust's Research and Development (R&D) office (see 4.5), thus demonstrating advantages of being an insider. However, the hospital approached, although part of the same NHS Trust, was largely unfamiliar to the researcher, giving an outsider perspective which was beneficial for several reasons. Morse (1994) advocates that the qualitative researcher should preferably enter the research setting as a 'stranger' so that the setting can be viewed with greater insight, sensitivity to the setting not having been decreased by familiarity. In addition, staff taking part in the study did not know the researcher in the different capacity of practitioner reducing the possibility of role clashes which can occur with insiders (Morse, 1994). Thus, this researcher was able to combine insider advantages with certain outsider advantages.

Following a meeting between the DN, the HNPD and the hospital's senior nurses, a ward expressed interest in taking part. The ward manager agreed to access but when re-contacted in November 2004, he informed the researcher that the ward's future was uncertain due to Trust reorganisation. The HNPD then identified another ward and after discussions, the ward manager, the directorate's modern matron, lead medical consultant and directorate general manager all agreed to access. The ward is code named 'Heron ward' throughout this thesis.

At a preliminary meeting, the ward manager gave information about the nature of Heron ward and its speciality (urology), the consultants and their teams. She explained that the ward admitted patients from other specialities (particularly general surgery and medicine) according to bed availability in the Trust. These patients were referred to by hospital management as 'outliers' and stayed on the ward for varying periods of time depending on when a bed on a ward of their own speciality became available. They were often transferred at very short notice so their presence on the ward was unpredictable. The ward team comprised all female nurses and HCAs of varying ages and experience. There was also a permanent cleaner, a ward clerk, a housekeeper and a regular volunteer. There were some permanent night staff but day staff also rotated to nights. The ward was fully staffed so there was minimal use of agency staff.

4.5 Ethical issues

While planning the research, ethical issues were addressed to fulfil requirements of the
Research Governance Framework for Health and Social Care (DH, 2001c; DH, 2005b).

The study was registered with the Central Office for Research Ethics Committees (COREC) and the completed COREC form was submitted to the Local Research Ethics Committee (LREC) with the research protocol in December 2004. In accordance with DH (2005b) advice that participant representatives should be consulted regarding the research design, the HNPD and the Trust's Patient Advice and Liaison Service (PALS) officer scrutinized the research protocol at a draft stage and they considered that it was sound. The researcher attended the LREC meeting in January 2005. One amendment to a patient information sheet was requested and a letter then confirmed that ethical approval had been given (see Appendix 3). A completed Trust research registration form was submitted to the R&D office with supporting signatures from the lead consultant and the general manager for the directorate, the LREC letters and research protocol. After seeking clarification on several issues, the office confirmed registration of the research (see Appendix 5). An honorary contract was not required as the researcher was an NHS employee (DH, 2005b). The approving letter from the LREC was also submitted to the University Ethics Committee with the protocol, and university ethical approval was confirmed.

As an RN, the researcher adhered to the requirements of her Code of Professional Conduct (NMC, 2004), which holds nurses responsible for their professional conduct as researchers as well as clinicians (DH, 2005b). The RCN (2004) identifies these issues for nurses conducting research to consider: respect for individuals, autonomy and the vulnerability of some patients. These were addressed by ensuring consent, protecting confidentiality and balancing risk of harm with potential benefits. Each of these will now be discussed.

4.5.1 Ensuring consent

The RCN (2005a) advises that informed consent requires that participants are mentally able to give consent, have been given adequate information that they have understood and that their consent is given freely and is on-going. Informed consent is central to the conduct of ethical research (DH, 2005b; RCN, 2005a) and of prime concern to ethics committees (Byrne, 2001).
Procedures were therefore developed to ensure that participants\(^3\) gave informed consent. Comprehensive and easily understandable information sheets (see Appendices 5-8) and consent forms (see Appendices 9-12) were developed for each group of participants. The COREC guidance for these documents was adhered to and they were also checked against the RCN's (2005a) criteria for informed consent (see Box 4.3). The documents were scrutinized for readability and clarity by the researchers' supervisors, the LREC, the HNPD and the Trust's PALS officer and minor amendments were made.

### Box 4.3 Requirements for informed consent (RCN, 2005a, p.3)

An understanding of:

- The purpose of the research.
- The practicalities and procedures involved in participating.
- The benefits and risks of participation and, if appropriate, the alternative therapies.
- How data about them will be managed and used.
- The consent form.
- Their role if they agree to participate in the research. How information will be provided to them throughout the study.
- That their participation is voluntary.
- That they can withdraw from the study at any time, without giving any reason and without compromising their future treatment.
- The insurance indemnity arrangements for the conduct of the research where appropriate.
- That the research has been approved by a research ethics committee.

They should also be given the following information:

- Contact details, should they have further questions or wish to withdraw.
- Details of the research sponsor and research funding body.

The RCN (2005a) recommends that prospective participants should not be asked to participate until they have had sufficient time to decide that they wish to take part. It was

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\(^3\) The term 'participant' is used throughout this thesis when referring generally to all staff or patients who participated in the research. Where discussion is specific to one group of participants only (e.g. patients, observed patients, staff, ward staff), the participants are then referred to as per their specific group identity in the text.
therefore aimed that potential participants would have at least twenty-four hours following receipt of the written information sheet and for most groups of participants this was easily achievable. However, when recruiting patients to be observed, timing of information-giving and consent, was more complex. In most instances these patients were admitted the day before their operations and observation took place the day after surgery. Two patients were, however, observed during the night on the day of their surgery, one patient was observed several days after his surgery, and three patients did not have surgery. Consent procedures considered issues such as patients' potential drowsiness following a general anaesthetic but several patients had surgery under epidural anaesthetic and were not so drowsy. All patients recruited for observation had a minimum of eight hours from receiving the information sheets before giving written consent but for most, a longer period was possible.

One ethical concern was the unpredictable presence of non-permanent staff on the ward, including HCPs who visited the ward infrequently and agency nursing staff. Prior to the research commencing, the ward manager advised that allied health professionals' and specialist nurses' visits to the ward varied according to patients' individual health and social needs. Therefore it was not possible to inform and seek consent from these staff prior to the study's commencement. They were informed about the study if they were involved in an observed patient's care and their consent was then sought. Although this was not an ideal situation, it was a pragmatic decision. If any concern had been raised the researcher would have refrained from observing that individual while they were interacting with the patient, but no staff member refused consent. No member of staff who had not previously consented had major involvement in an observed patient's care.

Regarding patient recruitment, ward staff made the initial approach as it was expected that patients could decline more easily than if the researcher approached patients directly. Nurses were prepared for this role and were asked to emphasise that there was no obligation to take part and that care would not be affected should patients not wish to participate. With one exception, all patients approached were interested in taking part. The study's criteria for patients participating included a stipulation that they should be able to speak English, could communicate verbally and could give informed consent. Patient interviews were a crucial source of evidence within the study design and their quality relied on ability to communicate experiences and feelings. Although this could have been overcome for non-English speaking patients with the use of an interpreter, the data
collection methods for these patients would then have differed from the data collected directly from the other patients. Communication barriers could themselves impact upon patients' dignity and the researcher considered that this should be addressed in a separate study with use of interpreters planned into the study design. This criterion also ensured that patients would be able to understand the information and decide whether they wished to take part, thus promoting informed consent. However, the criterion could prevent inclusiveness denying some patients the opportunity to participate. In addition, the DH (2005b) advises that the body of research evidence should reflect the population's diversity. Research participants were recruited from both genders, varied ages and social groups but diversity of ethnicity in the area local to the Trust was limited, being predominantly white British. In fact, only one patient was excluded from the study because of a lack of ability to speak English. The research protocol included that if a patient was unable to read because of illiteracy or a visual impairment, staff would read the information sheet to them, thus ensuring their consent was informed; this was necessary for one patient who was registered partially sighted.

The RCN (2005a) emphasises that consent must be on-going and Byrne (2001) advises that patients should be informed that their consent can be withdrawn at any stage without their care or treatment being affected. Thus patient consent, once obtained, was kept under review, for example patients who were being observed were informed that they could ask the researcher to leave at any point, but none of them did so. The researcher always checked with the nurse in charge about the patient's condition to consent and to be observed on the day of observation. On one occasion a patient who had previously given written consent was drowsy but still clearly gave verbal consent for the research to continue. She was not however interviewed on that day because of her drowsiness. When the researcher returned to interview her she confirmed that she had been aware and comfortable about being observed on that day. One patient declined to participate when consent was checked on the day, saying that he 'didn't feel like it this morning'. The researcher reassured him that this decision was fine and she then left the ward. This event indicated that patients did feel able to decline if they changed their minds about participating. Staff information gave similar assurance that they could withdraw consent at any stage. As the majority gave consent prior to the data collection period commencing, their consent was re-checked verbally on each new occasion that they were observed.
4.5.2 Confidentiality

Ensuring confidentiality of personal information is essential to conduct research ethically (DH, 2005b) and the research design detailed plans for ensuring confidentiality. Codes were used for all participants in data records (fieldnotes from observation of care and handovers, interview transcripts, notes made from patients' care records). All transcriptions were anonymised: any real names or places mentioned were substituted in the transcript with a letter (e.g. 'X'). Each interview was given a code to identify it, for example the first interview was coded as PPD11 (Patient post discharge interview 1). Hard data (tapes, printed transcripts and fieldnotes) were stored in locked filing cabinets; the DH (2005b) advises that security of data must be maintained. Electronic versions of these documents were stored on password protected computers. Interviews were conducted in privacy wherever possible but there were exceptions. In two instances patients interviewed at home had relatives present but this was their choice and they appeared comfortable with this situation. In the ward setting, the majority of interviews with patients were conducted by the bedside in the patient's bay; just two were conducted in privacy - one in a side room and one in the day room (with no other patients present). Some patients were not mobile enough to leave the bedside. Others could have gone to a more private area but preferred to stay at the bedside. The researcher offered on each occasion to pull the curtains round and some patients opted for this but others declined. No patients interviewed had any significant hearing impairment so the interviews were conducted in quiet, discreet voices. No patients appeared uncomfortable with these arrangements. Ward staff were interviewed in privacy (either in the day room, staff room or a seminar room in the ward) but on one occasion the interview took place at the nurses' station; however no one else was present. The interviews with the senior nurses all took place in private offices.

4.5.3 Balancing risks and potential benefits

As established in Chapter 1, the importance of patient dignity is incorporated within health policy, legislation and professional guidance (1.4) and research (1.3). However, there is a paucity of research into the meaning of patient dignity in an acute hospital setting (2.4) and the threats to patient dignity in hospital and how patient dignity can be promoted, particularly in acute care settings (3.2). The research is therefore justified as it will provide evidence to assist HCPs working in acute hospital settings to minimise threats to patients' dignity and actively promote dignity. These benefits will be mainly for future recipients of
healthcare rather than the study's patient participants but this is common in healthcare research (RCN, 2004). In addition, patients may benefit from the opportunity to talk about their experiences and feel that their views are valued. The HNPD considered that the research would benefit ward staff as it would give them opportunities to be involved in a research study thus learning more about the research process which could benefit their future practice and professional development.

However, the research could have caused participants inconvenience and/or feelings of discomfort. Being observed may be stressful and inconvenient (Johnson, 1992) and make people anxious and self-conscious (Patton, 2002). Thus while observing patients in hospital, the researcher checked that patients were comfortable with her being present to reduce any feelings of intrusion. Observation was conducted in as considerate and unobtrusive way as possible and the follow-up interviews were approached flexibly. As regards interviews with patients following discharge and interviews with senior nurses, inconvenience was minimised by carrying these out at a time and place of their choice. Being interviewed can be stressful (McCann and Clark, 2005) and there was a potential risk of patients becoming upset while being interviewed if they were discussing experiences where their dignity was compromised. The researcher was alert for any non-verbal or verbal signs of distress and would then have offered to stop the interview and give support. However, in practice this situation did not occur. Regarding the researcher herself, there was the potential for professional discomfort if patients described poor practice or poor practice was observed. Such instances have been reported in the literature (Costello, 2001) and Wilkes and Beale (2005) described the role conflict that can occur for nurse researchers, advising that a strategy for dealing with the 'worst case scenario' should be developed. As an RN, the researcher had a professional responsibility towards patients and therefore made it clear to participants that she would intervene if a patient was at risk and would report any situation where she observed poor practice. Conducting interviews in patients' own homes has personal safety issues (Gray, 2004) and a strategy to reduce risk was developed (see Appendix 14).

4.6 Preparation of Heron Ward and recruitment of staff participants

The RCN (2005a) emphasises that all healthcare staff participating in research should receive the same detailed information and have the same opportunity to ask questions as patient participants. Accordingly, following confirmation of LREC approval in February
2005, all ward staff received information sheets (see Appendix 5) with an accompanying letter (see Appendix 14) and had the opportunity to ask questions about the research at meetings following staff shift handovers and one-to-one meetings. The researcher's conduct during observation episodes was clarified (see Appendix 15) and it was explained that nurses taking charge of shifts would be asked to approach patients about taking part in the study. The ward's other consultants were written to seeking consent to observe them on the ward and access their patients (see Appendix 16), enclosing information sheets for the junior and middle grade doctors in their teams (see Appendix 5). The relevant consultant was contacted direct regarding the two outliers recruited to the study because it was unrealistic to contact all the large numbers of general medical and surgical consultants across the Trust prior to the study commencing.

Written consent (see Appendix 9) for participation was sought when staff were next encountered on the ward, therefore giving them at least twenty-four hours to consider whether they wished to take part. Following the ward preparation and information-giving process all staff approached consented to participate in the study. Although it was emphasised that there was no obligation to participate, in reality there may have been covert pressure to take part, particularly as staff knew that the ward manager was supportive to the research. One staff member expressed initial anxiety; her questions were answered honestly and she was assured that there was no obligation. About two weeks later she approached the researcher and said that she was now happy to take part. This example gave some reassurance that staff did not feel they had to participate.

4.7 Preparation for the research

The researcher agreed with the HNPD to obtain a Trust badge stating 'Nurse researcher' and to wear the uniform from the DGH where the researcher usually works, during participant observation, as the researcher intended to be involved in direct patient care and both staff and patients are accustomed to those carrying out such care wearing uniform. The importance of the researcher adopting an appropriate manner of dress has been highlighted (Byrne, 2000; Hammersley and Atkinson, 1995; Lofland and Lofland 1984). Other nurse researchers have also worn nurse’s uniform during participant observation believing that this aided access within the setting (Gerrish, 1997; Kennedy, 1999; White 1999). Kennedy (1999) reported that wearing uniform helped patients to feel relaxed and comfortable in her presence. Certainly, wearing uniform during participant
observation felt appropriate and the researcher seemed quickly accepted into the ward. Two shifts on the ward were worked in a supernumary capacity to develop familiarity with the ward environment. No observational data was collected during these two shifts but a research diary was maintained. Gaining participants' trust is a pre-requisite to them being willing to be observed, answer questions and be interviewed (Morse, 1994). Building rapport with participants is essential for the participant observer (Gerrish, 1997; Hammersley and Atkinson, 1995) and working with staff in practice was invaluable for developing rapport with the ward team. It was expected that the ward team would start to become accustomed to the researcher's presence, thus promoting more natural behaviour on their part (Byrne, 2000). Strategies for observing non-intrusively and note-taking were also identified during these preparatory shifts. It was discovered that each morning, staff were delegated to work in two teams on the ward, each team looking after patients in two bays and one side room. The researcher therefore worked one shift in each team to gain familiarity with the whole ward environment.

Two interviews with patients following discharge were conducted and two observation episodes with follow-up interviews were completed to pilot the main data collection methods (see 4.8 and 4.9). The two interviews were conducted first as the researcher wished to start by hearing patients' perspectives directly, prior to becoming involved in observation. The data collection process was then critically reviewed with the researchers' supervisors, scrutinizing the methods of recording, interview topic guides, the observation guide and the actual data collected. In discussion with the researcher's supervisors, it was agreed that the data collected through the research processes and tools was rich in nature and had been collected using a rigorous process. Therefore the pilot study data was analysed with the data subsequently collected and included in the study's results.

**4.8 Post discharge interviews**

Twelve interviews were conducted with patients who had recently been discharged from Heron ward. The interviews used open questions with probes and follow-up questions to deepen responses and increase richness of the data (Patton, 2002).

**4.8.1 Sampling and recruitment of participants**

Purposeful sampling was used to select information-rich participants whose responses
would illuminate the research questions (Patton, 2002). During the main data collection period (March 2005-July 2005), the ward was visited on a regular basis. On each occasion, the nurse in charge identified and approached patients meeting the criteria for selection in the study (see Box 4.4).

Box 4.4 Selection criteria for post discharge interviews

**Inclusion criteria**: (must fulfil all of these) The patient:
1. Has been an inpatient on Heron ward for a minimum of two days.
2. Is willing to be contacted by the researcher after discharge to arrange an interview.
3. Can speak English.
4. Is able to communicate verbally.
5. Is not taking part in another research study.

**Exclusion criteria**: (any of these excludes) The patient:
1. Has been an in-patient on Heron ward for less than two days.
2. Is unable to speak English.
3. Is unable to communicate verbally.
4. Is unable to give informed consent (e.g. if confused).
5. Is already taking part in another research study.

There are many different types of purposeful sampling (Patton, 2002). Initially criterion sampling was used but this was later stratified to ensure women and patients under sixty years old were recruited too; the majority of patients on the ward were always older men. In line with the specialty of urology, and acute healthcare in general, it was unusual for patients under forty years old to be present on the ward and those that were, were either in hospital for less than two days or were outliers, who were quickly transferred out. Therefore only one patient under forty years old was recruited for post-discharge interview. On some occasions no patients met the criteria; on other occasions several did. The nurse briefly explained the study to the patient and gave them an information sheet (see Appendix 6). Patients who were willing to consider participation in the study then completed a form with their details (see Appendix 17), and gave consent to be contacted following their discharge home.
Patients were telephoned a few days after discharge and any questions about the research were answered. If the patient was willing to be interviewed, a convenient date and time was arranged. At this stage of recruitment, one patient declined to take part and one patient could not be contacted. The patients came from varied social backgrounds but due to the area of the country where the study took place, ethnicity of all participants was white British. On the small number of occasions when non white British patients were in the ward they did not meet the recruitment criteria for various reasons. Table 4.2 summarises the study participants, identified by code names, their medical condition (mainly urological surgery - either open or urethral⁴) and their demographic details.

Table 4.2 Profile of patients interviewed following discharge from Heron ward

<table>
<thead>
<tr>
<th>Code</th>
<th>Age range</th>
<th>Gender</th>
<th>Medical condition</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr D1</td>
<td>70s</td>
<td>Male</td>
<td>Urological urethral surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr D2</td>
<td>60s</td>
<td>Male</td>
<td>Urological open surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr D3</td>
<td>60s</td>
<td>Male</td>
<td>Urological urethral surgery</td>
<td>Retired manual</td>
</tr>
<tr>
<td>Mr D4</td>
<td>70s</td>
<td>Male</td>
<td>Urological urethral surgery</td>
<td>Retired manual</td>
</tr>
<tr>
<td>Mr D5</td>
<td>55s</td>
<td>Male</td>
<td>Urological open surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr D6</td>
<td>50s</td>
<td>Male</td>
<td>Urological urethral surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mr D7</td>
<td>30s</td>
<td>Male</td>
<td>Urological open surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mrs D8</td>
<td>60s</td>
<td>Female</td>
<td>Urological surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr D9</td>
<td>60s</td>
<td>Male</td>
<td>Urological urethral surgery</td>
<td>Non-manual</td>
</tr>
<tr>
<td>Mrs D10</td>
<td>40s</td>
<td>Female</td>
<td>Urological urethral surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mrs D11</td>
<td>50s</td>
<td>Female</td>
<td>Urological open surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mrs D12</td>
<td>60s</td>
<td>Female</td>
<td>Urological medical</td>
<td>Retired manual</td>
</tr>
</tbody>
</table>

4.8.2 Interview procedure

Each participant was asked to identify a venue for the interview and all chose their own home. The researcher greeted the participant in a polite and friendly manner and showed them her identity badge. Gray (2004) advises that the researcher should first build rapport with the interviewee, helping them to feel relaxed. Similarly, Gillham (2000) advocates that the researcher should get to know the person to be interviewed and gain their trust. Therefore, rapport was developed by asking after the participant's recovery and friendly conversation such as admiring pets or the garden. Written consent to conduct and tape record the interview was obtained from all participants (see consent form, Appendix 10), who were advised that they could terminate the interview at any time and need only

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⁴ In urethral surgery, the operation is carried out through the urethra and patients have no open wound so recovery is usually quite rapid. Enlarged prostate (benign or malignant) and bladder tumours are often operated on urethrally. Open urological surgery involves an abdominal incision, resulting in impaired mobility and therefore greater dependence. Conditions requiring open surgery included more advanced cancer of the bladder or prostate, and renal cancer.
answer questions they wished to. All participants appeared comfortable to answer the questions and none asked for the interview to be stopped. Taping the interview was agreed by all participants allowing the researcher to concentrate on conducting the interview (Gray, 2004; Kvale, 1996; Patton, 2002). The interview topic guide (see Appendix 18) comprised open questions and further probes were used to gain more detailed responses. The interviews followed an open-ended, guided conversation approach, which is a common style of interviewing within case study designs (Yin, 2003). However, Yin (2003) emphasizes that the researcher must ensure that their specific information needs are achieved. This style of interviewing, consistent with a qualitative case study design (Stake, 1995), was adopted so that each participant had the opportunity to relate their experiences. Each interview ended with a final open question. Patton (2002) advises that this closing question gives the participant the chance for a ‘final say’ and can elicit particularly rich data, which was often found to be the case in this research. As talking about hospital experiences might have been uncomfortable, the researcher remained alert for any signs of this discomfort but this did not arise. Prior to the interview, one patient talked extensively and with some emotion about her problems with pain and the non-success of her operation so it was checked that she was still willing to proceed with the interview. She was certain that she wished to continue and did not become upset during the actual interview.

McCann and Clark (2005) suggest that a relaxed, private room should be used for interviews but as the interviews took place in participants’ own homes, the choice of room was their decision. In most instances a quiet room was selected and the tape recorder was placed on a table between them and the researcher. On one occasion the participant's wife stayed in the room but she did not participate and the man did not appear inhibited in his disclosure. On another occasion a participant's young children were playing in the far end of the room. This did not impact on the quality of the data collected but the tape was more difficult to transcribe due to background noise. Interviews lasted approximately thirty minutes; the shortest was ten minutes and the longest an hour. As advocated by Gray (2004), at the end of the interview, participants were thanked warmly for their contributions. On three occasions participants asked about a health related issue and the researcher listened with interest and suggested an appropriate person/organisation to telephone. In two interviews, participants related the same interaction between a staff member and another patient which they considered unkind. Following the interviews it was discussed whether they wanted to take this concern up with the hospital. Both participants
intended to write to the ward manager and the researcher encouraged them to do what they considered appropriate.

Fieldnotes about the interview process and impressions of the data collected were written immediately after the interviews. The tapes were then transcribed immediately so that participants’ non-verbal communication (for example, gestures) could be recalled and included in the transcripts. These details were useful when data analysis commenced as they helped to indicate meanings. If parts of a tape were difficult to hear, the researcher could remember what had been said because of the immediacy of the transcribing.

4.9 Participant observation

Twelve four-hour periods of participant observation were conducted on Heron ward, each focusing on one patient's experience. Prior to each observation period, handover between one shift and the next was observed. Following observation, the patient and the staff most involved in care during the observation period, were interviewed. The patient's notes were also examined. Byrne (2000) considers that one advantage of participant observation is that the researcher can gain a better understanding of the situation from the perspectives of those involved and this was certainly one reason why participant, rather than non-participant observation was used in this study. Gray (2004) identifies that advantages of participant observation include its immediacy with data being collected as it happened and, unlike non-participant observation, it can promote a more natural relationship to develop between the researcher and participants. In this study, the closeness achieved by working with the participants during observation meant that they seemed very relaxed and therefore open with the researcher during the follow-up interviews. However, it is an acknowledged weakness of any form of observation, however sensitively performed, that people may behave differently while observed (Patton, 2002).

4.9.1 Sampling and recruitment of participants

During the data collection period, the researcher visited the ward frequently (often preceded by telephoning) to recruit patients to be observed. The nurse-in-charge approached patients who fulfilled the criteria for inclusion in the study (see Box 4.5). As with the post-discharge interviews, purposeful sampling was used (Patton, 2002), initially using criterion sampling but later stratified to ensure women and younger patients were
recruited too. As discussed earlier (4.8.1), patients under forty years were rarely present on the ward and if they were, did not require assistance (Box 4.5, inclusion criteria 2). Therefore no patients under forty years were recruited for observation.

**Box 4.5 Inclusion/exclusion criteria for selection of patients for observation/follow-up interviews in the ward**

**Inclusion criteria:** (must meet all criteria)
1. Is an inpatient on Heron ward during an observation episode.
2. Requires at least some assistance from ward staff with activities of daily living (e.g. hygiene, mobilising, eating and drinking).
3. Is sufficiently alert and orientated to give informed consent to have their care observed for a four-hour period and be interviewed afterwards.
5. Can speak English.
6. Is not taking part in another research study.

**Exclusion criteria:** (any one of these excludes patient)
1. Is unable to give informed consent (e.g. if confused, not fully conscious).
2. Is unable to communicate verbally.
3. Is unable to speak English.
4. Is considered by ward staff to be too seriously ill to be asked to take part.
5. Is expecting a visitor for a lengthy visit during the four-hour observation period.
6. Is already taking part in another research study.

If the patient was interested they were given an information sheet about the study (see Appendix 7). After any questions were answered about the research, the patient signed a consent form (see Appendix 11) if they agreed to participate. The patients came from a variety of social backgrounds but as with the patients interviewed following discharge, they were all white British. Table 4.3 summarises the study participants, their medical conditions⁵ and their demographic details.

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⁵ In laparoscopic surgery the operation is carried out through a very small incision. Urethral and open urological surgery are explained in footnote 4. General medical patients were admitted when there were no beds available on the medical wards.
<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Gender</th>
<th>Medical condition</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr O1</td>
<td>70s</td>
<td>M</td>
<td>Urological urethral surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr O2</td>
<td>70s</td>
<td>M</td>
<td>Urological urethral surgery</td>
<td>Retired manual</td>
</tr>
<tr>
<td>Mr O3</td>
<td>80s</td>
<td>M</td>
<td>Urological urethral surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mrs O4</td>
<td>80s</td>
<td>F</td>
<td>General medical</td>
<td>Retired manual</td>
</tr>
<tr>
<td>Mr O5</td>
<td>70s</td>
<td>M</td>
<td>Urological open surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr O6</td>
<td>90s</td>
<td>M</td>
<td>General medical</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mr O7</td>
<td>50s</td>
<td>M</td>
<td>Urological urethral surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mr O8</td>
<td>60s</td>
<td>M</td>
<td>Urological open surgery</td>
<td>Non-manual</td>
</tr>
<tr>
<td>Mrs O9</td>
<td>70s</td>
<td>F</td>
<td>Urological urethral surgery</td>
<td>Retired non-manual</td>
</tr>
<tr>
<td>Mrs O10</td>
<td>50s</td>
<td>F</td>
<td>Urological (terminal illness)</td>
<td>Non-manual</td>
</tr>
<tr>
<td>Mrs O11</td>
<td>40s</td>
<td>F</td>
<td>Urological open surgery</td>
<td>Manual</td>
</tr>
<tr>
<td>Mrs O12</td>
<td>40s</td>
<td>F</td>
<td>Urological laparoscopic surgery</td>
<td>Unemployed manual</td>
</tr>
</tbody>
</table>

### 4.9.2 Observation procedure

In 1958, Gold identified a continuum of observation roles from the complete observer to a complete participant where the role of observer is not disclosed. The latter role would nowadays be considered unethical and only justifiable in exceptional circumstances. In this study a participant observer role was adopted and so the researcher was open about her role as observer while participating in the work on the ward.

Ten of the observation periods took place on the morning shift and two during the first part of the night shift. The afternoon and early evening were avoided as many patients have visitors during this period and it was envisaged that this would impact on observation opportunities. The night shift was observed as several patients mentioned night time during interviews. One woman and one man were observed at night and their beds were located in different bays in the ward, thus aiming that the observation should cover as wide a perspective as possible. On each occasion, the researcher arrived on the ward shortly before handover started. As Hammersley and Atkinson highlight, when developing field relationships:


Thus, as staff started to arrive, the researcher joined in the pleasantries that took place between staff as a means of developing her relationship with the team. On a few occasions there were agency staff present and the study was then briefly explained and an
information sheet given. When the nurse in charge of the next shift arrived, she was
informed of the intention to conduct observation of an identified patient, who had been
given information previously. During handover, all staff took notes about patients'
conditions and care and the researcher also made notes and included fieldnotes about the
handover. At the end of handover the nurse in charge of the next shift allocated staff
between the two teams. The researcher then checked with the staff who would be caring
for the identified patient, that they agreed to being observed and to be interviewed
afterwards. All staff reconfirmed their consent. The researcher also clarified her role
explaining that she could assist in the observed patient's bay but would not be able to
leave that bay for more than very short periods. The identified patient was then
approached and asked whether they were willing to be observed during the morning (or
first part of the night shift). For some patients this was verbally rechecking their previously
given written consent and for others, written consent was obtained at this stage. After
checking consent with patients, the researcher based herself in the observed patient's bay.
She introduced herself to the other patients and explained her role and that she would help
with care in the bay.

Note-taking during participant observation was carefully planned to enable reasonably
comprehensive notes to be recorded unobtrusively. Johnson (1995) advised that to take
notes while actually behind the curtains bed bathing a patient, for example, would be
inappropriate as it is not 'normal' practice, but he suggested rehearsing key words in order
to make fuller notes later. The researcher adopted a similar strategy for note-taking: not
actually taking notes while assisting with care as she considered that this could make
patients and staff feel uncomfortable. Sheets of paper with the observation guide (see
Appendix 19) were carried in the researcher's uniform pockets: one sheet to record the
patient's general condition (including notes from the care record), one sheet to record a
description of the environment and two sheets to record the patient's care and treatment
during the observation period including their interactions with nurses and other HCPs. The
latter were recorded as numbered events at the time of occurrence. Notes written were
anonymised with no identifying details recorded. Patients were referred to as a code (for
example PO1 represented 'Patient observation 1'). Ward staff (nurses and HCAs) were
randomly allocated an identifying number before the data collection period commenced.
Other staff observed on the ward were referred to by role (for example 'phlebotomist',
'doctor'). At an appropriate point during the observation episode or afterwards,
anonymised notes were made from the patient's care record about any aspect relating to
patient dignity.

Figure 4.1 portrays the layout of Heron ward.

**Figure 4.1 Layout of Heron Ward**

The majority of time was spent in the patient's bay, either directly observing the patient when events were occurring or assisting with care in the bay. If the observed patient was in bays 1 or 4, the nurses' station was used as a base to write notes in between events as the patient was still in view and the researcher could return to the bay if a new event occurred. If the patient was in bay 2 or 3, the sluice and utility area were used in a similar way. One patient observed was in the side room and with his permission, the researcher sat in his room some of the time and the rest of the time stayed in the corridor outside. In between taking notes, the researcher gave general assistance within the bay while keeping her focus on the observed patient. On occasions, all staff were busy elsewhere in the ward which engendered feelings of discomfort on the part of the researcher. Other nurse researchers have also identified that role conflict can occur (Kite,
1999; Wilkes and Beale, 2005). On these occasions, the researcher apologised that she could not help elsewhere in the ward, reiterating that if she did so, she might miss events happening with the observed patient. The importance of maintaining good relationships during participant observation is well recognised (Gerrish, 1997; Hammersley and Atkinson, 1995) and was attended to throughout the fieldwork. However staff appeared to accept the researcher's presence without judgement or criticism and thanked her for any help she offered.

Occasionally the researcher left the observed patient's bay to answer a callbell elsewhere in the ward if staff were too busy to answer it and it had been ringing for a while. Professional responsibility as an RN (NMC, 2004) took precedence on such occasions. However, the researcher did not get involved in the care in the other bays and so was absent from the observation area for only a short time. Within the observed patient's bay, the researcher carried out a variety of care (see Box 4.6) and took part in social conversations with the bay's patients.

**Box 4.6 Care undertaken during participant observation**

- Bedmaking
- Errands for patients (e.g. turning fan on, fetching a drink, fetching a member of staff, relaying information, collecting a clean urinal)
- Assistance out to shower/toilet
- Assistance with bedbathing
- Assistance with transfers to commode or armchair or in and out of bed
- Changing bladder irrigation bottles
- Maintaining fluid balance charts
- Calculating fluid balance charts (on night shift)
- Answering the telephone and relaying messages
- Checking intravenous drugs and fluids, and controlled drugs.

By participating in care, wearing a nurse's uniform and developing relationships with the staff it was hoped to achieve integration into the ward environment, thus increasing the likelihood of participants' behaviour being natural and valid data being collected. As previously identified, an observer must be aware that those observed may change their behaviour. It is important therefore to be reflexive, a process involving critical self-reflection
(Patton, 2002), and consider how the researcher is affecting the data collected. Williams (1995) defines reflexivity as:

'being aware of the ways in which self (experiences and assumptions) affects both research processes and outcomes, and to rigorously convey to readers of research accounts how this happens'. (p.36)

As suggested by Byrne (2000), following each observation and interview conducted, the researcher reflected on her impact on the data collected and made notes on this, both within the fieldnotes so that analysis could take any effects into account, and in the research diary kept throughout the research. The use of reflexivity assists in managing the researcher's influence on the situation studied (Byrne, 2000).

After each observation episode the researcher conducted a follow-up interview with the patient observed, comprising open questions based on a topic guide (Appendix 20). Probes were used to elicit further information, according to the patients' responses, and the interview concluded with a final open question about dignity on the ward. Koch (1994) noted that patients can be reluctant to speak openly about their experiences while still in hospital, preferring to talk in the safety of their own homes. Clearly, this was an advantage of conducting the post-discharge interviews but perhaps because of the relationship developed over the observation period, patients seemed relaxed and open during the interviews in hospital. As mentioned earlier, on one occasion the patient was very drowsy and so the researcher returned to the ward to conduct the interview a few days later. Patients whose care was observed during the first part of the night shift were asleep when observation was completed so the researcher returned to the ward the following morning to conduct the interview. During the interviews, there were sometimes interruptions from staff bringing refreshments or medicines, which were accepted by the researcher in a relaxed way as it was essential not to be seen to infringe on the work of the ward, to maintain good relationships. These interruptions did not impact negatively on the data collected. A deliberate decision was made not to tape these interviews so that they would appear less formal and potentially anxiety provoking. Although as discussed in 4.8.2, taping interviews has advantages, Burnard (2005) reported how he successfully conducted interviews without taping and he challenged the view that taping interviews is always essential. The researcher found that she could take quite detailed notes by writing rapidly using her own shorthand and could record some verbatim speech from patients. As they were written up in full on the same day, she felt confident that they were an accurate record.
At the end of each interview the patients were thanked for their involvement in the study. Often a close rapport with patient participants had developed by this stage and if they were still on the ward when the researcher was recruiting other patients or conducting observation on another occasion, they greeted her warmly, seeming pleased to have a conversation and discuss their progress. It was important not to imply that the researcher was only interested in patients when they were research participants but that she was interested in them as people too and concerned about their progress. The RCN (2004) confirms such a stance in its guidance for nurses on research ethics, as it highlights the importance of each individual being treated with respect and that research is done with participants rather than on them.

Follow-up interviews were also conducted with the staff who had mainly been involved with the observed patient's care. On most occasions this applied to only one staff member but on four occasions, two staff members were interviewed as they had both been involved to a large extent. Three staff members were interviewed more than once as they were involved in more than one observed patient's care. Only ward staff were interviewed as other staff (doctors and allied HCPs) had only brief interactions with the observed patients and were little mentioned by the observed patients. Interviews took place mainly in the staff room, usually while the staff member was having a drink and eating a snack. These interviews were often only obtained due to the good relationship that had developed between the staff and the researcher and, in addition, due to the assistance with the workload given during participant observation, thus ‘earning’ time for an interview. Other researchers have also highlighted the role of reciprocity during fieldwork (Gerrish, 1997; Kite, 1999). On some occasions, staff expressed gratitude that the request for an interview enabled them to sit down and have a break. As with the patient interviews, they comprised open questions, with probes used to prompt further detail and a final open question about dignity on the ward (see topic guide, Appendix 21). The interviews were not taped thus appearing informal so notes were taken with verbatim quotations recorded.

After the observation episode and follow-up interviews were completed, the researcher returned home and wrote up the notes from the observation and interviews in detail. Immediacy in writing up notes following case study observations and interviews is paramount (Gillham, 2000; Stake, 1995). The only exceptions were the observations and staff interviews that were conducted at night; due to the lateness of their completion, the notes were written up the next day.
4.10 Interviews with senior nurses

'Elite' interviewing is when a person in authority is interviewed with the expectation that they will be knowledgeable and able to give comprehensive and insightful answers (Gillham, 2000). Specifically they are likely to know where documents and records can be found and identify other people that should be spoken to (Gillham, 2000). Accordingly, one senior nurse at interview identified that the hospital's Older Age Champion would be a useful source of information as she has a role to promote dignity for all older people across the hospital. Following initial analysis of the data collected, interviews were conducted with the ward manager and deputy ward manager, the modern matron for the directorate, the unit's clinical nurse specialist, the HNPD and the Older Age Champion (also the modern matron for older people). These participants were written to (see Appendix 22) with an accompanying information sheet (Appendix 8). Their permission to be interviewed was sought after a minimum of 24 hours and all agreed. Prior to commencing the interviews, the senior nurses signed a consent form (see Appendix 12) and all agreed that the interviews could be taped. Interviews followed the topic guide in Appendix 23 and were carried out at pre-arranged times in the staff members' offices. The interviews comprised open questions with additional probes relating to responses received. The topic guide included asking about the existence of written policies about dignity in the Trust (see section 4.11). As with the other interviews there was a final open question about dignity on Heron ward. Following the interviews, fieldnotes were written and the tapes were transcribed promptly.

4.11 Examination of Trust documents

The Trust's DN consented for Trust policies relevant to patient dignity to be accessed. These documents were searched for and examined on an on-going basis, during fieldwork and after the interviews with senior nurses. Ward based documents were mainly accessed when the ward was visited to recruit patients, often while the researcher was waiting to speak with staff or patients. The Heron ward philosophy was displayed prominently on the window of the ward day room and a copy was taken. Folders of information and policies (for example, 'Infection control') were kept in the ward, both behind the nurses' station and in the staff room. The researcher scrutinized these for references to dignity and related issues and wrote notes about her findings. The ward's Essence of Care link nurse
informed the researcher that there were no written documents about Essence of Care on the ward. The senior nurses were asked at interview about ward and Trust policies relating to dignity and two staff members mentioned that such documents might be on the Trust intranet. Therefore the intranet was searched for any documents relating to dignity. Following her interview, the HNPD provided documents relating to the implementation of Essence of Care.

**4.12 Data analysis process**

Yin (2003) asserts that analysis of case study evidence is an under developed aspect of this research design. However, he recommends Miles and Huberman’s (1994) guidelines for qualitative analysis as being appropriate for guiding case study data analysis. They suggest a three stage approach of reducing the data (summarising, coding data, identifying themes), displaying data (use of matrices, charts) so that patterns can be looked for, and conclusion drawing and verification (looking for explanations). The principles of this approach were used throughout the data analysis process but the five stage framework approach (Ritchie and Spencer, 1994) (see Box 4.7) was found to be more detailed and systematic and was therefore the main approach used.

The application of each stage of the framework approach will next be discussed, with examples to provide illustration of the process.

**4.12.1 Familiarisation**

During the data collection period, the interview transcribing process and writing up of detailed fieldnotes following observation, promoted an in-depth knowledge of the data. Following completion of all the patient post-discharge interviews and the participant observation with follow-up staff and patient interviews, the transcripts and detailed fieldnotes were studied and the tapes re-listened to, ensuring re-familiarisation occurred. As suggested by Ritchie and Spencer (1994), hunches about key issues were developed during this process. The data was then reduced (Miles and Huberman, 1994) by extracting significant statements - those that might relate to dignity; each statement's source was noted beside it so that its origin and context were easily traceable. The observation fieldnotes were meticulously coded as in each of these there were multiple sources of data: handover, patients' notes, observed events, description of the environment, description of the patient's condition, follow-up interviews with patients and follow-up
interviews with staff. Appendix 24, example A, presents an example of significant statements, coded to source.

**Box 4.7 The framework approach to data analysis (Ritchie and Spencer, 1994)**

1. **Familiarization**
   Immersion in the data occurs, with the researcher taking stock of the data collected and gaining a feel for the whole. The transcripts and detailed fieldnotes are studied and the tapes re-listened to. The researcher lists recurrent key issues and themes found in the data.

2. **Identifying a thematic framework**
   Concepts identified in the research questions, the observation schedules and interview topic guides are combined with the key issues and themes noted during familiarization to form an index of categories which are used for coding the data. Thus the thematic framework is a combination of the theoretical framework (as this informs the research questions and data collection tools) and themes derived from the data.

3. **Indexing**
   The thematic framework is applied systematically to the data (transcripts and fieldnotes), coding the data according to the index. The researcher looks for patterns within the coding and the context in which these arise.

4. **Charting**
   Charts are used to rearrange the coded data into the thematic framework. The charts comprise main headings and sub-headings drawn from the thematic framework.

5. **Mapping and interpretation**
   The charts are reviewed and patterns searched for. They are used to define concepts explored in the research, to identify their key characteristics, and to map the range of responses. Associations between themes are looked for to search for explanations for the findings.

**4.12.2 Identifying a thematic framework**
Themes emerging from the data were combined with themes drawn from the theoretical framework to develop an initial thematic framework, with an index of codes (relating to over-arching themes and their categories). Referring back to the theoretical framework at this early stage of the analysis complied with Yin's (2003) recommendation that theoretical
propositions should be returned to during analysis. The number of categories which developed became increasingly unwieldy; Appendix 24, example B, presents the developing list of codes under the theme 'The impact of staff on patient dignity'. The researcher became concerned at this stage that the process was becoming too reductionist and that links between categories might be lost. Therefore the significant statements were each individually printed and while the main themes of the meaning of patient dignity, the impact of staff, patient factors and the environment remained, an open approach to categorising the statements was now undertaken. This process started with only the statements derived from interviews with participants (post-discharge patient interviews and interviews with patients/staff following observation) so that their views led the formation of the categories. The statements derived from the observational data were then categorised using the framework developed from the interviews. A large room with floor space and flip charts was used to carry out this activity. This more physical and visual data display assisted in the identification of recurring sub-themes in the data and links between them and led to redevelopment of the thematic framework. Appendix 24, example C, shows the refined coding framework for the theme 'How staff promote dignity' which developed at this stage.

4.12.3 Indexing
The revised thematic framework was then applied to the data (including the senior nurse interviews and data from Trust documents), with each significant statement coded and then grouped together in their categories on Word documents. As each statement had been coded by its source, there was easy recognition of the context from which it had arisen. Example D provides an example of one statement, coded to source, for each of the categories in example C 'How staff promote dignity' (see Appendix 24).

4.12.4 Charting
As per the framework approach, charts for each theme and its categories were developed. Appendix 24, example E, shows an extract from an early chart, indicating which patients and ward staff interviews provided significant statements supporting the categories. All the supporting statements were listed under each chart in the Word document, so they were easily accessible. Later the charts were organized according to gender of patients and their age groups, as well as ward staff, senior nurses, fieldnotes from observation of care and handovers and Trust documents. The charts assisted with identifying how widespread different views were (derived from the interview data), the effect of age group, gender and
role (ward staff or senior nurses) and how observational and documentary data supported
the categories, promoting data triangulation. This use of charts related closely to Miles and
Huberman's (1994) description of matrices being used to look for patterns.

4.12.5. Mapping and interpretation
The charts were displayed on flipcharts and their examination assisted with interpretation
and recognition of associations between the themes and categories, helping to identify
explanations and draw conclusions (Miles and Huberman's (1994) third stage of analysis).
For example the relationship between the staff behaviour that promoted dignity and the
meaning of patient dignity in hospital was clarified. The original themes and categories
were refined several times as the analysis process developed, returning frequently to the
raw data to ensure the analysis remained close to its sources. Overall, combining the
broad principles of Miles and Huberman's (1994) data analysis approach with Ritchie and
Spencer's (1994) framework approach provided a sound, systematic method of data
analysis. Table 4.4 presents an overview of the final themes and categories. A laminated
copy of these can be found at the end of the thesis.

4.13 Feedback to the Trust and data verification
In concordance with NHS research governance recommendations (DH, 2005b),
arrangements were made to feedback findings to participants promptly. Patton (2002) too
advises that as data collection finishes, the researcher must consider who to feedback
results to and at what stage, feedback being both part of reciprocity and a means of
verifying results. The ward manager was consulted as to how best to disseminate results
to staff and three feedback sessions were delivered, two during the day, following the
handover between morning and afternoon staff, and one during an evening meeting with
night staff. The staff appeared interested and eager to hear about the findings: particular
emphasis was given to results emerging from patient data as staff were very interested in
patients' views. It was aimed to give a balanced presentation, emphasising positive
findings but also highlighting what patients considered were threats to their dignity. The
staff seemed to find the results highly credible thus assisting with verification. A written
report was provided to the lead consultant for inclusion in a portfolio which was being
produced for peer assessment, and sent to the HNPD. The R&D office requested three
monthly reports regarding the study's progress which were provided. An annual report was
produced for the LREC as per the COREC guidelines.
Table 4.4 Overview of themes and categories

<table>
<thead>
<tr>
<th>Theme 1 The meaning of patient dignity in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feelings: comfortable, in control, valued</td>
</tr>
<tr>
<td>• Physical presentation</td>
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<td>• Behaviour to and from others</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2 Threats to patients’ dignity in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital environment</strong></td>
</tr>
<tr>
<td>• Lack of privacy</td>
</tr>
<tr>
<td>o physical environment</td>
</tr>
<tr>
<td>o bodily exposure</td>
</tr>
<tr>
<td>o mixed sex environment</td>
</tr>
<tr>
<td>• Hospital systems</td>
</tr>
<tr>
<td>o bed management</td>
</tr>
<tr>
<td>o staff workload and work patterns</td>
</tr>
<tr>
<td><strong>Staff behaviour</strong></td>
</tr>
<tr>
<td>• Curtness</td>
</tr>
<tr>
<td>• Authoritarianism</td>
</tr>
<tr>
<td>• Breaching privacy</td>
</tr>
<tr>
<td><strong>Patient factors</strong></td>
</tr>
<tr>
<td>• Impaired health</td>
</tr>
<tr>
<td>o loss of function</td>
</tr>
<tr>
<td>o diagnosis-associated intimate procedures</td>
</tr>
<tr>
<td>o psychological impact of diagnosis</td>
</tr>
<tr>
<td>• Older age</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3 Promotion of patients’ dignity in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital environment</strong></td>
</tr>
<tr>
<td>• Conducive physical environment and facilities</td>
</tr>
<tr>
<td>• Dignity-promoting culture and leadership</td>
</tr>
<tr>
<td>• Support of other patients</td>
</tr>
<tr>
<td><strong>Staff behaviour</strong></td>
</tr>
<tr>
<td>• Providing privacy:</td>
</tr>
<tr>
<td>o environmental privacy</td>
</tr>
<tr>
<td>o body privacy</td>
</tr>
<tr>
<td>o auditory privacy and confidentiality</td>
</tr>
<tr>
<td>• Therapeutic interactions to make patients feel:</td>
</tr>
<tr>
<td>o comfortable</td>
</tr>
<tr>
<td>o in control</td>
</tr>
<tr>
<td>o valued</td>
</tr>
<tr>
<td><strong>Patient factors</strong></td>
</tr>
<tr>
<td>• Attitude</td>
</tr>
<tr>
<td>• Relationships with staff</td>
</tr>
<tr>
<td>• Ability and control</td>
</tr>
</tbody>
</table>
4.14 Promoting rigour

As discussed earlier (4.3) there are acknowledged concerns regarding the rigour of case study research designs but the issues raised are often because case studies are being judged by quantitative criteria for rigour, such as objectivity. In this study, steps were taken throughout the research process to promote rigour; many of these have already been referred to as they were integral during data collection and analysis. Sandelowski (1986) suggests that auditability is a key strategy for promoting rigour (or trustworthiness), which can be achieved through leaving a clear decision trail. Accordingly, this thesis has explained why the researcher became interested in the topic (Chapter 1), the literature reviewed and the study’s research questions (Chapters 2 and 3) and, in this chapter, the decisions made at each stage of the research design, data collection methods and analysis. Using Lincoln and Guba’s (1985) criteria, Table 4.5 summarises the strategies used to promote rigour, with reference to the chapter sections supporting these points.

