PATIENT DIGNITY IN NURSING: A PHENOMENOLOGICAL STUDY

MILIKA RUTH MATITI

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DECLARATION

I declare that this Thesis is entirely my own work and is the result of my own investigations except where stated otherwise.

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ABSTRACT

This research is concerned with patient dignity in nursing. It proposes the introduction of the concept of Perceptual Adjustment Level (PAL) in order to resolve the problem of the definition of patient dignity and its maintenance within nursing care. The aims of the study are to identify how patients and nurses perceive patient dignity, to investigate the extent to which patient dignity is maintained and to identify nursing care activities in maintaining patient dignity. The implications of the findings of this study for nursing education and the development of policy on clinical practice are also examined.

The literature review revealed a paucity of research on patient dignity. There was no clear definition of dignity that could be understood by both nurses and patients during their day to day interaction. Little was known of the maintenance of patient dignity and its influencing factors. A qualitative methodology utilising a phenomenological approach was used. A total of 102 patients and 94 nurses from medical and surgical wards in three hospitals within the United Kingdom were interviewed using semi-structured interview techniques.

Although neither patients nor nurses specifically defined patient dignity, they came up with similar categories in terms of how they perceived patient dignity: privacy, respect, communication, the need for information, involvement in care, independence, patients' choice, form of address, decency and confidentiality. Control was only mentioned by patients. Although there was congruence between how the patients and nurses described patient dignity, it emerged that nurses tended to operate on different levels from how patients perceived the maintenance of their dignity. While nurses utilised primarily their own perception of dignity to maintain patient dignity, it was discovered that hospitalised patients went through a process of adjustment of their notion of dignity and came to a level they could accept. As a result a new concept termed Perceptual Adjustment Level (PAL) is proposed. Patients felt dignified if events matched with this level. This research has, therefore, proposed a tentative definition of patient dignity as the *fulfilment of patients' expectations or needs in terms of values within each patient's perceptual adjustment level taking into account the hospital environment.*

The need for assessing patients to discover their perceptual adjustment level has been highlighted. A number of patients were satisfied with how their dignity was maintained but a significant number were not. Ways of improving the maintenance of patient dignity have also been proposed. In order to maintain patient dignity, nurses should consider six questions: "*what?*" signifies the needs of dignity which should be met. "*Why?*" highlights the importance of full explanations of the purpose of tasks carried out on patients, and whether it matters to the patient. "*Who?*" relates to who is going to perform the task on her or him? "*Where?*" considers whether privacy will be ensured when the tasks will be done and "*how?*" sensitively the tasks will be done? It is also important to make the patient aware "*when?*" tasks will be carried out. The main factors that influenced the maintenance of patient dignity are revealed and implications for nursing practice, management, education and research are discussed.

CHAPTER 1: INTRODUCTION TO THE RESEARCH

1.1 Introduction

The concept of human dignity, which is the concern of this research, appears in disciplines such as philosophy, psychology, medical ethics, nursing and others where its importance in people's lives is emphasised. Seedhouse (2000) states that human dignity is important irrespective of situations people might find themselves in. Article 1 of the 1948 General Assembly of United Nations Declaration mentions that human dignity is a basic human right for everyone in the world and it should not be taken away from a person (Amnesty International 1999). The subject of human dignity has been of global concern in health care. The 1994 Amsterdam Declaration on the promotion of patients' rights recognised dignity as one of the main rights for patients to be achieved (World Health Organisation 1994). This is recognised by different health care organisations in countries such as the United Kingdom where the subject has been highlighted by a number of government documents and guidelines. For instance, the Patient Charter (Department of Health 1992) urges health care workers to take into account patients':

> Respect for privacy, dignity and religious and cultural beliefs (p.12).

The National Health Service (NHS) (1991) Patient Charter for Scotland also states that patients' dignity should be respected. A report by the Royal Commission on long term care of the elderly (Health Advisory Service 1998 p. xi) stresses that "the dignity of those who have or who may come to have the need of long term care should be recognised". Recently the National Health Service (NHS) (2000) Plan also emphasised the maintenance of patient dignity.

The International Code of Conduct of Nursing (1973) states that:

> Inherent in nursing is respect for life, dignity and the rights of man. It is unrestricted by considerations of nationality, race, creed, and colour, age, sex, politics or social status (p.63).

This has been embraced by a number of professional nursing bodies in different countries. The Canadian Nurses Association (Kerry and Macphail 1996) states that the nurse is guided by consideration for dignity of clients or patients. The American Nurses Association (2001) states that the nurses in all professional relationships should practise with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social economic status, personal attributes or the nature of health problems. The Australian Nurses Council (1995) also urges its nurses to respect the dignity, cultural values and beliefs of patients/clients and significant others in the provision of nursing care. In the United Kingdom, patients' dignity is stressed by the Nursing and Midwifery Council (2002) Code of Professional Conduct which states that as a registered nurse or midwife:

> You are personally accountable for ensuring that you promote and protect the interest and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs (p.3-4).

These examples signify the importance of the concept of dignity in nursing in many societies. The importance of dignity in nursing has also been emphasised by a number of health care specialisms. Hudson and Richmond (1994) wrote about the need for maintaining the dignity of dying residents in the nursing home to the end of their lives. Goodall (1992) emphasises the importance of maintaining dignity in clients with learning disabilities. Castledine (1996) talks about nursing the elderly with dignity and

respect and the Royal College of Nursing (1999) drew some guidelines for hospital staff on how to maintain dignity for older people with dementia or confusion

From the foregoing it can be seen that dignity is an important concept for the general treatment of every human being and for nursing care in particular. The importance of patient dignity has been highlighted by a recent high profile controversy on the way a 94 year old woman was treated in a London hospital where it was alleged by British politicians that she was left in an unkempt state for two and a half days. The patient was not offered a change of clothes or washed. Her hair, finger nails and feet were caked in blood (Baldwin, Hurst, Rumbelow and Brown 2002). Whilst there was controversy over the attitude of the patient, and whether she allowed herself to be washed, and whilst this case was used as a party political battle, it does demonstrate the centrality of the subject. At the heart of this argument was the notion of dignity and how best it can be achieved, and the policies the health service ought to adopt. Human dignity is important for patients. Strauss (1975), who reviewed the literature extensively and analysed interviews he conducted with a number of patients, concluded that individuals have inherent worth and need to be treated with dignity. Maslow (1968) postulated a hierarchy of needs from basic physiological ones, like food and air, to safety, belonging and love, esteem and self-actualisation. Esteem relates to a person's needs to feel of some worth and respected. All these scholars support the fact that dignity is important to human beings including patients. Fagermoen (1997) investigated values embedded in meaningful nursing practice in Norway. The first phase was a survey of 767 randomly selected nurses; in the second phase a convenience sample of six nurses were interviewed using an in-depth interview technique. The findings indicated that "human dignity" was the core value of an individual when caring for patients. Although patients were not part of the

sample, it confirmed the universality of the concept of dignity applied to patients. Kelly (1991) carried out a study in two educational institutions in England. The purpose was to examine and describe what English nursing undergraduates internalised as professional values. 12 students were interviewed. The findings revealed that informants perceived two concepts as central to their professional values. These were "respect for patients" thereby maintaining their dignity and "caring about little things". All this entails the fact that patients should be treated with dignity as unique human beings. The literature is consistent that dignity is important in patient care. What is not clear is the precise definition of the concept. It is to this that this work now turns.

1.2 Inspiration for this Research

The subject of human dignity was inspired by an incident which happened while the researcher was working on a surgical ward, in one of the hospitals in the Midlands. While being assessed, the patient said:

> Nurse I am not saying you have done anything wrong but I just like to let you know that I am very particular with my dignity, I would like it to be maintained. You are a nurse, I am sure you have learned about dignity in your training. I am very particular on how I am addressed. If you change my name it means you have changed me as a person. (Female)

It was clear from this that there was more to patient dignity than one had assumed. This led to an informal inquiry from colleagues on the ward as to what they understood by the concept of patient dignity.

A number of care plans were also checked to find out what nurses had documented on patient dignity. Only a general statement like "*maintain dignity at all times*" was found in some of the care plans. Documentation of the notion of patient

dignity was scanty. Further informal discussions with nurses revealed that not only were definitions different but they were also vague. Some respondents did not seem to understand the concept at all while others actually declared that they could not define the concept. All this experience revealed that although dignity is an important element in patient care, its definition and maintenance in clinical practice seemed a hit and miss endeavour.

A preliminary study by the researcher and a colleague (Matiti and Sharman 1999) on whether dignity was being maintained pre-operatively revealed a number of issues that warranted further research. Although the majority of the patients in the study were satisfied that their dignity was being maintained, further research was needed to explain why some felt that their dignity was not respected. For instance, some patients mentioned some factors which influenced the maintenance of their dignity, such as the attitudes of health care workers. Since these factors were mentioned in passing, it was deemed necessary to explore them in greater detail. Therefore, the following aims were devised for the present research.

1.3 Aims of the Research

(1) To identify how patients and nurses perceive patient dignity.

(2) To investigate the extent to which patient dignity is currently being maintained.

(3) To identify specific nursing care activities to maintain patient dignity.

(4) To examine the implications of the findings of this study for nurse education and development of policy on clinical practice.

1.4 The Questions Addressed

(1) How do patients define their dignity?

(2) How do nurses define patient dignity?

(3) To what extent is patient dignity currently being maintained?

(4) What are the specific nursing care activities that can be used to maintain patient dignity?

(5) What are the factors which influence the maintenance of patient dignity?

(6) What are the implications for nursing education and clinical practice?

1.5 The Initial Plan of Research Methodology

After a literature search and taking in consideration the complexity of the concept of patient dignity, a multi-method approach was used, utilising the principle of triangulation of methods (Robson 1993). To achieve the first aim, ten patients and ten nurses were interviewed while another set of ten nurses and ten patients participated in the Delphi technique to elicit perceptions of patient dignity from ten wards. Reid (1988) defined the "Delphi" technique as a systematic collection and aggregation of informed judgement from a group of experts on specific questions and issues (p131). Duffield (1989) recommended the Delphi technique to be used in research where the concept is vague and subjective, as is the case with patient dignity. The technique consisted of a number of stages with each stage building on the previous one (McKenna 1994) until a consensus of the responses was reached.

From both methods some categories emerged. Based on the findings of both the interviews and the Delphi technique a questionnaire was devised to be administered to a sample of 100 patients covering a range of settings, to corroborate the findings of the other technique. The same process was going to be replicated with similar samples of qualified nurses covering a range of settings. The third question was going to be addressed by using non-participant observation in different wards covering at least 20 nurse-patient interactions. Based on all information obtained, specific nursing care actions for maintaining patient dignity were going to be identified, thus addressing the fourth question. A discussion of the implications to nursing education and nursing practice would then follow. After analysing the results of the Delphi technique and interviews and also discussions with the supervisors of this research, it was decided to review the methodology as follows:

1.5.1 Review of the Initial Plan of the Research Methodology

Although a picture of what patient dignity started to emerged at that stage, two problems were identified with the methodology:

(1) The use of the Delphi technique was not appropriate to achieve the aims of the research. Although face to face interaction with participants in the first round and negotiations helped to increase the return rates of the Delphi technique questionnaires for subsequent rounds, there was a problem with response rates, also due to fast patient turn over. As a result it was difficult to repeat the rounds with other patients.

(2) The other drawback of the Delphi technique was that the questionnaire did not elicit adequate data from the participants. It became clear that to understand the meaning of patient dignity required an exploratory phenomenological approach which allowed participants to fully describe experiences and perceptions of their patient dignity.

(3) The sample was not adequate to give a comprehensive picture. In order to get a more comprehensive picture of the result, the sample was extended. More nurses and patients were added to the sample. It was apparent that health care support workers were central to the basic care of patients. It was decided to include them in the sample. To help in addressing the implications of nursing education, students were included in the sample, also because they form the foundation of the nursing career. Two more hospitals were added. After observing a pilot of two nurse-patient interactions, it was decided that the interview technique was adequate to yield sufficient data on maintenance of patient dignity.

After the review of methodology, this research design involved a critical review of the literature defining dignity generally and searching for patient dignity definitions specifically. Using a phenomenological approach, data were collected and analysed from patients and nurses on how they perceived patient dignity and whether it was maintained. Factors influencing the maintenance of patient dignity were also explored. A theoretical overview of the notion of dignity, a critique on dignity definitions and a justification of the need for clarifying the concept of patient dignity

is presented in the next chapter. The plan of the entire thesis eventually took the following shape:

1.6 Plan of Thesis

Chapter 1 starts with an introduction where the importance of the concept of dignity in everyday life and the embracing of the concept by the nursing profession internationally has been established. How this research was inspired and the aims of the research have been presented. To make sure the findings of this research were credible the researcher reflected on the methodology throughout the research. As a result, the initial plan of methodology was changed and the reasons for changing have been outlined. Definitions of terms used in the research have also been presented.

Chapter 2 presents the review of literature. It was realised from the preliminary study that the general concept of human dignity forms the basis of understanding of the concept of patient dignity. Therefore, the chapter starts with an exploration of the literature on different definitions of human dignity and their limitations. Although there was limited literature defining a general concept of dignity, the few definitions that were found were used as the foundation in understanding patient dignity. Although the researcher had an impression of what patient dignity would be, from these definitions no definition of patient dignity was found in the literature, necessitating the need for a research on the subject. Watson's theory of human caring has also been explored in this chapter.

Chapter 3 outlines the methodology and justification of choosing the phenomenological approach after the realisation that the Delphi technique was not a suitable method to elicit participant's experiences of patient dignity. The chapter

includes ethical issues, sampling methods and semi-structured interview techniques and a description of how the data were analysed. An example of how categories were extracted from data has been included.

Chapter 4 introduces the results of the research. This chapter discusses what human dignity is in general, taking into account findings from the interviews with participants.

Chapter 5 introduces a new concept; Perceptual Adjustment Level (PAL) which forms the basis of this research. The importance of nurses establishing PAL among patients has been emphasised.

Chapter 6 discusses how patients perceived their dignity within PAL and whether it was maintained or not. Relevant quotes and a diagram have been included to illustrate points raised. The application of PAL becomes clear as one reads through this chapter.

Chapter 7 explores factors that influenced the maintenance of patients' dignity in the three hospitals. The research would have been incomplete without considering these. The main factors identified were lack of resources: staff, ablutions/washing facilities, toilets, private rooms and lifts. It was decided to include gender, age, and the doctors' ward round as other factors which influence the maintenance of patient dignity as they were also frequently mentioned by patients and nurses.

Chapter 8 presents a summary of the research and discusses implications of the findings on nursing practice, management, education and research. Recommendations have been made based on the research findings.

The next section of this chapter presents a definition of terms which have been used in this research.

1.7 Definition of Terms

Parahoo (1997) stressed the need for researchers to give precise definitions of research terms, since people differ in the perception of the concepts.

Nurse – The term nurse in this research refers to qualified and unqualified nurses who give direct nursing care to patients. This included registered nurses, health care support workers and student nurses.

Bank Nurses – Nurses who agree to work a specific number of hours within a week or annually and arrange to work whenever available.

Agency Nurses – Nurses recruited from nursing agencies whenever there is a need of additional staffing in the hospitals.

Patient – Patient is defined as any person over the age of sixteen who was admitted on the sampled wards.

Medical Ward – A hospital room where patients with medical conditions were admitted for the purpose of receiving medical and nursing care.

Surgical Ward – A hospital room where patients with surgical conditions in need of operation were admitted for the purpose of receiving surgical and nursing care were admitted.

CHAPTER 2: REVIEW OF THE LITERATURE

2.1 The Concept of Patient Dignity

The literature on this subject indicates that discussions about human dignity have been ongoing for centuries. As early as 1486, Giovani Pico della Mirandola delivered a paper on "the dignity of man". His work on dignity was translated into English by Caponigri (1956). Mirandola believed that man is distinct from and superior to all other living things because man is created in the image of God: "how marvellous and splendid a creature is man". Humans are unique and deserve honour and admiration. Mirandola's paper emphasised the intrinsic worth of each individual human being.

The word dignity itself, however, comes from two Latin words "dignitus" which means merit and "dignus" meaning worth (Collins 1991). Definitions of dignity have mainly followed these two roots of origin. "Merit" implies that one has to achieve something in order to be dignified. Hobbes (1968) defines dignity as:

> The public worth of a man, which is the value set on him by common wealth is that which men commonly call dignity and this value of him by common wealth is understood, by offices of command, juncture, public employment: or names and titles, introduced for distinction of such value (p.152).

"Worth" means a quality of something which makes it valuable or having a value for what wealth one has; for example, "he is worth a million pounds". Kant (1948), whose arguments on dignity have been widely adopted, defines dignity as an intrinsic, unconditional and incomparable worth or worthiness that should not be compared with things that have economic value because unlike market value, a person's value does not depend upon usefulness and cannot be replaced. He argues:

> A thing has a "price" if any substitute or equivalent can be found for it. It has dignity or worthiness if it admits of no equivalent. Morality or virtue - and humanity so far as it is capable of morality - alone has dignity. In this respect it cannot be compared with things that have economic value (a market price) or even with things that have an aesthetic value (a fancy price) (Kant 1948 p. 36).

According to Kant, humans may never be "used" as a means to an end and this is the ultimate law of morality. Human beings have got value in themselves. Rachels (1993) gives two important perceptions which support Kant's claim; first people have desires and goals, and second, humans are generally rational agents, capable of making their own decisions, setting their own goals and guiding their conduct by reason.

Cherry (1997) distinguishes two types of value. The first is "extrinsic" or "instrumental", which is assigned to a person on the basis of his or her features. This is also called "relative". It is defined by wealth, skills, competence, creativity and looks among others. In this case, one is respected for what one has got, which entails a conditional value. The second is "ultimate" or "absolute" which is determined by whatever one's intrinsic values might be in this case, one is respected for what one is and not because of what one has. Absolute value is in agreement with Kant's concept of human dignity.

Laszlo (1971) agrees with Kant's concept of human dignity but describes it in terms of its maintenance. According to Laszlo, human dignity is the end result of matching inherent needs or norms with the cultural environment:

> Human dignity, I suggest, resides in the sum of satisfactions of human being in the sum of matching of innate norms with the corresponding environmental states, thus human dignity signifies the being (biological need - environment matchings) as well as the well-being (cultural requirement - environment matchings) of person. An existence in which intrinsic requirement are matched with extrinsic conditions possesses excellence and worthy of esteem (p.198).

Laszlo mentioned innate norms but he does not fully spell them out. However, one may interpret this definition to mean that everything that is done to an individual should correspond with what is expected by the person to feel valued and that the individual is aware of this. The end product of this matching of the innate norms with the corresponding environment is the feeling of worthiness, that is, the feeling of being valued by a recipient. A point that also deserves noting is that due to variation of norms, dignity can represent more than one perspective. It is how an individual perceives and values herself or himself. In line with Laszlo's views, Seedhouse (2000) defined dignity in terms of matching capabilities and the circumstances one finds himself or herself in. If there is a mismatch between capabilities and circumstances then the person's dignity is likely to be lost. The problem is that different people will have different capabilities under different circumstances, thus making it difficult to come up with an absolute definition. Seedhouse himself acknowledges the deficiency of his definition by saying that more detailed explanation is needed to find what dignity means for each person. However, all these scholars agree that a person possesses absolute value.

A number of scholars in the nursing profession have embraced the absolute value of human dignity as demonstrated by Caygill (1990) who defines dignity as a:

> socially recognised sense of worth that is generally accorded to and claimed by individuals (p.18).

Dignity is a recognition of the intrinsic value of people, regardless of circumstances, by respecting their uniqueness (HMSO 1990, Aspinall 1995). This is the kind of value about which this study is concerned.

From the definitions above one can see that worthiness of the individual and his or her being valued are paramount. Despite the growing interest among scholars

on the concept of dignity, a comprehensive and specific definition of dignity in general, let alone patient dignity in particular, is difficult to discern. Like all concepts, patient dignity is a mental formulation of diverse phenomena. It is an abstract representation of reality (Chinn and Jacobs 1983). Kaplan (1964) states that concepts can be described using observable empirical references which can on the one hand be directly observed or on the other be difficult to observe. Chinn and Jacobs (1983) argue that if a concept is difficult to define, its meaning can be inferred from other theoretical concepts. These concepts appear repeatedly in the literature and are sometimes referred as "attributes".

In the United Kingdom, Mairis (1994) interviewed 20 student nurses to find out their perception of dignity in general and identified self-respect, self-esteem and appreciation of individual's standards to be the central parameters by which the concept of human dignity might be defined. Haddock (1996) attempted to clarify the concept by seeking definitions from 15 participants including nursing colleagues, friends and family members. The participants did not come up with a specific definition of dignity but described human dignity by using the following parameters or attributes: respect, self-confidence, self-control, control of the environment, privacy and positive self-identity. The attributes in these studies provided pointers to what might constitute dignity. However, both studies were done with people in good health rather than with patients in hospital, therefore, these attributes may not be necessarily applicable to patients. Besides, the samples of research were small and the results cannot be easily generalised across different clinical practices.

In the United States of America, Porkony (1989) interviewed 9 patients as part of research which was meant to describe how nursing care affects dignity. She came up with the following attributes of human dignity: privacy, control, independence,

competence and care. Her study too had limitations and the differences in culture and in hospital organisation in the USA may mean that her results cannot be generalised to the United Kingdom Health Care System. The results are limited by the small sample she used. Some of these attributes identified in cited studies have been mentioned sparsely by other scholars as attributes of patients dignity. For example, Watson (1988) identified that maintaining one's privacy is maintaining one's dignity and Browne (1993) stated that to respect an individual is to give him or her dignity. Although all these definitions have contributed to the understanding of the concept of human dignity, the notion of patient dignity still remains to be resolved.

2.2 The Notion of Patient Dignity: A Critique

The principal problem of the definitions of dignity as stated above is that they are too broad; they are not specific enough for patient dignity. Other scholars have talked about dignity in a casual manner. For example, Barnett (2000) has sought to restore dignity in individuals with dementia, while Yeats (1990), trying to discuss the importance of restoring dignity in clients, does not actually define the concept. It is patent, therefore, that a clarification of the concept of patient dignity be sought. Besides the concept of dignity itself, which forms the basis of understanding the concept, patient dignity has numerous problems and needs clarifying.

The concept of dignity is abstract; the common word "worth" describing the concept is vague, while the attributes used to define it need defining. There is also some confusion in the use of the concept. For example, in Collins' (1991) Dictionary, "honour" has been used to define dignity. However, according to Berger, Berger and Kellner (1973) "honour" and "dignity" have separate meanings. They argue that

"honour" is the reward of effectively performed duties linked with status, whereas "dignity" relates to the individual's intrinsic worth regardless of his or her position in society. Scholars such as Wherry (1994) and those who compiled the Patient Charter (DOH 1992) and the NHS Plan (2000) treat "privacy" and "dignity" as separate words while in some circumstances, these words are perceived as having the same meaning. Collins (1991) dictionary definition of "dignity" is synonymous with "respect" while Rines and Monteg (1976) state that there is a difference between the two. They argue that "respect" is regard for the worth of someone or something, whereas "dignity" is described as nobleness, which in turn is defined as high excellence or worth.

Even in these distinctions, however, the meaning of the word dignity is not very clear. There are scholars who still see worth and dignity as different concepts, as exemplified by Blackstone (1970 p. 34-35) who states that "the rights designated as human are justifiable by reference to the principle that all humans are beings with intrinsic worth and dignity". Another problem is the failure to establish a connection between the notion of dignity and its attributes. For example, taking one attribute "privacy", scholars like Watson (1979) and Oliver (1993) claim that privacy relates to dignity without demonstrating what the relationship might be. Other scholars have taken privacy and dignity as two distinct concepts. The fuzzy relationship between the two concepts also applies to all attributes discussed above. Furthermore, the definitions found in the literature on human dignity lack empirical support. Most of what has been described are largely assertions from the scholars' point of view. Besides, although dictionaries are useful in defining concepts, their everyday and common sense meanings are less precise and may differ from scientific meanings (Waltz, Strickland and Lenz 1991). Norris (1982) states that common sense definitions may face two problems: the concept may be too widely used and so

broadly defined that it eludes a concise definition. In other words a person coping with broad definitions may use his or her personal experience to give them meaning, depending on their social and cultural environment, and mental capacity and age among other factors.

Given the above limitations, therefore, the questions that should be asked must be: does illness or the hospital environment change one's perception of dignity? How much control, autonomy or privacy, for example, should a patient have to perceive that he or she has dignity? Scholars have variously agreed that the concept "dignity" in nursing practice is vague and needs clarification. For example, Haddock (1996) has stated that despite attempts to define dignity there is still no clear definition of it in clinical nursing practice and Mairis (1994) in her study concluded that the concept needed clarification in practice. Recently, Seedhouse (2000) called for a more depth investigation to find out what dignity means in practice. These various positions are encapsulated by Johnstone (1994) who states that:

> the term has been freely used and there is room to question whether those who use it have a clear understanding of what exactly they mean (p.257).

This is echoed by Salsbeny (1994) who argues that:

> respect of human dignity is frequently identified as one of the basic values in nursing but what it means for practice is unclear (p.16).

For a very long time it has been assumed by the nursing profession that nurses know and understand what is meant by patient dignity. This has an implication on whether it is being maintained or not in clinical practice and how much research can be done on the subject. The next section presents previous research on patient dignity.

2.3 Previous Research on Patient Dignity

As indicated in the previous section, the expression "patient dignity" is used in the everyday life of health care settings but there is surprisingly little research on the topic that has been carried out in hospital settings. The literature so far has yielded a small number of studies which have attempted to define the concept of human dignity in general, as mentioned in section 2.1 and none on patient dignity. There is little research evidence that demonstrates the extent of the maintenance of patient dignity in clinical practice. The Health Advisory Services 2000 (1998) conducted a study in 16 randomly selected acute wards in general hospitals in England. The aim of the study was to investigate the kind of care given and the factors that might influence its quality. The sample consisted of patients from the age of 75 years upwards, their relatives, ward staff and managers. Researchers used different methods, including interviews, questionnaires, and direct observation. Among the problems that were highlighted were the fact that the preservation of dignity was missing when meeting patients' essential needs such as personal hygiene and dressing. Some of these were due to poor physical environments and others related to staff attitude. One significant finding of the research is that it identified the indignities patients faced in hospitals. The study tried to find out the views of patients but the sample was too small for the number of hospitals involved. It consisted of only 71 patients. The results could not, therefore, be generalised to other hospitals. Also the methodology was potentially flawed as patients and relatives were interviewed after being discharged from the wards. It is likely that patients might have forgotten some of the experiences which they had while in hospital or be so grateful to be released that they glossed over difficulties. The focus of the research appears to have been on the quality of care in

general. Poor maintenance of dignity was not specifically identified as part of the study and it was likely that other aspects of patient dignity were missed.

Recently, Gallagher and Seedhouse (2000) conducted a pilot study on elderly care wards. Three hospitals in England were used for the project whose purpose was to test the hypothesis that practice would improve if health workers were enabled to understand and apply a clearly defined notion of dignity. As part of the project, a convenience sample of six nurses and health care workers were interviewed on each site and a selection of patients and relatives were also interviewed regarding the maintenance of patient dignity in the wards. Although the sample was small, data emerged which revealed the indignities which patients face in hospitals. These included staff attitudes, nurses being busy, the use of agency nurses and environmental factors such as curtains not closing properly, lack of resources and patient or client conditions for example being confused. These were the factors which were identified as hindering the maintenance of patient dignity. Further qualitative research was suggested. The other limitation is that the above research concentrated on older patients. It was for this reason that patient dignity for a wide range of age group was explored in the present research. Apart from Gallager and Seedhouse's (2000) pilot study, research which has been done to investigate the factors which influence the maintenance of patient dignity in hospital wards is difficult to find. This research identifies numerous forces that influence the maintenance of patient's dignity. It is hoped to fill the gap of knowledge identified from the previous research.

Apart from the above research, scholars have concentrated only on specific attributes, finding out whether dignity is being maintained or not. For example, Bauer (1994) interviewed and used a questionnaire to examine the patients' point of view on the level of privacy in acute care hospital wards in Germany. There was some

dissatisfaction among patients about how their dignity was maintained. Again, due to differences in culture and hospital organisation, the results can not be generalised to other countries. In Britain, Matiti and Sharman (1999) utilising a questionnaire, concentrated on communication, body image and privacy in their investigation of a sample of 249 patients, in the hope of finding out whether or not nurses maintained patient dignity preoperatively. Although the majority of patients were satisfied with the maintenance of their dignity, one of the findings was that nurses did not understand patient dignity. Further research was, therefore, required to explore this and to find out other reasons why some patients felt that their dignity was not being maintained. The study had limitations. Items included in the questionnaire were based on previous scholars' points of views and not from the patient's perspective. The questionnaire was not a suitable tool to capture the complex nature of patient dignity. The sample was from surgical patients only, which did not represent other types of patients, making it difficult to generalise the results.

Coyle (1997) interviewed 41 participants in her study which explored the meaning of "dissatisfaction" with health care. The sample included patients, carers and relatives who had experienced problems in health care. They were identified from a household survey of health services users in Scotland. The results indicated that the patient's personal identity was threatened and patients felt dehumanised and devalued. Building on Coyle's (1997) qualitative study, Coyle and William (2001) conducted more research whose aim was to identify the frequency and distribution of inpatients' experiences of "personal identity threat". The study adopted a cross – sectional survey design. 97 patients from general medical, surgical and otolaryngology wards completed a questionnaire developed from the previous qualitative study containing items on dehumanisation, objectification, disempowerment and devaluation. Patients

revealed that they were being devalued, that they were not being involved in their care and that they lacked control. More importantly, staff discussed patients as if they were not there. Although the purpose of these studies was not to investigate patient dignity, they clearly illustrate the dehumanisation which patients go through while in hospitals. Such studies are important in that they make significant revelations of the patients' indignities in hospitals. However, there is a need for more research in different hospitals in order to specifically explore the concept of patient dignity. As different hospitals have different organisational cultures which contributes to these indignities, the more hospitals are used for research the clearer the concept of patient dignity and its maintenance becomes.

Apart from the research mentioned above, a number of scholars have mentioned anecdotally the causes of lack of patient dignity. Minardi and Rilley (1997) claim that when one is ill, one's self changes as there is a loss of sense of one's wholeness. Therefore, it is the illness itself which causes an individual to lose her or his dignity. The patient assumes the sick role (Parson 1951) which is characterised by being dependent on others physically, psychologically and socially. Pain, fatigue or loss of a part of the body may cause one to be unable to carry out certain body functions (Mairis 1994). He or she seeks medical help, hands over part of the control of his or her faculties to health care workers who decide what can be done on his or her body. This loss of control and dependence on others, may lead to loss of self esteem and, therefore, one's dignity (Johnson 1991). Autonomy is also eroded by illness (Morrison 1994); there is a threat to one's existence; the future is uncertain; all this brings a state of insecurity in the patient. For some patients the experience of illness is self shaming. Diagnosis, reaction of the family and friends, hospitalisation and many contacts during nursing care, may precipitate feelings of embarrassment.

The very fact that one is admitted to hospital and one is bed bound may threaten or violate one's dignity. As Goffman (1968) states, hospitals have a damaging effect on the patients; a hospital admission entails the removal of a person to new surroundings; the usual roles and routines are left behind; a person has a new set of expectations and a new routine of daily activities which are largely determined by the demands of the hospital setting. A person is forced to stay with strange people in unfamiliar surroundings with whom he or she shares such facilities as toilets and bathrooms. Activities in hospital may be invasive (Matiti and Sharman 1999). For example, patients are stripped of familiar items such as clothes. Physical examination and treatment in most cases require an intimate access to patients' bodies. Patients expose their bodies in humiliating postures to health care workers. Types of physical contact which are considered inappropriate in everyday life become permissible. Female and male patients are attended to by staff of both sexes often with little regard to patients' preferences. The body becomes an object (Gadow 1982), a "thing" to investigate and to be treated (Van den Berge 1980). Oliver (1993) blames the architecture of the wards in the hospital. There are a number of open wards which patients are meant to share when they come in hospitals. The problem is that all these assertions without research evidence could be regarded as mere assumptions. There is a need to understand these matters from the perspective of patients. MacDonalds (1985) argues, however, that although patients face some risks of losing their dignity when in hospital, it is up to nurses to recognise these risks and intervene on their behalf. Without some concept of what constitutes patient dignity, nurses cannot be expected to intervene on behalf of patients in their care.

Considering how important patient dignity is, it is surprising that, to date, the notion has been neglected in empirical research. The concept still lacks a solid base

which can be used by nurses while caring for patients on a day to day basis. This can also be attributed to the abstractness of the concept and lack of developed tools to measure the concept. Research is required in clinical practice to find out how patients perceive their dignity. Castledine (1996) supports the view that dignity can only be measured by knowing what these terms mean to patients and soliciting their feelings on whether it is being maintained or not. Patients are the proper judges of their own experiences. Further research in patient dignity can also be justified because most of the above mentioned studies have been carried out in different cultural settings. Dignity as a cultural concept is demonstrated by the fact that quite a number of nursing codes of conduct from different countries have embraced the concept. An inter-cultural research on the notion of patient dignity might provide a "global" operational definition. Operationalisation is a process of making a concept explicit in terms of observable indicators associated with the concept (Waltz, Strickland and Lenz 1991). A concept which is operationally defined is less likely to be misinterpreted. Rush and Quellet (1993) point out that it is the responsibility of a profession to describe or define concepts which are of concern to its practitioners, because without a clear understanding of them, ambiguity and confusion may not be avoided.

Furthermore, the implications for nursing education have not been addressed so far. It is important for nurse educators to address the claims of this study and its implications to nursing education, as findings in empirical research should influence curriculum development as well as practice. It is also apparent that apart from the paucity of the studies done on the subject, no researcher has interviewed both patients and nurses in the same setting on the subject. Although the main focus of this research was the patients' views on how they perceived their dignity and whether it

was maintained or not, it was also paramount that the views of nurses be considered. For nurses to effectively maintain patient dignity there is a need for them to reflect on how they perceive it and this will facilitate a common perception of what the concept means. Having a clear grasp of what the concept is and ensuring that there is a common perception between nurses and patients is the prerequisite to the maintenance of patient dignity. Another reason for including the nurses was that their perception would add to the understanding of the concept. Though every group of health care workers is responsible for maintaining patient dignity, nurses are potentially the most significant group because nurses comprise the largest group of health workers and there is a high level of personal contact between nurses and patients. Because of the extent to which nurses contribute to the maintenance of patient dignity it is important that the nurse-patient interaction should be explored further.

2.4 Nurse-Patient Interaction

Fawcett (2000) states that every profession has global concepts that are of central interest to that particular discipline. These metaparadigms act as a guide in structuring the knowledge and practice of the discipline. She further summarizes these metaparadigms for nursing in four aspects. The "person" which refers to individuals, families, communities and other groups who are participant in nursing is the first. The second is the "environment" which refers to a person's significant others and physical surroundings as well as the settings in which nursing occurs. This includes cultural, social, political and economic conditions. The third is "health", which refers to a state of well being at the time that nursing occurs. Lastly is "nursing" which are actions carried out by nurses. These are in agreement with the

thinking of a number of scholars in the nursing profession. When these metaparadigms are applied to a hospital situation, the person would be the patient in a state of illness, nursed in a hospital environment. It is through nursing activities in nurse-patient interactions that patient dignity is perceived to be maintained by patients and nurses. Despite scholars exploring these metaparadigms in different models and theories, they have not paid enough attention to the maintenance of dignity, despite its importance to every patient. A nurse looking after a patient without being humane treats that patient as an object. Being humane means feeling or showing tenderness or kindness to patients. Henderson and Nite (1967) say

> the function of a nurse is to assist the individual in the performance of those activities contributing to health or its recovery (or peaceful death) that he or she would perform unaided if he had the necessary strength, will and knowledge (p.34).

Although dated, this definition still holds true for current nursing practice. It is inherent in the notion of "care". Watson (1985b) and Leininger (1988) state that care represents the essence of nursing practice. According to Brencick and Webster (2000), there is subjective notion and objective notion in caring. The subjective part involves, for example, sentiments and valuing the patient while the objective notion entails tasks done. Watson (1985a) asserts that both notions should be a balance to make a patient valued. Otherwise nursing care becomes just a collection of tasks. It is the subjective notion that makes the care humane. There are a number of scholars who explicitly and implicitly advocate human caring. Atkinson (1994), calling on nurses looking after critical care patients, stressed human caring. Leininger (1990) asserted that human caring is the central concept to nursing. However, the theory which has been chosen to guide this study in understanding the nurse-patient interaction is Watson's theory of human caring. It is the most influential theory which

directly relates to this study. It specifically mentions the need of maintenance of dignity. Watson's (1985a) makes the following philosophical claim:

> Human caring is the moral ideal of nursing whereby the end is protection, enhancement and preservation of human dignity (p.29).

Human caring allows a nurse to be morally committed to a patient, restoring his or her humanity, without reducing the patient to an object (Watson 1988). Watson believes that in the caring process a nurse and patient enters a human-environment "field". Each person has a phenomenal field, the totality of human experience of one's being. This is the subjective frame of reference that can be known only to the person concerned (Watson 1985a). Both parties enter "an actual caring occasion" whereby both, possessing their own phenomenal field, come together in a human to human interaction and both are influenced and affected by the nature of the transactions. According to Watson the moment of coming together in a caring occasion presents the two persons with the opportunity to decide how to be and what to do in the relationship. She called this relationship, the "transpersonal caring relationship". Although Watson does not spell out precisely what she meant by this, thc relationship is centred on both parties who are viewed as co-participants in the process of nursing and a fundamental aspect on this occasion is the acknowledgement of each person's uniqueness. Both the nurse and the patient have high regard for the whole person and avoid reducing the being to an object. She developed "carative" factors which require intentions, caring values, a will, actions and human-human relationship (Watson 1989). Watson (1996) acknowledges the importance of human dignity of both parties in the caring relations. She claims that only if nurses treat themselves with dignity they will treat their patients or clients with respect, care, gentleness and dignity. In line with Watson's theory, Long (1992) stated that nursing is an interpersonal process

achieved by establishing a human to human relationship. Brencick and Webster (2000), commenting on Watson's theory, added that there are certain requirements that must be met. The nurse and the patient must have insight into their own conduct during the entire caring behaviour, otherwise the other partner's dignity would be violated. In addition, nurse and patient must have similar views about the nature of caring. With the current controversy in British Health Care in mind, Watson's (1985a) argument seems necessary in today's rapidly growing, complex technological health care systems. Watson (1996) claims that there has been a proliferation of the "curing syndrome" at the expense of human caring.

Undoubtedly Watson's theory is a useful guide in the maintenance of patient dignity. However, the theory has flaws. It assumes that everyone engaged in the caring occasion is rational and conscious enough to participate in the caring. Some patients lose their perceptual capabilities and are not aware of what is happening during nurse-patient interaction. Despite this they deserve the maintenance of their dignity. There is also an assumption in the theory that the two parties have similar perceptions regarding patient dignity. Research has examined the congruence of perceptions between patients and nurses. Holmes and Eburn's (1989) study revealed that nurses overestimated the degree of distress when this was compared with the patients' self-assessment. Biley (1989) discovered that nurses consistently assessed patients as worrying more than what patients actually reported themselves. This shows that incongruency of perception of patients' needs between nurses and patients has been a long standing problem. Farrell's (1991) comparative study of general and psychiatric patients, on how accurately nurses perceived patients' needs, also found incongruency between nurses' perception and that of patients' in relation to patients' needs. Using a questionnaire, 60 patients including 30 psychiatric from two acute and

30 from two general medical wards took part. 27 nurses, 13 from a general setting and 14 from a psychiatric setting took part in the study. The findings from the study revealed that there were variations of perceptions between patients and nurses. Nurses were stereotypical when assessing patients' needs. Although the research was done partly in a psychiatric ward, a different speciality to the present study, the results give a picture of incongruences of perceptions between nurses and patients. The above study supports the claim made by Schlotfeldt (1975) that in many nursing situations the nurse and patients' or clients' perceptions are incongruent. Although the claim is old, the position seems not to have changed much as this research has revealed. This demonstrates that the nurse-patient relationship is not necessarily on an equal footing.

The other problem is that Watson's (1985a) theory does not explore the factors which may influence the maintenance of dignity in this relationship. Nurse-patient interaction is a complex endeavour; both parties bring different perceptions to the interactions shaped by culture, education and experiences. These pre-existing beliefs and values influence how they perceive their dignity and how they expect their dignity to be maintained. They will also influence how they act or behave to one another, which can affect one's dignity. There is also a difference in the health status of the nurse and the patient. The patient is ill while the nurse is healthy. Therefore, the patient loses his or her normal "self" to perform on an equal basis with the nurse, for example, what the patient normally performs in terms of daily activities of living. As a result the patient depends on the nurse. The nurse is seen as an expert and provider of care while the patient is the receiver of the care. The patient divulges his or her private "self" to the nurse in order to be helped while the nurse does not. This makes it difficult to conceptualise the interaction as an equal human to human relationship. Part of the complexity is that the nurse and patient experience the hospital situation

differently. While for the nurse it is a usual work place which they are familiar with, for the patient it is unfamiliar environment which can affect their perceptions in the interactions. From all these factors, one can see that patients are in a disadvantageous position, vulnerable and powerless while nurses are in positions of power. It is crucial for nurses, therefore, to realise these factors and the effect this imbalance of power has on the maintenance of patient dignity.

The other point important to this research is that Watson (1985a) does not define clearly what she means by human dignity. This deficit was also picked up by Tschudin (1997) who stated that Watson did not clarify what she meant by the term. It is for these reasons that this research has proposed a working definition of patient dignity in the hope of clearing the ground. Clarifying the concept from both perspectives will minimise differences and facilitate the development of a common language in clinical practice (Rush and Quellet 1993). It is one way in which nurses will become conscious of the concept patient dignity itself.

