Protecting dignity

Doctors must cease protecting dignity, and strive to enhance it. This is critical amongst our elderly patients, who are the most vulnerable yet stand to gain the greatest benefit, both psychologically and physically. For too long the practical application of dignity has been left to the nursing profession, yet without a collaborative approach elderly patients suffer unnecessarily. Improvements in both education and communication are essential.

Tim Robbins **Oxford University**
email tim.robbins@bnc.ox.ac.uk

A dictionary definition of dignity would be "the state or quality of being worthy of honour or respect.[1]" However for a topic so critical to quality elderly care, we need to go much further than knowing the base meaning of dignity. The dictionary definition seems quite at odds to the expected usage from everyday medical practice, though strangely, a definition of dignity is often absent from specialist medical dictionaries.[2] Indeed on deeper inspection we find that dignity is a relatively new concept in medicine, emerging in the 1970s and then almost exclusively in relation to the dying process.

Alarmingly there remains very little consensus on it's meaning, and a BMJ article of 2003 even questioned it's purpose; arguing it to be an artefact of Roman Catholic writings that crept into medical ethics.[3] To seek a more useful definition of dignity, we must seek to ask those who are involved with it on a daily basis, and indeed the Royal College of Nursing noted an absence of clear guidance on this important topic, and have drawn up a statement of what they believe dignity to be. This provides a useful and practical definition for modern medical practice: "Dignity concerns how people feel, think and behave in relation to the worth or value of themselves and others. Dignity may be promoted or diminished by: Places: physical environments and organisational cultures. People: the attitudes and behaviour of nurses and others. Processes: how care activities are carried out."[4]

Dignity as concept, is made far more complex by a realisation that it is specific to the individual, and based on each patient's values, standards, norms and culture.[5,6] Therefore we can only truly comprehend what dignity means when we act on a case by case basis and take the effort to enquire from our patients what they think of their current and past situations. When we comprehend this, it becomes apparent why it is so often our hospitals' geriatric patients who are at greatest risk of their dignity being compromised. The reasons are threefold; firstly the geriatric giants universally restrict older patient's abilities to influence, and interact with their environment and healthcare staff[7] and so are unable to give that vital, personal information. Secondly these patients are repetitively or permanently in contact with healthcare services, with the potential for a steady erosion of their personal values, standards and norms, resulting in a progressive cumulative decline in their expectations and subsequent demand for dignity. Finally these patients were brought up on traditional patient-doctor models and are thus far less comfortable to discuss their grievances or concerns with the healthcare, or more especially, the medical team.[8]

Dignity's importance

The initial medical application of dignity solely to the dying process was woefully inadequate, and with better understanding of the term, it is clear that dignity's importance lies in life, and the benefits it has on life are far more wide ranging than many might suspect. Traditional views of dignity identity benefits to older patients' so called life spirit,[9,10] their sense of freedom and responsibility,[11] thus enhancing their self respect.[9] There is further strong evidence that an attention to dignity in the healthcare setting enables successful coping strategies to be developed to help deal with the patient's changing health and lifestyle.[12] Improving these psychological elements is no doubt

essential to high quality elderly care, yet the mind and the body are linked[13] and good psychological care, with due attention to dignity has been shown to improve diverse physical outcomes, including neuro-cognitive outcomes,[14] fall risk[14] and cardiovascular risk.[15] The postulated mechanism is that violations of dignity cause an unhelpful activation of the stress response and subsequent hormonal changes, potentially also involving psychological depression pathways.[15] It is quite remarkable that "a distinctly subjective experience grounded in social and political relationships"[15] can have such a profound impact on health and survival. Indeed this subjective concept has actually been shown to significantly benefit health at the population level[16] suggesting that dedicating more time to improving dignity in our elderly populations could have significant wide-ranging impacts on healthy ageing.

We must especially target our elderly populations, for their health is most at risk; they are more likely to experience dignity violations as described above and also have been shown to suffer more physical harm from such violations.[13] Furthermore that harm is occurring in bodies with already limited physiological reserves. More alarmingly still is that dignity promotion is particularly expensive within geriatric populations, and there are long standing questions by some as to whether this is something we can afford.[17]

Physicians and dignity

In our elderly populations it is clear that dignity is a therapeutic tool as much as any medication or operation. The selection, prescription and direction of such therapeutic interventions in a hospital elderly care setting, is a doctor's[18] or more especially a geriatrician's duty. Indeed this is clearly outlined in the General Medical Council's guidance "Duties of a Doctor."[19] What is alarming is the absence of this subject from medical school syllabi,[20] effective teaching on the subject,[21] or even evidence of research into how to teach such concepts to students. In addition to the absence from education, overall the medical literature carries many articles on the dignity of creating life by genetic engineering[22] and dignity around death[23] but there are very few articles covering practical means by which doctors can promote dignity, and none at all (based on a Scopus literature search of terms "geriatric" and "dignity") focused on dignity in our elderly populations. There is, I believe, a very clear explanation for this; it is the commonly held belief that dignity is to be "maintained" and research is therefore not needed to build on an already set and established baseline. To a doctor maintaining dignity applies to clinical examination, preparation for surgery and minor procedures. It is therefore a short term, time limited factor for when the doctor is in direct contact with the patient. Furthermore medical educationalists can see this baseline as an untaught, but naturally attained part of a medical school education, or even the entry criteria.[24] As outlined above however, simply maintaining dignity is completely unacceptable, we must seek to actively improve it.