While Lincoln and Guba’s (1985) criteria provided a useful framework to analyse the rigour of this study, there is continued debate about how quality in qualitative research can be judged (Rolfe, 2006). Ballinger (2006) argues that the variability of qualitative research makes applying rigid rules about rigour problematic. She suggests instead four considerations for qualitative researchers in relation to rigour and quality of their research. Firstly, there should be coherence between the study’s aims and the design; sections 4.2 and 4.3 detail how a qualitative case study design was specifically chosen to address the study’s research questions (3.6). Secondly, there should be evidence of ‘systematic and careful research conduct’ (p.241). This criterion relates closely to that of ‘credibility’ and is detailed in Table 4.5. The third criterion is that of a ‘convincing and relevant interpretation’ (p.241). Chapters 5 and 6 will demonstrate the achievement of this criterion, and in addition, as Table 4.5 displays, the research findings have been presented, and a paper based on some of the findings has been accepted for a peer-reviewed journal (Baillie, 2007), indicating that it was considered relevant for the readership. Finally, Ballinger (2006) suggests that the researcher’s role in the research should be explicit and compatible with the research orientation. Within this chapter, the researcher has provided details of her role and behaviour during the various data collection methods and has discussed the impact on her, for example the role conflict that occurred during participant observation (4.9.2).
Table 4.5 Summary of strategies to promote rigour, based on Lincoln and Guba's (1985) criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Strategies adopted and chapter section</th>
<th>How strategy promotes rigour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Use of case study design (4.3)</td>
<td>Results in a detailed holistic account based on real situation. Structured research design using tried and tested approach</td>
</tr>
<tr>
<td></td>
<td>Methodology guided by expert source (Yin, 2003) (4.3)</td>
<td>Data collection tools comprehensible and likely to collect relevant data</td>
</tr>
<tr>
<td></td>
<td>Data collection tools scrutinized by supervisors, participant representatives and LREC.</td>
<td>Accepted as part of the team which promoted more natural staff and patient behaviour and enabled wide access to setting and care delivery.</td>
</tr>
<tr>
<td></td>
<td>Wearing uniform (4.7; 4.9.2), building a rapport with staff during familiarization shifts (4.7) and participant observation (4.9.2)</td>
<td>Ensured methods were sound and led to rich data collected</td>
</tr>
<tr>
<td></td>
<td>Main data collection methods piloted and critically reviewed with supervisors (4.7)</td>
<td>Corroboration of same phenomenon from different sources</td>
</tr>
<tr>
<td></td>
<td>Data triangulation (4.3, Table 4.1)</td>
<td>Ensured information-rich participants were recruited</td>
</tr>
<tr>
<td></td>
<td>Purposeful sampling of patients (4.8.1; Table 4.2; 4.9.1; Table 4.3) and senior nurses (4.10)</td>
<td>Relaxed participants leading to rich data collected at interview</td>
</tr>
<tr>
<td></td>
<td>Developing rapport with patients (4.8.2; 4.9; 4.9.2) and staff interviewed (4.9; 4.9.2)</td>
<td>Participants encouraged to express their own feelings thus leading to rich data</td>
</tr>
<tr>
<td></td>
<td>Open questions with probes, assuring confidentiality and 'final say' questions (4.8.2; 4.9.2; 4.10)</td>
<td>Accurate and timely record of events</td>
</tr>
<tr>
<td></td>
<td>Fieldnotes taken during observation (4.9.2)</td>
<td>Accurate record of documents scrutinized</td>
</tr>
<tr>
<td></td>
<td>Trust documents copied or notes taken from them (4.11)</td>
<td>Accurate record of interview data</td>
</tr>
<tr>
<td></td>
<td>Interviews taped (4.8.2; 4.10) or notes taken and written up immediately afterwards (4.9.2)</td>
<td>Record of events observed complete and accurate</td>
</tr>
<tr>
<td></td>
<td>Observation base in or near bay (4.9.2)</td>
<td>Accurate and comprehensive data recorded</td>
</tr>
<tr>
<td></td>
<td>Immediacy of interview transcribing (4.8.2; 4.10) and writing up fieldnotes (4.9.2).</td>
<td>Accurate and comprehensive analysis and interpretation</td>
</tr>
<tr>
<td></td>
<td>Data analysed systematically applying tested framework; process and content critically reviewed with supervisors (4.12)</td>
<td>Researcher awareness of impact of self on data collected and process</td>
</tr>
<tr>
<td></td>
<td>Research diary facilitating researcher reflexivity (4.9.2)</td>
<td>Researcher can assess whether</td>
</tr>
<tr>
<td></td>
<td>Presentation of the research results</td>
<td></td>
</tr>
<tr>
<td><strong>Transferability</strong></td>
<td>Instrumental case study design using purposeful sampling: DGH and acute ward (4.3; 4.4); patient participants selected via purposeful criterion and stratified sampling (4.8.1; Table 4.2; 4.9.1; Table 4.3) Detailed description of case study ward, its speciality and participants (4.4; 4.8.1; Table 4.2; 4.9.1; Table 4.3; 4.10)</td>
<td>‘Typical’ DGH and acute ward with participants of varying age, social class and both genders leading to potentially greater applicability Readers can judge the fittingness of the findings to their own context</td>
</tr>
<tr>
<td><strong>Dependability</strong></td>
<td>Interview topic guides (Appendices 18, 20, 21, 23) Observation guide (Appendix 19) One researcher conducted all data collection Audit trail: detailed account provided of how the research was conducted and data analysed (Chapter 4) Research diary (4.9.2)</td>
<td>Consistency in questions asked Consistency in observation structure and content Consistency in researcher approach Auditability of research process Readers can follow the researcher's decision trail Self monitoring of consistency of research process</td>
</tr>
<tr>
<td><strong>Confirmability</strong></td>
<td>Detailed description and audit trail. Strategies detailed above to achieve credibility, applicability and consistency will promote confirmability.</td>
<td>Enables readers to assess context of findings and how research decisions were made.</td>
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### 4.15 Chapter summary

This chapter has explained the rationale for using a qualitative case study research design and explained how access to a research setting was obtained and ethical issues addressed. Each of the data collection methods and sampling methods was then outlined and the data analysis process was detailed. Finally, how rigour was achieved during the research process was explained. In Chapter 5, the findings related to the meaning of patient dignity in hospital and threats to dignity are presented and discussed in relation to the theoretical framework. Chapter 6 presents the findings related to how dignity can be promoted in hospital.
Chapter 5: 'In hospital you expect to be put into situations where you may feel a certain loss of dignity I suppose': the meaning of patient dignity in hospital and how it is threatened

5.1 Introduction

Chapter 4 explained the rationale behind the case study research design, the setting for the research, data collection methods and analysis. This chapter first presents the findings about the meaning of dignity for patients in an acute hospital setting and then how patients’ dignity is threatened. Threats to dignity relate to the hospital environment, staff behaviour and patient factors; each of these aspects is examined and then analysed in relation to previous research. The chapter ends with a summary, which indicates areas of new knowledge, and links forward to Chapter 6, which explains how patients’ dignity can be promoted in hospital. Table 5.1 presents the two themes 'The meaning of patient dignity in hospital' and 'Threats to patients' dignity in hospital' and their categories.

Table 5.1 Themes 1 and 2: 'The meaning of patient dignity in hospital' and 'Threats to patients' dignity in hospital'

<table>
<thead>
<tr>
<th>Theme 1 The meaning of patient dignity in hospital</th>
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<tbody>
<tr>
<td>• Feelings: comfortable, in control, valued</td>
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<td>• Physical presentation</td>
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<td>• Behaviour to and from others</td>
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<th>Theme 2 Threats to patients’ dignity in hospital</th>
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<tr>
<td>Hospital environment</td>
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<td>• Lack of privacy</td>
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<td>o physical environment</td>
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<td>o bodily exposure</td>
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<td>o mixed sex environment</td>
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<td>• Hospital systems</td>
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<td>o bed management</td>
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<td>o staff workload and work patterns</td>
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<tr>
<td>Staff behaviour</td>
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<tr>
<td>• Curtness</td>
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<tr>
<td>• Authoritarianism</td>
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<td>• Breaching privacy</td>
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<tr>
<td>Patient factors</td>
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<tr>
<td>• Impaired health</td>
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<tr>
<td>o loss of function</td>
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<tr>
<td>o diagnosis-associated intimate procedures</td>
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<tr>
<td>o psychological impact of diagnosis</td>
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<td>• Older age</td>
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Quotations from the data are included throughout this chapter to support the findings, coded to preserve anonymity.\(^6\)

5.2 The meaning of patient dignity in hospital

All participants interviewed were asked an open question inviting their views about dignity. The meaning of dignity emerged from both these responses and through their descriptions of how dignity was threatened or promoted, supported by observational data. The nature of dignity can be difficult to express: half the patients and several staff members struggled to find words to articulate it (see Box 5.1).

**Box 5.1 Difficulty in articulating the meaning of dignity**

'It's very hard as I'm sure you're aware to find words for this'. (Mr D2)

'I don't know really - how would you explain it? I don't know'. (Mr D3)

'Oh blimey! [chuckle] [pause] That's a good one! The answer is I don't really know to be absolutely honest'. (Mr D6)

'Not easy is it - surprisingly'. (Mr O2)

'Haven't really thought about it - everyone has their own ideas'. (Mrs O12)

'I'm trying to explain what I mean by it. [laughs] I know what it means but'. [laughs] (S1)

A few patients explained what loss of dignity would be, for example embarrassment (Mr D4), humiliation (Mrs D8) or being exposed to others (Mrs D11). Two staff members (N5 and N15) expressed that dignity concerned individuality. Despite some participants' initial difficulties with articulating their view, all offered suggestions. The central component of dignity in hospital is how patients feel, which is linked with their physical presentation and behaviour to and from others. Each of these aspects is presented next.

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\(^6\) Patient participants are referred to by a number, prefixed by Mr (if male), or Mrs (if female) as all the women participants had been married (one was widowed and one was divorced). Patient number is pre-fixed either with 'D' (interview following discharge) or 'O' (interview following observation). Nurse participants are coded 'N', health care assistants as 'HCA', and senior nurses as 'S' and they are all assigned a number. Observational data is coded 'FN' (fieldnotes of observation episode) or 'H' (observation of handover).
5.2.1 Feelings

Box 5.2 lists feelings associated with dignity, under the broad categories of feeling comfortable, in control and valued. Patients felt comfortable if they felt safe, happy, relaxed, not worried, did not feel embarrassed and had a sense of well-being. One staff member (N2) related patients feeling comfortable about their privacy but she was the only participant who linked privacy with feelings. Staff also related dignity to feelings and with patients feeling comfortable with themselves and their situation. Mr D4's comment summarized the view of dignity as feeling comfortable:

‘I think it's feeling sort of generally happy with your surroundings and where you are and who you're with and not feeling embarrassed by whatever’. (Mr D4)

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<tr>
<th>Feeling comfortable</th>
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<tr>
<td>Safe</td>
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<td>Relaxed</td>
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<tr>
<td>Not worried</td>
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<tr>
<td>Knowing your privacy is not invaded</td>
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<tr>
<td>without invitation</td>
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<tr>
<td>Not feeling embarrassed</td>
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<td>Well-being</td>
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<th>Feeling in control</th>
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<td>Able to cope</td>
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<td>Confident</td>
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<th>Feeling valued</th>
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<td>Self respect</td>
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<td>Of consequence</td>
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<td>Cared about</td>
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For four patients in particular, dignity was closely allied to feeling in control of one's situation (see Box 5.3). Hospital patients are vulnerable to feeling a loss of control over their environment, which some patients perceive is a loss of dignity. For Mr D4 (see comment Box 5.3) loss of dignity occurred particularly if he felt embarrassed and was unable to do anything about it. Mr D5 felt that hospitalisation inevitably led to feeling out of control and therefore a loss of dignity. Two staff members also referred to control in relation to the meaning of dignity.
Box 5.3 Dignity as feeling in control

'Not having people do things to you without asking. Having the opportunity to say 'actually thank you very much but no'…feeling that you're in control of your treatment'. (Mrs O10)

'Dignity is about feeling that you have some being of your own and that you're not under pressure to do things, in relation to what tests are carried out on you, what you have to wear'. (Mr O3)

'Something's making you embarrassed - well you can embarrass yourself I know. But when it's imposed you've lost control haven't you - you're not in charge…if you lose control in an embarrassing way… I think the two go together'. (Mr D4)

Participants also expressed that dignity entailed feeling valued, using terms such as self esteem and of consequence. N15 linked self respect with an individual's expectations of themselves and others, influenced by culture and upbringing. Two other nurses (N10 and S4) also referred to dignity being related to culture and religion; no patients referred to this aspect. Possibly some staff were more aware of diversity and its potential association with dignity than the white British patients.

Many participants associated patients' physical presentation with dignity, often as it affected how comfortable patients felt.

5.2.2 Physical presentation

About half the patients and over half the staff associated dignity with appearance: being dressed appropriately and not having their bodies exposed (see Box 5.4). Mrs O4 stated that, she would never go out without her make-up and always dressed 'nicely'. Following her bedbath she asked for her make-up bag to apply her make-up, later asking whether her lipstick was on straight (FN 31st May 2005). Physical presentation was closely linked with feelings, influencing how comfortable patients felt, and with feelings of control as patients had varying levels of control over their physical presentation. Patients' views about dignity and bodily exposure varied, for example, some perceived no loss of dignity if their bodies were exposed to HCPs during their care or treatment, rationalising its necessity for their well-being (see Chapter 6, 6.4.1). Some patients felt comfortable about bodily exposure with patients of the same sex in their bay but bodily exposure in front of patients of the opposite sex or visitors was perceived as a loss of dignity. A few patients
were unconcerned about bodily exposure in any circumstances. Section 5.3.1.1 discusses bodily exposure as a threat to dignity with reference to gender issues too.

Box 5.4 Dignity as being presented appropriately

'I presume it's the way you dress'. (Mrs D11)

'Not showing body parts'. (Mrs O11)

'It's probably just not showing your body to other people I think. Just keeping it covered all the time'. (Mrs D11).

'Not flaunting everything'. (Mrs O9)

'Modesty'. (Mr O5)

'Not letting yourself go'. (Mrs O4)

'Not exposing them, being conscious of their nudity'. (S4)

'If I walked out and my trousers fell down I would feel a loss of dignity!' [laughter] (Mr D4)

Behaviour to and from others was associated with dignity by many participants and impacted on how comfortable patients felt and whether they felt valued.

5.2.3 Behaviour to and from others

The meaning of patient dignity was strongly associated with behaviour, to and from others. Three quarters of the patients, all the senior nurses and half the ward staff referred to behaviour in relation to the meaning of dignity. Staff and other patients' behaviour towards patients could make them feel comfortable, in control and valued. Staff behaviour was also a key dimension in promoting patients' dignity (see 6.3); some participants discussed behaviour in relation to the meaning of dignity and all identified how staff behaviour could promote dignity. Table 5.2 summarises behaviour associated with dignity, with illustrative quotations and includes behaviour linked to personal standards, behaviour towards others and behaviour from others.

Respect was the most commonly used term relating to behaviour associated with dignity, expressed by half the patients, five ward staff and all the senior nurses. About a third of
the patients and a smaller number of staff believed that dignity entailed reciprocity, mutually respectful behaviour. S1 expressed that respect should continue after death too, implying that although people after death do not have feelings, they should still be treated as though they are valued. While providing privacy was a behaviour that promoted dignity (see 6.3.1), a few staff and patients also identified privacy as a behaviour associated with the meaning of dignity. Some comments concerned behaviour that should not be performed. Two patients identified dignity as being about how people are viewed by others, perhaps because of the likely effect on attitude and behaviour.

Table 5.2: Behaviour associated with dignity

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Illustrative quotations</th>
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<tbody>
<tr>
<td>Personal standards</td>
<td>‘It’s about principles. What you’ve been brought up to from childhood, e.g. brought up to respect people’. (N10)</td>
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<tr>
<td></td>
<td>‘Living to a certain standard - how I was brought up’. (Mrs O4)</td>
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<tr>
<td></td>
<td>‘Not doing anything bad7 to disgrace myself’. (Mrs D12)</td>
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<td></td>
<td>‘You try and set yourself standards to do things’. (Mr D7)</td>
</tr>
<tr>
<td>Behaviour towards others (includes reciprocity)</td>
<td>'Not having your self respect diminished. Part of that would be to treat other people as you would want to be treated'. (Mr O2)</td>
</tr>
<tr>
<td></td>
<td>‘I suppose it’s fairly well linked into respect and how you respect people hoping that they’ll obviously do the same and respect you’. (Mr D7)</td>
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<tr>
<td></td>
<td>‘I think it’s about treating people the way that one would like to be treated oneself if one was in a similar position. I’m thinking of patients in particular. What would I want if I was in that situation’. (S5)</td>
</tr>
<tr>
<td></td>
<td>‘I was brought up with a policy of you treat people how you want to be treated and ninety-nine per cent of the people do likewise. If you treat them good then they’ll treat you good’. (Mr D9)</td>
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<tr>
<td></td>
<td>‘Courtesy and manners’. (Mrs O9)</td>
</tr>
<tr>
<td>Behaviour from others</td>
<td>‘Respect from other people isn’t it? Respect and people treating you as you treat them, and not making you feel small’. (Mrs D8)</td>
</tr>
</tbody>
</table>

7 Underlining in quotations denotes that the participant emphasised the word.
To summarise, patient dignity entailed feeling comfortable, in control and valued, which was related to patients' physical presentation, personal behaviour and the behaviour of others towards them. The next section examines these findings in relation to the theoretical framework.

### 5.2.4 Discussion: the meaning of patient dignity in hospital

The literature review identified that the concept of dignity is poorly understood and open to interpretation (see Chapter 2, 2.2) yet it is a term used frequently in healthcare. Some study participants, like those in Matiti's (2002) study, had difficulty articulating their
perceptions of dignity and proposed varying concepts.

Previous research has indicated that dignity is an internal quality which was well supported by the findings as many participants expressed that the meaning of dignity was about feelings. Some feelings identified in this study's findings are strong themes in the literature too, in particular: self esteem (Chochinov et al., 2002a; Enes, 2003; Haddock, 1996; Jacobs, 2000; Matiti, 2002; Street, 2001) and self respect (Chochinov et al., 2002a; Coventry, 2006; Gallagher and Seedhouse, 2000; Griffin-Heslin, 2005; Haddock, 1996; Jacelon et al., 2004; Jacobs 2000; Marley, 2005; Matiti, 2002; Nordenfelt, 2003a; Tadd, 2004a; Tadd, 2004b, 2004c). However, feeling comfortable was specified in only two papers as being associated with dignity - the concept analyses by Mairis (1994) and Fenton and Mitchell (2002). For a few Heron ward patients, feeling in control was closely associated with dignity, but this specific interpretation of dignity was not so prominent in this study and only a few participants referred to control in relation to dignity. However, previous research has placed strong emphasis on the meaning of dignity being related to feeling in control (Calnan et al., 2005; Chochinov et al., 2002a; Enes, 2003; Fenton and Mitchell, 2002; Gamlin, 1998; Haddock, 1996; Jacelon, 2003; Mairis, 1994; Matiti, 2002; Pokorny, 1989; Randers and Mattiasson, 2004; Reed et al. 2003; Woolhead et al., 2005).

Thus, for most of this study's participants, other feelings relating to dignity were more prominent. One staff member identified privacy as an internal feeling associated with the meaning of dignity which also emerged from two concept analyses (Haddock, 1996; Marley, 2005), both of which, similarly to this participant, emphasised control in relation to one's privacy.

The meaning of dignity relating to outward physical appearance supports previous research with older people (Gallagher and Seedhouse, 2002), in terminal care (Chochinov et al., 2002a; Enes, 2003; Street, 2001) and acute care (Matiti, 2002). Specifically, the view of 'not letting yourself go' (expressed by Mrs O4) was also articulated by older people in the Dignity and Older Europeans Project (Woolhead et al., 2005). Supporting Matiti's (2002) category of 'decency', a few participants expressed that dignity was keeping the body covered. Being exposed was identified as an affront to dignity in studies with older people (Seedhouse and Gallagher, 2002; Woolhead et al., 2005) and is explored as a threat to dignity in 5.3.1.1.2. However, although Turnock and Kelleher's (2001) ITU-based study assumes that dignity solely concerns modesty of the body, this study's findings indicate that few people consider this to be the only meaning of dignity.
The study supported the link between behaviour and dignity which is prominent in the literature, reflecting the notion of 'interpersonal dignity', whereby behaviour from others conveys feelings of worth (Jacelon, 2003), expressed as 'feeling valued' in this study. The widespread association between dignity and respect in previous research (Calnan et al., 2005; Enes, 2003; Gallagher and Seedhouse, 2002; Gamlin, 1998; Matiti, 2002; Söderberg et al., 1999; Walsh and Kowanko, 2002; Woolhead et al., 2005) was confirmed in this study's findings too. Some participants considered dignity was behaving according to standards they had been brought up to, supporting previous research findings (Jacelon, 2003; Matiti, 2002). Reciprocity, expressed by several participants in this study, was indicated in focus groups with older people (Jacelon et al., 2004; Woolhead et al., 2005) and emerged from Street's (2001) work on dignity in end-of-life care. However, younger participants in Heron ward and staff also emphasised reciprocity in relation to dignity. Being treated as an individual, expressed by several participants, was identified in Enes' (2003) study in terminal care. A small number of participants considered that dignity is about how one is viewed by others, a perception expressed in Enes' (2003) study too. A few staff and patients associated providing privacy as a behaviour associated with the meaning of dignity, supporting research studies reviewed in Chapter 2 (Calnan et al., 2005; Chochinov et al., 2002a; Enes, 2003; Gallagher and Seedhouse, 2000; Jacelon, 2003; Matiti, 2002; Pokorny, 1989; Randers and Mattiasson; 2004; Reed et al. 2003). However, privacy was much more likely to be discussed in relation to how dignity was threatened (see 5.3.1.1; 5.3.2.3) or promoted in hospital (see 6.2.1; 6.3.1).

Having explored the meaning of dignity in hospital in relation to the theoretical framework, findings about how dignity can be threatened in hospital are next presented.

5.3 Threats to patients' dignity in hospital

Patients' dignity in hospital was threatened by the environment (lack of privacy and hospital systems), staff behaviour (curtness, authoritarianism and breaching privacy) and patient factors (impaired health and older age). Findings related to each of these are presented next.
5.3.1 Hospital environment

Nearly a third of the patients and a smaller number of staff implied that dignity and being in hospital are incongruent (see Box 5.5) and their comments are next explored.

**Box 5.5 Incongruence of dignity in hospital**

‘Being in hospital is in itself a threat to dignity’. (N5)

‘It's not a comfortable environment at all, coming here. It can be pretty uncomfortable. Whatever we do is not nice. It either hurts or it's unpleasant, or they're put in a compromising position’. (S4)

‘In hospital you expect to be put into situations where you may feel a certain loss of dignity I suppose’. (Mr D4)

‘Dignity is more sensitive in hospital...You can forget lots of ideas of your own conventional thinking and realise hospitals are different places. Many things are different about hospitals. ...You've got to be cooperative in hospital in a different sort of way. You've got to submit yourself to things you wouldn't usually put up with’. (Mr O2)

‘You're not in control in a hospital. You're outnumbered by the nurses and the doctors who are then going to say to you 'We think you should do this' or 'We feel that you should do this'... You're in the hands of them so the dignity I would think's slightly different. You can't dictate, you can't do it on your terms can you?’ (Mr D5)

‘Lots of elderly patients seem to just - they're in hospital and therefore they're in hospital and they accept what goes on in hospital and how they're cared for, and even if they question their dignity, they might be scared to say to the nurses - you know: “I'd rather not do it this way”’. (S6)

‘It's like having to take a step from your outside world into a totally different one and you kind of come to terms - before you go in there - with that’. (Mrs D8)

‘You kind of - leave that on your doorstep don’t you when you go in and you know that they're going to poke and probe in places you don't really want poked and probed’. [laughs] (Mrs D8)

‘You leave your dignity on the doorstep and pick it up on your way out. In some cases. Having said that, I’ve never come across any situation where my dignity's been - well what can I say - I've never felt ashamed. I've been able to keep my pride while I've been in hospital’. (Mrs D12)

‘Inside hospital as I said you just can’t wear that dignity in a urology ward’. (Mr D2)

‘I've never let myself go. Well I have in hospital but I'm not a happy person here’. (Mrs O4)
S4 expressed that the hospital environment is not comfortable, particularly for urological patients (see comment, Box 5.5) because of the nature of the procedures people experienced due to their diagnosis (see 5.3.3.1.2). Mr D2's comment implied that the ward's urological speciality prevented patients being able to experience dignity. Most patients had not thought about whether dignity would be affected in hospital but a few were uneasy prior to admission. Mr D4's and Mr O2's comments (Box 5.5) imply that patients have to fit in with the system and undergo procedures which they do not like. Similarly, Mrs O4 said that she probably would not let people do the things that they did to her in her own home, indicating that, like Mr D4 and Mr O2, she felt unable to decline certain procedures in hospital. However, her impaired health resulted in her being dependent on staff to carry out intimate care in hospital which she considered was a loss of dignity. For Mr D5, his illness and admission to hospital for surgery led to feeling a loss of control with staff making the decisions. S6 expressed too that patients lose control in hospital. Her comments were specifically about older people yet Mr D5 was only in his 50s and he felt similarly.

Mrs D8's comments highlighted the contrast between home and hospital, expressing that dignity is left behind on admission to hospital because of the intimate procedures which are carried out. Nevertheless she later stated that being in hospital 'wasn't too humiliating', the term 'humiliating' implying loss of dignity. Mrs D12 spoke similarly about the inevitable loss of dignity in hospital but she then appeared to contradict herself saying that she had never actually lost her dignity in hospital. However, Mrs O4 expressed first that dignity should always be retained 'You should never let yourself go' but she then stated that she had done so in hospital (Box 5.5). Her sad comment that she was not happy in hospital was linked to the dependency she was experiencing and she gave an example of how her dignity had changed in hospital related to the intimate care she needed and now accepted. She said she had told a relative:

'Young people wash me down below, and they think nothing of it and I think nothing of it!' (Mrs O4) [said in a shocked tone]

When asked why she thought nothing of this happening in hospital, she replied:

'You just think differently in hospital'. (Mrs O4)

Mrs O4's uncomfortable feelings in hospital were mainly related to her intimate care which was associated with her impaired health; how intimate care and procedures threaten patients' dignity is explored later (5.3.3.1.1; 5.3.3.1.2). Not all patients considered that hospitalisation threatened dignity, for example, Mr D3 stated that although being in
hospital was different from being in his own surroundings at home, he did not consider his
dignity to have been affected.

The most prominent environmental threat to patients' dignity in hospital emerged as being
the lack of privacy, compounded by bodily exposure and a MSE when present. Hospital
systems, relating to bed management and staff workload and work patterns, were also
identified as threatening dignity. Lack of privacy is explored first.

5.3.1.1 Lack of privacy

As discussed in 5.2, some participants associated privacy with the meaning of dignity but
privacy was more frequently discussed in relation to a lack of privacy being a threat to
dignity, or that provision of privacy promoted dignity. Overall, half the patients considered
that lack of privacy threatened their dignity in hospital but this was more likely to relate to
the impact of a MSE or bodily exposure than the physical environment of the ward. About
two thirds of the ward staff and senior staff referred to the ward environment's lack of
privacy and expressed great concern about MSE and patients' risk of bodily exposure in
hospital. Observational data supported lack of privacy as a major theme threatening
patients' dignity. The physical environment is first discussed.

5.3.1.1.1 Physical environment

Most patients felt that Heron ward's modern design comprising four five-bedded bays with
a bathroom promoted privacy (see Chapter 6, 6.2.1). The ward environment often
exceeded their expectations as it provided greater privacy than many other wards in the
local hospitals: Nightingale wards, bayed wards without a bathroom in each bay, and
wards with smaller bed spaces. Just two patients (see Box 5.6) perceived being in a bay
with other patients led to a lack of privacy.
Box 5.6 Lack of privacy

'Obviously it would be much nicer to have a private ward where you could feel as if you were your own little person but you know you're one of many many people who are there to be helped so you have to put those feelings on the back burner and know that you've got to cope with the situation of being thrown in with lots of other people with various problems'. (Mrs D8)

'You don't know what to experience in a hospital. I mean the privacy was - it's quite a shock to see people considerably worse off than you'. (Mr D5)

Mrs D8's comments indicated rationalisation about the situation while regretting the lack of privacy. Mr D5 surmised that other patients in his bay were very ill, illustrating how patients gain knowledge about each other in the hospital environment. Two staff members (HCA3 and N5) acknowledged that some patients (like Mrs D8 and Mr D5) found being in a bay with other patients was a loss of privacy and a threat to dignity and HCA3 said that some patients therefore liked to keep their curtains drawn. S3 considered that people who were dying should have the greater privacy of a side room but that this was rarely possible as side rooms were almost exclusively occupied by people with infections, a point confirmed by observation.

Bays 1 and 4 (see Figure 4.1) were in view of the nurses' station and one of these was passed by anyone entering the ward, potentially reducing privacy. Three nurses (N2, N14 and N10) commented that the openness of the ward might threaten dignity, particularly for patients in such exposed positions. However, they also pointed out that staff needed to observe patients easily, particularly when they are unwell. Mr D5 had had major surgery and therefore needed to be carefully observed but his perception was:

'I had a very unusual bed because it was in a corridor which was strange - the ward didn't seem a ward - it's this open plan business. Now that in many ways is slightly disrespectful - this open plan. It denies the cosiness which does in actual fact deny the privacy. Which I suppose ultimately does deny the dignity'. (Mr D5)

During their admissions, Mr D7 and Mr O6 were in the same bedspace as Mr D5 but neither of them commented about a lack of privacy indicating differences in perceptions of privacy. However N10, interviewed following observation of Mr O6, identified his exposed position in the ward as being a threat to dignity but commented that he could be easily observed there which was necessary when he was more ill. Mr O5 gave a similar view about balancing privacy with safety for patients. At the time of observation, he was in a side room (due to an infection) but he stated that people should appreciate that not all
patients could have single rooms and that in the recovery phase they needed to be where they could be observed easily. N14 too commented on the tension between privacy and safety in a hospital environment, particularly in relation to the risks of keeping curtains round patients to promote privacy. S1 explained that doors had deliberately been omitted from Heron ward's bays because of the need to observe patients closely:

'I said we can't have that [doors] on this ward because of [bladder] irrigations - you've got to be able to see. And we did have a bit of a battle. But we won it in the end'. (S1)

For S1, safety (and perhaps convenience for staff in being able to observe patients easily) was apparently more important than privacy. However, in private hospitals patients are generally in single rooms and presumably their safety is maintained, but staff: patient ratios may be higher. Perhaps NHS staff are so accustomed to maintaining safety in an open ward, they cannot envisage how they could achieve this in a more private environment.

Curtains have a crucial role in providing privacy within bays so it was essential that they could be closed fully. N3 expressed concern that the curtains in Mr O2's bay did not pull completely. N6 stated that she had recently visited another ward to conduct a patient's bladder scan and the ward had been mixed and the curtains had not shut properly. She commented that this was 'bad' and she used a safety pin to close the curtains. Her actions illustrated the strong commitment of Heron ward's staff towards patient privacy which was confirmed by observation (see Chapter 6, 6.3.1). Both nurses' comments also highlight how seemingly minor details are crucial in relation to dignity in hospital. In addition, some staff expressed that the privacy provided by curtains was easily jeopardised by staff themselves, indicating how staff behaviour could compound environmental threats to privacy (see 5.3.2.3).

A few staff and just one patient referred to the lack of auditory privacy on the ward (see Box 5.7), acknowledging that curtains did not prevent patients hearing information about other patients.
Box 5.7 Lack of auditory privacy: Staff and patients’ views

‘Other patients can hear even with the curtains round. Curtains are a visual but not a hearing barrier’. (N13)

‘I remember thinking, ‘Don’t speak so loud’ because everybody in the ward could hear what he’d done and what he’d found … you can’t help it can you - if you’re laying in the next bed…I just thought you know ‘Don’t speak too loud’ - I’m not exactly proud of what’s going on’. (Mrs D8)

Illustrating how patients adapt to the hospital environment (see Chapter 6, 6.4.1), N14 considered that there was an unspoken rule among patients: they accept that they will hear things and be overheard but she said:

‘Somehow patients seem very comfortable to talk about personal things even though they know others can hear’. (N14)

Only one patient (Mrs D8 - see Box 5.7) commented on a lack of auditory privacy, perhaps confirming N14’s view that most patients adapt to it, or that they did not associate auditory privacy with dignity. Mrs D8 stated that when the consultant came to talk to her about her surgery, she was worried about other patients overhearing. Mrs D8 was embarrassed about having surgery on her bladder and considered being in a bay with other patients to be a lack of privacy in itself (see Box 5.6). Thus her consultant explaining about her surgery in earshot of other patients compounded an already uncomfortable situation. Ward rounds were only mentioned by one other participant: N14 stated that ‘doctors stand at the end of the beds and discuss patients’, a situation that could lead to other patients overhearing what was said. Her comment was supported to some extent by observation, although usually after a brief discussion by the notes trolley, doctors would go over to talk to the patient and curtains were always drawn for examinations.

Patients’ attitudes towards privacy seemed to be the crucial element as a similar example of a lack of auditory privacy to that described by Mrs D8 was observed being initiated by Mr O1 (see Box 5.8). He did not appear at all embarrassed and did not mention this event in his follow-up interview as having been a threat to his dignity.
Box 5.8 Lack of auditory privacy observed

'The urology registrar was now in the bay with the house officer and staff nurse and notes trolley, reviewing their patients. Mr O1 had only just come from the shower and was standing by his bed when the registrar spoke to him. He told him he could have his catheter out tomorrow, then home the next day. Mr O1 asked him if he had found any more tumours in his bladder [during the cystoscopy] and the registrar said he hadn't. They stood discussing Mr O1's cancer with the man next to Mr O1 just about two feet away. No one seemed uncomfortable about this'.

(FN, 22nd April, 2005)

Bodily exposure in the ward compounded the lack of environmental privacy and is discussed next.

5.3.1.1.2 Bodily exposure

Bodily exposure was a lack of privacy of the body, which a third of patients and the majority of staff identified as a threat to dignity. Patients' concern about bodily exposure was evenly spread across age groups and gender. In the privacy of patients' own homes, bodily exposure as a threat to dignity does not usually arise. However in hospital, the public nature of the ward, the large numbers of people in the environment (staff, visitors and other patients), expectations that patients will be dressed in gowns or nightclothes and the fragility of privacy in hospital (e.g. curtains and doors which are easily opened) combine to create a situation in which bodily exposure in front of other people is a strong possibility. In addition, patient factors (such as diagnosis-associated intimate procedures) exacerbate the situation (see 5.3.3.1.2). Concerns about bodily exposure were heightened in some instances by the ward's urological speciality (see comments Box 5.9).

Box 5.9 Bodily exposure associated with urology

Mr D6 said that before going into hospital he worried about:

'what bits are they going to be looking at, because, well as far as that goes you know roughly what they're going to be looking at, are all and sundry going to be looking or is it just one or two people'. (Mr D6)

'Being a urology ward they know they're coming in with their particular problem that they're dealing with so they are aware. Although some people are probably more - not shy - but more conscious. I mean we all are. All have our private bits. Yes, so people are probably more apprehensive. Because it's this ward'. (S2)
S4 expressed that medical staff could be blasé about bodily exposure, for example on ward rounds, but her view was not supported by observational data nor patients’ comments. It was observed that most staff consistently provided privacy to prevent bodily exposure (see Chapter 6, 6.3.1) but nevertheless, some patients still identified occasions when they had felt exposed. Bodily exposure as a threat to dignity was compounded if bays were mixed sex, which is discussed later.

Concern about bodily exposure being a threat to dignity can extend to body products and on Heron ward, where the majority of patients had urinary catheters, their urine was constantly and publicly monitored by staff - measuring it, emptying the bags and commenting on its colour\(^8\). However, there appeared to be almost total acceptance of the exposure of urine on the ward in urine bags. Only one patient (Mr D2), but no ward staff, eluded to the public display and emptying of catheter bags as being a threat to dignity. S6 expressed concern about visible urine bags threatening older patients’ dignity and stated that staff should attach a leg bag under clothes instead. However, leg bags have only a small capacity and patients having bladder irrigation, as they frequently were on Heron ward, had to have large capacity catheter bags. S4, in relation to clinic patients, expressed concern that when patients passed urine, the urine must be disposed of discreetly to maintain privacy, thus she also considered exposure of urine to be a threat to dignity.

Several male patients commented that operation gowns allowed bodily exposure. These were worn by patients during surgery and immediately post-operatively and then a nightshirt was offered which still had an opening at the back. The rationale for not wearing pyjama trousers was that male patients inevitably had urethral catheters, which must drain freely and needed to be easily checked by staff. S3 emphasised that this was essential, particularly in the post-operative phase. However, some patients perceived that these garments caused a loss of dignity because of the associated bodily exposure. The laundry often ran out of nightshirts so patients stayed in operation gowns - a resource issue impacting on dignity. For example a patient asked the researcher one Saturday if there was a nightshirt on the linen trolley and, if so, could he have one before ‘they run out’.

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\(^8\) Patients who have had urological operations are at risk of bleeding and blood clot formation which can block the catheter. Urine colour is monitored to ensure there is no excess bleeding.
It was found that there were only pyjamas and operation gowns and the nurse in charge said that there would be no more nightshirts until the following Tuesday as it was a bank holiday weekend. The man was disappointed and said that he did not like wearing an operation gown as it was ‘indecent’. Box 5.10 provides quotations from patients about wearing operation gowns and nightshirts. Mr D6’s final comment highlights that not only did operation gowns cause bodily exposure, there was also a lack of control associated with having to wear them.

Box 5.10 Patients’ feelings about wearing operation gowns and nightshirts

‘How dignity’s compromised is these gowns you wear are wide open at the back aren’t they? I mean I noticed a man who was a good friend of mine in the next bed - every time he stood up and looked out of the window you could see all his back wide open - which is not the prettiest scene in the world …I’m only thinking about when I do it - that’s my dignity’. (Mr D1)

Mr D6 had to stay in an operation gown:
I never got one of them [nightshirts]. They’d run out. The laundry hadn't sent enough back. You know, usual old story. So I ended up with one of those [operation gown] until I’d had my catheter out and then I got my pyjamas on - but I mean if you were going anywhere you had to chuck your dressing gown over the top a bit quick because otherwise your bum was hanging out the back. And everybody said the same. The guy in the next bed - he was quite a big bloke - and they had a job to find one to fit him. And they couldn’t even get the tapes done up on that... I mean that was one of the worst bits, to be absolutely honest - that was one bit where you hadn't got any dignity cos you just couldn't do anything about it’. (Mr D6)

While operation gowns or nightshirts were arguably necessary for many patients much of the time, there was one instance observed of a patient (Mr O6) being unnecessarily kept in an operation gown, when he did not have a catheter and was not going to theatre. Patients wearing hospital gowns and nightshirts seemed ingrained as a ward ‘norm’ and only two staff members (N13 and HCA3) identified them as a threat to dignity. Mr D4 found wearing the gown and then the nightshirt embarrassing. He termed them ‘frocks’ and it seemed that as well as leading to a risk of exposure, he also considered them a problem as they were not what men usually wear: ‘I’m not used to a frock! Women are’. Mr D4 considered that bodily exposure was not such a problem if there were just other patients in the bay but he was concerned about exposure when visitors were present:

‘Not that it matters very much but you do get visitors don’t you? I mean people come from outside visiting and I had visitors there when this poor old chap opposite was walking around moving up his gown - so there he’s all exposed - there’s my son and his wife. You feel a bit embarrassed for that’. (Mr D4)

It seemed that exposure in front of other patients in the bay would not have been so bad
but exposure in front of visitors, who were from 'outside', was different.

Some staff referred to the ongoing situation of trying to prevent bodily exposure on the ward, particularly of men to women, as the ward was mixed. N2 stated that with some men:

'We try to keep them [genitals] under cover but they persistently expose themselves. Being a mixed ward this could be a problem - we try to keep things [men exposing themselves] to a minimum but there are times when things go awry'.

(N2)

An example of staff concern was observed when N4 reported during handover that a male patient was walking around 'with his crown jewels [genitals] hanging out' and she asked him to cover up (H6). The previous day, the researcher observed that this man was walking around in just a tee shirt. He was not confused but he appeared to be unconcerned about bodily exposure. S1 commented on the risk of bodily exposure due to urinary catheters and that some men are 'not always very good at covering themselves up'. Lack of concern about bodily exposure mainly related to the men and was therefore a gender issue. However, there were exceptions. Following observation of Mr O6, N10 related that a female patient that morning had been sitting in a wheelchair and 'her bottom was exposed at the back'. N10 suggested covering her up but the woman responded that she was not worried about it. However N10 was worried as she felt that it was 'not nice for the other patients' to see the woman exposed and that for her dignity she should be covered up: 'it's what I've been taught to do'. Thus there was a range of different views about bodily exposure in the ward: patients who considered bodily exposure a threat to their dignity which they felt was exacerbated by the attire they had to wear and lack of privacy, staff who perceived bodily exposure as a threat to patients' dignity and tried to prevent it and patients who did not perceive bodily exposure as a threat to dignity, which potentially caused offence to others (including staff) in the ward.

The weather was very hot during most of the observation period and after one such night, N4 commented at handover that most of the men had been lying in bed naked all night. During another hot night, when Mr O7 was observed, N5 commented that he had taken his gown off:

'He's lying there with just a sheet over his body - but that's his choice'. (N5)

She said that when patients rolled over and their bodies were exposed, she liked to cover them 'but tonight it's too hot.' In the women's bay during the hot weather the patients lay on their beds with no covers on and their legs exposed. When Mrs O10 lay with her legs
uncovered she tended to have her nightdress right at the top of her legs. Following observation of her care of Mrs O10, N14 stated that she was worried that Mrs O10’s legs were exposed but when she asked her if she would like her legs covered, she declined, so although N14 felt ‘a bit uncomfortable about it, it was her choice’. Such situations presented a dilemma to staff who wanted to prevent bodily exposure which they considered to be a threat to patients’ dignity while at the same time facilitating patient choice.

Several staff members identified that patients had to expose intimate parts of their bodies to staff during treatment and care (see Box 5.11) and felt that this posed a threat to dignity.

<table>
<thead>
<tr>
<th>Box 5.11 Staff concerns about patients’ bodily exposure during care</th>
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<tr>
<td>‘Strangers [staff] coming in looking at his [Mr O2] private parts’. [is a threat to dignity] (N3)</td>
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<tr>
<td>‘Some people get embarrassed about their bodies being seen - especially if they feel they haven't got perfect bodies’. (N6)</td>
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<tr>
<td>‘They're in for treatment of their private genitalia area so that they're always that bit self conscious - that bit aware of - you know - the bits that are exposed that shouldn't be exposed’. (S3)</td>
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<tr>
<td>‘They are aware that we're looking at their genitals and their lower abdomen so they will I think have the anxiety of being put in a compromising position’. (S4)</td>
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As S4 acknowledged:

‘It's not like going to have your arm examined or your leg examined’. (S4)
Staff identified exposure as a threat to dignity while carrying out procedures like bed bathing but many patients indicated a high level of acceptance towards bodily exposure in front of staff in the course of their care, rationalising its necessity, and their attitude promoted their dignity in situations where it was at risk (see Chapter 6, 6.4.1).

5.3.1.1.3 Mixed sex environment

As already eluded to, a mixed sex environment (MSE) further increased discomfort about bodily exposure in hospital and is discussed next. A number of participants spoke negatively of MSEs: staff generally considered them a threat to dignity and patients perceived a greater loss of privacy when in a MSE. Heron ward was mixed but staff endeavoured to ensure that patients were not mixed in the bays themselves. Usually,
three bays were male and one bay was female with the two side rooms used for either sex. S5 confirmed that NHS guidance and Trust policy was that patients should be cared for in single sex environments. However she acknowledged that difficulties arose particularly when there were unpredictable numbers of male and female emergency patients needing beds. S5 commented that in an emergency:

'Sometimes if there's only one bed, then it's better to have a bed in a mixed bay than not to have a bed at all'. (S5)

In support of her view, Mrs D11 rationalised being in a mixed bay when she was admitted as an emergency:

'I knew that I had to be in hospital, and if that was the only place that they could put me and I was on the right ward. Then - you know - so be it'. (Mrs D11)

However she later said:

'They always pulled the curtains when they dealt with me which is a good thing - it shut the men out'. (Mrs D11)

Her comment implied that although she accepted being in a MSE she was not entirely comfortable about it. S6 also talked of patients having to be admitted to a mixed bay when there was no other bed available but said 'most of them, are just thankful to be in a bed'.

S5 acknowledged:

'I think certainly for older people, and for people who're going through distressing things, I think it's easier if there are single sex bays'. (S5)

Her criteria would apply widely in an acute hospital setting as most patients are older and acute care inevitably involves some distressing experiences. Her comment also implies an assumption that older people are more uncomfortable in a MSE but concern amongst Heron ward patients was spread across the age groups.