2.5 Summary for Chapter 2

From the foregoing discussion, a theoretical overview of the notion of dignity in general and a critique of the inadequacy of definitions has been established. It has been revealed that scholars who have attempted to define dignity have done so in different ways. However, the general agreement is that a person has an absolute value which needs to be respected. Although the concept is important and a significant number of scholars have touched on the subject, the area is in a state of conceptual confusion. Inadequate research on the topic can be attributed to the fact that the concept is abstract, there is a lack of research tools to measure the concept and the

apparent assumption that how the notion of dignity is perceived in everyday use also applies to concept of patient dignity. This research is one of the attempts to address this deficit. However, one cannot discuss patient dignity without referring to caring, as patient dignity is an integral part of caring process. Human caring as proposed by Watson (1985a) and other scholars has therefore, been used as a theoretical framework for this research, proposing the preservation of human dignity for patients, rather than reducing them to objects. To find out how patients and nurses perceive patient dignity requires a suitable methodology which can capture the subjective experiences of participants. It is this research methodology that the next chapter examines.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Research Design

Having established the need for more research on patient dignity in the previous chapters, this chapter provides a detailed account of the research methodology used. The chapter is organised in sections that explain ethical issues, sample methods, data collection and data analysis. How "trustworthiness" (Robson 1993) during data collection was achieved is also discussed. Research design is an overall framework or "blue print" (Couchman and Dawson 1995) or the researcher's overall plan (Polit and Hungler 1997) for conducting a study. It is concerned with turning research questions into a research project and consists of purposes, framework and strategies or methods to be used (LoBiondo - Wood and Haber 1990).

Robson (1993) suggested that in choosing a research design, the researcher should consider the purposes of the research. He further stated that there are three types of research purposes, namely, "exploratory" which means finding out about a situation or assessing phenomena in a new light while "descriptive" means portraying an accurate profile of persons, events or situations and requires extensive previous knowledge of the situation and finally "explanatory" in which the researcher seeks an explanation of a situation or problem usually in the form of cause - effect relationships.

This study is exploratory because research on the notion of patient dignity is still limited. According to Brink (1998) exploratory designs have two major goals. The first is identifying and describing a problem area never previously studied or

known. The second is exploring the meaning and describing the concept when no or little literature exists on the topic like patient dignity.

3.2 Research Methods

This section begins with a critical analysis of other methods which have been used to analyse the concept of dignity before being followed by a justification of the method chosen in the current study. A number of scholars have used Wilson's (1963) method of concept analysis to clarify concepts. For example Morse, Bottorff and Hutchinsons (1995) used the method to analyse the concept of "comfort". Wilson designed these techniques to be used as class exercises in sixth forms for entrance to university. The steps involved are:-

(1) Isolating questions of concepts. A researcher may be faced with an ambiguous question; therefore, he or she should actually isolate the kernel concept from the minor ones.

(2) Develop "right answers". In this case Wilson meant that the question does not have clear cut answers. It might be followed by "what do you mean?" It depends on whether the researcher picks out the right answer or not.

(3) Finding the "model case". It is an illustration of an absolute instance of the concept.

(4) Contrary cases are instances which do not reflect the concept.

(5) Related cases; finding other concepts which are related to the concept.

(6) Borderline cases - are instances which may or may not reflect the concept and which the researcher is not sure of.

(7) To be imaginary and think of other examples of concepts in practice which are quite outside ordinary experience.

(8) Exploring the nature of circumstances, that is the social context in which the concept is uttered considering who, why and when.

(9) Underlying anxiety of the person who states the concept.

(10) Practical results entails putting it into practice by applying "yes" or "no".

(11) The last step is language and entails picking the most useful meaning which can be used to its full advantage.

Subsequently, Wilson's method was adapted in nursing research to clarify concepts by Walker and Avant (1988) and Chinn and Jacobs (1983) which have been very influential in concept clarification in nursing (Mairis 1994, Haddock 1996). Scholars like Rodgers (1989) and Schwartz-Barcott and Kim (1986) detected some deficiencies in Wilson's method and, therefore, modified it. Schwartz-Barcott and Kim (1986) constructed a hybrid model which occurs in three overlapping phases: theoretical, field work, and analytic. The selection of the topic is rooted in nursing practice encounters (Hilfinger Messias 1997). This method uses actual nursing situations as the basis of concept selection, conducting an extensive multi-disciplinary literature review, collecting and analysing empirical data, identifying "real" cases and working back and forth between empirical data and theory. This method has also been used by some scholars. For example Maden (1990) used the hybrid model to analyse the concept of therapeutic alliance and Verhulst and Schwartz-Barcott (1993) analysed the concept of withdrawal using a hybrid model. Although some modifications were made, Wilson's principles are still inherent in the model. Although Wilson's derived methods have been widely used, they are vague and

difficult to understand. As Hupcey, Morse, Lenz and Cerdas (1997) pointed out, Wilson based approaches have produced results that lack cohesion and explanatory power. They described the methods as being incomplete and vague, lacking in clarity about what is a suitable concept for analysis.

Generally, methods used in research are derived from two schools of thought, namely positivism and interpretivism (Gross 1992). The positivist philosophy claims that scientific knowledge must be based on pure observation that is free of interests, values and the psychological schemata of the individual (Stevens, Scade, Chalk and Slevins 1993). It is concerned with theories and hypotheses that are tested; it adopts a deductive approach (Brink and Wood 1998). Research carried out within this philosophy is usually quantitative and includes experiments (Holloway and Wheeler 1996). Patient dignity is a subjective concept which does not lend itself to quantitative measurement. According to interpretivism, human behaviour can be understood when the context in which it takes place and the cognitive processes which give rise to it are studied (Stevens et al 1993). The approach centres on interpretation and creation of meaning by human beings and their subjectivity (Holloway and Wheeler 1996) using the inductive method which goes from the particular to the general (Brink and Wood 1998). Research carried within this philosophy is qualitative (Morse and Field 1996). Neither school of thought is superior to the other because the use of either approach will depend on the purpose of the research.

A qualitative approach was adopted in this research. The aim was not to impose views upon the participants but to have them discuss their perspective as they perceived patient dignity. Qualitative research is any kind of research that produces "soft data" (Burns and Grove 2001). The goal of qualitative research is understanding of the phenomenon from the perspective of the people who are being studied

(Thomson 1998) which is called the "emic perspective" (Morse and Field 1996). It is used when the purpose is to gain an insight in a field where little is known. The main approaches in qualitative research are grounded theory, symbolic interactionism, ethnography and phenomenology. All meet the requirements of exploratory design (Stevens et al 1993). All these approaches have the common principle of exploring the participants from the "emic" point view. But each approach differs from the other in terms of purposes.

Ethnography is an approach whereby the researcher describes the culture of a particular society (Morse and Field 1996). The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time watching what happens, listening to what is said and collecting data to throw light on issues under study. It is not appropriate for this research as its purpose is to describe the culture and lifestyle of the group of people being studied (Stevens et al 1993). Grounded theory is a method that uses a systematic set of procedures to develop an inductively derived theory about a phenomenon (Strauss and Corbin 1990). It is used in areas in which little research has been done and the researcher starts afresh, hardly influenced by previous knowledge (Morse and Field 1996). This approach was not wholly appropriate because the researcher has conducted a study before on patient dignity and is familiar with the concept. Both symbolic interaction and phenomenology are concerned with how people define events or reality and how they act in relation to their beliefs (Chenitz and Swanson 1986). Stevens et al (1993) highlight the difference between the two approaches. The symbolic interactionists see the individual almost as a tabula rasa whose understanding, attributed meanings and behaviour arise to a large extent from his or her interactions with others, while phenomenologists are primarily interested in the deep subjective meanings attributed

to, and the experiences felt towards, particular objects or situations. Phenomenology is a way of thinking about what life experiences are like for individuals (Powers and Knapp 1990). Through an inductive approach this method attempts to describe human experience in its context. This approach was found to be a more fruitful way of uncovering and describing the meaning of lived experiences of patient dignity in medical and surgical wards than the other approaches. Patients described their experiences in relation to dignity from their own perspective while nurses added to the picture. It also allowed participants to reflect on the concept. Hallet (1995) agrees that:

> the greatest value of phenomenology for nurse researchers lies in the fact that it is the only approach available which deliberately takes a participant's subjective perceptions as its focus (p.63).

Streubert and Carpenter (1999) state that the choice of method to be used in a research should depend on the nature of the phenomenon under investigation and the appropriateness of the method to be used. Phenomenology as a research approach has been used extensively in different disciplines since its inception. There has also been enthusiastic usage of the method in nursing. Its long time usage in research can be inferred from its historical background which is part of the next section.

3.3 Phenomenology

Phenomenology as an approach for inquiry was developed by Edmand Husserl who was attracted by his teacher, Franz Brano's work on phenomenological inquiry in the last half of the 19th Century. Husserl's work was concerned with studying phenomena as they appear through consciousness (Spielgelberg 1975). Research following his work seeks the nature of meaning of human experience by answering

the question "What is it like?" (Koch 1996). According to Husserl, positivist science is abstract and incapable of dealing with human experience (Power and Knapp 1990). His work focused on the description of concepts. Thus in the context of patient dignity, a researcher would be concerned with purely describing aspects of the concepts as they surface from the data. The work was later refined by Martin Heidegger who introduced hermeneutic phenomenology in 1916. The basis of his phenomenology was that the origin of knowledge was embedded in everyday activities (Walters 1995). In other words a person can be understood from his or her experiences.

The work on phenomenology was further developed by German and French Philosophers in the first part of the 20th century. The German Karl Jaspers and the French philosophers Gabriel Marcel (1889-1973), Jean Paul Sartre (1905) and Maurice Merleau-Ponty (1908-1961) were the main proponents of this theory. Despite these different contributions, phenomenology approaches are grouped into three main schools of thought. The first is descriptive phenomenology, also called the Duquesne school (Cohen and Omery 1994) guided by Husserl's philosophical ideas. This focuses on description of concepts. Thus in the patient dignity context, a researcher would be concerned with describing aspects of the concepts as they surface visibly from the data. The second is the interpretative approach which is based on Heideggerian hermeneutics. It involves gaining a deeper comprehension of the concept, uncovering the hidden meanings taking into consideration the context in which it was said. Gadamer (1976 p.xii) states that "its field of application is comprised of all those situations in which we encounter meanings that are not immediately understandable but require interpretative effort". The approach is essentially the interpretation of phenomena appearing in the text or written word

(Streubert and Carpenter 1999). It is a useful mode of uncovering the hidden meaning in context. For example Macleod (1994) used the interpretative approach to investigate the everyday experience of nursing practice which is mostly taken for granted by nurses.

The third school of phenomenology combines the above two, description and interpretation (Cohen and Omery 1994). These broad approaches of phenomenology have been further modified by a number of researchers. For example in the descriptive approach, some modifications can be noted throughout the work of van Kaam (1959), Collaizzi (1978) and Giorgi (1985). Faced with different modifications of the phenomenological approach a decision had to be made on which type was suitable for this research. The aim of this research was to uncover and describe participants' live experiences of patient dignity. Therefore, Spielgelberg's (1975) phenomenological approach was found to be appropriate for this research. It combines the essence of both the descriptive and the interpretative approaches. This method identifies six steps namely:

(1) Descriptive Phenomenology which involves direct exploration, analysis and description of a particular phenomenon as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation.

(2) Phenomenology of essences which involves probing through the data to grasp the essential structure of the phenomenon (essences) and relationships with other appearing phenomena. It presupposes free imaginative variation in order to determine what is and is not the essence of phenomena and what is necessary or accidental.

(3) Phenomenology of appearances: while analysing the data, the researcher not only considers what phenomena is coming out but also how it appears.

(4) Constitutive phenomenology: this entails paying attention to the way the phenomena takes shape in the researcher's consciousness.

(5) Reductive phenomenology refers to the process of identifying and holding in abeyance any preconceived beliefs and opinions one might have about the phenomenon under investigation. This process is implicitly involved in other steps.

(6) Hermeneutic phenomenology involves unveiling concealed meanings in the phenomenon. The combination of descriptive and interpretative approaches enabled the researcher to analyse the data from different angles. The concept of patient dignity is abstract, with its meaning hidden in hospital language. Therefore, apart from describing the phenomena, it also helped to capture this covert meaning by interpretation.

After establishing the methods to be used, it was important to think about ethical issues. Couchman and Dawson (1995) state that ethical issues have to be considered when carrying out research, whether qualitative or quantitative, so that participants can be protected. The next section discusses ethical issues.

3.4 Ethical Issues

The effect of the research on participants was taken into account to ensure that the research was conducted in an ethically acceptable way. Polit and Hungler (1997) discuss ethical issues under three principles: the principle of beneficence, the principle

of respect for human dignity and the principle of justice. The principle of beneficence encompasses "do not harm", which entails that the participants should not be harmed physically, psychologically and emotionally (Couchman and Dawson 1995). As a result, the participants should not be exploited and the researcher should weigh the risk/benefits ratio (Polit and Hungler 1997) and the risks should not outweigh the benefits.

According to Polit and Hungler (1997) the principle of respect for human dignity should include the right to self-determination and the right to have all the information fully disclosed to the participant. These are the two major elements upon which informed consent is based: self-determination entails that the participants, as human beings, should be treated as autonomous agents. The participant should have the right to voluntarily decide whether or not to participate in the research Royal College of Physicians (1990) without the risks and also to decide at any stage of the research to terminate their participation. Self-determination also entails refusing to give information. Participants should be allowed to ask for clarification about the research. After the researcher has described the nature of the study, its purposes, and the procedures, participants should give free informed consent before participating in the study (Robson 1993, Couchman and Dawson 1995). Sieber (1992) stresses that informed consent should be given without inducement. The principle of justice entails that participants should have the right to fair treatment before, during and after their participation in the study. Privacy of participants also needs to be respected by the researcher (Polit and Hungler 1997). The participants should be guaranteed that they will not be identified using the information which they have provided.

All the ethical issues discussed above were considered in this research: permission to conduct the research was obtained from two (one for Hospitals A and B

and one for Hospital C) local Ethics Research Committees for the patients and nurses and from the Education Research Ethics Committee as the research also involved students. Permission was also obtained from medical directors, consultants, directors of nursing, senior nurses and ward managers. Informed consent was obtained from the potential participants in the research. Informed consent means that the participants have adequate information regarding the research, are capable of comprehending the information, have the power of free choice enabling them to consent voluntarily to participate in the research or decline participation (Polit and Hungler 1997). The purpose, nature of the research, time commitment, confidentiality, anonymity and patient's right not to participate in the research was explained verbally and reinforced by a letter (*See Appendix A*) to participants. The letter was read by the participants prior to obtaining their permission to participate and it was emphasised to patients that if they decided not to participate, it would in no way affect their treatment and they could withdraw from the research at any time if they wished to do so.

This point was stressed because of the awareness that patients in hospital settings are vulnerable because of their dependence on health carers, and they could have felt obliged to participate even though they did not wish to. Waltz et al (1991) argue that the provision of information does not necessarily ensure comprehension by potential participants. To ensure understanding, therefore, participants were asked to voice their understanding and interpretation of what was discussed and any questions were clarified. Behi and Nolan (1995) argue that it is difficult to define consent and know whether it was given or not and to emphasise this point, written informed consent (s*ee Appendix B*) was obtained from participants which was advised by Royal College of Physicians (1990). Holloway and Wheeler (1996) also pointed out the problem of informed consent in qualitative research. They state that informed consent

is recognised as problematic in this type of research because data collection and analysis occur simultaneously, and whilst consent may be implied at one stage of the research, it cannot be assumed at another stage when the researcher's objectives change on the basis of the information obtained. The renegotiation approach suggested by Munhall (1988) was adopted. The approach states that informed consent can be achieved in qualitative research by re-negotiation when unexpected events occur for example; one patient in Hospital A did not want to continue because she felt unwell during the process of the interview, and the participant was allowed to withdraw from the research and asked to make another appointment.

In terms of benefit it was also emphasised that this research will have no potential benefits to the participants at the moment but it would be a contribution to the knowledge and understanding of the concept of patient dignity. It would, therefore, make an ultimate contribution to the improvement of nursing care. Anonymity and confidentiality were ensured by the following measures: Each participant was assigned an identification code which was also attached to the tape, transcribed notes and field notes. Codes were used to identify the subjects. For example, if the tape was for Patient No. 1, "HAP 1" was used. "This meant Hospital A Patient No. 1". "N" was used for nurses instead "P" (HAN 1). The "main study" was added to differentiate it from Patient No.1 in the pilot study, for example "Main study HAN 1". A code assigned to the tape for the participant matched the number assigned to field notes. This was done to ensure the correct correlation between what was written and what was then tape recorded. Transcripts, tapes and consent forms were stored in a locked cabinet accessible to the researcher. Participants were told that the information would be destroyed and the tapes erased as soon as the project was completed and accepted by the University.

3.5 Sampling

Arber (1995) states that since it is difficult for a researcher to study the whole population, the researcher is required to determine a sample frame, which is a list of the members of the population under investigation. From this, a few can be selected using different sampling methods to represent the whole population. An individual member in the sample frame is called an element (Burns and Grove, 2001) which is the most basic unit from which the information is collected (LoBiondo – Wood and Haber 1990). But the word "participant" has been preferred over "elements" throughout this research. The word "element" sounds belittling for participants. The participants were patients and nurses in three district hospitals in the Midlands.

There are two types of sampling, probability and non-probability (Robson 1993). In probability sampling, each participant in the population has a known chance of being included in the sample and these include: simple random sampling, stratified random sampling, cluster sampling and multi-stage sampling. In non-probability sampling, participants are chosen non-randomly and examples include convenience, purposive, snowball and quota sampling (Brink and Wood 1998). Among others LoBiondo – Wood and Haber (1990) and Robson (1993) agree that non-probability forms of sampling are less rigorous than probability sampling. They produce less representative data and therefore, generalisations from the findings are limited. Bias in the selection of participants is an additional problem. It is for this reason that LoBiondo – Wood and Haber (1990) warn that studies utilising non-probability sampling should be regarded with caution. This was not regarded as a problem as this research was conducted in a very rigorous way. Measures were taken throughout the research process to ensure the credibility of the findings.

Bias can occur as easily in quantitative research as in qualitative, threatening the credibility of the findings. In other words convenience sampling undertaken with conscientiousness can produce credible data. Non-probability sampling can also be utilised where participants function as informants for the particular research (Bauer 1994). The other reason for using non-probability sampling was the availability of the patients. It was learnt from the preliminary study (Matiti and Sharman 1999) that it was difficult for the researcher to obtain a sufficient number of patients if a random sample is employed in the hospital. For example patients could be randomly selected but some of the patients' condition could prevent them from joining the sample. As a result the size of the sample would be reduced and it would take a long time to find the required number of participants. For these reasons convenience sampling was used to select patients and purposeful sampling to select nurses. Convenience sampling is a technique whereby participants are selected because they happen to be available for participation in the study at a certain time, while in purposive sampling, the sample is selected according to certain important criteria that are known to be significant or the informants have specific characteristics or knowledge of the topic under study (Morse 1991).

3.5.1 Sampling of Wards

The local hospitals included in this research were chosen for practical reasons as they were the nearest to the researcher. Three hospitals were decided upon to provide a comprehensive picture of the results of the research. The research was carried out in surgical and medical wards. In Hospital A, surgical wards included acute surgical, orthopaedic and gynaecology wards. Using surgical wards enabled the

researcher to further explore issues raised in preliminary study (Matiti and Sharman 1999) mentioned in chapter 1 which was conducted in a surgical ward. The researcher was interested in collecting a wide range of data from different hospital settings. Therefore medical wards were added to the sample. Subsequently similar 6 wards were chosen in Hospital B and 9 wards in Hospital C. A Gynaecology Ward was not included in Hospital C. In total 25 wards were used as indicated in Table 1. This provided a wide range of different ward organisation.

Table 1 **A sample of wards from Hospitals A, B, C**

Hospital	**Surgical**	**Medical**
A	6	4
B	3	3
C	5	4
Total	**14**	**11** **= 25 wards**

3.5.2 Sampling of Participants

LoBiondo and Haber (1990) claims that there is no single rule that can be applied to determine sample size because this will depend on the nature of the target population and the problem under study. Walker (1999) states that a qualitative researcher can study using a small sample because the objective of the researcher is to observe and understand things as they occur under specific circumstances. However, Leventhal and Israel (1975) state that the sampling of participants should be governed by both theoretical considerations and practical realities such as the time available for the researcher, the number of researchers involved in the study and the purpose of the

research. These were taken into consideration when deciding on the sampling of nurses and patients in this research.

3.5.2.1 Sampling of Patients

108 patients were approached but six declined to take part in the study, some due to tiredness while others simply did not want to take part. A research diary was kept to note who had declined and why. Altogether 102 patients, 53 males and 49 females, as indicated in Table 2, were included. All participants were white apart from one black African (male) who had lived locally for more than 10 years. This is a reasonable reflection of the population in the rural, predominantly white area in which the study took place. The criteria that was used to exclude and include patients in this research were as follows: any patient admitted in one of the sampled wards above 16 years of age was eligible for inclusion as it was believed that he or she was an adult and could give informed consent. All participants had to show willingness to take part in the research. Patients who were very ill, demented or confused were excluded on ethical grounds. On each day of the research, the nurse in charge of the ward was asked to verify that the selected patients were physically and mentally fit to participate in the study. Only patients who could speak and understand English were included as this would enable them to understand the aims of the research, the questions asked and consent expected.

Table 2 **A sample of patients from Hospitals A, B and C**

Hospital	Female	Male
A	18	20
B	14	14
C	17	19
Total	**49**	**53 = 102 patients**

3.5.2.2 Sampling of Nurses

A purposive sample of 94 nurses was selected. This method of sampling is also referred to as judgmental sampling and involves the conscious selection of participants to be included in the research (Ingleton, 1998). As the term suggests, participants were purposely chosen on the basis of their knowledge and experience in caring for patients, as it is part of the nurse's role to maintain their dignity (Nursing and Midwifery Council 2002). This type of sampling has been used widely by nurses in phenomenological research as it generates rich data relevant to the phenomena under study. Different grades (G, E, D and health care support workers) were involved in the research as indicated in Table 3. Nurses currently caring for patients in the sampled hospital wards, who were willing to participate in the research were included. Students who were at least six months in training were also included. These students were believed to have had enough experience in caring for patients to appreciate the importance of patient dignity. There were 87 female (2 Bank nurses) and 7 male, age range from 20 to 50 years. The nursing experience for qualified nurses and health care support workers ranged from one month to thirty years. No nurse refused to take part.

A day was identified to interview nurses and a phone call was made to the sister-in-charge to identify nurses, health care workers and students who were available on that particular day from the duty rota. The staff were informed that a researcher was coming to interview nurses. Separate phone calls were made to individual nurses to explain the aim of visiting the ward. It was clearly stated that it was voluntary for them to join the study and it was up to them to accept or to decline to participate when they were fully informed about the study on the day of the interview. Appointments to interview them were made on the days and times that were convenient and if nurses were busy on the day postponements were made accordingly thereby ensuring that care of patients was not disrupted.

Table 3 **A sample of nurses from Hospitals A, B and C**

Hospital	Grade	G	F	E	D	HCS W	Student Nurses	Total
A		2	3	9	9	7	8	38
B		1	3	6	4	6	6	26
C		1	1	8	6	7	7	30
Total Nurses								**94**

Key of Grading system for nurses

G - Ward Manager

F - Deputy Ward Manager

E - Senior Staff Nurse

D - Junior Staff nurse

Health Care Support Worker (HCSW) - Unqualified Nurses carrying out patients' basic care.

Student Nurse - A Nursing student enrolled in a Three Year Diploma Nursing School.

3.6 Trustworthiness of the Data

Regardless of the type of approach or method used, the truth of findings depends upon the credibility of measures and the two psychometric properties used to determine credibility, that is, reliability and validity (Burns and Grove 2001). Reliability is the degree of consistency and repeatability of data collection from one time and situation to another while validity is the extent to which an instrument actually measures what was intended to measure (Wade and Tavris 1997).

Guba and Lincoln (1981) suggest that researchers should not strictly apply the positivistic concept of reliability and validity terms in qualitative research as different criteria and concepts have been introduced. Guba and Lincoln (1981) and Robson (1993) use the word "trustworthiness" to describe the validity of qualitative research. Robson (1993) discusses the four alternatives to validity and reliability which were initially proposed by Guba and Lincoln (1981). These are credibility, dependability, confirmability and transferability. The four factors have been demonstrated in the research process and used to enhance the rigour of the analysis and obtain trustworthy data. The next section discusses the four alternatives in detail and a summary of how these were achieved is presented in Table 4, page 54.

3.6.1 Credibility

Credibility required the researcher to demonstrate the truth value of the research (Koch 1994) by carrying out the research in a way that confidence is placed on the data produced. This can be equated to validity in quantitative research. A number of scholars: Polit and Hungler (1997), Robson (1993), Holloway and Wheeler

(1996) refer to Guba and Lincoln (1985). They discuss steps to be taken to establish credibility such as peer debriefing which involves colleagues in data analysis and "member checks" which in turn involves the participants in checking the data to make sure that they reflect what was intended.

3.6.2 Dependability

Dependability refers to "the stability of the data over time and over conditions" (Polit and Hungler 1997 p.255). This is comparable to reliability in quantitative research (Robson 1993). The "inquiry audit" which requires external reviewers to scrutinise the data is a way of achieving dependability. Robson (1993) and Koch (1994) equate this inquiry auditing to business and finance auditing whereby the external auditors examine books and the financial statement as well as the way the accounts are kept. In research the external auditor checks the research process, i.e. the methodology used (Holloway and Wheeler 1996), therefore the research and its findings are auditable when another researcher can clearly follow the "decision trail" used. A "decision trail" involves the researcher presenting, clarifying and justifying both chosen methodology and data analysis (Koch 1994, Sandelowski 1986). This has been demonstrated in this research where supervisors of this research acted as external auditors of the research process.

3.6.3 Confirmability

Confirmability is a way of establishing the objectivity or neutrality of the data by establishing that the conclusions and interpretation arise directly from them (Guba

and Lincoln 1985, Polit and Hungler 1997). According to Koch (1994) confirmability occurs when the four components for achieving trustworthiness have been achieved. This has been demonstrated in the present research.

3.6.4 Transferability

This corresponds to external validity in quantitative research (Robson 1993) and refers to the generalisibility of the data to other settings or groups (Polit and Hungler, 1997). It is the applicability of the findings (Guba and Lincoln 1981), that is, whether they can be applied in other contexts or settings or with other groups. Guba and Lincoln (1981) further suggested that it is difficult for qualitative researchers to specify the transferability of the study. However, the qualitative researcher can provide only a "thick" description necessary to enable someone interested in making a transfer to reach conclusions about whether this transfer can be done. Thick description refers to a rich and thorough description of the research setting or context, and the transactions during the research process. (Polit and Hungler 1997). This has been achieved in this research and it is envisaged that the knowledge gained in this study will be utilised in the profession.

Table 4: **A summary of how Trustworthy of the Data was achieved while conducting the Research.**

Credibility	Dependability	Confirmability	Transferability
• Built rapport with participants. • Ensured participants' confidentiality allowing "openness". • Emphasising to the participants that the interview was not a fault finding exercise. • Patients' contribution in formulating the questions for the interview schedule. • The interview schedule was checked by supervisors. • Use of probes when interviewing the participants. • On the spot verification when interviewing the participants. • Confirming data with participants using field notes. • A sense of humour from the researcher encouraging participants to be more forthcoming. • The use of phenomenological-hermeneutic approach (reading in between the lines). • Participants were asked not to discuss their perceptions among themselves.	• Inquiry audit – scrutiny of the research by supervisors. • Interviews carried out by one interviewer. • Using an interview schedule. • Achieving a decision trail.	• Inquiry audit.	• Thick description.

Credibility	Dependability	Confirmability	Transferability
• Member check. • Triangulation: method of collecting data (interview, tape recording field notes). • Combining phenomenological approach and content analysis. • Bracketing personal definitions of dignity and patient dignity. • Peer debriefing – five colleagues were involved in analysing the transcripts. • One transcript was analysed by one of the supervisors to give an example of analysing data. • Being systematic and rigorous in conducting the research.			

3.7 Data Collection

In section 3.3 the phenomenological approach used in this research was discussed. The usual mode of data collection used in phenomenology is a tape recorded interview (Hallet 1995). An interview consists of data gathering through direct interaction between a researcher and respondent where answers to questions are gathered verbally (Rees 1997). It is a kind of conversation with a purpose (Robson 1993). According to Oppenheim (1990) the purpose of an interview is to obtain information on a particular topic from the respondents and in this study it was patient

dignity. Due to the abstract nature of the concept of patient dignity, other methods would not have provided the type and amount of information required. Participants needed to be questioned directly. The interview was appropriate because the researcher had a chance of clarifying questions during interviews, and therefore, was less likely to lead interviewees into misinterpretations of the questions. This increased the credibility of the research. It also allowed the researcher to explore the concept of patient dignity in depth and also the opportunity to observe the mood and context in which words were uttered. Guba and Lincoln (1981) also suggested that interview is the best method to be used when the researcher would like to investigate experiences of participants where values and beliefs are involved.

Britten (1995) discusses three main types of interviews: firstly, the structured interview which has a standard format with a predetermined set of questions. The researcher asks questions as set; secondly, it is in the semi-structured interview where the researcher has a set of questions (cf. Interview schedule or guide). Using the probes the researcher is free to modify the order of the questions based on the responses from the participants. The interview schedule was devised following the suggestions of Robson (1993) that an interview schedule or guide should include: introductory comments, headings and possibly key questions to be asked under these headings, a set of associated probes and closing comments (See *Appendix C* for the schedule for this study) and thirdly, unstructured interviews in which the researcher has no predetermined questions and the questions are asked in any order.

The structured and unstructured interviews were not appropriate for this research because the structured interview is mainly suitable for facts rather than feelings and perceptions. The varied perceptions of the concept of patient dignity precluded the use of predetermined and standardised interview. The structured

interview would have inhibited participants from expressing their views and although the unstructured interview is also appropriate for eliciting opinions, feelings and values, it has limitations because the researcher has no full control of the study and cannot guarantee consistency. Holloway and Wheeler (1996) further argue that a researcher needs some control of the interview so that the purpose of the study can be achieved as planned. They also claim that the unstructured interview has the highest "dross rate" which is described as the amount of material of no particular use for the researcher's study. The above reasons were considered and influenced the researcher in choosing the semi-structured interview technique for the present study.

Considering the complexity of the concept of patient dignity, the semi-structured interview was used as a means of data collection because it is effective in exploring the perceptions and opinions of participants (O'Donnell, 1992) and the use of interview schedule (Robson 1993) or guide (Bauer 1994) allowed the researcher to collect similar information from all the participants involved in the interview (Bryar 1990, Holloway and Wheeler 1996), especially where a comparison was going to be made between what the patients and nurses had said. Using the same set of questions increases dependability and ensures that the key topics are discussed fully with all participants. Dependability was strengthened by the fact that interviews were carried out by one researcher which allowed the interviews to follow the same style of questioning. The already set questions provided structure to the interview. This research has also adopted the claim made by Holloway and Wheeler (1996) that the interview guide serves as a reminder to the researcher and also saves time. The interview guide was checked by the supervisors of the researcher of this study.

3.8 The Pilot Study

"Behind every successful piece of completed research stands a pilot study" (Lackey and Wingate 1998 p.375). Mathers and Huang (1998) described pilot study as a small preliminary investigation of the same general character as the major study, which is designed to acquaint the researcher with problems that can be corrected in preparation for the larger research project. Subjects should possess the same characteristics as individuals who will comprise the main sample. The sample must be large enough to detect flaws or weakness in the methodology (Lackey and Wingate 1998). Treece and Treece (1986) recommend that about one tenth of the proposed sample of the major study is adequate.

As indicated earlier, one of the three hospitals was selected for the pilot study because of ease of access. A Day surgical care ward was sampled. Five nurses (one ward manager, two registered nurses, one health care support worker and one student nurse) were selected using purposive sampling. Due to rapid turnover of patients on the Day surgical care ward, it was difficult to interview patients within the short period of stay. An orthopaedic ward was used where five patients were selected using convenience sampling. One of the patients was interviewed at home within three hours of discharge. A phenomenological approach (Spielgielberg 1975) using semi-structured interview was used for both nurses and patients. Data was analysed as soon as the interviews had taken place. The pilot study was especially useful in practising interviewing technique and data analysis technique. Listening to the tapes also allowed checking for consistency in the wording of questions for the interview. It was apparent that more probing was required and being more attentive and interpretative - "reading in between the lines" as some patients saw the research as a fault finding

exercise. As a result of this it was planned to explain to patients at the introductory phase that the main aim was not to look for faults. Thus as a result of the pilot study, a few issues were identified.

3.8.1 Issues Identified in the Pilot Study

Initially, the first question to patients was, "can you describe to me what you understand by the word dignity?" It was difficult for patients to come up with a general description of dignity because of the wording of the questions. One patient felt as if it was an examination question and therefore, it was suggested by the participants that the following questions should have been used: For patients, "Can you describe to me what you think your dignity is?" As a result, the modified questions suggested by the participants were adopted and were used in the main study. There was one patient who did not even understand the word dignity; this was assumed that the concept might be used in a different way. This was resolved by including preamble questions such as "how have you experienced the care?", "what do you think are the important aspects of patient care?" If respect was mentioned and the patient found it difficult to describe dignity, then by referring back to the question of importance of care, some of the data would not be lost. In this case the notion of patient dignity was captured from different perspectives. These questions also helped to develop rapport with interviewees.

As recommended by Colaizzi (1978), Guba and Lincoln (1985) and Burnard (1992), the categories identified from data should be validated by being taken back to the participants. It was not possible to take the transcribed data back to all patients; only three out of five re-read the transcripts and verified the categories. This was

because three patients were discharged early. This fast turn over was further confirmed by some nurse-in-charges of wards in the sample. Likewise, due to nurses being busy, it proved difficult to make second appointments for some nurses to verify the data. It was therefore decided to use field notes to supplement the tape recording in the main study, writing main points and checking and confirming with the participants soon after the interview in case it was not possible to come back for verification. Field notes (cf Illustration in *Appendix D*) were used to corroborate the findings in the interview transcripts. Field notes were also useful for the participants to capture the data of the participants who started talking again after the researcher had switched off the tape recorder. To have a good comparison between nurses and patients, the same methodology applied to both.

3.9 The Main Study: Interviews with Patients and Nurses

Using the phenomenological approach patients and nurses were interviewed. All interviews for nurses and 74 patients took place in a quiet place for an average of 30 minutes. The pace of the interviews was slow so that participants had to reflect on the concept. Generally the length of the interview depended on the individual participant and also the patients' condition. In shared rooms, 38 patients were interviewed on their beds due to their immobility because it was difficult to take them to other rooms. These patients did not mind, provided curtains were drawn to avoid distractions from passers-by. Others were interviewed in single rooms or taken to private places. In all hospitals A, B and C, the nurse-in-charge of the ward or the named nurse for the particular patient introduced the researcher. The researcher then introduced herself and explained the purpose to the patients. The procedure was

explained verbally and reinforced with a letter which explained the purpose of the research and asked the participants to take part. A rapport was established by asking general questions first, for example, "How are you?" "How are you feeling at the moment?" Then it followed two general questions: "How did you experience your stay in hospital?" and "what are your important aspects of patient care?" and in terms of nurses, "how do you experience your work?" These were important open questions to elicit general feelings from the patients and nurses respectively which would not have been captured by the other questions on the guide. The questions also provided rich data on how participants felt about patient dignity.

Using the interview guide, patients were asked questions, probing whenever was necessary. Each participant was asked for his age, occupation and cultural background as it was thought these variables might have influenced the participant's perceptions of dignity. Field notes were written and read back to the participant at the end of interview to confirm that what was written reflected what was said. Patients and nurses were asked not to discuss their perceptions with others in the ward as this would have influenced other participants' perceptions. Tapes and field notes were coded and dated. Due to different perceptions by the participants of the concept patient dignity, new concepts emerged at different interviews. This necessitated "developmental interviews", in other words, developing the new emerged concepts. For example, if "patient choice" was mentioned for the first time in interviews, more interviews were done to add to the picture of the concept "patient choice". Data collection continued until saturation of data was reached (Glaser and Strauss 1967). This was when the researcher believed that no diversity of opinions was expressed by participants concerning the attribute that emerged. This explains the big sample of

patients and nurses involved in the research as represented in Tables 2 and 3. Data collection took place over a period of six months.

Most researchers advocate the use of tape recorders. It was thought that writing everything was going to be an arduous task and without a tape recorder much important data would have been lost as it would have been difficult to listen, observe the participant and take full detailed notes at the same time. Two tapes were used to record data in case one failed during the interview. The other advantage of tape recording was that it reduced interview time, which was important on hospitalised patients who were likely to tire easily. All interviews were taped except two in Hospital A, one in Hospital B and two in Hospital C, who were willing to be interviewed but preferred not to be taped. Their field notes were written in more detail than the other participants who did not mind being taped.

It was necessary to listen to what was said by participants and the meanings they provided as well as to what was said in between the lines, getting the implicit messages while considering the mood and the non-verbal communication of each particular participant. During the interview, paraphrasing, condensing and interpreting of the meaning of what the participants described was carried out. Sending the information back to the interviewee was one way of validating the information. The interviewee would confirm or disconfirm the interpretation. This allowed rapid verification of the researcher's interpretation. The same principles of interview were used for nurses. Other ways of ensuring the credibility of data during the interview were considered. Colaizzi (1978) pointed out that phenomenological data are valid to the extent that the interview has tapped the subjects' experience as an expression of their view of the world. The quantity and quality of data which can be seen on the transcripts (*see Appendix E*) reflects the rich data which the researcher

elicited from the patients regarding patient dignity. By using probes, which were devices to get the interviewee to expand on a response when a researcher intuited that the participant had more to say (Robson 1993), the participants were able to reflect and to focus on the concept. Probes were specific to the question asked or to the general query like; "Anything more"? Or "What do you mean"? Or there was a period of silence or the rephrasing of the sentences made by the participant. These increased the credibility of data. Reminding patients and reassuring them about confidentiality as the interviews went on allowed free discussions.

All questions were answered freely by all the participants. However, some participants were cautious in replying to the questions concerning the maintenance of patients' dignity at the beginning of the interviews. This was because patients thought they were being asked to scrutinise and thereby criticise the care given by nurses, which they did not want to do. Two common statements illustrated this. "I do not want to fault the staff, I am here to get better" or "I have no complaints, the staff are very good, it is not their fault, too much work". This reluctance to complain was mainly due to fear of reprisals. This is common among patients as has been shown by researchers such as Bauer (1994) and William, Coyle and Healy (1998). These researchers report that patients expressed satisfaction with the care even if they did not have a good experience of it. The defensiveness was apparent in a few qualified nurses and health care support workers; asking them how nurses maintained patient dignity was like an attack on their professionalism. In some instances, at the start of interviews the use of defensive words such as "yes we do", "what do you think?" "I am very good", "we try but we are busy" or "they are very good wards", was common. These and other expressions would follow including conflicting statements. It was clear nurses did not want to show that they or their wards were failing to

maintain patient dignity. These fears in patients and defensiveness in nurses could have affected the credibility of data. The researcher resolved the problem by developing good rapport with participants which encouraged them to "open up". It was re-emphasised that the purpose of the research was not to find faults and it was explained to nurses that they were not being judged. A sense of humour on the part of the researcher helped to relax the situation. The participants soon relaxed and were more forthcoming. In all this the researcher was constantly aware of the need for the objectivity in the interview. The phenomenological - hermeneutic approach to research methodology previously described proved to be essential to resolve the problem as the context and tone in which the words were expressed was examined.

The other point which increased the objectivity of data was the tendency for students to distance themselves from what was happening with regard to the maintenance of patient dignity. Possibly because of their supernumerary status in the wards which meant that they did not feel a major part of the ward staff establishment, they could stand back and observe objectively. One often heard students respond, "they do that" and "nurses do that". One student actually said:

> I think as student nurses, we tend to watch things like that. I don't know may because it is fresh in our minds. Everything is UKCC guidelines. We go through it a lot really (Female: HAN 21).

This did not necessarily mean that they were better in the maintenance of patient dignity than other cadres of nurses, but it meant that students were more objective and critical of what was happening in relation to the maintenance of patient dignity. As mentioned above, field notes were also used to verify the main points of the discussion with the interviewee in case an opportunity was not available to get back to

participants to verify their data. Therefore, notes were read back to the participants at the end of interview to confirm that what was written reflected what they said.

It was important to consider the closing of interviews too. Patient dignity might have been a sensitive topic to some participants. It could have raised strong emotional feelings while discussions were taking place especially when participants were reminded about the indignities they once went through while in hospital as patients or nurses. Apart from taking care in questioning the participants and looking for participants behaviour which showed signs of distress while discussions took place, the researcher ensured that no one was left in emotional distress. All participants were asked how they felt at the end of interviews to ensure that they were all right.

3.10 Data Analysis

Data analysis started with the process of collecting data. As interviews went on, incoming information was continuously reflected upon, trying to take on and understand the actual thoughts and feelings of participants. However, the data needed detailed analysis. The tapes were transcribed soon after the interview by the researcher. (Sample of the transcript in *Appendix E*). The transcription was done by the researcher to allow her to become more immersed in the data. Data analysis was in accordance with Spiegelberg's (1975) phenomenological approach and content analysis. All six steps suggested by Spiegelberg were employed: The tapes were listened to repeatedly while transcribing, building a picture of what patient dignity was thought to be by the participants. Transcripts and field notes were reviewed repeatedly in order to acquire a feeling for them, thus making sense of how the

participants described the meaning of patient dignity, that is, whether it was maintained and what factors influenced its maintenance according to the participants.

