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Guest editorial

Patient dignity: everyone's business in healthcare

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Previous editorials of this journal have drawn attention to issues of cultural competence (McGee and Johnson, 2004) and globalization and multiculturalism (Graham, 2005), among others, in the business of diversity within health and social care. I should like to address briefly a related subject that is often peripherally touched upon in discussions of healthcare education, research and management but which, I believe, should be at the centre of these endeavours. My subject is the concept of 'patient dignity' in healthcare. Dignity is a buzzword in every healthcare setting. Its relevance to all disciplines dealing with patients, including educators, researchers and practitioners in the management of patients' care, does not need defending as it is an important concept in every society.

That one's dignity needs to be upheld in whatever healthcare situation one finds oneself cannot be disputed; patients consistently demand dignity when they meet healthcare workers. The World Health Organization (1994) *Amsterdam Declaration* states that dignity is every patient's right. The European Region of the World Confederation for Physical Therapy (2003) urges physiotherapists to maintain patient dignity at all times. The International Council of Nurses' Code of Ethics for Nurses (International Council of Nurses, 2000, p. 2) declares, 'Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect. Nursing care is unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, nationality, politics, race or social status'. Patient dignity is highlighted in a number of government documents throughout the world, each from its own diversified perspective. In the UK there are documents such as *The Patient's Charter* (Department of Health, 1992), *The NHS Plan* (Department of Health, 2000) and others. Other professions with a code of conduct that underline the importance of patient dignity include the Royal Australian and New Zealand College of Psychiatrists (2004), the Occupational Therapy Association of South Africa (2005), the UK's Nursing and Midwifery Council (2004), the Australian Nursing and Midwifery Council (2005) – the list is probably endless.

The concept of dignity is abstract, multidimensional, complex, even elusive, although attempts have been made to define it. In the research I conducted recently (Matiti, 2002), the conclusion that patient dignity is an abstract concept which is socially and culturally driven came naturally. I assert after research that through the process of socialisation, each individual learns the standards of beliefs and values embedded in her or his culture; the maintenance of these standards boosts one's self-esteem and helps immensely in the process of healing. Because of its importance in patient care, I suggest that patient dignity has pivotal implications for the education and training of healthcare workers, for researchers and for hospital managers.

There seems to be an unwarranted assumption among professions that staff understand the concept of patient dignity. Johnstone (1994, p. 257) states, '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'. My research (Matiti, 2002) revealed that some nurses lacked the requisite knowledge, skills and attitudes for the maintenance of patient dignity on wards. It is obvious that the curricula for healthcare workers do not place patient dignity at the centre of their programmes. The notion of dignity is merely mentioned as part of the general subject of healthcare; it is hardly taught in its own right. I propose that patient dignity should take the centre stage in all healthcare curricula; that students and staff should be encouraged to explore the various complex avenues of this concept as part of their education and training.

In this respect I find Woogara's (2004) recent study in the UK challenging and revealing, for finding that medical and nursing staff had little awareness of the importance of government documents about patients' privacy. I find his conclusions encouraging – that the study of dignity should be integrated into undergraduate and postgraduate health curricula in nursing and medical education. Similarly, research by Jacelon *et al* (2004) conducted independently in the US, which corroborates these conclusions, is in the right direction.

They state that the creation of classroom situations that encourage students to interact in ways that enhance dignity helps them live these values.

In the UK, the government and the media are constantly bombarding us with the concepts of multiculturalism and globalisation. In his editorial to one of the issues of this journal, Graham (2005) suggests that we search for the meaning of globalisation and multiculturalism in a diversified healthcare. The pluralism that comes with global migration to create multicultural and global societies must pose challenges for educators in relation to patient dignity. Healthcare workers' schools have international students from different cultural backgrounds. Individuals who form the general public migrate to countries with different cultural backgrounds. There is movement of healthcare personnel to and from societies and countries with different cultural backgrounds. Caring for and treating patients are carried out by people from different cultural backgrounds. This state of flux inevitably brings or creates values and beliefs about human life depending on the cultural backgrounds from which individuals come; they all perceive the concept of dignity differently. Similarly, different perceptions of healthcare workers will be influenced by the context of the healthcare setting of their place of education and training, as demonstrated in our study (Matiti and Taylor, 2005), which involved international nurses in the UK. All this reinforces the necessity of exploring the concept of dignity in training in a diversified multicultural and global environment.

The cultural aspect of dignity can differ within communities in one country due to factors such as geographical location, social, educational and economic status (Campinha-Bacote and Yahle, 1996). Gerrish and Papadopolous (1999) urge nurse educators to create appropriate learning opportunities for students to develop what they call transcultural competence, which one might assume for similar studies on the notion of dignity for healthcare. Gerrish (2004) states that nurse educators are challenged to consider how they equip future nurses to practise in increasingly diverse communities.

Maintaining the dignity of patients in diversified multicultural and global communities depends on various circumstances. A general exploration of the different facets of the concept of dignity is required; factors that influence its maintenance, such as gender issues, should be explored. Healthcare workers need to reflect on what they take to constitute the concept of dignity for them. They will probably create their own construct of dignity, which will include how they might consider their own dignity to be violated in practice. The knowledge, skills and attitudes acquired during basic education and training and through their professional experience need to be constantly evaluated and reinforced. This can be done through induction programmes for newly recruited healthcare workers, which should be consolidated by periodic sessions and workshops; this in turn will ensure that the concept is reflected upon on a continuous basis. Further, qualified nurses need to be continuously updated on the concept of patient dignity. As Woogara (2004) suggests, joint reflective study days and/or seminars with doctors and nurses on the various aspects of maintaining patient dignity on the wards must be encouraged. Also, interprofessional learning among healthcare professions would be useful. All this calls for re-evaluation of all curricula for healthcare workers to see whether and how dignity is taught and maintained in practice, and what steps can be taken to improve.

Knowledge of what constitutes patient dignity and its management on the wards might be affected by many factors; these include shortage of staff, lack of resources, faulty equipment and others. As demonstrated in Matiti (2002), despite the nurses' commitment to maintaining patient dignity, lack of resources might hamper its maintenance. Shortage of resources and workforce are a factor that is common in different countries; the responsibility of addressing this deficit falls on management. The World Health Organization (1984) declared that all member states should build mechanisms for ensuring quality care for patients within their healthcare systems. This call requires commitment and the provision of resources from politicians, hospital managers and healthcare workers. Dignity is an integral part of patient or client care; therefore it is the business of all people dealing with patients.

There is no doubt that all countries and professions dealing with patients are generally committed to patient dignity. However, it should be noted that knowledge, skills and appropriate attitudes are required in its maintenance. This highlights the importance of emphasising patient dignity in undergraduate and postgraduate training of all healthcare workers. Induction programmes and update sessions or workshops should be organised for staff in order to discuss ways of better maintaining patient dignity on the wards. More research is needed to continue to understand the nature of the concept. By and large there is a commitment to the maintenance of patient dignity on the part of healthcare workers, but lack of resources often lets their noble efforts and good intentions down. However, with determination on everyone's part, that is, the politicians, educators, researchers, managers, healthcare workers in clinical practice as well as the patients themselves, 'patient dignity' would surely be everyone's business.

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