Heron ward's staff, led by the ward manager, believed vehemently that the bays should be single sex and strived to adhere to this philosophy but at times there was external pressure to mix bays. S1 stated:

'We do try and keep the men and women separately. We try very hard not to mix our bays, which occasionally does happen. But we avoid that if at all possible'. (S1)

S1 stated that when a mixed bay was unavoidable due to external pressure, she explained the situation to patients and promised to resolve the situation at the earliest opportunity. S3 confirmed that single sex bays were reverted to as quickly as possible:

'We really try to turn that round in the twenty four hours. So we get the bays back again'. (S3)

S5 stated that patients should be informed by nursing staff if they are being admitted to a mixed bay and she said:

'If they have very very strong objections to it, then we'd obviously try anything to avoid them having to go into a mixed bay'. (S5)
She acknowledged however that it was more difficult to address the views of patients already in a bay where a patient of the opposite sex was admitted:

‘If you’ve got five women and there’s a gent coming in. He might not mind but they might all mind’. (S5)

Observation indicated that it was a continual struggle to maintain the single sex bays on the ward. For example, N6 said that Mrs O4’s bay would probably be mixed later as there were two beds free and they had male patients to be admitted for surgery. She said that during the previous week there had been two men in the bay and the patients then kept their curtains drawn which made it claustrophobic. N14 commented that having curtains round beds all the time posed a safety issue (as it prevents observation) and was thus not a good solution to the mixing of bays.

During one observation period, N6 was observed informing N14 that the new male patients expected would be admitted into a bay with women patients:

‘They’re [the bed manager] going to mix a bay. They don’t care’. (FN 30th June 2005)

Shortly afterwards, a female patient approached the nurses’ station and complained about men being admitted into her bay. N6 agreed that this was undesirable and told her that they [the nurses] did not like it either but ‘we don’t get any say’. She told the patient that the men coming in for their operations have to go somewhere and the woman replied ‘But why to this ward? It’s immoral’ and N6 agreed with her. She told the patient that she would ask the bed manager to come and talk to her about it and she then bleeped the bed manager. Staff were thus in the difficult position of not being able to prevent a situation which they did not support and which was unpopular with patients. Staff used various strategies to deal with mixed bays, for example N6 said that they asked the men in a mixed bay not to use the bay’s bathroom but to use the bathroom/toilet at the back of the ward. However the men did not always comply with the request.

While most patients considered that curtains provided sufficient privacy in single sex bays, they felt differently in mixed bays. For example Mr D2 said that while curtains were adequate for privacy and dignity in a single sex bay:

_I don’t think I would have liked it very much in a mixed-sex ward_.

Several other patients mentioned that they would not like to be in a mixed bay, stating that this would threaten their dignity. Mrs O9 expressed that she hated mixed wards due to a previous experience which occurred in a mixed ward in a different hospital in the Trust (see Box 5.12).
Box 5.12 A patient's description of bodily exposure in a MSE

Mrs O9 said that she was trying to get out of bed without exposing herself, moving her legs round while trying to keep her nightdress pulled down. The man opposite her - instead of 'averting his eyes' - stared at her and she felt very uncomfortable. She said to the nurse that there was 'not much privacy here' and the nurse responded that she could always pull the curtains. Mrs O9 said that she could not draw the curtains until she was out of bed.

Since that incident, Mrs O9 had always dreaded being in a mixed ward. Her concern was written in her pre-admission notes but she was admitted to a bay in Heron ward with three women and one man. She stated that she and the other women agreed that they did not like being in a mixed bay. Mrs O9 told the man that she felt embarrassed for him having to be in a bay with women but he responded that he 'did not mind at all'; Mrs O9 thought that was 'odd.' Mrs O9 said that the government had said years ago that:

'mixed wards would stop but they're still here - they'll never get rid of them'. (Mrs O9)

However, by the time Mrs O9 returned from theatre the man had been moved to another bay so Mrs O9's bay was all female again. This was observed on other occasions when staff returned the bays to their single sex status as soon as it was logistically possible. Mrs O9 said that she was relieved when 'they took the man away' and that she felt 'perfectly happy now it's an all ladies bay'. She said that with 'all girls here', patients might not always pull the curtains round if they are getting out of bed but 'with a man here', the curtains had to be pulled.

S5 stated that complaints about MSEs in the Trust were often on behalf of patients rather than from patients themselves and that, from her experience, staff and relatives often felt more strongly about MSEs than patients, who were more concerned about staff approach. However while Mrs O9 felt particularly strongly about MSEs, several other patients commented negatively too. Although S6 asserted that 'men seem to adjust much better being told they're in a mixed bay with women', some men too expressed concern about MSEs. Like Mrs O9, Mr D1 was in a MSE on a previous hospital admission and he said 'I didn't like that at all', explaining:

'I think you really lose everything you know because there were elderly women over there in a state of undress and all this kind of thing - that worried me that'. (Mr
Mrs O10 stated that she liked the fact that 'it’s all ladies together’, saying that she felt ‘better.’ She said that there had been a man in the bay previously and ‘he was very pleasant’ but she felt that she had to keep her legs covered and sometimes she liked to lie with her legs exposed. She also said that when the bay was mixed:

‘as soon as they could they shuffled everyone round to make it a ladies’ bay’. Mrs O10

She thus confirmed the ward’s commitment to maintaining a single sex environment. Mrs O11 said that the fact that the bay was ‘all female is fantastic’, saying:

‘It’s bad enough having to come in without that’. [being in with men] (Mrs O11)

She said that men [patients] can be:

‘inconsiderate, they shout and walk around with everything hanging out’. (Mrs O11)

Her comment was supported by some of the ward staff who referred to men exposing themselves in the ward. Mrs O11 had been very unwell and drowsy post-operatively and she said:

‘If there has been an unguarded moment’ [where she was exposed] it wouldn’t have mattered so much because the other patients are only girls’. (Mrs O11)

She said that she played sport and was used to undressing in communal changing rooms but ‘they are single sex’. She reiterated that she would not have wanted to be in a bay with men who might have seen her exposed. These comments all indicated that a MSE threatened patients’ dignity because of the risk of bodily exposure to patients of the opposite sex. Patients implied that, despite curtains being available, these were not a guaranteed method of preventing bodily exposure which would threaten their dignity in a MSE.

Even when the bays were not mixed, staff sometimes found it challenging to ensure that the men remained separate from the women. N6 referred to the threat to dignity of ‘wandering men’ who wandered around the ward and strayed into the women’s bay. On one occasion it was observed that a man wearing a nightshirt and carrying a catheter stopped at the entrance of the female bay and asked N6 whether he was likely to have his catheter removed that day. Mrs O9 said that she had seen the man who was in her bay the previous morning walking past the women’s bay and she said that he ‘always has a good look’; she appeared uncomfortable about this. At one handover (H11), N4 spoke indignantly that a male patient walked into the women’s bay while she was doing the medicine round and asked for painkillers. She said that she told him: ‘this is a ladies’ bay - don’t come in here’. It appeared that the culture on the ward was that the sexes did not mix but some men were oblivious to this. As no similar comments were made about women, it
appeared to be a gender issue: women stayed in their bay and its immediate vicinity but some men roamed the whole ward making staff and women patients feel uncomfortable.

The outpatients area on the ward was mixed which, while not an issue if patients were in day clothes, posed a concern to S4, who was aware that patients changed into dressing gowns and then waited in a mixed waiting area. She felt that this was particularly uncomfortable for new patients but that regular patients adapted. She reported that patients occasionally made comments to her about the situation, for example:

"I was sitting out there - you know - with a gentleman who was in his dressing gown and I was in my dressing gown". Sort of thing. Bit difficult to know how you could get round that with the facility'. (S4)

With the facilities available, preventing patients sitting together in dressing gowns was problematic. However, S4's view (supported by patients' comments) was that the situation was uncomfortable; outside hospital, strangers do not usually sit together in dressing gowns. Presumably it was for staff convenience that patients had to sit undressed waiting to be seen; perhaps review of the systems might have avoided this situation.

The oldest two patients in the study (who were also the only two non-urological patients) expressed a lack of concern about MSEs. It may be that having a urological condition led to particular sensitivity about this issue and its effect on privacy. Mrs O4 (in her 80s) said that she did not mind her bay being mixed but her other comments inferred a general acceptance on her part to the indignities she experienced in hospital (see Chapter 6, 6.4.1), which seemed to be a coping strategy. Mr O6 (in his 90s) stated that he did not mind being in an all male bay but that he preferred women's company:

'can't understand why there's so much fuss and bother about mixed wards - they wouldn't bother me in the slightest'. (Mr O6)

However, N10 commented that Mr O6 being in an all male bay was a positive factor in relation to his dignity. Thus staff assumed that patients found it undignified to be in a MSE and, although this was generally the case, there were exceptions. S5 reported that in one of the rehabilitation areas for younger patients in the Trust, patients had requested MSEs as they felt that this was a more normal environment for their recovery.

Lack of privacy, particularly when associated with bodily exposure and a MSE, was strongly identified as threatening patients’ dignity but to a lesser extent, hospital systems also posed a threat to dignity.
5.3.1.2 Hospital systems

Hospital systems affected patients’ dignity in a number of ways but bed management was a key issue which had a major impact on the way Heron ward operated and patients' experiences. In addition, some participants identified that staff workload and work patterns threatened dignity.

5.3.1.2.1 Bed management

In the previous section, MSEs were discussed in relation to how they threatened patients' dignity. Comments from senior staff indicated that bed management, particularly in relation to finding beds for emergency admissions, was the direct cause of mixing bays, leading to patients being cared for in a MSE. When there was a shortage of beds, patients were admitted to any bed available in the hospital and were then moved when a more appropriate bed became available. S1 referred to the managerial pressure to mix bays as 'the biggest problem I think we have' and that she was:

'forced by the outside world - bed managers - managers even - to meet targets. And to make use of every bed I've got. And they don't care how we do that'. (S1)

In such circumstances, patients were also less likely to be cared for with patients with similar conditions, as they were allocated to any bed available so opportunities for mutual support were decreased. At one stage during the participant observation period, there were thirteen medical patients on the ward. As beds became available in other wards, patients were then transferred out. Patients thus experienced a lack of belonging and they had little opportunity to build relationships with other patients and staff, which promoted their dignity (see Chapter 6, 6.2.3; 6.4.2). Mr D2’s comment illuminated how bed shortages and being moved from ward to ward affected patients:

'I went in three different beds before I ended up in urology because they didn't have room anywhere so I understood why - but being trundled around like that … you feel a bit helpless'. (Mr D2)

On the morning during which Mrs O4 (a medical patient) was observed, a bed become available on another ward. Mrs O4 was very upset about having to move as she said she liked it on this ward. Both ward staff and patients seemed to feel powerless in relation to how beds were managed in the hospital. The way patients felt about being moved from one ward to another to optimise bed occupancy did not appear to be a managerial consideration.
When there were a large number of patients from other specialties on the ward, workload of staff increased due to the larger number of admissions and patient transfers and, as discussed later, high workload can impact on patients' dignity. Staff had to liaise with many more medical teams and were constantly interrupted as the teams arrived to review their patients. Conversely some staff felt that the non-urology teams did not communicate with them effectively as they tended not to visit the ward as regularly as their 'own' wards (H8). These issues made the working environment difficult for staff and increased pressures on them which may affect staff interactions with patients. However, S3 reported that soon after the participant observation period ended, the surgical beds became 'ring-fenced' so the admission of patients from other specialties was now rare. S3 explained that the rationale for this change related to safety issues of patients with similar conditions being cared for together, but in addition pressure on the ward staff reduced. S3 also considered that it was easier to prevent MSEs with the new bed management system.

5.3.1.2.2 Staff workload and work patterns

Some patients commented on the staff's excessive workload and most perceived a resulting adverse effect on their dignity (see Box 5.13), mainly because staff did not have time for the therapeutic interactions which were widely identified by patients as promoting their dignity (see Chapter 6, 6.3.3) and might instead appear curt which threatened dignity (see 5.3.2.1). Mr D9's comment in Box 5.14 clearly expressed his perception of how high workload affected staff approach. Mr D5 gained the impression that the hospital's busy routine, and associated paperwork and technology, took priority over what he termed the 'care aspect', which he associated with dignity. Mrs D8 considered that the high workload led to a lack of individuality and a feeling of being 'on a conveyor belt', illustrating her view by explaining that on arrival at theatre she had to wait for the anaesthetist for a long time as he was double booked:

'It just makes you aware that you are patient number - nine hundred and fifty nine and you don't matter. You're in a meat market. And you're on a conveyor belt'.
(Mrs D8)

These views were not commonly held and it may be that some patients happened to be in hospital at a much busier time than other patients. As Chapter 6, section 6.4.2 explained, some patients placed importance on developing relationships with staff but when staff were so busy, there was little time for conversation. Mr D4 commented that workload affected staff communication as niceties like introductions went by the board: 'They haven't time to keep stopping to talk to people'. He then felt uncomfortable not knowing who staff
were, in particular whether they were nurses and could therefore be involved in his personal care rather than support staff (non-nurses).

**Box 5.13 The impact of busyness on patients' dignity**

'I felt that in hospital that the question of dignity doesn't necessarily come into question when doctors and nurses and auxiliary staff are flat-out doing what they have to do. To keep up with the workload that's expected of them these days. So I am aware of although dignity of patients is important it's not always the most important - the important thing is the patient's health and the doctor's time that he has to deal with your particular problem... the question of dignity as regards to other people sometimes goes by the board because - it's not done with malice it's done with - literally I've got to get through this lot and I haven't got time to muck about. That's what I think. Seeing how all the nurses - particularly nurses - are literally rushed off their feet'. (Mr D9)

'Because it's a busy hospital - you've got such a busy routine that's perpetually changing - there's so much emphasis on them doing their work and they will do that and the patient just happens to be there. Their work goes before the patient... they're so busy doing what they're doing, filling in their forms, doing everything in the way they have to do it. The care aspect - it's quite difficult to know whether the care aspect is really really there'. (Mr D5)

'There wasn't a lot of indignity, would it were that you were treated more like a human person than on a conveyor belt that would be very nice but - that's time isn't it. And these poor souls presumably haven't got time you know... They can't sort of say, you know treat you, give you more time and chat to you or make you feel more comfortable, if they've got somebody else just down the line who desperately needs their help more than you do'. (Mrs D8)

'I suppose if staff appear very busy then that can impact upon dignity...that's almost unavoidable as well. If people are busy then they are busy and we both know how difficult it is when you've got a bay with six beds in and you've got somebody dying in that bay and you've got somebody else who's getting better and going home and you're trying to deal with different people going through different experiences'. (S5)

'I think it [dignity] can be easily ignored. Not easily ignored, not consciously, taken into account. I think sometimes with the hustle and bustle of hospitals, that that can be forgotten. Simple things like, patients walking along corridors with gowns exposed'. (S4)

Ward staff rarely identified workload as impacting on patient dignity but five of the six senior nurses interviewed did so. S5 emphasised the current speed of patient throughput and that patients in hospital are increasingly ill due to earlier discharges. She referred to an adverse impact on patient dignity as being 'unavoidable' (see Box 5.13) with staff struggling to meet patients' differing individual needs. She further stated that busy staff
found it difficult to respond to initiatives to improve patient care, including dignity, such as the benchmarking process used to implement Essence of Care (DH, 2001a). S4 identified that busyness can lead to patient dignity not being a priority (see Box 5.13) and further stated that:

'Sometimes people aren't taken as individuals, they're taken as a sort of en masse really.' (S4)

Her perceptions as a senior nurse closely related to Mrs D8's comment about feeling as though she was on a conveyor belt.

During many of the observation periods the ward was clearly very busy and sometimes short staffed. The mood of the staff altered accordingly, for example, during observation of Mr O6 the ward was well-staffed and there was a more relaxed mood among the staff. The ward manager and N3 spent some time reassuring Mr O6 about his concerns, which he later commented had promoted his dignity. However, following observation of Mr O2, N3, who had had eleven patients to care for virtually unassisted, said:

'It's been so busy this morning. I feel I've been a bit short with them - shorter than I like to be. Usually I like to talk with patients'. (N3)

Her comment inferred her perception that her high workload had adversely affected her communication with patients, which she saw as important for promoting dignity. However Mr O2's perception was that N3 was:

'Excellent, like a nurse should be - what you expect - firm but caring'. (Mr O2)

Despite her high workload, N3 was observed to use gentle humour in her interactions with the patients during the morning. It seemed that some staff were better able to cope with a high workload than others, still being able to convey a caring manner.

Staff work patterns, involving shifts to ensure there is 24 hour cover, led to patients encountering different staff during their hospital stay. Two patients (see Box 5.14) commented on this lack of continuity affecting the development of relationships with staff, considered by some patients to promote their dignity (See Chapter 6, 6.4.2). Mr D4 related forming a good rapport with a nurse on admission and was disappointed not to see her again. Mr D5's comment inferred that patients feel more comfortable when they are ill having familiar staff caring for them rather than having to relate to different staff all the time.
Box 5.14 Effects of lack of continuity of staff

'The lady who took charge of me when I went in with a great sense of humour, and got me sorted out - labelled and all this sort of business you know. All quite amusing. But I never saw her again you see. And I was waiting for her to come back because she was amusing. I was comfortable with her'. (Mr D4)

'It was very difficult to meet the same nurses - the following day it'd just be a different shift, …and that discontinuity of it - you couldn't control it, but it did seem a bit unusual. …you're relating to different people all the time… if you really wanted to preserve dignity - the patient doesn't want that. He wouldn't would he because he's got enough problems in himself trying to get himself right without wanting to put up with "who's that nurse"'. (Mr D5)

| 150 |
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However, no other patients referred to a lack of staff continuity impacting on their dignity. The nurse in charge each morning allocated staff to the same patients as the previous day where possible, thus aiming to promote some continuity. Nevertheless, staffing issues such as staff sickness and annual leave, meant that there could never be total continuity for patients. It appeared from previous comments that Mr D5 was on the ward at a particularly busy time which may have affected staff continuity. Mr D4's comment seemed to relate to the particular nurse that he had built a relationship with on admission.

In summary, environmental threats to dignity arose mainly from a lack of privacy in hospital, exacerbated by the risk of bodily exposure and compounded further by a MSE. To a lesser extent, hospital systems - bed management and staff workload and work patterns - were also found to have a negative impact on patient dignity. These findings are next discussed in relation to previous research.

5.3.1.3 Discussion: Hospital environment and threats to patient dignity

Several participants described incongruence between the hospital environment and dignity, supporting previous studies indicating patients' vulnerability to a loss of dignity in hospital (Gallagher and Seedhouse, 2000; Jacelon, 2003; Matiti, 2002). As in Matiti's (2002) study, several patients commented that they had had expectations prior to their admission to hospital that their dignity was likely to be threatened. Two patients referred to leaving their dignity 'on the doorstep', echoing some patients in Matiti's (2002) study, although both of these patients later stated that they had encountered little or no indignity. Several participants in this study referred to the expectation that patients should cooperate
with unpleasant procedures and several patients expressed disempowerment in hospital, supporting previous research findings (Bauer, 1994; Douglas and Douglas, 2004; Jacelon, 2003; Matiti, 2002; Reed et al., 2003; Schuster, 1976; Woogara, 2004).

Although the DH (2004) asserts that NHS hospitals in England must provide a care environment that supports patient privacy and confidentiality, there was a lack of privacy in some aspects on Heron ward, despite it being relatively newly built. However, only two Heron ward patients expressed that being in a five-bedded bay had a negative impact on their privacy, despite research indicating patients’ preferences for single rooms due to greater privacy (Kirk, 2002; Matiti, 2002; Woogara, 2004). A few Heron ward staff identified curtains not being able to be pulled properly as a threat to dignity, which has been highlighted previously (Barron, 1990; Gallagher and Seedhouse, 2000; Jacelon, 2003; Matiti, 2002; Turnock and Kelleher, 2001; Woogara, 2004) but no patients identified this problem. A lack of auditory privacy in hospitals is well-recognised (Barlos et al., 2001; Bauer, 1994; Hooper, 1995; Jacelon, 2003; Matiti, 2002; Matiti and Sharman, 1999; Maxwell, 2005; Pattison and Robertson, 1996; Rylance, 1999; Walsh and Kowanko, 2002; Widång and Fridlund, 2003; Woogara, 2005) but only a few staff and one patient expressed concern that inadequate auditory privacy threatened dignity on the ward. Thus either Heron ward patients did not perceive there was a lack of auditory privacy, even though it was clearly present, or they did not (with the exception of one patient) associate it with being a threat to their dignity. As in Woogara’s (2004) study, staff expressed more concern about the lack of auditory privacy in the environment than patients. It may have been that patients readily adapted to this aspect of hospitalisation and that other worries about dignity took priority. One nurse implied that patients accepted a lack of auditory privacy, being all in the same situation, an effect described by a few of Bauer’s (1994) patient participants, in relation to their lack of privacy, as ‘levelling out’. While ward rounds have been identified as breaching privacy (Bauer, 1994; Matiti, 2002; Rylance, 1999; Woogara, 2004), few participants identified these as a threat to dignity.

Of much greater concern to some Heron ward patients was their potential bodily exposure in the ward and some participants suggested that the ward’s speciality - urology - raised levels of concern due to the intimate body areas involved. The findings support previous research from a variety of settings that bodily exposure threatens dignity (Matthews and Callister, 2004; Reed et al., 2003; Turnock and Kelleher, 2001; Walsh and Kowanko, 2002; Woolhead et al., 2005). For the male patients in Heron ward, wearing operation gowns and
nightshirts added to their vulnerability, also identified previously (Bauer, 1994; Denner, 2004; Matiti, 2002; Matiti and Sharman, 1999; Maxwell, 2000; Walsh and Kowanko, 2002; Woogara, 2005). Wearing operation gowns was not identified as an issue by any female patients in this study, perhaps because they are similar to nightdresses, familiar items of clothing for women. Men may have felt more uncomfortable as they are used to wearing trousers. Several staff in Heron ward gave examples of where patients were unconcerned about exposing their bodies in front of other patients and visitors, which staff felt was an affront to dignity within the ward, for the patient concerned and also for others around them. Walsh and Kowanko (2002) also cite an example of a patient's lack of concern about bodily exposure. Only one other study reported patients' self exposure but the example given was with patients with dementia or confusion (Gallagher and Seedhouse, 2000) rather than being a patient's rational choice. Public display of urine in catheter bags was a prominent feature on Heron ward and could be considered a breach of privacy (Bauer, 1994; Volker et al., 2004; Woogara, 2004) but it seemed to be an accepted part of the culture.

Department of Health assurances and directives about MSEs have been offered in a number of documents (DH, 1995; DH, 1997; DH, 2005a) but this study's data collection which took place in 2005 indicated that MSEs remained an on-going concern amongst staff and patients. Although the DH (2005) implied that a mixed sex ward, with single sex sleeping areas and bathroom facilities, constitutes a single sex environment, this study's findings indicated that there remained a risk of bodily exposure in these circumstances and female patients experienced some discomfort with men wandering around the ward when not properly dressed. In addition, pressure on beds led to mixing of sexes within bays on a regular basis. Patients' perceptions that a MSE threatened their dignity supported previous studies with older people (HAS 2000, 1998; Gallagher and Seedhouse, 2002; Woolhead et al., 2005). However, two of the patients in this study who expressed particular discomfort were in younger age groups (one in her 40s and one in her 50s), indicating that MSEs are not just an issue for older people. Fear of bodily exposure was their main concern as, being patients in an acute hospital setting, they were not dressed in day clothes and their mobility was restricted by tubes and attachments making it easy for clothing to come astray and exposure to occur. Dislike of a MSE was mentioned by two male patients but the women seemed much more uncomfortable about this situation. However, previous research has not reported any gender difference in views and furthermore, the few studies which have specifically focused on patients' views about MSEs (Page, 1995; Rhodes et
al., 2003) have not made links with dignity. Page's (1995) study found that patients were worried about potential bodily exposure and embarrassment in MSEs and Heron ward patients expressed similar concerns. Johnson's (2005) view that shared facilities between sexes infringe privacy was thus supported by many of this study's participants.

Hospital systems also emerged as a threat to patients' dignity in this study, supporting previous research. In Heron ward the negative effects on dignity of NHS priorities were particularly apparent in relation to bed management, with MSEs (discussed earlier) being a direct result as well as frequent transfers between wards. These findings support views expressed by UK professionals who identified NHS priorities and managerial targets were organisational barriers to dignity (Calnan et al., 2005). Previous studies indicated an undignifying culture within the care environment (Seedhouse and Gallagher, 2002; Walsh and Kowanko, 2002) but on Heron ward, a dignity promoting culture was more apparent (see Chapter 6, 6.2.2) with the few patients who referred to a conveyor-belt approach indicating that it was workload-related rather than culture. A few patients identified that they felt like a number rather a person, which may have been caused by high workload, a factor which jeopardises an individualised approach (Byrne, 1997; Matiti, 2002; Walsh and Kowanko, 2002). A few Heron ward patients specifically commented that high workload of staff threatened dignity through its negative impact on staff interactions, supporting previous research (Enes, 2003; Matiti, 2002; Walsh and Kowanko, 2002). However, there were examples on Heron ward of staff working under great pressure but, from patients' perspectives, they still promoted patients' dignity. Although Woogara (2005) identified that staff routines on the ward took precedence over patients' needs, just one patient in this study expressed that staff routines took priority over caring. This patient also considered that a lack of staff continuity adversely affected his dignity, which was reported in Jacelon's (2002) study with older people. However the Heron ward patient concerned was only in his 50s thus younger patients too may consider staff continuity important.

The literature review identified that a lack of physical resources in the environment can threaten dignity (Calnan et al., 2005; Enes, 2003; Seedhouse and Gallagher, 2002; Woolhead et al., 2005). In contrast, Heron ward was fairly well-resourced but a lack of nightshirts often led to patients having to remain in operation gowns and some curtains were inadequate. Generally, however, the study participants considered that the physical environment of the ward and its facilities promoted dignity (see Chapter 6, 6.2.1). Seedhouse and Gallagher (2002) argue that there is a direct link between good resources
and dignity being upheld and vice versa and this study's findings support this claim.

To summarise, the study's findings, that the hospital environment has potential to negatively impact on patients' dignity is well supported by studies from a variety of settings. Few of these studies were based in acute hospitals and thus there may be common factors that adversely affect patients' dignity, regardless of age and setting. This study's findings highlighted the risk of bodily exposure in hospital and how this is compounded by MSEs but little previous research has addressed these issues in depth. The fragility of privacy within an acute hospital setting was illuminated supporting existing research, mainly with other patient groups. Finally, the negative impact of bed management policies, which are driven by NHS targets, was also highlighted but has been little considered in previous research.

The next section presents the findings relating to how staff behaviour can threaten dignity.

5.3.2 Staff behaviour

Patients have no control over the staff who enter their environment in hospital and staff behaviour is highly influential in relation to patient dignity, playing a crucial part in whether patients felt their dignity was promoted or not. In Heron ward, with a dignity-promoting culture (see Chapter 6, 6.2.2), most staff, most of the time, behaved in a way that promoted dignity (as evidenced through patients' interviews and observational data). However, some patients identified individual staff members whose behaviour had threatened their dignity or, they perceived, that of other patients. Although these examples were rare in comparison with the many examples of where staff behaviour promoted dignity (see Chapter 6, 6.3), they highlighted the potential of staff behaviour to threaten dignity and patients vividly remembered these experiences. In situations concerning other patients, witnessing such interactions left patients feeling vulnerable. Staff behaviour that threatened dignity was curtness (otherwise described as 'off-hand', 'stand-offish', 'brusque', 'ignoring'), authoritarianism and breaching privacy. Each of these is next discussed.

5.3.2.1 Curtness

Half the patients interviewed described a situation where a staff member behaved in a curt manner which threatened their (or another patient's) dignity. Such behaviour showed a
lack of courtesy and kindness towards patients and a lack of interest in them, giving the
impression that the staff member did not care about the patient or respect them as a
person. Mr D2 and Mr D9 were in hospital at the same time and both described a situation
where a member of staff shouted at a patient while serving breakfast (see Box 5.15).

Box 5.15 Staff behaviour that threatened dignity: curtness

‘On one occasion - this poor chap opposite me who was clearly quite deaf and
obviously very confused - didn't know where he was - and she was shouting at him in a
- she was a bully. She shouldn't be in that job’. (Mr D2)

“She came round and opened the curtains, obviously woke him up, woke everybody up,
switched the lights on, was going round saying, would you like breakfast? And he was
fast asleep, and when he woke up he didn't know where he was and was struggling to
understand where he actually was because he was either sedated or he was so
incoherent that - I don't think it was - looking at it, I don't think it was her fault - her not
knowing that he was deaf, it's only that she saw his deaf aid on the side, she said "put
your deaf aid in" and he's going "XXXX" [incoherent type sounds ].Which was - I
couldn't understand what he was saying. The nurse certainly couldn't. And she said
"Do you want breakfast? What would you like?" And - out of all the nurses she was -
the most - sharpest. If she was a nurse. She might have been the auxiliary or whatever.
She was - she was - quite sharp. "What do you want?" [said in a bark] "Do you want
porridge or?" Didn't have time to muck about. She had a whole lot of people to go and
serve. And serve while the stuff was hot, particularly the porridge. So she said "Right.
What do you want? Oh if you can't tell me". And she walked away. And - then she
looked at me - and I think I probably looked at her saying [made a sort of questioning
facial expression]. Then she walked back and said "Right you're going to have
porridge" gave him - whacked the porridge in and gave it him with a spoon and said
"There you go. Eat your porridge". (Mr D9)

This was the most vividly described example, portraying unkindness to a patient who was
clearly vulnerable, being apparently confused and having a hearing impairment. The staff
member, instead of being understanding, was impatient and harsh. Mr D9 attempted to
excuse her behaviour, pointing out that she was under a lot of pressure and that she had
been on duty all night and was 'really just sounding off because it was the time of
morning'. However, the vast majority of staff did not adopt such behaviour when they were
working under pressure. Other examples given by patients were less extreme but clearly
still made patients feel uncomfortable. Mr D4 described some staff being 'a bit brusque'
with a 'frail' patient opposite him, saying: 'Oh get back in bed.' He said:

'I suppose perhaps he needs talking to like that I don't know. I just felt sorry for him
really'. (Mr D4)

Like Mr D9, he seemed to be trying to excuse the staff member's behaviour in this situation
but he instinctively recognised that the patient was vulnerable and that he himself would not have liked to be spoken to like that. Mrs O12 identified that there had been a nurse the previous night who she felt 'couldn't be bothered'. This nurse was 'off-hand' in the way she spoke, saying to one of the other patients: 'you should know better'. This was Mrs O12's first post-operative night, and witnessing staff being uncaring to other patients must have made her feel uncomfortable.

The previous examples involved patients witnessing staff interactions with other patients that threatened dignity. Several patients encountered an approach from staff which they felt threatened their own dignity. Mr O1 described an incident that occurred shortly prior to the observation period where an HCA dealt with a request in a 'grumpy' way. When she eventually responded it was 'resentfully'. He reported the situation to N1 who was sympathetic and tried to make amends. During N1's follow-up interview, she mentioned the incident, obviously aware of its significance to Mr O1, and said that she felt that the HCA (who was not a regular ward team member) 'couldn't be bothered with him'. Mr O6 said that on a few occasions there was a 'stand-offish attitude' from staff which was a threat to his dignity. Being 'stand-offish', he explained as:

'having a lack of conversation, doing a job in a matter-of-fact way and not bothering much about it'. (Mr O6)

He added that he had not encountered this type of attitude from staff during the actual observation period. Mr D6 gave a similar example of a nurse's approach being affected by a lack of motivation:

'We did have one little nurse one evening that - basically she didn't want to be on the ward, it was as simple as that, she, you know, it was not where she wanted to be, so she wasn't particularly good'. (Mr D6)

Mr D1 considered that the approach of the night staff was 'a little bit different'. He said that they did their job 'nicely' but:

'I think they're more matter-of-fact. They've got a job to do and they do it. Bang, bang, bang. They don't mess about. They haven't got time for a lot of conversation or anything like that'. (Mr D1)

Mr D1 appeared to simply accept that the staff at night just did their job without much conversation but other patients might perceive this approach as curtness. Two observation periods occurred at night and no such approach was observed on these occasions. Mr O2 gave several examples where the attitude of staff dealing with his incontinence affected whether his dignity was lost rather than the incontinence itself. He felt by some staff's attitude, that his incontinence 'put their backs up'. Mr D9 discussed the approach of one of
the doctors who dealt with him:

'I felt he could have been a little bit more 'right well you're next' [gentler tone] 'you're going to be looked after by us'. Feel that he was talking to me as an individual, not you're a number'. (Mr D9)

Mr D9's comment implied that it was important for patients' dignity that staff treated patients as individuals. Again, he excused the doctor's approach saying he realised that 'they have not got time to chit-chat'. The above examples implied that staff behaviour that threatened dignity was probably portrayed more through non-verbal communication and tone of voice than what was actually said to patients.

Patients who were feeling vulnerable could easily feel that they were being ignored and thus unimportant to staff. Mrs D12 described feeling ignored when she reported a problem to a member of staff 'till rationale kicked in', that the nurse had probably just forgotten. Mr O2 reported that staff did not always respond to emergency bells. During the observation periods, delays in answering bells were seen sometimes if the ward was very busy and patients who were already feeling vulnerable could perceive this as a lack of interest in them. The layout of the ward (Figure 4.1) meant that patients could not see staff busy in other bays. Mr D9 described feeling ignored by doctors following his scan to the extent that he was unsure of his diagnosis:

'I didn't know what was going to happen because the doctors didn't even come and talk to me. So I was pretty miffed'. (Mr D9)

Mr D9 perceived that being ignored had a negative effect on his dignity but he was also left worrying about the possibility of a serious diagnosis. Mr D9 felt that one doctor in particular ignored him, from which he gained the impression that the doctor did not like him, making him feel 'a little shunned'.

Only a few ward staff identified that interacting in a curt manner might threaten dignity but then none of the staff interviewed displayed such behaviour during the observation periods. Staff concerns about dignity were much more often about privacy issues (see 5.3.2.3). However, S2, while saying that she was not aware of such behaviour on Heron ward, described the potentially negative effect of staff approach:

'If you're abrupt with the patient and not approach them calmly or what ever they can react. That can happen anywhere. If your approach is not good and the patient feel threatened then you won't get the same reaction from patients'. (S2)

HCA3 said that had she done things to Mr O5 without speaking to him that would have threatened his dignity, thus indicating awareness of the effect of staff ignoring patients.
Authoritarianism by staff also threatened dignity and is considered in the next section.

### 5.3.2.2 Authoritarianism

Authoritarianism entailed staff taking on a controlling approach and not offering choices to patients or respecting their requests and was identified as a threat to dignity by a few patients. Mrs O10 and Mr D4 both perceived dignity as being about feeling in control and gave examples of where they felt that an authoritarian approach by staff threatened their dignity (see Box 5.16).

**Box 5.16 Staff behaviour that threatened dignity: authoritarianism**

‘Just a few staff who have a tendency to look at the drug chart and say “you're having that” but I'm one of those people who likes to know what I'm having. It's like: “you're a thing in a bed and I'm coming round. You have to have all these tablets whether you want them or not”.’ (Mrs O10)

‘One or two of them you sort of feel a bit annoyed at being bossed around’. (Mr D4)

Mrs O10 described a staff member questioning her about the tablets she was prescribed and she felt that she had to justify to the nurse why the doctor ‘had ordered it for me’. She said such an approach made her ‘feel sad’ and:

‘upset - feeling everything's being taken out of your hands - makes you feel small - almost invisible’. (Mrs O10)

She also said that there were a few staff who, when she requested painkillers from them, said:

‘You're obviously not in that much pain at the moment - I don't think you need it - why don't you wait a bit?’ (Mrs O10)

She said this ‘Can be very hurtful’. Her example demonstrated the control staff can exert over patients in a hospital environment (at home Mrs O10 would have controlled her analgesia herself) and that staff did not respect Mrs O10’s judgement about her own pain. Mrs O10 emphasised that it was only a few staff who took this approach.

Mr D4 described two situations where staff took an authoritarian approach (see Box 5.17). In the first example Mr D4 decided not to argue with the nurse but in the second case he felt that he had to stand his ground and take control as it concerned the removal of his catheter which was causing him problems.
Box 5.17 Examples of an authoritarian approach

"The surgeon came in and he said "you can start back again on the aspirin now" - and I thought "that's good". And the nurse comes round in the evening, and I said "Doctor says I can have an aspirin" [the nurse responded] "I don't think you should have aspirin yet". So I didn't get it! I thought - well I can't argue with you'. (Mr D4)

"There was a doctor on the ward … and he said "we'll have the catheter out" ….it was just at the time they were changing over [handover], I said "oh this catheter's coming out". "No it's not", she [nurse] said, "tomorrow". So I got the one who was in charge who's going out - she says - "I don't know about that" - so you get a bit worried about that. But she went off and spoke to this other nurse, and they said, "yes, it's coming out". So that sorted itself. For a time you can feel - you're up against authority and that you're not quite getting anywhere you know. So you have to do something about it'. (Mr D4)

Just one nurse identified that an authoritarian approach could threaten dignity: N3 cited 'not bossing him' as a way in which she had promoted Mr O3's dignity. Likewise, when explaining his views about dignity, Mr O3 expressed feeling in control as being important for his dignity: 'If you're asked to do something [by staff] that you're not pushed into it'. Mr O3 was thus cared for by a nurse who shared his own view about dignity and on interview, the only threat to his dignity he identified was having the urinary catheter in situ.

5.3.2.3 Breaching privacy

The ward's environment provided a structure for attaining privacy which needed to be combined with appropriate staff behaviour. Most staff were consistently vigilant about providing privacy (see Chapter 6, 6.3.1) but there were a few examples of participants (mainly staff) identifying that staff behaviour led to a breach of privacy. Several nurses commented that other staff sometimes walked in behind the curtains without warning. N6 said that she was aware that another staff member walked in while she was bedbathing Mrs O4 without 'saying knock - knock'. She said that in such situations she then hastily said 'Hang on' and tried to cover up the patient quickly. N2 too said that sometimes [during a bedbath] there were interruptions: 'people come and peep round the curtains'. Mr D4 gave a vivid example of where, while having a bladder washout, a staff member entered behind the curtains and talked to the nurse carrying out his procedure. As he was lying exposed at the time, he felt a loss of dignity due to this breach of privacy that occurred despite curtains being drawn (see Box 5.18).
Box 5.18 Breach of privacy

'There were the circumstance when I was having these [bladder] spasms where they said, right we'll give you a wash through - bladder wash - right. So a nurse comes in, draws the curtains round, which didn't happen to me very often because they didn't do things to me essentially - so I'm there, I'm on my back, my frock's [nightshirt] up round my waist - I don't know - my legs are apart - they've got a bowl in me - and she's syringing me...she [another staff member] puts her head through the curtain. Chats to this nurse who's treating me. And I thought - what are you doing - as far as I know, you're not a nurse - you've not come in here for my benefit, and you're stopping this nurse from doing what she wants to - I'll be only too pleased to get over - and I felt a bit annoyed. And a bit embarrassed. At the thought that someone who was not - medical staff as far as I know. You see, if another nurse comes into help - that's different isn't it. If they've come to sort of help. I don't know what they were talking about. But it was nothing to do with me. So I got a bit - narked. And felt a bit embarrassed. And a certain loss of dignity because I was not in a very dignified position': (Mr D4)

'Mr O2 was still behind the curtains. The other patients were eating their breakfasts. The HCA was now in the bay giving out teas/coffees. She put her head just inside his curtains and asked him which he'd like. She poured out the drink and put it on the windowsill just inside his cubicle'. (23rd April, 2005 FN)

The staff apparently showed no insight into how Mr D4 felt about his body being exposed as they talked together, ignoring him. Thus the environmental threat to dignity was compounded by staff behaviour during this intimate care situation which arose because of Mr D4's medical condition (patient factor - see 5.3.3.1.2). HCA3 said that she remembered once a staff nurse was doing a bladder washout and another member of staff just walked in without warning and the patient was embarrassed. There was no way of knowing whether she was referring to Mr D4's experience or a different occasion. Box 5.18 also presents an observed example where an HCA (who was not a permanent staff member) intruded when a patient was on the commode. However, Mr O2 did not mention this situation as being a threat to his dignity during his follow-up interview, demonstrating the tolerance often displayed by patients to such occurrences.

In summary, the behaviour of individual staff towards patients can threaten dignity if it indicates a lack of care towards them through a curt approach, employs an authoritarian approach, thus taking away control, or breaches privacy. These findings are discussed next, in relation to previous research.
5.3.2.4 Discussion: How staff behaviour can threaten dignity

The study found that although dignity-threatening behaviour by staff was uncommon, such situations were vividly remembered. Jacelon (2002) too found that nurses who were memorable to patients tended to be those who were unpleasant in their interactions. Overall, the study's findings supported previous research identifying that staff behaviour can threaten patients' dignity (Gallagher and Seedhouse, 2000; Matiti, 2002; Öhlén, 2004; Randers and Mattiasson, 2004; Rylance, 1999; Walsh and Kowanko, 2002; Woolhead et al., 2005). However, the examples given by patient participants appeared to be isolated incidents involving specific staff members (sometimes temporary staff) rather than there being any pervading staff culture that threatened dignity on the ward, as found in previous research (Seedhouse and Gallagher, 2002; Walsh and Kowanko, 2002).

The curt approach from staff which patients identified as threatening to their dignity is little described in the literature but brusqueness (HAS 2000, 1998; Öhlén, 2004), harshness (Calnan et al., 2005), ignoring patients (Enes, 2003; HAS 2000, 1998; Matiti, 2002; Tadd, 2004a; Tadd, 2004c; Walsh and Kowanko, 2002) and not attending to patients promptly (Matiti, 2002) have been previously recognised as threatening dignity. Such an approach may infer a lack of respect for patients which is strongly supported in previous research as threatening dignity (Gallagher and Seedhouse, 2000; Lai and Levy, 2002; Randers et al., 2002; Tadd, 2004a, 2004c; Woogara, 2004). Similar to curtness is a cold approach employed by some staff (Holland et al., 1997; Kralik et al., 1997) and unkindness (Applegate and Morse, 1994) but these studies' findings were not specifically linked to patient dignity. A few patients referred to staff behaviour that conveyed that they were just doing a job and similarly, Jacelon (2002) found that staff threatened dignity by communicating that getting the job done was more important than focusing on the person as a unique individual. Two patients in Heron ward described a staff approach which threatened dignity with the phrase 'could not be bothered'. Tutton and Seers (2004) also used this phrase to describe staff who did not provide comfort to older people and had a harsh, unsympathetic approach. It is thus likely that staff employing a curt approach not only threaten dignity but diminish comfort too.

An authoritarian approach was identified by a few patients as threatening dignity, supporting previous research in a variety of settings (Hewison, 1995; Hucksttsdt, 2002; Jacelon, 2002; Martin, 1998; Öhlén, 2004; Randers and Mattiasson, 2004; Reed et al.,
2003; Woolhead et al., 2005). Jacelon (2004) cites one patient stating of staff 'their word was law' (p.552) and a few Heron ward patients encountered a similar approach. The patients in Heron ward who cited an authoritarian approach as threatening their dignity described situations where staff gave orders or denied requests, which Hewison (1995) refers to as overt power. In relation to Collopy’s (1988) theory of autonomy, some patients were unable to exercise executional autonomy because of their physical illness but staff could have promoted decisional autonomy by respecting their choices but sometimes failed to do so. Two of the examples of authoritarianism cited by Heron ward patients related to medication and similarly, Volker et al. (2004) found that some staff were reluctant to administer analgesics. One patient in Heron ward felt that a staff member, when refusing her analgesics, questioned whether she was really in that much pain. As well as such an approach being authoritarian, it implied that she was not believed, which she perceived as a threat to her dignity, supporting previous research findings about the impact of not being seen as credible (Söderberg et al., 1999; Werner and Malterud, 2003).

Hewison (1995) identified that power is also displayed through staff using terms of endearment and several studies have identified that inappropriate manner of address threatened dignity (Calnan et al., 2005; Matiti, 2002; Woogara, 2004; Woolhead et al., 2005). However, very few Heron ward patients mentioned term of address in relation to dignity (discussed in 5.3.3.2; 6.3.2.3).

Although Heron ward staff appeared strongly committed to preventing bodily exposure (see Chapter 6, 6.3.1), a few examples of staff breach of privacy were identified as having threatened dignity. In particular, there were examples given of staff entering curtains without warning patients, a situation which several other studies have highlighted (Applegate and Morse, 1994; Ariño-Blasco, 2005; Barron, 1990; Bauer, 1994; Lai and Levy, 2002; Walsh and Kowanko, 2002; Woogara, 2005). However no patients in this study reported that staff threatened their dignity by treating their bodies like objects, which has been previously reported (Applegate and Morse, 1994; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). Staff provision of poor quality care (e.g. inattention to patients’ personal hygiene and lack of assistance with elimination and nutrition) was not raised as threatening dignity by any of the study’s participants although some studies have identified this as an issue (DH, 2006b; HAS 2000, 1998; Woolhead et al., 2005; Öhlén, 2004). This may have been because observational data showed a high commitment from staff to fundamental care such as patients’ personal hygiene or perhaps participants did not relate quality physical care with dignity issues.
In summary, the study's findings support the theoretical framework which proposed that staff behaviour can negatively affect patients' dignity by breaching privacy and use of certain types of interactions but poor quality physical care was not raised as an issue. Many of the previous studies have not been based in acute hospital settings or have focused solely on older people's experiences or those of people who are terminally ill. This study's findings indicate that staff behaviour in an acute hospital setting can threaten patients' dignity regardless of their age and condition.

Intrinsic factors render patients vulnerable to a loss of dignity in hospital and the next section presents findings related to this aspect.

5.3.3 Patient factors

Impaired health threatened patients' dignity as it caused loss of function, led to intimate care procedures and in some instances, fear for the future and uncertainty. From some participants' perspectives, older age increased patients' vulnerability to a loss of dignity for both physical and psycho-social reasons. The effects of impaired health are first explored.

5.3.3.1 Impaired health

Patients' impaired health threatened their dignity in three different ways: loss of function, diagnosis-associated intimate procedures, and the psychological impact of diagnosis. Findings relating to each of these are presented next.

5.3.3.1.1 Loss of function

Several patients and staff identified that patients' loss of function due to their impaired health could threaten dignity, particularly as patients then required help with their personal care. For example, Mr O2 had previously had a stroke and needed a lot of assistance from N3 in relation to his personal hygiene following his surgery. However, a patient opposite him had had the same operation on the same day but was otherwise fit and when his bladder irrigation was discontinued he showered independently. Mr D4 reported that the patient opposite him was unable to do much for himself and he commented that he 'felt embarrassed for him'.
"The chap opposite, he was very frail and he'd obviously sort of made a mess of his bed or something - he's out and about and he's holding his frock [nightshirt] up - you know - cos it's all wet I suppose - he can't pull his curtains'. (Mr D4)

Mr D4’s description inferred that this patient's lack of functional ability led to loss of dignity, although how the patient himself felt could not be ascertained. Mrs O11, as a younger patient in her 40s, was usually fully independent at home. Box 5.19 describes her condition on her first post-operative morning, summarised from the fieldnotes, which illustrates how major surgery causes temporary incapacity and can threaten dignity.