3.10.1 Content Analysis

After analysing different types of analytical methods, content analysis appeared to be the most appropriate method of analysing data of the present research. Content analysis was, therefore, incorporated within the phenomenological approach and involved the analysis of narrative data to identify prominent themes and patterns among themes (Polit and Hungler 1997). The reason why content analysis was chosen was that it helped to organise data into manageable units which permitted detailed analysis by selecting a unit of analysis or what Robson (1993) called a recording unit. The unit of analysis usually used by researchers is a word or a group of words; a theme or an assertion or a paragraph. It was not appropriate to use words for this research as some words have more than one meaning causing confusion in interpretation while a paragraph can contain more than one idea. The Unit of choice was a theme, which Budd, Thorp and Donohew (1967) describe as a single thought or idea unit that conveys a single item of information extracted from a segment of content. The transcripts and field notes were, therefore, re-read and the themes identified, underlined or highlighted.

The other reason for incorporating content analysis was that the focus of content analysis corresponded to the Spielgelberg's (1975) phenomenological steps of analysis adopted for this research. Robson (1993) describes two types of content analysis, the manifest and latent content analysis. At the manifest level, the analysis was simply a direct description of the theme in terms of patient dignity. At the latent

level, the researcher went beyond transcription of what was said directly to what was implied, meant or inferred. Due to the abstract nature of the concept both types were employed. Therefore, each method had a purpose in the process without diluting another method. Both Spielgelberg's (1975) steps of analysis and Robson's (1993) content analysis allowed description and interpretation of data. It allowed easy extrapolation of meanings, a grasp of the essences and the building of the picture of what patient dignity constituted, while relating to other phenomena which appeared. "Interpretative reading" otherwise referred to "reading in between the lines" was employed. Attention was also paid to the context in which the utterance was made. This was crucial in order to grasp that the participants actually meant what they said.

After comparing, interpreting and extrapolating meanings of the data, they were coded into 11 categories that directly pertained to patient dignity as presented in Table 5.

Table 5 **Categories of Patients Dignity elicited from Patients' and Nurses' from Hospitals A, B & C**

Total Number of Patients: 102

Total Number of Nurses: 94

Category	Hospital A		Hospital B		Hospital C		Total Patients	Total Nurses
	Patients	Nurses	Patients	Nurses	Patients	Nurses		
Privacy	36	36	30	28	36	30	102	94
Confidentiality	2	13	1	8	3	4	6	25
Need for information	10	14	12	9	10	4	32	27
Patient's Choice	6	9	6	7	5	4	17	20
Patient's Involvement in their care	10	2	9	3	2	2	21	7
Patient's Independence	8	14	8	6	9	5	25	25
Patient's forms of Address	15	3	9	1	7	1	31	5
Patient's Decency	5	9	4	1	2	2	11	12
Patient's Control	7	0	0	0	5	0	12	0
Respect for Patients	15	13	3	10	10	7	28	30
Nurse-Patient Communication	9	5	4	2	6	4	19	11

Coding entailed identifying persistent themes related to patient dignity. As identifiable categories emerged, constant comparison (Glaser and Strauss 1967) was used to explore similarities, relationships, disjunctions and connections of these categories to the notion of patient dignity. The categories generated were put on the margin of the transcripts and then organised according to each ward of the hospital. This facilitated comparison of what both patients and nurses perceived in each ward. A scissors-and - tape system was used to cut out themes that related to each category which were taped together from each hospital accordingly. This allowed the researcher to discriminate between what was essential from what was accidental about what participants described. The frequency and extent of occurrence in the data is also the focus of content analysis. The analysis included establishing the frequency of response of each category and the whole process was one of working back and forth between the transcripts.

To increase the validity of the data, five colleagues (five Nurse Tutors, one Doctor and two Nurses familiar with the Spielgelberg phenomenological approach technique) were asked to code the transcript information into categories. Two were not familiar with the content analysis technique; therefore, the researcher briefed them on what content analysis was and how to incorporate it into the Spielgelberg's phenomenological approach. They practised on two transcripts. Each coder was given a sample of five transcripts. Four transcripts were analysed by one of supervisors of the research, this increased credibility as it set an example of how to analyse the data properly. Coding using a single person is limited to the perceptions and introspection of the individual (Mays and Pope 1995) who may impose his or her own values on the data. Clarke (1992) also stated that the attribution of the meaning

or importance is through the researcher's perceptions as they read through the data. That is why it was important to recruit other coders to help in analysing the data.

It was also acknowledged that the backgrounds of the coders as health professionals could have influenced the interpretation of data. Therefore, coders were reminded that data analysis involved bracketing out personal definitions of dignity as well as patient dignity. Colleagues were asked if they clearly remembered the meaning of "bracketing". Preconceived beliefs and opinions about patient dignity were held in abeyance. They sorted the data into categories independently of each other and compared with those of the researcher's. Each theme or assertion was examined to see if all the coders came up with the same category. Any differences and agreements in coding were discussed between the coders. There were no differences which did not require rejecting some of the categories. This procedure was important to make sure that there was consistent coding among coders. The procedure applied to both patients and nurses.

3.10.2 An Illustration of Formation of Categories

Categories are the components of concepts that may be arranged in some sort of pattern in order and are related to one underlying dimension (Field and Morse 1985). One example how categories were developed will be demonstrated. The Spielgelberg (1975) phenomenological approach (described in section 3.3) and content analysis (described in 3.10.1) will be used.

Question	Response
Can you describe what your dignity is?	*Pause?* Oh! I don't really know as long as I am called what I like. When they come round, they will put a towel around my top while they are washing my back. They pull the curtains whenever they are done properly. (Male: HBP8)

The researcher bracketed out personal beliefs about dignity shaped by previous personal experience relating to patient dignity and also knowledge gained from literature. The underlining represents the unit of analysis or a recording unit and it denotes the essential structure of the concept of patient dignity grasped by the researcher.

"Oh! I don't really know." At the manifest level analysis, the patient did not know. This is equivalent to Spielgelberg's descriptive phenomenological approach. There is a direct exploration and description of the phenomenon. The latent analysis and using the phenomenological - hermeneutic approach revealed *oh*!, an exclamation which the researcher interpreted as the patient's surprise as she did not expect such a question *Pause*, was interpreted as the patient did no have a ready reply and she was trying to think. It was a difficult concept to describe.

"As long as I am called what I like." According to the manifest level of analysis, the patient was stating that being addressed by preferred name was very important to her. However reading in between the lines, there was a sense that she was not always addressed properly. There was also a feeling of resignation but there was nothing she could do.

"They will put a towel around my top." At the manifest level of analysis, the direct meaning was "covering the body" but according to latent and hermeneutic deeper analysis the expression shows that the patient wanted privacy.

"They pull curtains whenever they are done properly." At the manifest level the patient wanted privacy by curtains being drawn all the time. Deeper analysis revealed that most of the time, whenever the curtains were drawn they were not closed properly thereby compromising the patient's privacy. There was no consistency in the closing of curtains. There was a feeling of frustration from the patient.

One of the steps in Spielgelberg's phenomenological approach is the phenomenology of appearance. In this step, the researcher considered how the concept of "patient dignity" appeared. There was no direct definition. The patient could only describe her dignity using other words, such as privacy and forms of address. In the above example the two categories describing what patient dignity was were *Privacy* and *Form of address*. It can be noted that although the patient had some difficulties in describing what her dignity was, she managed to describe how she wished it maintained.

3.11 Summary for Chapter 3

In this chapter, the phenomenological approach, the sampling methods, how patients were protected and the semi-structured interviews used throughout this research have been explained. Justification for using them and how they were utilised

have been presented. Spielgelberg's (1975) phenomenological approach and Robson's (1993) content analysis were used to analyse data. The audit trail has been clearly established to show the confirmability, dependability and credibility of the data collected. This provides some confidence on the research findings. It is hoped that the example on how the eleven categories were coded is clear enough to show how the categories were generated. The next chapter discusses the results.

CHAPTER 4: THE CONCEPT OF HUMAN DIGNITY: CLARIFIED

4.1 Introduction

The discussions of the findings of this research are presented in four chapters. This chapter discusses human dignity in general; Chapter 5 introduces a new concept called Perceptual Adjustment Level while Chapter 6 discusses how patients perceive patient dignity and its maintenance within their perceptual adjustment level. These chapters have been presented in a way that paints a clear picture of patient dignity as perceived by the participants. Chapter seven explores factors which influence the maintenance of patients' dignity.

As stated in chapter two, this study focuses principally on the patients. Nurses were included in the interviews in order to provide a comprehensive view of the notion of patient dignity. The focus is more on how patients perceive their dignity. Results of the research will be discussed and illustrated with supporting representative quotations from participants of the interviews conducted. Quotations from research participants summarise common characteristics of the written transcripts. In this summary they have been used to represent the thoughts, feelings or moods of the participants and also to illuminate the subtleties of experiences (Sandelowski 1994).

The quotations used are verbatim, unless words or phrases are bracketed within the quote to indicate where they are paraphrased. Real names have been removed. The results of the research from the three hospitals will be discussed in conjunction with literature discussions. Conflation of the two approaches is probably the most effective way of providing a clearer picture of what patient dignity is and how the categories that were elicited from participants relate to the concept. Analysis

of data obtained from the three hospitals revealed the patterns that were similar in terms of the patients' and the nurses' perception of patient dignity, and also on its maintenance. These have been presented together.

4.2 The Concept of Human Dignity

Patients' descriptions of their dignity in hospital were drawn from their everyday life experience, prior to admission. Likewise nurses' concepts of dignity were drawn from their everyday life experience. It is, therefore, logical that the discussion of patient dignity should start from dignity in general in order to set a background to the understanding of patient dignity. From the literature review it was shown that the concept of dignity in general was also difficult to define. However, when information from the literature review was combined with the results from the interviews a clearer picture of dignity emerged. It was also noted that the word "self" kept appearing when patients were describing their concept of dignity. This is because dignity is an expression within "self". As one of the patients expressed:

> To have dignity means to look at oneself with respect with some sort of pride.
> (Male: HBP 6)

"Self" can be seen as a person's awareness of his or her individuality and the value a person puts on it. In the above example dignity was how the patient perceived his own worth within himself. Therefore, when considering the meaning and understanding of dignity in general and patient dignity, it is appropriate to examine briefly the concept of "self". This chapter will not explore the concept of "self" extensively. While it offers the starting point in the understanding of the concept of

patient dignity, a complete discussion is beyond the scope of this study. The structure of self and how it is formed will be discussed.

One of the early psychologists, James (1890 p.291) described "self" as "the sum total of all he can call". He categorised "self" into constituencies namely, material, spiritual, social and pure ego, self-feeling, self-seeking and self-preservation. The material self included the body which he regarded as the outermost part of material self. This also included his possessions, family and all materials that belonged to the individual. The inner "self" was referred to as a person's inner or subjective being, his psychic faculties or dispositions, while the social was referred to as the recognition the person gets from others. He described "self-feeling" as the feelings and emotions aroused. "Self-seeking" and "self-presentation" are actions which they prompt, for example, bodily defence or acts of bodily self preservation of the way one would like to look. Cooley (1902) coined the "looking glass self" when describing the social self which emphasised the part played by other peoples' perception of an individual. He noted that the social milieu, from which an individual comes, influenced how he or she viewed himself or herself. Mead (1934) also looked at "self" as an "object awareness" and believed that "self" was socially constructed.

Sullivan (1953) also contributed to the understanding of "self". According to him each individual is immersed in a continual flow of interactions in which a person receives ceaseless reflective appraisals and it is through these appraisals that a person tends to see himself. If appraisals are negative, one will have a negative view of himself or herself and if positive the person will have a positive view of himself or herself. Rogers (1951) contributed to the knowledge of "self" through his "self-theory". According to Rogers the "self" is made up of the body and the phenomenal field which is the total experience of the individual. It is also the conscious perception

and values of "I" and "me". The work and thoughts of Combs and Synagg (1969) were formative in understanding the relation of what participants described as patient dignity to "self". The authors described "self" as a perceptual field which includes all of a person's perceptions, including about himself and things quite outside himself. They called different parts of "self" as "concepts". Some concepts appear to be much more central or basic part of us than others: these are called "self concepts". While there are varied definitions and classifications, scholars such as Gross (1992) and Oliver (1993) agree that "self concept" consists of self-image, ideal-self and self-esteem. Self-image refers to the way in which an individual describes herself or himself. In this research, patients perceived dignity as how they viewed themselves. As one patient illustrated:

> Dignity is the mental state of how one sees himself or herself. (Male: HCP 15)

Each patient had an image of the sort of a person he or she wanted to be. This image was also influenced by how other people viewed the patient. "This is how I would like to look like", therefore, expresses the inner image of themselves and an outward image which patients wanted to present to others. "Ideal-self" refers to what kind of a person one thinks he or she should be. Self-esteem is the evaluative component of self concept and refers to the extent to which one likes, accepts or approves of himself or herself and how worthwhile he or she is (Oliver 1993). Taking the above example, anything that undermined the way the patient liked to think of himself or herself lowered self-esteem and reduced the sense of worth. Therefore, dignity is one way of asserting and valuing one's "self". Some scholars agree that self develops out of socialisation processes (Mead 1934). As the child grows a sense of self develops

which helps him or her explore the "self". The child develops a feeling of "I" and "me" as she grows and interacts with others. Mead (1934) claimed:

> ... The "self" is something which has a development; it is not initially there at birth, but rises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to the process as a whole and to the other individuals within that process (p.35).

This is supported by recent literature. For example, Lewis (1990) stated that "self" starts at early age as a result of personal experiences and contacts with other people. According to Combs and Synagg (1969), the "self" is the beginning of a person's conception of what "I" and "me" mean and entail. Through the process of socialisation one acquires and internalises sets of values, for example, privacy, decency, forms of address and choices (cf. the categories in Table 5). Then a value system (Price 1992) is formed which becomes an integral part of the self concept. The present research confirms the existence of these various values. Two patients at two different sites exemplify this point. One patient claimed:

> My dignity is standards which are set according to values I have acquired from my parents. (Male: HAP 10)

And another patient declared:

> You know, when you are talking about dignity, one sets standards. You know yourself that this is what I am and what I want to be. You would like to know if these standards are being maintained and this gives you confidence, if not you feel worthless and undignified. (Male: HBP 12)

This view was supported by a nurse at one of the sites who claimed:

> When one talks about patient dignity, I think dignity is a mixture of beliefs which one forms, which are actually inherited or infringed upon you by upbringing. (Female: HAN 8)

Each person learns shared standards of beliefs in a particular culture through groups of people or a family. This learning starts at an early age in life as evidenced by research that a child can set his or her personal standards as early as two years old (Lewis, Alessandri and Sullivan 1992). Standards are defined as accepted examples against which others are judged (Collins 1991). They may be either carefully constructed images of the kind of a person one would like to be or merely a number of aspirational goals or values that one would like to achieve depending on the norms of a particular society (Sundeen, Stuart, Rankin and Cohen 1994). Personal standards can be equated to what Travelbee (1971 p.30) called the "scale of relative value and worth" which was described as a criterion or guide to assign or accord varying degrees of worth. It is against these standards that one judges what is acceptable. When one perceives that one has reached these standards, one's self esteem is boosted; one feels one's worth. Self-esteem contributes to the dignity of an individual. From the above patients' comments and foregoing discussion, one could claim that dignity is acquired. One learns his or her dignity and how to maintain the dignity of others through the process of socialisation, but the findings of this research indicated that every individual has got some notion of dignity. One patient declared the point boldly in these words:

> Everyone has got it but as for explaining it, is a hell of a job. (Male: HBP 13)

It can be deduced from this that dignity belongs to every individual regardless of gender, nationality, ethnic origin, culture and age. Even a new born baby probably has rudiments of the concept of dignity; the baby at birth has potential dignity. This assumption raises the issue of whether the concept of dignity is inherent or not. This is obviously an area for further research and further speculation. What can be inferred

from this research is that every individual has the concept of dignity whether hospitalised or not. This was due to the fact that every patient interviewed wanted his or her dignity to be maintained. From this fact it is not difficult to assume that the maintenance of dignity is a human right. Everybody wants his or her dignity properly maintained whether at home, work or hospital. As dignity is everybody's right, we can understand why it is assumed under the United Nations Universal Declaration of Human Rights (Wilkinson and Caulfield 2000). It is a right for everybody, and the ability to maintain patient dignity will be influenced strongly by health care workers' beliefs about human rights for patients.

A dignified person develops a sense of pride which in turn forms an integral part of one's personality and identity. One of the patients summed up the points in these words:

> Dignity is the way you look, the pride you have when you feel worth, when you look the way you want to look. That is what I would call my dignity. If this is not upheld one feels embarrassed and humiliated. (Male: HBP 13)

Research by Lewis, Allessandri and Sullivan (1992) concluded that pride indicates success in meeting the set standards. It starts at an early age; even at the age of three children are capable of engaging in self evaluative judgements and demonstrating pride or shame. For example, the above patient would feel worthy and proud and, therefore, dignified when he felt that his perceived ideal body image was being maintained. Shame is the loss of dignity; it is a reflection that the standards which the individual set for himself or herself have not been met. Lange (1970) lists four signs of shame: first, complete or partial withdrawal from visual contact - lowering the eyes, blinking, bowing the head, turning the back, avoiding eye contact, glancing up furtively, covering the face with hands. Second, sudden changes in the skin colour - blushing. Third, nervous physical gestures or manifestations - twisting fingers,

nervously playing with hair or clothes, inspecting hands carefully, scuffing the feet, tremors, a vacillating manner, weak knees or tense muscles. Fourth, difficulty with speech, very soft voice, voice pitched very high or very low (or breaking) dryness of the mouth, inability to speak and incoherence.

These are relevant to the understanding of patients' reactions and responses to health care workers. A negative effect of failing to meet perceived set standards is manifested by a person's embarrassment. Embarrassment results from failure by an individual to meet certain social expectations, leading to low self-esteem. Therefore, there is a discrepancy between the set standards and the expectations of the situation in which one finds himself or herself. For example, one patient narrated her embarrassing experience thus:

> I tell you what! when they came to give tablets to patients, they asked date of birth, well! I had a bit of embarrassment at first because I had just met somebody younger than me and he did not know my date of birth. Of course, he was sitting there and the nurse came. What is your date of birth while my boyfriend was listening? Oh! god, I blushed! thank god it did not matter. I do not mind being asked. (Female: HAP 7)

In the above instance a hospital patient's routine required the disclosure of her birthday, but as this being done in the presence of someone from whom she wished to hide it, there was discrepancy between what the requirements of hospital routine and the personal needs of the patient. This led to embarrassment leading to the lowering of her self esteem. Although shame and embarrassment are described differently in the literature the effects are almost the same. Throughout this research, the word embarrassment will mostly be used as it was widely used by participants. Patients expressed embarrassment in a number of ways; blushing, inappropriate smiling, laughing and general uneasiness.

The other important issue to note is that concepts of dignity change with the passage of time. Values evolve and standards are adjusted in the light of the new perceptions. Combs and Synagg (1969) state that:

> We are continually engaged in the process of self discovery, sometimes more rapid than others, but never completely absent from our experiences (p.157).

One would, therefore, expect standards to differ between age groups and from one culture to another. In terms of age, for example, standards relating to privacy will not be the same in childhood compared to those in one's adulthood, especially old age. A child may not object to being bathed in an open place, while an adult would find this unacceptable and embarrassing. In this research, differences in the perception of dignity were further illustrated by patients between the age of 16 and 35 years who considered themselves young. This group thought that dignity was more for the elderly than young ones, as expressed by a 29 year old male patient:

> I think it is harder to think about dignity as a young person. It is the old people who are concerned about their dignity more. When young, you are not too bothered about dignity. Do you see what I mean? As you grow older you feel you need your dignity. But with me I am fine. I think it is the old people who need more dignity. Old people respect themselves more. At my age you can just have a laugh and push it aside. (Male: HBP 12)

The above example demonstrates how many young patients perceived their dignity. An 82 year old patient from Hospital B illustrated the point in a different way:

> Older people have got a lot of pride; they have got their own ways, unlike the young ones. So the nurses have to deal with that. I want to be treated the way I want to be treated. This is my dignity. (Female: HBP 10)

Young patients still wanted their dignity maintained. The main difference between them and the elderly was how it should be maintained. The perception that the elderly feel more need for dignity than the young people may explain why most research and

publications concentrate on the maintenance dignity for older patients. The literature which discusses the maintenance of dignity of younger patients is sparse. These two quotations further demonstrate the influence of maturity and changing values on the passage of time. Throughout history young ones have shown that they like to have fun and do not take things as seriously as older people. Because of evolving values old people tended to be more individualistic in their thinking and valued, for example, independence and privacy more than the youthful people.

4.3 Summary for Chapter 4

This chapter has explored the definition of human dignity in general to foreground the discussion of patient dignity which follows in the next chapter. It has been established so far that dignity arises from socialisation, it forms part of "self". A person sets standards which act as a yardstick for the maintenance of his or her dignity. A person has a sense of pride if the standards are met, and becomes ashamed or embarrassed when these are not met. How dignity is perceived changes with age and time. Younger patients viewed dignity differently than older ones. From the data analysis provided in this chapter, it is claimed that every person has a right to dignity. The following chapter discusses how patients' perception of dignity changes when hospitalised.

CHAPTER 5: PERCEPTUAL ADJUSTMENT LEVEL - A NEW CONCEPT PROPOSED

5.1 Introduction

This chapter introduces a new concept called Perceptual Adjustment Level, "PAL" for short, which is proposed in order to help to clarify the concept of patient dignity as one of the aims of this research. It was clear from the literature review that definitions of the concept of dignity are often inadequate, and there is no precise definition of patient dignity. Previous scholars who have attempted to define dignity in general have not discussed the issue specifically in relation to patient dignity. As pointed out in chapter two, Laszlo (1971) defined dignity in terms of norms matching with the environment, while Seedhouse (2000) stated that capabilities should match with the circumstances in order for one to feel dignified. When patients are ill and hospitalised however, their environment or circumstances change. This is in line with Coser's (1991) work which implies that when a person moves to a new environment a mental adjustment to the new situation takes place. This research has shown that patients' perception of dignity adjusted accordingly as a result of the hospital environment in which they found themselves. One would, therefore, expect patients to define their notion of dignity within this new adjusted situation.

The results of this research have indicated that a specific definition of patient dignity is difficult to construct. The concept is difficult to define because it is multidimensional and is better understood through other concepts. Patient dignity is a subjective, relative and evaluative concept. It is subjective because it depends on the individual patient's perception of the concept; the sense of being dignified comes from the self. It is relative as each patient expresses it differently, and patient dignity is

evaluative because personal and subjective value judgements are used to determine it. Patient dignity could also be described in terms of physical, psychological and social factors. A patient could deduce whether one's dignity was maintained or not through physical signs, for example signs of embarrassment. Psychologically it involves perceptions, how patients perceive themselves; it could also be deduced from how the patients behaved that they felt dignified, that they felt contented and happy with confidence and high self-esteem. The concept is a social construct because it arises from socialisation. The interpretation of patient dignity depended on cultural expectations, context and situation. It is also social, in that it involves patients interacting with other people. It is dynamic and could easily be lost or violated depending on how others behave towards patients. All these characteristics demonstrate that patient dignity is a complex phenomenon. It seems simple but is hard to define. It was difficult to come up with a specific working definition of the concept. Whatever the position with regard its definition, the main goal in nurse-patient interaction is whether the patient feels dignified.

However, two points were clear from this research in terms of maintaining patients' dignity: first, the majority of nurses maintained patients' dignity by using their own notion of dignity acquired through personal and professional experience. A common statement from nurses from the three hospitals was:

> I treat patients the way I would like to be treated.

As much as there were good intentions behind this statement, nurses maintained patient dignity by using their own standards of dignity as a yardstick. Nurses' perceptions were not necessarily similar to those of patients, as nurses may often have come from different family and educational backgrounds. Therefore, personal

experience together with professional socialisation determined the standards set for the maintenance of patient dignity. Almost every nurse, including student nurses, mentioned that they maintained patient dignity based on their life experiences and from knowledge acquired from training. The nurses' ways of maintaining dignity which were learned from training and their social life did not match with what the patients expected in some instances. This led to the imposition of nurses' values on patients which had the potential of leading to violation of patient dignity. Second, although patients' perception of dignity changed when hospitalised, often nurses were not fully aware of the extent of their adjustment. It could be, therefore, argued that nurses were operating at a level of perception of patient dignity which was different to that of the patients. These factors may have contributed to a lack of maintenance of patient dignity in the British health care system as mentioned in Chapter 2.

It is important to emphasise that categories or attributes which define the concept of dignity do not change whether one is a patient or not. This is supported by the fact that categories identified by Mairis (1994) and Haddock (1996) (cf Chapter 2) utilising participants who were not patients, were similar to those identified by participants in this study (cf. in Table 5 p.68). For example, the need for privacy, choice, independence and for patients to be addressed by a preferred name will remain the same irrespective of whether a person is admitted in hospital or not. This is further supported by Combs and Synagg (1969) who asserted that one only adjusts and reorganises the perceptual field of one's self while the rest of the values and beliefs remain intact. This can also be illustrated in a nurse-patient interaction. Take privacy, which was mentioned by both nurses and patients in this research as one of the categories that defines patient dignity. Both parties might have had the same value of privacy, but because the patient's circumstances changed due to illness and nature

of hospital environment and hospital procedures, the perception of how they wanted their privacy maintenance was adjusted. One 72 year old female patient commented:

> Your dignity does not change, for example, your name remains, you still want your privacy, but if you are in hospital you adjust your thinking. You do not want to think about dignity because you want to get better. Men doctors are like women doctors. That is what you tell yourself. (Female: HCP 12)

Here we have an example of the conscious perception adjustment, she tries to dismiss some levels on the concept, but cannot. Despite telling herself that the sex of the doctor is not important the notion of privacy remains central. She adjusts her thinking. She says "you do not want to think about dignity" but this only highlights her concern and the fact that she is far more aware of it than she would be in other circumstances. In contrast, nurses who were healthy and in a familiar hospital environment perceived patients' dignity from a different perspective and used this perception in the maintenance of patient dignity. This is consistent with the findings of research done by Back and Wikblad (1998) in Sweden. One of the aims of their study was to investigate whether nurses' perceptions of patients' privacy corresponded with the patient's own reported needs. A questionnaire for each group was designed and administered to 120 patients and 42 nurses. The main findings indicated that patients and nurses agreed in the ratings of the major components of privacy in general but privacy in hospital was estimated more highly by nurses than by patients themselves. Despite the fact that the study was conducted in a different culture, the research provided the evidence that patients' values remained the same. The difference in rating by nurses and patients indicated that there were some differences in their perception of the notion of patient dignity. It has been established throughout this research that nurses operated at a "different" perceptual level in respect to patient dignity, in being less aware of it, since they need to carry out their tasks as sensitively

as possible. Patients try hard to adjust; but as the centre of attention, all levels of dignity conscious and sub-conscious apply, and are applied to them. Patients had to adjust their perception on how their dignity should be maintained. This has been proposed as the *perceptual adjustment level* which will be discussed in detail next.

5.2 Perceptual Adjustment Level (PAL)

There is a lot of literature on dignity, and research on how patients adjust or adapt to illness in general, but no research so far has discussed how patients adjust in relation to their dignity in a hospital environment. The introduction of the notion of perceptual adjustment level does precisely this. The discussion of "PAL" will be guided by concepts derived from Loss and Stress Theory (Gross 1992). The essence of these theories is that when one loses something, one becomes stressed; one therefore goes through several stages in order to come to terms with one's loss. Kubler-Ross (1970) has been instrumental in understanding the stages a person goes through when experiencing loss. She termed them denial, anger, bargaining, depression and acceptance. Other scholars have described the stages in different ways, for example Speck (1978) described them as shock and disbelief, developing an awareness and resolution. Most scholars, however, agree that the progression is never the same for everyone. Patients who were interviewed for this research went through some of the above mentioned stages in relation to their dignity, while others did not go through all the stages.

There was a general agreement among patients that admission to hospital was usually associated with potential loss of dignity. There were feelings of anticipatory loss of dignity by patients. Patients developed images of what would happen in

hospital in relation to their dignity. Typical fears harboured by patients relating to dignity included how they would cope; being naked, invasion of space, loss of self control and loss of their independence. As expressed by one of the patients:

> Although you don't tell anyone, one starts to think about what happens in the hospital. Undressing, being bathed after theatre, you lose your dignity any way. (Female: HAP 27)

Such potential violation of patient dignity was anticipated by patients. Losing dignity entailed losing something which had been valued throughout their lives and this brought them anxieties. For those patients who had experienced such indignities in hospitals before, anxieties were aroused by the thought of going through the same experience again, leading to stress as demonstrated by the following comments:

> As for dignity, it just goes out of the window when you come here. Everything is to be shown. Is it not? Sometimes it is stressful to think about what is going to happen, loosing your dignity. But you still have to come to hospital. You have no choice. The only alternative is not to think about it. That is the only way you could cope. I just let them carry on with the job. (Female: HAP 11)

This reveals that the patient did not like suspending her dignity when she went in hospital but she felt she had to. The thought of this happening was stressful. This state of ambivalence was experienced by a number of patients from the three sites and it was often a source of stress to them. The first response to this threat was denial. "This is not happening to me". The second response was anger. The third stage was acceptance of the situation with resignation. The patients were resigned to the fact that the only solution to get better is for them to be admitted to hospital. They had two alternative points of view about being admitted to hospital, on the one hand they saw the need for treatment of their illness, and on the other they feared the loss of dignity in the process. They had to submit to it, and recognised this. At the same time they were worried by it. The very threat to their dignity made them perceptually

aware of it too. However much they reasoned with themselves they were forced to consider something they otherwise took for granted. Patients were aware that there were limitations as to how their dignity could be maintained in hospital. When they weighed the benefits against the costs of the whole experience, the benefits outweighed the potential loss of their dignity; they realised that being hospitalised was the only way to get better. Therefore, patients found the means of dealing with these anxieties and accepted what was to follow. They coped with these anxieties by rationalising their position; they assumed that as long as they got better, being hospitalised with the loss of some of their dignity was a worthwhile price to pay. After all, hospitalisation was only temporary. All patients, whether male or female, accepted the hospital situation as a *"necessary submission"* of their "self" to the hospital situation. As one patient claimed in resignation:

> In terms of dignity, I have been in hospital before and I know what is expected of you. You just accept what is going to happen because you want to get better. (Female: HAP 10)

According to the Heinemann English Dictionary (1990) to "submit" means to surrender to the authority of another while "necessary" means indispensable or unavoidable. Therefore, because of the need to value their lives, it was essential for patients to surrender themselves to health care workers. It is, however, important to recognise that this submission was only accepted within the context of the illness and the process that alleviated it. In other words, the submission was selective. Any activity which the patient perceived as being outside the parameters of medical attention caused embarrassment and loss of dignity. Health care workers should be aware of this necessary selective submission in order to minimise loss of patient dignity. This necessary submission can also be seen within the context of the role of the sick as described by Parson (1951). The ill person is exempted from normal social

roles but there is an expectation from society that the person will seek help that will facilitate a rapid return to normal functioning. Admission to hospital may be one way of achieving this. The patients desire to get better and society's expectation further compels necessary submission. Despite patients awareness of necessary admission to hospital there was still fear of loss of dignity when admitted. This caused inner conflicts in a number of patients.

This "necessary submission" also entailed being subjected to invasive procedures, being told what to do, exposing themselves or being dependent on health care workers because of their "expert power". The problem is that in such situations there is an imbalance of power. When power is not balanced between the two parties, one party feels vulnerable, in this case the patients. "Necessary submission" also meant patients complying and fitting in the hospital system, subordinating their individuality, thereby losing their identity. There was that feeling of "being at their mercy", that loss of part of their "self" and the general loss of their dignity. All these caused anxieties among patients. To cope with these fears of potential or real loss of dignity, it emerged that the majority of the patients made mental adjustment to their perception of how their dignity could be maintained in hospital. One patient echoed the views of many patients in the three hospitals when she said:

> When you go to hospital everyone does anything to your body, you expect it, you want to get better and you do not feel embarrassed as when you are well. (Female: HBP 10)

Goffman (1961) points out that in institutions like hospitals, boundaries of "self" are likely to be violated. "Self" has perceptual boundaries which are adjustable depending on the situation. The "self" can be threatened if it perceives that it is unable to control the boundaries. Experiences that are not compatible with "self" are perceived as threats and are either distorted or denied, or the self may change. These conclusions

are relevant to research on patient dignity as they explain how the patients' "self" can be adjusted.

It was evident from the findings that patients' perceptual boundaries changed from time to time depending on the threat or the invasion of self. This showed how fluid and fragile these boundaries were and therefore required a lot of sensitivity from nurses and other health care workers. In this research patients' mental adjustment of their notion of dignity has been termed "perceptual adjustment" (PA), and the levels at which patients adjust their perception is called "perceptual adjustment level" (PAL). Therefore, perceptual adjustment can be described *as a process in which a patient forecasts the potential indignities that he or she expects to suffer when in hospital, mentally analyses the situation and adjusts to a level he or she feels comfortable enough to accept them.* Perceptual adjustment is a psychological preparation for potential violation of dignity in a hospital situation. It was a strategy patients could use to come to terms psychologically with the real, imagined or potential indignities in the hospital. It was a self-protection measure in which the patient had settled for alternative ways of maintaining of their dignity, that would not have been accepted under normal situations. All patients constructed accounts which implied that they perceptually adjusted in relation to dignity in a hospital situation. One patient corroborated these findings in the following words:

> When you come in hospital, obviously you change the way you think about maintaining your dignity. You come to accept that nurses or doctors see naked bodies all the time and you expect to be treated and be looked after anyway. But I think your privacy is still an important part of patient dignity as far as I am concerned. (Male: HBP 11)

Throughout this research, patients who were interviewed adjusted the way categories or attributes of their dignity needed to be maintained while in hospital. Their perceptual boundaries got redefined, for instance, in levels of patient interaction with

other patients or staff, and limits for hospital staff during the course of executing tasks. As one patient commented:

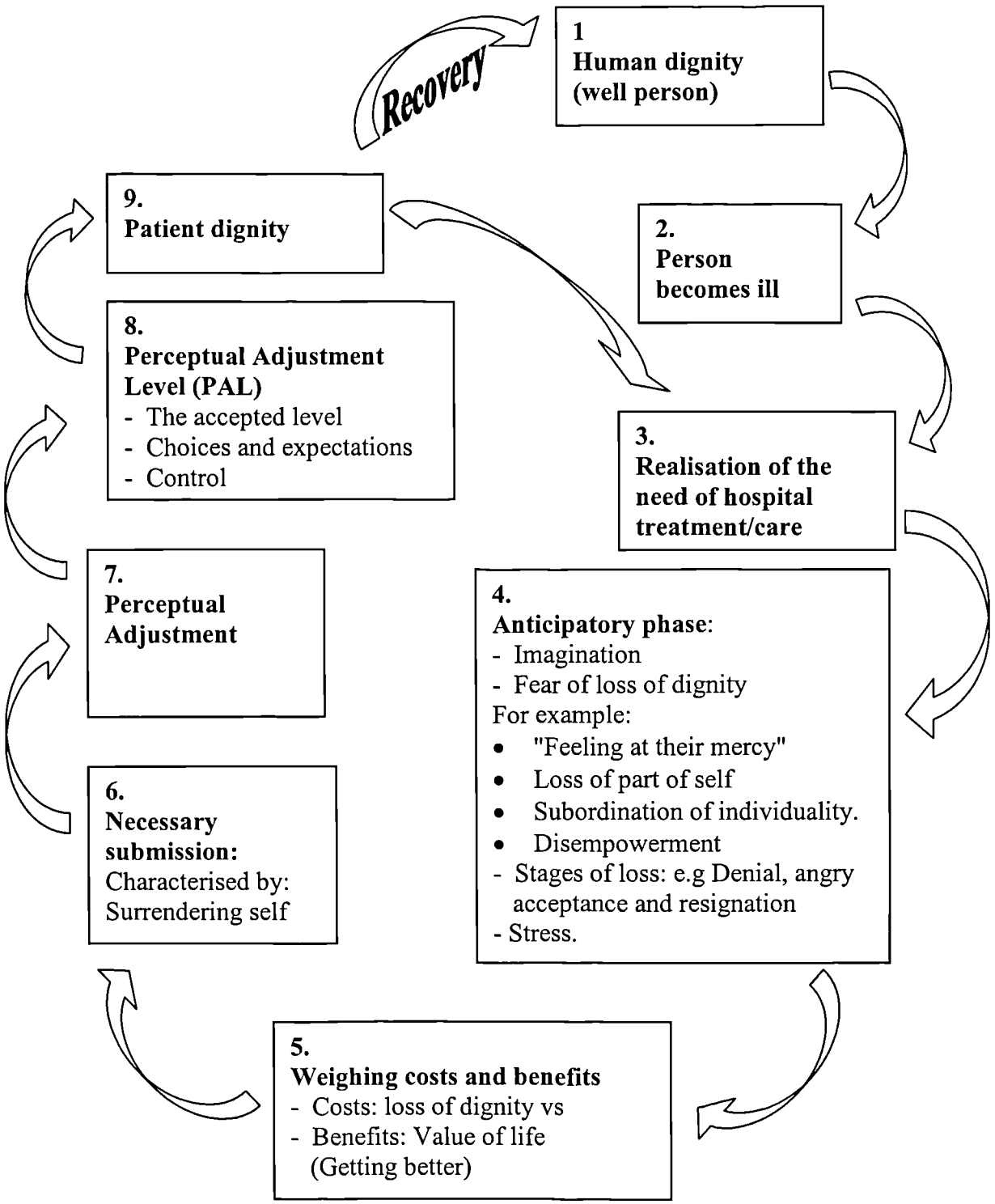
> I would feel embarrassed if a nurse asks me questions which do not relate to my illness or lets say I have got a wound on my leg and the nurse exposes up to here [showing the thigh]. That is not right (Female: HAP 10)

This entails that within the perceptual adjustment level "PAL", patients perceptually set limits as to what extent the hospital staff can be expected to perform their tasks on them. As illustrated in the above example, it was within her perceptual boundary that nurses were expected to ask questions or perform their tasks which pertained to the wound in the leg. The patient would have found it not justifiable to expose the entire thigh in order to dress the wound on the leg. Any act which was not relevant or which was unjustifiable was out of the bounds and caused embarrassment. This was also observed by only one nurse from the sample of nurses.

> People have their own standards of dignity I suppose. So it is a matter of perceiving at what level they are. (Female: HAN 19)

The phases patients go through to reach perceptual adjustment level is represented in Figure 1.

Figure 1. **An illustration of the phases patients go through to reach Perceptual Adjustment Level**



The diagram illustrates that any perceived potential loss of dignity evoked another episode of the cycle. This emphasises the fact that the process continued to evolve throughout a patient's stay in hospital. For patients who came as emergency admissions with little or no time to acquire information about the hospital, adjustment started as soon as they realised their position. This process also went on in any nurse-patient interaction in the hospital. Take the example of a nurse-patient interaction when a nurse gave an enema to one of the patients

> I tell you, I was okay I did not mind with whatever was happening to me, I did not feel embarrassed but as soon as they [nurses] mentioned that they would give me an enema, I could not imagine myself in that position – showing my bottom [buttock]. It is a nurse after all. (Female: HBP 10)

Although this patient had adjusted to the hospital situation when she was being admitted, the giving of an enema posed another threat to her dignity, therefore the cycle started again. There was a realisation of the need to undergo the enema in order to get better. In the anticipatory phase the patient imagined the humiliating position she was going to be in, being exposed and on the other hand how considerate and sensitive the nurses would be. There was fear of loss of dignity, an apprehension and anxiety. She might have denied that the whole process was happening to her. Then the benefits outweighed the costs as she needed to get better. She therefore necessarily submitted herself to the nurse then perceptually adjusts to the situation. "It is a nurse after all". "It is all right". She reached her perceptual adjustment level. In another nurse-patient encounter in which her dignity is threatened the cycle would start again. This shows how dynamic perceptual adjustment level is.

There were some differences among patients as regard to duration in each phase. How a patient felt through the process was never the same for every patient and situation. For instance for some it took longer to weigh the costs and benefits.

Perceptual adjustment level was a unique and a subjective experience for each patient. Nevertheless most patients went through all the phases.

It has to be emphasised that the important aspect in the examples above was how the patients perceived dignity in the context of "PAL": how they separately adjust to "PAL" in each situation. Because it was the patients themselves who made the mental decisions, whatever was performed within this level was accepted. They felt dignified at that level as there was a sense of control and choice. One patient at one of the sites for this research declared:

> When they come in they draw the curtains so that nobody can see me anyway and they say, you are having this injection in your stomach and I say oh! my God !and I just pull my night dress off and they do it off they go. They just lift the corner to get my stomach. If they lift up to here [showing chest] I would be embarrassed because there is no need for them to pull it up there. (Female: HAP 7)

This shows that the patient decided the level of exposure that was acceptable and any exposure beyond this would cause embarrassment and, therefore, loss of dignity. Patients felt that their dignity had been maintained if "PAL" was compatible with ward activities. This ties up with Seedhouse's (2000) definition of matching capabilities and circumstances to maintain one's dignity. Maintaining each individual patient's dignity depended on establishing this perceptual adjustment level (PAL), acknowledging the patients' values and maintaining them according to the patient's wishes.

Throughout this research, patient's perceptual adjustment level was reached in different ways. What was also evident was that some patients did not go through the process of adjustment smoothly. There were maladjustments which were detected. This maladjustment was more tied to lack of information relating to what was expected in a hospital or during any nurse-patient interaction. There was a sense of ambiguity in relation to how their dignity would be maintained. Some of them were

just resigned to the fact that they did not care whatever happened. A common statement expressed by patients was: "I do not care" or "it doesn't matter they have seen it [the naked body] before". Patients surrendered their "self" and accepted procedures that were potentially undignifying and chose to rationalise their action by saying that these procedures were part of everyday life on the ward and the nursing staff would not find anything unusual in them; they do not, therefore, take any notice. This helped the patient in accepting the necessary perceptual level compatible with the procedure.