Nurses and dignity

In the absence of a meaningful medical research literature covering dignity we must look elsewhere. Fortunately the nursing journals provide an abundance of practical, sensible and cost effective solutions to not just maintaining, but improving patient dignity, that clearly highlights the nursing professions dedication to this area. Indeed the Royal College of Nursing's stance is clear; "Dignity: At the heart of everything we do.[25]" They are prepared to motivate both nursing and healthcare leaders to ensure they are able to fulfil this,[26] with particular success recorded in ensuring the dignified care of elderly people.[27]

The nursing professions dedication to dignity would seem to be beyond question, however recent media coverage could disagree.[28,29] It is interesting to consider that doctors, whose governing body places dignity equally high on their professions proscribed duties, have seemingly escaped such criticism. Undoubtedly however our healthcare system is an interconnected one, and one profession cannot act alone in such a broad ranging and overarching challenge such as dignity. It could well be argued that the physicians have dragged their heels, and the nurses have paid the price. The need to support our colleagues has however become more acute for nurses who are finding it increasingly difficult to dedicate time to dignity and the psychosocial care of their elderly patients.[30] Furthermore the physical benefits of such dignity increasing interventions are hard outcomes to measure and as such are often ignored and superseded in a healthcare system with significant financial and manpower constraints.[30] We, as physicians therefore, owe a debt to the nursing

profession; we have left them isolated in their attempts to strive for dignity, isolated when the media criticised dignity standards in hospitals, and yet now to improve we require their extensive research.

Improving dignity

The nursing literature provides a strong evidence base for dignity improvement; as doctors we must study this, and identify those improvements which we could implement. Baille et al[31] identified five such improvements for general hospital patients: recognising vulnerability to dignity loss, enhancing privacy, improving communication with family and building relationships, care environment improvements and addressing issues that matter to individuals—such as clothing, mobility aids or dentures. Specific research has also focused on elderly patients, here there is increased emphasis on maintaining identity, creating community and sharing decision making.[32] Ward leadership, actively seeking feedback on patient satisfaction, increasing staffing levels and working in partnership with private and voluntary organisations have also all been shown to produce a positive effect on geriatric patient outcomes.[33]

It is clear therefore that patient dignity can be improved by both a systems (privacy and environment) and personal approach, though naturally these categories overlap. What is most important is that the personal improvements almost universally centre on the importance of communication, but that communication must be targeted specifically to improving dignity. Targeted communication requires an understanding of what dignity is and what influences it. It is essential to understand that dignity is a subjective, personal concept,[5,6] but also that it exhibits significant intra-individual variability dependent on how unwell the patient is, and what level of indignity they are prepared to endure for recovery.[34] Useful communication with patients therefore is grounded on theoretical understanding, hence the importance of education whist at medical school and through continued professional development. There are however significant hurdles to educating students about the importance and practice of dignity, particularly towards older people.[35] Indeed certain seemingly innovative learning tools have been shown to actually have a negative impact and attitude towards elderly people and their dignity.[35]

In addition to the communication between patient and caregiver is the importance of doctors and nurses

working and communicating in collaboration; without both parties involved appropriate dignity is hard to achieve. Dignity during life, and the understanding that dignity provides physical benefit are clearly relatively new concepts, it is therefore essential that doctors develop innovative tools and approaches to maximise the dignity of our elderly patients. It is therefore reassuring that innovative approaches are now being taken to inform and educate doctors about dignity, including an online module provided by the Institute for Healthcare Improvement released in July 2011.[35]

Conclusion

Improving dignity amongst our elderly patients is a challenge, it is challenging to teach, and challenging to implement. Nevertheless the benefits are potentially immense to our patients and their wellbeing, especially to the vulnerable elderly population. We must set our sights beyond simply maintaining dignity but actively seek to improve it, which we can only do with fuller understanding. Geriatricians can no longer delegate this responsibility to nurses, but must take up the challenge and collaborate fully, focused on improved and educated communication. This topic also has a much wider importance; illustrating the importance of the nursing literature to physicians, encouraging us to bridge that gap and become fluent in each others research. Geriatricians are perfectly placed to lead such innovation, and their patient group perfectly placed to benefit from it.