**Box 5.19 Mrs O11 Condition first post-operative morning**

Mrs O11 was lying in bed, sleeping most of the time, dressed in an operation gown covered by a sheet. She had oxygen therapy in progress via a facemask, a cardiac monitor, patient controlled analgesia (PCA) attached to her left hand and an intravenous infusion (IVI) attached to right hand. She had a urinary catheter in situ, with the catheter bag attached to the side of her bed, and her urine output was being measured hourly. She had boots in place on her calves attached to an electronic pump to prevent deep vein thrombosis. She had a blood pressure cuff around her upper arm, which was attached to a dynamap (to electronically measure her vital signs), with a pulse oximeter attached to the index finger of her left hand. During the morning that she was observed, Mrs O11 was very drowsy and unable to do anything for herself. She was dependent on N2 who was looking after her to closely monitor her physical condition, attend to her hygiene needs, administer her medication and encourage her to drink sips of water from a straw. (FN, 7th July 2006)

N2, interviewed following observation of Mrs O11’s care, acknowledged that Mrs O11’s dependence threatened her dignity:

'Not being able to do much for herself at the moment leaves her a bit vulnerable'.

(N2)

Mrs O11’s condition worsened later that day and she was transferred to ITU. Due to her drowsiness, she was not interviewed until five days later. Mrs O11 stated that during the first few days post-operatively there were times when she 'couldn't be bothered' to maintain her own dignity and staff stepped in and 'straightened me up'. She said that she was glad that they had done this for her; she felt that they prevented her loss of dignity when she could not do this for herself. This example illustrated how Mrs O11’s physical condition and resulting loss of ability rendered her vulnerable to a loss of dignity.

Several staff and patients identified use of bedpans or commodes as threats to dignity and these are used when patients cannot independently mobilise to the toilet because of physical impairment. Mrs O4 needed a lot of help due to her impaired physical ability which she believed led to a loss of dignity. She described using a bedpan as 'degrading'
and that 'nurses having to wipe my bottom' was a threat to dignity. She said that there was nothing that nurses could do to promote her dignity in that situation but: 'I know they've got to do it'. Mr O2, whose mobility was impaired, identified using the commode as a situation where he could have lost his dignity but he had not because:

'The commode was brought in time, the curtains were drawn round, given everything I needed.' (Mr O2)

Mr O2 implied that on other occasions his request might not have been attended to so promptly, leading to a loss of dignity:

'There's other situations in here where I wouldn't have been taken notice of and it would have been too late.' (Mr O2)

Thus for Mr O2, the use of the commode was not in itself undignifying but faecal incontinence would have and staff behaviour affected whether his dignity was lost in this situation. In the follow-up interview N2 expressed that use of the commode was a threat to Mr O2's dignity but she did not identify that her response to his request prevented a loss of dignity. Mr O2 identified that his occasional urinary incontinence was a threat to his dignity but it seemed that staff behaviour again determined whether he actually lost his dignity. With some staff, he felt his incontinence 'put their backs up' which caused a loss of dignity and implied a curt approach (see 5.3.2.1).

Some staff and patients stated that being washed or bathed by staff was a threat to dignity. For example, N2 identified bedbathing as a threat to Mrs O11's dignity as it was an invasion of her privacy. She considered that despite her efforts to lessen this threat there would still have been some loss of dignity for Mrs O11: 'you can't minimise it totally'. N14 considered that assisting Mrs O10 in the bathroom posed a threat to her dignity saying 'She probably would have liked to be on her own' but as she did not know what Mrs O10 was capable of she needed to 'make sure she was ok - there's a safety issue'. However, at interview, Mrs O10 expressed that she felt that her bath was handled well so she had not lost her dignity. Mr O2 commented on needing assistance with washing, as a situation that he had to 'submit' himself to in hospital, but he rationalised its necessity.

Rationalisation by patients in situations where their dignity was under threat is discussed in Chapter 6 (6.4.1). It was the more intimate part of bedbathing that some patients perceived as being threatening to their dignity while accepting that they needed this care. For example, Mrs O4 identified 'When they wash you down below' as a threat to her dignity but then said:

'You have to put it [dignity] to one side. You've got to accept it because they've got to do it.' (Mrs O4)

N13 identified that Mrs O12's bedbath might have threatened her dignity and that:
‘As nurses you can sometimes forget - you go in there [to do a wash] and don’t think [of impact on patient]’. (N13)

However, N13 felt that Mrs O12 was not that uncomfortable about it. Mrs O12 confirmed her impression saying that she did not mind being washed but she thought that some people would be embarrassed. She added that had it been a male nurse washing her, she would not have wanted him to wash ‘between my legs’ but a female nurse doing this ‘didn’t bother me at all’. She said that she did not have the energy to wash herself and the wash made her feel refreshed.

5.3.3.1.2 Diagnosis-associated intimate procedures

As well as patients’ impaired health affecting their functional ability, they often experienced associated intimate procedures. Almost half the patients but a smaller number of staff considered intimate procedures, associated with patients’ diagnoses, threatened dignity. S3 expressed that because of the ward’s specialism of urology, patients were particularly anxious on admission because of the procedures they were likely to undergo:

‘They’re in for treatment of their private genitalia area so that they’re always that bit self conscious - that bit aware of - you know - the bits that are exposed that shouldn’t be exposed’. (S3)

Intimate procedures associated with urological conditions involve bodily exposure, which is a threat to dignity, but they also involve private areas of the body (genitalia) and body products being handled by staff. Although the urological speciality of Heron ward increased the likelihood of such procedures for patients, most are commonplace in any healthcare setting. For example, almost every patient interviewed or observed had a urethral catheter during their hospital stay but this is a common procedure throughout healthcare. Two of the study’s participants (Mr O6 and Mrs O4) were not urological patients but Mrs O4, because of her health problems, had a urethral catheter.

Mrs D8 considered that having surgery on her bladder (an intimate and embarrassing area of her body in her view) was in itself a threat to her dignity, highlighting the additional vulnerability of patients undergoing urological surgery. She said:

‘I mean in my case, I had an operation on the bladder so obviously the thought of what they were going to do to me was a feeling of - oh - how awful, you know’. (Mrs D8)

Her embarrassment led to her opting for a general anaesthetic as undergoing surgery while she was awake during epidural anaesthesia would have been too ‘humiliating’ to contemplate. She said:
‘I thought it was better to go for the general one and have a few more problems afterwards’. (Mrs D8)

When she was interviewed following discharge, she was still coughing due to the general anaesthetic thus she appeared to have considered her dignity to be more important than her physical well-being. In addition, being able to make this choice gave her a feeling of control, which was closely associated with dignity by some patients. Several other patients in the study had their urological surgery under epidural anaesthesia and did not identify it as being a threat to their dignity. Perhaps they were able to rationalise its necessity; as previously mentioned, rationalisation was used extensively by patients to promote their dignity in such situations (see Chapter 6, 6.4.1) but clearly not all patients were able to use this mechanism, which staff need to be aware of.

S4 discussed how, when carrying out chemotherapy for bladder cancer, which necessitated catheterisation, some patients obviously felt uncomfortable about the procedure. She then used additional reassurance to reduce their discomfort and put them at ease. Many patients identified that having a catheter and the associated procedures such as catheter removal, emptying of catheter bags and bladder washouts, were threats to their dignity. In addition, the operation gowns and nightshirts worn by patients (which caused bodily exposure - see 5.3.1.1.2) were worn because patients’ surgery led to the need for urethral catheters. Mr D2 expressed that having a urethral catheter was incongruent with dignity:

‘You’re walking around with a catheter up your penis and so on - it’s not very - it can’t be dignified at all’. (Mr D2)

Mr O3 similarly stated that it was not easy keeping his dignity when he was ‘carrying a catheter bag around’. Mrs O4 considered that having a catheter was beneficial as she was taking diuretics9 and she was concerned about incontinence:

‘Having the catheter is a good thing in hospital’. (Mrs O4)

However, she said that it was a loss of dignity but that she had accepted it: ‘I’ve accepted a lot of things’. Several staff also acknowledged that catheters threatened dignity (see Box 5.20).

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9 Diuretic medication increases urine output.
Box 5.20 Catheters as a threat to dignity: staff views

'Just the catheter being there [threatens dignity]. But we have to look after the catheter and it has to be there'. (N3)

'Having a catheter is a major thing, being in a very personal part of the body. Anything to do with private parts of the body is worse'. [greater threat to dignity] (N5)

'Well all patients we have - mainly catheters - most of the men - men and women - so it's a very private thing, isn't it, your private parts'. (S2)

N5 expressed that her being female and Mr O7 being male might increase the threat to dignity imposed by the catheter due to the associated care:

'We have to check the catheter - we're female and he's a man - whether it makes any difference to him [how he feels]. But you think of yourself, and how you would feel, and what you wouldn't like - if that was me in that situation and there was a male nurse looking after me - wouldn't like it'. (N5)

However, Mr O7 did not mention the catheter as a threat to his dignity and none of the male patients expressed that having intimate procedures carried out by female staff was a problem. Mr O5 explicitly said that he did not mind the 'lady doctors' being present in his physical examination on the ward round: 'a doctor is a doctor'.

Several patients mentioned removal of their catheter was a threat to their dignity. However the way in which staff carried this out, and/or patients' attitudes, could prevent loss of dignity occurring (see Box 5.21).

Box 5.21 Prevention of loss of dignity during removal of urinary catheter

'I think it was her attitude and the way she went about it actually. She didn't say anything to make me feel bad. She just said, "I'm going to take your catheter out. Lay down". Lay down. Drew the curtains. Catheter out. No problems no nothing, you know. I mean - there was no palaver. No nothing. No saying, no talking, no worrying. Just as if it was a natural thing to her'. (Mr D1)

'It comes back to having a sense of humour again and, if you play ball with them, they'll play ball with you. That's what it amounts to, you know. So no, you don't lose - well - any dignity in as in the fact that - you're laying on the bed with all your bits hanging out, and you've got two nurses messing about trying to pull things out, well - I don't suppose anybody likes that really, but it's got to be done so - get on with it and do it'. (Mr D6)

N13 was observed removing a female patient's catheter behind curtains in a very unobtrusive quiet manner. Both staff behaviour and patients' attitudes that promote dignity
are explored in Chapter 6, and these were particularly relevant to reducing the threat to dignity of intimate procedures. Being given suppositories was another procedure mentioned by several patients that could have threatened dignity but they all reported that staff approach to the procedure prevented dignity being actually lost. For example, Mr O8 mentioned that his suppositories had been ‘just quickly and quietly done’. Overall, it was clear that although the procedures discussed in this section threatened dignity, staff behaviour (6.3) and patient attitude (6.4.1) reduced the threat to dignity.

5.3.3.1.3 Psychological impact of diagnosis

The psychological impact of diagnosis could also threaten dignity and is discussed next. Three patients and two senior nurses expressed that undergoing investigations and having a serious health problem threatened dignity, as patients felt vulnerable and out of control (see comments Box 5.22).

**Box 5.22 Impact of diagnosis**

‘Everybody's vulnerable - when they come into hospital. They may have been told - they've got cancer, whether it's bowel or prostate or bladder - or it can be just having a tube in your bladder which you've never had before’. (S2)

‘If you're in the realms of the unknown when you're desperately ill and you don't know anything about the illness you've just got to lie back and let them deal with it. They're [staff] going to do it as they see fit’. (Mr D5)

‘I didn't know what was happening to me because I'd got this pain in my - and I kept having all these Xrays done, and it was the not knowing’. (Mrs D10)

S2 commented that all patients admitted to hospital are vulnerable, because of the impact of a serious diagnosis or the fear associated with unpleasant procedures. Mr D5 described how having a serious illness took away control from him due to a lack of knowledge. Mrs D10’s diagnosis was unclear until she went to theatre and she found the uncertainty about her diagnosis difficult to deal with. Mr D9 was having investigations for his health problems and talked in depth about the effect of having to wait for results, not knowing what his diagnosis was, compounded in his view by a doctor who he felt ignored him. In all these instances, staff behaviour had the potential to reduce the threat to dignity through therapeutic interactions that kept patients informed, thus helping them to keep some control (see 6.3.2.2).
Patients' health impairment thus threatened patients' dignity in a number of ways, which have been detailed in this section. Older age was identified by some participants as threatening dignity, which is explored in the next section.

5.3.3.2 Older age

Five of the patients, two ward nurses and one senior nurse expressed that older people were more vulnerable to a loss of dignity. S5 reported that, in line with DH policy, the hospital had an Older Age Champion (S6) who visited all wards to monitor older people's care including their dignity. No Heron ward staff mentioned the Older Age Champion nor was she observed visiting the ward. However, S6 expressed that she considered older people's dignity in Heron ward was promoted well (due to the ward manager's leadership - see 6.2.2) and that it was the acute medical wards that gave her most concern. Thus she presumably gave more attention to these wards where she perceived dignity of older people was more at risk.

As an older person himself, Mr D1 (in his 70s), said: 'I like them [other people] to respect that I'm elderly':

-'When you're getting old, you don't want people looking down on you or bossing you about - you want them to treat you respectfully'. (Mr D1)

His inference was that older people are more sensitive to dignity issues and he stated that outside hospital there was a lack of respect for older people but that he had not found this in hospital. However, in S6's view, older people in hospital are more vulnerable to a loss of dignity, partly because of staff attitudes and assumptions about older people and their capabilities (see Box 5.23).

### Box 5.23 Older people’s vulnerability to loss of dignity in hospital

'I think older people are more at risk and I think it's because of our culture...particularly in a hospital environment. I mean it's things like you know you get an older person in and the next thing you hear them being called "You alright ducks" "You alright love" you know, and that's not right and people shout at them and think that because they're older they might be deaf, might not understand what's being said'. (S6)

'I mean, the assumption is if you're old, or older, and you're not that mobile, then you should use a commode at your bedside. Why? Why not be wheeled into the bathroom and use the commode in the bathroom, which is dignity isn't it. And the same with washing as well, you know, why have them washed at the bedside when they could be wheeled into the bathroom and washed in the hand basin in the bathroom which again, helps to give them a bit of dignity, privacy'. (S6)
S6 considered that the way older people are addressed in hospital can negate their individuality as they are not called by their preferred name but in demeaning terms of endearment. Only one Heron ward patient (Mr O1, in his 70s) expressed discomfort with the form of address used, having been called by his first name without asking which he considered ‘over-familiar’. No patients of any age mentioned being called by endearments, although HCA2 was observed to address all staff and patients of all ages as ‘darling’. S6 expressed that older people were vulnerable as they were not always able to self-advocate, as younger people could. N15 similarly stated that patients, particularly older people, may be conditioned to feel they cannot have their say. While this view was not supported by participant observation, several patients described staff behaviour which threatened dignity (see section 5.3.2); two instances involved apparently frail, older patients. Mr D6, who was in his 50s, remarked that older patients were less fit which led to them needing more help and being more vulnerable to a loss of dignity. However, there was no direct link between older age and dependence - health status was the central issue. For example, Mrs O11 (in her 40s) needed far more assistance than Mr O6 (in his 90s).

Three patients of varying ages considered that older age was a threat to dignity because of psycho-social reasons. Mrs O9 (in her 70s) said that she was probably more sensitive about bodily exposure (particularly to men) because of how she was brought up. She explained that her parents were Victorians and insisted that she and her sisters never exposed their bodies to their brothers. On a similar note, Mr D1 (in his 70s) stated:

‘I'm a man who was brought up in the innocent age if you want to call it that and your body being touched and played with by women and that kind of thing is a bit difficult’. (Mr D1)

His comment implied that undergoing intimate procedures was more threatening to his dignity than if he had been younger. Mr D7 (who was in his 30s) expressed similarly that older people were less comfortable about bodily exposure than younger people because of their upbringing. N6 stated that some older people may never have been seen undressed by anyone other than their spouse, leading to discomfort about bodily exposure in hospital. Mr D7 thought that there might be issues because of the greater age gap between the older patients and, in some cases, quite young staff who were caring for them. However he commented:

‘Even with some of the older people that were actually there on the ward - they seemed to be quite happy with the way they were treated’. (Mr D7)
In summary, there were varied views about whether, and how, older age increased patients' vulnerability to a loss of dignity. Suggestions included intrinsic factors (physical frailty and psycho-social factors) but also extrinsic factors: hospital culture and staff attitude.

In the next section the identified patient factors that threaten dignity are examined in relation to previous research.

5.3.3.3 Discussion: Patient factors threatening dignity

The findings supported previous research that impaired health has a negative impact on patients' dignity (Enes, 2003; Hack et al., 2004; Matiti, 2002; Rozmovits and Ziebland, 2004; Wiegman, 2003). This study's results explicitly identified that physical impairment or illness (e.g. in the immediate post-operative period) caused loss of function with a resulting threat to dignity, thus supporting previous research (Chochinov et al., 2002a; Hack et al., 2004; Huckstadt, 2002; Jumisko et al., 2005; Matiti, 2002; Söderberg et al., 1999; Sundin et al., 2001; Volker et al., 2004). Unlike participants in some other studies, for example patients with advanced cancer (Volker et al., 2004), Heron ward patients' loss of function was usually temporary and they were often quite accepting of the situation while staff were more concerned about the impact on dignity. Mrs O4, however, was likely to remain dependent because of her chronic health problems and she expressed that she had lost her dignity which she had accepted. The study's results thus support Matiti's (2002) findings, that the degree and type of illness experienced by patients affects their perceptual adjustment to their dignity in hospital. In Bauer's (1994) study, also in acute care, many patients considered that being washed by staff breached privacy but Heron ward patients did not express this view. Just one staff member and one patient (both female) mentioned a preference for a nurse of the same gender for intimate care, supporting previous research (Chur-Hansen, 2002; Matiti, 2002) but men expressed no views on this issue. Though Woogara (2005) found that patients who were dependent on staff for help with personal care then had little choice over these activities, Heron ward patients generally seemed to appreciate being helped, particularly post-operatively, and none referred to lack of choice in this context. However, staff offering choices to patients was frequently observed and found to promote their dignity (see 6.3.2.2).

The literature search identified no previous research which has investigated the specific
impact of urological conditions on patients' dignity, which emerged in this study and is published in Baillie (2007). However, Rozmovits and Ziebland's (2004) work on colorectal cancer and the associated disrupted body function and invasive procedures is relevant as it also involved personal body areas, and the findings highlighted the associated embarrassment, expressed by some Heron ward patients. Having a urological condition increased the likelihood of patients undergoing intimate care situations, a situation associated with loss of dignity in previous research (Jacelon, 2003; Lai and Levy, 2002; Matiti, 2002). In most instances Heron ward patients felt that their dignity was promoted in these situations by staff approach and/or their own attitude (see 6.3; 6.4.1). In contrast, a few patients expressed that they could have accepted the procedure they had to undergo but staff behaviour - either their interactions or through breach of privacy - led to a loss of dignity (see 5.3.2.3). Thus staff behaviour that promoted dignity was critical as to whether patients lost their dignity in these vulnerable situations. Women undergoing vaginal examinations in labour expressed very similar views (Lai and Levy, 2002). In other instances, patients considered that dignity was lost while undergoing intimate care and that staff could not have done anything more to prevent this. They then adjusted their attitude to one of acceptance that the procedure had to be done and there was no alternative, indicating a 'perceptual adjustment', as described by Matiti (2002).

The psychological impact of impaired health on patients' dignity, identified by a small number of this study's participants, was particularly related to uncertainty of diagnosis or a lack of knowledge. This situation led to feelings of not being in control, which was identified in Chochinov et al.'s (2004) research with terminally ill patients too. The findings also lend support to Råholm and Lindholm's (1999) observation of the fear and uncertainty which can accompany illness. Jacelon (2004) identified that older people felt out of control when awaiting results from investigations but all three Heron ward patients who expressed this view were under 65 years. The negative impact of illness on self-image and identity (Nordenfelt, 2003b; Pearson, et al. 2004) was not specifically supported in this study.

The perceived additional vulnerability of older people to a loss of dignity in hospital is only partially supported in this study. Eleven of the twenty-four patient participants were over 65 years old but only a few made specific reference to their age in relation to dignity and they did so in variable ways. Some considered that older people were more vulnerable because of greater physical dependency (also expressed by professionals in Tadd, 2004c) while others considered that older people were more vulnerable due to upbringing and attitudes.
to modesty, a view not identified in previous research. There was no indication however that younger Heron ward patients considered that dignity was any less important to them than the older patient participants; vulnerability appeared to be linked more with the extent of physical dependency and severity of their illness.

It has been implied that older people's dignity is at greater risk in hospital because of the disempowerment they experience and staff attitudes to older people (DH, 2001b; DH, 2006a; Redman and Fry, 2003; Stratton and Tadd, 2005; Woolhead et al., 2004). S6 identified such attitudes as being present in the hospital, but not specifically in Heron ward, where she felt standards of dignity were high for patients of all ages. S6 expressed dislike of the patronising and disrespectful manner of address which hospital staff used with older people, supporting previous research findings (Bayer et al., 2005; Woogara, 2004; Woolhead et al., 2005) but only one Heron ward patient expressed concern about how he was addressed. Participants in Woolhead et al.'s (2005) study expressed that older people can feel inferior and unequal in hospital due to a lower level of knowledge and fitness than those caring for them. Interestingly the only Heron ward patient expressing a similar view was in his 50s (Mr O5) but he did have a serous illness and had had major surgery, indicating that age is not the only factor.

To summarise, patients' impaired health which initiated their hospital admission threatened dignity in a number of ways. The loss of function and intimate care procedures, which were found to accompany physical impairment and threaten dignity, supported research findings from a variety of settings. The specific impact on dignity of having a urological condition was highlighted in this study but has not been previously examined. Psychological factors associated with health impairment which were found to threaten dignity have been identified in only a few research studies. While ageing was found to potentially increase vulnerability to a loss of dignity in hospital, supporting previous research, younger people were certainly vulnerable to a loss of dignity too.

5.4 Chapter summary

This chapter has presented findings about the meaning of patient dignity in an acute hospital setting and illuminated how patients' dignity is threatened. This study's findings drew on a range of data sources and included patients across the adult age range. Many of the findings support the existing body of knowledge indicating there are core features
about patient dignity, regardless of age or setting, but greater clarity has emerged. The findings have also provided greater depth of knowledge in relation to how patients' dignity is threatened in hospital.

The meaning of dignity for patients in hospital comprised feeling comfortable, in control and valued, and was closely linked with their physical presentation, and behaviour, to and from others. For many patients and staff, dignity entailed correct and socially acceptable physical presentation, in particular the body being covered. Physical presentation was closely linked with whether patients felt comfortable. Staff had clear and consistent views relating to physical presentation associated with dignity but patients' views portrayed some variation. Given that NHS patients are drawn from across society it is not surprising that there are individual interpretations of acceptable physical presentation but all patients co-exist in the public arena of a hospital ward. Behaviour to and from others was also closely related to patients' feelings. For hospital patients, dignity could be conveyed through the responses of others in their surrounding environment, in particular staff, which affected whether patients felt comfortable, in control and valued. Many patients also identified that their behaviour towards staff was associated with their dignity, reciprocity emerging as important. Patients felt comfortable if they perceived that their behaviour towards staff was mutually acceptable.

Threats to patients' dignity in hospital are closely related to the meaning of dignity that emerged. Patients have no control over the environment into which they are admitted and the staff who will be caring for them. For most people, this situation contrasts with home where they have choice and control. Lack of privacy threatens patients' dignity in hospital due to the sharing of a communal space for all patients, except for the few in siderooms. Patients are surrounded by strangers who witness their impaired health and the related dependence and intimate procedures. While curtains, if pulled fully, present a visual barrier, patients know that other patients and visitors are aware of what is happening behind the curtains. Aspects of patients' lives that are usually private, such as urine, were visually displayed on Heron ward and discussed publicly. Patients quickly learn about each others' diagnoses; they may volunteer such information to each other but will otherwise inevitably overhear conversations or surmise from each others' appearance and thus information considered private becomes public. Yet patients in this study displayed remarkable tolerance to the lack of privacy in a hospital bay with only two patients expressing that being in a bay with other patients threatened dignity. Perhaps this situation
can be linked back to the concept of dignity being about feeling comfortable. In hospital, the usual social norms change. All patients have limited personal space, all generally wear nightwear (or hospital gowns), all overhear conversations about each other, and all can see each others' urine in catheter bags. The majority of patients will require intimate procedures. Thus for many patients, the obvious lack of privacy was not identified as a threat to dignity as they did not feel uncomfortable.

However, there was a fine line between a hospital environment in which patients felt comfortable and one in which they did not. The use of curtains during intimate procedures and examinations was crucial but not always performed to an acceptable level if curtains were ill-fitting, not fully pulled or entered by staff without warning. Again, in many instances, patients displayed remarkable acceptance of the limitations of curtains for providing privacy. Patients also accepted without any apparent loss of dignity that they could not be fully dressed in hospital due to their attachments such as intravenous infusions and catheters. However, bodily exposure of patients was an ever-present threat to dignity on the ward and the inadequate use of curtains and requirement to wear ill-fitting hospital attire (operation gowns and nightshirts with no underwear) were the two main factors increasing the risk of bodily exposure occurring. Some patients expressed high levels of discomfort about their imposed bodily exposure in the public area of a hospital ward as for the majority of patients, exposure of areas of the body usually kept private, threatened their dignity. In addition, patients had no control over these elements of their environment. Staff showed a high degree of awareness of the risk of bodily exposure and its threat to dignity but also acknowledged that use of curtains in particular was subject to human failure. A small number of staff mentioned that operation gowns and nightshirts were a threat to dignity but there was no obvious insight into the levels of discomfort experienced by some patients.

A MSE, which occurred sporadically due to hospital bed shortages, also led to an uncomfortable environment for patients because of the ever-present risk of bodily exposure. While many patients could tolerate a risk of bodily exposure occurring in a same sex bay, in a mixed sex bay it was totally unacceptable. Risk of bodily exposure occurred because patients were dressed inadequately and their mobility was restricted by medical devices attached to the bodies. Women expressed that simple situations such as getting out of bed became unnerving, as they worried about bodily exposure occurring. Male patients appeared much less concerned about being in a MSE and even when bays were
not mixed, there was no guarantee that they would remain in their single sex bay but wandered round to the women's bay. As not all men were covered up adequately (often because of the hospital attire they had to wear) there was a high risk of women being faced with bodily exposure from the men. Staff showed strong awareness of the threat that a MSE posed to patients' dignity and tried hard (often in conflict with management) to prevent mixed sex bays and to ensure that the male patients covered themselves adequately. The environmental threats to dignity discussed thus far are strongly related to patients' physical presentation impacting on how they felt.

Hospital systems threatened patients' dignity mainly through bed management policies which led to MSEs but also led to frequent patient transfers and increased staff workload. With hospital being an unfamiliar environment, having a stable group of people (staff and other patients) with whom patients can become comfortable with, helped to counteract the unfamiliarity, but frequent transfers prevented this situation. The high throughput of patients and obvious pressure could engender patients feeling like a number rather than an individual, thus affecting self esteem. Resulting high workload reduced opportunities for staff to interact with patients as individuals thus impacting on their behaviour. Just a small number of patients commented on lack of continuity of staff and its subsequent effect on relationships. It may be that these patients were simply unlucky or perhaps other patients felt comfortable with relating to different staff from one shift to another. Patients bring with them their own experiences and personalities and relationships with surrounding staff and patients may be much more important for some patients’ dignity than for others.

Staff behaviour towards patients had a strong impact on whether patients felt comfortable. It appeared that only a small number of staff behaved in a way that threatened dignity but unfortunately such situations had a major effect on patients. Staff made patients feel uncomfortable by being curt towards them, authoritarian or breaching their privacy. It is impossible to know whether staff who behave in this way have any awareness that such behaviour threatens dignity. As regards a curt approach, it did not appear that patients expected long conversations with staff: most were well aware that staff were busy. They merely expected a friendly and polite greeting, to have concerns listened to and superficial conversation, which was observed on numerous occasions and commented on positively by patients. Clearly, from some patients' reports however, there are some staff who do not adopt such behaviour consistently and instead adopt behaviour that in other settings would be considered rude. Outside hospital, patients would have the opportunity to retaliate in
kind or to leave the situation. But in hospital they are in a powerless position, in some instances not even able to leave their bed unassisted. Being subjected to such behaviour affects patients’ dignity and they feel uncomfortable, out of control and unvalued.

Staff behaviour was particularly influential when patients were undergoing procedures that threatened their dignity and could make the risk of dignity loss become actual, or prevent loss of dignity occurring at all. A curt approach or breach of privacy occurring in such situations led to patients feeling uncomfortable and a loss of patients' dignity. A small number of patients remarked on an authoritarian approach from staff threatening their dignity and it was notable that for these patients, feeling in control was their major concept of dignity. Patients experience little control in hospital and yet many are very tolerant of the obvious power imbalance that exists. While some staff offer choices in everyday care (see 6.3.2.2), a small number apparently adopt a more rigid dictatorial approach. Patients who are used to making their own decisions and maintaining their control find such behaviour uncomfortable and a threat to their dignity.

Patient factors rendering patients vulnerable to a loss of dignity were mainly related to their impaired health. Being in an acute hospital setting, patients’ impaired health status was often temporary. However, for some patients their health problems were of a more chronic nature. Patients almost all had some loss of function associated with their physical health problem and often needed assistance with activities such as hygiene and mobilising. Most patients accepted that they needed the help and did not consider it threatened their dignity as they would otherwise have experienced physical discomfort, but some staff were concerned that their loss of function was a threat to their dignity. However, patients rationalised the need for help and that the situation was usually only temporary. The more personal the care required, however, the more likely patients were to identify a resulting threat to their dignity. Many of the patients on Heron ward required intimate procedures due to their particular physical impairment and for some, such a situation was too personally uncomfortable to be congruent with dignity. However, as discussed previously, staff behaviour could often redeem these situations, at least to some extent, but conversely could ensure that dignity was lost. For some patients, health impairment had a psychological impact too, with the accompanying fear and lack of control threatening their dignity.

In the UK, the perceived increased vulnerability of older people to a loss of dignity in
hospital has had an increasingly high profile, following reports of older people's dignity being negated in hospital. None of the older patients in the study actually considered that their dignity had been threatened in hospital because of their older age. A few patients of varying ages supported the view that older people were more vulnerable due to increased likelihood of physical impairment, but several of the younger patients in this study had more serious physical impairment than the older patients. In two of the situations reported by patients who witnessed staff behaviour that threatened dignity, the patients affected were older and clearly frail, possibly indicating that they are more vulnerable to staff behaviour that threatens dignity. However, some patients referring to behaviour that was curt or authoritarian were only in their 40s or 50s. Some patients considered that older patients are more concerned about their modesty and the two male patients who expressed being comfortable with bodily exposure were younger (30s and 60s). However, several younger patients (in their 40s and 50s) strongly considered that bodily exposure was a threat to dignity. Thus findings related to the impact of older age on patients' dignity are quite varied but what is clear is that younger patients too value their dignity and are vulnerable to loss of dignity in hospital.

To conclude this chapter, patient dignity in hospital relates to patients' feelings, which are closely associated with their physical presentation and behaviour to and from others. The hospital environment, staff behaviour and patient factors can all contribute to threaten dignity in hospital. The findings in this chapter generally support the theoretical framework developed but provide new perspectives and a greater depth of knowledge about the meaning of patient dignity in hospital and how it is threatened. Despite the obvious threats to patients' dignity, however, most patients, most of the time felt that their dignity was promoted. Chapter 6 details how dignity was promoted on Heron ward.
Chapter 6 'From the cleaner to the sister, I got the same respect and reaction, which was nice': promoting patients' dignity in an acute hospital setting

6.1 Introduction

Chapter 5 asserted that the hospital environment, staff behaviour and patients' intrinsic factors (impaired health and possibly older age) threaten dignity in hospital. This chapter examines how patients' dignity can be promoted in hospital, with a section relating to each of the environment, staff behaviour and patient factors. The quotations incorporated are coded in an identical manner to those in Chapter 5 (see 5.1, footnote 6). Each section is followed by a discussion linking the findings to previous research. Table 6.1 presents Theme 3 'Promotion of patients' dignity in hospital' and its categories. The chapter concludes with a summary of how patient dignity can be promoted in the acute hospital setting and indicates areas of new knowledge.

Table 6.1 Theme 3 'Promotion of patients' dignity in hospital'

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<td>• Conducive physical environment and facilities</td>
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<td>• Dignity-promoting culture and leadership</td>
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<td>• Ability and control</td>
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6.2 Hospital environment

The hospital environment comprises not only the physical structure of the ward and its facilities but also the organisational culture and leadership, which is influenced by the wider hospital environment. When asked about how the environment affected their dignity, patients often referred to other patients, indicating that they perceived them to be part of the environment and, generally, they had a positive effect on dignity. Each of these aspects will be presented in turn.

6.2.1 Conducive physical environment and facilities

Patients feel comfortable in a clean, well-maintained environment which also makes them feel valued and thus promotes dignity. Ward layout strongly contributes to the maintenance of environmental privacy, for example numbers of patients in bays, available personal space and bathroom location. Sufficient resources such as bed linen not only promote physical comfort but help patients to feel that they are worthy of resources and confident in the hospital's organisation.

More than half the patients (evenly across age groups and gender) perceived that Heron ward provided a physical environment which promoted their dignity; their comments referred to layout, space, facilities and cleanliness. S5 asserted that ward layout 'has a massive impact on dignity' and in support of her statement, many patients commented on the layout too. Heron ward's layout, comprising five bedded bays with a bathroom in each bay, was popular with almost all the patients; just two patients expressed a preference for Nightingale style wards (Mr O2 and Mr D5). Mr O2 associated Nightingale style wards with the familiarity of his local hospital where he had a long admission following a stroke. Mr D5 disliked Heron ward's layout as he felt its open-plan nature reduced privacy and he preferred the traditional layout of Nightingale wards. Their views indicate that it is not possible to achieve total consensus on a ward layout that promotes dignity. S1 explained that the ward staff were involved in designing the ward layout:

'I think we made the best use of this ward, because it was just a space, and we planned it more or less ourselves'. (S1)

S5 confirmed the trend towards smaller bays of patients, stating that the new hospital building elsewhere in the Trust would have more, smaller rooms for two or three patients rather than larger bays and that in her view this would be better for both dignity and...
infection control. Some patients (particularly those who were in hospital longer) personalised their bed space with cards and sometimes a balloon attached to their bed or soft toys. Box 6.1 presents comments from patients and staff about the ward's layout, which are then discussed.

Box 6.1 Views about Heron ward’s layout

'I think the wards [bays] themselves being five [patients] in a ward - I think that's ideal, to be honest... When you've got big long wards you know - that's a different thing altogether'. (Mr D1)

'There's only five beds in a bay, so you can talk to everybody in the bay'. (Mr D6)

'It was nice to be in a small ward - 5 beds with a shower and a toilet in the corner. That makes it easier doesn't it to sort of manoeuvre about - you don't have to go walking down a long corridor with your frock [nightshirt] flapping in your bottom - things like that'. (Mr D4)

'I think location of where toilets and bathrooms are - in relation to where beds are, is a significant factor. If you have to walk across vast expanses to get to a toilet, then I think that could compromise dignity'. (S5)

'You don't feel embarrassed about going to the loo - it seems sound-proofed and it's accessible'. (Mr O8)

'I think here on this ward - the environment is actually perfect - I think it's a good environment. Because it's all five bedded bay. Not like the old Nightingale ward where people walk up and down'. (S2)

'It's quite easy to maintain dignity because of the bays and the side rooms and we do have a little area where they can go to the day room'. (S3)

Many patients appreciated interaction with others and found it a source of support (see 6.2.3) and the physical ward layout encouraged patient relationships (see Mr D6's comment). Patients seemed to feel safe in their bay, particularly as there was no need to go out of the bay, reducing the risk of bodily exposure when wearing a gown or nightshirt (see Mr D4's comment). S5 similarly commented on the impact on dignity of bathrooms being located close to patients’ beds. Some patients expressed that if bodily exposure inadvertently occurred, there was less risk to dignity in a small bay. For example, Mr D6 referred to a confused patient in his bay who persistently uncovered himself but he said that this was not a problem because it was 'just a small private bay'. Mr O8 said that if you were in a long [Nightingale] ward, if you were using a bedpan it would be more embarrassing than in the small bay.
The physical environment of Heron ward was newer and more spacious than wards elsewhere in the hospital. Mr O7 had been in a ward in the older part of the hospital to start with and expressed how Heron ward's environment was more conducive to his well-being (see Box 6.2). Other comments about the physical environment included spaciousness and cleanliness (see examples, Box 6.2).

**Box 6.2 Comments about Heron ward's physical environment**

'This ward has more open space - it's clean and new - it makes you feel better'. (Mr O7)

'They [patients] like coming here. They feel comfortable here, it's cleaner and lighter and airier'. (S4)

'It's a nice bright environment in here. It's nice and clean'. (Mrs O9)

S1 expressed that ward cleanliness was important for promoting patients' dignity and that the ward endeavoured to maintain high standards. The cleaner was well integrated into the ward team and cleaned the ward thoroughly during the morning observation periods. Infection control was a high priority; each patient's bed had an alcohol handrub dispenser and each patient had their own blood pressure measurement cuff. There were glove and apron dispensers and handwashing facilities at the entrance to each bay. The 'Cleanyourhands' campaign (initiated by the National Patient Safety Agency) was running in the hospital and there were campaign posters displayed around the ward. Observational data indicated high compliance among staff to infection control measures. Mrs D12 identified staff hand hygiene as important to her dignity and Mrs O9 said that she was:

'impressed to see everyone uses the hand cleaning stuff'. (Mrs O9)

Adherence to infection control appeared to engender feelings of safety and confidence in staff. S1 considered the ward appearance to be important:

'I have terrible battles with the cleaners to come and hang the curtains properly. To me it's important that the ward is nice. And - you know - I think that goes a long way. Patients feel better. That people care'. (S1)

Her comment implied the importance of the physical care environment to how patients feel but also her leadership (see 6.2.2) and commitment to ensuring that standards were maintained.

Each bedspace had its own television (with headphones) and telephone, a system which patients had to pay to use but had personal control over. These facilities were evidently
popular with patients and a few specifically related them to their dignity. They gave patients some degree of control in an environment where they had little control and being able to watch familiar television programmes of their own choice gave a feeling of comfort. The personal bedside telephone increased levels of social support as they could telephone and receive calls at any time. Often several patients in the bay were each watching their television with their headphones on, increasing auditory privacy in the bay.

About two thirds of the patients (evenly spread across ages and gender) and almost all staff commented that environmental privacy was important for promoting dignity. S2 and S4 emphasised that privacy was particularly important for patients with urological conditions due to the procedures they undergo. Both staff and patients generally considered that Heron ward's layout promoted privacy. Several patients and staff commented that the use of curtains provided privacy in the environment (see Mr D7's comment, Box 6.3) and many considered that this was sufficient, although they acknowledged that other patients knew what was happening behind the curtains. However, Mr D2's comment (Box 6.3) implied that while curtains promoted privacy, they were not an ideal solution.

**Box 6.3 Curtains for providing environmental privacy**

*The curtains round the bed certainly give you a fair amount of privacy and dignity when you're being examined - by whoever and the treatment you're getting*. (Mr D7)

*You have the curtains drawn round your bed when your visitors come or when they're doing some treatment to you. That's as good as you can get… in terms of - privacy and dignity*. (Mr D2)

Mr D2 was one of several patients who had experienced being in a side room on previous admissions so they could make comparisons with being in a bay with other patients. Mr D2 said:

*In a private room anything that goes on to you - when they're changing the urine bag or anything like that is not seen by anybody else*. (Mr D2)

N10 also suggested that dignity is easier to achieve in a private room due to the greater degree of privacy possible. Only one patient (Mr O5) in the study was being cared for in the side room but he had previously been in a bay. HCA3 commented that Mr O5 was lucky to be in the sideroom as he could do what he wanted - 'be his own person' in there.

Bays 2 and 3 (see Figure 4.1) were at the back of the ward and were not in view of the
nurses' station. Staff commented on the greater privacy of these bays, for example both nurses caring for Mrs O9 during the observation period commented that her bay was good for privacy. The bathroom in each bay provided further privacy for those able to get up to the bathroom.

While the physical environment provided the structure for dignity, ward culture and leadership are also important and this dimension is explored next.

6.2.2 Dignity-promoting culture and leadership

The culture of the ward was about the collective attitudes and behaviour of staff (as opposed to individual staff behaviour - see 6.3) and the atmosphere. Leadership, both at ward and hospital/Trust level, impacted on the ward culture. Heron ward philosophy (Box 6.4), which was prominently displayed on the dayroom window opposite the nurses' station, did not actually refer to dignity but it did describe staff behaviour that the study's findings indicated promoted dignity.

**Box 6.4 Heron ward philosophy**

'We, the staff of Heron ward, will aim for all patients, their relatives and friends to feel welcomed and secure in the knowledge that we shall care for them in a friendly and professional manner. That care shall be planned and carried out in partnership with the patient.

*Individual and cultural differences will be respected and we shall aim to give support to all who need it, including each other.*

*We shall continue to increase our knowledge and develop our roles as patient advocates and health educators*."

The philosophy promises that patients and their relatives/friends will be welcomed which is likely to make patients feel valued. Staff being friendly and professional contributes to patients feeling comfortable. Working in partnership with patients infers patients will be offered choices, giving control. Respecting individual and cultural differences infers that patients will be treated as individuals, making them feel valued. The philosophy also states that staff will aim to be supportive to each other, patients and relatives. The literature indicated that patients' dignity is promoted through social support and the research findings indicated that good relationships with staff were important to patients. The promise that staff will increase their knowledge should help patients to feel confident in the
staff. Thus the ward philosophy articulated a collective staff approach that would promote patients' dignity on the ward. However, the two ward-based senior nurses interviewed did not identify the ward philosophy when asked about documents relating to dignity, indicating that they did not perceive it as being related to dignity. Perhaps the philosophy was so well integrated into the ward culture it was taken for granted.

When asked about the ward environment's effect on their dignity, almost half the patients referred to aspects of ward culture and leadership which promoted their dignity. However, just three ward staff interviewed commented on ward culture in relation to the environment indicating that most did not associate this with dignity. In contrast, all the senior nurses discussed aspects of ward culture and leadership indicating a greater awareness of the effect of culture on dignity at their level. Box 6.5 presents patients' and staff comments. Three staff members (N2, S3 and S4) specifically referred to the speciality of urology leading to greater staff awareness of dignity.

**Box 6.5 A dignity promoting culture**

'I must admit I thought Heron ward was a very nice place. I mean - there wasn't anything wrong with X [ward she was in previously] but I just must admit I did feel much more comfortable and relaxed in Heron Ward'. (Mrs D10)

'There's a very caring, respectful approach. The ward is friendly - there's a nice feel about the place...People on this ward are sensitive to making you feel dignity is promoted all the time'. (Mr O8)

'On this ward dignity is good - there's a positive atmosphere - patients shouldn't fail to do well'. (N15)

'We're all very aware [of dignity] because we have to deal with men's genital areas'. (N2)

'I think on Heron ward especially I think staff are more aware of patients' dignity. Not saying that we always perform it to an acceptable level but - they are more aware'. (S3)

'We're quite a good team. We're here - our sort of ethos is - we're here for the patients. Want to deliver the best for them. I like to think we're quite patient focused and like to treat the patients as individuals. Take into account all their needs and anxieties. And that dignity is one of the most important things really apart from alleviating their concerns as to why they're here. Because of the nature of our department it's very easy to be blasé about it. So, hopefully we aren't'. (S4)
A few patients commented positively on friendly relationships among staff. There was a lot of humour between staff and patients which helped to promote a relaxed atmosphere and good relationships between the ward team were observed. Mrs O9 appreciated the positive staff relationships:

‘The nurses and domestic staff all talk together like friends. They don't act as if one's at a lower layer’. (Mrs O9)

Mr O3 referred to the ward as being a ‘tightly knit community’ implying closeness between staff and patients. As staff started to arrive on the ward before handover there were pleasantries and chatting which helped maintain staff morale and the friendly atmosphere on the ward.

Ward staff were observed to work collectively rather than just individually to promote dignity, an example being their united stance to prevent mixed sex bays. For this to be effective (which it was most of the time) required a commitment from all staff on every shift, supported by senior staff. S1's comment implied firm leadership and direction relating to patient dignity:

‘The staff are very well aware that we do not mix the bays. And I do have fights sometimes with the managers - bed managers - or whoever. And I don't like it’. (S1)

The senior nurses interviewed were asked about their roles in relation to promoting dignity and they expressed that they felt responsibility to provide direction for junior staff. S1 also stated that staff could approach her if they encountered any problems relating to patients' dignity. S3 emphasised her role as being supportive to the ward team in relation to treating patients as individuals. She further stated that ensuring staff had access to education, for example to enhance communication skills, was part of her role in promoting dignity.

Box 6.6 contains senior nurses' comments relating to dignity and leadership on Heron ward; several of which specifically refer to the ward manager's role in promoting dignity. S3's and S6's comments imply that the ward manager's experience and traditional training 'old school' led to her having a strong dignity-promoting philosophy which permeated the ward. Mr D9, having commented positively on the nurses' approach to patients, implied that the ward manager acted as a positive role model to staff in this respect. S3's and S5's comments also emphasised the importance of role modelling good practice.
Box 6.6 Dignity and leadership on Heron ward

'My role as their manager - to see that the ward runs smoothly and that they uphold the patients' dignity'. (S1)

'Patient dignity's got to be of prime importance when you're dealing with urology - any patient - but especially urology. So my role would be - if I see somebody is not doing it correctly - is to put them right… my role is to make sure it's being done properly'. (S2)

'It's such a nice unit. And run so very well. We don't have a lot of problems. And Sister X is of the old school and she is very up on privacy and dignity'. (S3)

'We've got a very good sister in Heron ward whom - I dare say - a bit like myself, comes from the older school of thought and in fact does know how to or how people should be treated - every patient should be treated with dignity, irrespective of age'. (S6)

'I think that goes down to the sister [ward manager] that was on the ward. I think she was brilliant with her staff - everybody has a massive amount of respect for her'. (Mr D9)

'I think more mature people are more aware of a patient's privacy and dignity - you've got a good mix on Heron ward of the older nurse and the younger nurse, and you do lead by example'. (S3)

'I think that that [staff approach] is a leadership issue. And I think if we can promote good leadership at all levels in the organisation, those are the kind of characteristics that will be role modelled for other people - I think we tend to assume that things that are common sense, people who look after patients will actually know about. But they don't necessarily. People need to learn about details and they need to learn them from other people who are experienced'. (S5)

Although the senior nurses' comments suggested that promoting dignity was very important and comments from other staff and patients indicated a dignity-promoting culture, there were few written documents, either ward or Trust based, which explicitly related to patient dignity, apart from the Essence of Care (DH, 2001a) documentation and, as previously discussed, the prominently displayed ward philosophy which was implicitly, but not explicitly, linked to promoting dignity. S6 was currently working on a document about promoting privacy and dignity for the Trust's Nursing Practice Group which would then be implemented at ward level. However, she expressed reservations about the impact of written policies:
'It's the same old story, you come up with all these wonderful ideas, you put them into print and does anyone read them. It's how it's presented, how it's flagged up to them. I often wonder how many nurses actually sit and go through some of the stuff that's on some of the wards really'. (S6)

The ward's various policy folders were examined for any references to dignity but none were found. Three of the senior staff interviewed thought that there might be a policy about dignity on the intranet. For example S3 said:

'I'm sure yes. [there is a policy on dignity]
Interviewer: Do you know where that would be?
You could get it on the intranet. I mean I'm sure that - it's not anything I've actually looked at myself.' (S3)

This exchange supported S6's views about the questionable value of written policies; if senior Trust nurses do not read policies it is even less likely that other staff will do so. In addition, an extensive intranet search revealed no written Trust policy about dignity; the only policy found was one generated from the other DGH in the Trust relating to preserving dignity during intimate examinations. It mainly concerned providing a chaperone and consent issues and was specific to the other DGH. S5 confirmed that no policy about patient dignity currently existed but both she, S3 and S6 considered that Essence of Care played such a role, with S3 expressing that Essence of Care had a high profile in the Trust. In S3's view, Essence of Care had increased awareness about not mixing bays. S5 stated:

'I would expect people to be aware of the benchmarks in the Essence of Care document - which really is guidance itself in there about dignity'. (S5)

S5 explained how Essence of Care benchmarking was approached in the Trust with the document having been interpreted by a working party to make it more readable. Box 6.7 contains the audit tool for hospital staff to audit their wards in privacy and dignity, which was carried out in thirty Trust areas between August and December 2004.
Box 6.7 Trust Privacy and Dignity audit tool, adapted from Essence of Care (DH, 2001a)
Reproduced with kind permission from the Trust.