There were also those who did not want to think about the experience of losing their dignity in hospital. A common statement among such patients was "I leave my dignity at the door and pick it when I go home". There was a sense of disconnectedness from the situations in the hospital. What it meant was that patients necessarily submit themselves but did not come to terms with what would happen to them in hospital. Patients' perception of how their dignity should be maintained did not adjust. They had the denying "it is not happening to me" feeling. They detached themselves from the situation. It was a defensive mechanism, a way of coping with the whole situation. Dissociation permitted the patients to go through the hospital procedures appearing to be unaffected mentally in the process of protecting themselves from the indignity of embarrassment. However, data analysis showed that due to perceptual maladjustment these patients felt more stressful, vulnerable and embarrassed in nurse-patient interactions because there was a discrepancy between their perception and what was expected in the hospital situation. At the other extreme there were those patients who did not cherish the thought of being exposed to a stranger like nurses, as exemplified by a male patient who claimed:

> I am lucky I have got my wife who comes to help me with the bath. In my case it makes me feel better for the fact that no total stranger has to see my naked body (Male: HBP 2)

It is evident that patients perceive dignity in the hospital situation in a different way. Therefore, maintenance of patient dignity would be inadequate if nurses failed to recognise the level at which the patient regarded his or her dignity as paramount. This is the position which will be argued throughout this chapter.

5.3 Factors Influencing Patient Perceptual Adjustment

There were a number of factors which influenced each patient to reach the acceptable perceptual adjustment levels. The main factors were as follows:-

5.3.1 Degree of Illness

In terms of the degree of illness, the more helpless the patient was, the greater the need for the nurses to be involved in patient activities, thereby consciously or unconsciously helping the patient's adjustment of perception of dignity. For example a bed bound patient expressed:

> I know I am a private person at home. But I cannot manage on my own here. Nurses have to do their job. As long as they do it sensitively I am okay. I am not bothered. It does not embarrass me at all. (Female: HBP 10)

There was the patient's "self surrender" to nurses which was not embarrassing as long as the nurses were sensitive when caring for him. In this case the nurse's sensitivity would have helped the patients to reach the acceptable perceptual adjustment level (PAL) with regards to their dignity. Trust and rapport established between the nurse

and patient was another important factor which helped the patient to feel what was perceived to be acceptable. In contrast, a patient with a broken toe had a different perceptual level of what constituted acceptable dignity:

> I can manage. I would feel undignified if nurses do it all for me. (Female: HCP 11)

Different states of illnesses determined the perceptual boundaries set and choices available to the patients. What activities should be performed and how much exposure of themselves also determined the patient's control of what was performed on them. As the condition of the patient changed so did the Perceptual Adjustment Level (PAL). Patients seemed to exercise more control over what happens to them when they got better. It was also evident that the type of illness also influenced the patients' perceptual adjustment level. For example, one of the patients who was admitted for sigmoidectomy compared it with his previous illness:

> It was different when I was admitted with a broken leg. I did not think much about the loss of my dignity. This time there is something wrong inside. I have to show everything that is not supposed to be shown [anal area]. It is more embarrassing. (Male: HAP 24)

The patient knew that the present illness was going to lead to more exposure of his private parts, losing his dignity in the process. There were more conjectures about how his dignity was going to be maintained, and therefore, far more emotional adjustment than the previous hospitalisation. It needed more sensitivity from health care workers and more privacy for the patient. This would also be argued for illness which affects the state of consciousness of the patient. It would be very hard for patients to know what is expected of them in terms of loss of awareness. However, as a human being, he or she still needs to be dignified. For patients who became very ill or unconscious and completely dependent on the carer, some patients felt some

embarrassment at a later time when they realised what had gone on, and which type of procedures had been used on them when they were unconscious or very ill.

5.3.2 Information

Exercising choice and the degree of control within the perceptual level depended on the kind of insight the patient had on his or her disease as well as on information acquired from the staff on her or his condition. This was very important in terms of helping the patient to adjust. Information helped patients to build realistic hospital images and conceptualise what it meant to be in hospital in terms of their dignity. The sense of control over the activities at the perceptual level was reinforced by providing the patient with information to make an informed decision. As one patient, echoing the views of a number of patients from the three sites, declared:

> Knowing what to expect helps to know what one would expect from staff. It gives you control and one's dignity is maintained. (Male: HCP 5)

This clearly demonstrates the importance of information in influencing patients' modes of adjustments and their perceptual level. Most patients in the three hospitals expressed the view that feeling embarrassed varied with each situation depending on how well procedures or tasks had been explained to them.

5.3.3 Patient's Willingness

According to Aspinall (1995), it is a basic common principle that a person's body is not violated. Any intentional touching of it without consent, is trespassing and encroachment on one's boundaries of "self". This can cause embarrassment to the

individual and set in motion a sense of loss of dignity. Consider again, the example below, where the patient had an injection which involved some degree of intrusiveness:

> When they come in they draw the curtains so that nobody can see me any way and they say, you are having this injection in your stomach and I say oh! my God! and I just pull my night dress and they do it off they go. They just lift the corner to get my stomach. If they lift up to here [showing chest] I would be embarrassed because there is no need for them to pull it up there. (Female: HAP 7)

We notice that the patient was made aware of the procedure and submitted herself to the nurse who would give her the injection to get better. She accepted having her stomach exposed as long as the exposure was within her perceptual level. The procedure would have been regarded as undignified if the patient felt that the nurse had gone beyond a perceptual boundary – the distinction between what was strictly necessary and that which is not. Willingness on the part of the patient and an agreement on where the boundaries lie is important for patients to feel that their dignity is being maintained.

5.3.4 Previous Experience of Hospitalisation

The patient's previous hospital experience strongly shaped the perceptual adjustment level (PAL) of his or her sense of dignity. Familiarity in the ward influenced the way patients perceptually adjusted. A lady patient who had a wound on the breast and got familiar with other patients in the ward said:

> The nurse wanted to close the curtains and I said oh! no I do not mind to take off my bra. Everybody knows and I have done it before. I know them and we chat. So it doesn't matter. But the nurse insisted and said it was undignified. (Female: HAP 17)

The above illustration also shows how experience in hospital helped the patient to adjust even beyond the rules from the nurses' point of view. This is consistent with Back and Wikblad's (1998) research who found that *previous experience of* hospitalisation influenced the setting of standards for what was to be expected concerning privacy. What the patient accepted in the maintenance of her dignity might not have been adequate for the patient being admitted for the first time. This is illustrated by the nurse's action which could be interpreted as being over cautious, retaining her own perceptual level, and not adjusting to the changing perception of the patient.

5.4 Summary for Chapter 5

It has been established in this chapter that patients submitted themselves to hospital staff. It was a 'necessary submission' because they wanted to get better. In the process, patients changed their perception in relation to the maintenance of their dignity and reached the acceptable perceptual adjustment level. It is this perceptual level that will enable nurses to individualise patient care in terms of dignity. It has been highlighted throughout this chapter that the "PAL" for each patient needs to be established if patient dignity is to be maintained. This should be done at every nurse-patient interaction during their hospital stay as every patient's perceptual adjustment level will change with each situation. This entails asking patients how they perceive their dignity and how it should be maintained, even if presented in such terms. The next section will, therefore critically discuss how patients perceived their dignity within their perceptual adjustment levels. The nurse's responses will strengthen the views as to whether patient dignity was properly maintained or not.

CHAPTER 6: PATIENTS' AND NURSES' PERCEPTION OF PATIENT DIGNITY AND THE EXTENT OF ITS MAINTENANCE

6.1 Introduction

The previous chapter has discussed how patients necessarily submit themselves to hospital staff as they realise that this is the only way they can get better. How patients adjusted their perception of dignity as a result of illness and admission to hospital has also been highlighted. This chapter will further present and discuss patients' perception of patient dignity and its maintenance in the context of the perceptual adjustment level (PAL) which has been introduced in the last chapter. Nurses' views have been added to the picture of what constitutes patients' dignity.

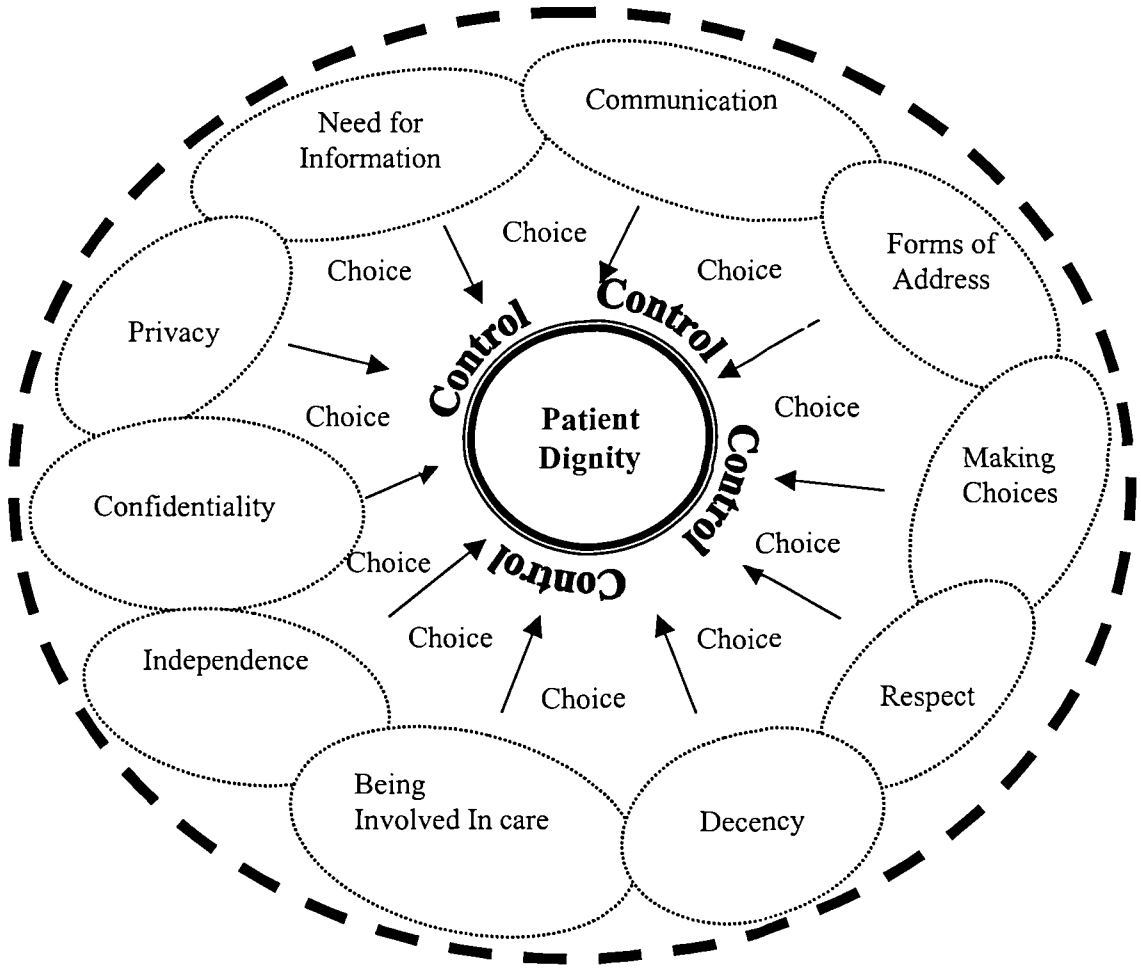
6.2 The Concept of Patient Dignity – What is it?

As indicated, defining patient dignity was not easy for either nurses or patients. There was an initial hesitation, a laugh or a sigh from most participants before responses were given. The reason for this was made clear after analysing their responses. Patient dignity was taken for granted; patients did not expect anyone to think about it. All research participants from the three hospitals believed that patient dignity was a complex phenomena. However, the interviews made the participants aware of, and reflect on, the concept. Most patients said that this was the first time they had consciously reflected on their own dignity. One is not aware of its existence in everyday experience unless it is threatened or violated. Though it is important in one's life, it is not tangible. This was echoed by one nurse who said: "Since I qualified, I have never given patient dignity any serious thought", and many nurses

alluded to the fact that the interviews in which they participated helped their understanding of the concept and made them more aware of its importance.

Irrespective of the level of perceptual adjustment reached, patients described their dignity in terms of categories. Eleven categories were identified: privacy, the need for information, patient choices, involvement in their care, decency, forms of address, independence, confidentiality, control, respect and communication. These were presented in Table 5, Chapter 3. They are interrelated like a mosaic within patients' perceptual adjustment levels and are depicted in Figure 2.

Fig. 2 A diagram showing categories within Perceptual Adjustment Level



These categories within the perceptual adjustment level represent patients' values or needs in relation to their dignity. Patients set standards or expectations relating to each one of these categories, taking into account the new environment in a hospital situation. The diagram demonstrates the relationship of categories within the perceptual adjustment level surrounded by perceptual boundaries. The *sum total* of all the categories or attributes of each patient makes up patient dignity. It is through these attributes that patient dignity was maintained. If one or more categories were not maintained the patients felt undermined. In each category there was an element of choice and if each one of them was maintained, a patient felt in control, thereby feeling dignified. How much each patient valued each category could be a topic for further research.

In general, there was an agreement in the perception of the eleven categories between patients and nurses. Nurses came up with similar categories except for "control". The omission of control by nurses may have been a reflection of the fact that nurses were not incapacitated as most patients were. They could not appreciate readily the importance of control in relation to patient dignity. Patients described their expectations within these categories while nurses' perception added to the picture. The difference in the maintenance of patient dignity was a manifestation of the individuality of each patient. These constitutes of the "PAL" are unique to the individual patient. A patient might have all the categories mentioned in Figure 2 or might have more or less. This research has proposed a tentative definition of patient dignity which is designed to capture and summarise what has been discussed so far:

Patient dignity is the fulfilment of patient's expectations or needs in terms of values within each patient's perceptual adjustment level taking into account the hospital environment.

Central to this definition is that to maintain patients' dignity, nurses were required to match patients' expectations within each category with nursing activities. This is in line with Seedhouse (2000) who stated that dignity is matching the needs of the person with circumstances. In this research the circumstances are the nursing activities which have been identified and interpreted as shown in Table 6, addressing the third aim of the research.

Table 6 **Categories and examples of specific nursing care activities to maintain patient dignity elicited from patients and nurses from Hospitals A, B, C.**

Key

P - Identified by patient

B - Identified by both patients and nurses

	Category	Indicators	Indicated by
1	Privacy	**In a general ward**	
		* Discussing matters pertaining to illness	P
		* Avoiding unnecessary exposure	B
		* Curtains drawn around the bed when a procedure is done.	B
		* Arrangement is made to take patient to a private area for discussion or a procedure to be carried out when condition of patient allows	B
		* Staff request permission to open closed curtain if there is a need.	B
		* Staff not coming in and out the closed curtains when procedure is in progress.	P
		* Staff speak in low voice to avoid other people listening to the discussion.	B
		* Hard of hearing patients to be in single rooms to avoid other patients listening to conversation when staff are trying to raise voices.	P
		In single rooms	
		* Patients to use single rooms.	B
		* Requesting permission.	P

	Category	Indicators	Indicated by
		* Knocking on the door to come in the room if patient's condition allows.	P
		* Closing curtains and doors when procedure is being done.	B
		General	
		* Patients using a commode/bedpan/urinal with nurses standing there within the room or curtains only if necessary.	P
		* Providing space for patients when condition allows.	P
2	Confidentiality	* Information not to be discussed or given to another person unless there is a purpose for the benefit of the patient.	B
		* The giving of the information should be done with patients' consent.	P
		* Patients' matters not to be discussed at nurses' desks or corridors.	B
3	Need for information	* Providing enough information to patients.	B
		* Procedures to be explained to patients.	B
		* Nurses to confirm patient understands what is to be done.	P
		* Information to be given in time.	P
		* Patients given up to date information	P
		* No conflicting information.	P
4	Patients' choices	* Patients given opportunity to make choices about care.	P
		* Allow patient to make choices about care.	B
		* Patient choice to be implemented.	P
5	Patient's involvement in their care	* Discuss patient care <u>with</u> patient not <u>at</u> the patient.	P
		* Involve patient when condition allows.	B
6	Patient's Independence	* Encourage patients to do activities which they can manage.	B
		* Patients to be given opportunity to do their own tasks within their capabilities.	P
		* Allow patients to carry out own tasks.	P
7	Patient's forms of address	* Address a patient by name.	P
		* Address patient by preferred name.	B
		* No condescending names.	B
8	Patient's Decency	* Acceptable dressing code by patient.	P
		* Acceptable make up by patient.	B
		* Keeping jewellery on unless there is a purpose for removing it.	P

	Category	Indicators	Indicated by
		* Patients should be given explanation for the removal of for example clothes, jewellery and make up during examinations or when going to theatre.	P
9	Patient's Control	* Patients to direct their care when condition allows.	P
10	Respect for patients	* Prompt attention. * Assessing patients for dignity needs. * Nurses to find out from patients how these needs should be met. * Treat patients as equals. * Being sensitive when performing a procedure. * Making the patient comfortable. * Nurses being advocates for vulnerable patients.	P B P P P P P
11	Nurse-Patient Communication	* Nurses introduce themselves to patients. * Asking permission from patient before the procedure is done. Do you mind? * Nurses to have time to talk to patient. * Proper tone of voice. * Nurses to listen to patients. * Nurses to be polite. * Patients to be involved in conversations * Patients to be given opportunity to express their needs. * Body language to correspond with verbal language. * Nurses eye contact with patients during nurse-patient interaction.	P P P P P B P P P P

Although some patients conveyed satisfaction with the maintenance of the identified categories, it is evident from the above table that not all expectations were identified by nurses. In other words they did not match patient dignity expectations with the nursing care activities on some of the occasions. This led to some patients' dignity not being maintained. The reason for this can be attributed to different levels of standards between nurses and patients in relation to dignity. This emphasises the

need for establishing each patient's perceptual adjustment level by nurses as this will take into account each patient's uniqueness and individuality.

The eleven categories will now be discussed in detail in the following sections. Privacy and confidentiality will be discussed together as there were more similarities in the two categories than in the others.

6.3 Patients' Privacy – Patients' Perception

Privacy was highly rated by all participants from the three hospitals as the main attribute of patient dignity, emphasising its importance in the maintenance of patient dignity. Patients described various ways of maintaining it within their perceptual adjustment level. Interpersonal differences will lead to multifarious perceptions of privacy (Wainright 1994). This was evident in this research as patients had different standards of privacy; their perception of how their privacy could be maintained was developed according to their perceptual adjustment level. As data analysis progressed, it was evident from the three hospitals that patients' perception of privacy also depended on sex, age and the crucial matter of the room the patient was admitted to; whether it was a single ward or a general shared ward. Comparing male and female, female patients were more particular about how they were exposed than males. One 60 year old female patient commented:

> We ladies are particular with almost every part of the body. (Female: HCP 15)

In contrast one 62 year old male patient commented as follows:

> I do not mind my body being exposed as long as my private parts are covered, that is what I would be worried about. (Male: HAP 14)

This gender difference in exposure of the body is culturally constructed. Males can expose most of their bodies apart from genital parts without feeling embarrassed while females cannot. This gender difference is supported by findings from Baeur (1994) and Back and Wikblad (1998). In terms of age it was noted that elderly patients were more particular with their privacy than young patients. This could be attributed to the way the young patients are prouder of their bodies and therefore less self-consc ous. Young patients have an "I do not care attitude" in terms of dignity while the older patients were more particular. It was also inferred from the data that due to the different styles of architecture of the rooms in the wards, patients on general shared wards had different comments from those on single wards. In the three hospitals where this research was conducted there were two types of wards which were used for patients' admission, general shared wards and single wards. The general shared wards had 4-8 beds, each bed being separated by curtains. Patients on these wards performed in broad day light activities they would have preferred to perform in private. They also shared facilities which they would not normally share at home. Normally the act of opening bowels or passing urine is done in private where there is complete exclusion of others and the person is in full control. In general shared wards these activities were done within the proximity of others. All this played a part in influencing how patients' perceptual adjustment level developed in terms of privacy in hospital.

Although there were the above mentioned differences, there were commonalties among patients from the three sites on how they perceived the maintenance of their privacy. Patients mentally examined the situation and came up with the following themes as to what constituted their privacy: personal information, appropriate covering of their bodies, privacy related to hospital procedures and being

provided with space. Patients set their perceptual boundaries relating to each one them within their perceptual level. In terms of personal information, most patients made perceptual decisions as to what information should be shared. Though patients were happy to disclose and share some intimate information with nursing staff because they wanted to get better, they were not prepared to reveal information which did not affect their illness or did not relate to their illness. This also applied to questions asked on admission and during their stay. Patients did not feel in control when asked questions they perceived to be irrelevant. One patient declared:

> I have got a wound on my leg. I know how much or what answers to give the staff but if a nurse or doctor asks questions not relevant to the wound, I would see it as a loss my privacy. Really it is loss of my dignity. It is important to have that control depending on how one feels. (Female: HAP 10)

The "necessary submission" by the patients to nurses or doctors is clear in the above illustration. Expectations are demonstrated in his perceptual adjustment level which gave him control and increased his self esteem. Patient dignity was threatened less when patients felt that information shared with nursing and medical staff was relevant to the diagnosis of their condition. Discussions of issues that were intrusive were a source of embarrassment as the patient felt that the nurse was going beyond perceptual boundaries.

There was also a perceptual decision as to who was entitled to hear the information shared. Patients did not mind discussing their illnesses with nurses. In any case, they were in hospital to be cared for by the nurses. However, after sharing the information, patients expected the confidant not to impart it to other persons without their consent; otherwise they felt betrayed. This was a breach of confidentiality. Sutherland (2000, p.243) defines confidentiality as "to trust another person with private and personal information about yourself". Personal information is

part of one's self, therefore, patients felt in control and dignified when they knew that only the people intended got the information. There were others to whom it was inappropriate to pass on information. As claimed in the previous chapter, most patients had their perceptual adjustment level of exposure set depending on the severity and type of illness. Patients felt dignified when the exposure of their bodies conformed with the level of adjustment. The explanation which nurses gave before exposure also lessened patients' embarrassment as it made them appreciate the purpose and expectation of the exposure. A comment from a 54 year old male patient represented the views of most patients:

> As long as it is explained to me, I would not feel embarrassed. No part should be exposed unnecessarily. To me dignity is being covered properly. (Male: HCP 8)

Another patient declared:

> Taking off my blouse to examine my chest was okay but not beyond that. (Female: HCP 13)

These examples show how patients in the three hospitals anticipated some form of exposure when they were being examined. The use of words like "necessary" and "properly" in the first quotation denotes patients' perception of appropriateness of the act. Every action taken by hospital staff on a patient should be justifiable. As stated before, patients surrendered themselves for a purpose. Patients perceptually adjusted to a new acceptable level as far as the maintenance of their privacy was concerned. The extent to which health care workers could expose them was defined within their "PALs".

The need for privacy as procedures were carried out was also expressed by the majority of patients from the three hospitals. Some felt that not everyone in the ward

was entitled to know what was happening to them unless the patient decided to share the information.

> I am a private person; I do not expect every one in the ward to know what is being done to me. (Female: HAP 7)

This was the reaction of a lady whose arm was being bandaged. This clearly demonstrated the patient's "PAL" has been reached. Although this would have been perceived as a non invasive procedure by another patient who would not have minded sharing it with anyone in the general ward, this patient thought otherwise. Some patients did not want fellow patients to know what was happening or being discussed within the curtains. They wanted curtains to be closed or preferred to be taken to a private place for discussions if conditions allowed. The type of illness also determined where patients felt comfortable for the discussion to take place. For example, for some patients, discussion about toe operations could be discussed without much embarrassment in a general ward, while discussions of disease affecting the genitalia did cause embarrassment.

The four areas of privacy identified by patients and discussed above are in line with some of the descriptions of privacy found in the literature. Altiman (1976) described privacy as the extent to which one perceives control over contact about oneself or one's group. It is the selective control of access to "self". Westin (1967) describes four states of privacy. The first is "solitude" which means separation of the individual from the group; the person should not be observed by others. The second is "intimacy" and refers to seclusion of pairs or small groups to achieve personal relationships. The third is "anonymity" which is the state where an individual in a public place is free from personal identification. The fourth is called "reserve" in which an individual does not want to reveal certain aspects of himself or herself.

Bloch (1978) describes privacy in terms of zones, regions or circles. The inner region contains the secrets, thoughts and beliefs which are not shared with anyone except in situations of extreme stress, when this is done for emotional relief. The outer rings consist of regions which denote the decreasing privacy from inner to outer layers. Thorndike-Barnheart and Thorndike-Barnheart (1985) defined privacy as the condition of being away from others; seclusion; the absence of publicity; and secrecy. An individual needs an opportunity to be alone with thoughts and feelings in privacy. Despite all the above definitions, Waltz, Strickland and Lenz (1991) stress the importance of choice on what should be shared with others as a factor in the maintenance of privacy. All definitions show multivalent attributes and levels of perceptual distinction.

This research showed that a number of patients stated that dignity becomes important according to the extent of invasion by staff and they expressed the importance of taking control of what they shared or allowed with the nursing and medical staff depending on their perceptual adjustment level to privacy. Patients' privacy was breached when their perceptual boundaries were not identified and was not met by staff as they made them feel exposed.

Collins (1991) defines "exposure" as to exhibit, disclose or reveal. Patients would have felt undignified if either their information or bodies had been revealed more than they had bargained for. In this research there were two types of exposure, personal information exposure and body exposure. These are in line with two types of exposure identified in Bauer's (1994) research on privacy. He called them "identity" and "physical" exposure. According to Bauer, identity exposure was concerned with revealing private feelings while physical exposure was taking off patients' clothes or not adequately covering them according to their expectations. The personal

information exposure in this research is more than a matter of exposing the inner feelings of the patients. It is also whether patients' information goes beyond the intended ears.

Patients also expressed the need for personal space in the maintenance of their dignity and expected nurses to provide this. Macionis (2000) defines personal space as the surrounding area over which a person makes some claim to privacy. It is an expression of the "self". Patients emphasised that it was a way of maintaining their dignity. The following examples demonstrate the importance some patients attached to personal space:

> ..Not fussing around all the time. They come and do their job and they go. If you need them you ring them. I was in hospital larger than this place and they were there all the time. *Here they seem to leave you alone to your privacy. (Male:* HAP 15)

> To me, part of dignity is that *they give you a bit of space. They don't fuss over you.* But they are there whenever you need them. (Female: HBP 28)

These two patients were emphasising that patients created micro environments within which they felt physically and mentally free. Within this environment patients reflect, for example, on their illnesses and their possible outcomes. Because the environment was under their control they felt secure. Any unwarranted intrusion into this was not welcomed and could cause distress. Due to necessary submission, patients were willing for nurses to care for them within this micro environment. "Not fussing over you all the time" meant they allowed the nurses to invade their space at times; they wanted to be left alone in thoughts or deeds at other times. Patients created new perceptual boundaries and expected to have them respected. For them to be able to decide on who should be allowed to invade the boundaries and when this should be done gave them control, thereby enhancing their self esteem and maintaining their dignity.

To understand more fully what is involved in the discussion of personal space, it should be related to territoriality and proxemics. Territoriality and proxemics are words used to refer to personal space. Territoriality is the physical area that animals claim as their own and defend it from predators. Proxemics relates to the use and interpretation of space in communication processes by individuals (Northhouse and Northhouse 1998) and it refers to closeness. Hall (1966) proposed four main zones:-

(a) Intimate, from contact to 6-18 inches. This includes for example touching.

(b) Personal distances between 1.5-4 feet when for example nurses were discussing with the patients.

(c) Social distance between 4-12 feet is used for formal business purposes; and

(d) Public distance which is over 12 feet or more.

Using Hall's typology most nurse-patient contact fell within the intimate and personal distance zones. This had an implication on the way nurses should have conducted themselves during patient-nurse interaction. Because of this closeness coupled with the type of procedures carried out on patients, it was important for nurses fully to explain to patients the nature of interactions so that they were commensurately aware. It was very important to ascertain that the patient had granted his or her permission for the procedure. If these steps were taken during nursing activities fewer anxieties were created and patients felt dignified.

6.3.1 The Extent of Maintenance of Patients' Privacy – Patients' Perception

There were varied responses as to whether patients' privacy was maintained or not. There was satisfaction from some patients in all three hospitals that their privacy was being maintained, particularly those in single rooms. All patients who were interviewed in single rooms in the three hospitals appreciated being in those circumstances. They expressed the view that side rooms helped them in the maintenance of their dignity. They believed that it was a privilege which all patients should have when in the hospital. There are times when a person wants to be alone. At home one can retreat to one's room and yet patients in hospitals are made to feel this is a luxury. Single rooms provided patients with space where they could exercise control which is lost on shared wards. The majority of patients, in all the three hospitals, appreciated the closing of curtains. They also appreciated steps taken by nurses to minimise unnecessary exposure whenever procedures were carried out on the wards. Some patients in all the three sites said their privacy was maintained to some extent, while some said it was not. Some patients expressed the need for health care workers to lower their voices while discussing issues with them within drawn curtains, as curtains are not sound proof. This overhearing was compounded by the lack of space in between beds which was so narrow that it defeated the purpose of closing the curtains as far as most discussions were concerned. This was more pronounced when a patient was hard of hearing. It was important for nurses to be sensitive to patients' anxieties when discussions were taking place.

Overhearing was a problem not only to the concerned patient, but also to neighbouring patients who could hear other patients' discussions. Patients did not like others to hear their illness being discussed. Likewise they did not feel happy listening

to discussions pertaining to other patients. They felt uneasy as it was an intrusion into other peoples' affairs and forced them to participate in the violation of other patients' dignity. For some this was a reminder of previous undignified encounters in the hospital while for others there was an anticipation of what was to come. Therefore, patients were apprehensive at the thought of losing their own dignity. Some took measures to distract themselves by finding something to do. For example, a 50 year old male patient said:

> Personally when I can hear what is happening in other curtains, I put on my walkman or read a book. (Male: HBP 13)

Patients were forced to use different ways of distracting themselves in order to avoid listening to other people's conversation. These included reading books, talking to other patients in the neighbouring beds while others went to the extent of pretending that nothing was happening around them. Distracting themselves was also a relief from the thoughts of distressing feelings of the loss of dignity. This problem was identified by patients in the general shared wards only. Some patients realised that at times nurses were not aware that their actions were breaching patient dignity as the following patient pointed out.

> They might shout for help from fellow nurses that ..."a certain patient has a wet bed can we change his bed linen?" while all the patients were hearing. They do not really mean in a nasty way but slips off. Also asking whether bowels are open when everyone is hearing. (Female: HAP 20)

The patient would have preferred this to be dealt with discretely. Patients stressed that nurses should be aware that some of their actions have the potential of breaching patient confidentiality. Patients also identified nurses' desks as places where confidentiality was not maintained as some of them could overhear the nurses'

discussions of other patients. For example, it was pointed out by a patient who was in a bed near the nurses' station:

> I can overhear some of the discussions at nurses' desk. One thinks, suppose it was me being discussed and everyone is listening, that is not good. (Female: HCP 19)

Although the nurses were not discussing her, she was made acutely aware of her own vulnerability as far as confidentiality was concerned.

A number of patients felt that at times they were unnecessarily exposed. The effect of this unnecessary exposure was felt more by patients on the general shared wards. Some patients appreciated that nurses were trying their best in providing an exclusive environment by drawing curtains. It became a protected space and patients felt in control of the space enclosed by the curtains. They could claim it as their own territory. However, it was not always possible to have curtains closed properly, particularly when some doctors examined in a hurry. One patient complained:

> By the time the nurse closes the curtains the doctor [consultants] had finished what he or she came for. (Male: HAP 4)

Nurses tried to close curtains during ward rounds but certain doctors' impatience frustrated these efforts. Some doctors only concentrated on the part of the patient needing examination. The provision of privacy was left to the nurse. This might be a historical development of doctor and nurse relationships during ward rounds. Doctors have always seen themselves in the context of treating patients while nurses have been perceived as the providers of care to the patient. The result of this is that some doctors did not consciously think of drawing the curtains as a necessity especially when they were in a hurry. It was also observed by patients that nurses tended not to close curtains properly, especially when they were busy. They were more concerned with getting through with the job than considering patients' privacy.

The poorly fitted curtains aggravated the situation by leaving gaps in the curtains as demonstrated by a 40 year old female patient from Hospital A, said:

> I think curtains need a bit of maintenance, they do not pull properly, they leave some gaps. (Female: HAP 13)

A 29 years old male patient also claimed:

> To be in a ward of eight is a different experience. It is the first time I have been in hospital, sharing a room with other people. It doesn't bother me because we do have a laugh and chat. But curtains do have gaps when they are closed. They do not close completely. (Male: HBP 11)

Although it was his first admission to hospital, the patient seemed to have perpetually adjusted smoothly in terms of his dignity. The patient accepted being on a shared ward but had defined his boundaries relating to privacy. Faulty curtains compromised his privacy. This was a common problem and some nurses took the initiative by using pins and pegs in rectifying the ill-fitting curtains when carrying out procedures. One of the reasons why this problem was perpetuated was because some nurses did not perceive the maintenance of curtains as their personal responsibility. If nurses' responsibility is to maintain patient dignity, they also have a duty to make sure that curtains are working properly. Therefore, nurses should report faulty curtains to whoever is concerned so that patients' privacy is ensured all the time. The problem is that the nurses commitment to patient care can be undermined by a poor or unwieldy management system.

In one of the three hospitals, it was noticed that some curtains were transparent. One patient remarked:

> When walking in the corridor and facing against the light, one can see a shadow of a person that she or he is having a wash. I do not know the criteria they use to choose the curtains. (Female: HAP 5)

Doctors, nurses and other staff often did not respect closed curtains or closed single rooms when patients' procedures were being carried out. Patients from all wards of the three hospitals did not approve of staff including nurses, doctors and domestic workers, going or peeping into closed curtains or rooms unexpectedly. A 44 year old male patient commented:

> Even if curtains are closed sometimes people come in and out, for example, nurses looking for colleagues. (Male: HCP 16).

As pointed out earlier, patients perceived the space within the curtains or closed rooms as protected areas for them and they felt in control. Patients were entitled to grant permission of entry to whoever wished to do so. This formed part of their perceptual boundary. The staff carrying out the procedure within the curtains would have been mentally accepted by the patient as her or his presence would have been perceived as necessary. Other health care workers entered the space enclosed by curtains or closed private rooms unexpectedly. For instance, a nurse-in-charge of a ward holding keys for a medicine cupboard for patients would be administering an enema to a patient in closed curtains. Another nurse would pop in behind the curtains asking for the keys so that she could give analgesics (pain killers) to another patient in need of the medication at that moment. As one of the patient expressed in disappointment:

> It is the "key" issue. When I was having an enema, one of the nurses wanted keys for the drug cupboard and came in asking for them from the other nurse. I must admit I was a bit embarrassed. (Female: HBP 10)

The perceptual level had been breached by staff entering inappropriately into the allowed and agreed personal space. Shortage of staff also meant that assistance would be requested from a nurse who was attending a patient behind the closed

curtains. Sometimes the staff would enter the closed curtains when the patient was alone having a wash or using a bed pan. Though some reasons were valid for entering the curtains, the entry of another nurse disturbed the set perceptual boundaries. Patients felt that their dignity had been violated by the unexpected entry as they felt that control of personal space was lost, resulting in embarrassment. One can see that embarrassment could have been minimised if these were discussed and negotiated with the patient. The patient would then know what to expect, enabling them to adjust their perceptual levels accordingly. This was made worse when the nurses talked to each other without including the patient. One patient commented:

> When another nurse comes in, you don't even know what they are talking about. (Male: HBP 2)

Patients wanted to be consulted with regard to entry in the curtains as it was perceived as their own territory.

Patients in single rooms gave varied responses. Some patients expected staff to request permission to come in rooms, for example, by knocking on the door when a procedure was being done while others expected this every time they entered the room. One patient expressed:

> They knock first. I like that. Obviously you cannot have that in the main ward. (Female: HBP 5).

Another patient supported this:

> Staff working in hospitals take it for granted. Sometimes they just come in without knocking and find you indecent. Anyway it is a hospital! But if you are talking about dignity, that is part of your dignity. (Female: HAP 7)

Not knocking was taken as a violation of dignity by some patients. Taking this example, the frustration is very evident in her comments. Although she realised that

in a hospital situation it was not possible to maintain her dignity as she wished, nevertheless she felt that a slight change of attitude by the staff in respect to her space was all that was needed. One could also sense the conflict between her understanding of the hospital situation and her desire to have her dignity maintained but she perceived dignity to be so significant that it had to be maintained irrespective of the situation. While the examples discussed are of those who valued asking for permission, at the other end of the scale were those who did not care to the same degree. As one patient remarked:

> I am not bothered; this is not your house anyway. (Female: HCP 15)

These varied responses are important to note as they signify different perceptual adjustment levels which need to be established by nurses in order to maintain patient dignity. It cannot be assumed that all patients expect nurses to knock on the door. Some patients in single rooms had the doors open all the time which in some cases was the preference of the patients. However, patients felt that their privacy was breached if this was done by the nurses without consulting them.

A number of patients in single and general shared rooms pointed out that some nurses at times stood nearby when patients were using a commode, urinal or a bed pan. This caused embarrassment:

> I would rather they just put me on the commode and left. Unfortunately the nurse did not do that this morning. She was busy talking about horses. I could not hang on any longer. I felt pleased because I am also into horses as well. But I was sitting and thought to myself I cannot hang on any longer and you know I had to wee while she was there and I could have wet myself. She was still standing there. It is ridiculous. Oh! I just thought put it at the back of your mind; she is a nurse for Gods sake. I did that, I stood up and she helped me back to bed. But I wished she could have left me alone first to do what I wanted to do. Where is your dignity in all that? (Female: HAP 16)

Even though standing there while the patient was using the commode was meant with good intentions by the nurse, it was perceived as intrusive on the patient's privacy. Patients found it difficult to ask the nurse to leave, to do something that in other circumstances would have been taken for granted. Although the patient had realised that the nurse was breaching her privacy she did not want to point this out to the nurse because she did not want to compromise the nurse-patient relationship. This was one of the ambivalent situations most patients found themselves in, which is another example of the difficulties of patient perceptual adjustment. To help the patient (HAP16) to adjust to what she was expecting from the interaction, the nurse could have asked the patient whether the patient minded her being there. Alternatively the nurse would have explained why the patient could not be left on her own.

It was apparent on a number of occasions that patients' safety was taken seriously especially in regard to those that were deemed helpless. That was why nurses were standing nearby when patients were using a commode or urinal. This was for the patient's sake as well as to avoid litigation. However, a delicate balance was needed while achieving this so that space was provided to the patient thereby maintaining dignity at the same time as carrying out professional duties. The crucial point for nurses is to recognise this balance. The insensitivity of the attending nurse as indicated by the above example was not a one-off event; patients from the other two hospitals mentioned this point as well.

6.3.2 Patients' Privacy – Nurses' Perception

Privacy was mentioned by all the nurses as one of the attributes of patient dignity. Like patients, nurses could describe how patients' privacy should be

maintained. Commenting on the maintenance of patient privacy in general shared wards, they talked about lowering voices when discussing matters with patients. Nurses also related privacy to patients' information in the maintenance of patient dignity. They only related this to patient dignity in terms of confidentiality, sharing patients' information without their consent with unintended persons. Not exposing patients' bodies unnecessarily was mentioned by a number of nurses. The drawing of curtains while doing procedures both in shared wards and single rooms was also noted. The point was exemplified by a nurse who claimed:

> Patient dignity is closing the curtains around the patient whenever one is carrying out a procedure. Not over exposing them. (Female: HBN 21)

Although there was an agreement between nurses' and patients' perception that closed curtains were important in the maintenance of patient dignity, the nurses' recognition of their importance was based on their personal definition of what privacy was. Therefore, nurses closed curtains when they themselves perceived the need for privacy for the patients. On some occasions patients' perceptual levels in relation to maintenance of privacy was not established. Patients were not asked to state when they needed curtains closing. Some patients preferred closing curtains for every nurse-patient encounter while others did not. Therefore, because at times it was not based on the assessment of patients, some nurses did not close curtains when patients would have wished them closed.

6.3.3 The Extent of Maintenance of Patients' Privacy – Nurses' Perception

The issue of "no respect for the closed curtains and closed doors when a procedure was being carried out" was also noted by nurses themselves. Nurses

recognised that at times patients did not have the privacy their deserved. However, most nurses blamed doctors in that they usually entered closed curtains without any regard as to what was happening within the curtains. A health care support worker claimed:

> We can be half way through doing a bed bath and all the doctors will just come in. They don't close the curtains properly. When they go out they don't close the curtains, they will leave the gap and they don't ask if it is convenient for them to come in. They just think they are doctors; they can come in as they wish. (Female: HCN 16)

This can be attributed to the attitude some doctors have. Due to the perceived curing power doctors have on patients, there is a tendency for doctors to think that they are in control of what is happening to patients while in hospital. This may explain why doctors sometimes enter closed curtains without permission. Everyone involved in the caring of patients was a culprit according to one of the nurses:

> In terms of hindering the maintenance of patient dignity, sometimes I frown and makes me think what were you thinking? This includes all staff. The curtains can be around the patient, they budge in but the patient is probably sat on the bed pan, having a wash or something. Sometimes some domestic staff do that when they are giving breakfast; they will just shove the breakfast tray through the curtains not thinking what the patient is doing behind. (Female: HAN 13).

This is one of the examples of the task oriented attitude on the part of the domestic staff who get through with the work without considering patient dignity. They are not conscious of patient dignity, but only aware of carrying out their tasks.

It appears that this problem is not only confined to the three sampled hospitals. Wherry (1994) devised practical guidelines pertaining to his wards in one of the hospitals in England to address the problem of curtained areas. Some of the measures were: all curtained areas were out of bounds to visitors and relevant nurse would have to be approached regarding access; other staff such X-ray staff had to telephone before

coming to the ward so that the patient could be prepared. These were important steps in valuing patient dignity.