Conflict of interest: none

References

1. Concise Oxford English Dictionary, Oxford University Press, 2011
2. New Revised Webster's Medical Dictionary, The Lewtan Book Line, 2004
3. Maklin R. Dignity is a useless concept. *BMJ* 2003; **327**: 1419–20
4. Adapted from RCN 2008
5. Killmisdter S. Dignity: not such a useless concept. *BMJ J Med Ethics* 2010; **36**: 160–64
6. Anderberg P, Lepp M, Berglund AL, Segesten K. Preserving dignity in caring for older adults: a concept analysis. *Journal of Advanced Nursing* 2007; **59**: 635–43
7. Isaacs B. An introduction to geriatrics. London : Balliere, Tindall and Cassell, 1965
8. Woolhead G, Michael C, Dieppe P, Tadd, W. Dignity in older age: what do older people in the United Kingdom think? *Age and Ageing* 2004; **33**: 165-170.
9. Edlund M. Plikten Att Vara en Ordentlig Människa den Äldre Patientens Upplevelse av sin Värdighet (The Duty to be a Proper Person – the Elderly Patients Experience of the Own Dignity). 1999 Åbo Akademi, Vasa, Finland (in Swedish)
10. Woolhead G, Calnan M, Dieppe P. Tadd W. Dignity in older age: what do older people in the United Kingdom think? *Age and Ageing* 2004; **3**: 165–170
11. Edlund M. Värdighet ur ett kliniskt perspektiv (Dignity from a clinical perspective). In Gryning 2 (Dawn 2) (ErikssonK. & LindströmU.Å., eds), 2003 Åbo Akademi, Vasa, Finland, pp. 123–132 (in Swedish)
12. Mann J. Dignity and Health: The UDHR's Revolutionary First Article. *Health and Hum Rights* 1998: **3**; 31–38
13. Shapiro D. The Bodymind Workbook. Element Books, 2009
14. Bicket M, Samus Q, McNabney M, Onyike C, Mayer L, Brandt J, Rabins P, Lyketsos C, Rosenblatt A. *Int J Geriatr Psychiatry* 2010; **25**: 1044-1054
15. The physical environment influences neuropsychiatric symptoms and other outcomes in assisted living residents. *Int J Geriatr Psychiatry* 2010; **25**: 1044–54
16. Chilton M. Developing a measure of dignity for stress-related health outcomes. *Health and Hum Rights* 2006; **9**: 208–33
17. Mann J. Dignity and health: The UDHR's Revolutionary First Article. *Health Hum Rights*1998; **3**: 30-38
18. Johnson M. Dignity for the Oldest Old: Can We Afford It? Dignity for the Oldest Old: Can We Afford It? *J Gerontol Soc Work* 1998; **29**: 155-168
19. G Robertson. Dignity and cost effectiveness: analysing the responsibility for decisions in medical ethics. *J Med Eth* 1984; **10** 152-154
20. Oxford University Integrated curriculum in medicine and surgery 2011-12
21. Quality in Ageing - Policy, practice and research (2005) Volume 6 Issue 2 July 2005
22. Quill T, Dignity and Death, *NEJM*. 1991; **324**: 691–94
23. Caulfield T. Human cloning laws, human dignity and the poverty of the policy making dialogue. *BMC Med Eth.* 2003; **29**:4:E3
24. BMA Medical School Charter September 2006
25. Royal College of Nursing- Dignity campaign pack
26. Gallagher A, Wainwright P, Baillie L, Ford P. The RCN Dignity Survey. Nursing Management 2009; **16**: 12–16
27. NHS Quality Improvement Scotland 2005
28. http://www.dailymail.co.uk/news/article-2082883/NHS-care-David-Cameron-says-nurses-told-talk-patients-hospital-wards.html
29. http://www.telegraph.co.uk/health/healthnews/8996459/Nurses-should-make-hourly-ward-rounds-David-Cameron-to-say.html
30. Rittman MR. In Nursing Theories and Nursing Practice F.A. Davis Co., Philadelphia, 2001; 126–130
31. Baille L, Gallagher A. Respecting dignity in care in diverse care settings: strategies of UK nurses. *Int J Nursing Practice* 2011; **17**: 336–341
32. Bridges J, Wilkinson C. Achieving dignity for older people with dementia in hospital. *Nurs Stand 2011:* **25**; 42–47
33. Nursing Management. 2011 Volume 18
34. Matiti M, Trorey G. Patients' expectations of the maintenance of their dignity. *J Clin Nurs* 2008: **17**; 2709–17
35. Nolan M, Davies S, Brown J, et al. Beyond person-centred care: a new vision for gerontological nursing. *J Clin Nurs* 2004; **13**: 45–53