**Factor 1 – Attitudes and behaviours**
Benchmark of best practice: Patients feel that they matter all of the time

<table>
<thead>
<tr>
<th>Question</th>
<th>Available Evidence</th>
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| 1  Is there evidence of good attitudes and behaviour of staff including consideration of non-verbal behaviour and body language? | Observation of staff  
Accolades – written and verbal  
Patient survey                                                                 |
| 2  Is there evidence of an induction programme that includes promotion of good communication skills with all patients and families including those from minority groups? | Induction package                                                                 |
| 3  Is there evidence that patients feel that they matter all of the time? | Patient survey                                                                     |

**Factor 2 – Personal world and personal identity**
Benchmark of best practice: Patients experience care in an environment that actively encompasses respect for individual values, beliefs and personal relationships

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<th>Available Evidence</th>
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| 1  Is there evidence that stereotypical views are challenged?             | Discussion at ward meetings/handovers  
Sister/Charge nurse meetings                                                                 |
| 2  Is there evidence that diversity (e.g. gender, race, religion, age) is valued? | Documentation                                                                 |
| 3  Is there evidence that individual needs and choice are ascertained and reviewed? | Care plans, evaluation documents  
Ask patients                                                                  |

**Factor 3 – Personal boundaries and space**
Benchmark of best practice – Patients’ personal space is actively promoted by all staff

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<th>Question</th>
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| 1  Is there evidence that staff agree with patients what they want to be called and adhere to this? | Admission documentation  
Ask patients                                                                                        |
| 2  Is there evidence that personal space is respected and protected for individuals? | Observation of ward environment e.g. space around bed, respect for personal belongings |
| 3  Is there evidence of privacy being effectively maintained, for example using curtains, screens, blankets, appropriate clothing and appropriate positioning of patient? | Observation of ward environment  
Ask patients  
Induction package for new staff and student nurses highlighting the importance of privacy and dignity |
| 4  Is there evidence that single sex facilities are provided?             | Observation of ward environment  
Ask staff                                                                                       |
| 5  Where patients are not in single sex accommodation is there evidence that they have been informed of reasons for this e.g. bed availability, clinical condition? | Ask patients                                                                               |
| 6  Is there evidence of access to segregated toilet and washing facilities? | Observation of ward environment  
Ask staff                                                                                       |
7. Is there evidence that privacy is achieved at times when the presence of others is required? E.g. ward rounds
   - Patient survey
   - Observation of ward rounds

### Factor 4 – Communicating with staff and patients
Benchmark of best practice – Communication between staff and patients takes place in a manner that respects their individuality

<table>
<thead>
<tr>
<th>Question</th>
<th>Available Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there evidence of access to high quality translation and interpretation?</td>
</tr>
<tr>
<td>2</td>
<td>Is there evidence of appropriate records of communication exchanges?</td>
</tr>
</tbody>
</table>

### Factor 5 – Privacy of patient – confidentiality of patient information
Benchmark of best practice: Patients’ information is shared to enable care, with their consent

<table>
<thead>
<tr>
<th>Question</th>
<th>Available Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there evidence that patients’ informed consent is sought when special measures are required to overcome communication barriers for example when using trained interpreters?</td>
</tr>
<tr>
<td>2</td>
<td>Is there evidence that precautions are taken to prevent information being shared inappropriately for example telephone conversations being overheard, computer screens being viewed and white boards being read?</td>
</tr>
<tr>
<td>3</td>
<td>Is there evidence that there are mechanisms in place for protecting patient confidentiality?</td>
</tr>
</tbody>
</table>

### Factor 6 – Privacy, dignity and modesty
Benchmark of best practice: Patients’ care actively promotes their privacy

<table>
<thead>
<tr>
<th>Question</th>
<th>Available Evidence</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there evidence that appropriate clothing is available for patients who cannot wear their own clothes? E.g. dressing gowns, range of sizes</td>
</tr>
<tr>
<td>2</td>
<td>Is there evidence of facilities available for patients to have a private telephone conversation?</td>
</tr>
<tr>
<td>3</td>
<td>Is there evidence of modesty being achieved for those moving between differing care environments?</td>
</tr>
</tbody>
</table>

### Factor 7 – Availability of an area for complete privacy
Benchmark of best practice: patients and or carers can access an area that safely provides privacy

<table>
<thead>
<tr>
<th>Question</th>
<th>Available Evidence</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there evidence that patients have access to a ‘quiet’ and or private space?</td>
</tr>
</tbody>
</table>
As can be seen, the tool incorporates many issues relating to staff behaviour (see 6.3), including communication (see Factors 1 & 4), promoting privacy (Factor 3), preventing bodily exposure (Factor 6), individuality (Factor 2) and confidentiality (Factor 5) as well as environmental aspects such as single-sex facilities (Factor 3). S5 explained that each ward carrying out the audit in Box 6.7 then developed an action plan to address problems identified. On examination, the working group's summary of problems with privacy and dignity (made available to the researcher) was found to relate to environment, communication with patients, personal privacy, confidentiality/data protection, documentation, education/training and others (included management of confused patients), with prescribed action for each problem raised. S5 identified her leadership role relating to the staff conducting the audits but emphasised that action plans had to be implemented at ward level, with support from their head nurses, who had the authority to implement change, as it would be impossible for her to follow up all clinical areas. She acknowledged that this was an area of Essence of Care which needed more work in the hospital. In support of this, the Heron ward link nurse for Essence of Care made no reference to follow-up actions after completion of Essence of Care audits. S5 explained that an Essence of Care report was produced on a quarterly basis and the most recent one (dated August 2005) was made available to the researcher. The report included some aspects relevant to the privacy and dignity benchmark but they were specific to individual ward areas and Heron ward was not among these. However they highlighted developments in other areas of the Trust related to privacy and dignity.

Heron ward’s link nurse for Essence of Care had no recollection of the privacy and dignity audit having been carried out. The two Heron ward-based senior nurses interviewed did not identify Essence of Care when asked about written policies relating to dignity, confirming its low profile at ward level. S5 acknowledged that nurses on busy wards found carrying out work for Essence of Care difficult to fit in and that it was impossible for them to attend meetings. She also identified that scoring privacy and dignity was problematic as care can vary from one day or shift to another. Her view highlights the importance of a dignity promoting culture rather than relying on individual staff behaviour.

In relation to other Trust guidelines, S5 expressed that dignity should be incorporated into patient care guidelines rather than having a specific ‘dignity’ guideline:

‘I’d expect some mention of it in guidelines in relation to nursing care. But not a specific guideline that says “dignity”’. (S5)
She gave the 'bereavement' guideline (currently being developed in the Trust) as an example of where dignity would be incorporated. S5 also stated that the NSF for Older People (DH, 2001b) incorporated dignity. In relation to mixed wards, S5 stated that national guidance was that there should not be mixed sex bays and that the situation is monitored, for example, by the Health Care Commission. S6 also referred to the Trust’s written policy about avoiding MSEs. Nevertheless, as discussed in 5.3.1.1.3, MSEs did occur on a regular basis on Heron ward.

Overall there was evidence of a dignity-promoting culture in Heron ward and supportive leadership at both ward and hospital levels. However, the culture of promoting dignity was not entirely overt to ward staff and patients in the form of written statements and Essence of Care had no obvious influence on the ward's practice.

Having explored how ward culture and leadership promote dignity, the next section examines the influence of other patients in the ward environment.

### 6.2.3 Other patients

Many patients commented on the impact of other patients in relation to how the hospital environment promoted dignity. Interestingly this was one area where there was an obvious gender difference: only two of the nine women interviewed commented on the role of other patients in promoting their dignity but two thirds of the men did. The age groups of the patients commenting on this aspect were widely spread. Only a small number of staff identified that other patients in the environment promoted patients' dignity. The comments portrayed a camaraderie between the patients who understood what each other was going through and gave mutual support. Data collected through observation supported the patients' views. Mr O8 commented that he had been in a private hospital a few times for small operations and that being in a sideroom was boring and lonely. He was therefore happy to be in a five bedded bay in Heron ward, with other patients to interact with. Camaraderie was particularly evident where patients were in bays with other urology patients and many patients felt that the structure of the ward with its five-bedded bays promoted interaction between patients (see 6.2.1). Several patients (see Box 6.8) used the phrase 'all in the same boat' (or similar) to describe the comfort of being on a ward with patients with similar conditions, which reduced the risk of dignity being lost if bodily exposure occurred or they were undergoing intimate procedures.
Mr D7 explained how such a situation helped him to feel more comfortable:

'It does relax you a lot more that they're going through the same thing, so when the curtains go up and round or whatever, you don't feel so isolated that the person next to you knows what's happening'. (Mr D7)

As mentioned in Chapter 5, (5.3.1.2.1), soon after the main data collection period, a Trust reorganisation led to the 'ring-fencing' of wards' beds for their speciality admissions, which increased the likelihood of Trust patients being cared for with others with similar conditions, undergoing similar procedures. From patients' comments it appeared that this strategy would promote the social support valued by patients and which promoted their dignity.

Box 6.9 presents positive comments from patients about other patients, which referred to friendliness, humour and respectfulness. Mr D6 related how on admission, he had made friends with two other patients who were having the same operation on the same day, one of whom had a similar sense of humour to himself. Mrs O12 commented on the importance of the initial reception by patients already in the bay. Mr O2 had been in the ward longer than many other patients and identified that the right mix of individuals in the bay could have a positive effect. It was observed that the interactions between patients in the bays varied considerably. Sometimes all was quiet and there was no interaction between patients while in other bays there would be lots of chatting and laughter.
Box 6.9 Positive comments about other patients

‘The patients are quite respectful in this ward - they were - quite friendly and respectful you know’. (Mr D1)

‘I like a good laugh and a joke with anybody and I went in with - well we only met in the dayroom as it happened - and two other blokes that were having the same op on the same day, and we sort of palled up if you like. And - two of us were in one ward [bay] and one old fellow was in the other ward, and we used to wander round and see him two or three times a day. And that’s all we did was - we took the rise out of everybody…That made life a lot more bearable’. (Mr D6)

‘If you’re made to feel welcome by the other patients it makes a difference’. (Mrs O12)

‘If you get the right balance of patients - [the environment] can be quite good. At the moment there’s the right mix - we get on with each other’. (Mr O2)

It was more difficult for patients confined to bed to talk to each other so more mobile patients stopped at their bedside and chatted to them. In Mr O7’s bay, there was a very mobile patient who walked around the bay talking to the other men and checking if they needed anything. While this approach could have been intrusive no patient ever commented that it was. Mrs O12 said:

‘All the girls [other patients in the bay] are brilliant. Especially Mrs O11’. (Mrs O12) Mrs O11 was observed to be very sociable and caring with other patients in the bay, ensuring that they got telephone messages left for them, for example.

Patients talked to each other about the problems associated with their conditions, knowing that they would understand. For example, the man next to Mr O2 said to him: ‘How are you this morning?’ Mr O2 shook his head and replied ‘I’ve got this sore dingle [penis]’ and the other man made a sympathetic reply (FN 23rd April 2005). N1 commented on the men being friendly to each other in Mr O1’s bay and that the men talked together about what was happening and compared experiences. Only one other nurse referred to other patients’ impact on dignity; N15 commented, when asked about environmental effects on Mrs O9’s dignity, that in her bay, ‘The ladies are all getting on well together’. It was observed that patients often helped each other in various ways, for example buying a newspaper for another patient if the newspaper trolley arrived while they were in the shower. Patients often showed concern about others in their bay, indicating a general caring ethos between the patients. Mr O7 commented that the man in the corner [he was terminally ill] was ‘in a bad way’ and when Mr O7 was interviewed the next morning, almost
the first thing he said was 'He's still with us'. On several occasions patients were observed summoning help for others and Mrs O12 confirmed the impression that patients cared about each other:

'Everyone seems to root for everyone else'. (Mrs O12)

Patients' concern included the safety and welfare of other patients, for example, Mrs O11, after coming out of the shower, immediately reported that the floor was very wet and that she was concerned that other patients might slip.

However, not all patients felt able to involve themselves with others. Mr D5, after referring to a patient opposite him falling from a chair, stated that the incident had made him think that it would be beneficial to 'see what your fellow companions were up to', but on the other hand:

'When you've got enough problems of your own getting over your pains and your problems, you can't take on half a dozen others'. (Mr D5)

It seemed that Mr D5 felt too pre-occupied with his own health to become involved with other patients, although he felt some sense of duty to do so. Not all patients were interested in social interaction, for example, Mr O3 seemed indifferent, saying:

'Sooner or later you talk to the other people in the bay - but this doesn't matter either way'. (Mr O3)

There were just a few instances of where other patients' impact was considered negative. Mr D5 related an experience where a patient had been admitted who was 'screaming all through the night'. He said that there were a few patients like that who were 'demanding'. Mr O2 commented that 'You only need one clown or lunatic' to disrupt the ward environment.

Overall, other patients generally had a positive impact on dignity because they met each others' needs for social interaction and helped them to feel understood and more comfortable in the environment. Patients who were less incapacitated helped other patients, which gave them a positive role possibly increasing self-esteem and marking their recovery. Mrs O11 was a striking example of this. She was very unwell and incapacitated for several days post-operatively, but in her final few days on the ward, now making a good recovery, she was observed helping other patients to feel more at ease in the environment. Conversely, of all the patient participants, Mr D5 and Mrs D8 were the most negative about being in the hospital environment, feeling that loss of dignity was an inevitable accompaniment. Both expressed discomfort about being in a bay with other patients and neither mentioned relationships with other patients. The potential positive
effects of other patients were maximised when patients with similar conditions were in
bays together during their hospital stay so clearly bed management policies have a key
role.

To summarise, an environment that promoted dignity comprised a clean, pleasant physical
environment which facilitated privacy and patient interaction, a dignity-promoting ward
culture and leadership and other patients with similar conditions who cared about each
other and showed consideration. These findings are discussed in relation to the theoretical
framework in the next section.

6.2.4 Discussion: environmental factors promoting patient dignity in hospital

The importance of the physical environment for promoting patients' dignity has been
highlighted in previous studies but ward culture and other patients have featured much
less strongly. Each of these three dimensions of the environment is next considered.

The findings supported previous research which identified that privacy is important for
dignity (Ariño-Blasco et al., 2005; Clegg, 2003; Enes, 2003; Gallagher and Seedhouse,
2000; Jacelon, 2004; Randers and Mattiasson, 2004; Reed et al., 2003; Turnock and
Kelleher, 2001) and indicated that environmental aspects are important in providing
privacy although staff behaviour is also highly influential (see 6.3.1). As discussed in 1.4,
the DH (2004) has set a core standard requiring health care services to be provided in
environments which support patient privacy and confidentiality. Heron ward's patients
generally evaluated the ward layout positively in relation to privacy, supporting previous
research findings about patients' preferring bayed wards to traditional Nightingale wards
(Pattison and Robertson, 1996). The Heron ward patients, with just a few exceptions, did
not express a preference for single rooms as in Lawson and Phiri's (2003) research
because, as discussed later, they found the social support of other patients promoted their
dignity. The bays were considered quite spacious which was commented on positively too,
and previous research has identified the importance of personal space to patients in
hospital (Douglas and Douglas, 2004). Overall, the finding that an environment that
promotes privacy is important for patients' dignity supports previous research and indicates
that bays, with good size bedspaces and their own bathrooms, provide such an
environment.
Apart from privacy, other aspects of the physical environment on Heron ward found to promote dignity have not emerged strongly in studies about dignity, although Gallagher and Seedhouse (2000) found that a clean, pleasant environment promoted dignity. The important of a conducive physical environment and facilities has however been identified in studies of patient satisfaction with ward environments (Lawson and Phiri, 2003) and indicators of patient-friendly environments (Douglas and Douglas, 2004). Some patients and staff commented that the new environment of Heron ward promoted dignity and Lawson and Phiri (2003) found higher patient satisfaction with new wards. Cleanliness in the ward, considered important for dignity by some participants, was rated as a high priority by patients in Lawson and Phiri's (2003) study and a feature of a patient-friendly environment (Douglas and Douglas, 2004). A safe and comfortable environment which facilitates patient interaction, provides an accessible bathroom and personal control over facilities such as the television, was identified as promoting dignity in this study and also reflects the features of a patient-friendly environment (Douglas and Douglas, 2004). An accessible bathroom has been found to be important for patients' privacy (Bauer, 1994).

Overall, the environmental factors that promoted patients' dignity in this study have been found to be positive for patients in previous studies but specific links to dignity have not been identified.

The physical environment is a tangible dimension but culture and leadership, also prominent in the study's findings, are less concrete. Only a few studies have identified the positive impact that a dignity-promoting culture can have on patients' dignity (Gallagher and Seedhouse, 2000; HAS 2000, 1998). The study's findings indicated that leadership was important in developing a dignity-promoting culture which has not been discussed in previous research about dignity. However, in Holland et al. (1997)'s study there were very similar views expressed about how role-modelling and leadership can help to promote a caring culture. Her study was not directly linked to dignity but a caring culture is likely to be one in which dignity is promoted. Section 6.3.2 presents findings indicating that staff interactions that make patients feel cared about and valued promote dignity. Such interactions are likely to occur if staff work in an environment with a culture of caring. Written protocols and guidance about dignity were not apparent in Heron ward or the Trust, supporting previous research findings highlighting an absence of written codes of practice about dignity (Calnan et al., 2005, Woogara, 2005). However, the ward philosophy did articulate dignity-promoting staff behaviour and some senior staff asserted that the Essence of Care was prominent in the Trust. The Essence of Care did not appear to have
impacted on Heron ward though, as evidenced by the senior ward staff not mentioning it in relation to dignity-promoting documents. As one of the senior staff identified, written documents may not in reality be effective in promoting good practice anyway. Despite the Heron ward staff being mainly oblivious to the implementation of Essence of Care in the Trust, this study found much evidence that the seven factors in the Trust's Privacy and Dignity audit (Box 6.7) were being achieved in practice as most patients, most of the time, felt that their dignity was promoted and were content with levels of privacy. It appeared that the unwritten ward culture on Heron ward had a positive impact on how dignity was promoted.

The positive effect of other patients has been identified in a few other studies, but their benefits have rarely been linked to dignity. However, Chochinov et al.'s (2004) dignity-conserving model for terminally ill patients includes social support. This study's setting was very different being an acute hospital ward but many patients identified that other patients in their environment had a positive effect on their dignity. Patients were potentially together, 24 hours a day, for several days or more, while relatives are present for only brief visits and staff work shifts and are not in their bay all the time when on duty. It is not surprising then that interaction with other patients was found to be so important yet its positive impact on dignity has been rarely identified. Other studies have however indicated other patients are beneficial in terms of support, while not making links with dignity (Douglas and Douglas, 2004; Kralik et al., 1997; Lawson and Phiri, 2003; Pattison and Robertson, 1996; Söderberg et al., 1999; Street and Love, 2005). Two previous studies have identified that patient-patient relationships can positively affect perceptions of privacy (Bauer, 1994; Schuster, 1976). More men in Heron ward talked about the beneficial effects of other patients on their dignity but other studies have not reported gender differences and some (Kralik et al., 1997; Pattison and Robertson, 1996; Söderberg et al., 1999) had all female participants anyway. Conversely, the HAS 2000 (1998) observed that male patients were much less likely to be supportive to each other than women; again no links to dignity were made. The camaraderie evident in Heron ward seemed very similar to the 'group spirit' described by Pattison and Robertson (1996).

The ward layout was identified as promoting interaction between patients in this study supporting previous research (Douglas and Douglas, 2004) but contrasting with Pattison and Robertson's (1996) study which found that ward design had no significant effect on the development of patient relationships. Patients in Heron ward with urological conditions
often explicitly discussed the comfort of being with patients with similar conditions, supporting research with other client groups (Söderberg et al., 1999). Generally, although there are research findings which indicate the benefits of social interaction with other patients, they have not previously been associated with patient dignity.

To summarise, the findings in relation to the physical environment's role in promoting dignity, particularly regarding privacy, support previous research findings. The less tangible dimensions of ward culture, leadership and other patients provide mainly new knowledge about how the environment promotes dignity in hospital. The next section presents the findings relating to how staff behaviour can promote patients' dignity.

6.3 Staff behaviour

Individual staff behaviour can have a major impact on whether threats to patients' dignity, such as aspects of the hospital environment and patients' impaired health actually lead to a loss of dignity. Conversely, there may be an environment which is highly conducive to dignity, in terms of physical environment, culture, leadership and other patients, but the behaviour of individual staff with individual patients still strongly influences patients' experience of dignity. As Chapter 5, 5.3.2 demonstrated, the behaviour of just one staff member on one occasion can have a profoundly negative impact on how patients feel. This section details the behaviour of staff which promotes patients' dignity.

From an organisational and managerial perspective, the importance of staff behaviour in promoting dignity was recognised. The Trust's Essence of Care audit for Privacy and Dignity (Box 6.7) identified many relevant aspects of staff approach. S5 emphasised the influence of staff behaviour on patients' dignity:

'I think it [staff] can have a massive impact. How patients feel about the way they've been treated - and I suppose that is about dignity'. (S5)

All staff and patients identified ways in which staff behaviour promoted dignity and there were two main categories: providing privacy and therapeutic interactions. These impacted on patients' dignity as they affected how patients felt about the environment and their impaired health and associated procedures.
6.3.1 Providing privacy

Bodily exposure was frequently identified as a threat to dignity (see 5.3.1.1.2) and providing privacy helped to reduce this threat. As already explored in 6.2.1, the physical environment of the ward formed a basis for the provision of privacy. However, without complementary staff behaviour, it would be impossible for privacy to be actually provided. Approximately half the patients interviewed identified that staff providing privacy by preventing bodily exposure promoted their dignity, a view expressed equally across gender and age groups. All ward staff interviewed, and five of the six senior nurses, identified providing privacy as a means to promote dignity. Interviews with staff indicated general sensitivity to the potential for intimate procedures to threaten dignity and that providing privacy was paramount in such situations. One senior nurse (S3) highlighted cultural and religious issues relating to bodily exposure, identifying that some women may not wish to be exposed to men, or may require chaperones during exposure. Providing privacy to prevent bodily exposure required staff attention to the environment and privacy of the body. Auditory privacy and confidentiality were identified by only a few staff in relation to dignity.

6.3.1.1 Environmental privacy

Box 6.10 presents comments from staff and patients about environmental measures used to provide privacy.

Box 6.10 Environmental privacy

'We're very conscious about - you know - simple things like - doors being closed, not having lots of traffic coming in whilst the patient's being examined, drawing curtains'. (S4)

'My experience and my observation is they [ward staff] approach the patient - tell them what they're doing, screen the patient when they've told them what they're doing, and then go behind the screens to perform their tasks'. (S3)

'How it works on the ward is as soon as the doctor turns up or whatever they're quite happy to put the curtains round. Obviously there's quite a few people having bedbaths or whatever - the nurses there were straight round with the curtains as soon as anything happens'. (Mr D7)

Generally, patients experienced a strong commitment from staff to provide privacy in the
environment to prevent patients’ bodily exposure in the ward, a finding confirmed through each of the data sources. Staff prevented exposure to other patients, staff and visitors through pulling curtains, or by shutting the door in the sideroom or bathroom. When patients described intimate procedures such as catheter removal they always mentioned the use of curtains to provide privacy and promote their dignity. The observational data confirmed that staff used curtains during any situation where there was a risk of exposure including helping patients out of bed when they were wearing only a gown. Mr O8 stated that ‘Staff always screen me when carrying out procedures’. Mrs O10 expressed that a doctor who was going to examine her had noticed that the curtain was not quite pulled close and he asked another doctor to pull the curtain properly across. She felt that this prevented her from losing her dignity while being examined. Curtains round a patient's bed (or a bathroom or sideroom door closed) portrayed the message that the patient was likely to be exposed inside. Therefore care was taken not to enter without warning, and not at all by non-HCP staff. For example N1 said:

'The staff who bring the water round know not to go in if the curtains are round'.

(N1)

The awareness of non-HCPs about the risk of bodily exposure behind closed doors or curtains was illustrated when an occasion was observed where the cleaner wanted to clean the bathroom but the door was shut (FN 2nd June 2005). She was unsure whether there was a patient in there as one patient was missing from the bay. She therefore asked N3 to check the bathroom was empty before going in to clean it. At the back of the ward was a bathroom and staff were observed to put a sign saying 'Engaged' on the outside of the door if a patient was inside. In the sideroom the door held the same significance as curtains and when Mr O5’s care was observed, N8 knocked on his door before entering. HCA3 identified that although shutting the door prevented exposure, ‘staff must knock before entering’. She said that she knew she did not always remember to but she tried to. Mr D4, however, gave one example (see Box 5.18) where this general ward 'rule' was broken causing him a loss of dignity as he believed he was exposed in front of a staff member who was not a HCP.

6.3.1.2 Body privacy

S4 referred to this aspect of dignity as being ‘practical’ dignity, N15 as ‘physical dignity’ and N14 described it as ‘body dignity.’ S4 explained:

'Dignity to me would be first of all on a practical level, not exposing them, being conscious of their nudity or revealing themselves so being sensitive to that.' (S4)
Two senior staff (S4 and S6) referred to providing privacy in relation to body products too, for example disposing of urine discreetly. As discussed in Chapter 5 (5.3.1.1.2), several men and a few staff identified the use of operation gowns and nightshirts for men with catheters as a loss of dignity due to the resulting bodily exposure. Staff were observed trying to minimise these effects, pulling operation gowns properly round patients prior to them setting off to the bathroom but this was easier with slimmer men. Staff also suggested using a blanket to cover patients when they were sitting in a chair or lying on (rather than in) the bed. On some occasions staff were observed encouraging patients to wear a dressing gown over their gowns. However during the heat of the observation period, patients were unwilling to wear dressing gowns. Following catheter removal, patients could wear pyjamas instead and HCA3 identified getting pyjamas for Mr O5 as a way in which she promoted dignity for him. N1 stated that dignity is about allowing the patient to feel comfortable, for example, not doing anything to embarrass them during intimate procedures: ‘Even like when taking the catheter out, not exposing him’. N14 cited using towels to cover Mr O8 and making sure that he was covered up when sitting in his chair as ways in which she achieved ‘body dignity’.

There were instances where staff were more committed to preventing bodily exposure than patients who sometimes seemed unconcerned about it. Thus the perceived importance of privacy of their bodies varied amongst patients. When Mr O3 put his gown on back to front he walked through the bay with the front of his body exposed. N3 went over to his bed, drew the curtains and explained that he had his gown round the wrong way and helped him to rectify this. On another occasion, during handover (H8), N10 said that the men during the previous evening had kept ‘exposing themselves - lying there with nothing on!’ She had asked them to cover up but they said that ‘they didn’t mind!’ She said that she replied: ‘Yes but I mind - and the visitors might mind!’ S1 said similarly about preventing men from being exposed:

‘You have to remind them sometimes. If they don’t care, other people might’. (S1)

These responses from staff implied that the ward culture was to prevent bodily exposure through body privacy and staff strived to provide this even though it was unimportant to some patients. Mrs O11 described how staff prevented bodily exposure when she was very ill in the first few days following major surgery, by covering her up; she said that they had prevented her loss of dignity when she could not do this for herself. Mrs O11’s final comments about dignity were that she felt that it had not been compromised at all and that staff had ‘gone above and beyond’ to ensure that she kept her dignity when she was too
unwell to do this for herself.

Once staff were behind curtains with patients carrying out intimate care, they reduced exposure of the patients through keeping their bodies covered as much as possible during the procedure. Patients rarely commented on this strategy as a means to promote their dignity as there was strong acceptance by patients towards exposing their bodies to nursing and medical staff when necessary (see 6.4.1). N1 said:

‘You should never expose any more of the body than absolutely necessary when carrying out care’. (N1)

She said that she did not feel that Mr O1’s dignity had been at risk during the morning as she had kept him covered and not exposed his body. When discontinuing Mr O1’s bladder irrigation, N1 lifted back the sheets and then Mr O1 moved them back a bit more but she pulled the sheets back again so that only his tubes were exposed (FN 22nd April 2005). Several other staff also stated during follow-up interviews that they promoted dignity by covering patients' bodies during personal care (see Box 6.11).

Box 6.11 Covering patients' bodies during procedures

HCA2 said that she felt that she promoted dignity by ensuring Mrs O4’s body was kept covered during her bedbath - exposing only the area that was being washed.

N14 said that when Mr O8’s wound leaked and there was blood everywhere, and she was uncovering him she was careful about not exposing him in case staff walked in behind the curtains.

N13 felt that she promoted Mrs O12’s dignity during her bedbath by ensuring that she was covered with a towel when she took her gown off and putting her new gown on as soon as she had finished washing her front so that she was covered when she turned over.

N2 defined dignity as: ‘Knowing your privacy is not invaded without invitation’, which implied that gaining consent to invade privacy is important. Staff were observed specifically checking with patients before exposing them behind curtains. For example N3 said to Mr O2 ‘Is it alright to take back the covers?’ when she was assisting him out of bed (FN 23rd April 2005). Mrs O10 commented similarly that when the doctors examined her, they always covered her first with the sheet before pulling her nightdress up and they always asked first ‘if it’s ok’. Mrs D12 expressed strong satisfaction with prevention of exposure by staff, not just on her recent admission to Heron ward but on other admissions too:

‘I’ve been many times into hospital. Many operations, female-related and obviously
surgical, and I've always been able to say - hand on heart - I've not been ever left naked or uncovered - everything's been screened off when it's needed to be screened off'. (Mrs D12)

6.3.1.3 Auditory privacy and confidentiality

As discussed in 5.3.1.1 a lack of auditory privacy was seldom mentioned in relation to a loss of dignity and likewise, providing auditory privacy was rarely associated with promoting dignity by staff or patients. However, N15 emphasised the importance of confidentiality (an issue also raised by N14 and N10), saying that in the hospital environment staff must keep their voices down so that patients don't overhear conversations: 'you have to be aware that voices carry'. Curtains were drawn when private information was discussed, for example during an admission interview. However, staff acknowledged that curtains were poor at maintaining auditory privacy (see Chapter 5, 5.3.1.1). S4 expressed that there was strong awareness of confidentiality within the department.

In summary, both staff and patients identified that staff providing privacy was important for dignity, which was supported from all the data sources, but staff interactions were also crucial and are examined in the next section.

6.3.2 Therapeutic interactions with patients

The findings indicated that therapeutic interactions are those which have a beneficial effect and that they promoted dignity by making patients feel comfortable, in control and valued. All patients but one (Mr D5), and all but one of the staff interviewed, identified therapeutic interactions that they felt promoted patients' dignity. Generally, however, patients talked more extensively about staff interactions promoting dignity while staff put a greater emphasis on providing privacy.

Mr O8 detailed the qualities of the nurse who had cared for him during the morning thus:

'N14 [first name] is sensitive, explains what she’s going to do before she does it, she's cheerful, she has a sense of humour, she appears interested in me as an individual, she has a caring approach, appears to enjoy her work - doesn't appear as though it's a chore. She's dedicated'. (Mr O8)

He added that all these attributes promoted his dignity. On interviewing N14, she demonstrated insight into how her behaviour promoted patients' dignity saying:
'It's [dignity] about manner - how you approach patients, the way you are towards patients'. (N14)

She expanded:

'It's the things that you do for patients that makes them dignified. Not just what you do but the way that you do them'. (N14)

Her statement implied that whether patients experienced dignity was largely due to staff behaviour and she indicated that underlying attitude was important rather than actions alone. N15 also expressed that approach to patients was very important and she asserted that this is something 'you develop over time as a nurse'. In her view 'Staff attitude is the main thing' [in promoting dignity]. The Trust's Essence of Care audit tool (see Box 6.7) identified a measure of promoting privacy and dignity as being:

'good attitudes and behaviour of staff including consideration of non-verbal behaviour and body language'. (Factor 1 'Patients feel they matter all the time')

Thus there was Trust acknowledgement of the importance of staff behaviour for promoting dignity. N15 commented similarly on the importance of communication:

'Patients listen to every little thing, your tone of voice, how you look - your facial expression, your body language, your persona'. (N15)

The interactions that promoted dignity are looked at in more detail next.

### 6.3.2.1 Interactions that make patients feel comfortable

Types of interactions that made patients feel comfortable included use of humour, reassurance, friendliness and professionalism.

Seven patients and four staff members identified that staff using humour promoted dignity and this was observed in practice on many occasions. Mr D6 stated that the staff:

'were all a good laugh, which helped all the way round, basically'. (Mr D6)

Mrs D12 said of her readmission:

'It so happened I was in the same bed - so the joke went on - 'we saved it for you' - 'see you again' - all that kind of thing. [laughs] It was a friendly banter'. (Mrs D12)

Mrs O4 said that staff helped to promote her dignity by laughing with her, and this was observed in practice (FN 31st May 2005). HCA2, who was caring for Mrs O4 that morning, said, in relation to promoting dignity, that she liked to have a joke with patients but that she knew 'when to stop', implying that humour should be applied sensitively. Mr O5 said that he found the jokes from staff 'great' and that he had not encountered any 'unhappy' staff. During the ward round (FN 1st June 2005), the registrar was observed listening to Mr O5's abdomen for bowel sounds and he said that he could hear something but not a lot - perhaps they were in 'stage fright'. Mr O5 later said that he appreciated the humour the doctor used in this situation. HCA3, who was observed caring for Mr O5, said that she
liked to take a light-hearted approach but she was careful about using humour with patients and took it from their cue. Mr O8 commented during his interview on N14’s cheerfulness and sense of humour. It was observed that Mr O8 said to her, laughingly:

‘Good news - my tummy’s been rumbling all morning and I’ve farted twice’. (Mr O8, FN 22nd June 2005)

N14 laughed with him agreeing that these were all good signs of recovery from his abdominal surgery.

N3’s gentle use of humour was observed with several patients and she said, during the interview following her care of Mr O2, that she used joking to help him to relax which she felt promoted his dignity. During that morning she was observed walking with a patient who had mild dementia to the bathroom arm in arm and joking ‘Don’t you get too close now - I’ve got a husband!’ He replied ‘And I’ve got a wife!’ She said ‘So we both know where we stand now don’t we!’ Everyone in the bay laughed including Mr O2. On the same morning she said to Mr O2: ‘You haven’t had your shower yet have you Mr O2?’ He said ‘Yes’. She looked puzzled for a minute and asked again. He chuckled and shook his head. Everyone in the bay laughed, including N3, who said ‘good try!’ The ward was very short staffed that morning but N3 still used humour in her interactions.

Mr O1 stated during interview that he liked to have a laugh with people and that he thought that N1, who cared for him that morning, was ‘great’. He commented that this was the first time that he had met her and that it was nice to have a joke with people. N1 used a great deal of humour in her interactions with Mr O1 and the other patients in the bay; it permeated everything she did (see fieldnotes extracts, Box 6.12).

Box 6.12: Use of humour by staff

‘N1: ‘Oh you’re early [reference to Mr O1 shaving] - you expecting company then’.
Mr O1: ‘Oh it’s army training’.
N1: ‘Well I’ll expect you to get up and make your bed next then!’

Mr O1 to N1: ‘What’s your name - I don’t know your name’.
N1: ‘You can call me sweetheart!’
Mr O1: ‘I can’t call you that - if I call ‘sweetheart’ everyone else will come running’.
Everyone was laughing.
N1: ‘XX’ [her first name]
Mr O1: ‘I used to have a cat called XX’.
N1: ‘Did you love her, stroke her, make her happy?’
Again there was lot of laughter.

(Extracts from fieldnotes, 22nd April 2005)
Mr O1 obviously enjoyed the banter, looking relaxed and grinning and N1 was smiling and laughing. At her follow-up interview N1 said 'I don't want grumpy patients' but she did not identify her use of humour as a way of promoting dignity. There was obviously a good match in this situation of both the nurse and patient enjoying humour. Mr D4 described N1 having admitted him to the ward and commented on her being very amusing which made him feel comfortable with her.

Over half the patients identified that staff who were reassuring, friendly and built a rapport with them promoted their dignity. However, only two ward staff members and one of the senior nurses, identified that these types of interactions promoted dignity, although staff were frequently observed using them in practice. Mr O3 commented that staff were able to ‘develop a close affinity with patients quickly’. As many of the patients were on the ward for a relatively short space of time this was obviously an important skill. Some patients, however, returned on a regular basis and then it was important for them to feel that staff remembered them. Mrs D12 was one such patient and commented:

‘With it not being my only admission, it was like old friends meeting’. (Mrs D12)

While observing Mrs O10 in the same bay (FN 30th June 2005), prior to Mrs D12’s discharge, the ward volunteer was seen to remember how she took her coffee ‘Cold milk and half a sweetener?’ and she laughed and said ‘You’ve got a good memory’. He said to her ‘Here for your six monthly visit then?’ and she laughed again and they had a brief friendly chat. On the same morning, N14 was walking back from the bathroom and at that point a man walked down the corridor (FN 30th June 2005). N14 said warmly ‘Hello XXX[first name]. How are you?’ and gave him a hug. He said he had come up to the investigation unit and thought that he would just ‘drop into the ward to say hello’. They had a friendly chat and when he left N14 said that he was an old patient. S4 talked of building relationships with patients who frequently returned:

‘Particularly if they see the same faces, it just gives them I suppose confidence and reassurance really that - they know that we will respect their dignity. We know them as people’. (S4)

S4 talked extensively about how she reassured patients when they were undergoing intimate procedures to try to ‘give them a safe environment’. She stated that she did this particularly where the patient seemed uncomfortable about exposing themselves - 'guarded'. She said that she would reassure them, talk them through the process and be 'sensitive to their needs'.

Seven patients specifically commented that the friendliness of staff putting them at ease
and making them feel comfortable had promoted their dignity. Mrs O9 said:

'They're [nurses] friendly - they put you at ease and the doctors are the same these days. They used to be all prim and proper - you couldn't ask them anything. Now you can talk to them [doctors] easier.' (Mrs O9)

Similarly, Mr O1 said:

'Nurses are so good these days - so easy to talk to and relaxed'. (Mr O1)

Friendly conversation, particularly during personal care such as bedbathing, was observed on many occasions. N2 was observed attempting to make conversation with Mrs O11 during her bedbath, for example, as she looked brown, she asked her if she had been away recently (FN 7th July 2005). At interview, N2 stated that she promoted Mrs O11’s dignity by attempting to engage her in conversation; she felt that this took patients’ ‘minds off things’ and helped to build rapport. It also, she felt, helped patients not to feel quite so ‘invaded’.

There were many other instances observed of staff being friendly and reassuring towards patients. On the morning that Mr O5 was observed (FN 1st June 2005), HCA3 came into his room and said; ‘Good morning Mr O5, how are you?’ He replied that he was fine. He addressed HCA3 by her first name and obviously knew her well and they had a brief chat; the whole interaction was very friendly and relaxed. On another occasion the Pain Management Team was observed visiting Mrs O12 (FN 14th July 2005) and greeting her in a friendly manner, asking her if she remembered meeting them the day before, which she did. Mrs D10 made several comments about the friendliness of staff and also related how staff had reassured her when she was upset about having to return to theatre. When Mr O6 expressed concern to the ward manager that the district nurse was due to do his leg ulcer dressings the next day (FN 2nd June 2005), he was reassured that ‘the girls’ [nurses] could do his dressing if he was still in the ward. While the ward manager was talking to him she was holding his hand. N3, also present, reassured him that they could ring his surgery and check exactly how the district nurse dressed his legs. On interviewing Mr O6 later, he said that staff saying ‘Don't worry’ and reassuring him promoted his dignity. Likewise, N3 identified that she promoted Mr O6's dignity by listening to his concerns and reassuring him about his leg ulcer care.

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10 The Pain Management Team comprised an anaesthetist and nurse pain specialists. They visited all patients on the wards who had epidural or patient-controlled analgesia following surgery.
It was particularly important that reassurance was effective when potentially upsetting incidents occurred, one example being incontinence. Mr O2 related how some staff when dealing with his urinary incontinence promoted his dignity by attending to him quickly, changing his bed and nightclothes, and reassuring him ‘It’s not your fault’ and he felt that this approach promoted his dignity in a situation where it was threatened. A reassuring approach to incontinence was observed when N16 was observed changing a patient’s bed during the night after he had been incontinent (FN 24th June 2005) and responding to his apology ‘for causing so much trouble’ by reassuring him quietly that ‘it's no trouble at all’.

About a third of the patients commented that a professional approach from staff promoted their dignity but only a few staff did so (see examples, Box 6.13).

**Box 6.13 A professional approach**

‘To promote dignity, staff need to combine being businesslike and professional with sensitivity and caring’. (Mr O8)

The staff were:
‘All very professional, all got on with their job’. (Mr D7)

‘Oh he [operating department practitioner] was super. Very good…that made me feel better. Because he was obviously so efficient …He was very good. He kept my confidence up. Kept me relaxed and happy…very calm - very efficient - which gave me a feeling of confidence about what was going on’. (Mr D4)

‘They like to feel safe. What you're telling them and that you are professional - and the patient feels safe in your hands, totally in your hands when you're dealing with their problems’. (S2)

‘Being professional but in a relaxed way’. (N14)

A professional manner portrayed efficiency and competence and inspired confidence in patients, making them feel safe and comfortable. Mr D4 expressed that the approach of most staff inspired confidence; he felt that they knew what they were doing and were efficient (see comment, Box 6.13). In addition, he said:

*‘It's almost a sort of a negative thing. They [staff that promoted dignity] didn't do things that made me feel uncomfortable'* (Mr D4)

The way staff behaved was particularly important when performing intimate care procedures making the difference as to whether dignity was promoted in these situations. The potential of these procedures to threaten patients' dignity was discussed in 5.3.3.1.2 Mr D1 talked of the nurse’s approach while taking his catheter out saying that:
‘she did it very nicely without any bother or fuss or anything’. Likewise he said that insertion of his suppositories (another procedure that he felt could have threatened his dignity) was carried out in a way that promoted his dignity:

‘She did it nicely and she’s only a student nurse’. (Mr D1)

Mr D2 said that the intimate care he had to undergo did not bother him because ‘I was amongst professionals’.

N14 and N15 expressed that promoting dignity entailed making sure patients were comfortable and had everything they needed. Several patients referred to staff checking on them to make sure they were alright. Mr O5 stated that at night the staff came round quietly checking on patients with a torch. Mr D6 and Mrs D10 were both in bays that could not be seen from the nurses’ station and both mentioned that the staff regularly checked on them. Mrs D10 felt that the staff maintained a good balance of allowing patients ‘private time’ but:

‘They always did come and check on you as well even if nobody was calling, you’d always see one of them come round just to make sure everyone was alright and I think that made you feel a bit safer’. (Mrs D10)

Her comments portrayed an approach that instilled patients’ confidence in staff, feeling that staff were observing them without being over intrusive and invading privacy.

Interactions which made patients feel in control were also important for their dignity and are discussed in the next section.

6.3.2.2 Interactions that made patients feel in control

Interactions that made patients feel in control included explanations and information giving, offering choices, gaining consent and promoting independence.

About half the ward staff and all but one of the senior staff identified information giving and explanations as being strategies that promoted dignity or reduced threats to dignity when procedures were carried out. About a third of the patients cited explanations and information giving by staff as promoting their dignity; for these patients, understanding what was happening to them gave greater control of their situation. S3, as a senior nurse, stated that from her observation, the majority of staff always gave explanations prior to procedures and this was frequently observed in practice. Mr O3 said that staff answered questions and gave information and explanations and Mr D1 specifically commented on the clear explanations he was given pre-operatively, which enabled him to make informed
choice about anaesthesia. Box 6.14 provides examples from interviewed patients, commenting on how information giving and explanations promoted their dignity.

**Box 6.14 Explaining interactions from staff**

Mrs D10 was admitted to the ward from A & E as an emergency:

“They made you feel at ease straightway when you got in there, because I didn’t know what urology was - didn’t know even where I was going at the time. And they really did settle you in really well and they explained roughly what had been happening and ‘you’ll be having more tests tomorrow’ and all this kind of thing and that did help a lot’. (Mrs D10)

‘Telling you exactly what’s going on - that is very helpful isn’t it in a hospital when you’re worried and you’re slightly concerned about what’s going to happen to you - if people just sit on the end of your bed and say what’s going to happen - I know they haven’t got much time these days but that makes you feel - doesn’t it, more able to cope’. (Mrs D8)

Mr D9 described his pre-operative visit where his condition and operation were explained:

‘Pre-op. I have to say they were brilliant. Absolutely brilliant. The young lady I saw that explained what the walnut was like [description of enlarged prostate], what they would do. I could not fault her one bit…I went home feeling - really happy. At long last I know exactly what they’re going to do, and did I want an epidural and be awake and did I want an anaesthetic and be unconscious and perhaps eat a lot later and - everything was explained to me! And I felt really good’. (Mr D9)

Staff on the morning shift were observed to start by greeting patients and explaining that they would be carrying out their care and then checking that they knew what was happening to them during the day. Explanations being given to patients about their treatment and care were observed on a number of occasions. For example, Mrs O12 was starting oral analgesics and N14, when bringing the tablets to her, explained exactly what the medication was for and the strength of the drugs (FN 14th July 2005). When staff carried out procedures, such as venepuncture, discontinuing bladder irrigation or intravenous infusions or removing a catheter, they always explained first and gained consent and then gave additional information afterwards, for example recommended fluid intake following catheter removal. During ward rounds doctors explained to patients about the surgery they had carried out and what they had found. Patients sometimes probed further and were given additional information or told that this would be available at the clinic when tests had been performed.