Most nurses also said that single rooms were ideal for the maintenance of patients' privacy. However, only three nurses from the hospitals mentioned the importance of asking patients' permission before entering their rooms. This may be explained in terms of the nature of their work. They were there to care for the patients so they did not usually perceive the need to knock on doors. Familiarity of the wards by the nurses, who considered themselves as in control and permanent, made them behave in that way. This explains why nurses did not consider patients' personal space as part of their privacy.

In conclusion, this section of the chapter has claimed that although patients and nurses could not explain fully the connection between privacy and dignity, privacy was highly valued. Privacy is also an abstract concept but patients expressed clearly what they expected within the terms of their perceptual adjustment level. This was influenced by gender and the age of participants. The importance of establishing perceptual adjustment levels was also emphasised. However, nurses were using their own definition of privacy to maintain patients' privacy. This resulted in their not always knowing what patients wanted in terms of privacy. It is important that the perception of both patients and nurses of privacy should be in agreement. This would assist them in the maintenance of each patient's dignity. It was noted that some aspects mentioned by the patients, for example, knocking on the door, standing next to a patient while on the commode and giving patients space were not highly rated by nurses. This demonstrated that nurses did not know the perceptual level of patients. This was probably because nurses did not see themselves as intruders on patients' privacy as they were professionally involved in patients' everyday activities whilst in

hospitals. It has been mentioned that nurses should be aware that their behaviour can be a cause of loss of patient dignity. Comparing patients on the two types of wards, general, shared and single, one could see that dignity was breached less in single rooms. Patients in general shared wards suffered more in terms of exposure. It was worse when patients were hard of hearing. This calls for special consideration for them. By virtue of being in single rooms those patients were excluded from a number of factors which violated their dignity.

These findings are consistent with Matiti and Sharman (1999) who found that some patients' privacy was not maintained. Every patient should be guaranteed privacy and confidentiality. It is important that all staff involved in caring for patients should identify and rectify habits that might cause a loss of dignity. Nurses as patients' advocates should promote the maintenance of patients' privacy by encouraging other carers like doctors to maintain patient dignity. This should be done despite the fact that the majority of nurses found it difficult to tell doctors things like this as they are still regarded as authority figures. It was obvious that some nurses were not aware that certain situations could endanger patients' confidentiality. According to Nursing and Midwifery Council (2002) nurses are expected to protect all confidential information concerning patients. Every effort should be made to reassure patients that information obtained during their care will not be shared with those not concerned with it.

6.4 Patients' Need for Information – Patients' Perception

Being admitted to hospital meant being removed from a familiar home environment with which patients could identify. A familiar environment reaffirms

one's sense of identity which in turn increases self-esteem. Information was vital as it helped patients to familiarise themselves, and attempt to restore their identity and it also made them anticipate what would happen to them during their stay in hospital. Some of the patients did not know what was happening to their bodies. Information that explained patients' illnesses and what was going to be done to them, in the process of treating them, was important. It helped them realise what sort of expectations they should have when they were hospitalised. Averill (1973) stated that information enables patients to form cognitive images of events and predict what would happen. This gave them control in maintaining their dignity. Four characteristics of information were identified by patients throughout this research: first, patients emphasised that they needed *enough* information regarding illness. This then can easily be illustrated. One patient for example said:

> To me dignity is when you are given enough information, you know what sort of operation you are going to have, what to expect, to know the part they are going to have a go at in the theatre. You feel in control. (Female: HAP 9)

Another patient pointed out:

> I would like to be told more about what is happening to me. They do this and that to your body. You do not know what they are doing and what it is for. You just lose control of your body. Knowing what is being done to you also minimises embarrassment. (Female: HAP 17)

Whatever was described as enough information depended on each patient's perceptions and expectations. Second, patients also wanted *up to date* information. The public is increasingly being informed by the media and some patients come to hospital with information regarding their illnesses and what care they would receive in the hospital situation. It was easy for such patients to identify that some of the information given by some nurses was not up to date. Thirdly, a significant number of

patients pointed out they wanted information which was *not conflicting* and fourth, the information should be given *at the right time.* Achieving these characteristics by the nurses helped patients to make choices within their perceptual adjustment level as to what they expected from health care workers.

Hospital admission is associated with embarrassment. This can be minimised by information. As discussed in Chapter 4, a patient can feel embarrassed and lose her or his dignity when there is a discrepancy between the set standards and expectations of hospital situations. The discrepancy comes in when a person lacks information about the situation or is given conflicting information. There is a potential danger of a patient not knowing what to do at times, making mistakes and feeling stupid and embarrassed. It was paramount that patients were given information about their diagnosis, of their stay in hospital and a full explanation of any procedures carried out on them.

6.4.1 The Extent to which Patients Received Information from Nurses – Patients' Perception.

A majority of patients in all the three hospitals complained about the quantity and quality of information given. The four essential characteristics of information - *amount, accuracy, consistency* and *timing* - were not fulfilled on a number of occasions. Patients ruefully commented on this.

> I think some nurses just tend to storm in - just start doing some things without explaining fully. (Male: HAP 14)

Another patient put this same basic expectation more succinctly when he said:

> They have given me a drip and some antibiotics and that is as far as I know and then wait and see. I do not know anything else. I do not know what I have got on my leg. They say what do you call cellula.....? A word which starts with c. They talk

> among themselves what they think it is and try to get a second opinion from one another. That is okay but I was left in the dark, I do catch some things that is how I heard the cellula....whatever it is. (Male: HBP 15)

In these instances the lack of information on the part of the patient was evident. Diagnoses were not properly explained to patients. Though nurses were in a unique position to find out whether patients had been given enough information, it was also evident that they failed to do so. As patients' advocates, nurses should have made sure that patients received enough information. Lack of information prevented the patient exercising their choices and this caused stress among them. Stress due to lack of information was endorsed by Volicer and Bohnno's (1975) study in which 261 medical and surgical patients were asked to rank in order 49 events as being stressful events while in hospital. The most stressful event included not being told what one's "diagnosis is", "not knowing the results or reasons for treatment", "not knowing for sure" and "not having your questions answered". This research also confirms the long standing nature of this problem.

In some instances nurses gave conflicting information to patients. The patients were unsure of what to do and this undermined their confidence and self esteem. This was emphasised by an account of a 35 year old female patient:

> There came a nurse who came to tell me that I wouldn't take sips of water because I was coming from theatre but 10 minutes later another nurse came and told me that I could take some water and she asked me if I wanted some, I said yes. I didn't ask her then there was tea and coffees which came round and one of the nurses said it was too early. I felt stupid. They do contradict themselves. So you do not know whether you are doing right or wrong by drinking or eating. (Female: HAP 25)

This patient was under the impression that nurses did not know what information they needed to give to patients. She even continued to state in the interview that nurses needed to up date themselves with new information regarding patients' care to avoid making patients feel stupid. A 69 year old male patient noted:

> If you ask for anything, you do not get it. I asked for tablets. They couldn't let me have them and when I asked the doctor she said there is no reason why I couldn't have them. But the nurses said I couldn't have them. Very conflicting information and it is the patient who feels stupid at the end. (Male: HCP 18)

Conflicting messages caused inner conflicts within patients as they did not know what was expected of themselves at times. This caused some anxieties and stress among patients. The other concern patients had was the timing of information. One lady resentfully expressed this as follows:

> I thought it was going to last longer, about my stay here but they didn't tell me yesterday [when she was admitted], they told me at dinner time today that I was supposed to go to theatre so that they could look at my arm. (Female: HAP 1)

Again this emphasises the importance of information in assisting patients in reaching their perceptual adjustment level. Some patients did not want to solicit more information from nurses because they did not have enough information to make informed decisions as to what they should do. They were resigned to the fact that nurses knew best. Others did not want to reveal their medical ignorance especially when a lot of medical jargon was used by doctors and nurses. All this led to perceptual maladjustment of their dignity causing embarrassment.

6.4.2 Patients' Need for Information – Nurses' Perception

Some nurses identified information as important for patient dignity although nurses did not clearly explain how. A number of them said that information enhanced patient self-esteem. Although some nurses identified information giving as important in maintaining patient dignity, they did not mention the characteristics emphasised by patients namely; the provision of up to date and not conflicting information, and the correct timing in presenting it to patients. Most of the nurses were not aware of the

four characteristics of information as expected by patients; however, it should be the responsibility of the nurses to find out these expectations.

6.4.3 The Extent to which Patients Received Information from Nurses – Nurses' Perception

Throughout this study nurses felt they were explaining matters adequately to patients or at least doing their best. The incongruence in the perception of information giving between nurses and patients is a major issue in perceptual adjustment levels. Those nurses who were aware of this said that lack of time caused them not giving patients enough information.

In conclusion, although both patients and nurses were aware of the importance of information giving, areas of differences both in the amount of information and the quality of information were identified. Patients had set their expectations in relation to the receiving of the information, in terms of amount, accuracy, consistency and timing. It was evident that nurses were not aware of this. Adequate consistent information given at the right time assisted patients in understanding their illness and care. It also assisted patients in exercising choices during their hospital stay as discussed in the next section.

6.5 Patients' Choices – Patients' Perception

Patients identified freedom to make choices while in hospital as an important aspect of maintaining their dignity. Choice is defined as having an opportunity to select from alternatives (Collins 1991). Generally there were limitations of choices for patients in hospital settings. For example, there were neither a choice of rooms

nor beds and patients were forced to share facilities like toilets and bathrooms in some wards. Patients had to accept what they were given and to conform to the routines of the hospital. But as already discussed in Chapter 5, patients were aware of these limitations and most of them did not mind up to a point because they wanted to get better and realised that in one sense this was the only thing that mattered. They had not "chosen" to be ill: their helplessness was a necessary consequence. The acceptance of this fact, however, was only up to a particular point. Within their perceptual adjustment levels patients had some expectations in terms of choices. One patient declared:

> As much as you would have liked to have choices as a patient you have got some limitations. One tends to comply with hospital environment and what the doctors say anyway. But they are certain things which we expect. (Female: HCP 10)

Although this patient appreciated limitations in terms of choice within the hospital environment, she knew what she expected and that was her source of control. There was a general agreement among patients from the three hospitals that patients expected to be given opportunities to make some choices. To make these choices required a conducive atmosphere which included a non hurried explanation of their availability. Due to illness patients required plenty of time to reflect on the benefits of the alternatives presented to them in the hospital. Having enough information to make an informed decision was important for patients. The choice of alternatives would, however, be meaningless without its implementation. It was imperative that nurses should have met these expectations to avoid anxiety, "why did they ask me in the first place?" If a nurse asked a patient whether he or she wants a bath or a shower, and the patient's preference was a shower and this was ignored, the patient then felt more devalued as his or her choice was not implemented

The choices mentioned were mainly concerned with the day to day activities in the ward such as: asking patients what name they would prefer to called by, choosing what to eat, what time they could have a bath or a shower, choosing what to wear on a particular day, and what time to go to bed. They wanted to have some say in the daily living activities whilst accepting the essential decisions were in the hands of the nurses. A 70 year old patient illustrated this:

> Small things like choosing what to eat, whether you want a shower or not do matter in terms of your dignity because you feel you are treated as a person. (Male: HBP 3)

In disease management some patients preferred to be given a range of treatments for their illnesses so that they could make a choice depending on the information given. This could only be achieved if patients were offered information about their illnesses and issues concerning their hospital stay.

6.5.1 Were Patients Given Choices by Nurses? – The Patients' Perception

Some patients appreciated that they were given chances to make choices by nurses in all three hospitals. The following remarks represent the views of some patients:

> They care about you and how you feel. They would not bring anyone else [in the closed curtains] if I want the curtains shut, they will get them shut. But if I do not want they will leave them open. (Female: HCP 11)

> Dignity to me is, well, I shall say, when they come to wash you in the morning and they put the bath tab and they do the inaccessible parts then they say, would you like to do the rest for yourself and you say yes, I can manage that, then you get on with that. This shows one is respected by being given choice (Male: HCP 12)

However, dissatisfaction was evident in some patients: A few examples will be discussed which were commonly mentioned by patients: first, the issue of choosing

meals. The limitations of an already prepared "food menu" were recognised by patients. A number of patients did not mind as they understood the problem of "mass cooking". However, dissatisfaction arose when the food was not cooked properly and patients were not offered an opportunity to choose a replacement. They had to eat the food whether they liked it or not. The patient's right to make a choice was compromised.

Problems were also experienced by some smokers. The hospitals had a "no smoking policy" although patients were allowed to smoke in designated areas. There were some bed ridden patients who wanted to smoke. Patients had to be wheeled to a designated area or outside the hospital for smoking whenever the nurses had time to do that. Not being allowed to smoke whenever they felt like was considered a violation of their choice by some patients thereby breaching their dignity. Some of them did not see that smoking in their rooms was hazardous to their health and the health of other patients. The following was a comment from a 40 year old male patient

> I have got habits and those habits need to be respected. The fact that I am in hospital does not mean that habits have changed. It is still me. I know I smoke. Every one has got habits and things like that. They need to be respected as people, the way you would like to be respected back home. (Male: HAP 4)

This patient's comments raise the issues of individual rights versus responsibility towards others. A hospital is a communal place where it is likely that one patient's choice might affect others. In this instance, smoking was not entirely banned in these hospitals. Special areas were provided for smoking. This patient, however, still wanted to smoke in his shared room as if this was his personal right. There might have been other patients with diseases that could be made worse by smoking. Perhaps this is where the principle of the common good should have been

gently explained to this patient to assist in his perceptual adjustment. This case shows how complex the notion of dignity can be. An insistence that it consists of a personal right, to the detriment of other people, shows a kind of maladjusted personal level of demand.

Three points are important in maintaining patient dignity through choice; being given the opportunity to make a choice, actually to make a choice and the implementation of the choice. It is breaching patient dignity if a nurse makes a choice for the patient who is capable of doing it (Dunlop and Hockley 1990). For those who were given the opportunity to make choices, it was frustrating for their hopes to be raised and not met. This was mentioned on a number of occasions during interviews. One patient said:

> I have not had a bath since I have been here, I was asked whether I wanted to have a bath or a shower, I said a bath because that would relax me. But the health care support worker asked me if I could have a shower because they were busy. Putting me in a bath would have taken longer. Then I thought .."what was the point of asking?". (Female: HAP 13)

Though the patient was given an opportunity to make a choice, her preferred choice was then not implemented. It was frustrating for the patient as well as the nurse. This situation deterred some of the patients from making choices. For other patients, this demonstrated not showing any regard to patients' needs and expectations. Unless an explanation was given, patients felt that nurses did not care.

6.5.2 Patients' Choices – Nurses' Perception

Like patients, some nurses realised the importance of patient choices in hospital as a way of maintaining patient dignity. The agreement between patients' perception of choices and those of nurses was confirmed by the findings from the

three hospitals where equal numbers of nurses and patients mentioned the importance of giving patients choices. A 49 year old female health care support worker observed:

> You don't just go marching into them and say go in the bath or after the operation, you don't say, we are doing this and that for example put you in the bath. You ask them whether they want a bath, a wash or shower. It is for their dignity at the end of the day. (Female: HAN 15)

Another nurse from hospital A also added:

> Patients need to be given a choice, for example, what they would like to eat or at what time they would like to have a bath. As this implies that you are respecting them as a person rather than just deciding for them. (Female: HAN 8)

The agreement between nurses' and patients' perception did not necessarily mean that nurses implemented what they perceived. A lack of awareness of patients' needs with regard to choices and also a lack of time hindered the implementation of patients' choices.

6.5.3 Were Patients given Choices by Nurses? – Nurses' Perception

It is encouraging that both nurses and patients' had the same views concerning the importance of patient choices. Yet most of the nurses failed to identify the three important factors raised by patients about choices. There was still a problem of nurses not establishing patients' perceptual adjustment levels, thereby not knowing what patients expect in terms of making choices while in hospital.

In this section, the importance of patient choices for patient dignity has been highlighted. Areas for improvement were identified, for example, nurses not exactly knowing patients' expectations and fulfilling them or, worse still, giving false hopes. Nurses should respect patients' choices in whatever form they are and they have a duty

to provide the necessary information to patients to allow them make appropriate choices that can be met. When patients are given choices they can decide how they can get involved in their management as discussed below.

6.6 Patients' Involvement in their Care – Patients' Perception

A number of patients said that being involved in activities affecting them while in hospital was considered important in the maintenance of their dignity. Different terms have been used for this involvement of patients' in care. For example, Wilson-Barnet (1990) talks of partnership in care. Despite the difference in conceptualisation of the term, it refers to patients' participation in their care. That was what patients wanted as part of their dignity. Patients expected to be included in planning, implementing and evaluating their care. This entails building mutual trust between the nurse and the patient and in this interaction the nurse brings professional knowledge, skills and experiences while the patient brings his or her personal knowledge, expectations and experiences too. There is sharing and making decisions together. It is a joint endeavour. Being involved in the activities that concerned their own health made patients feel that they were being acknowledged and accepted as human beings with a capacity to understand and reason. It meant patients' views were taken into consideration. Patients' involvement in their care also brought a sense of ownership of the activities taking place and all these increased patients' self-esteem and they felt valued thereby. These views were represented by patients as follows:

> Dignity is making me feel involved in decisions without pretending that a patient has no sense at all. That is the most important thing. I do not accept that being a patient is being unintelligent and one can only make a decision if one is told what is happening and you are involved. You nurses and doctors you tend to discuss things among yourself about my body. (Male: HBP 3)

The patient was clearly feeling that his intelligence was being undermined by the staff who were making assumptions that the patient could not comprehend information which was given to him. Another patient supported the point as follows:

> I think again it comes back to what I have already said that if your care plan is to discuss the progress for your well-being it is important to involve you in the discussion and see how you are progressing. That way I would feel dignified. That is how I feel. (Female: HBP 13)

These two examples confirm that creating partnership of care in which a patient is fully involved is important for patients' treatment and the maintenance of their dignity. Patients have a right to decide how they want to be involved in what is done to their bodies and in the decisions about their care. Unless a patient is too sick or too irrational to interpret information, and unless he or she cannot make decisions or prefers not to be involved, the patient should be fully involved from admission to discharge. Leddy and Pepper (1998) supported this view that there should be a shared decision making, bearing in mind that at times the patient may be required to be in full authority because the patient is an expert of his or her own situation. This will make the patient feel respected, have trust in the nurse and most likely the care will be tailored to agreed needs which will increase self-confidence and self-esteem and assist in empowering the patients, thus enabling them to have a measure of self-control and actually speed up their recovery process. McGee (1994) claimed that for nurses to demonstrate respect they need to involve patients in decision making and value their point of view. Bearley (1990) in her extensive review of literature regarding patients' participation confirmed that a number of studies do suggest that involvement of patients in care is beneficial to the patients in terms of their health.

6.6.1 The Extent of Patients' Involvement in their Care – Patients' Perception

The degree of involvement in care differed between patients. The spectrum ranged from those who were happy with minimal involvement to those who wanted to be involved in everything. Some patients were selective in what they wanted to be involved in. For example, they were happy in getting involved in non medical issues like when to have a bath, while they were not happy to take part in medical decisions. A subgroup of patients who did not mind being excluded from participating in decision making on their care was also unveiled in this research. However, a significant number of patients who wanted to participate in their care were not involved to the extent they had expected.

Data analysis exposed a number of reasons that prevented them from being involved, sometimes they did not expect to be involved and sometimes they felt they were prevented by nurses or doctors. Patients "necessarily submit" to health care workers because they trusted and respected them. Some patients felt that because nurses had more knowledge of diseases and their management it was better to let them make decisions on their behalf. Therefore, the feeling that they lacked knowledge and that nurses had expert knowledge encouraged patients to feel excluded. This was illustrated by one of the patients:

> I am in their care and they do what is better and you put yourself in their hands. I mean if you come to me now, I would not lay and sit there and saying, oh nurse do not do that, do this, but you will be saying come on you do this, then I do it. Whatever it is, I have got to do. If you see what I mean. (Female: HAP 1)

Patients felt that they did not have enough medical knowledge to enable them to participate. This was even more important for those patients who valued their being actively involved in all aspects of their care. Patients would not be expected to

participate without clear and adequate knowledge. Information is important for patients to make necessary decisions in their care. Nordgren and Fridlund (2001) have shown similar results. The findings for the 17 patients who they interviewed showed that information is important for patients to make decisions. The research provides an insight into the importance of information for patients in terms of participation in their care.

The perception that nurses were very busy made some patients refrain from making suggestions about their care in case they caused more stress to already overworked nurses. Patients tried to interfere with nurses' work as little as possible so that it could continue as smoothly as possible. The fear of being unpopular among nurses by asking too many questions was another reason for not asking questions. These patients conformed to whatever the nurses were doing or saying despite wanting to be involved as they did not want to "rock the boat". This was an example of patients who "handed over" themselves completely to health care workers and took a passive role. They were other patients who believed that it was the duty of health personnel to cure them. They saw themselves as helpless and, therefore, had no part to play in their care and management of their illness. These findings are consistent with Waterworth and Lukers' (1990) research results in which they explored the degree to which patients wished to become involved in decision making about their care. The research revealed evidence that patients were most concerned with pleasing the nurses, "staying out of trouble" and "creating the right impression". "Accepting the situation" was viewed as part of hospitalisation. Therefore, they preferred not to participate in decision making. One could argue that this decision should also be respected as it is also an example of making choices, however, insignificant such a choice is. Analysing the nuances of the patients' discussions, it was revealed that such

a lack of involvement was not, in fact, what these patients wanted. They would like to be involved. Such patients did not have enough information to help them to adjust to and realise what was expected of them in terms of involvement. Since Waterworth and Luker's (1990) research, the level of patients' participation in their care appears not to have changed. It was up to the nurses to identify such patients. With more information and discussion, these types of patients could have been empowered to participate, thus acknowledging them as individuals. The other group were those who wanted only to be involved in non-medical activities, such as nursing care. The varied degrees of likes of involvement emphasises the fact that each patient perceptually adjusted differently. Finding out how much each patient would like to be involved was important. Patients needed to be involved from the time they were admitted in the ward so that the mutual levels of perception are established.

6.6.2 Patients' Involvement in their Care – Nurses' Perception

In contrast, very few nurses identified patient involvement as a factor in maintaining patient dignity. This is supported by the fact that many patients were not involved in their care as much as they wanted to be. Goffman (1968) argued that although the aim of professionals is to care or treat patients, they implicitly control patients and are accustomed to making decisions for patients irrespective of what they want. There was a lack of awareness among nurses that patients' participation was important for patients. The label "patient" was perceived as a person who was helpless and needed care by the nurses. This in turn made them assume that the patient was at the receiving end and had no say in his or her care, as revealed by one health care support worker:

> It is difficult to do things with patients. They are patients, they are ill and need care. Sometimes we have to think for them. (Female: HAN 22)

Travelbee (1971) argued that when a person is "labelled" as a patient and perceived that way, the title has an obscuring effect in which the label or position may be given precedence over the actual person. An individual may be perceived on the basis of his or her function and not in terms of his or her human qualities. Some nurses did not take patient involvement in their care as an important factor for patient dignity.

6.6.3 The Extent of Patients' Involvement in their Care – Nurses' Perception

The majority of nurses who mentioned the involvement of patients in their care as a category of patient dignity were under the impression that they did involve patients in every aspect of care. However, the seriousness of illness of the patient was mentioned as one factor which hindered nurses from involving patients fully. Nonetheless, nurses knew that at an acute stage of illness, for example, when a patient is unconscious, it is not possible for him or her to determine what his or her expectations are. This is the time a nurse can implement her professional judgement and the involvement of the family without the knowledge of the patient. As the patient recovers, the patient should be encouraged gradually to establish his perceptual adjustment level. It is important at that stage to start involving the patient to a degree depending on his or her wishes.

In conclusion, the importance of patients' involvement in maintenance of dignity during their care has been stressed. A mutual relationship in which the patient is actively involved as an equal partner in nurse-patient interaction is required to increase patient self-esteem and confidence. The need to assess patients' degree of

involvement has also been highlighted as this may help in identifying individual preferences in term of participation in the care. Nurses should be aware of preferences and factors that hinder the involvement of patients during provision of care. It is important for nurses to be aware of the effect of their perceived power in hindering patient involvement so that they can make the caring environment conducive for participation. It was also significant for nurses to be aware of the dynamic nature of the level of patient involvement as it changes throughout a hospital stay depending on the state of the illness, among other factors. Nurses should realise that patients' involvement in their care will also encourage independence, which was identified as one of the other categories of patient dignity to be discussed in the next section.

6.7 Patients' Independence – Patients' Perception

Independence was identified by patients as an attribute of patient dignity. According to Collins Dictionary (1991) independence means not being subjected to others or being self-reliant. True independence means being free to take control of one's life, to take important decisions and act upon them (Goodall 1992). The words independence and autonomy are usually used synonymously. Autonomy is derived from Greek word "autos" (self) and "nomos" (rule or law) and when combined, the product means self-governance (Beauchamp and McCullough 1994). It is concerned with self-determination which means making decisions by oneself without other people's influence. However, this assumes that the person has enough knowledge and is capable of using it rationally. Patients were deemed to be mentally independent by nurses when they could make decisions on their own and also be able to act upon

them. Davies, Laker and Ellis (1997) argued that the two words autonomy and independence should be viewed as separate; independence is mostly associated with a person's level of physical functioning and the ability to perform daily living activities unaided. Patients used it in the latter context. Therefore, the notion of patients' independence will be discussed in the context of their attempts to participate as fully as possible in looking after themselves.

When one is born, one is naturally dependent on other people but growing up means learning to be independent. This independence gives the individual a sense of confidence and competence which is necessary for personal esteem and dignity. However, there are a number of factors which force a state of dependency, and one of the factors is when one is a patient. Parson (1951) claimed that a patient depends on others as a right because activities of daily living are carried out on his behalf. However, despite this dependence it was shown that patients were constantly striving for independence. Depending on mental state and illness, patients adjusted and reached a perceptual adjustment level as to how much they needed to depend on others. As one patient put it:

> Although I am lying in bed, they are things I can manage to do, certain things on my own. I do tell some nurses that I can do this and that. That gives me a sense of control. (Female: HBP 10)

Another patient from a different hospital also explored the same issue:

> It is difficult to explain but let's say, I am lying here and they have been giving me a bed bath, although I have got a drip I can manage to wash my face. If the nurses are doing it for me, to me I am being treated like a child. If I do some of the things myself the embarrassment is reduced and my confidence is built. Do you understand? When one is able to do things it boosts confidence and self esteem. I would like to be in control of my own things... unless I cannot manage. I expect to be treated like a person in control of my own activities. (Male: HAP 15)

Usually the label "patient" carries with it the notion of dependence. Although these patients were ill, seemingly dependent on nurses, there were other tasks they could manage for themselves such as washing their faces. Patients expected to be given opportunities to carry out their own tasks within their capabilities by being encouraged and allowed to perform them. These formed patients' perceptual boundaries which if not identified and met made them feel a loss of dignity. It was up to the nurses to establish what could be done, how they wanted the tasks to be done and to encourage them. Independence was very important for patients as for some it was a sign that they were getting better and they were coming out of the "necessary submission". It gave patients a sense of hope and achievement which gave them confidence. Patients saw it as a way of gaining control. It was a sign of going back to a normal self, striving to carry out what a normal healthy person can do. Supporting and encouraging their independence was crucial for them. All this made them feel worthwhile. It was important, therefore, to establish patients' expectations in terms of independence, how patients could perform tasks and being encouraged to perform these tasks within their capabilities because this boosted their confidence and self esteem.

6.7.1 Was Patient Independence Maintained? – Patients' Perception

The majority of patients from the three hospitals expressed the view that there were times when patients felt a loss of dignity because of their dependence on carers. Four reasons emerged why patients did not exercise their independence at times; the first was because the nursing staff were busy. The need for nurses to "get on" with the work led them not to consider the patients' independence. On a busy day it was

quicker for nurses to do the tasks for patients. This meant that patients were neither given opportunity nor encouraged to perform tasks. The nurses assumed that the most efficient way for them to function was to carry out all tasks without any distraction, including the impediment of taking patients' personal needs into account. This is clearly exemplified by one patient below:

> Due to nurses being busy, some nurses do not ask you what you can manage and what you cannot. It is just treating you like a child. May be it is difficult on their part as they are racing against the clock they want things done. You as a patient you do not have the strength to do tasks as fast as they expect. (Female: HAP 17)

It is clear that the patient needs to feel useful and worthy. This demonstrates the conflicts the nurses and patients found themselves in regarding patient independence. This example is typical. Due to shortage of time, the nurse was busy and in a hurry, wanting the task done as quickly as possible within the limited time available. At the same time the patient would like his or her independence but due to illness cannot perform the tasks as quickly as expected by the nurse. This difference in perception to the situation caused conflicts in both patient and nurse. The patient was more affected because he or she was already vulnerable; as a result his or her confidence and self-esteem went down.

The second reason why patients did not exercise their independence was due to the type of illness. Some patients were perceived as helpless by nurses, so they were doing tasks within the principle of beneficence (Beauchamp and McCullough 1994) in other words, doing good for and on behalf of the patients. Sometimes this was done to protect patients so that they could not hurt themselves. Third, some patients felt a loss of dignity because of their own perceptual maladjustment. They would not come to terms with the idea of being dependent and asking for help. This is demonstrated by one of the patients:

> Being dependent on other people can easily violate one's dignity. It was embarrassing and humiliating during my first days in hospital when I had to ring the bell to ask staff to do things for me. I felt like a child and unworthy. (Female: HAP 10)

Although his illness necessitated nurses doing tasks for him, the patient did not come to terms with that. There was a discrepancy between what the patient hoped for and what was happening. The patient was having difficulties in mentally adjusting to the situation. Hence he felt embarrassed and humiliated. Nurses failed to identify this discrepancy. It is important to be aware of this conflict and assist patients in coming to terms with their new status.

When nurses carried out activities which patients might have done themselves, the latter felt a lack of control and a loss of self-esteem. This lack of control led to a state of "learned helplessness", which is a "psychological state that frequently results when events are uncontrollable" (Seligman 1975 p.9). According to this theory people tend to behave resignedly if their personal competency levels have dwindled and they feel that whatever activity they engage in they cannot produce desired outcomes. Therefore, unless the environment in which they are in is changed, low esteem and depression is likely to occur. This can have dramatic effects on patients' health, and suggests the patient dignity is not just an ethical issue, but an essential medical one.

6.7.2 Patients' Independence – Nurses' Perception

The same proportion of nurses to patients also felt that being independent was part of patients' dignity. They said that patients were to be encouraged to do things for themselves as far as possible as this helped in maintaining patient's self esteem. One nurse said:

> Dignity relates to independence in the sense that it is very undignified lying in bed having a nurse coming in to wash you when you are able to do it after yourself. The onus is taken away from the patient. It could be embarrassing for some patients. (Female: HBN 4)

It is encouraging that in this study significant proportions of nurses and patients valued independence in the maintenance of dignity. Nurses should strive to foster independence and every opportunity should be taken to promote it.

6.7.3 Was Patients' Independence Maintained? – Nurses' Perception

Although nurses agreed that independence was one of the attributes of patient dignity, in some instances nurses realised that they were not practising what they perceived. Nurses expressed the opinion that on a number of occasions patients were not encouraged as much as they would have liked, at times due to shortage of staff. One nurse echoed the views of other nurses in the three hospitals:

> One becomes task oriented because you want to finish the job and go home. This is due to shortage of staff. You realise the importance of it but what can you do? (Female: HAN 29)

Some nurses were aware of giving patients the opportunity to implement whatever tasks they could do within their capabilities. Nurses expressed their frustration and admitted to the fact that finishing the task was a priority that overrode all others.

Summarising what has been discussed in this section, independence was one of the constituents of perceptual adjustment level of patients. Nurses also realise the importance of it in the maintenance of patient dignity. Loss of it led to a feeling of not being useful and to a loss of self esteem. However, it is evident that some nurses failed to identify patients' expectations in terms of independence. Although busy, nurses should constantly assess patients to determine how much they can do on their

own and encourage them to do so. Nurses should avoid habits of carrying out tasks which patients are able to do themselves.

6.8 Patients' Forms of Address – Patients' Perception

The use of names and preferred names when addressing patients was also identified by a majority of patients as a factor in the maintenance of patient dignity. A name is of particular importance in the identity of the individual. It emphasises the uniqueness of that individual. In some societies names have added significance or a meaning. For example, a name could signify that she or he is the first born giving the individual status or as in Ghana, children are named after the day they were born (Othieno 1998). Children may also be given a name of someone admired by parents or a name that sounds good. Christians sometimes give their children names after saints. Thereafter the name becomes the person: it is the crucial signifier.

Patients said that it was important that nurses acknowledged that patients had names rather than being referred to for example "as a gentleman inside room one". This preferred name was either the first or second name. The distinctions in preferred usage are important since the name of a particular nickname or even the first name may be invoked only by a few. Some prefer instant friendliness. Others wish to maintain formalities. The reaction of people such as family members or friends to a person's name is also important in its acceptance by the individual and it increases self confidence and self-esteem (Marcus 1976).

Patients perceptually adjusted to how they wanted to be addressed in a hospital situation. Some patients preferred to use names with which they have been addressed

during their entire life. Changing it meant changing them as a person. A male patient commented:

> All my life, even at work, I have been called by my first name. But coming here nobody has asked me what I should be called. They call me Mr...I find it strange and I feel it is no longer me as a person that they address. That is what I feel is part of my dignity. (Male: HAP 28)

Some elderly patients were addressed by first names despite wanting to be addressed by surnames. There was a general perception that using first names created a relaxed atmosphere. For example, a 72 year old patient stated:

> I am usually called Mrs..... I feel respected that way. But in here I think it is better to be addressed by first name as it creates a friendly atmosphere. (Female: HBP 19)

This is another example of perceptual adjustment. Her preference was changed because of new circumstances and the assumption that this will assist in building a smooth nurse-patient relationship. She was trying hard to adapt, to change her own perception according to how she interpreted the circumstances, and the general collegial social atmosphere. There were a number of patients in the three hospitals who found themselves in this position. This may be the reason why most patients preferred first names in the three hospitals. This is supported by findings in Matiti and Sharman's (1999) research. Out of 249 patients, age ranged from 16 to 90 years, first names were preferred by 172 (59%) and surnames were preferred by 37 (15%) patients. 34 (14%) did not mind being addressed by either first name or second name and no preference was indicated by just 6 (2%). Nurses could have identified these wishes from the start and addressed patients as they wished. However, it was taken for granted by nurses that patients preferred to be addressed in a familiar way. When

patients were addressed by a particular name which they did not like, shyness or embarrassment ensued and their self esteem went down.

How patients preferred to be addressed varied. It is important to ascertain patients preferred names all the times by asking the patients' choice.

6.8.1 Were Patients Addressed by Preferred Names? – Patients' Perception

All patients in the three hospitals, who identified forms of address as important in the maintenance of their dignity, said that nurses addressed them by name. However, some patients overheard nurses refer to a patient by a bed number if they were discussing a patient among themselves. Patients empathised with fellow patients who were referred by bed numbers. There was a realisation that this could also happen to them. In some wards some patients were not asked what names they preferred to be addressed with. As a result patients felt denied of their choice. It was a distortion of who they were, thereby losing identity and dignity. These findings are consistent with the results of a study conducted by Health Advisory Service 2000 (1998). Despite the recognition of the emphasis of name, some patients were not asked how they wanted to be addressed.

It was noted that on some wards asking patients' preferred names on admission was adhered to strictly. However, despite this some patients on the wards were still not addressed appropriately. Patients between 16 and 30 years old who considered themselves to be young preferred to be addressed by their first names. Most of these patients were satisfied with how they were addressed. Further analysis showed that some patients above 30 years of age were addressed by their preferred names all the time, some at times, while the other group was not addressed by preferred names at

all. Sometimes nurses made assumptions about patients' preferred names when addressing them, for example first names or surnames. Invariably, this meant that they got it wrong at times. For example, some elderly patients were addressed by their surnames because the nurses wrongly assumed that this was their preference due to their age while in fact first names were their preference:

> May be they think I am too old for first name. (Female: HAP 29)

This emphasised the importance of asking patients to state their preferred names at all times instead of making assumptions due to age or any other factors. This was highlighted by the following comments made by another equally elderly patient who, unlike the above patient, preferred a surname.

> Because you have asked me about my dignity, I would like you to understand that calling one by first name is disrespectful. This is an example which younger people get terribly mixed up about. (Female: HBP 16)

Another example of the dangers of assumption was demonstrated by the use of condescending names like "deary" or "duck" in all three hospitals. Some nurses thought this was going to establish a relaxed atmosphere but instead it made patients feel patronised. Nevertheless it was a well meaning activity that patients felt they had to put up with and try to understand. A 69 old lady who preferred to be addressed by her first name reported:

> "My dear", my "duck", "sweetheart", is fine as long as they are looking after me. (Female: HCP 7)

The patient did not particularly like being addressed as portrayed. However, because of her reliance on nurses she resigned herself to those forms of address. It was also observed by patients that a lot of "Bank" or "Agency" nurses tended to address

patients by their surnames irrespective of what patients wanted. A 45 year old female patient observed.

> All regular nurses call me by my preferred first name but not Bank nurses who are not here long enough. (Female: HAP 20)

This was because of the short relationships they formed with patients, unlike those which were established on the wards. Doctors were also indifferent to patients' preferred names. Because of the short relationship they formed with patients, they addressed patients in a formal way using surnames whatever the individual preferences.

6.8.2 Patients' Form of Address –Nurses' Perception

Fewer nurses than patients stressed the importance of addressing patients by their preferred names. There were few nurses who even identified this category as important. These nurses who did so were in agreement that a name increases self-esteem and a patient needs to be addressed by the preferred name. For example one of the nurses noted:

> Preferred names are important for patient dignity but sometimes we nurses forget that. (Female: HAN 13)

Few nurses relating forms of address to patient dignity realised fully the importance of its maintenance. All nurses who mention this category stated that they asked patients their preferred names and addressed them accordingly. This shows a discrepancy between what patients noted and nurses' perceptions of preferred names: no doubt the nurses meant well but if they assumed they could anticipate patients' wishes they could easily be wrong: either over-familiar or over-formal.

Within patient perceptual levels, patients expected to be addressed by name, they needed to be given a choice of the name they preferred to be addressed by and, equally important, this choice needed to be implemented. At the first encounter, it is wise to err on the side of caution and address patients formally. However, the preferred names should be established and used all the time as this enhances the patients' sense of worth. This may be assisted by nurses developing ways of reinforcing remembering patients preferred names. One of these may be by increasing nurse-patient interaction.

6.9 Patients' Decency – Patients' Perception

In this research, decency was perceived as a state of outward appearance acceptable to a patient thereby giving a positive self image. This outward appearance, which also symbolised individuality, was influenced by clothes, dentures, make up and jewellery among others. Patients adjusted and reconstructed the perception of their "self". They set standards to how they wanted to look. Confidence and self-esteem was boosted when patients perceived that these standards were met and they looked decent. Decency helped patients to preserve the "self" which had been partly lost due to illness. There was a sense of pride if they perceived that they looked decent. Satisfaction also depended on how others perceived and acknowledged their appearance. When this need was not met, patients experienced conflicts in themselves because they did not look the way they wished to look and lost their self-esteem. Female patients were more particular than male patients. This is probably due to the fact that there are social expectations that females should look beautiful. This echoes a general social and cultural norm.

Patients were at times required to remove clothes, jewellery and dentures during examination and patients would sometimes be expected to expose their bodies to be examined. When going to theatre patients were asked to take off jewellery, clothes, dentures and to change into hospital gowns. Due to the necessary submission, most patients did not mind and did not feel embarrassed with these activities. As long as an explanation was given, patients felt that there was a purpose for removing them. Since the ultimate aim was for them to get better they accepted it and did not feel their dignity was threatened. Apart from the above situations, patients preferred wearing their own clothes rather than hospital uniform. They appreciated that patients were allowed to put on their clothes while in hospital. They also preferred keeping on their jewellery and make up. Again, this was particularly so with female patients. It was evident too that situations also influenced standards of appearance acceptable to an individual.

> I feel dignified if I look the way I want to be. That is why I have been so particular with nurses that when I come back from theatre I would like make-up on me. It sounds silly but that is how I feel. (Female: HAP 6).

This signified that the patient was aware of theatre requirements and accepted being without make-up there while she found it undignifying to have no make-up on the ward. This is an example of perceptual adjustment to a specific situation. It demonstrates the dynamic nature of the perceptual adjustment level.

6.9.1 Maintenance of Patients' Decency – Patients' Perception

Patients' from all the three hospitals gave mixed responses to whether their decency was maintained or not. Some patients were satisfied; some said it was maintained at times, while other patients expressed that on numerous occasions there

were assumptions by nurses that patients knew which clothes to take off during examination and particularly for surgical patients, some patients did not know why they had to take off make up, dentures and jewellery before going to theatre. As one patient explained innocently:

> I just assumed it was important. My clothes could interfere with the operation. But I have not thought about the make up. They were busy any way. (Female: HAP 5)

This illustration demonstrates that patients were not fully informed. Nurses were busy and concentrated on the task, giving less emphasis on patients' dignity. Because patients did not know the purpose and justification of taking their clothes off, there was a discrepancy between what was happening and their expectations. To reduce potential embarrassment among patients, they needed to be informed which part of the body needed to be exposed for examination. For surgical patients, they should be told why they had to take off jewellery and clothes to wear theatre gowns rather than assuming that patients know already.

Two patients from Hospital B who used hospital pyjamas for various reasons, questioned why couldn't they use ordinary hospital clothes rather than using pyjamas during day time. They thought pyjamas should be used only during the night. This was more embarrassing because most of hospital pyjamas were ill-fitting and caused a feeling of indecency as the following complaint from a male patient highlights:

> Sometimes you keep the blanket on but sometimes everything is displayed because they have got no zips. (Male: HCP 12)

Ill-fitting pyjamas exacerbated embarrassment already brought on the patients by not having their own pyjamas either because they did not bring them into hospital or because they could not afford them. Nightdresses with slits and theatre gowns also caused embarrassment as the following shows:

> I had a gown and it did not fit properly and opens at the back. It showed your bottom. You don't want to do that because you are not at home, you are in a strange environment. (Male: HCP 1)

Most hospital nightdresses or theatre gowns had slits at the back so that it was easy for patients to put them on. The mere fact that the slits or opening on the gowns were at the back, means that patients could not manage to tie or cover themselves. They relied on nurses to assist them, rendering them helpless. Even when the slits at the back of the nightdress or gowns were secured properly the patients could never be sure of this. Therefore, they were in a state of perpetual vulnerability as far as exposure was concerned. Some hospitals have already made changes to patients' theatre gowns. For example, in one hospital in England mentioned by Hart (1993), their gowns do not have ties and tabs at the back; instead a complete piece of "wrap around" material is used by patients. Despite patients being of different sizes some wards in the three hospitals tended to have theatre gowns of the same size. This meant that there was a greater chance of patients being given *ill-fitting theatre gowns*. As a result patients tended to be exposed by slits in the gowns and felt undignified and embarrassed. Being provided with the same size for every patient signified that patients were treated as a group, therefore losing their individuality. What is required is that hospital management should provide different sizes of gowns and to look into how these gowns could be designed.

6.9.2 Patients' Decency –Nurses' Perception

Almost an equal number of nurses identified this category as part of maintaining patient dignity. As one nurse said:

> Allow ladies to wear their make up. Try to help if possible, to keep their hair nice to maintain their appearance. This helps to maintain their dignity. (Female: HAN 5)

Even some health care support workers expressed the opinion that they took pride of making someone look good. Nurses also corroborated patients' observations as the following interview illustrates:

> Patients are stripped off. They wear that open theatre gown, with splits at the back. You are not supposed to wear any under wear. You are pushed on the trolley down to theatre. I am just looking at surgical perspective. It is not dignified. On this ward there is only one size of gowns. This leads to old ladies having gowns wrapped around them. (Female: HAN 18)

Decency is important to patient dignity and it has to be observed by nurses. Wearing what one prefers symbolises one's personality and identity, so nurses should make sure that patients put on what they prefer.

6.9.3 Maintenance of Patients' Decency – Nurses' Perception

Despite the above declaration about the importance of decency in relation to patient dignity by nurses, it was evident that many nurses were not aware of all of patients' expectations in terms of decency. Though some nurses were aware of the problem of gowns and pyjamas, they expressed that it was beyond their control. It was management's responsibility. Though they felt helpless they sometimes improvised in order to minimise patient embarrassment.

In summary, there was agreement about this perception between nurses and patients. Both nurses and patients identified decency as an important aspect of patient dignity. However, nurses needed to establish what patients wanted in terms of their decency if dignity was to be maintained. Appropriate information assisted patients in adjusting their perception of decency depending on circumstances. Areas and actions

that threatened patient dignity were also highlighted and nurses needed to be aware of them.

6.10 Patients' Control – Patients' Perception.

Control was also identified by most patients as an attribute of their dignity. Furthermore, control appeared in all the categories constituting perceptual adjustment levels. This supports Kolnai's (1976) claim that control is central to dignity. In this research, it acts as a link between all attributes of dignity as depicted in Figure 2 (p.102). Collins (1991 p.153) defines control as "power to direct or determine". For patients this meant determining the way each category or attribute within their perceptual adjustment level was to be fulfilled and also having some influence in activities affecting them during their stay in hospital. For example, one patient said:

> They come round in the morning with the pill trolley and I tell them, I will take the tablets with my breakfast, they are quite happy to do that. They do not say... "You have to take the tablets now". They do not do that. You are left to do things on your own (Female: HAP 10)

Such comments suggest that although patients submit themselves to health care workers they still perceive having some control. This is extremely important for patients and needs to be activated and reinforced in order for their dignity to be maintained. In the above example, although the hospital had its own routine of giving medication, the patient was able to negotiate with the nurse as to when she could take her medication. She felt dignified when she was allowed to do this. Having to know or perceive that they had control in some areas gave them a sense of worth.

The other sense of control which was noted among patients was control of inner feelings and being able to control one's body, for example, emotions. This was

expressed by some patients. They felt dignified when they were able to control themselves. As a 30 year old patient said:

> I was told what was wrong with me. It shocked me. I could feel tears in my eyes but I didn't want to cry in front of the whole team of doctors and nurses otherwise I would have been embarrassed. (Female: HCP 29)

This also illustrates the influence of socialisation on setting standards for one's self on how to conduct oneself in public. According to her cultural values, she was not supposed to shed tears in front of a group of strange people. She felt more satisfied with herself when she did not lose control completely.

6.10.1 Extent of Patients' Control – Patients' Perception

There were mixed responses as to whether patients felt in control or not while in hospital. Some patients said they did have control of what was happening to them at times while some said not at all. Obviously, it depended on whether each patient's expectations were met or not and what was meant by control to individual patients. No nurse mentioned control as a category of patient dignity.

In conclusion, the importance of control in relation to patient dignity has been highlighted in this section. It is evident that although there is "necessary submission", patients still have some perceived control while in hospital. However, nurses did not consider it important or did not realise that it was one of the attributes of patient dignity. Nurses should be aware of its importance in the maintenance of patient dignity. It should be identified and encouraged in order to make patients feel valued.

6.11 Respect for Patients – Patients' Perception

"Respect" was also identified by both patients and nurses as an important aspect of patient dignity. It formed a central part of patients' perceptual adjustment level. The personal standards set by an individual patient in terms of values could sometimes be met by the individual herself or himself and is called "self respect". The individual patient has regard for personal values. However, patients did not act in a vacuum. They continuously interacted with other people such as nurses, who were expected to have regard for and to acknowledge patients' standards. Mann (1999) pointed out that dignity flows from two components, one internal which represents the way one sees and respects himself or herself and one external which is the way one is respected by others. It is a two way system in which nurses and patients needed to respect each other as human beings. As Watson (1985a) stated, patient-nurse relationship is a human-to-human relationship; both parties' dignity need to be respected by one another. What was required from both parties is the realisation that each person needs to be acknowledged as a human being. The majority of patients regarded themselves as at "par", at the same level as nurses, emphasising the need for nurses to recognise patients as fellow human beings with a value equal to their own.

It emerged that there was also "role respect". Patients respected nurses because of their caring role. This was in addition to the basic respect they received as fellow human beings, and because it was their choice to respect nurses for their caring role, patients experienced a sense of psychological well-being. However, this was enhanced when nurses respected the patients as well.

McGee (1994) asserts that respect is paying attention, recognising and giving regard for the protection of individual patients. In this research, patients expected

prompt attention to their needs. They also expected nurses to ask them what their needs were to find out how these should be met. Protecting meant making patients comfortable, ensuring their confidentiality and guarding their interests. Nurses were expected to be patients' advocates during the time of vulnerability. All these signified appreciation of patients' individuality and also that nurses were treating patients as partners in the nurse-patient relationship, having what Rogers (1951) called unconditional positive regard towards patients. It implied nurses accepting patients as equal human beings with absolute value (Cherry 1997), that was not conditional on external factors, for example, looks or status in society. One patient commented:

> Being dignified is when one's dignity needs are valued and taken in consideration without looking at what I have got. (Female: HCP 6)

Another patient said:

> The treatment you give to a chair is different from that you would give to a person. A person expects respect, not ridicule and that is what I would expect nurses to know anyway. This is what I call dignity. (Male: HAP 21)

The above patient is emphasising that a patient's worth does not diminish and has feelings that need respecting. He does not like being treated like an object. An object can only have a priced value which can change at any time. In contrast a person has unconditional value which needs to be fostered. This was echoed by a number of patients stressing that they had values, beliefs and needs and were not just objects. Nurses needed to know what their needs were and how they wanted them to be met. This could be achieved by establishing each patient's perceptual level in order to know their expectations.

6.11.1 Were Patients Respected? – Patients' Perception

Half of the patients said they were respected by nurses, while the other half said they were either respected to some extent or not at all. For those who were not happy, they felt nurses did not find out from patients themselves how they wanted to be respected. One of the patients echoed some of these views:

> They did not ask how my dignity should be maintained as you are asking me now. (Female: HBP 10)

A group of patients expressed that they were not attended to promptly. An 80 year old male patient stated:

> Some times you feel as you are a nuisance. One evening I rang the bell twice for different reasons but one of the pink nurses [health care support workers] said, "We have other patients to look after I will be with you a minute?" I felt small and pity with myself. My dignity went. I know they are short staffed but I had to ring the bell. (Male: HAP 31)

Another example was given by a 78 year old male patient:

> When asking for a bottle [urinal], it has been at times, they would say we will be there in a minute, we will come back, but they don't. Sometimes they come after a long time by that time it is too late and sometimes they will say "it is you again". I suppose they are short staffed and they have other important things to do. (Male: HAP 33)

Despite patients being given the impression that they were going to be attended to in time, patients felt nurses took their time. Some elderly patients were wetting themselves because of delays. This delay was mentioned by patients repeatedly in the three hospitals. Patients were made to think that they were troubling nurses with trivial issues. A number of patients sympathised with the nurses due to shortage of staff, while at the same time they were in need of prompt attention, finding themselves in this ambivalent position on a number of occasions. Not being attended

to despite being promised undermined patients' confidence and self esteem. Patients felt helplessness and loss of control which made them feel undignified. In this vulnerable situation the patients regressed and felt as if they were treated as children and not being respected as adults. A number of patients expressed that they were seen "as a group" at times, and cited situations in relation to this. A 72 year old female patient claimed:

> For example I wanted a bed pan and made a mess on the bed pan and I got a nurse saying "Oh! You are another one tonight". "You are the third one tonight" something like that. This is not dignity. I have not been treated as an individual and that is not respecting my personal needs. (Female: HBP 9)

The patient was treated as "one of them". There was a failure on the part of the nurse in recognising patient individuality. Patients' needs were subsumed in a group's general identification. If patients were treated as a homogeneous group they felt as if they were objects and, therefore, depersonalised. Some patients expressed the need of respect in a different way:

> I do like respect. I have been a councillor helping people, therefore, one should also have respect. (Male: HCP 20)

> They are certain nurses who treat you...I mean, I am 74 years now, I used to operate a jet in the air force and I am an educated man and I can think and I object to be treated like a small boy. Mostly it is during the night. (Male: HCP 23)

These patients expressed that they were intelligent people who could understand and interpret what was implied in nurses' behaviour. They were treated by nurses as children while they deserved to be treated like adults who could think. One would argue that these patients failed to recognise that their roles or positions outside hospital would not necessarily influence how they were respected in the hospital. Their high standing in the community made it difficult for them to adjust because they had been used to giving orders and wielding power. The reversal of roles was not

easy to come to terms with. This emphasises the importance of asking patients how their dignity could be maintained, thereby establishing their perceptual adjustment level. They can be helped adjusting by explaining to them about what to expect in the hospital.

Some patients noticed that they were not respected by nurses as a result of inadequate training. These comments applied more to health care support workers in the three hospitals. One patient echoed the views of other concerned patients:

> Can I comment about some health care support workers since this is confidential? Probably some of the health care support workers were not very well trained. Obviously they are not going to be as caring as nurses but they are dealing with people. I do not like the attitude of some of them. If you ask for something they tend to ignore you, they pretend as if they have not heard you. On a couple of occasions they have left me on a bed pan for quite a while before coming to remove it and I know they are quite few bells ringing. It is not all the time but I think they lack proper training. Some of them are very good they cheer you up. (Female: HAP 18)

There might have been two main reasons why health care support workers behaved this way. They could lack awareness of patients' dignity needs and also have the wrong attitude, which was interpreted by patients as due to lack of training. Appropriate nurses' attitude is important for the maintenance of patient dignity and this can be manifested through nurses' behaviour towards patients. The other reason could have been that health care support workers might have been genuinely busy with other patients during those times when patients needed help. If the situation was explained to the patient, how busy the ward was, she might have understood that the nurses were busy, therefore, helped her to adjust to the circumstances and probably not feel demeaned and embarrassed as much as she did. This again emphasises the importance of giving information to patients.

6.11.2 Respect for Patients – Nurses' Perception

Nurses too realised the importance of respecting patients. One nurse representing the others remarked:

> Patients need to be respected. They are human beings and have got needs, cultural values and beliefs which need to be recognised. That is what I see as patient dignity. (Female: HBN 3)

It was encouraging that the majority of nurses recognised the importance of respecting patients. They recognised the fact that patients were people just like them. A majority of them said they treated patients as they would be expected to be treated themselves. Some nurses did not however, mention some of the patients' expectations, such as prompt attention, asking patients what their needs were.

6.11.3 Were Patients Respected? – Nurses' Perception

All nurses felt they treated patients with respect. All nurses agreed that it was necessary to ask patients what their dignity was but there were differences in whether this was implemented or not. Half of the nurses from the three sites said they did. These were nurses mainly from Hospital A. This was presumably because some wards in Hospital A used a standardised assessment tool which incorporated the assessment of dignity, which reminded nurses to ask patients about their dignity. However, they expressed that they did not do it well. The other group of nurses felt they did not assess patients at all in relation to dignity. The failure to ask patients about their dignity was attributed to the following reasons: The first reason was the

abstractness of the concept. Nurses did not know what to ask patients as illustrated by one of the nurses:

> It is difficult to know what questions to ask to elicit the right answers. It is something that is quite "woolly", very difficult to put a finger on really. (Female: HAN 9)

Some nurses confessed that they left the section on the assessment tool blank while most of those who commented on the patient care plan said they wrote a general statement, "maintain patient dignity and privacy" without asking the patient. The following demonstrates this:

> Yes, it is written on the Kardex, you always have to complete something, you have to write something in the box there. So for every patient there will be something. (Male: HAN 20)

This illustrates how much nurses were struggling with this abstract concept. Nurses did not have the necessary skills to assess patient dignity needs, especially questioning skills. A number of studies have indicated that nurses do lack questioning skills, for example, Wilkinson's (1991) research in which factors that influence the way nurses communicate with cancer patients were investigated. 54 registered nurses participated in the study. The results showed that most of the nursing assessments of patients were very superficial and because of the limited information obtained sometimes nurses were planning care on assumptions rather than evidence.

A number of nurses also assumed that patients would also find it difficult to respond to questions relating to dignity because of the potential abstractness and complexity of the term. Some nurses felt there was no reason to ask patients what their dignity was, as they maintained patient dignity automatically drawing strategies from their own life and professional experiences. As one nurse illustrated:

> I think one does it automatically; actually we do a lot of things automatically. Just being a sort of caring person you hope to maintain somebody's dignity without assessing and writing down that you are actually doing it. (Female: HAN 23)

This confirms this research's findings that nurses use their own standards of dignity in the maintenance of patient dignity. Bourdieu's (1990) work on "logic of practice" can help to understand this form of practice. He discusses what he called "habitus" which was defined as "spontaneity without consciousness or will" p.56. The underlying argument is that much of one's daily life is taken for granted; knowledge and practices are carried out habitually and routinely. These practices are influenced by past knowledge and experiences accumulated during one's life. However, one does not directly feel the influence of these past selves because they are so deeply rooted within oneself. They constitute the subconscious part of the person. That is why nurses maintained patient dignity habitually and unreflectively without asking the patients themselves. Wilkinson and Campbell (1997) warns that an automatic process of doing things can keep one unaware of the existing problems and prevent opportunities of challenging old ways and introducing new approaches. It can be seen in this research that however the abstract the concept might be to define, "dignity" is a word that keeps appearing in the account of patients.

Half of the nurses mentioned that patients' dignity was seriously considered when a patient complained that dignity had been violated. What it meant was that nurses were not aware of it unless a problem in relation to dignity arose. Nurses expressed that they were more conscious of patient dignity when an intimate activity was performed such as bathing, toileting or inserting catheters. As one nurse said:

> I think sometimes, we only think of patient dignity when we have patients who have prosthesis, who have mastectomy and some patients who have had colostomy. It is not something which comes to mind consciously with every patient. (Female: HAN 7)

Another nurse said:

> If they have a colostomy, it tends to be well documented in relation to dignity. It is things like that, which probably are well covered and other patients would be asked very standard questions. (Female: HAN 4)

Patient dignity was not thought about when carrying out procedures like giving medicines which were perceived as not intimate enough to warrant consideration of patient feelings. It is evident that nurses did not realise that patient dignity is an integral part of every nurse care activity. Even though nurses considered patient dignity when they were carrying out intimate procedures, they admitted that they did not ask patients how their dignity would be maintained. On a positive note, some nurses were good at identifying physical or behavioural signs of embarrassment in patients when dignity had been violated. This would have been more helpful in the maintenance of patient dignity if it would have been accompanied by prior asking of patients in relation to the maintenance of dignity.

A number of nurses admitted that it probably was a lack of awareness on their part for not respecting patients at times, as expressed by a deputy manager of one of the wards:

> I think we need to educate staff such as Health care support workers; even some of the trained staff are disrespectful to patients. They tend to discuss patients without due regard. Mostly it is their attitude towards patients. (Female: HAN 18)

This was confirmed by one of the health care support worker's attitude to patients:

> I do respect patients, but other patients are demanding. They do not see that nurses are busy and they keep ringing bells. (Female: HAN 17).

The nurse believed that the patients had no consideration about nurses being busy. That is why they kept on ringing bells to draw attention. As a result the nurse had

negative feelings towards such patients. Such patients were ignored at times when they rang the bells. Being ignored was interpreted as disrespectful by the patients, thereby violating their dignity. These types of behaviour from nurses were not uncommon in the three hospitals.

When student nurses were asked whether they were prepared enough during training to maintain patient dignity, responses varied. Out of 21 student nurses interviewed from the three hospitals, only six said it was emphasised during training while the rest felt it needed more emphasis as it was just mentioned in passing during the theoretical courses of other subjects. There were theoretical gaps between what was taught in class and what was practised. This deficiency in training was echoed by a third year student, representing views of students from the three hospitals:

> I think the best place to learn how to maintain patient dignity is in the ward. I think certainly it should be emphasised and discussed in school but the best place is in the wards although sometimes you see scenarios quite contrary to what you are told in school. (Female: HAN 19)

This example demonstrates the need for a sound foundation of patient dignity in theory and continuing reinforcement while on the wards. The nurses' views and attitudes discussed above reinforce what patients claimed, that some nurses lacked knowledge, skills and the appropriate attitude needed for respecting patients' dignity.

In conclusion, it is encouraging that both nurses and patients identified respect as important in the maintenance of patients' dignity. It was a constituent of patient's "PAL". Half of the patients were satisfied that they were respected. However, there was still room for improvement as demonstrated by comments from those who thought they were not respected. It is evident that a number of nurses did not assess patients in relation to dignity, despite acknowledging its importance to patients. The goal of nursing care is to ensure that every patient admitted to hospital gets the respect

he or she expects within his or her perceptual adjustment level. Otherwise the care is not complete. Patients need to be asked what their concept of dignity is and how they want it to be maintained. Patients should not be stereotyped as people who do not understand their dignity. It can be learned from this study that although some patients had difficulties in defining it, they managed to describe how their dignity should be maintained. If a patient is unconscious or confused, families or relatives can give information about the patient which could be combined with nurses' professional judgement until such a time as a patient is aware of what he or she expects. The importance of knowledge, skill and appropriate attitude in the maintenance of patient dignity cannot be over emphasised.

6.12 Nurse-Patient Communication – Patients' Perception.

It was through nurses-patients' communication that patients inferred that they were respected, hence dignified. It was regarded as a vehicle for respecting patients. Communication is the process of giving and receiving information and it can be verbal and non verbal (Leddy and Pepper 1998). Language is part of verbal communication and through this human beings can express respect for each other. Within their perceptual adjustment level patients expected staff to introduce themselves to patients, and to ask permission before a procedure with words like "do you mind?" as one way of showing respect to them. It gave patients a choice in the interaction and as a result reinforces a sense of control. This also showed courtesy which was raised by a number of patients from the three hospital. As one patient commented:

> One needs to be respected to be dignified and the magic word for respectfulness is courtesy. (Male: HBP 17).

Courtesy meant patients were recognised as a person. Patients expected to be involved in conversations while two nurses were performing tasks near them or on them, as stated by a 74 year old patient:

> The thing is, while they are giving me a bath, they should involve me in their talk. I mean nurses. You feel you are a person. It also helps you with embarrassment. (Female: HAP 9)

This included both conversations about patients' illnesses and also casual conversations between nurses in the presence of patients. Being noticed or being acknowledged is part of being valued. In everyday life this is manifested by greetings and social conversations when people meet. People feel undervalued when they are excluded from conversations. The same feelings apply to patients while in hospital. A number of patients expressed that they felt like objects, thereby feeling dehumanised when nurses ignored them while talking amongst themselves. Patients expected nurses to be polite. Obviously this depended on what the patients perceived as politeness. Politeness can be expressed verbally or non-verbally. Patients were particular as to how communication was carried out by nurses. Verbal communication has developed to an extent that other features of speech carry extra meanings, for example, tone may carry hidden messages. It may denote annoyance or that a nurse is irritated by a request from the patient. Some patients did not like some nurses' tones of voice.

Non-verbal communication include: Gesture, touch, facial expression, distance and posture (Long 1992). Patients also expected nurses to have time for patients and to listen to them and provide opportunities to express their needs because this made them feel valued. They also expected nurses' body language to correspond with verbal communication. One patient expressed:

> One can see whether the nurse is interested in caring for you. I mean my wound. I know the smell embarrasses me at times. It is hard for them too. (Male: HAP 26)

The nurse's body language did not correlate with her behaviour or verbal communication. This conveyed inner feelings of the nurse in a nurse-patient interaction and respect is deduced from this interpretation. Eye contact is a cultural concept which may be interpreted in different ways. However, in this research some patients appreciated eye contact with nurses. This indicated that the nurse was not embarrassed with the procedure that she was carrying out.

6.12.1 Was Nurse-Patient Communication Effective? – Patients' Perception

Some of the patients in the hospitals said they were satisfied with communication with nurses. Nurses were generally polite and listened to them. However, there was some evidence in this study that nurse-patient communication was not effective. Patients appreciated that most of the nurses introduced themselves but there were some nurses who did not have the courtesy of asking patients that "would you mind or do you mind?" An 80 years old lady expressed disappointedly:

> Some nurses think they own you. They just come and do things [procedures] on you without asking do you mind if I do this. This morning she just came. I have come to take off the needle [Venflon] from your arm. (Female: HAP 25)

Although this patient necessarily submits herself to the nurse, she expects the nurse to have some courtesy. The subjective feelings towards the patients were not taken into account, as long as the job was done.

Some patients felt some nurses discussed personal things between themselves without involving those patients they are working with. There was a tendency among patients of feeling like objects when they were ignored. This is consistent with Geller,

Goodstein, Silver and Sternberd (1974) who examined the effect of being ignored. They found that when patients were ignored, they were made to feel like objects resulting in a feeling of worthlessness. This is supported by recent research findings by Coyle and William (2001) who also revealed that some patients felt that they were treated as unintelligent human beings. Staff stood near them, talking about them as if they were not there and they felt devalued.

Some patients from the three hospitals pointed out two areas of discontent concerning non-verbal communication. First, patients stated that communication between nurses and themselves was mainly task oriented. In other words, nurses talked to patients when there was a task to be done. For example, some patients observed that nurses only talked to them when they were writing their care plans. This was mainly because nurses were busy all the time. Whatever reasons there were, patients felt ignored:

> If you are not talked to, you feel you do not exist and ignored. (Male: HCP 17).

Secondly, some patients from Hospital B and C pointed out that they noticed that some nurses did not make eye contact when carrying out intimate procedures like bed bathing. This is illustrated by comments from two patients. A 62 year old patient said:

> There is something which nurses should do when you are being bathed. Making eye contact. There is no eye contact when you are being washed. I feel that it is important from a nurse because it shows that she is not embarrassed. I have come across two nurses here where eye contact was not there for what ever reasons. I do not know but I did notice. (Male: HBP 27)

There could be three reasons why the two nurses did not make eye contact. The nurse might have come from a culture where direct eye contact may mean, for example, rudeness. Therefore, there might have been cultural conflicts. Nurses'

personalities can also play a role in not making eye contact. Some nurses are born shy and do not know how to handle such situations or the nurse could have been embarrassed herself, as the patient interpreted in the above illustration. Whatever the reason, nurses' embarrassment can easily affect patients. The "necessary submission" is based on the patients trusting the health care workers. They have confidence in nurses and if a nurse gets embarrassed, the patient loses trust and confidence. The patients become self conscious and feel more embarrassed. Northouse and Northhouse (1998) give a word of caution. Good eye contact does not require long gazes. Too much eye contact can be uncomfortable and interfere with the normal ebb and flow of an interaction. Too little eye contact may make the other individual feel impersonal. They suggest that "good" eye contact requires moderate amounts of gazing which are appropriate to the situation. However, one would argue that what each patient may consider "moderate" may mean too much to another patient. Therefore, it is important to establish patients' perceptual adjustment levels. The nurse can discuss with the patients what is expected because what might be acceptable eye contact to one patient might not to another.

Patients were aware that some procedures were embarrassing. However, the embarrassment would be lessened if the patients were made to feel that the nurses were doing an everyday professional activity and carrying out tasks sensitively. One can only get embarrassed if one is not comfortable with what is happening. It is vital that nurses should be aware of their embarrassment and also able to detect non-verbal cues from patients. These can help nurses anticipate patients' needs in terms of dignity.

6.12.2 Nurse-Patient Communication – Nurses' Perception

Good communication as a way of maintaining patient dignity was endorsed by a number of nurses in all the three hospitals. There were varied responses from nurses relating to this category. Some qualified nurses and health care support workers felt that they had effective communication skills in maintaining patient dignity. Others acknowledged that they did not have good communication skills. It is clear that maintenance of patient dignity depended on nurses' communication skills. This would assist them in having a comprehensive understanding of the patient's needs and thus in understanding their perceptual adjustment level. However, there was a difference in emphasis between patients and nurses on how communication should have been carried out to maintain patient dignity. While patients emphasised the importance of expectations such as tone, courtesy, involving patients in conversations and eye contact, nurses did not.

6.12.3 Was Nurse-Patient Communication Effective? – Nurses' Perception

A number of factors were identified by nurses which contributed to nurses not communicating properly with patients. Some nurses agreed with patients that good communication with nurses was hindered by nurses being busy. They did not have time to communicate with patients. Some nurses acknowledged that sometimes nurses ignored patients as a result of stress due to workload. The effect of stress on nurses affected their behaviour. At times nurses became agitated and this affected communication, and nurses became abrupt thereby appearing rude. They felt that sometimes it was beyond their own control. This was supported by Milne and

McWilliam's (1996) research findings in which nurses felt that they had inadequate time to spend with patients because they had to deal with other aspects of their role. Talking to patients in some cases was not seen as an important aspect of nursing care. This is confirmed by the Audit Commission (1992) findings that talking to patients was seen as taking nurses away from real work. Whatever the reason, nurses needed to be aware of these areas so that action can be taken to rectify them, as they were clearly a source of indignity to patients. Some nurses felt that lack of communication with patients was influenced by educational preparation and it was generally felt that communication skills were not related to patient dignity during nurse training.

The problem of communication between patient and nurses is long standing. This is supported by the fact that as early as 1985, Faulkner identified this lack of communication skills among nurses. Wilkinson (1991) (cited in section in 6.11.3) highlights that this problem was still evident in her study. This present study's findings confirm that this problem persists up to the present time. If patient dignity is to be implemented to patients' satisfaction, nurses need to improve their communication skills.

This section has emphasised the importance of both verbal and non-verbal communication in the maintenance of patient dignity. However, it has been revealed that there were shortcomings in its maintenance. There were several areas that were identified by patients but not nurses as the ones that caused most concern.

6.13 Summary for Chapter 6

The chapter has discussed what patient dignity is in the context of patients' perceptual adjustment level (PAL). The 11 categories which were mentioned by

patients, supported by nurses, have been discussed in detail. Patients have their own expectations in each category which need to be matched by nursing activities. This emphasises the importance of assessing patients' perceptual adjustment level which has been stressed throughout this chapter. However, it is evident that patients' expectations were not met by nursing activities, thus violating their dignity.

To illustrate the necessary submission and the perceptual adjustments of patients and how patients' dignity was not maintained by nurses at times, (HAP1) in *Appendix E* has been analysed below.

6.14 An Example of a Transcript HAP1 (*Appendix E*) Demonstrating "PAL" and the Categories

A white female patient in her 60s who lived locally was interviewed on the third day of her admission to the ward in Hospital A. A rapport was established before starting the interview by the researcher introducing herself to the participant and asking general questions like "how long have you been in hospital?" "How have you experienced your stay in the hospital?" This rapport was reflected in the interview as it progressed. A sense of humour from both parties helped to ease the situation. It was important to build such a relationship with the participant as it helped to yield rich and useful data relating to the research.

Perceptual Adjustment Level

> I have always taken that nurses and doctors in the hospital do what is best, I am in their care and they put yourself in their hands
>
> From the start, you tell yourself that they are nurses, they are doing their job, let them go ahead.

There was "necessary submission" of herself to the doctors and nurses. Within this necessary submission, the patient surrendered herself to the health care workers. It was not a comfortable experience for the patient, but there was a purpose and justification for her to be in the hospital. The lady's perception adjusted because she wanted to get better.

> At first there is a bit of apprehension oh dear! What is going to happen? I am going to be laughed at. But once you have seen, how kind and considerate the staff are you feel part of it. Somehow and I am so grateful when they put you right.

Although she found it difficult to define her dignity, the patient knew what she expected from nurses. Within her level of adjustment, she wanted her dignity to be maintained. She expected nurses to close curtains in order to maintain her privacy, to be respected by staff and for them not to act arrogantly, sufficient information which was given at the right time, independence and to be addressed by her preferred name. These constituted her "PAL". For her to feel dignified, all these values or needs needed to be fulfilled by nurses. Standards were set for what she expected, for example:

> I would not like them to be...eh! What shall I say ... Hoity toity.

This gave her a sense of control and choice within her perceptual adjustment level leading to the maintenance of her dignity. That is why at times, the patient did not mind what was happening and did not feel embarrassed.

> I stripped to the waist. One of the nurses giggled and said let me give you a bit of dignity and covered me up I said oh! all right because she was a nurse, I was quite prepared and I had no reservations. They are just doing their job.

The patient reached a perceptual adjustment level that made her not mind stripping in front of the nurse. It was, therefore, important for the nurse to establish this "PAL",

finding out how the patient perceived the situation. The nurse in this case did not. The main factor which influenced her perceptual adjustment was her previous experience of hospitalisation. This is illustrated by what she stated:

> ...It is just getting used to it because I have been brought up such an independent person and once you get used to the idea that someone is helping you then say it is all right. You do get used to it and you take it not for granted. That is the wrong word but you take it what shall I say - in your stride.

Although the patient had her expectation as stated above, nurses failed to establish her perceptual level at times to find out her expectations. They did not identify most of her dignity needs and how she particularly wanted them to be met. It was evident that her dignity was violated a number of times. The following quote reveals the conflicts the patient faced in trying to describe her experience in the ward:

Patient:	Everyone has been absolutely great *(smile)*
Researcher:	What do you mean by great?
Patient:	Well, kind, showing consideration in telling you what is going on. In making you comfortable. I am not very good at this actually- to put things into words eh! making sure you are comfortable, otherwise everything is all right especially the doctors and surgeons.

Although the patient painted a picture that her stay in hospital was all right, the initial hesitation and the word "great" accompanied by a smile indicated that there was some dissatisfaction of the care given. This included the violation of her dignity. For example, there was a need of information which the patient scarcely received. When the chance arose, it was given at the wrong time. This can be interpreted from the following:

Patient:	I was just confused a bit, I thought it was going to last longer, about my stay here. But they did not tell me yesterday, they told me at dinner time.

Researcher: What didn't they tell you yesterday?

Patient: Yes, they told me yesterday that, oh no they didn't, they thought I was going home last night but they didn't. Do you see what I mean? I was supposed to go down to theatre so that they can look at my arm and go home this morning *(A laugh)*.

Researcher: So you were not sure what was happening?

Patient: No. *(A laugh)* No body was. There was another lady opposite me and another lady who is just there. We all thought we were going home dinner time and because it did not work that way and we gathered from nurses and that the surgeons and consultants were all down to theatre. They have been there since morning. So we got to wait a bit longer and my husband was coming this afternoon to pick me up and nurses did not know. I mean it was not their fault and we found out later from whoever it was that they would like to have my plaster finish off.....

She gained her information by talking to other patients. Eavesdropping appeared to be the means of obtaining information. The interview also shows poor communication between nurses and doctors which led to the patient not getting the information. Information was important for the patient to plan, to know what was happening to her and also it helped her in adjusting to a level to which she could not feel embarrassed. Lack of it caused perceptual maladjustment which resulted in embarrassment and loss of her dignity as illustrated in this interview:

Patient: Oh yes I give you another example – It is confidential anyway. I had a hernia repair. I felt so relaxed when the surgeon and the nurse entered the room to check the wound because I was going home. I did the wrong thing *(Trying to demonstrate)*

Researcher: You mean pulling down the clothes?

Patient: Whichever to expose the part. Everything was pulled down *(Patient laughing)*

Researcher: So all your clothes were off?

Patient: Yes, the nurse just say – lets cover you up the doctor does not want to see all.

Researcher: You mean the doctor pulled down your clothes?

Patient: No! I did.....because she said he wanted to look at the wound so I just went..... She [nurse] just said, you are not taking all off. He just wants to look at that. That embarrassed me. I told myself

> you fool. You shouldn't have done that. It really embarrassed me, but there you go – when you are nervous.

There was perceptual maladjustment because the patient did not know what was expected from the situation. Therefore, her perceptual adjustment level was based on wrong assumptions or doing wrong things, hence exposing herself unnecessarily losing her dignity. There were some discrepancy between her perception of the situation and what was expected of her. She even went to the extent of blaming herself. If this lady had a proper explanation of what was expected in terms of undressing, she would not have felt embarrassed the way she did. Explanations would have also prevented ambiguous situations which the patient found herself from time to time, for example, in this situation:

> You take off the clothes then you stand there and say oh! cracky he is coming now (*A long laugh*). Do you see what I mean? All of sudden he is looking at you to make it right what is wrong in you. So that is that.

Although she had necessarily submitted herself as she wanted to get better, she still had some anxieties, she had not adjusted properly, therefore, had conflicting feelings within herself which led to loss of control of the situation making her feel undignified. A sense of humour was her "survival kit". Embarrassment is a stressful occurrence. Humour created an atmosphere which was less threatening and this enabled the patient to trivialise events which could have been otherwise made her feel more anxious. It created a relaxed atmosphere between staff whom she considered to be arrogant. The importance of humour to her in dealing with embarrassment is supported by the fact that at times she initiated humour when nurses and doctors were not forthcoming.

Humour is important for patients to deal with embarrassing situations. Astedt-Kurki and Isola (2001) conducted a study on humour. The aim was to investigate the occurrence of humour both between nurses and patients and among staff. The data

consisted of diaries written by 16 nurses. They concluded that humour between nurses and patients enabled them to cope with various procedures. Although the sample was small and the study was done in Finland which is a different culture to the United Kingdom, it shows how humour is important in embarrassing situations. It is important to note that humour is personal and cultural and it depends on the context. Although humour was important for this particular patient in reducing her embarrassment, each patient should be assessed as to how receptive he or she is otherwise the humour can be counterproductive, causing embarrassment when used inappropriately. It is a skill which needs to be learned properly.

There were also times when the participant felt she was at the health care worker's mercy which was a sign of losing control of the situation. In terms of being addressed by preferred name, the patient said:

> Once upon a time if you are married person and you are talking to a 20 years old, you are always called by Mrs., but these days they call you by your Christian name, wouldn't they? I suppose it is less formal.
>
> ... When I am with the nurses I am on Christian name terms because it makes them feel friendly.

This is another example of perceptual maladjustment. It is obvious the patient wanted to be addressed by "Mrs"; however, she decided on first name terms because she was under the assumption that first names built a friendly nurse-patients relationship. It was the patient who was trying to build a friendly relationship in the nurse-patient relationship at the expense of her dignity. What was also observed was that there was no reciprocal use of first names between the nurses and the patient as a she expressed:

> I still cannot call nurses by first names, even when I know her. I will call her nurse.

The patient did not address nurses by first names because it implied disrespect. Coincidentally, this was confirmed by one nurse in the same ward as follows:

> Professionally, I don't think it would be right for patient to call us by first names. (Female: HAN 31).

This reinforced the fact that nurses were in authority and that their patients were in subservient roles. It corroborates the concept of nurses having expert power: "we are capable when they are not" (Hugman 1991 p.133). This compromised the patients' dignity. This nurse was also demonstrating a degree of control over the patients by maintaining a social distance. This was not showing respect to the patients. When this was coupled with health care workers' arrogance, the participant felt disrespected at times. The need to establish her perceptual adjustment level in terms of dignity was important. This included ascertaining how she wanted, for example, her privacy to be maintained or wanted to be addressed.

There were factors which helped and also hindered the maintenance of her dignity. Factors that hindered the maintenance of her dignity were, for example, nurses being busy. The patient was angry with the system which did not allow nurses to have time with her, thereby compromising her dignity. She was ignored. As much as she regarded nurses as a source of information, out of respect and not wishing to disturb them, she did not want to ask for more information and felt helpless on a number of occasions.

The above example is typical of a patient adjusting to hospital situations and adjusting to indignities in hospital. Factors that influence the maintenance of patient dignity are clearly illustrated. This leads to the next chapter which discusses factors that influenced the maintenance of patient dignity.

CHAPTER 7: FACTORS INFLUENCING THE MAINTENANCE OF PATIENT DIGNITY

7.1 Introduction

What has been established in the previous chapters is that nurses are required to match nursing activities with what is expected within the perceptual adjustment levels for patient dignity to be maintained. Practice is partly influenced by resources or their lack within the hospital. The aims of this research would be incomplete without addressing these matters. Despite organisational differences between the three hospitals used for the research there were similarities in the resources which each hospital had. The lack of resources in the wards was a common feature. Age, gender and doctors' ward rounds were the other factors frequently mentioned by most patients.

Both patients and nurses valued resources such as curtains around beds when they were available in the wards. Treatment rooms which were found on certain wards provided space to discuss private matters and were used for carrying out invasive procedures. Single rooms were clearly considered an asset in the maintenance of patient dignity. However, patients and nurses were dissatisfied with the quality and quantity of some of the resources in the wards; and they felt that these hindered the maintenance of patient dignity. These will now be discussed one by one.

7.2 Shortage of Staff

Shortage of staff has been mentioned in Chapter 6 as one of the factors which influenced the maintenance of some of the categories of patient dignity. However,

because of its huge impact, it will be discussed further in this section. There were fewer nurses than the established number of staff per shift. This resulted in nurses being busy and working harder than expected. It could have been tolerated if this were a one-off event but it appeared that it was a regular occurrence on most of the wards as evidenced by the fact that many arranged research interviews were cancelled more than once because of this. Nurses were not the only ones aware of shortage of staff. All patients commented on it as well. Shortage of staff has been a long standing problem in the National Health Service as confirmed by Hulse (1999) and Buchan (2000). The consequence of shortage of staff on patients' dignity was manifested in a number of ways. Because of it the completion of tasks was more important to nurses than the maintenance of patient dignity. This resulted in patients feeling as objects. An account of an experience was given by a 62 years old paraplegic patient who angrily commented:

> The auxiliary nurse who came to feed me was feeding the two of us at the same time. She would put two spoon mouthfuls in my mouth and at the same time the other person and moved to and fro until she finished feeding us. I did not want that. It was like just putting food in a hole or bin. (Male: HBP 27)

The patient felt rushed as though he was just another task to be performed on. It made him feel less valued as a human being. The problem was emphasised by a patient from another hospital:

> They come and give us all a bowl and go round each of them and one person might sit for half an hour with a towel in front waiting for a nurse to come and do the back and that nurse might be with somebody else which is not dignified. (Female: HAP 18)

In both situations the patients felt as if they were on a conveyor belt, making them lose a sense of individuality. This was demeaning to patients as there was no personal touch. It was frustrating to both patients and nurses. Tasks seemed to take a long

time to complete as far as the patients were concerned. While a number of patients sympathised with nurses for being overworked, they were frustrated and angry with the system which allowed this type of care to happen. Some patients seemed to use interviews which were conducted for this research in order to vent their anger.

Shortage of staff had an impact on nurse training in relation to patient dignity. Experienced staff nurses did not have enough time to teach student nurses. Tasks were also not always done according to acceptable standards. This meant that student nurses were copying bad habits in the maintenance of patient dignity which had implications for their future nursing practice. This was illustrated by two students as follows:

> When washing patients in the morning, there might be two on the go. You wash this one then nip out to wash someone else. (Female: HAN 33)

While another student said:

> If patients are wetting themselves or soiling bed and pyjamas, whatever, it takes a lot of time changing them. Even if you have been taught, you just put them on a pad initially and come back later when you find time. (Female: HBN 12)

This demonstrates that time was more important than maintenance of patient dignity. Patients were left unattended in uncomfortable and undignifying situations. They felt helpless and useless especially when their medical conditions did not permit them to perform the tasks on their own. Furthermore, because nurses were working under pressure, they felt frustrated and this put the maintenance of patient dignity at stake.