Staff gaining patients’ consent and offering choices enabled patients to retain some control.
but only five patients, five ward staff and one of the senior nurses (S2) identified that these interactions promoted dignity. However, for some patients, consent and choice were vital for them to feel that they were in control. Clearly information giving underpins choice and consent, highlighted by Mr D9 (Box 6.14) being able to make an informed choice about what type of anaesthesia to choose. Mrs D8, too, cited being able to choose to have a general anaesthetic rather than an epidural anaesthetic, as a way in which her dignity was promoted. For one patient in particular (Mrs O10), consent and choice were central to her dignity, which she defined as:

‘Feeling that you’re in control of your treatment’. (Mrs O10)

During the interview following observation, Mrs O10 was explaining that the way staff talked to her was important and at that point N14 came behind the curtains and said: ‘Would you like your paracetamol now XXX? [Mrs O10’s first name]’. Mrs O10 said ‘Yes please’ and N14 brought them to her in a medicine pot. When N14 left, Mrs O10 said:

‘That’s the sort of thing I mean - she said “Would you like your paracetamol now?” Not “Here’s your paracetamol” or “Here’s your tablets” without telling me what they are’. (Mrs O10)

She said that at night when the staff brought her fragmin [anticoagulant] injection, they said ‘Would you like this? Whereabouts would you like it?’ and gave her choice. Mrs O10 further identified that she could have lost her dignity in the bathroom but N14 gave her choices, which promoted her dignity. She said that if she had felt weaker she would have been happy to be bathed and that N14 had offered to help her and to wash her hair - ‘little things like that’ and it was ‘nice to be offered these things’. Box 6.15 presents the fieldnotes from this event illustrating how N14 offered choices to Mrs O10 in the bathroom.

Box 6.15 Offering choices

‘N14 asked Mrs O10 if she’d like her to push her to the bathroom in a chair but Mrs O10 wanted to walk. We walked with her slowly to the bathroom. In the bathroom we shut the door and N14 asked her if she wanted to use the bath hoist to get in and out but Mrs O10 said no, she wanted to step in. N14 asked her to check the temperature of the water and Mrs O10 said she wanted a bit more cold in so N14 put the cold tap on a bit more. Mrs O10 then took her nightdress off. She had a large well-healed horizontal scar on her left side (from her nephrectomy) and N14 commented on how well healed it was. Mrs O10 stepped into the bath. I passed her her face flannel and soap. N14 asked her if she’d like her to wash her back for her but she said she could manage. N14 also said, ‘Do you want me to wash your hair?’ but Mrs O10 said ‘Not today’. N4 then said would you like us to stay or would you like us to leave you for a bit and you can ring when you’re ready? She said we could leave her. I handed her the call bell. As we walked back to the bed N14 commented that Mrs O10 is obviously trying hard to keep her independence and control over what’s happening to her - that she obviously won’t be able to reach her back but didn’t want us to wash it for her’. (FN 30th June 2005)
Mrs O10 gave a further example of being offered choice which related to pain control. She said that she had been offered tramadol when she expressed that she had pain but at that point she had not wanted to take it. When she later asked for it, it was fetched 'without any fuss', she said. Box 6.16 displays the fieldnotes for these events.

Box 6.16 Choice and control in pain relief

'Mrs O10 told me she has pain in her shoulders. She told me she thinks it might be caused by wind or perhaps she's been lying down for too long. I looked on her drug chart and saw that she had had paracetamol this morning but was written up for prn tramadol. Mrs O10 said she didn't want a painkiller at the moment. She asked me to pass her her windeze tablets from her table which I did and she took one out to chew. I also adjusted the pillow in her chair to try to make her more comfortable. I said if the pain didn't ease and she wanted tramadol just to say'.

'Mrs O10 still complaining of pain in her shoulders. N14 discusses this with her and again offers to give her tramadol but Mrs O10 still declines. N14 suggests that a bath might be more comforting than a shower for her pain'.

'N14 is administering the chemotherapy for the patient opposite behind the curtains, with the student nurse. Mrs O10 says to me, 'I think I will have the tramadol now'. I said 'fine' and took her [prescription] chart. N6 had the keys and she opened the trolley. I took the tramadol to Mrs O10'.

(Extracts from fieldnotes, 30th June 2005)

N14, who cared for Mrs O10 during the observation period, also identified choice and consent as being important for promoting dignity. She cited comfort as important:

'not as in pain but that the right thing is done for them [patients] and not doing things they don't want done'. (N14)

She stated that she had asked Mrs O10 whether she wanted a bath or shower and whether she wanted assistance. It was observed that N14 offered choice to Mrs O10 throughout the morning and accepted the choices that she made. N14 was concerned about Mrs O10's pain control and said:

'Some people don't want to give in to things'. (N14)

However she felt that it was good to make suggestions as it was then the patient's choice. As Mrs O10 was terminally ill her loss of function was likely to increase and she appeared to be desperately trying to hold onto control despite her worsening physical condition. As referred to in section 6.3.2.1, with the example of Mr O1 and N1 who both enjoyed humour, there was also a very good nurse-patient match in this situation. For Mrs O10, having control was central to her concept of dignity and N14 showed good insight into how important this was to her. She was also confident enough to take a measure of risk while
meeting Mrs O10's dignity needs, as Mrs O10, being very weak and quite unsteady, might have collapsed while walking to the bathroom or had difficulty getting out of the bath without the hoist.

For N3, consent and choice were central to promoting dignity. She cared for three of the patients observed and identified consent and choice in the follow-up interviews on each occasion: 'not bossing him' [Mr O3], 'doing things in his own time as he wanted it' [Mr O2], 'asking him each time before I did anything' [Mr O2], 'gaining his [Mr O3] consent before carrying out care', and 'making sure he [Mr O6] gets done what he wants to get done'. A small number of other staff also recognized choice and consent as promoting dignity for patients (see Box 6.17) and they were frequently observed to do so throughout the patient care they delivered: offering choice about meals, asking patients before taking away their water jugs for washing, and checking consent with patients before taking bed covers back. Some situations were more difficult as when N2 needed to turn Mrs O11 to wash her and change her sheet and Mrs O11 was worried about moving. N2 explained more about the importance of it and then Mrs O11 asked whether she could turn on her right side rather than her left. N2 agreed and thus Mrs O11's consent was gained and she was enabled an element of choice.

**Box 6.17 Promoting patients' dignity through choice and consent: staff views**

'Let patients be the kind of people they want to be'. (HCA3)

[Promoting dignity is] about patients being given free choice, not having to do anything they don't want to'. (N15)

'They're in control of what they want to do - how they want to dress, what they want to eat, going to the toilet, bathroom, personal hygiene, that sort of thing'. (S6)

'How much we get their consent, respect their feelings, take their opinions into account'. (N16)

As dependence due to loss of function was identified as a threat to dignity (see 5.3.3.1.1), it was expected that encouraging independence would promote dignity, enabling control over where and when activities such as washing and dressing were carried out. However, only one patient and two nurses related encouraging independence to promoting dignity but many instances were observed where staff promoted independence during care. It seemed, therefore, that most patients and staff did not associate promoting independence
with dignity. The exception was Mr O7 who said that staff ‘let you do things for yourself as much as possible’. He said that the day following his surgery, staff took down his bladder irrigation so that he could shower independently. He said:

‘Some patients want staff to do more for them than is necessary - if staff make them do more for themselves this helps them keep their dignity’. (Mr O7)

Many situations were observed where staff enabled patients to be independent in their hygiene, dressing and mobilising. For example, N6 changed Mr O3’s catheter bag over to a leg-bag so that he could walk around more easily. N2 expressed that she had lessened the threat to Mrs O11’s dignity during her bedbath by letting her do what she could for herself. N13 also identified promoting independence as a means of promoting dignity: ‘Encouraging patients to do things for themselves’. While she was bedbathing Mrs O12, she gave her a bowl and cup of mouthwash to clean her teeth and Mrs O12 also brushed her hair herself. There were several other situations observed where patients who were fairly dependent were encouraged to do small parts of the bedbath themselves such as washing their faces, thus retaining some control.

Interactions that made patients feel valued were also important for patients’ dignity and are addressed in the next section.

6.3.2.3 Interactions that made patients feel valued

S5 expressed the view that:

‘It’s the details that matter to patients. And - if you can get the little things right for them, then their overall perception of their experience will be good’. (S5)

Attending to details is likely to make people feel that they matter to staff and are valued; helpfulness, consideration, showing concern for patients as individuals and courteousness all had this effect.

While just over half the patients identified helpfulness and consideration from staff promoted their dignity, only one nurse (N15) and one senior nurse (S5) did so. Yet many such examples were observed in practice and thus it seemed that staff did not recognise that their helpfulness and consideration to patients promoted dignity. Box 6.18 presents comments about staff helpfulness and consideration.
Box 6.18 Helpfulness and consideration

'Staff are very helpful, and this helps dignity in an environment where you're not sure about what's going on and what's going to happen next. ...with the awkward things one has to do having staff being helpful is a very good thing.' (Mr O3)

'If you say you can't get to the toilet they'll bring you a commode - never make a fuss.' (Mrs O10)

'I have to say some of the nurses - were really, really good. Very considerate, in the positive side of dignity. There was one young girl, when she went to help the old boy, when he had a bed gown on - I have to say she covered him up and helped him to the bathroom.' (Mr D9)

Mr D2 and Mrs O10 referred to staff trying to solve problems for patients. Mr O1 expressed a concern to a nurse on admission and 'she was very understanding' and offered him a solution to his problem. Patients talked of how staff helped them with washing and showering. Mr D9 suggested that the ethos of helpfulness and consideration on the ward arose from the ward manager saying:

'She was brilliant. Very considerate, very kind, very understanding. When she came round with the doctors she'd come back - if you wanted to ask a question she'd always stop.' (Mr D9)

Mrs O11 said of the staff 'nothing's too much trouble' and that when she asked them to do things, like passing her a drink when she was unable to reach it herself, she 'never felt I've bothered them'. She said that this attitude was displayed through their body language saying that she had never seen an eyebrow raised or any body language indicating that staff felt that she was a nuisance.

Considerateness and helpfulness towards patients was often observed, confirming the patients' views. For example, the cleaner on seeing that Mr O1 was about to go to the shower offered to bring him fresh coffee afterwards, rather than leaving it on his table to get cold and she kept her promise to do so (FN 22nd April 2005). Mr O1 commented on her consideration at his follow-up interview. Staff who were going to carry out procedures for patients offered to come back later if they were having their coffee. During the morning, staff offered assistance with hygiene, giving help with washing and dressing. When patients requested help, staff responded promptly and pleasantly. If patients had a problem such as pain, staff offered help in various ways. Mr D4 stated that staff responded to callbells quickly and observational data supported his view with a few exceptions when all staff were busy. Staff encouraged patients to seek help when necessary, for example,
N13 said to Mrs O12, after helping her out to a chair the morning following surgery:

'Don't be surprised if you feel really tired - just let us know and we can help you back to bed'. (FN 14th July 2005)

Just over half the patients, half the senior nurses and a third of the ward staff considered that courteousness (including politeness, how patients were addressed, greetings and using a respectful approach) promoted dignity. Courteousness from staff was observed constantly on the ward and Mrs O10 and Mrs D11 both commented on the general politeness of staff to patients. The Trust's Essence of Care audit on Privacy and Dignity (see Box 6.7) identified that staff should agree with patients how they want to be called and adhere to their preference. On one occasion N14 was heard asking a patient what he would like to be called and he said XX (a shortened version of his first name) (FN 14th July 2005). It was observed that staff addressed patients in variable ways. For example, N3 always addressed patients as 'Mr/Mrs X' rather than using first names or the men as 'Sir' while many other staff always used first names. It was not possible to ascertain whether form of address had been agreed in every instance. Only four patients (Mrs D12; Mr D1; Mr O1; Mr O5) mentioned form of address in relation to dignity and so for most, it was either not associated with dignity or was not felt strongly about. However, Mr O1 stated that he had been called by his first name without being asked which he considered was over-familiar (see 5.3.3.2). Box 6.19 presents comments from two patients and S6.

**Box 6.19 Form of address**

'I gave her the opportunity to use my Christian name - if she so wished. It wasn't assumed that I wanted to be known as my Christian name. Doesn't matter. It's not so big a thing but it's one thing that sticks out in my mind - that was really nice ...It's old school. It's just something that you remember. What a nice thought'. (Mrs D12)

'Even in business I liked being on first name terms - all the staff used to call me XXX[first name] anyway so why shouldn't people who're looking after me call me by my Christian name. Fine if you don't want to be called by your Christian name I'm sure they'd call you Mr XXX [his surname] without any bother'. (Mr D1)

'It's very simple, I mean, 'Do you want to be called 'Fred' or 'Mr Bloggs' or whatever' you know. And usually then you can work it out from there'. (S6)

Mrs D12 identified that one member of staff always addressed her as Mrs D12 rather than using her first name (see Box 6.19). Mr D1 said that he had been asked how he would like to be addressed and had said that he would prefer to be called by his first name (see Box 6.19). Mr O5 said that he had been asked what he would like to be called and he had
given his first name. However he said that most staff (especially younger staff) called him Mr O5 but that he did not mind how people addressed him as long as they were polite. Only one staff member identified form of address in relation to promoting dignity. S6 felt strongly that, particularly for older people, it was important to ask patients how they would like to be addressed (see Box 19).

Introductions and greetings from staff were another aspect of courteousness. S5 expressed that:

'Staff who smile and introduce themselves - say who they are and say they're looking after them, say goodbye at the end of the shift, I think it makes a big difference to the way patients feel. I do speak as a patient - it made a big difference to me when I was a patient - when I knew who was on duty and who was looking after me'. (S5)

The social niceties of greetings were used by the majority of staff of all disciplines, usually in combination with the patient's name. These greetings occurred during doctors' ward rounds when patients were addressed: 'Good morning Mr X. How are you?' Staff arriving on duty started the shift by going into their allocated bays and saying 'Good morning gentlemen' or 'Good morning ladies'. Likewise support staff going into bays carrying out tasks, such as giving out hot drinks or collecting water jugs for washing, smiled and greeted each patient in turn by their name as they worked round the bay.

Patients talked about being treated respectfully as promoting their dignity and Mrs O9 and Mr O5 commented that they had never seen any 'off-hand' behaviour from staff. Mrs O12 said that she expected to be treated with respect, in the way she believed she treated other people and that staff promoted dignity by not speaking down to patients. Similarly, N3 expressed that one way she promoted Mr O3's dignity was the way she spoke to him - 'not speaking down to him'. Mrs D12 specifically mentioned being treated with respect as being good for her dignity, saying:

'From the cleaner to the sister, I got the same respect and reaction, which was nice'. (Mrs D12)

Her comment indicated a ward culture which promoted respect (see 6.2.2). Mr D1 highlighted the importance of a whole ward team approach to dignity as he mentioned the way food was served by staff, usually non-HCPs:

'The way it's [food] served - you can't complain about - that's not served - dumped on you or anything like that - it's given to you nicely. That's part of being looked after'. (Mr D1)

Apologising was another way in which staff were courteous to patients. Mrs O10 said that if the staff 'have to wake you to take your observations they say sorry'. S5 said:
‘Even if you can’t do what it is that they need at that moment in time, to say I’m really sorry, I can’t deal with that right now, I’ll have to deal with that later. And trying to make every effort to meet what the patient wants’. (S5)

Staff were observed apologising to patients when inconveniencing them or causing discomfort, for example, when removing a dressing stuck to a patient’s arm hairs, disturbing a patient to take blood or asking a patient to wait while they did something else more urgent.

The Trust’s Essence of Care ‘Privacy and dignity’ audit tool (Box 6.7) included the statement: ‘patients feel that they matter all of the time’. In concordance with this, S4 expressed that they aimed that:

‘The patient is made to feel they’re the most important thing and we’re focusing on them’. (S4)

Several patients commented that their dignity was promoted by staff who demonstrated concern about their welfare and as individuals. Mrs O11 said that she did not feel as though she was on a conveyor belt at all and in her view dignity was about staff ‘treating you as an important person’. She said that she had felt ‘positive vibes’ [from staff] and this ‘makes you feel better’ and ‘you recover better’. In some instances it was how staff talked to patients, rather than what was said, that indicated concern and understanding. For example, Mrs O12 said that the staff ‘seem to care’ and that she felt this by ‘the way they talk to you’. Mr O8 said of N14 that ‘she appears interested in me as an individual’. Mrs D10 said that she felt well looked after and treated as an individual, saying staff were:

‘always concerned about you. As much as they have twenty other odd patients but they did always enquire how you were’. (Mrs D10)

She had her birthday while she was on the ward and:

‘They were [said] ’Oh happy birthday!’ You know and they really did - they did care’. (Mrs D10)

Several staff stated that they promoted patients’ dignity by showing concern for them as individuals, for example: ‘asking him [Mr O5] how he feels’ (HCA3). HCA1 was observed greeting a patient the day after his operation by saying ‘You’re looking much better today’, which indicated concern for him. At the beginning of a shift, staff checked each of their allocated patients for any immediate needs and attended to these as necessary. The nurse in charge of each shift did a round of the patients talking to each individually and ensuring that they were all comfortable. Staff checked how patients were feeling while carrying out their care, for example when assisting patients to stand up for the first time following surgery.

There were many observed examples where staff showed concern about individual
patients. N4 had obviously been worried about Mrs O11 during her first post-operative night and said that she had spent most of the night with her (H11). She stayed on duty after the end of her shift until the pain team arrived to review Mrs O11 so that she could be reassured about Mrs O11’s condition (FN 7th July 2005). N2 was observed asking Mrs O11 how she was feeling in a quiet and gentle voice several times on her first post-operative morning (FN 7th July 2005). On the ward round the registrar was observed to come round to the side of Mrs O10’s bed, crouch down at her level, and put his hand over her hand to gently explain that what ever the result of the test she was awaiting, it was unlikely that they would be able to do anything for her and that he was sorry. Staff portrayed concern by listening, for example, with Mr O3, N3 listened to him expressing how difficult it was to sit about when he was used to being active and she agreed sympathetically. Overall, there were many examples related and observed of staff conveying concern for patients as individuals. These and other interactions such as helpfulness and courteousness led to patients feeling valued in the hospital environment.

6.3.3 Discussion: staff behaviour that promotes patient dignity

The study’s findings highlighted the central role of staff in promoting patient dignity but while staff particularly referred to provision of privacy to promote dignity, patients emphasised how therapeutic staff interactions promoted their dignity. The findings generally support previous research, although some of the literature about interactions does not explicitly make links to dignity, and this study’s findings provide greater insights.

As discussed in section 6.2, the physical environment is important as regards privacy but the findings confirm that staff behaviour is crucial too, supporting previous research about the importance of staff behaviour in relation to privacy (see 3.4). Most patients in this study felt that staff were attentive to their privacy, which was confirmed by observational data and supported previous research that has found good sensitivity to privacy by staff (Matiti and Sharman; 1999; Scott et al., 2003). As other studies indicated that staff frequently breached patients’ dignity (Turnock and Kelleher, 2001; Woogara, 2004) ward culture could be particularly important regarding staff provision of privacy. As 6.2.2 demonstrated, Heron ward had strong leadership and a generally dignity-promoting culture while Woogara (2004) reported a distinct lack of leadership and good role-modelling on the wards he studied, where standards of privacy were poor. Thus this study’s findings support a link between ward culture and individual staff behaviour. From an organisational level,
the Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7) had a strong focus on privacy with five of the seven benchmarks of practice specifically related to privacy, including personal space, modesty and confidentiality. However as discussed in 6.2.2, in reality the Essence of Care had a low profile on Heron ward and the unwritten ward culture was more influential.

While provision of privacy was important for patients’ dignity, the potential of therapeutic interactions to promote dignity was particularly strongly identified by patients. It was apparent, that provision of privacy was not enough to promote dignity from patients' perspectives; other staff actions such as demonstrating respect for individuals are also necessary, supporting previous research (Applegate and Morse, 1994; Matiti, 2002; Walsh and Kowanko, 2002). It is through such behaviour that attitudes are conveyed and previous studies have highlighted the importance of appropriate staff attitudes in relation to dignity (Bayer et al., 2005; Nåden and Eriksson, 2003). The Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7), however, focused on staff interactions in only two of the seven benchmarks which could indicate poor recognition at organisational level of the high impact that staff interactions have on patients' dignity. This study identified that for patients to feel that their dignity was promoted staff needed to use interactions which made them feel that they were comfortable, in control and valued. Each of these three categories of interactions is next considered.

In relation to patients feeling comfortable, several patients expressed that they needed to feel confident in the staff as professionals, which supports previous research (Holland et al., 1997; Lai and Levy, 2002; Matthews and Callister, 2004; Sundin et al., 2001; Widäng and Fridlund; 2003). On Heron ward, patients were in an acute situation and likely to experience stress and anxiety and, in some situations, an uncertain outcome. Lai and Levy's (2002) and Matthews and Callister's (2004) studies both related to women in labour which, though an apparently very different setting, also involves people who are in a stressful situation with some degree of uncertainty about the outcome. In such situations patients need to feel that the staff are competent and professional.

Humour was a specific interaction identified by both patients and staff as helping patients to feel comfortable. Chapter 3 (3.4) discussed research indicating that staff use of humour in their interactions with patients is beneficial but staff use of humour has only been explicitly linked with promoting dignity in two studies in terminal care (Dean, 2003;
McClement et al., 2004). However, in Chapter 5 (5.2.1), some participants indicated a link between embarrassment and loss of dignity and several studies have identified staff using humour to reduce embarrassment (Maxwell, 2000; Seed, 1995; Skogstad, 2000; Walsh and Kowanko, 2002), which could promote dignity in such situations. As already discussed, an acute hospital setting like Heron ward can be stressful and staff use of humour has been used to reduce stress (Bennett et al., 2003; Sumners, 1990) and help patients to relax (Sundin et al., 2001). The latter seemed particularly apparent on Heron ward, use of humour leading to a relaxed atmosphere even when pressure on staff was great. Patients considered that staff humour made them feel relaxed and happy. Use of humour also lightened potentially serious conversation, for example two examples were observed relating to the return of bowel sounds following abdominal surgery, which is a crucial sign of recovery. Two staff explicitly referred to the need to be sensitive when using humour, also emphasised by Olsson et al. (2002). No patients ever commented on staff using humour inappropriately on Heron ward.

Reassurance and friendliness in staff interactions were major findings, identified by over half the patients as promoting their dignity but few staff who, though frequently observed to use such interactions, apparently did not associate such interactions with promoting dignity. The Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7) did not include any statements which related to friendliness and reassurance so at Trust level, the potential of such interactions to promote dignity was unacknowledged. References to reassurance and friendliness, as ways in which staff can promote dignity, were identified in only a few studies, one with older people (Jacelon, 2002) and the other in maternity care (Matthews and Callister, 2004). However, Heron ward patients from all age groups and both genders identified reassurance and friendliness from staff as important. It appears that friendliness and reassurance, as strategies to promote patients' dignity, have been little recognised.

Interactions that made patients feel in control included explanations and information giving, offering choices, gaining consent and promoting independence, although some of these interactions were more often identified than others. The findings thus support Matiti's (2002) work in a similar setting, from which she proposed that control impacts on all other aspects of dignity. The Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7) includes just one reference to staff interactions that relate to control: ascertaining personal choices is referred to in Factor 2, indicating that links between control and dignity are
barely recognised at management level. In this study staff were more likely to cite information giving and explanations as promoting dignity than patients but for some patients, it was very important for their dignity to understand what was happening. There were no apparent age or gender differences affecting patients' views. Several other studies from varying settings have identified that giving explanations and information promote dignity (Bayer et al., 2005; Enes, 2003; Holland et al., 1997; Jacelon, 2002; Lai and Levy, 2002; Matti, 2002; Söderberg et al., 1999). In addition, information is essential in order for patients to make choices and give their consent, which are also linked with patients feeling in control.

As presented in Chapter 3, there are many previous studies suggesting that facilitating choice, for example in decision making, promotes dignity (Doutrich et al., 2001; Gamlin, 1998; Kabel and Roberts, 2003; McClement et al., 2004; Matthews and Callister, 2004; Nåden and Eriksson, 2003; Perry, 2005; Randers and Mattiasson, 2004; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003; Woolhead et al., 2005). However, this was not a strong theme emerging from this research, referred to by a relatively small number of patients and slightly more staff. Many of the previous studies have related to more long-term care situations, such as terminal care and care of older people. In an acute surgical environment, the hospital routines that negate choice, such as mealtimes, seem widely accepted by patients. In addition, choice about surgically related care, for example when to remove bladder irrigation, is influenced by patients' physical progress and many patients accept HCPs' decisions about these aspects of their care. For one patient, who was terminally ill, retaining control through choice being facilitated was crucial for her dignity, thus supporting research in terminal care which emphasises choice (McClement et al., 2004). Her examples of where choice was offered, and thus her dignity promoted, illuminated the positive impact that offering minor choices can have on dignity. This patient was physically quite incapacitated but exercising decisional autonomy (Collopy, 1988) was important to her dignity. Staff were often observed offering patients simple choices, for example, about when and where to carry out their hygiene, and the significance of such choices, when so little choice is available, should not be under-estimated. Two patients commented positively about being able to choose their type of anaesthesia, which was obviously a more major choice, requiring them to be well informed.

Gaining consent prior to procedures, identified as important for dignity by a few participants, was observed to be strongly adhered to by staff on Heron ward. The 'Dignity
in Older Europeans' study (Tadd, 2004a, 2004c) highlighted the importance of consent in relation to dignity but a previous study with older people in long-term care found poor levels of consent by staff prior to procedures (Scott et al., 2003). These studies indicated that older people are particularly concerned about consent being gained prior to procedures and vulnerable to this not occurring. However, although eleven of the twenty-four patient participants were over 65 years old, no patient gave any example of where consent was not gained nor was this observed. This might have related to the ward culture but visiting staff, such as phlebotomists, were also observed to pay close attention to consent. As independence gives patients more control over their activities it was surprising that encouraging independence was rarely identified as an interaction that promoted dignity, although it was frequently observed. Several previous studies have associated independence with dignity (Clegg, 2003; Hack et al., 2004; Matiti, 2002; Walsh and Kowanko, 2002; Woolhead et al., 2005). For this study's participants, however, it seems that other staff interactions were more closely associated with dignity. For example, interactions that made patients feel valued were a particularly strong theme and are discussed next.

In this study over half the patients but much fewer staff identified that interactions that made patients feel valued promoted their dignity. The Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7) included a benchmark specifically focused on this aspect: 'Patients feel that they matter all of the time'. Thus there was Trust recognition that if patients feel valued their dignity is promoted. There is a further benchmark relating to patients' individuality. However, as previously discussed, Essence of Care had a low profile on Heron ward. This study found that staff being helpful, considerate and courteous, and conveying that they were concerned for patients as individuals, promoted dignity. Previous research has indicated that feeling valued is important for patients' dignity (Chochinov et al., 2002; Jacelon, 2002; Matiti, 2002) and similar interactions, such as courteousness, helpfulness and consideration were identified in these studies. Heron ward staff and the senior nurses interviewed were most likely to cite concern for individuals as promoting dignity; few identified helpfulness, consideration and courteousness. Such interactions were frequently observed by Heron ward staff so it appeared that staff underestimated the value of such interactions in relation to dignity, being much more likely to identify the provision of privacy as how dignity was promoted.

Courteousness includes treating patients with respect and was identified as being
important for promoting dignity by over half the patients in the study but much fewer staff. The findings support previous research findings identifying that treating patients with respect promotes dignity (see 3.4). Form of address, in relation to dignity, emerged as a minor finding being rarely identified by patients and only one staff member but previous research has found some strong feelings expressed about use of first names and endearments being disrespectful (DH, 2006b; HAS 2000, 1998; Matiti, 2002; Woolhead et al., 2005; Woogara, 2004). The Trust's Essence of Care Privacy and Dignity audit tool (Box 6.7) included a criterion that staff should ask how patients wished to be addressed. It appeared that on Heron ward, patients considered that other interactions such as helpfulness and consideration were more important for their dignity than how they were addressed. Tone of voice and accompanying non-verbal communication may be as important as what form of address is used. One patient in this study indicated that this was the case by saying that he did not mind what he was called as long as staff were polite. On Heron ward, staff invariably smiled, made eye contact and used niceties like 'Good morning' when addressing patients.

Chapter 3 (3.4) identified that staff providing quality care, for example, good pain relief, nutrition and hygiene, was considered to promote patients' dignity in some research studies and health policy documents. In this study, references to such aspects of care in relation to dignity were only found when associated with the accompanying staff approach, for example helpfulness with hygiene and elimination, and meals being served in a respectful way. The provision of care relating to aspects like hygiene and nutrition had a high priority on Heron ward and perhaps both staff and patients, being content with the care provision, focused on other perspectives of dignity. Provision of quality care to promote dignity is particularly likely to be associated with terminal care and care of older people but none of the older patient participants associated dignity with quality care. Many patients on Heron ward had cancer but were at the acute stage of their treatment, undergoing surgery, and most had an optimistic prognosis. One patient was terminally ill but her main concern about her dignity was retaining control. It may be that Heron ward patients and staff viewed quality care as being about comfort rather than dignity. In a study of comfort in older people's care, Tutton and Seers (2004) found that staff emphasised quality, fundamental care (such as attending to hygiene). While comfort and dignity appear to be linked, psychological comfort seems to be more associated with dignity than physical comfort. DH documents which relate dignity to quality care may be using the term 'dignity' to equate with quality in the ambiguous way which has been criticised by a number of
writers (see 2.2). Alternatively, perhaps the DH associates provision of good quality physical care with dignity as being about respect and individuality. However, this study's findings indicate many other types of staff interactions which were strongly associated with promotion of dignity and so perhaps these should be more prominent in DH documents.

To conclude this section, staff behaviour clearly has a central role in promoting patients' dignity and the research findings support previous research about the provision of privacy and therapeutic interactions to promote dignity. Much of the previous research, however, has been in very different settings and while some studies indicate the benefits of staff behaviour to patients' experiences of care, explicit links to dignity have not always been made. The underpinning attitude of staff appears to be crucial for behaviour that promotes dignity. It was also evident that staff and, from an organisational level, the Trust, overwhelmingly associated provision of privacy with promoting dignity but are much less likely to recognise the role of therapeutic interactions.

Whilst the hospital environment and staff behaviour have an important impact on promoting dignity, patient factors also have a role. The next section presents findings relating to these patient factors.

6.4 Patient factors

Many patients referred to their own role in promoting their dignity in hospital, particularly their attitudes towards their hospital stay and procedures but also by developing relationships with staff and being physically able. These factors were confirmed during participant observation but were rarely mentioned by staff in relation to promoting dignity. It should be noted, however, that patients who were very unwell and dependent would be much less able to promote their dignity actively, rendering them yet more vulnerable, and thus the staff behaviour discussed in 6.3 is even more critical.

6.4.1 Attitude

Two thirds of the patients expressed that their attitude towards potentially undignifying situations assisted them either in promoting their dignity or in accepting a loss of dignity, thus feeling more comfortable. The crucial factor was the patient's frame of mind about their situation. Patients particularly described using rationalisation, but adaptation and
humour were also referred to. Adopting these attitudes helped patients to feel more comfortable about situations which could have threatened their dignity. In addition, patients brought into hospital with them their pride as a person with life experiences and achievements. A few patients described an attitude of acceptance towards what they considered to be an inevitable loss of dignity in hospital which, while not actually promoting their dignity, helped them to cope with it.

Many patients described rationalisation about situations that threatened their dignity. For example, patients rationalised that seeing patients' unclothed bodies was part of HCPs' jobs and was necessary due to the care and treatment they needed (see Box 6.20).

**Box 6.20 Patients' rationalisation about bodily exposure in front of staff**

'The doctors and nurses are there to do a job - if they've got to see you without any clothes on, then they've got to see you without any clothes on. There's nothing you can do because obviously you're in hospital to get better'. (Mr D7)

'Encroaching on the body's modesty when undergoing treatment is a necessity … it's just part of their [medical/nursing staff] job'. (Mr O5)

'Once you've had children you can cope with most medical procedures - like having things done by nurses and doctors as they're medical people'. (Mrs O11)

'Everyone's [nurses] in uniform - they're here to do a job'. (Mr O7)

'The staff are all professionals, they've seen it all before. They understand what you're going through. And they just get on with the job. The fact that they're handling a man's penis - it doesn't matter to them. It's just a piece of the body. You know [laughs]. And therefore it doesn't matter to me either'. (Mr D2)

Viewing staff as 'professionals' helped patients to accept both bodily exposure and intimate procedures being carried out, rationalising that staff have 'done it' or 'seen it' many times before. Patients' knowledge that other patients around them were going through similar things helped them to cope with these situations too (see 6.2.3).

Rationalisation about intimate procedures such as having a catheter and being washed also occurred. Mr O3 stated that it was not easy to keep his dignity while carrying a catheter bag around but that 'there's nothing else that can be done about this'. Mr D6 accepted the presence of a young female student nurse being present while his catheter was removed saying:

'Alright, I suppose I could have turned round and said 'I don't really want her there'.
But … poor girl's got to learn somewhere - so she might as well practise on me as…. [laughter] You know, we've all seen it all before'. (Mr D6)

Mr O2 stated, of being washed by staff:

'There's nothing else I can do - unless it would take ten times longer. I'm not embarrassed by it'. (Mr O2)

Mr D4 gave several examples of experiencing intimate procedures and bodily exposure (see Box 21) and in each of these instances, he rationalised their necessity.

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**Box 21: Mr D4: Rationalization about intimate procedures and bodily exposure**

**Insertion of catheter:**

'When I went into the A&E and a lovely young staff nurse put in a catheter I didn't lose my dignity over that, I didn't, because I was being taken care of medically in a sense that I knew had to happen'.

**Having a transurethral prostatectomy under epidural anaesthetic:**

'I wasn't embarrassed - there were half a dozen people there - all doing their job for my benefit. That's what I've gone there for. You see. And I'm totally in their hands - but I'm happy with that - because that's what it's about'.

**Catheter blockage:**

'You go in to wash and then find you're dripping blood on the floor and down the outside of the catheter. So you've got to call somebody and you haven't got any clothes on [laugh] …So, it's slightly embarrassing but I was sort of accepting that because - you know - this is the situation I'm in'.

On one other occasion, however, a staff member intruded during his bladder washout (see Box 5.18) and because her presence was unnecessary (he believed her to be a member of support staff who had entered the curtains to chat to the nurse) he felt he lost his dignity. Thus in his view there was a clear difference between necessary bodily exposure (not accompanied by loss of dignity) and unnecessary bodily exposure, which caused a loss of dignity as it could not be rationalised. Emphasising how adopting a positive attitude promoted his dignity, Mr D6 commented 'it's [dignity] how you approach it'. He made extensive comments about this, for example:

'If you're positive and - you know you go in - you know things are going to happen that you don't really want to happen but it's got to be'. (Mr D6)

Some of Mr D6's comments related specifically to intimate care procedures encountered in hospital. Several patients described rationalising environmental aspects which they considered threatened their dignity. Mrs D8 would have preferred not to be in a bay with other patients but she rationalised that a single room was not an option. Mrs D11 accepted being in a mixed sex bay saying that although she was initially perturbed, she needed to go into hospital and this was the only bed available.
Adaptation was described by a few participants, for example, Mr D4 described adapting to the strangeness of the hospital environment. HCA3, one of the only staff who referred to patients’ attitudes in relation to dignity, also referred to patients adapting to the hospital environment, particularly if they were in hospital for some time. S4 described that patients who regularly attended clinic adapted to the potential indignity of waiting in their dressing gowns together.

Some patients used humour to deal with being in hospital and the procedures that had to be endured. In Mr D6’s view, keeping a sense of humour and being cheerful were essential for promoting his dignity. He described how he and another patient became ‘pally’ and they:

‘wondered round the ward just having a good laugh and a joke with everybody’. (Mr D6)

Mr O1 was observed to use humour when his bladder irrigation was being removed and his catheter spigoted - an intimate procedure that involved bodily exposure (see Box 6.22); his humour seemed to make him more comfortable with the situation.

Box 6.22 Patient’s use of humour during an intimate care procedure

'Mr O1 said jokingly ‘be careful with that [meaning his penis] - I’ve only got one - though it’s rather lost its purpose now!’ N1 said ‘Oh don't worry I'll be careful of the crown jewels'. She disconnected the irrigation and put a spigot into the catheter tube to block it off. Mr O1 joked that the spigot looked like a golf tee and then commented about it being near the balls as well'.

(FN 22nd April, 2006)

As discussed in Chapter 5, 5.3.1.1.2, nightshirts and catheter bags potentially caused a loss of dignity to patients. On one occasion a patient was observed to say to the other patients in his bay that he had heard that there had been some ‘nice pink nightshirts’ delivered and that these would ‘go well with their handbags’

His comment caused merriment among the patients and is another example of the humour patients used to deal with threats to dignity.

Bodily exposure (perceived as a threat to dignity by most patients and all staff) was of no

\[\text{Patients sometimes referred to catheter bags on stands as 'handbags' as they were carried about.}\]
concern to some patients and therefore no loss of dignity accompanied it from their perspective. However staff did feel uncomfortable (particularly as there were women on the ward) and strived to prevent bodily exposure (see N5’s and S1’s comments, Box 6.23). Mr D7 and Mr O8 both expressed in their interviews that they did not perceive bodily exposure as a threat to their dignity (see Box 6.23).

<table>
<thead>
<tr>
<th>Box 6.23 Patients’ unconcern about bodily exposure</th>
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<tr>
<td>‘Some patients don’t worry about being exposed’. (N5)</td>
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<tr>
<td>‘We often comment on some of these men ‘Oh look at that man sitting over there’ and they’re showing everything they’ve got. And you have to remind them sometimes. Not - if they don’t care, other people might’. (S1)</td>
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<tr>
<td>‘The younger people are quite happy to - if something needs to be done - they’re sort of quite happy to wander around with just a gown on or whatever’. (Mr D7)</td>
</tr>
<tr>
<td>‘I’m lucky - in my family a body is a body - my daughter’s the same - we’re all fine about being nude’. (Mr O8)</td>
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Mr D7 was in his 30s and he felt that being younger, he was less concerned about bodily exposure than older people, because of how they had been brought up. Mr O8’s attitude to his body being exposed was perceived by N14 who said that although she was conscious of maintaining Mr O8’s dignity while washing him, ‘he seems a very relaxed, liberal person’.

S6 expressed that older people’s previous life experience and achievements can provide them with an inner sense of worth which they bring into hospital with them, helping them to maintain an attitude of having value:

‘You've had a good life, you've served your country, or you've raised lots of children and grandchildren, or you've been married for sixty years, or you didn't retire till you were seventy, these are all very positive things which preserve people’s dignity and of course particularly if they've had a tremendous health record as well’. (S6)

She talked of older people telling their stories of their lives with pride but acknowledged that this was more likely to happen in wards where patients had longer stays. However, some examples were observed in Heron ward, for example Mr O5 talked extensively about his previous career in overseas development, and several staff commented on his ‘interesting’ life. Many patients, given the opportunity, would talk to staff about their lives outside hospital, thus promoting themselves as a valued individual with past achievements rather than solely a ‘patient’.
Some patients referred to acceptance in relation to dignity and loss of dignity. Mr O6, who was the oldest patient taking part in the study (in his 90s) considered that age impacted on attitude towards dignity, with older age leading to acceptance:

‘When you get to my age you don't look at it [dignity] in the same respect as you would when you were forty years younger. You're not worried about your dignity so much, you just take things as a matter of course - you don't look at things as dignifying or undignifying - you're more accepting’. (Mr O6)

His view contrasted with those of other participants who considered older age increased vulnerability to loss of dignity (see Chapter 5, 5.3.3.2). A few patients referred to acceptance as a means of coping with a loss of dignity and it could be considered that patients who had adopted an attitude of acceptance had become disempowered by the environment. Nevertheless, acceptance helped patients to feel more comfortable about situations over which they had no control and could not change, such as having to be dependent on staff for personal care (Mrs O4) and having to have a urinary catheter (Mr D2) (see Box 6.24).

**Box 6.24 Acceptance of loss of dignity**

‘You have to accept that you're going to lose some dignity. You can't maintain your normal appearance and dignity when you're being treated like that. Especially in a urology ward’. (Mr D2)

‘In some ways I suppose I've lost my dignity but I've accepted it’. (Mrs O4)

Mr D2 said that his acceptance (see Box 6.24) led to a removal of worry about his dignity saying: ’it didn't worry me in the slightest' and:

‘To sum up I didn't feel a loss of dignity was at all important to me’. (Mr D2)

Mr D2 asserted that there was nothing more that staff could do to promote his dignity as a loss of dignity was inevitable: 'I honestly don't see what else they could have done'. Mrs O4 used the term ‘accept’ on a number of occasions in relation to the loss of dignity which she considered resulted from undergoing intimate care in hospital. She expressed that having a catheter was a good thing in hospital: 'It is a loss of dignity’ but she had 'accepted it'. She added: 'I've accepted a lot of things'. In relation to having her 'bottom wiped’ she said that she felt that there was nothing nurses could do to promote her dignity in that situation but 'I know they've got to do it’. As both Mr D2 and Mrs O4 expressed that staff could not promote dignity in such situations, acceptance was all that could be aimed for and having achieved acceptance, both Mrs O4 and Mr D2 seemed comfortable.
Developing relationships with staff was another strategy patients used to promote their dignity.

6.4.2 Relationships with staff

Some patients described building and maintaining relationships with staff and in some instances, patients made conscious decisions not to complain about incidents to prevent jeopardising these relationships. Six patients (five men and one woman) explicitly referred to developing good relationships with staff to promote their dignity and patients were often observed taking the initiative to build relationships. Attaining good relationships with staff increased their social support, helped patients to feel more comfortable in the hospital environment and would also, they reasoned, have a positive impact on how staff related to them, implying reciprocity. Mr D2 expressed that in hospital, dignity was about:

'Being able to cooperate with the nursing staff in the best way possible'. (Mr D2)

His comment indicated that he saw achieving a cooperative relationship with staff was important for his dignity. Mr D7 felt particularly strongly about approach to staff being central to promoting his dignity (see Box 6.25).

Box 6.25 Approach to staff

'I know it's obviously hard in hospital or whatever because obviously you are in pain, and you are suffering, but I mean, it doesn't cost much to be nice to people. Especially if you're in a strange place, with strange people that you don't know, they're there to help you, they're there to make you better, you're there because you want to get better, So - you being nice, and you treating them with the respect and dignity they deserve, cos they're a trained professional, I suppose it's as you would like to be treated for any job that you do'. (Mr D7)

When Mr D7 was asked whether he had encountered any situations that had threatened his dignity his reply was illuminating:

'No, I never let myself get into that position. You know, be nice from the start'. (Mr D7)

His response implied that it was his responsibility to promote his dignity, or perhaps that for him, dignity was about treating other people respectfully and by doing so, he promoted his own dignity. He considered that his upbringing was the reason for his approach: ‘always taught to be polite to strangers’. He expressed several times how important it was to get on with staff and be respectful towards them so that they would reciprocate in turn:
'If you don't set off on the right foot, and treat them with respect or whatever then, they're not going to do the same to you'. (Mr D7)
Mr D7 himself had got on well with the staff but his comments indicated his perception of the power balance between staff and patients. Developing relationships with staff increased his control over the situation too.

Mr D6 also put a lot of effort into developing relationships with staff, a key strategy being use of humour:

'Providing you can have a laugh with them [staff] and they can respond back and you can have a good laugh and a good joke it sort of makes it go away, if you know what I mean, you know you don't think about it'. (Mr D6)

He described how one nurse had come to work with a poor attitude 'basically she didn't want to be on the ward' and how he and another patient worked to improve her approach:

'We did make her laugh in the end but it was hard work! It was seriously hard work!' (Mr D6)

His description implied a collaborative approach to the situation with two patients working together to improve the nurse's attitude and build a relationship with her. Mr D6 was philosophical about the behaviour of the nurse saying:

'You're always going to get one somewhere along the line that's maybe a little miserable, or something like that, they've got out of bed the wrong way'. (Mr D6)

The staff appeared to appreciate Mr D6's approach with one nurse apparently saying to him:

'It's lovely to have a ward full of cheerful people - occasionally we get a ward full of miseries and one, it makes the day go longer, and two it's not nice'. (Mr D6)

Her comment seemed to confirm Mr D6's view (and that of Mr D7) that patients had a responsibility to be cheerful and get on with staff. However, it is questionable whether this can be an expectation of patient behaviour, particularly when people are unwell and under stress.

Patients were observed using humour with staff on a number of occasions. For example, Mr O5 was concerned about his swollen scrotum and asked the doctor to examine it on the ward round. The doctor reassured Mr O5 that his swollen scrotum was very common following his type of surgery and Mr O5 joked: 'So I'm not unique anymore then?' Mr O6 was also observed using humour in his interactions which were reciprocated by staff (see Box 6.26).
Mr O1 made a particular point of using humour in his dealings with staff and stated that he tried to create a 'flippant joking atmosphere'. He said that he used humour with staff so that the nurses did not feel that he was 'some awful old tyrant' indicating his desire to be liked by staff. Mr O1 was observed joking with various staff during the morning and as N1 who was looking after him used a lot of humour in her interactions, (see Box 6.12), he was very happy with her care. When he was reviewed by the registrar on the ward round, Mr O1 made a point of thanking him and said 'we had fun down there [in theatre] didn't we' and they shook hands.

Mr D9 (in his 60s) considered that younger people had more insight into staff workload and were therefore more considerate to staff:

'I was aware that the younger people were far, far more resilient and understanding and saying, “Christ look at these poor nurses”.' (Mr D9)

He stated that he tried to be considerate to staff saying 'I never once used that [call] bell'. Although he witnessed a member of staff being 'curt' to another patient (see Box 5.15), he tried to empathise with the staff member who had been on duty all night and was under a great deal of pressure in the morning. His view was that 'there's always two sides to every story' and that although this staff member's approach was 'a tad offensive' at that moment 'reflecting back on it I could see where she was coming from'. Thus some patients actively endeavoured to make allowances for staff even if their behaviour was clearly unacceptable. Mr D3 also conveyed empathy with staff stating that it was difficult for them to promote dignity because of the 'people they have to deal with in hospital'.

Several patients expressed choosing not to complain about incidents which had made
them feel uncomfortable so as not to jeopardise their relationships with staff. Their stance highlighted the vulnerability of patients and perceived power of staff. Mr D9 related how a receptionist was rude to his wife when he arrived at the ward for admission and his wife wanted to complain but Mr D9 had said to her: ‘Leave it - I don't want to make waves’. Several comments from other patients highlighted the importance they attached to getting on with the staff. Mr D4 gave two examples of where staff approach caused him concern but on both occasions he chose to do nothing about it to preserve his relationships with staff (see Box 6.27).

Box 6.27 Choosing not to complain, to preserve relationships

In receipt of conflicting views about his care from staff:
‘I don’t like to go around stirring it up. So I’m always a bit hesitant to get hold of somebody else because I don’t agree with what this other person's done. You don’t like to override people - after all, I've got to stay there haven't I. And the other person’s going away - and I’m now stuck with this one!’ (Mr D4)

Following an upsetting incident:
‘I didn’t do anything about it. I didn’t want to upset anybody because I don’t want anybody taking it out on me. [Laughs] Not that they would but you know what I mean’ (Mr D4)

Patients appeared to be making deliberate choices not to complain, thus maintaining amicable relationships with staff. Mr O7 told the researcher that he was worried about his bladder irrigation running out as the theatre staff had told him that his irrigation must be continuous to prevent clot formation. However, earlier in the evening he had told a nurse that the bottle needed changing and she seemed ‘put-out and unconcerned’ (FN 17th June 2005). Now, with the night shift commencing, he was unsure whether he should tell staff if he saw that the bottle had run out or not and he asked the researcher to ask the staff what they wished him to do. He was evidently concerned about doing the right thing for his health but at the same time he did not want to endanger his relationship with staff.