One way of addressing shortage of staff in all the three hospitals was the use of bank or agency nurses. This is a system where nurses outside the hospital establishment are used to fill up shifts which regular nurses cannot cover for a variety

of reasons. These nurses did not work on the same ward all the time. Because of this they were not familiar with the ward environment and also there was no continuity of care. This caused anxiety and stress in the bank nurses. Sometimes bank nurses were called in to work on a ward that was already understaffed thereby exposing them to an already existing stressful situation. Because of these factors they were more likely to violate the maintenance of patients' dignity than the usual ward nurses. This explains why some patients were concerned at the way some of the bank and agency nurses maintained patients' dignity. This was supported by one of the nurses as follows:

> Occasionally we use bank nurses.... Sometimes, you sort of go round with them and they just sort of doing things. You go Oh!! And then you go through the training with them. (Female: HAN 19)

This regular nurse is describing the bank nurse as a hindrance. Instead of helping she is in need of training and this slows down the work of the nurse further. There is also frustration as the bank nurse may not come back to the ward for a long time. Some bank nurses can be a source of frustration to both patients and nurses.

Against this background of mounting empirical evidence, supported by this research there can be little dispute that the shortage of nurses has a negative impact on the maintenance of patients' dignity. The quality of working life for staff is an important marker of the likely quality of service provision (Cox and Leiter1992). The implication is that with more staff and less pressure nurses would consider patients' dignity more of a priority than they do now. Therefore, action to improve the recruitment and retention of nurses is more urgent than ever for patients' dignity to be maintained.

7.3 Effect of Facilities in the Maintenance of Patient Dignity

A number of nurses and patients expressed that there were not enough facilities for the maintenance of patient dignity. Lack of adequate good quality facilities hindered the maintenance of patient dignity in some of the wards. The following are a few examples to illustrate this.

7.3.1 Ablution and Toilet Facilities

Patients in the three participating hospitals said there were not sufficient resources in some wards for the maintenance of patients' dignity. This view was represented by a comment from a lady from one of the wards.

> Very short on toilets. There is one for ladies down there and you have to walk round to the others. This afternoon I am going to go there but I am not sure I should. There were not very clean so I had to go round again to the other toilet. We would do with more toilets. They are not enough. (Female: HCP 11)

The problem of washing facilities was more prominent in "mixed wards". Mixed wards have become unpopular and have been discouraged (Snell 1997) except for high dependency bays where female and male patients were still mixed, for example, in Hospital A. The common practice was that wards were arranged in such a way that females were on one end while male patients were on the other end. They were provided with separate ablution and toilet facilities. However, in some wards female and male patients were using the same toilets. Some patients felt that male and female patients should have separate wash rooms. This was because they were experiencing some embarrassment when using "mixed" facilities. Facilities for disabled patients

were not available on some of the wards as illustrated by the following comment from one of the nurses:

> Showers are designed for able bodied patients. You cannot take a patient on wheel chair. We have got one bathroom where there is step. You actually have to climb over this step. There are only 2 washrooms for ladies and 2 for gentlemen. (Female: HAN 23)

The quality of facilities was not up to standards in some of the wards. As mentioned previously, curtains were not functioning properly in almost every ward in the three hospitals. Dirty toilets were an issue for some patients in wards of two hospitals (two in Hospital B and one in Hospital C). A 50 year old woman said:

> You don't feel dignified if you are forced to use dirty toilets. I don't sit on the seat, I just stand when I am using it. Is that being dignified? (Female: HCP 21)

This quotation gives a picture of the state of the toilets in some of the sampled wards. Some toilet doors could not be locked properly and sometimes some of them got open while a patient was using the toilet. In some wards it was a practice to lock toilet doors from outside in case a patient fell or needed help while using it. This was to enable the nurses to have easy access to the patients in the toilet. However, it was noted by patients and nurses that some of the doors could not be locked leaving the patient feeling vulnerable. These small subtle things were significant for patients' dignity. One nurse highlighted this problem:

> You cannot lock the doors from outside and while the patient is sitting on the toilet, there is nothing to pull the door to actually lock and if they [patients] are sat on the toilet with limited mobility you cannot expect them to go across to the door. This being a busy ward , you cannot always guarantee that you can actually stand outside the toilet door for twenty minutes while someone is on the toilet because you have got other jobs to do. (Female: HAN 31)

This shows that nurses saw dignity as important for patients but they were frustrated because of faulty toilets. This caused anxiety among nurses. It also meant that

instead of doing other nursing activities, nurses were spending time standing outside toilet doors in an already understaffed ward. In one of the wards in Hospital A nurses had to improvise by using a coin to lock doors from outside. Nurses were also getting frustrated because despite reporting faults, repairs were not carried out in time.

> We are trying to have them mended. eh! It doesn't work as quickly as you would like. (Female: HAN 4)

Nurses felt that many technical matters were out of their control. There were signs of "learned helplessness" (Seligman 1975) among nurses which had led to lack of motivation and they ceased to try to sort out some of the problems. As one of the health care worker commented:

> You do come across the curtains where there have been there like that and no body has done anything about it. Then you just notice it. (Male: HAN 20)

All the above discussions exposed the poor state of maintenance of ward facilities in the hospitals. This had an impact on the maintenance of patients' dignity. However, if patients' dignity is to be maintained, every nurse should strive to have wards with facilities in working order and this should be augmented by support from management.

7.3.2 Private Rooms

As stated in Section 6.5, the maintenance of privacy when discussing confidential matters was highly appreciated by patients. However, it was noted that some wards had no private rooms where these discussions could take place. Nurses also noticed and appreciated the need for private rooms in all the wards. This was illustrated by a nurse from one of the wards as follows:

> In order to provide patients with privacy we do need to have more quiet areas in the ward, not only for patients but relatives as well. We would like to have a quiet room. (Female: HAN 18)

The fact that some wards did not have them is a matter of concern and needs to be addressed. The designation of rooms for this purpose in all wards is required for patients' dignity to be maintained.

7.3.3 Lifts

At times patients had to be taken from one area to another, for example, when going to theatres, x-rays or being brought from home to hospitals by ambulance on a stretcher. Lifts had to be used most of the time. Some patients and some nurses observed that at times patients' dignity was lost when using lifts. This problem was particularly noticed in Hospital A. *Though there were designated lifts for patients at* times ordinary people like visitors used them as well. One patient from Hospital A made the following comment:

> When I went to theatre using the lift, some people came in the lift and it happened to be someone I know. Obviously she was going to tell my family. I didn't want them to know that I was admitted to the hospital and being a small town it makes it worse. All my dignity was gone. (Female: HAP 2)

Some patients and nurses felt that there was lack of confidentiality in the lifts. Whilst it is the responsibility of the management to see that lifts are designated only for the use of patients' transportation, nurses and other health care workers also have a responsibility. They should discourage the use of patients' lifts by others so that dignity can be maintained. This lady wanted her admission to hospital to remain a secret but obviously it did not. This led to a breach of her confidentiality and caused

embarrassment. This emphasises the importance of maintaining patients' dignity even when being moved from one area to another.

In conclusion, it is evident that the availability of resources were necessary in the maintenance of patients' dignity. However, they were rather restricted or ill functioning. There is an urgent need for this to be addressed. It is clear from nurses' comments that they were frustrated due to the constraint of resources. They felt helpless and trapped in problems which they could not do anything about. It is imperative that management and nurses should work hand in hand to make sure that facilities on wards are adequate and functioning.

7.4 Age

It emerged that the age of both nurses and patients had an effect on maintenance of patient dignity in some nurse-patient interactions. This applied to the ages of both nurses and patients. The findings have been presented in Table 7.

Table 7: **Nurse-patient Interaction - The Effect of Age Resulting in Embarrassment.**

Type of interaction	**Feeling Embarrassed**
Young male patients cared by young female nurses	Yes (B)
Young male patients nursed by old female nurses	No
Young male patients nursed by young male nurses	Yes (B)
Old male patients nursed by young female nurses	Yes (P)
Old male patients nursed by young male nurses	No
Old female patients nursed by young female nurses	No
Old female patients nurses by old female nurses	No
Old female patients nursed by young male nurses	Yes (P)

Key

Young - 16-30 years

Old - 30 years upwards

P - mentioned by patients only

B - mentioned by patients and nurses

There were no old male nurses in the sample. Three young male nurses expressed that they felt embarrassed when giving intimate care to young male patients. One of them, a 22 year old stated:

> Sometimes I can tell that I am intimidated by having a young bloke, [male patient] particularly private parts' care. I quite find it a lot awkward at times. It becomes an awkward position. I make sure we are two when we are washing the patient. (Male: HAN 14).

This was also expressed by young male patients who felt embarrassed when nursed by male nurses of the same age. These problems with such interactions also involved the opposite sex, especially when intimate procedures were carried out. In this research intimate care meant any care which involved patients removing their under clothes or exposing genital areas or breasts. It was either the patient or the nurse feeling embarrassed. Sometimes it was both parties in the same interaction especially when intimate procedures had to be carried out. Therefore, it did not matter who it was but there was some embarrassment as a result of breaching one party's dignity, especially with disparities of age. This was illustrated by a 22 years old female health care support worker:

> Perhaps it is like a young lad who comes in and is embarrassed because he had to be shaved for operation and there is a male staff on, I would always ask the patient if he minds me shaving him or prefer male staff to do it. (Female: HCN 21)

The nurse felt uncomfortable despite presenting herself as if she was doing it for the patient's sake. It was her who felt embarrassed. A 23 year old student nurse also explained her feelings when nursing a patient of the same age:

> Just because you have mentioned age, I find it easier with the older people compared with those of the same age as my self. To help some one with a wash or a bed-bath, I feel embarrassed. I don't know why. I suppose it is my own age. I don't know. (Female: HBN 10)

In all the above situations it was not clear why exactly patients or nurses felt embarrassed. However, one would speculate in terms of existing theories relating to these age groups. According to Erikson's (1966) theory young nurses in the examples above are in the intimacy stage; there is potential of attraction between the opposite sexes. The touching could easily be misinterpreted as an inappropriate behaviour from someone he or she is not attracted to. This could also be attributed to the fact

that around these ages they are conscious about their self image. They would feel uncomfortable undressing in the presence another young person with whom he or she is not familiar. The other explanation would be that, in all these interactions, nurses and patients were perceiving the situations as everyday encounters rather than hospital situations. Therefore, what was perceived was not matching with the expectations, causing some embarrassment in either or both of them. It is important that a nurse should be aware of the situations that may undermine their own dignity and take measures to address them, as nurses' embarrassment does affect patients' dignity. A nurse should feel valued first to enable her to value others (Sieh and Brentin 1997, Watson 1996).

Some male elderly patients felt undignified when nursed by young female nurses. Again it was especially when the nurse-patient interaction involved intimate procedures. They were made to feel as if they were being nursed by their own daughters. As stated by an 82 year old male patient:

> It is very undignified to be lying in bed having a young member coming in to wash you. It just feels I am being washed by my own daughter. (Male: HAP 34)

In the above example, the patient adjusted to a perceptual level of accepting being nursed by old nurses but found it difficult to be nursed by young ones. This may be because most parents would not undress in front of their children as this causes embarrassment. It is important that nurses should be aware that some elderly patients may be embarrassed when nursed by young nurses and should treat these patients with sensitivity and also encourage independence.

Mixing younger patients with older ones also brought a sense of discomfort among some patients. The younger ones felt out of place because of different interests which led to inadequate interaction between the two age groups. They felt their needs

were not respected as individuals. One of the patients also felt distressed on seeing elderly patients in hopeless states as this reminded him of things to come. He put it as follows:

> I do not know how to put it. I am 62 years of age. The age of the people that I am in with, I am possibly fifteen years younger. It is depressing to me to see others in a sombre, hopeless state they are in... makes me think that it is only 15 years to reach that age. Is that what I should look forward to? I am in the wrong ward. This is a geriatric ward. I know the word geriatric has changed. Due to this reason I do not feel respected. (Male: HBP 2)

This was disrespecting patients in a subtle way. This was also noted by some of the nurses.

> Because the age range of our patients is from 16 to 106 it is very difficult... I would feel bad if we put an 18 years old girl with three 85 years old incontinent elderly people. (Female: HAN 18)

The young girl would feel uncomfortable and anxious because her needs have not been respected. The nurse expresses her uneasiness but realises that due to the system she was unable to do anything.

The effect of age on the maintenance of patients' dignity needs to be acknowledged. It is also important to know the limitations of fulfilling certain patient choices. For example, while some elderly patients may not like being nursed by young nurses, this may not be achieved as these young nurses will get their experience by nursing a wide spectrum of patients. What is required is to be aware of the effects and also explaining to patients why certain choices cannot be fulfilled due to hospital limitations.

7.5 Gender

Gender was one of the factors which was found to influence the maintenance of patients' dignity. Gender means any classifications given according to the sex of a person. While some female patients did not mind being nursed by male nurses, a group of female patients felt uncomfortable with them. This was more pronounced especially when intimate procedures such bed baths or toileting were being done.

> Actually I do not mind very much because they are female nurses. I do not know how I would feel if it was male nurses. I would feel totally different if it was a male nurse. I know they have got a profession. They are all the same but I do not feel comfortable about it. (Female: HAP 7)

> I do not feel comfortable when it is a male nurse coming to give me a bed pan (Female: HCP 26)

The above illustrations show how some female patients felt uncomfortable when nursed by male nurses. This should be seen in a wider context, in the way males have been viewed in society in relation to nursing. Traditionally nursing has been a profession for females and patients are just slowly beginning to accept male nurses. Despite this acceptance it was revealed in this research that it was still much harder for some female patients to accept being nursed by male nurses without embarrassment. Some patients actually repressed the fact that male nurses were part of the nursing team. Because of this some patients perceived all nurses as female and male nurses did not form part of their perceptual adjustment level. That was one way of coping with the potential embarrassments which they envisaged. Interestingly, in contrast to patients' attitudes about male nurses, the majority of them seemingly did not feel embarrassed when being examined by male doctors. This was due to patients' expectations that doctors have to examine them in order to diagnose and give appropriate treatment for their illness as this was the main purpose of being in a

hospital. They had adjusted and expected to be examined as this was the only way to be diagnosed.

This corroborates the findings of Bauer (1994) and Back and Wikblad (1998) who had similar results. Like patients, male nurses also felt uncomfortable and vulnerable when nursing female patients in closed curtains by themselves. They felt they could not defend themselves if accused of indecent assault as it would be their word against that of the patient. This is more so with the present rise of litigation. This is expressed by the following comment from a male nurse:

> When I go behind the curtains with female patients, I am not only protecting myself but the patient as well. I am actually vulnerable, the patient as well but ... If they were to say well, staff nurse went behind the curtains and what have you. (Male: HAN 20)

All the male nurses interviewed found themselves in this ambivalent situation. Male nurses expressed conflicting feelings between their professional role of caring for patients and protecting their actions being misinterpreted by female patients. They felt vulnerable as they were always conscious that their caring might be construed as a sexual encounter by the female patients. This was emphasised by one of the male nurses in the following way:

> The abuse side comes to the fore front in your mind when looking after female. (Male: HAN 14)

This mutual discomfort between male nurses and female patients was confirmed by a male nurse who expressed that some female patients refused to have intimate procedures done to them and also by the fact that they had to have a chaperone most of the times before carrying out intimate procedures. This is consistent with research findings of Lodge, Mallet, Blake and Fryat (1997). The study was carried out to ascertain gynaecological patients' perceived levels of embarrassments with physical

and psychological care given by female and male nurses. 91 questionnaires were analysed and it emerged that some female patients did not like to be nursed by male nurses. This was mainly on intimate procedures such as bed baths and giving bed pans. This male nurse expressed his opinion:

> I might be looking at a 65 years old female patient. From their point view, if I am going to help them with hygiene needs, I always ask them whether they would prefer a lady to come and help them. (Male: HAN 12)

Procedures like taking temperature or taking blood pressures did not cause any embarrassment. Fanning (1997) raised this concern when he asked that "How can issues such as dignity and privacy be maintained if in order to protect himself a male nurse has to ensure that he is in "public" view when providing care?" p.9. This had an implication on staffing as two nurses were involved in a task that could have been done by one nurse or the male nurse would leave the procedure to be done by a female colleague as they sometimes felt helpless and found it difficult to ask female colleagues to chaperone. In whatever they did with female patients they had to be extra careful than their female counterparts. Because of this extra caution patients sometimes were left in states that they found undignified while waiting for female nurses. It was evident that the dignity of the male nurses was also at stake as this rendered them to feel vulnerable and also have a sense of insecurity and feeling of loss. This state of affairs was interfering with the nurses' ability of maintaining patient dignity. This brings in the argument that nurses cannot be expected to maintain patients' dignity if their own dignity is at stake. There is a need to explore and discuss these issues in depth during nurse training so that nurses will be fully aware of the effect of gender on caring patients. This male nurse who had four weeks to finish his training supports the fact.

> It is hard to explain, it is something I feel *pause*...coming from experience, picking up from patients, I can tell, they [female patients] are uncomfortable with you. (Male: HAN 10)

It shows the student is ill equipped to deal with such gender issues in the wards. He has an inner conflict between his role of caring and being rejected by those he is being trained to care for. This is supported by Milligan's (2001) research in which the aim was to facilitate reflection upon an aspect of practice chosen by the participants. Although patient dignity was not one of the practices explored by the participants, the study revealed a need for gender issues to be explored in nursing training. This research is specifically proposing gender to be emphasised relating to patient dignity. Training for nurses will be discussed in detail in Chapter 8.

It is important, therefore, for nurses to be aware of the effects of gender in the maintenance of patients' dignity. The perceptual adjustment level of each patient in relation to what he or she expects in relation to gender should be assessed. Patients need to be made aware of the gender of nurses available on the wards. This also applies to male patients as it appears that it has been taken for granted by the nursing profession that male patients will automatically accept being cared for by female nurses. At present the majority of nurses are female. However, discussion with patients on the gender of nurses on the ward will help the patients to adjust their perceptual level in relation to who is going to nurse them and enable them to be prepared for such situations. In Lodge, Mallet, Blake and Fryat's (1997) study it was found that patients who had no prior experience of hospital admission or being cared for by male nurses preferred not to be cared for by female nurses. The gender area in relation to patient dignity needs urgent empirical investigation as more male nurses are joining the profession. Certainly, further research would extent the knowledge and understanding of gender issues relating to the maintenance of patient dignity.

7.6 The Doctors' Ward Rounds

The doctors' ward round was identified by patients and nurses as one of the factors that had an impact on patients' dignity. In order to understand how the doctors' round affected patients' dignity, a discussion of activities before, during and after the round will be considered. A lot of preparation goes on before doctors' ward rounds; nurses have to make sure that patients are ready, and paper work must be ready too. Junior doctors assess patients in preparation; although all this preparation is for the review of the patients' medical problems by the doctors, it has been shown in this research that patients themselves are not properly prepared for the ward rounds. Not all patients are aware that in addition to their consultants, nurses and the junior doctors looking after them, there would be other health care workers during the ward round. As expressed by one of the patients:

> You do not have someone to warn you that other people will be on the ward round. You do not prepare for embarrassing situations which might make you lose one's dignity. (Male: HCP 2)

If patients were warned that they were to be examined in front of a big group before hand, they would prepare themselves mentally and be ready with questions to ask, thereby reducing embarrassment.

During rounds, doctors discuss and plan patients' disease management. This is also the time that they teach junior doctors and medical students. Some patients in all the three hospitals complained that medical jargon was commonly used which excluded them during ward rounds. Because of preoccupation with teaching and discussion, patients tended to be forgotten, resulting in patients not being involved in the discussions taking place around them. In one instance, a patient claimed:

> It is good you are addressing the issue of dignity. Doctors and nurses during ward rounds talk in jargons which I do not understand. They are dealing with my body that something is wrong with it. They talk over me rather than at me. They need to talk in simple statements that I can understand because I am not a medical person. It's just like your car. If it breaks down you take it to the garage you need to know in simple terms what is wrong with it. It is the same with my body; I would like to know what is exactly wrong with it. (Male: HBP 1)

Apart from lack of information, patients from the three hospitals felt as if they were objects and felt that this violated their dignity. They felt excluded from the knowledge of their own body and ignored. As shown in section 6.12, being ignored results in loss of dignity; this confirms the recent research findings of Stevenson, Barry, Britten, Barber and Bradley (2000) who examined 62 consultations, together with patients and general practitioners, to consider participation. Little evidence was found that doctor and patients participate in the same way; measures to maintain patient confidentiality were not taken, doctors did not lower their voices and other patients could overhear doctors' discussions. Patients felt let down. Poor communication between doctors and patients has occurred for a long time since early research of Ley and Spelman (1967) which found that there was poor communication between patients and doctors. In the past medical schools did not put much emphasis on the need for doctors to communicate with their patients. Doctors' behaviours in a ward round are mainly influenced by a biomedical model of disease. A biomedical model is a disease-centred model which focuses on the pathophysiology rather the psychological or social factors which patients experience. This is reinforced by educational training. Doctors in general were not taught interactive communication skills which were necessary for effective communication with patients (Tate 1983). Tate (1983) explained that the physician's ability to preserve his power in doctor-patient relationship depended largely on the ability to control the patient's uncertainty. Discussion without meaningful explanations maintains the doctor as a powerful

figure. Communication problems between doctors and patients are still manifested as revealed in this research. The problem has been gradually realised by the medical profession by incorporating more communication skills in medical training (Thistlethwaiste 1999, Henderson, Johnson, Barnett and Weaver 2001). As a result of poor doctor-patent communication there were problems between some patients and doctors. Some patients experienced vague fears and felt intimidated and vulnerable during ward rounds. Lack of proper communication did not help the patients in adjusting to their acceptable perceptual adjustment level.

The other issue which a number of patients talked about was being examined by doctors while other health care workers such as junior doctors were watching. There were varied opinions from patients. Others did not mind and did not feel embarrassed because they wanted to get better. Most of these patients had previous hospital experience and knew what to expect. For some it was a new experience, they could not conceptualise what a doctor's ward round entailed. Although they necessarily submit themselves, there was perceptual adjustment in relation to what they were expecting and what was happening during doctors ward rounds. One patient said:

> The complaint I have got is about my bowels, which is embarrassing really to tell someone. It is worse when two or three are standing there listening and they are examining you. I get embarrassed with that sort of thing. But it is one of those things. I suppose it has to happen that way. (Male: HCP 2)

The embarrassment came in because there was a mismatch between what the patient was expecting and what was happening during the ward round. The patient did not expect to be examined by a doctor in front of other people. It is clear from the patient's words that he felt as if he was being treated as an object and not as a human being. Similar comments were made from the nurses' perspective:

> Doctors round are intimidating for some patients. Sometimes six or seven doctors stand round the patient. Procedures are done in front of all these people sometimes without explaining why all these people are there. (Female: HCN 3)

Some patients expressed the view that if they were told in advance that they would be examined in front of a group of people they would prepare mentally for it. In other words, they would go through what was described in Figure 1 in Chapter 5 namely: realisation of care, anticipation, weighing the benefits and costs, necessary submission, adjust and then reach the perceptual adjustment level. Advanced preparation would have equipped the above patient with information which would help him to mentally adjust to the new situation, reducing his embarrassment and thereby maintaining his dignity. Some patients noted the arrogance of some doctors which made the patients feel devalued.

It follows from the above example that doctors and nurses have a role to play in maintaining patient dignity before, during and after the ward rounds. After each round, nurses are expected to implement doctors' instructions in relation to nursing. Nurses' duties include finding out from patients what was not clear during the doctors' ward rounds. The majority of nurses in all the three hospitals were aware of their role in maintaining patients' dignity during doctors' ward rounds. Mallik's (1992) study also demonstrated that some of the nurses mentioned patient dignity as part of their role in doctors ward rounds although they did not see it as a major role.

This research also revealed that the majority of nurses in the three hospitals knew that they had a role to play in the maintenance of patient dignity during doctors' ward rounds. What was not clear to them was the extent to which they had to play this role. For example, nurses saw their role as mainly that of closing curtains and not overexposing patients during rounds. The majority of patients appreciated how diligently nurses tried to maintain their privacy during the doctor's ward round. One

of the responsibilities nurses have is that of acting as advocates for patients; the role of advocate involves acting on behalf of the other (Tadd 1998). As already identified some patients felt vulnerable during doctors' ward rounds. Nurses need to assess and identify this. Nurses have an advantage over the doctor as they spend more time with patients and, therefore, easily develop rapport with patients; this situation should, therefore, be used in promoting patients' dignity. Besides, most patients in this research claimed that they felt more at ease with nurses because of the long term relationship which they developed with them. It was discussed in Chapter 6 that some doctors did not address patients by their preferred names and that patients were afraid to correct them. As an advocate of a patient during ward rounds, the nurse can intervene in such a situation and say "Excuse me doctor, John prefers to be addressed by his first name". During the round nurses can assess whether the patient feels ignored or requires more information. Reassurance by the nurse that she would come back after the round to clarify any issues the patient did not understand would give the patient confidence and maintain his or her dignity.

However, it was evident that the role of advocate was not fulfilled adequately by nurses because they concentrated on the doctor's discussions. Some nurses did not feel at ease during ward rounds; they found their dignity at stake too because doctors tended to talk to themselves, often excluding the nurses who accompanied them. Some of the nurses did not look forward to doing ward rounds because of the hostile and dismissive attitudes of doctors. A male nurse claimed:

> We have medics [doctors] who tend to be aggressive sometimes.....You have to be quite hard otherwise you become intimidated by doctors particularly the consultants. It does put you in an awkward position. (Male: HAN 14)

The nurse's own dignity was compromised as he experienced inner conflicts regarding his role and the attitude of the doctor. There were many more nurses who felt anxious

and vulnerable during ward rounds. This type of experience tended to make nurses passive during the ward rounds, claims which have been confirmed by research findings by Jones (1998) who stated that doctors dominate ward rounds. This corroborates this position. Similar findings were revealed in Manais and Street's (2001) study carried out in Australia. The study comprised of six registered nurses working in a critical care unit. Data collection involved professional journals, participant observation, individuals and focused group interviews. Findings revealed that nurses experienced enormous barriers to participate in decision making activities during ward rounds discussions. In the United Kingdom Mallik (1992) had similar findings. Whale (1997) more explicitly claimed that passivity has attributed to nurses not being assertive enough to contribute to discussions in doctors' ward rounds. It was implicitly inferred from interview data that a number of nurses involved in doctors' ward rounds were not assertive enough. For example, an experienced nurse who was a deputy ward manager could have intervened if she was assertive enough in the following interview:

Nurse:	The curtains are appalling..... because, they are not very covering. You try and pull them and by the time you get them round, normally the consultant has finished what he is telling the patient; any way; or you have got them half way round and the consultant might have whipped the sheet back and pulled it back.
Researcher:	Don't they wait until the nurse draws the curtains?
Nurse:	It is very difficult sometimes, if we are doing major consultants' rounds.
Researcher:	Are the consultants' not conscious that the curtains are not closed?
Nurse:	It depends on which one. It is not only one consultant, it is the medical profession as a whole; you have the very good ones and you have the very bad ones. (Female: HAN 18)

It is difficult to expect a nurse to think about patient dignity if she or he is not assertive and when her or his own dignity is at stake due to poor communication

between doctor and nurse. Unless these factors are improved upon, we could not expect nurses to play an active role in maintaining patient dignity during doctors' ward rounds.

To recap what has been discussed in this section, during doctors' ward rounds patients' dignity is not well considered. The senior doctors are too busy teaching junior doctors and students to the detriment of patient dignity. Therefore, patients felt that they were considered as objects rather than human beings who have got rights. As much as maintaining patients' dignity is a collective endeavour for all those involved in doctors' ward rounds, nurses, as patients' advocates, should realise their full role in terms of maintaining patients' dignity. Nurses need to reflect on their role in terms of maintaining patients' dignity in a broader way in relation to doctors' ward rounds, considering what each patient considers to be her or his dignity.

7.7 Summary for Chapter 7

In this chapter, it has been demonstrated that resources and structural factors play an important role in the maintenance of patient dignity. It has also been demonstrated that age, gender and doctors' ward rounds also had effects on the maintenance of patient dignity. Ways of promoting dignity in each one have been suggested. These factors should be seen as context related but, although they are specific to these three hospitals, due to their different organisational structures it is unlikely that these essential factors would be different in other hospitals. It is important to learn from this research that maintaining dignity is not as simple as one would expect. It does not happen in isolation but is meshed in a complex web of factors which influence its maintenance. It can also be learned from the discussions

how these factors affect patient dignity. Nurses from different hospitals can reflect upon their own practices to make them aware of factors that would affect the maintenance of patient dignity on every nurse-patient interaction. Whatever has been discussed in this chapter has implications for nursing as a whole including management, research and education. This will be the subject of the next chapter.

CHAPTER 8: IMPLICATIONS OF THE RESEARCH FINDINGS

8.1 Summary of the Research

This chapter summarises the findings of this research followed by their implications for nursing practice, management, education and research. The purpose of this research was to investigate patients' and nurse' perception of patient dignity as well as an exploration of the extent of its maintenance. Factors that influence its maintenance were also investigated. The literature and data gathered from participants in this research has confirmed that human dignity assumes a great significance irrespective of background, gender, and age or health status. Nurses and patients in this study endorsed that everyone needs their dignity to be maintained. The importance of dignity was reflected in the fact that nursing codes of conduct and Patients Charters' from different countries have embraced the need for maintaining patient dignity. It has been reiterated throughout this research that dignity is a human right that everyone deserves.

It follows that if dignity is of fundamental importance to an individual its maintenance is likewise of paramount importance irrespective of situations that the individual may find himself or herself in. These situations include the hospital settings which was the central focus of this research. Despite the overwhelming evidence in the literature of the importance of dignity and its maintenance, it has been revealed that there is little research on the concept. Though some attempts at definitions have been made which have assisted in conceptualising the term, they have not been specific enough to be of much practical use and in some cases dignity's attributes have been used interchangeably with the concept itself. The lack of a

specific definition of dignity has made it difficult to find a starting point in defining patient dignity and has resulted in health care workers and patients not having a common perception of patient dignity. A common definition of the concept between health care workers and patients would greatly assist in the maintenance of patient dignity. This research confirms the lack of a specific definition of the notion of dignity; it agrees with literature findings that abstract concepts like patient dignity are more easily grasped in observing the attributes of the concept. In this research nurses and patients came up with similar categories or attributes of the concept. There were some differences in the way that maintenance of these categories were perceived between the two groups. This difference has been attributed to a lack of awareness by a number of nursing staff that patients go through perceptual adjustment in relation to the maintenance of their dignity as a result of admission to hospital. Consequently on some occasions nurses and patients did not concur in what they thought patient dignity meant and how they thought it ought to be maintained.

In this research it emerged that patients went through a process of adjustment in relation to the maintenance of their dignity. This process has been termed "Perceptual Adjustment" and the resulting new level has been termed "Perceptual Adjustment Level" (PAL). It is a theoretical construct which can be applied in any situation in a hospital setting. It is within this level that patients define their dignity. "PAL" gives a clearer picture of how the various attributes are related to the concept, which are interwoven within it. It is through the perception of these categories or attributes that the maintenance of patient dignity is achieved. What helps patients to not lose their dignity is "PAL" which is constantly adjusted according to situations. "PAL", therefore, offers a more concrete explanation of patient dignity. The findings

discussed in this research and the proposals made, for example the introduction of "PAL", have implications for nursing practice, management, education and research.

8.2 Implications for Nursing Practice

It is of paramount importance that nurses are aware of this "PAL". The understanding of "PAL" by nurses has implications for day to day nursing activities. If a nurse is aware of "PAL", she will acknowledge that the process of adjusting in hospital starts before admission. The nurse's duty will, therefore, be to assist the patient complete this process and adjust in a realistic way in relation to ward activities. This will involve giving enough information and being seen to be empathetic. In this way patient anxieties will be minimised. Nurses need to understand and appreciate the make-up of "PAL" as this will make them concentrate on all categories of dignity identified by a patient. It is also important to emphasise that while in hospital "PAL" is constantly changing, being influenced, for example, by the changing hospital environment, state of illness and information given to the patient. "PAL" has been demonstrated to possess dynamic characteristics. Nurses need to understand and appreciate the dynamic nature of "PAL" in their assessment of patients' needs in relation to their dignity. The realisation by nurses that this will be an ongoing process will enable them to be aware of changes in the patient's "PAL" and enable them to respond to patient dignity needs appropriately. It is important for the nurses to know that this adjustment applies to all categories of patient dignity as patient dignity is the sum total of these categories, emphasising the significance of a holistic approach in dealing with patients in general.

This research has identified a number of indignities experienced by patients while in hospital, most of which were due to lack of awareness by nurses of "PAL". This resulted in nurses using their own standards of patient dignity. Environmental factors like lack of resources were identified as a cause of failure in the maintenance of patient dignity. Nurses should realise that the maintenance of patient dignity is influenced by multiple and interconnecting influences.

Maintenance of patients' dignity is an integral part of nursing care. As stated in Chapter 2, nursing care is a complex partnership between a patient and a nurse. Each partner brings to the interaction of his or her own personal values and perception of dignity and its maintenance which have been acquired through socialisation. Apart from acknowledging patient "PAL" and appreciating values within it, nurses should engage in self-awareness as this will prevent imposing their own values on patients violating their dignity. This research has demonstrated that losing dignity causes distress. It is therefore the responsibility of nurses to maintain patient dignity which is also emphasised by the Nursing and Midwifery Council (2002) Code of Professional Conduct. The next section has proposed a way of helping nurses in the maintenance of patient dignity.

8.2.1 Maintaining Patients' Dignity – the Way Forward

It is difficult to be prescriptive about the maintenance of patients' dignity as this will depend on situations and also on individual nurse-patient interactions. However, this research has proposed the use of six questions which can assist nurses in the maintenance of dignity within the context of "PAL". The following six questions will be useful: WHAT?, WHY?, WHO?, WHERE?, WHEN? and HOW?.

Although a number of nurses have utilised these questions to help them in planning and implementing patient care, it is clear that advantage has not been taken to utilise them specifically in addressing the maintenance of patient dignity. In every nurse-patient interaction nurses should consider *what* needs of dignity ought to be met. This entails the identification of what constitute each patient's perception of dignity within the "PAL". It is crucial, therefore, to establish this patient perceptual adjustment level earlier on during the admission of a patient to hospital and to continue doing this at every nurse-patient interaction. This is what has been emphasised clearly in this thesis. Patients need to be given time and be listened to so that they can feel accepted. This will facilitate openness and confidence. It will make it easier for patients to share their needs. Establishing "PAL" includes sensing patients' verbal and non-verbal cues as this may assist in picking up subtle points that may be relevant in the maintenance of dignity. For those who cannot articulate their position or are too ill to answer questions, members of the family should be asked until such a time that the patient is able to participate in the care. Families are in better position of knowing the needs of patients.

Why indicates a purpose. The task should be fully explained to the patient so that he or she knows why it is being done. This will assist the patient in perceptual adjustment. If the task is done as explained, the patient will feel that his or her dignity is maintained. It is then important to find out whether the patient minds as to *who* is going to meet these needs. This is particularly in terms of gender. If the patient has no choice at that particular time, this can be negotiated and discussed with the patient. *Where* the task should be performed should also be considered and discussed. This implies the awareness of the appropriateness of the place where the nurse-patient interaction is to take place. This will give the patient a choice of a place where he or

she will feel comfortable to expose himself and still feel dignified. *When* tasks or procedures will be done are matters which should be included in the discussion with the patient, if possible including a time scale. Hospital routines need to be explained and negotiated with the patient so that frustrations are minimised. For example, the patient might be warned that certain tasks will not be done at stipulated times because of staff shortage on the ward. *How* patients' needs are going to be carried out has a major impact on the maintenance of patients' dignity. This includes the performance of tasks within the patient adjustment level as this will meet the patient's expectations. The nurse should be aware of the potential embarrassment which can result from nurse-patient interactions. Nurses should carry out tasks within an atmosphere conducive to the promotion of trust in order for patients to feel at ease. The nurse should be seen to be genuine, empathetic and respectful to the patient. Depending on culture, timing and the receptivity of the patient, a sense of humour can help to reduce embarrassment. However, nurses should be aware of the limitations of humour because if used inappropriately it can itself cause embarrassment. Sensitivity to verbal and non verbal communication is important and the nurse should be on the lookout for these and deal with them accordingly by helping the patient to deal with the anxieties incurred due to loss of dignity.

For patient dignity to be maintained satisfactorily, all questions need to be considered and used at every nurse-patient interaction. This will make the patient feel accepted, valued and in control of the situation and feel dignified. The resources and routines of the hospital which will influence the maintenance of patient dignity should be considered too. The implications on hospital management will be the subject of the following section.

8.3 Implications for Management

Throughout this research there was a widely shared view among patients and nurses of the lack of resources necessary for the maintenance of patient dignity in all the three hospitals. The responsibility of addressing this deficit falls on management. In this research management will mean government and hospital authorities. The World Health Organisation (1984) declared that all member states should have built in mechanisms for ensuring quality care for patients within their health care system. This requires commitment from politicians, hospital managers and health care workers which includes nurses. The provision of quality care is in the forefront of current debate in the media, literature which includes the maintenance of patient dignity (NHS 2000) in health care. One of the major government proposals is clinical governance, which helps health care workers to improve standards of care (Crofts 1999). As part of this, the government has included "privacy and dignity" as one of the clinical benchmarks in raising the standards of care (DOH 2001). Benchmarking is defined as the process through which best practice is identified and continuous improvement pursued through comparison and sharing (DOH 1999). This emphasises the need to continuously monitor and improve the maintenance of patient dignity on hospital wards. It is encouraging to know that these strategies are already being implemented in hospitals as well as primary care. The importance of patient dignity as an integral part of care is also manifested by the commitment to it by the government, as highlighted in the Patient Charter and in the NHS (2000) plan. With this commitment one would have hoped that the government would put enough resources to enable the improvement of both patient care and the process maintaining patient dignity.

The hospitals in this study have, however, demonstrated a lack of resources. As a result dehumanisation of patients in hospitals still exists as the order of the day. More needs to be done in terms of provision of adequate resources both in quantity and quality. More nurses and ablutions facilities in hospitals are required so that patient dignity can be maintained. This problem is not limited to the three hospitals only; other hospitals have recently expressed similar lack of resources. Barber (2001) claimed:

> I think nurses do really care about dignity. But they find it difficult to maintain it in the current situation. At the moment nurses are trying to cope with the crisis in the NHS and that means dignity is one of the last things people think about. There is a limit to what we can do because there are not enough resources (p.24).

This research has revealed that there is a shortage of staff. This is despite an increase of 17,000 qualified nurses between 1997 to 2000 (Mullay 2000). It is apparent that this increase has had no significant impact on the national need for more nurses including those of the three hospital wards where the research was carried out. The NHS (2000) plan set a target of increasing the nurse work force to 20,000 by 2 04. Though this has been welcomed by the nursing profession, Buchan (1998) predicted that there would be a shortage of staff for many more years to come, making it a continuing problem. The need for more nurses is very urgent if patient dignity is to be maintained. As a result of this shortage, the numbers of internationally recruited nurses are increasing in the United Kingdom. According to UKCC (2001) 8,003 nurses from overseas were admitted to the register during 2000-2001 and more nurses are applying. While this situation remains on the increase, these nurses will continue to form a significant part of the future work force. This has implications for the maintenance of patient dignity. Overseas nurses will inevitably have different cultural backgrounds, with different values and beliefs and may, therefore, perceive patient

dignity differently. It is important that these nurses should have structured orientation programmes which include the maintenance of patient dignity.

The hospital management should also make sure that there are enough good quality facilities such as ablution for patients on the wards. Male and female patients should have separate ablution facilities and whenever this cannot be done patients should be made aware of the fact. Despite nurses' commitment, this research has shown that a lack of resources hampered maintenance of patient dignity. This frustrated them, leading to the lowering of their confidence. There is a need for managerial support in terms of resources. There should be continuous lobbying of the government so that more resources are allocated for health services because if resources are not provided, it will be impossible to implement the maintenance of patient dignity in hospitals. Whilst waiting for the increase of nurses, nurses should maximise the use of limited resources in the maintenance of patient dignity. This can be achieved better with improved nursing knowledge, skills and attitude. The investment in resources in order to enhance patient dignity is not, however a cosmetic matter or matter of general social justice. All the attributes on patient dignity studied here show that they also contribute to the patients' physical as well as mental well-being. The investment in understanding and accommodating patients perceptual adjustment levels is not only a question of ethics but of cost benefit.

8.4 Implications for Nursing Education

The cadre of nurses who participated in this research were registered nurses, health care support workers and student nurses. This section will concentrate on the implications of the research findings on education of these cadres. This research has

identified lack of knowledge, skills and poor attitudes by nurses as some of the factors contributing to the loss of patient dignity. The perceptual adjustment patients made when they were admitted to hospital was not realised by nurses. Assessment of skills relating to patient dignity were lacking among them. It was revealed by nurses that patient dignity was not emphasised during nurse training, neither in theory nor in clinical practice. This was compounded by conflicting information received by students from more experienced nurses in clinical practice. Health care support workers identified the same problem. Patient dignity was only mentioned in passing in the process of learning other clinical subjects. Most of the literature which is written and used in the teaching of health care support workers mentions dignity briefly while covering other topics. This is illustrated by a book edited by Swiatczak and Benson (1993) written for health care support workers. Recently Nolan (2001) has written a book, called "Care *S/NVQ Level 3"* which mentions patient dignity only obliquely. While such literature makes a contribution to the understanding of caring for patients, it undermines it by leaving out an important topic like the maintenance of dignity which patients cherish.

This research leads to the view that patient dignity should feature in all clinical practice books in detail. This inclusion will assist in equipping student nurses and health care workers with the knowledge, skills and attitudes required for the maintenance of patients' dignity. It is significant and reassuring that the nurses, student nurses and health care support workers themselves realised the need for training on the concept of patient dignity. This awareness could facilitate learning. Nursing education should play a major role in developing nurses' knowledge, skills and proper attitudes that will enable them maintain patients' dignity. It is crucial that all those involved in the training of nurses and health care support workers are aware

of patient dignity. Thus its importance should be highlighted during the training period. Learning needs in relation to patient dignity of specific groups of nurses should be identified and curricula must recognise the importance of patient dignity.