There were many instances observed where patients made efforts to be friendly and sociable with staff. For example:

‘HCA2 entered the bay with a tea trolley. Mrs O4 greeted her by her first name. HCA2 said "Morning - how are you? You remembered my name then?" She asked Mrs O4 what she’d like to drink - they were exchanging pleasantries about the weather’. (FN, 31st May 2005)

At the start of Mrs O4's bedbath she told N6 and HCA2 how much she liked them and HCA2 reciprocated ‘I love you too darling’. It seemed that Mrs O4 felt it was important to
have a good relationship with staff who would be carrying out her intimate care.

Two patients found that they already knew staff on the ward and both commented positively about this in relation to their dignity as they felt it helped them in forming relationships; it meant that the staff were not all strangers which helped in an otherwise unfamiliar environment. Mr D7 knew several staff members from the village he lived in and Mrs D10 also knew one of the staff members (see comments, Box 6.28).

**Box 6.28 Knowing ward staff**

“So they sort of like knew me or knew of us and whatever so that made it a little bit easier. Just semi knowing a couple of nurses or whatever. "Oh he’s from XX[name of village]. We know him””. (Mr D7)

‘Knowing that someone you know is there, you think - oo - you know - it makes me feel a bit better…. I think it's nice having somebody there that you knew really'. (Mrs D10)

Patients' own ability and control were identified by a small number of participants as promoting dignity and are discussed in the next section.

### 6.4.3 Ability and control

Although patients with good functional ability were able to be more independent and in control of their situation in hospital only five patients identified that this helped to promote their dignity (see comments Box 6.29).

**Box 6.29 Good functional ability**

'I didn't sort of suffer with anything like that [loss of dignity] as such. I suppose it's because - I was sort of - perhaps - younger and fitter than a lot of chaps that were in there'. (Mr D6)

'I was mobile - I could get up walk about…They [staff] didn't have to do a lot of things to me - or at me or round me or… or in a sense that I didn't know quite what was going on'. (Mr D4)

‘Doing things for yourself helps you keep your dignity’. (Mr O7)

'I wasn't in an undignified situation to be frank with you. I was able to walk about, I wasn't sort of having to ring for help from nurses and things, there were no emergencies - I didn't start bleeding or whatever - heart or anything - so you know - at this particular stage, I would say - no - there wasn't a lot of indignity’. (Mrs D8)
Mr D6 expressed that fitness (which he associated with being younger) promoted dignity. Mr D4 and Mr O7 also identified that being able to do things for themselves promoted dignity. Mrs D8 commented that because the surgery on her bladder was through her urethra (rather than being open abdominal surgery) she was able to move about and did not need to use a bedpan, which was in her view the ‘saving grace’ (in relation to her maintaining her dignity). Her comment inferred that she was able to be quite independent in the ward and needed little assistance. Observation supported the comments by Mr D6 and Mrs D8 that fitter patients required less intimate procedures and had more control over their activities and thus fewer threats to dignity.

It was also observed that although Mrs O10’s functional ability was impaired by her advanced cancer, she was determined to continue doing things for herself, walking to the bathroom and independently bathing, even though it was very difficult for her, but she clearly saw this as important for her dignity. As discussed previously (6.3.2.2), she was also determined to keep control over other aspects of her care, for example, her medication.

Overall, many patients considered themselves to have a significant role in promoting their dignity in hospital, through their attitudes, relationships with staff and maintaining their functional ability. However, staff rarely recognised that patients were actively promoting their dignity through these strategies.

6.4.4 Discussion: patient factors promoting dignity

The role of patients in promoting their own dignity emerged strongly from the data, particularly interviews with patients, yet was little recognised by staff. Patients' attitudes (rationalization, adaptation, acceptance, humour) were particularly prominent, being used to cope with threats to dignity. The research supports previous work by Matiti's (2002) findings that patients admitted to hospital adjust their perception of their dignity and its maintenance, rationalizing about the need to be in hospital to get better and that any loss of dignity accompanying hospitalization was worthwhile. Similar attitudes were expressed by women undergoing vaginal examination in labour too (Lai and Levy, 2002). Rationalising that staff are professionals and that intimate care procedures involving bodily exposure are just part of their job was a commonly used way that patients rationalised
such procedures, supporting some previous studies (Bauer, 1994; Chochinov, 2002; Matiti, 2002; Schuster, 1976). In relation to staff behaviour, it is thus important that staff present a professional and confident approach, which was identified as helping patients feel comfortable (see 6.3.2.1). Two studies in acute care have reported that some patients were unconcerned about bodily exposure (Walsh and Kowanko, 2002; Woogara, 2004) and in this study a few patients had relaxed views about bodily exposure too. In an environment where, as discussed in Chapter 5 (5.3.1.1.2), bodily exposure is a constant threat, adopting an attitude of acceptance towards bodily exposure may be one way of coping. Similarly, Bauer's (1994) theory relating to privacy proposed that with a low need for privacy, there is no violation of privacy perceived and thus resulting well-being.

Two patients in particular were unable to make the perceptual adjustment needed as they considered their dignity was incompatible with having a urinary catheter in situ, or having personal care performed. These patients then adopted an attitude of acceptance, previously identified in relation to dignity in chronic and terminal disease (Campbell, 2005; Chochinov et al., 2004) and Woogara (2004) in relation to loss of privacy in acute care. Matiti (2002) too identified patients working through the loss of their dignity experiencing denial and anger and then acceptance with resignation, which Mrs O4's experience seemed to portray. By reaching a position of acceptance, patients appeared to feel comfortable but both talked extensively about staff behaviour which they considered important.

The use of humour was previously discussed as a strategy used by staff to relax patients (6.3.2.1) but patients too used humour to promote their dignity, possibly as a defence mechanism to reduce embarrassment (Matiti, 2002; Maxwell, 2000; Skogstad, 2000; Seed, 1995; Walsh and Kowanko, 2002) and anxiety (Olsson et al., 2002). One patient's example of how he used humour to improve a nurse's poor attitude illustrated how humour can be used to gain control too (Mahony et al., 2002). One other patient who particularly tried to keep control over her situation was terminally ill and Chochinov et al.'s (2004) model of dignity in terminally ill patients identifies retaining control as a patient factor promoting dignity. Matiti (2002) suggested that the perceptual adjustment patients make, for example their rationalisation about the procedures in hospital, is a way of exerting control over the situation. Patients in an acute hospital setting may have little means of exercising control but their own attitude is one way in which they can do so.
Another aspect of attitude is adopting a sense of self-worth (rather than it needing to be conveyed by others). However, only one senior member of staff in this study referred to patients' past achievements helping them to sustain their sense of worth although patients were observed to offer information about themselves and their lives. Thus previous findings about patients drawing on their past experiences to sustain their dignity (Chochinov et al., 2004; Jacelon, 2003) were only weakly supported in this study.

Developing relationships with the staff caring for them was identified as important for some patients in Heron ward but has rarely been acknowledged in previous research into dignity, the exception being Jacelon's (2004) study of older people's hospitalisation. Interestingly it was the youngest patient in this study (Mr D7, in his 30s) who particularly emphasised reciprocity in relationships with staff, indicating that Jacelon's (2004) findings may be applicable not just to older patients. A few patients in Heron ward, as in Jacelon's (2004) study, described trying not to bother staff but again, this was not necessarily older patients. Matiti (2002) also found that patients endeavoured to avoid breaching their relationships with staff. Social support has been identified as important for maintaining terminally ill patients' dignity which included their relationships with staff (Chochinov et al., 2004). In acute hospital settings patients have only limited contact with their family and friends so staff and other patients (6.2.3) become an important source of social support. In a care home setting, Applegate and Morse (1994) found that some residents actively tried to form relationships with staff and in the acute setting of Heron ward, some patients seemed to view relationships with staff as just as important.

In relation to ability, previous research indicated that loss of function threatens dignity (see 3.5) and this study's findings confirm this (5.3.3.1.1). Two previous studies in acute settings indicated that patients with greater functional ability can be more independent and exercise greater control (Jacelon, 2004; Matiti, 2004). Specifically Matiti (2002) identified that patients' embarrassment was reduced if they were more independent in personal care. While it was observed that Heron ward patients who had good functional ability could carry out their own personal care, only a few patients associated functional ability with independence. Similarly, as discussed in 6.3.2.2, staff promoting independence was rarely recognized as a way that dignity could be promoted.

In summary, many patients in Heron ward indicated that they played an active role in promoting their dignity particularly regarding their attitudes towards their situation but also
in developing relationships with staff. Patients with greater functional ability could better promote their own dignity as they had more control and were less exposed to situations that threatened dignity, but this factor was identified by only a few patients. While there is some theoretical support for these findings, much of the previous research has been conducted in different healthcare settings.

6.5 Chapter summary

This chapter has demonstrated that patients themselves, staff behaviour and the hospital environment can all either remove or reduce threats to patients' dignity and instead promote dignity. While some of the findings support previous research, often in different care settings, there are some areas that are mainly new knowledge.

Heron ward provided a fine example of a physical environment conducive to patient dignity, confirmed by nearly all the research participants’ comments and observation. While previous studies have highlighted the importance of an environment that provides privacy, other aspects of the environment that might promote dignity have been rarely identified or have been linked to patient satisfaction or well-being, rather than dignity. Some research studies have recognized features of the environment that threaten dignity (as discussed in 5.3.1) but features that promote dignity, other than privacy, have not been illuminated. The clean, new environment of Heron ward, which ward staff had been involved in designing, appeared pleasant for staff to work in and provided a good structure for patients' privacy to be promoted. Patients had bedside control over some aspects of the environment such as the television and because the bathroom was in each bay, many could be largely or completely independent for their hygiene and elimination at an early stage in their recovery.

However, just as important was the not so tangible ward culture, which clearly had a strong impact on staff behaviour. Again, few studies have previously identified how culture and leadership of a ward can promote patients’ dignity though a few studies have identified that a dehumanizing culture and lack of leadership threatens dignity and privacy (see 3.3). The challenge therefore for any ward is to engender a culture that not only promotes dignity but makes it unacceptable for individual staff to engage in behaviour that threatens dignity. Stability of staff, as there was on Heron ward, ensures that a dignity-promoting culture in the ward becomes established and permeates all staff actions. The importance
of a whole ward approach towards dignity was conveyed through patients’ recognition (confirmed by observation) of the role of support staff such as the ward volunteers and cleaner in promoting dignity, not just the HCPs. The role of non-professional staff is rarely mentioned in any healthcare literature in relation to promoting dignity but they can have a lot of patient contact in the course of their work. While written policies, both at DH, Trust and ward level, are important to support initiatives which promote dignity, on Heron ward it was the unwritten culture which seemed more influential though the ward philosophy appeared embedded.

The role of other patients in the environment provides new knowledge about how patients' dignity is promoted in hospital. Previous research findings have identified the negative impact of other patients, their effect on patients' privacy in the environment for example, and therefore patients' preferences for single rooms. However, patients on Heron ward gained valuable support from each other. This may have been in part because of the conducive physical environment of bays with their own bathrooms and reasonable sized bedspaces. Patients who were undergoing unpleasant and embarrassing procedures felt that they were with others who understood their situation and they also met each others' needs for social interaction. Other patients could help each other to feel cared about and reduce unfamiliarity. However as discussed in 5.3.1.2.1, bed management policies could jeopardise this situation, if resulting in frequent moves between wards. Staff rarely referred to the positive impact that patients can have on each other and it is probably unrecognised at a managerial level too.

The study's findings generally support previous research about how staff behaviour can promote patients' dignity (see 3.4) but there are some areas of new knowledge. The important role of staff provision of privacy - environmental and of the body - in promoting dignity was confirmed but in this study auditory privacy was associated with dignity by only a few participants. The relationship between dignity and privacy was discussed in 2.5 but this study indicates that provision of privacy, through the environmental structure and staff behaviour, contributes towards patients' dignity being promoted but is not in itself enough to promote dignity. Particularly from patients' perspectives, therapeutic interactions from staff were crucial for patients to feel comfortable, in control and valued. While patients all recognised the value of therapeutic interactions, these were less often identified by staff as being ways that they promoted dignity even though such behaviour was frequently displayed. This suggests that many staff have quite a narrow view of dignity as being
primarily about providing privacy but patient data emphasised the importance of staff interactions and their impact on how patients feel. While some interactions (for example courteousness) support previous research, other interactions such as staff use of humour, reassurance and friendliness, which help patients to feel comfortable, have been rarely linked with patient dignity. Overall this study's findings more explicitly identify the staff interactions which promote dignity than most other studies. Staff provision of quality care, though apparent in the ward, was not associated with dignity by this study's participants, as it has been in some previous research and in several health policy documents.

The active role that many patients articulated that they played in promoting their dignity while in hospital seems unrecognised in health policy documents and in most previous research with the exception of some more recent studies based in acute care settings. This study lends support to previous research concerning how patients adjust their perceptions of their dignity in hospital, are able to rationalise what is happening to them, adapt to the situation or adopt a stance of acceptance. These patients' attitudes increased their control over their situation but it must also be recognised that some patients may not be able to take on this active role in promoting their dignity and need additional support from staff. The study supports previous research findings that some patients use humour to reduce embarrassment, which helps them to take control. That patients actively work on developing relationships with staff has been rarely identified in relation to patient dignity but there was strong support for this strategy from a few patients, indicating another area of new knowledge. Patients being functionally independent appeared to promote their dignity as it increased their control over their personal care but this factor was only explicitly identified by a few participants and is little supported in previous research either.

To conclude, patients' dignity can be promoted through a conducive physical environment, a dignity promoting ward culture and leadership and patients with similar conditions being cared for together thus forming an informal support network. Staff behaviour which provides privacy and interactions which make patients feel comfortable, in control and valued are also central to promoting dignity and should be instilled in all staff and supported by the hospital environment and culture. Patients themselves actively participate in promoting their dignity, adopting attitudes which assist them in coping with threats to dignity, building relationships with staff and possessing good functional ability. These patient factors cannot necessarily be achieved, particularly where patients are seriously ill, and staff behaviour is then even more crucial. While some of these findings
support previous research, others constitute new knowledge.

Chapters 5 and 6 have presented the study's findings related to three themes: the meaning of patient dignity in hospital, threats to patients' dignity in hospital and how dignity can be promoted in hospital, thus addressing the aims identified in 1.5 and the specific research questions (3.6). In Chapter 7, a definition of patient dignity in hospital portrayed in a model, and a model portraying how patients’ dignity is threatened and promoted in hospital, are presented and the implications of the study's findings will be discussed.
Chapter 7 New models for understanding patients' dignity in an acute hospital setting, implications and conclusions

7.1 Introduction

This thesis started in Chapter 1 by establishing that dignity is important to patients in an acute hospital setting and that healthcare staff have a duty to promote patients' dignity. The literature review (Chapters 2 and 3) identified that the meaning of dignity is unclear and there is a limited body of knowledge concerning how patients' dignity is threatened in hospital and how dignity can be promoted. The theoretical framework (3.6) developed from the literature review proposed that patient factors, the environment and staff behaviour all impact on patients' dignity in hospital. Research questions were identified (3.6) and addressed by conducting a multi-method qualitative case study based in an acute hospital setting, detailed in Chapter 4. Chapters 5 and 6 presented the findings about the meaning of patient dignity and how it is threatened and promoted. These findings were discussed in relation to previous research, identifying areas where this research study reached new conclusions and highlighting where the findings support previous research, often in different settings.

In this chapter a new model and definition reflecting patients' conceptualisations of dignity in an acute hospital setting will be presented and discussed. The chapter will then examine the impact of the hospital environment, staff behaviour and patient factors on patients' dignity and the study's major contributions to knowledge are explained. A model portraying how patients' dignity can be threatened or promoted in hospital is then presented. The chapter will discuss the implications of the research findings for management, clinical practice and education. The strengths and limitations of the research will also be discussed and further research studies suggested. The chapter concludes by summarising the recommendations for policy, practice and education.
7.2 Patients' conceptualisation of dignity in an acute hospital setting

Figure 7.1 portrays patients' conceptualisation of dignity in an acute hospital setting which emerged from the study's findings.

![Figure 7.1 Patients' conceptualisation of dignity in an acute hospital setting](image)

The meaning of dignity shown in Figure 1.1 indicates that in an acute hospital setting how patients feel is a central feature associated with their dignity, which supports notions of dignity as an internal quality, previously identified (Jacelon, 2003). Dignity means feeling comfortable, in control and valued; some of these feelings are more prominent than others for different patients at different times. The meaning of dignity also relates to patients' physical presentation (their appearance and behaviour), and how they feel about this and the behaviour of other people in the environment (staff and other patients). The important role of patients' own behaviour and that of others in this model reflects notions of behavioural dignity (Jacelon et al., 2004). Patients' behaviour towards others affects their own feelings (such as self-respect) and influences how others behave towards them.
Drawing from patients' views about the meaning of dignity, the following succinct definition (portrayed in Figure 1) was developed:

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

This definition was developed from patient data so that patients' interpretations of dignity in hospital remain central to the thesis. However, staff interpretations of dignity also clearly supported this view. The main difference was that staff views often emphasised physical presentation and behaviour and did not always acknowledge the centrality of patients' feelings in relation to dignity. This definition of dignity aimed to be accessible and relevant to patients and staff working in a hospital setting. As will be discussed later, it clearly links to how dignity is threatened or promoted in hospital.

Definitions and models of dignity were included in some concept analyses (see 2.3) and a few of the primary research studies (see 2.4) in Chapter 2. These are, for convenience of the discussion here, presented in Box 7.1; Chochinov et al.'s (2002a) model is not included as it specified that it relates to terminally ill patients. This study's definition starts with the patient 'feeling valued', which reflects Haddock's (1996) view that dignity is 'feeling important and valued' but Haddock (1996) continues that there must be the ability to 'communicate this to others’. Surely what is important is that the patient feels valued; not all patients may be able to communicate this feeling. Several other definitions included 'valued' or 'values' in their definitions but with different connotations: people being valued by others (Fenton and Mitchell, 2002) or being worthy of value (Enes, 2003). Matiti (2002) however associates values with patients' expectations according to their 'perceptual adjustment level'. This study's definition continues that patients should feel 'comfortable psychologically with one’s physical presentation and behaviour, level of control over the situation, and the behaviour of other people in the environment'. Mairis (1994) includes a similar statement, that dignity entails feeling 'comfortable with his or her physical and psychosocial status quo' and Fenton and Mitchell (2002) refer to 'physical, emotional and spiritual comfort’. Enes' (2003) model's category 'maintaining the individual self' includes appearance and body image. Nordenfelt's (2002a) model includes the category of moral stature, which being 'respect for oneself as a moral person' could relate to psychological comfort, and the model's component of 'personal identity' includes physical identity. Thus several authors have also recognised a physical dimension to dignity.
Box 7.1 Definitions and models of dignity (from Chapter 2)

1. ‘Dignity may be said to exist when an individual is capable of exerting control or choice over his or her behaviour, surroundings and the way in which he or she is treated by others. He or she should be capable of understanding information and making decisions. He or she should feel comfortable with his or her physical and psychosocial status quo’. (Mairis, 1994, p.952)

2. ‘Dignity is the ability to feel important and valuable in relation to others, communicate this to others, and be treated as such by others, in contexts which are viewed as threatening. Dignity is a dynamic subjective belief but also has a shared meaning among humanity.’ (Haddock, 1996, p.930)

3. ‘Dignity is a state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated. Dignity is promoted when individuals are enabled to do their best within their capabilities, exercise control, make choices and feel involved in the decision-making that underpins their care’. (Fenton and Mitchell, 2002, p. 21)

4. Four concepts in the model of dignity: menschenwürde (dignity that all humans have), merit (due to position in society or earned through achievements), moral stature (respect for oneself as a moral person), and personal identity (includes integrity, physical identity, autonomy and inclusion). (Nordenfelt, 2003a; Nordenfelt, 2003b).

5. Relationship and belonging: being heard and understood, giving and receiving love, self- and other-perception, being included, feelings. Having control: over decisions, body, behaviour and what is happening. Being human: being worthy of respect, worth, value and esteem, having rights. Maintaining the individual self: independence, individuality, space and privacy, having needs met, appearance and body image, role/position, maintaining normal life, freedom to be. (Enes, 2003, p.264)

6. ‘Dignity is an inherent characteristic of being human, it can be felt as an attribute of the self and is made manifest through behaviour that demonstrates respect for self and others’. (Jacelon et al., 2004, p.81)

7. ‘Patient dignity is the fulfilment of patients’ expectations in terms of values within each patient’s perceptual adjustment level, taking into account the hospital environment’. (Matiti, 2002)

Few definitions or models of dignity refer to patients feeling comfortable with their behaviour, with Jacelon et al.’s (2004) definition being the closest, stating that dignity is ‘made manifest through behaviour that demonstrates respect for self and others’. This study’s definition includes control, but that patients feel comfortable with their ‘level of control over the situation’. Several other definitions include control and/or autonomy (Enes, 2003; Fenton and Mitchell, 2002; Mairis, 1994; Nordenfelt, 2002a) but they emphasise ability, capability and independence. However, in an acute hospital setting, some patients...
have very limited control so the important issue is that patients are comfortable with the level of control they have at that time. Finally the definition refers to patients being comfortable with the 'behaviour of other people in the environment'. Only Haddock (1996) includes a similar statement: patients being treated by others as though they are important and valued. Thus the role of other people in the environment is little recognised but Matiti’s (2002) definition does include the impact of the hospital environment.

In summary, the definition of dignity developed in this thesis supports and builds on findings which emerged in previous concept analyses of dignity and the few primary research studies which offered definitions or models of dignity. This definition is fully grounded in the experiences of adult patients in the acute hospital setting, and while patients’ perceptions held central place in its development, it is supported by the views of experienced staff working in the setting and the observations conducted. As such, the definition offers a new conceptualisation of patient dignity in acute hospital settings, in particular the central place of feelings and how physical presentation and behaviour inter-relate.

The hospital environment, staff behaviour and patient factors all have potential to threaten and promote patients’ dignity in hospital. The main findings related to each of these areas are next discussed.

7.3 The hospital environment and patient dignity

The research findings indicated that the key components of the hospital environment are the physical environment (including other patients), the ward culture and hospital systems. Each of these is next discussed illuminating how the environment can threaten or promote patients’ dignity in hospital.

The physical environment has an important impact on how patients feel in hospital (6.2.1). This thesis provides a much more detailed account of the contribution the environment makes to promotion of patients’ dignity than was formerly available. Previous references to the environment have mainly concerned environmental privacy in hospital (Gallagher and Seedhouse, 2000; Woogara, 2004; Woolhead et al., 2005). To promote dignity, the physical environment should be clean and either new, or well maintained and updated, with adequate facilities such as bed linen; these aspects help patients to feel both valued
and comfortable. There should be mechanisms for patients to control aspects of their environment such as lighting, telephone and television. The provision of a good physical environment for patients' dignity is largely a hospital managerial responsibility but staff actually working in the environment should be involved in monitoring the quality of the physical environment.

The environment should provide privacy, which affects how comfortable patients feel. While patients have individual views about an optimal environment for privacy, for most patients a small bay which offers interaction with same sex patients with similar conditions, good size bedspaces, well-fitting bed curtains and their own bathroom in the bay provides a sound physical structure for privacy and thus dignity (6.2.1). For most patients, other patients offer important social support helping patients to feel comfortable and valued (6.2.3). Patients are better able to adjust to aspects of their physical presentation, which threaten their dignity, when they are in an environment with patients with similar conditions also undergoing intimate procedures. An old study of patients' privacy in hospital (Schuster, 1976) refers to this effect as a 'levelling', with patients accepting their comparable lack of privacy because they were all in the same position. Both Schuster's (1976) and Bauer's (1994) research into patients' privacy, identified that patient-patient relationships in hospital are important. With the exception of work relating to the dignity of terminally ill patients (Chochinov et al., 2004) few other recent studies have recognised the positive effect of other patients in the environment on patients' dignity.

In an acute hospital ward bodily exposure is an ever-present threat to patients' dignity over which patients have little control and suffer varying degrees of discomfort about (5.3.1.1.2). Bodily exposure occurs because patients are not dressed in the normal day clothes which people usually wear in public and their medical conditions lead to tubes attached to personal areas of their body and their body products displayed. The lack of mobility due to existing health problems or caused by surgery and various attached tubes affect patients' ability to move around and adjust their clothing. Even pulling curtains round the bed or putting on a dressing gown unaided is impossible for many patients so patients have a lack of control over their physical presentation and environmental privacy. Patients feel most uncomfortable about privacy levels, and particularly their physical presentation, when they are in a MSE because of the high risk of bodily exposure due to patients not being fully clothed (5.3.1.1.3).
Hospital systems require patients to wear operation gowns when undergoing surgery and this attire promotes bodily exposure which threatens patients' dignity (Matiti and Sharman, 1999; Matiti, 2002; Walsh and Kowanko, 2002; Woogara, 2004). Design of operation gowns should be reconsidered; it must be possible to reduce the accompanying bodily exposure and some hospitals are beginning to address this issue. Most patients adjust their usual feelings about bodily exposure in the hospital environment (see 7.5, Patient factors) and feel comfortable with bodily exposure in front of staff during essential treatment and care and more minor bodily exposure in front of patients of the same sex in their bay. However, patients feel uncomfortable and suffer a loss of dignity if unnecessary bodily exposure occurs and if bodily exposure occurs in front of patients of the opposite sex, or visitors. Hospital managers who enforce mixed sex bays to increase throughput should be made aware of why these threaten patients' dignity and that risk of bodily exposure is the central issue and makes patients feel uncomfortable.

The culture of the environment relates to the collective ethos of the staff and accepted working practices and a few studies have identified ward culture as affecting patient dignity (Gallagher and Seedhouse, 2000; HAS 2000, 1998). This thesis presents much stronger evidence than previously available about how ward culture can promote patients' dignity (6.2.2). Having a permanent team of staff with a dignity-promoting culture and strong ward leadership is crucial for setting and maintaining the standard of dignity in the ward. Although there will always be some staff turnover and use of temporary staff, a core team of permanent staff helps to develop a team commitment to a dignity-promoting culture and individual staff behaviour is affected by the pervading ward culture. Trust leadership and managerial support for promoting dignity is important and written documents should reinforce that patient dignity is a high priority. However, the unwritten ward culture is more influential in ensuring high standards of dignity in relation to both the environment and individual staff behaviour. NHS targets which have patient throughput as the highest priority detract from patients' dignity being promoted which is why written Trust documents need to overtly support the dignity-promoting ward culture.

### 7.4 Staff behaviour and patient dignity

Staff behaviour during individual interactions with patients, plays a crucial role in promoting dignity. Previous research into patient dignity has also associated staff interactions with patients' dignity (Ariño-Basco et al., 2005; Enes, 2003; Gallagher and Seedhouse, 2000;
Staff interactions have the potential to help patients to feel comfortable, in control and valued (6.3.2). Patients feel comfortable if staff appear professional and inspire patients' confidence, make them feel relaxed through use of humour, and are friendly and reassuring. Patients feel in control when staff are informative and give explanations, offer and respect choices and ensure consent is gained. Patients feel valued when staff are courteous towards them, show concern for them as individuals, and are helpful and considerate. Patients feel uncomfortable and unvalued when staff are curt or ignore them (5.3.2.1). When staff take an authoritarian approach, patients feel out of control and not valued (5.3.2.2). In this study, most staff, most of the time used therapeutic interactions and were observed to do so even when under great pressure with a high workload. Individual staff behaviour which promoted dignity was supported by the ward culture and leadership with dignity-promoting interactions role-modelled by the ward manager (6.2.2). However, even within this ward culture, some patients gave examples of staff interactions which threatened their dignity or, they perceived, the dignity of other patients. Constant vigilance of staff is needed, to monitor their own and others' interactions. Staff need to be self-aware and ask themselves: how do my interactions make patients feel? Do my interactions help patients feel comfortable, in control and valued? Patients gave rich examples where the phrasing of a staff communication was crucial to how they felt, for example staff asking rather than telling.

Staff also have a key role in providing privacy for patients, as environmental structure for privacy must be complemented by behavioural aspects (6.3.1). The thesis confirmed the importance of provision of privacy for promoting dignity which has been previously identified (Gallagher and Seedhouse, 2000; Matiti, 2002; Tadd, 2004a; Turnock and Kelleher, 2001; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). Staff attention to details like ensuring curtains are pulled completely, not intruding in curtains without warning patients, and keeping patients' bodies covered as much as possible during procedures involving bodily exposure, are all important. Maintaining the privacy of patients' bodies was referred to by one nurse as 'body dignity' and another as 'practical dignity'. These nurses seemed to be acknowledging that dignity relating to the body was only one aspect as their interactions with patients also influenced patients' dignity. Ensuring privacy
of the body helped patients to feel comfortable about their physical presentation and as patients often had limited control over preserving privacy of their body, staff attention to this on their behalf was appreciated. There was high staff awareness of their actions that provided privacy, which many of them identified as the main or only way they promoted dignity, not recognising that their interactions were equally or even more important. Greater privacy can be attained in a bathroom with a lockable door than behind curtains and on Heron ward, there was great commitment to getting patients to the bathroom to carry out their hygiene and elimination needs if at all possible.

7.5 Patient factors and dignity

Patient factors, in particular physical health conditions, can render patients vulnerable to a loss of dignity in hospital as they can lead to patients feeling uncomfortable and out of control (5.3.3). Conversely, patients who are less unwell and more physically able, are better able to maintain their dignity as they have greater control over their activities and require less intimate care (6.4.3). However, many hospitalized patients have a combination of a worrying medical condition with a related varying degree of uncertainty, impaired mobility and loss of function leading to assistance being required with personal care, and intimate procedures. Other research studies have also highlighted how illness and associated loss of function can threaten dignity (Chochinov et al., 2002a; Enes, 2003; Matiti, 2002). These factors may relate to any hospital patient but for patients with urological conditions, intimate care procedures and bodily exposure are even more likely. For some patients, these factors alone can, in their view, guarantee a loss of dignity, even without the hospital environment and staff behaviour, although these latter factors can certainly compound the situation. Yet for many patients these factors did not lead to a loss of dignity because of their attitude; the role of patients’ attitudes in promoting their own dignity was a major finding in this research emerging from patient data but rarely referred to by staff. As it was an important factor, it must be highlighted that not all patients had the physical or mental capacity to use these strategies, which to some extent compensate for the threats to dignity posed by the hospital environment, staff behaviour and their own condition; such patients may need increased support from staff.

Like patients in Matiti's (2002) study, patients adjusted their attitudes to their situation (6.4.1). In particular, patients used high degrees of rationalisation about what was happening to them, including that there was nothing else that could be done. Other
common rationalisations were that the situation was necessary to improve their health and, particularly in relation to bodily exposure and intimate procedures, that staff are professionals who deal with such situations every day. While these patient attitudes arose from the patients themselves and could be innate defence mechanisms, staff interactions could reinforce these attitudes, for example through behaving in a professional manner that inspired patients' confidence. Patients could better rationalise these situations when they could see that they were commonplace in the ward, again reinforcing the value of being with other patients with similar conditions. Some patients exerted their own control over such situations by using humour and it was then important to them that staff responded in turn. For a small number of patients, the only way of dealing with their situation was by adopting an attitude of acceptance but having done so, they appeared to feel comfortable. In a sense, the decision to accept a loss of dignity brought a certain level of control which seemed to reduce the impact of the loss of dignity.

The value of social support has already been discussed in relation to other patients in the environment. Some patients also emphasised relationships with staff (6.4.2) which may be due to their need for social support and to reduce the unfamiliarity in hospital. It may also have arisen from the hope that if they treated staff well, staff would reciprocate, helping patients to feel more comfortable and valued. Developing relationships with staff was another way that patients could gain some control in the hospital environment but this strategy also indicated the perceived power imbalance between patients and staff. Previous research has rarely referred to how patients promote their dignity through developing relationships with staff, Jacelon's (2004) study being an exception.

Health policy (1.4) has emphasised that older people are vulnerable to a loss of dignity and there was some evidence that physical and psycho-social factors may lead to their increased vulnerability (5.3.3.2). However, much more relevant were patients' particular physical conditions and certainly some younger people, at specific points of their hospital stay, were highly vulnerable. While there is much literature about a pervading negative attitude towards older people in healthcare, this was not apparent in this study. Perhaps, the ward culture is the crucial element here. A ward with a dignity-promoting culture is likely to promote the dignity of patients across the full age range.
To summarise, the hospital environment, staff behaviour and patient factors can threaten or promote patients’ dignity in a number of ways and these are portrayed in a model in the next section.

7.6 A model of how patients’ dignity is promoted or threatened in hospital

A model is now presented (Figure 7.2) to portray how patient factors, staff behaviour and the hospital environment can promote or threaten patients' dignity.

Figure 7.2 How patients' dignity is promoted or threatened in hospital

The upper half of the model portrays why patients are vulnerable to loss of dignity in
hospital. Patients' impaired health results in loss of function and the need for assistance with personal care, intimate procedures, and fear and anxiety. Although impaired health is the major patient factor, older age may increase risk of a loss of dignity. Patients' vulnerability to a loss of dignity can be further compounded by staff behaviour (curtness, authoritarianism or breach of privacy) and the hospital environment (hospital systems and a lack of privacy). The lower half of the model identifies how patient factors (attitude, relationships with staff, and ability and control), the hospital environment (conducive physical environment and a dignity-promoting culture and leadership) and staff behaviour (providing privacy and therapeutic interactions) can promote dignity. The patient takes centre place in the model, surrounded by the environment and staff behaviour which can threaten their dignity or promote dignity. Patients' impaired health and older age (if applicable), are 'given' factors which render patients vulnerable to loss of dignity but may not inevitably lead to a loss of dignity. The dignity promoting factors of staff behaviour, the hospital environment and patient factors may counteract the threat to dignity posed by these patient factors. However staff behaviour and/or the hospital environment may instead increase the likelihood of dignity being lost.

7.7 Implications of the research findings for management, clinical practice and education

The research findings have implications for management, clinical practice and education, and each of these will be considered.

From a managerial perspective, the DH (2004) 'Standards for Better Health' (see 1.4) identified a requirement for hospitals to provide environments and systems that enable privacy and dignity in hospitals, but details were not included so there is potential for varied interpretations. These research findings indicated that to promote dignity in an acute hospital setting requires fundamental structural environmental aspects such as adequate size of bedspaces, small bays and accessible bathrooms, and sufficient day-to-day resources, including ward cleanliness and well-fitting curtains. From a human resource dimension, wards need an adequate and stable workforce with dignity promoting leadership and a whole ward culture and commitment to patient dignity. Bed management systems should endeavour to ensure single sex environments (as per the DH, 2005a, guidance), minimal transfers, and that patients with similar conditions share their environment thus promoting social support and mutual understanding. Staff and
management should recognise the value patients place on developing relationships between themselves and with staff, even when their stay in hospital is short. Hospitals should establish systems for staff to report patient dignity issues and for these to be addressed, thus empowering clinically-based staff. Some hospitals have used Essence of Care benchmarking in order to enhance the environment and address hospital-wide concerns (Denner, 2004). Hospital managers should ensure that all staff with patient contact (including non-clinical staff such as receptionists) are educated about patient dignity (see later, regarding educational recommendations) and there should be written policies regarding patient dignity that apply to all staff, to ensure that there is a hospital-wide standard. The DH (2006c) ten-point Dignity challenge (see 1.4) could provide a framework for a written policy but as the guidance is very general (being aimed at all health and social care services), more specific guidance relating to these research findings should be included. There should be a clear policy about what staff should do if they observe patients' dignity being threatened; issues might relate to managerial aspects (e.g. lack of resources, excessive patient transfers) as well as individual staff behaviour. As regards the dissemination of these research findings, a presentation to the Trust management meeting is planned and it is intended to submit a paper to a health service management journal.

The study's implications for clinical practice relate to staff working directly with patients. Staff can make a vital contribution to whether patients' dignity is promoted in an acute hospital setting. All staff have an individual responsibility to behave towards each patient in a way that promotes dignity during each and every interaction. Staff must understand that their behaviour is highly significant in relation to patients' dignity and the impact of curt or authoritarian behaviour on patients' feelings. They must adopt behaviour that makes patients feel comfortable, in control, and valued. Patients in the study did not expect lengthy conversations but merely courteous, friendly and helpful behaviour. Staff should also be educated about how patients themselves play an active role in promoting their dignity and should recognise that many patients rationalise threats to their dignity and use defence mechanisms such as humour in such situations. Patients who are unable to use such internal resources need greater support to reduce their feelings of discomfort and a loss of dignity.

Staff should provide privacy within the environment, by closing curtains fully, not intruding without warning and invitation, minimising bodily exposure and promoting auditory privacy.
Bodily exposure which is uncomfortable to patients should be avoided which will require challenging practices such as traditional hospital gowns and searching for other creative solutions with management support. Staff should be aware of situations where there are heightened threats to dignity (e.g. intimate care) and actively seek to promote dignity but they must also be aware that promoting dignity must be integral every time they interact with patients. Staff should be alert to threats to patients' dignity caused by the environment or other staff and address them, using systems established by management. The research findings and their implications have already been disseminated verbally to the case study ward staff and in a written report to the Trust and the ward's consultants. The research findings relating specifically to patients with urological conditions are being published in an international urological nursing journal, thus disseminating the findings to nurses working in this speciality (Baillie, 2007). The findings are being presented verbally to a Trust ward managers' meeting and it is intended to publish a paper in one of the journals aimed at ward based nurses focusing on how nurses can promote patients' dignity.

As referred to earlier, there are implications for education for all hospital staff. Education programmes should be reviewed to ensure that patient dignity is both explicit and integral in pre-registration and post-registration education for HCPs. All new staff inductions and all pre-registration programmes for HCPs should include dignity awareness workshops. Initially, staff need to gain an understanding of the nature of patient dignity, why patients are vulnerable to a loss of dignity in hospital and the impact of staff behaviour on patients' dignity. Education should be active, with staff rehearsing interactions which promote dignity and how they can provide privacy, in simulated care situations. Active learning promotes deep learning which can be applied more readily in practice (Biggs, 1999). Staff should also be educated about how patients promote their own dignity while considering how patients' conditions might make them particularly vulnerable to a loss of dignity. Patient involvement in these workshops may increase their impact, perhaps through the PALS.

Special consideration as to how patients' dignity can be promoted during intimate and personal care and examinations should be included in clinical staff education. However, promotion of dignity during all other care and procedures should also be addressed, for example administration of medicines, admission or discharge of patients, assistance with nutrition and so on. Staff must also be educated about the legal and professional responsibilities to promote patients' dignity (see 1.4) and managing ethical dilemmas; use
of critical incidents and reflective practice could help staff learn from their experiences (Johns, 1994). Education should also address how staff can ensure that they and their colleagues promote patients' dignity, emphasising the importance of role modelling good practice to junior staff (RCN, 2005b). Staff also need to learn how to manage situations where they observe practice that threatens patients' dignity. It is intended to present the research findings locally, discussing their implications for education, and disseminate them more widely through publications proposing how staff education needs regarding patient dignity can be addressed at both pre and post-registration level.

7.8 Strengths and limitations of the research and recommendations for further research

A major strength of the research was that it was conducted in the real world of an acute hospital setting and used multiple sources of data collection achieving data triangulation. Patient participants were actually in hospital at the time or had recently been discharged from hospital and so they could respond from their current experience rather than hypothesising about how they might feel about their dignity if they were in hospital. Ward staff participants were directly and currently involved in acute patient care and so their responses were closely related to their actual practice rather than idealistic views. Using participant observation enabled direct involvement in acute hospital care and situations where dignity could be threatened. Patients' and staff views about observed events and their relationship to dignity were ascertained using follow-up interviews, rather than making assumptions about how the events observed related to dignity, which other observational studies have done (Gallagher and Seedhouse, 2000; HAS 2000, 1998; Turnock and Kelleher, 2001). A further strength was that due to the lack of strong evidence about what constitutes dignity in hospital and how it is threatened and promoted, data collection took an unstructured approach, so participants' views held centre place. Interviews with senior ward and Trust nurses provided valuable data, particularly in relation to culture and leadership and written policies.

Participant observation rather than non-participant observation enabled closer involvement in patient care and thus richer data were collected. It seems likely that this enabled the researcher to be better integrated into the ward environment leading to more natural behaviour by staff and patients. Nevertheless, participants, particularly staff, might have changed their behaviour when the researcher was observing, for example paying more
attention to dignity (according to their interpretation of its meaning) than they do usually. Data from interviews with patients following discharge, when they should have felt able to be entirely honest about their experiences, enabled monitoring of whether there were differences between observed practice and practice described at interview. Conversely, there was a risk that interviewees may have provided answers which they believed were desirable or that their views may have changed since discharge. However, the observational data and in-patient interviews enabled any such contrasts to be identified. There was in fact close consistency between the findings derived from the different data sources.

Apart from the possible problems relating to the research methods adopted, the main limitations of the study are its size. The study involved only one NHS Trust, and specifically one ward's staff and patients, although three of the senior nurses had Trust wide roles. The ward specialised in urology and with more resources, additional wards with different specialities might have been included, which could illuminate other factors affecting patient dignity. Ideally, a multiple case study design would have been used with other acute Trusts involved. In particular, a case study in a city teaching hospital, with a more multi-cultural population, would be valuable, providing a contrast with the rural, DGH studied here, and use of interpreters could be built into the study design for patients who do not speak English. However multiple case study designs require extensive resources and are often beyond the resources of a single researcher (Yin, 2003), but these are ideas for future research. The data collection sources focused on patients and staff but relatives' views might have provided a different perspective and could also be included in future research.

As well as further case studies in different settings, there are other implications for further research too. An action research study of patient dignity would be valuable as it would enable a study of how practice might be changed and incorporate further study of dignity-promoting cultures. To gain a wider view of the factors which the research findings identified were important for dignity, a survey could be conducted, asking patients their perceptions of whether their dignity was obtained and asking them to rate the importance of the factors identified in this research study. Following patients through their hospitalisation, gaining insight into the nature of their rationalisation and adjustment to the threats to their dignity was conducted with a small sample of older people (Jacelon, 2003) but would give valuable insights if replicated with a sample of younger adults. Finally, the
impact of other patients has been little studied to date and further study of this dimension, and how ward staff can capitalise on this potential benefit, should be considered.

7.9 Summary of recommendations

The recommendations resulting from this thesis relate to how patients' dignity can be promoted in hospital and are aimed at policy, practice and education.

7.9.1 Summary of recommendations for policy

While government policies to promote patient dignity are important, their local application must be addressed by each hospital. Therefore both government and individual hospitals must develop and implement policies to ensure that the physical environment and resources provide a structure for patients' dignity to be promoted. The message portrayed should be that promoting patients' dignity is everybody's business. Hospitals should provide a physical care environment that is conducive to patients' dignity: one that is clean, enables privacy and has adequate resources. Hospital systems should prevent unnecessary bodily exposure and thus the expectation of patients to be undressed and wear hospital attire that exposes them must be reviewed. There should be policies in place to guide staff in dealing with situations where patients' dignity is at risk. Wards should be resourced by an adequate and stable team of staff with experienced and strong leadership, who are committed to patient dignity. The promotion of patients' dignity should be a written expectation in job descriptions of all staff working with patients, and staff in leadership positions. Bed management policies should maintain single sex environments for patients, minimise moves between wards and enable patients with similar conditions to be grouped together, thus promoting social support and enabling patients to feel more comfortable.

7.9.2 Summary of recommendations for practice

All staff working in practice must take individual responsibility for promoting patients' dignity. Staff should provide privacy for patients and use interactions that make patients feel comfortable, in control and valued, as these promote patients' dignity. Experienced staff should role model behaviour that promotes dignity to more junior staff, offering guidance as necessary. All staff should reflect on their own behaviour with patients and
take action if they consider a patient's dignity is at risk due to the environment or staff behaviour. Staff must recognise patients' vulnerability to their dignity being threatened in hospital and be extra vigilant in situations where a loss of dignity is more likely, for example intimate procedures and when patients are unable to take steps to promote their own dignity.

7.9.3 Summary of recommendations for education

All staff working with patients should be educated about patient dignity. This should entail initial education for all new healthcare staff (in staff inductions and pre-registration education) about the importance of dignity for patients, the meaning of dignity to patients in hospital and how dignity is threatened or promoted. All pre-registration and post-registration healthcare professional programmes should be reviewed to ensure that students have initial and subsequent education about patient dignity. There should be particular emphasis on the role of staff behaviour in relation to patient dignity. Education should be interactive, involving simulated care scenarios, to aid retention and application to practice. Education should include awareness of situations where patients are particularly vulnerable to a loss of dignity, while emphasising that promotion of dignity should occur throughout clinical practice and every interaction with patients. Staff should also be educated about the ways in which patients themselves promote their dignity and the importance of social support from other patients. For more experienced staff, education relating to patients' dignity should include legal and professional responsibilities to promote patients' dignity, and managing ethical dilemmas. Education should emphasise the importance of role modelling dignity-promoting practice to junior staff and responding appropriately to situations where patients' dignity is at risk.

The recommendations summarised above are listed in Box 7.2.
Box 7.2 Summary of recommendations for policy, practice and education

Policy

- Policies should be developed and implemented to ensure that the physical environment and resources provide a structure to promote patients' dignity.
- Hospitals should provide a conducive physical care environment that is clean, enables privacy (including well-fitting curtains, adequate bedspaces, small bays, accessible bathrooms) and has adequate resources (including linen).
- Patients' bodily exposure in hospital should be minimised and thus systems requiring patients to be undressed and wear hospital gowns which expose them, must be reviewed.
- There should be policies to guide staff in dealing with situations where patients’ dignity is at risk.
- Wards should be resourced by an adequate and stable team of staff with experienced and strong leadership.
- The promotion of patients' dignity should be a written expectation in job descriptions of all staff working with patients, and staff in leadership positions.
- Education about patient dignity should be mandatory for all staff working with patients.
- Bed management policies should maintain single sex environments for patients, minimise moves between wards and group patients with similar conditions together.

Practice

- All practice staff should behave towards patients in a way that promotes dignity during each and every interaction.
- Staff must provide privacy within the environment, by closing curtains fully, not intruding without warning and invitation, minimising bodily exposure and promoting auditory privacy.
- Staff should use interactions that make patients feel comfortable (humour, reassurance, friendliness and professionalism); in control (explanations and information giving, offering choices, gaining consent and promoting independence) and valued (helpfulness, consideration, showing concern for
patients as individuals and courteousness).

- Staff should not use interactions that are curt or authoritarian nor breach patients’ privacy.
- Experienced staff should role model behaviour that promotes dignity to more junior staff.
- Staff should take appropriate action if they consider a patient's dignity is at risk due to the environment or staff behaviour.
- Staff should be extra vigilant in situations where a loss of dignity is more likely (e.g. during intimate procedures and when patients are unable to take steps to promote their own dignity).