My current experience as a nurse educator confirms this; patient dignity is mentioned as part of other topics rather than on its own. It should be taught as a separate topic so that students can explore and understand the subject, from which should develop a greater understanding of its importance. It should then be threaded through all the teaching contents and emphasised in all relevant subjects that are being taught to student nurses and health care support workers. This will provide a firm foundation for the maintenance of patient dignity and help nurses' practice. Nurse educators should consciously see patient dignity as an important notion for student nurses and health care support workers, one based on nurse educators' philosophical beliefs relating to patient dignity. This is the importance that should be placed on the concept.

Although the responsibility for teaching methods rests with educators, it is suggested that experiential learning or "learning directly through experience" (Burnard and Morrison 1994 p.x) would seem to be the most effective mode of teaching student nurses in relation to patient dignity. Morrison and Burnard (1991) argue that experiential learning includes reflecting on action. They identified three aspects; personal experience, reflection on that experience, transformation of knowledge and meaning as a result of that reflection. It has already been pointed out in Chapter 4 that a person's perception of dignity is learned through socialisation. This means that student nurses already have a base on which educators should build on during the period of training, and it is important for nurse educators to be aware of this. Reflection can be summarised as learning by thinking on experience (FirtzGerald and

Chapman 2000). Marks-Maran and Rose (1997) stated that the purpose of reflection is to develop personal knowledge or self awareness. It helps to bring out aspects of patient dignity which were in the subconscious, so that they can be critically examined. The students individual perceptions of dignity can be greatly influenced by nurse educators, by encouraging students or health care support workers to explore their own values and beliefs relating to dignity. Self awareness will enable them to be more aware of their own dignity. By doing this they will appreciate dignity and be in a better position to dignify patients. They should reflect on experiences encountered in clinical practice and learn to apply the six questions proposed by this research in section 8.2.1 *what? why? who? where? when?* and *how*? Students should be able to identify patient dignity needs and know how and when to address these needs. If student nurses are trained to go through this process, patients' dignity will be maintained. Factors that undermine the maintenance of patient dignity such as gender and shortage of staff should also be explored so that they can be managed with. Advantage should be taken of knowledge and skills already inherent in training programmes, such as interpersonal skills and this should be related centrally to the core notion of patient dignity. It is important to explore and understand patient dignity at a theoretical level then follow it in clinical practice, and to make sure that the theory is based on practice. Ward experience makes the student nurse aware of the realities of dealing with patients. The part played by assessors and mentors is important in emphasising the significance and the maintenance of patient dignity among student nurses and health care support workers.

In training all staff, the concept of patient dignity is paramount and this can be achieved through continuing education programmes. There is particularly an urgent need for updating nurses in practice on the maintenance of patient dignity.

Knowledge, skills and attitudes acquired during basic training and through their professional experience need to be reinforced through continuous education. Recently similar conclusions have been reached by Lothian and Philp (2001) after conducting a literature review on the maintenance of dignity of older people in health care settings. For a concept that is taken for granted like patient dignity, experience is not enough. One has to reflect on one's perceptions and actions on a continuing basis. This is agreed by Wilkinson and Campbell (1997) who argue that experience alone does not result in understanding but one has to reflect upon experience to learn from it.

In addition to consolidating nurse's knowledge, skills and attitude, continuous education on patient dignity should also be aimed at assessors of students in clinical practice. This will confer proper guidance and good role models thereby avoiding conflicting information in practice. Their knowledge and skills will inevitably be very important in shaping the maintenance of patient dignity among student nurses. If assessors or mentors have poor understanding of what patient dignity is and if their philosophical belief is at odds with patients' requirements it is unlikely that they will be in a position to lead students in the right direction. This highlights the importance of emphasising patient dignity, in both basic and post basic nursing education programmes, as a central and practical concept which underpins all practice.

8.5 Implications for Research

This research has demonstrated the significance of the knowledge of patient dignity. The contribution of "PAL" to knowledge has been established and can be applied to a number of specialities in nursing practice. Furthermore this research tried to raise awareness of patient dignity in the nursing profession and should act as a

catalyst for more research. There is a need for more research to be carried out in different settings and with particular foci of attention. This will assist in refining the findings further and test the universality of these categories. Asking how nurses from different cultural backgrounds perceive patient dignity will broaden the understanding of the concept. There were other issues raised in this research which have the potential to influence the direction of further research on patient dignity. These include issues like inherent ideas of dignity and factors influencing its maintenance such as gender and age. Factors influencing maintenance of patient dignity in terms of resources require additional research in different wards from a variety of hospitals so that the effect of different organisational settings can be compared.

The literature review has highlighted a paucity of tools that were used in research relating to patient dignity. The phenomenological approach remains the appropriate choice for further research in exploring patients' perception in relation to their dignity and observational methods can be used to see whether nurses and other health care workers are actually maintaining patient dignity. There is a need for researchers to refine the tools for measuring the concept.

Developing and analysing concepts through research should be a continuing process. Chinn and Kramer (1995) assert that if the concept is important for nursing, even a limited study of experience is useful. Every piece of research on patient dignity will make a significant contribution to the concept. Culture is always evolving. It is logical, therefore, to assume that perceptions of dignity will also change with time, necessitating updating of the concept. Research findings will also be important in influencing nurse education and clinical policies.

8.6 Recommendations

As a result of this research the following recommendations are made:-

(1) This research has shown that patient dignity is important for every discipline dealing with patients' care. It is proposed that a committee that includes all groups involved in patient care be formed for each hospital to look into issues of patient dignity. The committee will be responsible for raising awareness through in-service training and monitoring the maintenance of patient dignity. It will encourage, carry out research and develop policies for the maintenance of patient dignity.

(2) It has been established in this research that patients would like to be asked what constitutes their dignity. However, it is evident that it was difficult for some patients to respond to this question spontaneously due to abstract nature of the concept. To give time for patients to reflect on their dignity and help them in the process of perceptual adjustment, it is proposed that information which can assist in the maintenance of patient dignity should be sent to all patients being admitted electively or routinely before the actual date of admission. This should be included in any package of information sent to patients before admission. The advantage of sending this information as part of the general package is that families can help patients in exploring their perceptual adjustment levels. The package should include information relating to patient dignity:

General information about the ward, its physical lay out, the number of shared wards and single wards, and the room the patient is likely to be admitted can be included. It should be made clear whether toilet facilities and ablution facilities are shared by both sexes. Patients should be assured that curtains are available for maintaining privacy in general shared wards. Information on the general routine of the wards the patient is to be admitted, including number of staff and gender should be included. The likely shortage of staff in the ward should be highlighted as well as their consequence. Doctor's ward-rounds and what they entail should also be explained. The patient should be assured that they will be addressed by the name they prefer. A section should be provided in the pack where the patient can be asked to add any relevant information concerning their dignity. Nursing staff should review this information with the patient on admission as it will form the basis in planning the proper maintenance of patient dignity, and the speeder care. Those admitted as emergency should be given enough information as soon as possible and assessed in relation to dignity.

(3) It is imperative that curricula for student nurses and health care support workers should be evaluated to ensure that patient dignity is being taught. Nurse educators should integrate the concept of patient dignity in all relevant activities. Dignity should also be taught in its own right as a separate topic so that nurses can explore it fully in theory. What has been learned should then be implemented in clinical practice

(4) Induction programmes for newly recruited nurses and health care support workers should include patient dignity and this should be consolidated by periodic mandatory sessions and workshops for all qualified nurses. This will ensure that nurses reflect on the concept at all times. The training should include assessment of patients in relation to patients' dignity. Nurses should be trained to ask specific questions in relation to patient dignity. Nursing models used in the implementation of nursing care should be evaluated to determine the degree of incorporation of assessment of patient dignity. Nurses should learn to implement the six questions proposed in Section 8.2.1 *what? why? who? where? when?* and *how?* Workshops should also be organised for nurse educators to explore and learn how to help students in the enforcement of patient dignity.

(5) The ward environment should be made conducive to the maintenance of patient dignity by providing adequate and quality resources with special consideration for people with disabilities. Private rooms for discussing patient confidential issues should be provided on each ward. "DO NOT DISTURB" signs should be used all the time while procedures are in progress in private or single rooms. This should apply to procedures that are being carried out within closed curtains in general shared wards. A regular inspection of ward facilities should be done by a designated committee, for example, checking curtains, toilets and bathrooms for faults. Any faults identified should be promptly corrected. Theatre gowns and nightdresses with slits which expose patients should be reviewed so that necessary changes can be made. It is

important to ensure and reinforce that lifts designated for patients are only used for patients.

8.7 Conclusion of the Research

This research has demonstrated how difficult it is to establish a narrow definition of patient dignity, largely because it is a mental construct. The central claim in this research is that patients necessarily submit themselves to health care workers and perceptually adjust in terms of how their dignity should be maintained in a hospital situation. The whole point about the concept is that it is a balance between the general requirements of all human beings, embedded in different cultures, and the specific needs of each individual. "Dignity" is a complex construct: but it becomes crucial in circumstances that make it vulnerable. The most obvious example of this is the frailty of illness and the subsequent dependence on others. This vulnerability can be undermining. Those concerned with the health care of those in their care realise that they are dealing with psychological entities as well as physical problems. The balance between the needs of the individual and the specialised hospital community, between the desire to be treated with respect and the actual helplessness and the dependence on others, and between the simple notion of assertive independence and the submission to the debilitating fact of illness, all show how complex and multi-dimensional is the notion of "patient dignity". No simple definition can be applied all the time. This is why health care workers must have an insight into how each patient adapts and reaches perceptual adjustment level (PAL). In essence, all the categories discussed in Chapter 6 are constituents of "PAL" which is unique to each person and changes with situations. The discrepancy between nurses' and patients' perception of

expectations within these categories of patient dignity has been noted. What has been emphasised throughout this thesis is the establishing of patients' "PAL" in order to determine the patients' dignity needs and acknowledging and meeting them accordingly. This entails matching these needs with tasks which are being done. This can be done by using the proposed questions; what? why? who? when? where? and how? What constitutes human caring includes self awareness, being sensitive and having good communication skills. It also involves being aware of factors which influence the maintenance of patient dignity as indicated in this thesis. Nurses should be aware that every patient has a need for dignity and maintaining it enhances the patients' wellbeing. Loss of it causes psychological distress.

Although this research provides a useful theoretical construct, "PAL", which explains how patients adjust in a hospital setting, limitations of this research should be acknowledged. First, it has to be noted that "PAL" comes about as a result of a perceptual process, which arguably, applies to patients who have the ability to perceive. Nurses should be aware that unconscious patients cannot define their "PAL" despite the fact that they still need their dignity to be maintained. Patients who may be conscious but have an altered state of awareness, for example, suffering from dementia or other forms of mental illness affecting perception, will not be able to adjust to "PAL", though again these patients will need to have their dignity maintained. This is where the nurses' professional judgement and involvement of family members are critical for the maintenance of patients' dignity. Second, the research was conducted in three hospitals from one county, therefore, the findings of this research need to be tested by further research in other hospitals in different counties and indeed in other countries for their transferability and universal applicability. Third, the data were collected from participants from surgical and

medical wards, subsequent study should include patients and nurses from other hospital settings, for example, psychiatric wards. This will allow further validation of the results of this research. Finally, except for one black patient all participants in this research were white. Although this reflects the local population from which patients were drawn, the findings may, therefore, be considered to reflect the views of white patients and nurses. Patients from different cultures may have different values and expectations in relation to their dignity; further research involving different ethnic groups would strengthen these findings and the claims made about them.

Despite these limitations, it is hoped that the findings of this study will stimulate positive changes in the nursing practice, leading to an improved maintenance of patient dignity. It is also hoped that the results of the research will influence nursing education and management and encourage further research in order to refine the notion of patient dignity and "PAL" as proposed in this thesis.

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APPENDIX A

A LETTER TO PATIENTS AND NURSES FOR INTERVIEW

University of Nottingham
Education Centre
Sibsey Road
BOSTON
Lincolnshire
PE21 9QS

Dear .....

I am a nurse teacher conducting research into patient dignity. Nurses are expected to maintain patients' dignity while in hospital. However, it is not clear what patients and nurses views are in relation to the topic. The aim of this research is to find out your views on patient dignity and also whether it is being maintained in hospital. While this research has no immediate benefit to you, it is hoped that the findings will contribute to the understanding of patient dignity and ultimately improve nursing care.

I will ask you questions, taking approximately thirty minutes and if you have no objections, the interview will be tape recorded. Participation in this study is voluntary and you can withdraw from the study at any time.

Information collected will be kept confidential and no names will be used in the study and final report. All tapes will be erased after the study.

If you decide to join, you will be asked to sign a consent form to indicate that you have agreed to be interviewed.

Thank you.

Yours sincerely

Mrs Milika Matiti (Researcher)

APPENDIX B

CONSENT: FOR PATIENTS AND NURSES

The nature of this Research Project and my rights regarding participation in it have been explained to me.

This is to certify that I, ... hereby agree to participate as a volunteer in this study with the understanding that:

1. There will be no health risks to me resulting from my participation in the research.

2. My identity will be safeguarded.

3. I am free to withdraw my consent and terminate my participation at any time.

Finally, I have been given an opportunity to ask for clarifications and all such questions have been answered to my satisfaction.

Participant .....

Researcher .....

Date .....

APPENDIX C

INTERVIEW SCHEDULE FOR THE NURSES AND PATIENTS

Thank you for accepting to take part in this study. The interview will be tape recorded and tapes will be identified by a number instead of your name so that you remain anonymous. The information you give is confidential and the recordings will be erased at the end of the research. There are no right or wrong answers, so feel free to provide honest answers to the questions asked.

A QUESTIONS FOR THE NURSES

1 What post do you hold?

2 How long have you been working in your post?
(For a student nurse: what year are you in your training?)

3 What do you feel are the important aspects of patient's care?

While the nurse is describing aspects of patients' care, the following questions will be asked to probe more answers:

If dignity has not been mentioned, the nurse will be asked what she feels about dignity in relation to patient care. For example:-

- What do you understand by the term patient dignity?
- How do you assess patients in relation to dignity?
- How do you feel about the maintenance of patient dignity in your ward?
- How do you ensure that patient's dignity is maintained?

4 What factors influence the maintenance of patients' dignity in your ward?

- What are the factors in your ward that help in the maintenance of patient dignity?
- What are the factors which hinder the maintenance of patient dignity in your ward?

5 Is there anything about patient dignity that you thing we have left out in this interview?

6 Additional questions for students:

How do you feel about your preparation in training in relation to maintaining patient dignity?

After interview, the following will be noted:

- Age of the Nurse
- Ethnicity
- Gender

B QUESTIONS FOR PATIENTS

1 How long you been in hospital?

2 Can you please describe your experience of care while in hospital?

To probe more information relating to dignity, the following questions will also be asked:

3 What are aspects of care that you consider important?

4 Do you think the staff treat you with a sense of dignity?
What do they do? How would you like to be treated in terms of dignity?

5 What are the factors which help to maintain your dignity while in hospital?

6 What are the factors which hinder the maintenance of your dignity while in hospital?

7 Is there anything about your dignity that has been left out in t his interview?

After the interview, the following noted:-

- Patient age
- Reason of admission
- Occupation
- Ethnicity
- Gender

PROBES:

The following are examples of other probes which will be used:

"What do you mean?" Or "Would you like to clarify on that?" "Can you give examples?" "Would you explain more?"

APPENDIX D

FIELD NOTES

Hospital: A **Date:** 23/6/2000

Patient/Nurse: MAIN STUDY 1 HAP1

Sex: FEMALE

QUESTION	DESCRIPTIVE NOTES	ANALYTICAL NOTES
Introduction		
How long have you been in hospital?	Since Wednesday	3 days
How have you experienced your	(smile) Everyone great	Generally good experience but
stay in hospital?	Patient was not told at the right time when to go to theatre	didnot mean what she said - wrong time of information
What is your dignity?	(Pause)	Difficult to define
	respect nor being haty - both	respect nor being arrogant
		Privacy
Is patient dignity being maintained?	- not really	
	- in the hands of doctors and	Submitting to staff
	nurses	

QUESTION	DESCRIPTIVE NOTES	ANALYTICAL NOTES
Do you want them to do anything in terms of dignity?	Not really	Still finding it difficult to define dignity
What aspect of care is important?	Everything	Not sure what to say
What are the factors which help to maintain patient dignity?	I don't know	Finding it difficult to explain
What are the factors that hinder the maintenance of Patient dignity?	I don't know Patient doesn't get embarrassed because she is used	Experience influencing the adjustment (perceptual)
Age bos	~~Patient~~ Patient would like to be addressed by Mrs.	

APPENDIX E

MAIN STUDY
HAP 1
(FEMALE)

Researcher: Thank you very much for accepting to take part in this study. As I have explained earlier on, what ever is being discussed here will be anonymous, in other words no names will be attached. There is no right or wrong answer so feel free to answer whatever you want to the questions asked.

Patient: If I don't want to answer any questions, can I leave it?

Researcher: Oh yes! It is up to you. If you also want to stop being interviewed while in the middle of the interview, I will respect what ever you say. Is that clear?

Patient: OK! No problem. Do you also come to work in this ward apart from teaching in the school?

Researcher: No.

Patient: They were short staffed here today. It is hard for them.

Researcher: How long have you been in the hospital?

Patient: Since Wednesday.

Researcher: Today is Friday. Did you come two days ago?

Patient: You are not counting the outpatients visits. Are you?

Researcher: I was asking about the period you have been admitted in the ward?

Patient: I came on Wednesday two days ago.

Researcher: How have you experienced your stay in the hospital?

Patient: Fine, everyone has been absolutely great *(smile)*.

Researcher: What do you mean by great?

Patient: Well, kind, showing consideration in telling you what is going on. In making you comfortable. I am not very good at this actually - to put things into words eh! Making sure you are comfortable, otherwise everything

is all right especially the doctors and surgeons, whichever way you look at it. I was just confused a bit, I thought it was going to last longer, about my stay here but they didn't tell me yesterday, they told me at dinner time today.

Researcher: What didn't they tell you yesterday?

Patient: Yes, they told me yesterday that, Oh! No! They didn't, they thought I was going home last night but they didn't. Do you see what I mean? I was supposed to go down to theatre so that they can look at my arm and go home this morning. They told me this morning. *(A laugh).*

Researcher: So you were not sure what was happening?

Patient: No *(A laugh)* No body was. There was another lady opposite me and another lady who is just there. We all thought we were going home at dinner time and because it didn't work that way and we gathered from the nurses and those in the ward that the surgeons and consultants were all down in theatre. They have been there since morning. So we got to wait a bit longer and my husband was coming this afternoon to pick me up and nurses still did not know. I mean it wasn't their fault and we found out later from who ever it was that they would like to have my plaster finish off because they cut in half last time. It was softer than this and I am staying overnight because they want to make sure it is all right. It has dried and I am all right.

Researcher: So are you happy with how you experience in the ward?

Patient: Apart from the pain, yes everybody has been very great. Nothing is too much for them. When someone has to go to the toilet with you, you start feeling it.

Researcher: How do you feel?

Patient: You start feeling it, embarrassed but they never make you feel uncomfortable, anything like that.

Researcher: Do you mean when they are taking you to the toilet?

Patient: Yes, you can't just believe it really. They help you get the clothes down and up. I was poorly last year and I had a set of panic attacks. I was absolutely terrified. I was in the hospital again. The nurses come with me to the toilet again not actually holding me but just come with me you know. When I finish, I shout.

Researcher: So they leave you there.

Patient: Oh ya! They don't go far away.

Researcher: When they take you to the toilet. Do they maintain your dignity?

Patient: Oh yes, they are wonderful. Oh Yes. You just feel as if you are just going for a walk- to the clinic or just around the corridor, something like that. You see what I mean.

Researcher: What do you mean?

Patient: It is all right.

Researcher: What is your dignity?

Patient: What is it? (A *long pause)* I told you I can't find words for it.

Researcher: What do you expect from the staff in terms of dignity? Let us say the nurses are coming to help you. The way, they were taking you to the toilet or they are coming to have a chat with you. How would you want them to conduct to you in terms of your dignity?

Patient: Well, with respect as I would definitely treat them with respect. But I would not like them to be, eh! what shall I say ' hoity toity' Can you understand that word?

Researcher: How do you say it?

Patient: 'Hoity toity'

Researcher: 'Hoity - toity' what does it actually mean?

Patient: Arrogant (*patient demonstrated how a person who is hoity - toity would present herself or himself).* Have you worked with somebody who walks like this? That sort of thing. Can you understand what I mean?

Researcher: Sort of being arrogant.

Patient: Yes. Some one who talks like this (*demonstrated in arrogant way)* something like that.

Researcher: How do you spell hoity-toity?

Patient: You have learnt a new word. I haven't got a clue.

Researcher: Yes I have learnt a new word.

Patient: There you go.

Researcher: Thank you.

Patient: You know who I mean who I am talking about. Here I talk to nurses the way I am talking to you because they are friendly. I don't mean any disrespect. In fact I mean respect. Do you understand what I mean? I make them joke.

Researcher: When they are talking to you, do you want them to do anything to maintain your dignity?

Patient: Not really because I have always taken that nurses and doctors in the hospitals do what is best, I am in their care and you put yourself in their hands. I mean if you come to me now , I wouldn't lay and sit there and saying, oh nurse don't do that , do this , but you will be saying come on you do this , then I do it. Whatever it is, I have got to do. If you see what I mean.

Researcher: Do you mean whatever the nurses or doctors ask you to do you will do without questioning?

Patient: Oh ya! I would not do it if it was another person.

Researcher: If you don't want to do it can't you say I don't want to do it.

Patient: Oh yes, I might say. Do I really have to do that or this or have I got to do it? If they say yes, I will do it. When I went to the clinic, they were taking my blood pressure and putting these pads on here (Showing *the chest*). Sticker pads.

Researcher: Do you mean the ECG? It is done to find out how your heart is running.

Patient: I stripped to the waist, one of the nurses giggled and said let me give you a bit of dignity and covered me up. I said oh! all right because she was a nurse, I was quite prepared and I had no reservations. They are just doing their job.

Researcher: So you are happy that way and you do not mind.

Patient: Oh yes.

Researcher: You said you have been here since two days ago. What aspect of your care do you think is important?

Patient: The care.... what?

Researcher: The care which you have received while in hospital.

Patient: To put into best, second best and so on.

Researcher: You can do that if you like. That is all right.

Patient: I think all is just as important.

Researcher: So everything is important to you.

Patient: Yes I mean, for argument sake, the lady who brings the tea around or the lady who sweeps the floor. I think every little thing is important. I am not sure that answers the question.

Researcher: Oh yes. What about in terms of the care you receive from nurses?

Patient: I was in the hospital last year about this time and I had an awful fall I had broken my ribs, pierce my lungs, my lungs collapsed and you can imagine that.

Researcher: What happened?

Patient: I tumbled down and I had tubes. I was in the intensive care and they moved me to the ward. All the nurses were splendid.

Researcher: Was it in this hospital?

Patient: Can you understand what I mean? Put it this way. Do you watch television?

Researcher: Yes

Patient: Have you seen Mrs Bouquet?

Researcher: Yes.

Patient: There was this lady in here absolutely double.

Researcher: A nurse or a patient

Patient: The patient in another bed - oh dear! when doctors came to sort her out. It was terrible. One night she wanted an ice cream. The nurse said, well darling I will fetch you one. She got it and then later she said I don't want it.

Researcher: She said she didn't want it but she had asked for the ice cream?

Patient: That is true. I cannot really understand treating the nurses like that. I really can't.

Researcher: May be it was how she was. Everyone is different and the nurses are trained to accommodate these differences.

Patient: It must be difficult for you nurses.

Researcher: Any other thing that helps to maintain your dignity in the ward?

Patient: I don't know. I find it a job to find the right words. When you are gone, I will soon think of it (*a laugh*). Put it this way, when things need doing, the job is done that is part of dignity isn't it? May be if you like doing something, either doing operation, without making you think you are a nuisance.

Researcher: Can you explain more on that?

Patient: Yes, but also in return the patient should be nice to their helpers. He is a person, that person needs dignity as well. I can't think anymore- I can't put anything else into words. Are you satisfied with that?

Researcher: I am satisfied, whatever you say, what are the things that hinder the maintenance of your dignity?

Patient: I don't know there is always improvement in hospital. I can't think of anything.

Researcher: Coming back to nurses taking you to the toilet what do you expect from nurses in terms of dignity?

Patient: The reason for nurses to take me to the toilet is that I don't fall down. Do you see what I mean? When they are behind me like that - when they come back and say are you all right, if I get up and if I cannot get up, they help me up and have a laugh at the same time. Then you don't feel undignified anymore.

Researcher: When they help you and at the same time you have a laugh!

Patient: That is right. If for arguments sake, you went out for the evening and you tumble down in the loo or something like that. Ordinary people probably will come and help you. But you feel a little bit..... Wont you? Do you see what I mean?

Researcher: You mean embarrassed?

Patient: Yes. I don't with the nurses on the ward.

Researcher: Do you feel embarrassed sometimes?

Patient: Not really. It is just getting used to it (a *laugh*!) because I have been brought up such an independent person and once you get used to the idea that someone is helping you then it is all right. You do get used to it and you take it not for granted. That is the wrong word but you take it what shall I say - in your stride.

Researcher: I beg your pardon what did you say? In your what?

Patient: In your stride. If you see what I mean.

Researcher: What do you mean by in your stride?

Patient: (*Pause*) Eh!! Eh!! Well like if she says take off your clothes and I would like to put these things -pads on (*showing chest).*

Researcher: Putting the E.C.G. on to monitor your heart. I am still not very clear.

Patient: I told you, I don't know how to explain things. It depends on the person who is doing it. You could say oh dear! but when the nurses are doing it you take it, and that is it. They are doing it. They are doing their job. I don't become embarrassed really because there is no need because they know me.

Researcher: So you tell yourself they are nurses, so they can do whatever. Is that what you are implying here?

Patient: Because there is a need.

Researcher: Let me put myself into a picture here. From the start you tell yourself they are nurses, they are doing their job, let them go ahead.

Patient: That is right.

Researcher: So you do not feel embarrassed in that way.

Patient: I used to feel embarrassed but not now.

Researcher: Why?

Patient: *(Pause)* -- I don't know.

Researcher: Is it because you are used to the nurses or because you have been in the hospital before?

Patient: Because I found out that if you have been nursed before for some reason, you get used. At first there is a bit of apprehension oh! dear what is going to happen? I am going to be laughed at. But once you have seen, how kind and considerate the staff is, you feel part of it. Somehow and are so grateful when they put you right.

Researcher: You don't feel embarrassed in that way.

Patient: No - Because for arguments sake, when the consultant wants to look at you or anything, just for a start you think oh dear! You go through that and then it just passes.

Researcher: It just passes.

Patient: Yes -You know they are going to look at you and see what is wrong and hopefully help to put it right,- so you relax.

Patient: We haven't had our tea. Have we? I haven't missed my tea.

Researcher: No you haven't

Researcher: If you have prepared yourself that this is a consultant who is taking my clothes. You do not really feel... *(Interrupted by patient)*

Patient: He does not take them off you do yourself- You take them off then you stand there and you say oh cracky! He is coming now - (a *long laugh*!) Do you see what I mean? And all over sudden he is looking at you to make it right what is wrong in you. So that is that.

Researcher: So how do they maintain your dignity?

Patient: Oh yes I give you another example- It is confidential anyway. I had a hernia repair. I felt so relaxed when the surgeon and the nurse entered the room to check the wound because I was going home. I did the wrong thing. (*Trying to demonstrate*).

Researcher: You mean pulling down the clothes?

Patient: Whichever to expose the part. Everything was pulled down (Patient *laughing*)

Researcher: So all the clothes were off?

Patient: Yes, The nurse just say -lets cover you up the doctor does not want to see you all.

Researcher: You mean the doctor pulled down all your clothes?

Patient: No, I did.

Researcher: You yourself?

Patient: Yes, because she said he wanted to look at the wound so I just went----

Researcher: So you took off the clothes and the nurse came and covered you up properly?

Patient: Yes. She just said, "You are not taking off all of it", he just wants to look at that. That embarrassed me. I told myself you fool. You shouldn't have done that, it really embarrassed me, but there you go- when you are nervous.

Researcher: Anything you want to talk about?

Patient: I do not think so. If you are happy with that then that is it.

Researcher: The next question is a personal one, In terms of age. You don't have to tell exact age - you can say either in 40's or 50's

Patient: I am in 60's you can have my age, I thought you are asking something else- I have never known my mother's age. When she died I had to find out from someone else. I always say I have never told anyone else.

Researcher: You have never told anybody your age?

Patient: Until I came to the hospital, everybody who comes, nurse or doctor or any of the orderlies or whatever -- what is your date of birth? *(A laugh)*.

Researcher: Asking your date of birth - how do you feel about that?

Patient: Well, now I think or I know why they do it. It is to recognise who you are is not but at first I thought my dignity was going.

Researcher: Anything else?

Patient: No I don't want people to know I have said these things.

Researcher: As I said whatever you have said - no names will be attached.

Patient: How are you going to know that our conversation will be good?

Researcher: You mean the conversation which we have had, as I said, I have interviewed other patients and I will put together what other people have said.

Patient: The respect is there they have to do the job. You are at ease with it. If you know what I mean. I am still remembering my incident of undressing -oh! When you are here undressing and dressing. Do you see what I mean? It is embarrassing.

Researcher: It could be embarrassing when you are in hospital dressing and undressing.

Patient: Yes. If you see what I mean. It is embarrassing until you get used to it.

Researcher: If you are embarrassed how do you want the nurses to reduce the embarrassment?

Patient: If the nurses want to do something, look at what she wants. She is doing her job.

Researcher: Before we started the interview, I did ask you how you would like to be addressed. You said by..... (First *names)* did the nurses ask you how you would like to addressed?

Patient: Oh ya! They used to do so but not now- modern times Once upon a time if you are a married person and you are talking to a 20 year old you are always called by Mrs, but these days they call you by your Christian name, wouldn't they? I suppose it is less formal.

Researcher: You would like to be called Mrs?

Patient: No, when I am with the nurses I am on Christian name because it makes them feel more friendly'.

Researcher: Did they ask you how you like to be called.

Patient: Yes they did - for argument sake. It's just like in the church. I take part in church services - during this time no way. I would call them in the church by Christian name, maybe afterwards when the services over-but not during service. It is just the same in the hospital. I still can't call nurses by first names, even when I know her. I will call her nurse. Do you see what I mean? I do not know why.

Researcher: You call the nurses, 'nurse'

Patient: Yes, but not shouting. I will just ring the bell - *A pause.*

Researcher: Anything more?

Patient: No.

Researcher: Are you alright?

Patient: Oh! yes I'm alright.

Researcher: Thank you for the interview.

Interview closed.

APPENDIX E

MAIN STUDY
HAN 4
(FEMALE)

Researcher: Thank you very much for accepting to be interviewed. As I said everything which will be discussed will remain anonymous. No names will be attached to the tapes and the notes I will write while discussing. There are no right or wrong answers, so feel free to provide an honest answer to the questions asked.

Nurse: Okay!

Researcher: What post do you hold?

Nurse: Registered General Nurse.

Researcher: Which Grade?

Nurse: E

Researcher: Already!!

Nurse: It is almost a year now.

Researcher: Congratulations.

Nurse: Thank you.

Researcher: How long have you been working on this ward?

Nurse: Three years on this ward.

Researcher: This is your first ward?

Nurse: Yes.

Researcher: How do you enjoy it?

Nurse: I love the ward. It is a very good ward. It can be very busy and one gets very tired when it is very busy. But generally it is very good. Very nurse led.

Researcher: What do you mean by nurse led?

Nurse: We work on our own initiative, although we work very much along the consultants. It is a ward where we do

make a lot of decisions and the doctors follow us if they are happy. This is how it goes. We are quite lucky really.

Researcher: The other question is that how do you experience your work generally?

Nurse: Very enjoyable, can be very satisfying, yes there can be the downside as well.

Researcher: What are these down sides?

Nurse: The down side eh! Very much eh! Oriented toward heavy work and because we have got trauma and elective cases. We can be absolutely choker blocked on Monday morning to get eight people. No beds. It is just pressure we get a lot of pressure particularly in the early shifts, but you get good side as well. Satisfaction.

Researcher: What do you feel are the important aspects of the care?

Nurse: Eh! I do find in this ward we are very good in trying to look at patient from the minute they walk in. The discharge planning is always on admission. We tend to look at the holistic care of the patient like who do they live with. What support services have they got. All that is addressed in the first hour of a patient being admitted which is good. This is the only way we can work here because if we need referrals to Occupational Therapy and Social Services, it can be done quickly. So I think the whole patient is looked at, but not always on the assessment. It may be that the nurse-in-charge will pick it up probably after assessment. You may get a Grade D who may go and assess the patient and it will take the Grade E Grade to come to come back and say "Who do they live with? What are the circumstances?"

Researcher: Why can't it be done by a Grade D nurse?

Nurse: Often it is not. *Faint voice* ... We try to bring that along to have everybody think in the same way, but it tends to be the more experience of the staff that actually addresses these problems eh! If we could get into lower grades it would help.

Researcher: Any other things which are important for the patient.

Nurse: *A pause.*

Researcher: I am not saying there are other things, but may be you have got other things to add which are important aspects of patients care. I don't know whether there are some other things. I am just asking to find out more. Anything else?

Nurse: Particularly patients' past medical history is quite important and how they have dealt with hospital admissions before. That can be very helpful particularly if you have a very anxious patient. How they have dealt with hospital admissions in the past. How the staff have been. Do they have worries of being in a hospital and particularly, silly things like do they have animals at home? Who is looking after the badger? Things like that even thought it may be totally irrelevant to you for the patient it could be very important. We do try.

Researcher: In relation to patient dignity, how do you feel about it in this ward?

Nurse: I feel it is probably not always assessed. On the blue Kardex, although we ask them, how do you feel about hospital admission? I think one way, I can get round it is how do you feel about hospital admission? Do you have any anxieties? And it will come up there. It is very difficult to assess the dignity. I feel it is difficult to know what questions to ask to elicit right answers. It is something that is quite "woolly". Very difficult to put a finger on really?

Researcher: My dignity would be different to someone's dignity. How would you describe patient dignity?

Nurse: *Pause.*

Researcher: What do you expect from patients in terms of dignity?

Nurse: Eh! It is very difficult. I think sometimes just one to one chat. Instead of questions, you can get a general feeling by just having a conversation. I don't think I ask direct questions regarding dignity. I probably take cues and things on how they are reacting and what they are saying.

Researcher: What are these cues?

Nurse: Sometimes I find when we have consultants and think the older woman would not like to have their vests. Things like that and – just may be the way they generally act. It is very difficult to ask direct questions.

I think a lot of it is done on how you feel with the patient and how much confidence you have got – with the rapport you have established.

Researcher: Okay, you have said it is difficult to assess because of the abstractness of the term, when you are doing a procedure on a patient how do you maintain patient dignity?

Nurse: First, I would ask the patient if they have got any concerns with what I am going to do. Say, if it is a catheterisation. Has he had catheterisation before? How did he feel when he had the catheter? Did you have major worries? Eh! Did you have a smear test in the past? Thinks like that, just generally how they feel. So regarding catheterisation, you try and maintain their dignity as much as you can by covering them up, explaining what you are doing, and just keep them as comfortable as possible till the procedure is done.

Researcher: Anything else?

Nurse: I do not think so.

Researcher: From your point of view as an E Grade staff nurse, what are the things you think can enhance the maintenance of dignity?

Nurse: I do believe it is quite difficult on this type of ward with four bedded bays. It is easier when you are in a side room, when you can close the doors then you have got privacy. I was thinking a four bedded bay you can't get away from hearing every word that you are saying and if they are having a procedure done – even if they are having an ECG. It is still invasive and everyone can hear what is going on, so in four bedded bay I try to keep my voice down as much as possible to make it as comfortable as I can for them. To make sure that curtains are closed. Our curtains on the wards don't always pull round properly. They are usually hanging down. You know just little things like that. You will often find that somebody is using a bedpan and the curtains are slightly open and if people can miss it and if it was me sitting there I would be mortified. You should always make sure that privacy is maintained.

Researcher: So what has been done to the curtains which are not closing?

Nurse: We are trying to get people to mend them, eh! It does not work as quickly as would like you know! We try; I think the patients do understand. They are quite understanding really. If someone is going to use the toilet for the first time, may be after their first knee operation, I would rather let them go to the toilet even though it may be difficult and probably having pain and discomfort. I would rather take them to the toilet. So that they can go in private and sit in the room with a commode. I don't like commodes in four bedded bays, I think it is unnecessary. On the odd occasions they can use the commode but most of the time they can be wheeled to the toilet.

Researcher: Coming back to assessment, you are saying it is difficult to assess the patient and difficult to pin point which questions to ask. So in other words may be if I put it this way, do you document assessment in relation to dignity?

Nurse: Yaa!! I tend to ask them how they feel about the admission, are there any requirements not met? That tends to be well documented. I tend to change bags in the toilet. Things like that get probably well covered. It is probably due to my lack of awareness and how to get around it. It is something we tend to forget.

Researcher: The reason why I am asking is because on the assessment form there is a section of the assessment form about privacy and dignity, and I am wondering what you actually put on it.

Nurse: Yaa! I tend to put 'privacy dignity maintained' at all times. I tend to write like that, probably like I say. Are there any special requirements? And the patient will be saying not so well, we will try to maintain your privacy and dignity as much as we can, so really I am just repeating myself.

Researcher: The other thing is that as you said my dignity might not be your dignity, if it has not been assessed, how do you know that you have implemented patient dignity?

Nurse: Very difficult.

Researcher: Very difficult. Do you see what I mean there?

Nurse: Yaa! Yaa! It is very 'woolly', I feel, I do not think that the assessment part of dignity is filled properly. I feel a lot of it is left blank by individuals because they

probably do not know how to get round the subject. Sometimes it may be just lack of awareness really. I do not know. I found it very difficult, also, it would have been very simple if they just said I have got these needs, some of them would say I have not got any problem at the moment.

Researcher: Are you still okay with time?

Nurse: Yes.

Researcher: What were we talking about? Oh! We were talking about the difficulties of assessment.

Nurse: We are talking about things we actually do to enhance the maintenance of patient dignity. Using the family eh! You might get vibes from the family what he is not happy with, I do not know. After doctors examining them, then you can go back to the patient and ask whether there was a problem with the examination, but we are not proactive. You tend to deal with it after it has happened. I don't think we give much care to privacy and dignity. You do it generally as you would like to be looked after yourself. I don't think we address it.

Researcher: So the reference point is yourself?

Nurse: Yes, it is how you feel.

Researcher: I know you have mentioned about the curtains, is there any other thing that hinders the maintenance of dignity?

Nurse: I think the ward layout is difficult. If we could have single bays, which we know we can't, probably you get more privacy there. I do not know what we could do really. Sometimes the consultants attitude on the ward, they always pull curtains around, at times they could be a little bit thoughtless.

Researcher: In what way?

Nurse: Many when examining, they do not pull the curtains back (*nurse laughing*). If it is the leg, we tend to bring them this way (*demonstrating*). You know may be we could get the ethos of trying to get round to them, saying 'how would you feel, me lifting the covers from you?'

Researcher: We have always talked about patient dignity, now in that case, you as a nurse, can you say no to that?

Nurse: Yes we do, you try sometimes, they are good generally but sometimes you get the odd one and you say God please *(nurse laughs)* you are fighting with the covers. It is very rare but things like that tend to bother me. I am sure they also bother the patient. So you try to correct the situation but you do get embarrassed for the patient. It is just changing attitudes.

Researcher: Is it only the consultants?

Nurse: Habit of everybody really, I do find that they are few, probably they are just busy, they do not think.

Researcher: You talked about busy, how does busy hinder the maintenance of patient dignity?

Nurse: Tend to do a bit fast than they should may be. It shouldn't be like that but they cut corners. You can see corners being cut eh! I know I am obsessed with curtains but curtains may not fully come round. Just things like that. I think sometimes it can be eh! I can not think of any particular incidence but I think if you are busy, you tend to be so busy and something *(patient dignity)* which you may not automatically think of. You may be too busy with whatever you are going to do and probably it could be fleeting thing in your mind unless you are reminded.

Researcher: You have mentioned fleeting thin, what is that? You have puzzled me.

Nurse: It may be something of which you think of very quickly in your mind.

Researcher: All right any other thing.

Nurse: I do not think so, think so.

Researcher: Anything you think needs improving in relation to patient dignity?

Nurse: I cannot think of anything on top of my head. No, may be if we could have a bit of awareness – then that is up to the individual. I think you know, just exploring with them what they feel on the issue. Generally it is difficult, particularly if the patient is not willing to. Some of our patients are not willing to communicate at

all. On admission and you have to bring up the nursing things, how do they cope with the bowels, do they walk, that is a difficult assessment but for the patient who are very good to talk to you, ether you will just spend 5 to 10 minutes saying, how do you feel about dignity? Do you have any problems? Is there any thing you want not doing? Probably it could be incorporated. I feel it is something which is forgotten sometimes by everybody really. I don't know the best way of addressing it, I don't know. It is not something which comes up in general conversations. It is something you address when it becomes a problem.

Researcher: Is there anything about patient dignity we have left out in the interview?

Nurse: No, I don't think so. It is something that I have not really thought about although you do it naturally. I don't ask the patient about dignity. You probably go round in circles and you address it. I don't really use the word dignity.

Researcher: But you feel you do it automatically.

Nurse: Like I say, it is very much how I feel, I have been quoted to say to somebody to say recently "How would you feel?"

Researcher: What is a patient asking you?

Nurse: No it was me asking a consultant asking about a patient. I said how would you feel. It is very much you own perception, probably not theirs.

Researcher: This question is personal, it is about your age. You don't have to tell me about your exact age, you can tell me you are in your 30s or 40s. What age are you?

Nurse: 27 years old.

Researcher: You still look like one of 18 years.

Nurse: Thank you.

Researcher: How long have you lived in this area?

Nurse: Most of my life.

Researcher: Anything else you would like to talk about?

Nurse: No.

Researcher: Thank you. That is the end of the interview.

Interview ends.