**Education**

- All staff working with patients should be educated about patient dignity.
- All pre-registration and post-registration healthcare professional programmes should be reviewed to ensure that students have initial and subsequent education about patient dignity.
- All new healthcare staff should be educated, in staff inductions and pre-registration education programmes, about the importance of dignity for patients, the meaning of dignity to patients in hospital and how dignity is threatened and promoted.
- The role of staff behaviour should be emphasised in education about patient dignity.
- Education should be interactive, involving simulated care scenarios.
- Education should include awareness of situations where patients are particularly vulnerable to a loss of dignity, while emphasising that promotion of dignity should occur throughout clinical practice and every interaction with patients.
- Staff should be educated about how patients themselves promote their dignity and the importance of social support from other patients.
- More experienced staff should be educated about legal and professional responsibilities to promote patients' dignity, managing ethical dilemmas, the importance of role modelling dignity-promoting practice to junior staff and responding appropriately to situations where patients' dignity is at risk.
7.10 Conclusion

To conclude, this thesis started by establishing that patient dignity is important and that all HCPs, but specifically nurses, have a duty to promote patients' dignity in hospital. It was found that there was a lack of clarity about what dignity means from patients' perspectives and a practical definition, grounded in patients' experiences, has been provided, with an illustrative model. The factors that threaten and promote patients' dignity, relating to the hospital environment, staff behaviour and patient factors, have been identified and incorporated into a model representing all these dimensions and their relationships. While the thesis illuminated how patients' dignity can be promoted in an acute hospital setting, it also demonstrated that many patients use their own internal resources to adapt to the threats to dignity they encounter in hospital. Implications of the research findings for management, clinical practice, education and further research have been discussed. It is important that the hospital environment provides the physical and managerial structure for promoting patient dignity but each individual staff member must promote dignity in their behaviour with patients and be aware of the impact they can have on vulnerable patients' dignity during each and every encounter.
Glossary of acronyms

A&E: Accident and Emergency
COREC: Central Office for Research Ethics Committees
DGH: District General Hospital
DH: Department of Health
DN: Director of Nursing
HCA: health care assistant
HCP: health care professional
HRA: Human Rights Act
HNPD Head Nurse for Practice Development
ICN: International Council of Nurses
ITU: Intensive Therapy Unit
LREC: Local Research Ethics Committee
MSE: Mixed sex environment
NMC: Nursing and Midwifery Council
NSF: National Service Framework
PALS: Patient Advice and Liaison Service
RCN: Royal College of Nursing
RN: Registered nurse
R&D: Research and Development
USA: United States of America
UK: United Kingdom
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Appendix 1 Literature search process

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was the main database used for literature searching as it provides access to virtually all nursing and allied health journals published in English since 1983. The British Nursing Index (which includes nursing literature from 1994) was also used but searches rarely identified additional papers. Literature searching commenced in 2001 but has been repeated regularly over the development of the thesis as many more relevant papers have been published due to the growing interest in patient dignity, and as other relevant concepts were identified during the course of the research.

Searching initially commenced with combining the keyword 'dignity' with 'hospital' and 'acute care' but as few papers were found, the search became much broader, using only the keyword 'dignity' thus ensuring no papers of relevance were missed. On each occasion the search results were then scrutinized, examining the title and where available the abstract for relevance, which was defined as papers that considered:

- the meaning of dignity with reference to healthcare
- how patients’ dignity in hospital is promoted
- how patients’ dignity is threatened in hospital
- the importance of dignity to patients
- the role of healthcare professionals/nurses in relation to patients' dignity.

The term dignity is applied broadly throughout healthcare so papers excluded included those debating issues such as end-of-life decisions (voluntary euthanasia). Papers based in certain specialised healthcare settings (e.g. mental health, learning disability) were also excluded as they were too far removed from the focus of the thesis. However, papers relating to dignity in terminal/palliative care were included as such care is often conducted in acute hospital wards. Studies focusing on older people were included but only if the studies were of potential relevance to acute care (rather than solely care home focused). As the thesis progressed further searches were conducted relating to areas which had been found to be linked to patient dignity (either from the literature reviewing or the research conducted), including the hospital/care environment, mixed sex environments, ward culture, nurse-patient communication/relationships, privacy, control/power, comfort and respect. Papers and texts then accessed were examined for their links to patient dignity.
Primary research papers specifically were accessed by using the keyword 'dignity' and selecting 'research' from the CINAHL 'limit' option. Concept analyses of dignity in healthcare literature were initially identified by combining the term 'concept' and 'concept analysis' with 'dignity' but then 'dignity' and 'concept' to ensure none were missed. Other papers were of variable quality and usefulness to the thesis and were included in the review depending on the quality of their debate and relevance to acute care. There were a number of scholarly papers which argued about the meaning of dignity from a philosophical or ethical perspective and these were included in the review if they were applicable to healthcare. The reference lists of useful papers of all types were examined and often led to further papers/texts being identified.

The National Research Register (NRR) was also searched for studies which were registered with Research and Development Offices in the UK, either completed or in progress, using the keyword 'dignity'. Again this search was repeated during the thesis development as new studies became registered. Due to the broad application of the term 'dignity', the majority of studies listed were not relevant as they did not relate to the aims of the thesis or were based in a very different setting (e.g. mental health). However, accessing the register led to early access to unpublished material from two relevant studies which have now completed. Of the studies still in progress (as at January 2007), one further study's results will be relevant to this thesis ('Promoting the privacy and dignity of older people in hospital and home': lead G. Byrne) but results are currently unavailable from the NNR website.
### Appendix 2 Timeline for the thesis development

<table>
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<tr>
<th>Date</th>
<th>Work conducted</th>
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<tr>
<td>July 2003-August 2004</td>
<td>Initial literature review and development of theoretical framework. N.B. Literature reviewing continued throughout the thesis development</td>
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<tr>
<td>September 2004-</td>
<td>Research protocol development, COREC form completion and gaining access to the research setting</td>
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<td>Trust R&amp;D Department registration</td>
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<td>Preparation of research ward and gaining staff consent</td>
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<tr>
<td>March-April 2005</td>
<td>Piloting and review of research methods</td>
</tr>
<tr>
<td>May 2005</td>
<td>Post-discharge interviews</td>
</tr>
<tr>
<td>June-July 2005</td>
<td>Final post-discharge interviews</td>
</tr>
<tr>
<td></td>
<td>Participant observation: staff handovers, patient care, in-patient interviews, ward staff interviews, patient care records examination</td>
</tr>
<tr>
<td></td>
<td>Examination of ward-based Trust documents</td>
</tr>
<tr>
<td>August-September 2005</td>
<td>Initial data analysis</td>
</tr>
<tr>
<td>October 2005-January</td>
<td>Senior nurse interviews</td>
</tr>
<tr>
<td>2006</td>
<td>Examination of Trust documents</td>
</tr>
<tr>
<td></td>
<td>Data analysis continued</td>
</tr>
<tr>
<td></td>
<td>Thesis writing</td>
</tr>
<tr>
<td>February 2006-February</td>
<td>Data analysis and interpretation continued</td>
</tr>
<tr>
<td>2007</td>
<td>Thesis preparation</td>
</tr>
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</table>
Appendix 3 Letter from Local Research Ethics Committee giving approval for the study

Local Research Ethics Committee

15 February 2005

Mrs Lesley Baillie
Principal lecturer
London South Bank University
Faculty of Health and Social Care
103 Borough Road
London
SE1 0AA

Dear Mrs Baillie

Full title of study: A case study of patient dignity in an acute hospital setting
REC reference number: 04/Q1607/62
Protocol number:

Thank you for your letter of 5 February, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Version</th>
<th>Dated:</th>
<th>Date Received:</th>
</tr>
</thead>
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<tr>
<td>Application</td>
<td>1</td>
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<td>14/12/2004</td>
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<tr>
<td>Investigator CV</td>
<td></td>
<td>09/12/2004</td>
<td>14/12/2004</td>
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<tr>
<td>Protocol</td>
<td>1</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
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<td>Protocol Letter to ward's medical</td>
<td>1</td>
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<td>14/12/2004</td>
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## Appendix 3 (continued)

<table>
<thead>
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<th>Document Description</th>
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<th>Date Closed</th>
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<tr>
<td>Covering Letter</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Interview topic guide for senior nursing staff</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Supervisor CV</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Summary of Research</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Letter to ward staff inviting participation in study</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Staff information sheet: observation/follow-up interviews</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Researcher's behaviour during observation episodes</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
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<td>Letter to healthcare professionals visiting the ward</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
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<td>Consent form for observation and follow-up interviews (staff)</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
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<td>Selection criteria for post discharge interviews</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Patient information sheet: interviews with patients after discharge from hospital</td>
<td>04/02/2005</td>
<td>08/02/2005</td>
</tr>
<tr>
<td>Patient contact details for interview following discharge</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Patient consent form to be interviewed following discharge</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Post-discharge patient interview topic guide</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
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<td>Inclusion/exclusion criteria for selection of patients for observation/follow-up interviews in the</td>
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<td>14/12/2004</td>
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<tr>
<td>Patient information sheet (in-patient observation and follow-up interview)</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>In-patient consent form (observation, follow-up interview and examination of in-patient record of care)</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Observation guide</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
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<tr>
<td>In-patient topic interview topic guide</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Staff post-observation interview topic guide</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Letter to senior nursing</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
</tbody>
</table>
Appendix 3 (continued)

<table>
<thead>
<tr>
<th>staff inviting participation in study</th>
<th>1</th>
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<th>14/12/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff information sheet (senior nursing staff interviews)</td>
<td>1</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
<tr>
<td>Consent form to be interviewed (senior nursing staff)</td>
<td>1</td>
<td>09/12/2004</td>
<td>14/12/2004</td>
</tr>
</tbody>
</table>

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q1607/62 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

Chairman LREC

Enclosures

List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Site approval form (SF1)

An advisory committee to Strategic Health Authority

289
Appendix 3 (continued)

List of names and professions of members who were present at the meeting and those who submitted written comments:

- Consultant Haematologist (Chairman)
  - Lay
  - General Practitioner
  - Lay
- Pharmacist
  - Research Nurse (Deputy Member)
- Lay
  - Consultant Anaesthetist
  - Consultant Clinical Neuropsychologist
- Consultant Haematologist
### Appendix 3 (continued)

**LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION**

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

<table>
<thead>
<tr>
<th>REC reference number:</th>
<th>Issue number:</th>
<th>Date of issue:</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/Q1607/62</td>
<td>1</td>
<td>15 February 2005</td>
</tr>
</tbody>
</table>

**Chief Investigator:** Mrs Lesley Baillie

**Full title of study:** A case study of patient dignity in an acute hospital setting

This study was given a favourable ethical opinion by the local Research Ethics Committee on 11 February 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.
### Appendix 3 (continued)

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Site application N/A</td>
<td>Single Site application N/A</td>
<td>The urology ward (in the surgical directorate) has agreed to take part in principle.</td>
<td>Research Ethics Committee</td>
<td>15/02/2005</td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Chair on behalf of the REC:

[Signature of Administrator]

[Signature of Administrator] (Name)

---

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant developments. The site should be recorded.

SIF 1 Site approval form, version 2, September 2004

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292
Appendix 4 Letter from Research and Development Office confirming registration of research with the Trust

Mrs Lesley Baillie  
Principal Lecturer  
Allied Health Professions, Faculty of Health & Social Care  
London South Bank University  
103 Borough Road  
LONDON  
SE1 6AA

24th February 2005

Dear Mrs Baillie,

RXQ/096: Research Study – A Case study of Patient Dignity in an Acute Hospital Setting

Thank you for all the documentation regarding this trial and providing a prompt and detailed response to our points of clarification. Subject to the proviso that all records are stored securely until Doctoral Award and then archived in accordance with the Trust procedures, I am pleased to confirm that your research proposal satisfies Hospital requirements for full Trust Registration and indemnity Insurance. Would you let us know the actual start and end dates of the project.

Additionally, please would you keep the Research Office informed of any changes to the protocol and let us have a copy of the text of publications resulting from the project (which we will make available to the Trust libraries). If you give a presentation about your research, would you also let us have a copy of the summary / synopsis.

May we wish you well with your project.

Yours sincerely,

Research & Development Manager
Appendix 5 Staff information sheet: (observation/follow-up interviews)

Invitation to take part in a research study about patient dignity in an acute hospital setting

Please read the following information carefully. Do not hesitate to contact the researcher (or her supervisors) if you have any questions

Introduction
You are invited to take part in a research study about patient dignity, which we hope will take place on Heron ward. Before you decide it is important for you to understand why the research is being done and what it will involve. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The research aims to gain a deeper knowledge of patients' experiences of dignity in hospital. This will help hospital staff understand factors that affect patients' dignity and how they can promote it. The research will start with a pilot study in March 2005. The main study will take place over about 2-3 months in the summer of 2005.

Why have you been chosen?
The researcher will explore all factors that could affect dignity of patients on the Heron ward. A key part of the research is observing patients’ care, within the ward setting. Each observation period will be for four hours and focus on one patient who has given consent. As you are either based on Heron ward or regularly visit Heron ward you may carry out care/treatment with a patient who has consented to be observed.

What will happen if I take part?
The researcher will observe you carrying out your usual care/treatment/interaction with the observed patient. Afterwards, she may wish to ask you one or two brief questions to clarify an issue. If you had a major role with the patient during the four hour observation period, the researcher may ask if you are willing to take part in a follow-up interview lasting about 15 minutes at a time and place convenient to you. Questions will relate to your view about the dignity of the patient during the care observed. As a registered nurse, the researcher will work to her Code of Professional Conduct. She will thus take any necessary action if she observes a patient is at risk at any time (for example, if a patient was about to fall).

Do I have to take part?
It is up to you to decide whether or not to take part. If you do you will be asked to sign a consent form, in advance of the observation on the ward starting. If you decide not to take part, the researcher will simply refrain from observing the patient’s care/treatment while you interact with the observed patient.
Appendix 5 (continued)

What are possible disadvantages of taking part?
You may dislike the idea of being observed carrying out your job. However, the researcher aims to carry out observation in a manner that does not affect the everyday work of staff.

What are the possible benefits of taking part?
The benefits will be a greater understanding of how patient dignity can be promoted in an acute hospital setting. This is an area in which little research has been carried out.

Will my taking part in this study be kept confidential?
Yes - all information collected during the study will be confidential. No names or personal details of anyone taking part will be recorded in the notes taken by the researcher. All information collected will be stored in a locked filing cabinet.

What will happen to the results of the research study?
The results will be presented to the Trust and published in suitable journals. No one who has taken part will be identifiable in any of the reports/publications.

Who is organising and funding the research?
The research is being carried out and self-funded by a registered nurse, working in healthcare education and studying part-time for a PhD with London South Bank University.

Who has reviewed the study?
The XXX Local Research Ethics Committee has reviewed the study. The Trust’s Research and Development Office has also approved the study.

Thank you for taking the time to read this. Please do not hesitate to contact the researcher or her supervisors if you have any questions. Here are their contact details.

**Researcher:**
Lesley Baillie (Telephone: 020-7815-8457; email: baillilj@lsbu.ac.uk)

**Research supervisors:**
Professor Ann Taket (Telephone: 020-7815-8097; email: a.r.taket@lsbu.ac.uk)
Dr Dee Burrows (Telephone: 01494 866997; email: dee.burrows@painconsultants.co.uk)
Appendix 6 Patient information sheet: interviews with patients after discharge from hospital

Invitation to take part in a research study about patient dignity in an acute hospital setting

Please read the following information carefully. Do not hesitate to contact the researcher (or her supervisors) if you have any questions

Introduction
You are invited to give an interview about patient dignity, as part of a research study based on Heron ward. Before you decide it is important for you to understand why the research is being done and what it will involve. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The research aims to gain a deeper knowledge of patients’ experiences of dignity in hospital. This will help staff understand what affects patients’ dignity and how they can promote dignity in hospital.

Why have you been chosen?
The researcher aims to find out about all aspects affecting patients' dignity on Heron ward. She is keen to find out from patients, like yourself, how you feel about your dignity while a patient on Heron ward. As you will soon be discharged from Heron ward, the researcher would like to interview you after you have gone home.

What will happen if I take part?
If you agree to take part, you will be asked to complete a form with your contact details. The researcher will telephone and ask if you have any questions about the research. If you are willing to be interviewed, she will arrange this at a place and time convenient for you. This could be at your home or at another address if you prefer. When the researcher arrives she will ask you to sign a consent form to be interviewed. You will have a copy of this to keep. She will ask if she can tape the interview, so she has a better record of what you say. She will only tape record if you agree, and you can ask for the tape recorder to be switched off at any time. You need only answer the questions you want to, and you can ask for the interview to stop at any point. The interview will last about 30 minutes. The questions will be about what dignity means to you and how being in hospital affected your dignity. If during the interview you describe care that you felt unhappy about, the researcher will discuss with you whether you want to take this up with the hospital. Should you wish to do so, she will discuss with you how to go about this. She will not take any action on your behalf without your consent.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you can withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care you receive now or in the future.

What are the possible benefits of taking part?
You may like the chance to talk about your stay in hospital, knowing that what you say could improve care for other patients in the future. There has been little research into how patients’ dignity can be promoted when in hospital.
Appendix 6 (continued)

What are possible disadvantages of taking part?
You may not enjoy talking about being in hospital. The interview will take up about 30 minutes of your time.

Will my taking part in this study be kept confidential?
Yes - all information collected during the study will be confidential. The only exception would be if, as a result of the interview, you ask the researcher to take up with the hospital an aspect of your care you felt unhappy about. The researcher will in this instance only use your name if you have given permission. After the interview has taken place the researcher will destroy the contact details you provided. No names or personal details of anyone taking part in the research will be recorded. The researcher will keep all information collected (tapes and written transcripts of tapes) in a locked filing cabinet. The tapes of the interviews will be destroyed when the researcher has completed her PhD qualification (March 2007).

What will happen to the results of the research study?
The results will be presented to the Trust and published in suitable journals. No one who has taken part will be identifiable in any of the reports or publications.

Who is organising and funding the research?
The research is being carried out and self-funded by a registered nurse. She works in healthcare education and is studying part-time for a PhD with London South Bank University.

Who has reviewed the study?
The XXX Local Research Ethics Committee has reviewed the study. The Trust’s Research and Development Office has also approved the study.

Thank you for taking the time to read this. Do not hesitate to contact the researcher or her supervisors if you have any questions. The contact details are below.

**Researcher:**
Lesley Baillie (Telephone: 020-7815-8457; email: baillijj@lsbu.ac.uk)

**Research supervisors:**
Professor Ann Taket (Telephone: 020-7815-8097; email: a.r.taket@lsbu.ac.uk)
Dr Dee Burrows (Telephone: 01494 866997; email: dee.burrows@painconsultants.co.uk)
Appendix 7 Patient information sheet (In-patient observation and follow-up interview)

Invitation to take part in research about patient dignity in an acute hospital setting

Please read the following information carefully. Do not hesitate to contact the researcher (or her supervisors) if you have any questions

Introduction
You are invited to take part in a research study about patient dignity, which is based on Heron ward. Before you decide it is important for you to understand why the research is being done and what it will involve. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The research aims to gain a deeper knowledge of patients' experiences of dignity in hospital. This will help staff understand what affects patients' dignity and how they can promote dignity in hospital.

Why have you been chosen?
The researcher aims to find out about all aspects affecting patients' dignity on Heron ward. Part of the research involves observing care and asking patients and staff questions about dignity. On twelve different days, the researcher will observe one patient who has given consent for their care to be observed. You will be a patient on Heron ward on a day when the researcher plans to carry out observation.

What will happen if I take part?
The researcher will observe your care over a four-hour period, while staff carry out your care and treatment as usual. If you would like the researcher to leave during any aspects of your care she will do so. If at any time you change your mind about being involved, you can withdraw from the research. As a registered nurse, the researcher will take any necessary action if she observes you or another patient to be at risk at any time (for example, a patient about to fall or becoming suddenly unwell). When the observation episode is finished, the researcher will ask if she can carry out a short interview with you. If you agree, she will ask you about the care she observed during the morning, and your feelings about your dignity. She will make notes of your answers. You need only answer the questions you want to and can ask for the interview to stop at any time. If during the interview you describe care that you felt unhappy about, the researcher will discuss with you whether you want to take this up with the hospital. Should you wish to do so, she will discuss with you how to go about this. She will not take any action on your behalf without your consent. The researcher would also like to look at your record of care for this admission, to make notes about any aspects that relate to your dignity.
Appendix 7 (continued)

Do I have to take part?
It is up to you to decide whether or not to take part. If you wish to do so, the researcher will talk to you later today and you can ask questions if you wish. If you agree to take part you will be asked to sign a consent form. You will have a copy of the consent form to keep, along with this sheet. On the day of the observation, the researcher will check that you are still happy to be observed. If you decide to take part you can withdraw at any time and without giving a reason. A decision to withdraw, or a decision not to take part, will not affect the care you receive now or in the future.

What are the possible benefits of taking part?
You may like the chance to talk about your experience of care. Taking part could help hospital staff gain a better understanding of how patient dignity can be promoted in an acute hospital setting. This is an area in which little research has been carried out.

What are possible disadvantages of taking part?
You may dislike the idea of your care being observed. The follow-up interview will take 15 minutes of your time.

Will my taking part in this study be kept confidential?
Yes - all information collected during the study will be confidential. The only exception would be if, as a result of the interview, you ask the researcher to take up with the hospital an aspect of your care you felt unhappy about. The researcher will in this instance only use your name if you have given permission. No names or personal details of anyone taking part will be recorded in the notes taken by the researcher. All information collected will be stored in a locked filing cabinet.

What will happen to the results of the research study?
The results will be presented to the Trust and published in suitable journals. No one who has taken part will be identifiable in any of the reports/publications.

Who is organising and funding the research?
The research is being carried out and self-funded by a registered nurse. She works in healthcare education and is studying part-time for a PhD with London South Bank University.

Who has reviewed the study?
The XXX Local Research Ethics Committee has reviewed the study. The Trust’s Research and Development Office has also approved the study.

Thank you for taking the time to read this. Do not hesitate to contact the researcher or her supervisors if you have any questions. Contact details are below.

**Researcher:**
Lesley Baillie (Telephone: 020-7815-8457; email: baillilj@lsbu.ac.uk)

**Research supervisors:**
Professor Ann Taket (Telephone: 020-7815-8097; email: a.r.taket@lsbu.ac.uk)
Dr Dee Burrows (Telephone: 01494 866997; email: dee.burrows@painconsultants.co.uk)
Appendix 8 Staff information sheet (senior nurse interviews)

Invitation to take part in research about patient dignity in an acute hospital setting

Please read the following information carefully. Do not hesitate to contact the researcher (or her supervisors) if you have any questions

Introduction
You are invited to give an interview about patient dignity as part of a research study, based on Heron ward. Before you decide it is important for you to understand why the research is being done and what it will involve. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The research aims to gain a deeper knowledge of patients’ experiences of dignity in hospital. This will help hospital staff understand factors that affect patients’ dignity and how they can promote patients’ dignity in hospital. The research started with a pilot study in March 2005, and the main study is taking place over the summer of 2005.

Why have you been chosen?
The researcher is exploring all factors that could affect dignity of patients on Heron ward. As you are a senior member of nursing staff, the researcher would like to find out your views on this topic.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do you will be asked to sign a consent form, and the researcher will arrange a time and place for the interview at your convenience.

What will happen if I take part?
The researcher will carry out the interview asking you your views about dignity and the factors affecting patient dignity in an acute hospital setting. She will ask if she can tape the interview, so she has a better record of what you say. She will only tape record if you agree, and you can ask for the tape recorder to be switched off at any time. You need only answer the questions you want to, and you can ask for the interview to stop at any point.

What are possible disadvantages of taking part?
The interview will take about 30 minutes of your time.

What are the possible benefits of taking part?
The benefits will be a greater understanding of how patient dignity can be promoted in an acute hospital setting. This is an area in which little research has been carried out.

Will my taking part in this study be kept confidential?
All information collected during the study will be confidential. No names or personal details of anyone taking part will be recorded in the notes taken by the researcher. All information collected will be stored in a locked filing cabinet.

What will happen to the results of the research study?
The results will be presented to the Trust and published in suitable journals. No one who has taken part will be identifiable in any of the reports/publications.
### Appendix 8 (continued)

**Who is organising and funding the research?**  
The research is being carried out and self-funded by a registered nurse. She works in healthcare education and is studying part-time for a PhD with London South Bank University.

**Who has reviewed the study?**  
The XX Local Research Ethics Committee has reviewed the study. The Trust’s Research and Development Office has also approved the study.

**Thank you for taking the time to read this. Please do not hesitate to contact the researcher or her supervisors if you have any questions. Contact details are below.**

| Study title: A case study of patient dignity in an acute hospital setting |
| Researcher: Lesley Baillie (Telephone: 020-7815-8457; email: baillilj@lsbu.ac.uk) |
| Research supervisors:  
  Professor Ann Taket (Telephone: 020-7815-8097; email: a.r.taket@lsbu.ac.uk)  
  Dr Dee Burrows (Telephone: 01494 866997; email: dee.burrows@painconsultants.co.uk) |
Staff Identification code: __________

CONSENT FORM

Title of Project: A case study of patient dignity in an acute hospital setting

Name of Researcher: Lesley Baillie

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to being observed carrying out care/treatment of patients recruited to the study and being asked brief clarifying questions.

4. If requested by the researcher I agree to taking part in a brief follow-up interview after being observed carrying out care/treatment.

____________________ ________________ _____________
Name of staff member Date Signature

___________________  _____________
Researcher's name   Date    Signature

1 for staff member; 1 for researcher
Appendix 10 Patient consent form to be interviewed following discharge

Patient Identification code: _____________

CONSENT FORM

Title of Project: A case study of patient dignity in an acute hospital setting

Name of Researcher: Lesley Baillie

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

4. I agree/do not agree to the interview being taped.

Name of patient __________________ Date ______________ Signature _____________

Researcher’s name __________________ Date ______________ Signature _____________

1 for patient; 1 for researcher;
Appendix 11 In-patient consent form (observation, follow-up interview and examination of in-patient record of care)

Patient Identification Code: ____________

CONSENT FORM

**Title of Project:** A case study of patient dignity in an acute hospital setting

**Name of Researcher:** Lesley Baillie

Please initial box

<table>
<thead>
<tr>
<th>1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.</th>
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<tbody>
<tr>
<td>2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.</td>
</tr>
<tr>
<td>3. I agree to take part in the above study.</td>
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____________________ ________________ _____________
Name of patient   Date   Signature

___________________
Researcher's name   Date    Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes
Appendix 12 Consent form to be interviewed (senior nurses)

Staff Identification code: __________

**CONSENT FORM**

**Title of Project:** A case study of patient dignity in an acute hospital setting

**Name of Researcher:** Lesley Baillie

Please initial box

| 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. |
| 3. I agree/do not agree to the interview being taped. |

<table>
<thead>
<tr>
<th>Name of staff member</th>
<th>Date</th>
<th>Signature</th>
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<thead>
<tr>
<th>Researcher's name</th>
<th>Date</th>
<th>Signature</th>
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</table>

1 for staff member; 1 for researcher
Appendix 13 Personal safety while conducting interviews in people’s homes

I intend to conduct twelve interviews in people’s own homes, two as part of the pilot study, and then a further ten for the main study. The interviewees will be patients who have been recruited while in hospital. They will have completed a form agreeing that I can contact them, and providing their name, address and telephone number. I will then telephone them, invite questions about the research, and if they are still willing to go ahead with the interview, I will arrange with them a convenient date, time and venue for the interview. The venue can be of their choice, but as they are recovering from being in hospital I think it is likely they will request the interview is conducted in their own home.

The interviews could take place during the day or early evening (but still within daylight), on any day of the week, as the arrangement depends on identifying a mutually convenient time. For interviews taking place on a weekday, I will:

- Provide one supervisor (depending on their availability) with the date and time of the interview, the interviewee’s name, address and telephone number, and my mobile phone number.
- When I arrive at the person’s house, before getting out of the car I will ring the supervisor as agreed to confirm I have arrived at the address. I expect the interview to last 30-40 minutes, but extra time may be needed for introductions, preparing seating and audio equipment. Therefore the supervisor will expect a call after 2 hours maximum to confirm I have left the house. When I leave the house, I will immediately contact the supervisor as agreed to confirm I have left the house. The supervisor will then destroy the interviewee’s contact details supplied.
- Before I start the interview I will explain to the interviewee that I expect the interview to last about 30-40 minutes, but if for some reason we overrun I will need to make a short phone call from my mobile phone to a colleague about a work issue. Then, if the time in the participant’s home is approaching 2 hours, I will say ‘As I mentioned earlier, I have to phone my colleague briefly’. I will ring the supervisor and say ‘Hello, I’m just ringing to check that Mr Evans has arrived as planned…. He has - that’s fine. Thanks, Bye’. The supervisor will then know not to expect a phone call from me after the agreed two hours but after a further hour. Under no circumstances will I stay longer than three hours. About 15 minutes before this maximum time allocated I will say ‘I will have to go in 15 minutes as I have another appointment’ and I will then start to prepare to end the interview.
- If I do not telephone the supervisor as arranged, they will first try ringing my mobile phone. If I do not respond, they will then ring the interviewee’s number. Depending on the response to this, the supervisor will contact the police.
- When I arrive at the door I will introduce myself and show ID, and ask for the person by name. If the person I am expecting to interview is not there I will not enter the house. I will only enter the house when invited to do so. I will observe how the front door is closed/opened.
- If when I arrive at the interviewee’s house I have any concerns about my safety for whatever reason, I will explain that unfortunately I cannot go ahead with the interview today. I will then discuss with my supervisors whether to abandon this participant or rearrange the interview, preferably at a date/time when my husband can accompany me and wait in the car outside.
Appendix 13 (continued)

- I will ensure my approach to the person I am interviewing is friendly but with a professional distance, and will show respect remembering I am a guest in their home. I will be suitably dressed - professional but informal - so I am in no way threatening or provocative. I will wear shoes easy for moving in fast. I will respect the interviewee's personal space so I am not threatening.
- I will gain informed consent for the interview and tape recording, ensuring the person is comfortable with the process.
- During the interview I will keep my mobile on (so an emergency call could be made quickly) but on silent so it does not disturb the interview. I will explain to the participant that for work reasons I need to keep the phone on but it will be with the tones off.
- I will ensure the chairs are arranged so that I am not cornered, and the door is in sight (so I can see if anyone enters) and easily accessible. I can use the pretext of the tape recording equipment's positioning to organise this.
- I will be alert to any non-verbal cues that the person is agitated/aggressive. As I have many years of Accident & Emergency experience I feel able to recognise this. Should this arise I will remain calm and non-defensive and use de-escalation techniques to defuse the situation. If the person is angry because of their hospital experience I will ask if they would like me to provide details re PALS or contact them on their behalf.
- I will be prepared to terminate the interview immediately if I feel in danger. I will simply say 'I have to pop out to the car a minute for my notes' and leave immediately. If I am easily able to grab my coat and tape recorder I will do so but will otherwise leave them behind. I will keep my car keys and a small amount of money in my pocket.

If neither supervisor is available during a scheduled interview, I will follow the same steps as above. However, I will provide my husband with the contact details for the interviewee in a sealed envelope and phone him before entering the house and when leaving, as described above. My husband will only open the envelope if he has concerns about my safety and needs to phone the interviewee's address or contact the police. After the interview has been completed, the interviewee's details in the envelope will be destroyed. My husband is a registered mental health nurse, and therefore will maintain confidentiality of the interviewee's details, should he need to access them, as per the NMC Code of Professional Conduct.
Appendix 14 Letter to ward staff inviting participation in study

Dear staff member,

[name of ward manager] has expressed interest in Heron ward being involved in a research study about patient dignity, subject to further discussion with the ward team. I am writing to invite you to take part in this study which will help us better understand patients’ experiences of dignity in an acute hospital setting.

I am a registered nurse working in healthcare education at London South Bank University, and I am carrying out this study for a PhD. I am also a XXX NHS Trust employee, working part-time in Accident and Emergency at XX Hospital. I am therefore familiar with the Trust, and its policies.

The study will include interviews with patients after their discharge from Heron [name]. I also plan to carry out observation on the ward, observing staff handovers and patient care. I plan to conduct brief follow-up interviews with patients observed, ward staff involved in their care, and other health professionals who have key involvement with observed patients. I will examine these patients’ records of care, and ward/Trust policies, and carry out interviews with senior nursing staff.

Please find attached an information sheet about the study. It explains what being involved in the study will mean for you. If you have any questions do contact me, or one of my research supervisors. Our telephone numbers and email addresses are on the information sheet and any questions you raise will be treated confidentially.

I will contact you in the near future to find out whether you are interested in taking part and if so, to ask you to sign a consent form.

With best wishes,

Lesley Baillie
RGN, BA(Hons), RNT, MSc
Principal lecturer, London South Bank University
Appendix 15 Researcher’s behaviour during observation episodes

The researcher undertakes to adhere to the following:

1. Abide by the Nursing and Midwifery Council’s Code of Professional Conduct. In an extreme instance this would mean reporting to an appropriate person if dangerous/abusive practice is observed.
2. Assist with the care of patients selected for observation, under direction of the staff responsible for their care.
3. Familiarise herself with the ward environment, in particular fire exits, location of emergency equipment etc.
4. Initiate interventions only if an emergency situation arises (e.g. patient about to fall, cardiac arrest). The researcher will, in such an instance, take any necessary immediate action (in accordance with Trust policy), and report the situation, and any action taken to the nurse in charge.
5. Make her identity and role known to other patients in the vicinity of the patient being observed.
6. Patients expecting visitors (for anything other than a short visit) during the observation period will be excluded from the study. If the patient unexpectedly receives a visitor during the observation period, the researcher will discontinue observation of the patient, and write notes elsewhere until the visitor leaves.
7. Where care is personal (for example bathing) the researcher will verbally check with the patient that they are willing for their care to be observed. If they are not willing for a particular aspect of care to be observed, the researcher will refrain from observing this.
8. If the patient unexpectedly becomes seriously ill during the observation period, the researcher may continue to observe, ensuring that her presence does not impinge on the patient’s treatment or care. If advised by the nurse-in-charge, or if the researcher feels continuing observation is inappropriate, the researcher will discontinue observation.
Appendix 16 Letter to ward's medical consultants

Consultant's name and address

Date

Dear [Consultant's name],

Re: Research study on Heron ward

I am a nurse researcher who is planning to conduct research into patient dignity, based on Heron ward, and I am writing to ask your permission to include your patients in the study.

I am a registered nurse working in healthcare education at London South Bank University, and I am carrying out this study for a PhD. I am also a XXX NHS Trust employee, working part-time in Accident and Emergency at XX Hospital. I am therefore familiar with the Trust, and its policies. The Local Research Ethics Committee has given ethical approval for the study to take place, and the research is registered with the Trust's Research and Development Office. I will adhere to ethical principles throughout: anonymity, confidentiality and informed consent.

The study plans to involve the following:
- interviews with patients after their discharge from Heron ward
- participant observation on the ward, observing staff handovers, and patient care,
- brief follow-up interviews with patients observed, ward staff involved in their care, and other health professionals who have key involvement with observed patients
- examination of the observed patients' records of care,
- examination of ward/Trust policies
- interviews with senior ward/Trust nursing staff.

It is possible that you or members of your team may interact or carry out examinations or treatment with patients who I am observing. I therefore enclose letters about the research, with information sheets attached, for you and your team. If you are in agreement I would like to gain consent to observe members of your team if they interact with patients I am observing and, if applicable, to request a brief follow-up interview at a convenient time.

Should you, or any member of your team, wish to discuss the research, or if you have any objections to the study taking place on Heron ward, please do not hesitate to contact me or my supervisors. Contact details are on the information sheets enclosed.

Yours sincerely,

Lesley Baillie
RGN, BA(Hons), RNT, MSc
Principal lecturer, London South Bank University
Appendix 17 Patient contact details for interview following discharge

I am willing to be contacted by the researcher following discharge from hospital to discuss arranging an interview about my experiences while in hospital.

Signature ________________________ Date____________________________

Name  __________________________

Address

________________________________

________________________________

________________________________

________________________________

Telephone number __________________________

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<thead>
<tr>
<th>Patient contact details for interview following discharge</th>
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<td>I am willing to be contacted by the researcher following discharge from hospital to discuss arranging an interview about my experiences while in hospital.</td>
</tr>
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<td>Signature ________________________ Date____________________________</td>
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<tr>
<td>Name  __________________________</td>
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<td>Telephone number __________________________</td>
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</table>
Appendix 18 Post-discharge patient interview topic guide

Opening question:
Dignity is often mentioned as being important in healthcare. What does the term dignity mean to you?

The researcher will use the patient’s own expressed understanding of what dignity is to explore their thoughts and feelings about the following topics:
- Whether, before being admitted, they had any thoughts about their dignity being affected in hospital.
  - If so, what these thoughts were and where they came from.
- Whether the hospital setting affected their dignity, and if so how.
- Whether staff affected their dignity during their hospital stay, and if so how.
- Whether there were any particular situations while in the ward when they felt they lost, or could have lost, their dignity. If yes, explore:
  - what the situation was,
  - whether/how it related to their condition, treatment or care,
  - their feelings at the time,
  - anything they did to try to keep their dignity,
  - how staff affected the situation (did they make the situation better or worse),
  - anything else they would have liked staff to do in this situation

Anything else they would like to say about their dignity as a patient on Heron ward.
Appendix 19 Observation guide

Patient identification code

Description of patient's general condition and appearance

Description of physical environment of care

Events during observation period:
For each event: time of occurrence; description of staff (discipline, grade) involved; actions taken by staff and patient, and their responses; verbal and non-verbal interactions between staff and patient, and their responses.
Appendix 20 In-patient topic interview topic guide

Opening question:
Dignity is often mentioned as being important in healthcare. What does the term dignity mean to you?

The researcher will use the patient’s own expressed understanding of what dignity is to explore their thoughts and feelings about the following topics:

- Any occasions during the morning when they felt they lost, or could have lost their dignity.
  - If so, when this happened.
  - What they felt caused it.
  - What effect staff had on the situation - whether they made the situation better or worse, and if so how.
  - Whether there was anything else staff could have done in this situation to help promote their dignity.
- If there were no occasions when the patient felt they lost or nearly lost their dignity:
  - What they feel helped promote their dignity during the morning.
  - Whether there was anything staff did which helped to promote their dignity
  - What effect, if any, they feel the ward setting has on their dignity,
  - Whether there is anything more that could be done to the ward environment to promote patient dignity
  - Anything else they would like to say about their dignity as a patient on Heron ward.
Appendix 21 Staff post-observation interview topic guide

What does the term dignity mean to you?

The following topics will then be explored in relation to the observed patient and their care/treatment of him/her:

**Threats to dignity:**
- Whether they felt [patient's name] dignity was lost, or threatened at any point during the observed care episode.
  - If so what they feel caused this to happen,
  - What effect they feel they had on the situation - whether they feel they improved or worsened the situation, and how.
  - How they feel other staff improved or worsened the situation, and how.
  - Whether they feel they or any other staff could have done anything else to promote [patient name]'s dignity in this situation, and if so, what.

**Promotion of dignity:**
If they feel the patient kept their dignity during their care/treatment:
- What they feel helped promote the patient's dignity.
- What their role was in promoting the patient’s dignity.

**Effect of the ward environment**
- How they feel the ward environment affected [patient name]'s dignity.
- Whether there is anything more that could be done to the ward environment to promote patient dignity.

  Anything else they would like to say about patient dignity on Heron ward.
Appendix 22 Letter to senior nurses inviting participation in study

Staff member's name and address

Date

Dear [staff member's name],

Re: Research study on Heron ward

I am a nurse researcher who is conducting research into patient dignity in an acute hospital setting. I am a registered nurse working in healthcare education at London South Bank University, and I am carrying out this study for a PhD. I am also a XXX NHS Trust employee, working part-time in Accident and Emergency at XX Hospital. I am therefore familiar with the Trust, and its policies. The Local Research Ethics Committee has given ethical approval for the study to take place, and the research is registered with the Trust's Research and Development Office. I will adhere to ethical principles throughout: anonymity, confidentiality and informed consent.

The study involves the following:
- interviews of patients after their discharge from Heron ward,
- participant observation on the ward, observing staff handovers, and patient care,
- brief follow-up interviews with patients observed, ward staff involved in their care, and other health professionals who have key involvement with observed patients,
- examination of the observed patients' records of care,
- examination of ward/Trust policies
- interviews with senior nursing staff.

As you are a senior member of Trust/ward nursing staff I would like to conduct an interview with you. I therefore enclose an information sheet for you to read so you can decide whether you are willing to take part. I will contact you in the near future to ask whether you have any questions about the research. If you agree to be interviewed, we can then arrange a convenient time and place.

Should you wish to discuss the research, please do not hesitate to contact me or my supervisors. The contact details are on the information sheet enclosed.

Yours sincerely,

Lesley Baillie
RGN, BA(Hons), RNT, MSc
Principal lecturer, London South Bank University
Appendix 23 Interview topic guide for senior nurses

1. What does the term ‘dignity’ mean to you?

2. Do you feel there are any characteristics of the patient group on Heron ward that could threaten or promote their dignity? If yes, what are these?

3. In your experience, how do staff, and their approach to patients, affect patient dignity?

4. How do you feel the environment on Heron ward affects the patients ‘dignity’?

5. As a senior member of staff, what do you feel your role is in relation to patient dignity on Heron ward?

6. Do you feel there are any factors outside the immediate ward environment which affect patient dignity, positively or negatively? (e.g. hospital, Trust government, society) If yes, could you tell me about these?

7. Are there any ward/hospital policies that specifically relate to patient dignity? If yes, which are they? What effect do you feel these have on patient dignity in practice?

8. Is there anything else you would like to say about patient dignity on Heron ward?
Appendix 24 Data analysis process

Example A Examples of significant statements coded per source

A lot of it [dignity] is the way I'm treated (PI1)

N1 was now doing Mr O1’s drugs and going through the chart with him, discussing which drugs he was due now. She then got them out for him. She was very chatty and friendly with him. At this point N2 walked into the bay and said 'Are you still doing those drugs?' (but in a joking tone). N1 replied 'Do you mind - I'm making a rapport with my patients!' (O1E3)

The staff nurse (N5) doing the handover refers to the male patients as 'gentlemen'. (H2)

N5 had made no particular comment about Mr O2’s condition, except that he had had a previous stroke and so wasn't so mobile. His admission assessment indicated he was usually fully independent. (O2PC)

All five patients were, at the start of the observation period, lying in bed with operation gowns on. They were quiet and not interacting with each other. (O3E)

She felt there were no situations where Mr O5 had lost his dignity but he could have done had his door been left open for example (O5H3I)

For patients, dignity is a very personal thing about themselves. (O7N5I)

N14 is amazing. She is sensitive, explains what she's going to do before she does it, she's cheerful, she has a sense of humour, she appears interested in me as an individual, she has a caring approach, appears to enjoy her work - doesn't appear as though it's a chore. She's dedicated. (O8PI)

Data analysis codes for data sources above:
PI1: Patient post-discharge interview 1
O1E3: Observation 1 Event 3
H2: Handover 2
O2PC: Observation 2 Patient Condition
O3E: Observation 3 Environment
O5H3I: Observation 5 HCA3 Interview
O7N5I: Observation 7 Nurse 5 Interview
O8PI: Observation 8 Patient interview
Appendix 24 Data analysis process (continued)

Example B Initial developing thematic framework: Theme 3 The impact of staff on patient dignity

3.1 Choice, control, consent
3.2 Exposure/privacy
3.3 Communication
   Introductions/greeting
   Manner of address
   Tone - not speaking down
   Non-verbal communication
   Listening
   Conversation
3.4 Humour
3.5 Understanding/empathy
3.6 Respect - for rights, religion
3.7 Quality of care
3.8 Confidentiality/discretion
3.9 Response to patients' needs/concerns
3.10 Information giving/explanation/openness/honesty
3.11 Caring: Consideration, supportiveness, helpfulness, sensitivity, kindness
3.12 Attitude
3.13 Gender effects
3.14 Language effects
3.15 Treating patients as human beings/individuals/important
3.16 Manner: Friendliness, cheerfulness, politeness, niceness
3.17 Making patient feel comfortable/at ease
3.18 Professionalism
3.19 Relationships with patients
3.20 Checking/monitoring patients
3.21 Give patients space/own time
3.22 Reassurance
3.23 Encouragement
3.24 Approach to intimate procedures
3.25 Factors affecting staff approach
   Effect of ward sister
   Effect of workload/shift pattern
Appendix 24 Data analysis process (continued)

Example C Refined thematic framework for Theme 3 How staff promote dignity
3.1 General positive comments
3.2 Explaining and informing
3.3 Helpfulness and consideration
3.4 Courteousness
3.5 Humour
3.6 Concern
3.7 Friendly and reassuring
3.8 Verbal communication
3.9 Attitude and approach
3.10 Consent and choice
3.11 Promoting independence
3.12 Providing quality care
3.13 Preventing exposure

Example D Examples of significant statements coded to source and the categories in example C Theme 3 How staff promote dignity

They [the staff] were all good. You know. I've got no complaints as far as that goes. They were all excellent. (PI6) (3.1)

Telling you exactly what's going on and - that is very helpful isn't it in a hospital when you're worried and you're slightly concerned about what's going to happen to you - if people just sit on the end of your bed and say what's going to happen. (PI8) (3.2)

If you say you can't get to the toilet they'll bring you a commode - never make a fuss. (O10PI) (3.3)

N 10 entered the bay and said 'Morning gentlemen' in a very pleasant voice and smiling and they returned the greeting. She then turned to Mr O6 on her left and said 'Morning Mr O6' and he smiled and said 'Morning' back. (O6E1) (3.4)

'They were all a good crowd, and all the sort of ward auxiliaries and what ever you call them - healthcarers and what have you, they were all a good laugh. Which helped all the way round, basically'. (PI6) (3.5)

'Staff sort of keep popping their heads round the corner and having a look - see how everyone's getting on' (PI6) (3.6)

They're [nurses] friendly - they put you at ease and the doctors are the same these days. They used to be all prim and proper - you couldn't ask them anything. Now you can talk to them [doctors] easier - they put you at ease. She 'never has any fears about coming into hospital'. (O9PI) (3.7)

She emphasised again that the way staff talk to patients is the key. (O7N15I) (3.8)

It's [dignity] about staff 'treating you as an important person'. (O11PI) (3.9)

She [N6] asked him [Mr O3] which leg he would like his bag attached to and he said his right one. She slipped the bag over his right foot and up his leg, and inserted the catheter bag into the net bag. (O3E13) (3.10)

N6 and HCA2 then helped Mrs O4 out of bed, after applying her slippers She was still nervous about it but they kept reassuring her and saying she could do it. With minimal difficulty they assisted her to stand and then encouraged her to take short steps to sit down in the chair. (O4E10) (3.11)

N13 then gave her a bowl and cup of mouthwash to clean her teeth and Mrs O12 also brushed her hair. (O12E19) (3.12)

One aspect is body dignity: drawing curtains, using towels to cover the patient up, making sure he was covered up when sitting in his chair. (O8N14I) (3.13)
### Appendix 24 Data analysis process (continued)

**Example F Extract from early chart mapping significant statements in Theme 3 'How staff promote dignity'**

<table>
<thead>
<tr>
<th>General Positive Comments 3.1</th>
<th>Explaining and informing 3.2</th>
<th>Helpfulness and consideration 3.3</th>
<th>Courteousness 3.4</th>
<th>Humour 3.5</th>
<th>Concern 3.6</th>
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