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Practice paper

Dignity, equality and diversity: an exploration of how discriminatory behaviour of healthcare workers affects patient dignity

Lesley Baillie PhD MSc BA (Hons) RNT RGN
Florence Nightingale Foundation Chair of Clinical Nursing Practice, Faculty of Health and Social Care, London South Bank University and University College London Hospitals, London South Bank University, London, UK

Milika Matiti PhD MSc BCur (Iet A) MCM RGN
Lecturer, Adult Nursing, Faculty of Medicine and Health Sciences, School of Nursing, Midwifery and Physiotherapy, Education Centre, Pilgrim Hospital, Boston, UK

What is known on this subject
- Healthcare settings are diverse communities of people with different characteristics.
- Equality is an important principle within society and healthcare.
- Dignity is a complex and multi-factorial concept.
- Dignity is a human right that is important to every individual in society, but people are vulnerable to a loss of dignity when receiving healthcare.
- Staff attitudes and the care environment and organisational culture affect dignity in care.

What this paper adds
- Discriminatory behaviour of healthcare workers can diminish the dignity of people accessing healthcare.
- Healthcare workers need to recognise and value the diversity of those they care for, and endeavour to reduce inequalities in healthcare experiences.
- A person-centred approach to care can promote dignity by responding to and valuing the diversity of individuals.
- Healthcare organisations should promote a culture that values diversity and person-centred approaches to care, in order to promote patients' dignity.

ABSTRACT

This paper explores dignity within the context of equality and diversity, and examines some of the ways in which discriminatory behaviour of healthcare workers contributes to loss of dignity in healthcare. We argue that dignity is a human right for every individual, but one that has different interpretations and may thus be easily compromised.

Healthcare professionals have an ethical and professional duty to promote dignity and to adopt anti-discriminatory behaviour. We argue therefore that a recognition and understanding of diversity and equality, and how these concepts can be applied in healthcare, is essential for the provision of dignity in care. A person-centred approach can support dignity in care, acknowledging and valuing each person's diversity. We also argue that organisations have a duty to support dignity and equality in care delivery and to recognise and respond to the diversity of their patient populations and workforce.

Keywords: dignity, discriminatory behaviour, diversity, equality, human rights, person-centred approach

Introduction

Dignity is an important concept in healthcare practice. Everybody accessing healthcare services has the right to have their dignity as a human being recognised and promoted. However, there are continuing concerns that not all patients have dignified care experiences; the underlying reasons for this are multi-faceted, but include both staff behaviour and the care environment (Baillie *et al*, 2008). This paper aims to examine the concepts of *dignity, equality* and *diversity* with reference to healthcare, and to analyse the ways in which discriminatory behaviour by healthcare workers contributes to undignified care experiences for patients. In this paper we use the term *healthcare workers* to include members of any profession or occupation involved in direct patient care (i.e. nurses, midwives, allied health professionals, medical staff and others). We conclude by considering how increasing healthcare workers' understanding of equality and diversity might support dignified care by challenging discriminatory behaviour in healthcare delivery.

The concept of dignity within healthcare practice

The word 'dignity' is frequently used, particularly in relation to the experience of healthcare, but it is often not defined and has been described as an ambiguous, vague concept (Tadd *et al*, 2002; Macklin, 2003). Nordenfelt (2003), in a detailed examination of the meaning of dignity, identified four types. *Menschenwûrde* is the dignity that all humans have equally, *merit* is due to position in society or earned through achievements, *moral stature* is a virtue arising from moral deeds, and *dignity of identity* is integrity of body and mind. The notion of *menschenwûrde* or human dignity is linked to the Universal Declaration of Human Rights (UHDR) (United Nations, 1948), which recognised the 'inherent dignity' of human beings, stating that 'all human beings are born free and equal in dignity and rights' (Article 1). Many countries have since incorporated the UDHR provisions into their laws and constitutions. The European Convention on Human Rights was signed in 1950 but was only incorporated into UK law when the Human Rights Act (HRA) c. 42 (www.legislation.gov.uk/ukpga/1998/42/contents) was passed in 1998. In relation to healthcare, the 1994 Amsterdam Declaration recognised dignity as one of the main rights for patients (World Health Organization, 1994), regardless of nationality, race, tribe, creed, colour, age, gender, politics, social and educational status, cultural background or the nature of their health problems. In England, the Department of Health (2012) has set out patients' rights and the duties of National Health Service (NHS) staff in a Constitution which states that patients have 'the right to be treated with dignity and respect, in accordance with your human rights' (Department of Health, 2012, p. 6), thus firmly embedding dignity as a human right within healthcare. Primary research studies based on healthcare (Matiti, 2002; Jacelon, 2003; Reed *et al*, 2003) and other concept analyses of dignity (Jacelon *et al*, 2004; Griffin-Heslin, 2005; Jacobson, 2007) all support the notion of *human dignity* as a fundamental right for all human beings. However, the concept of dignity as *merit* or *moral stature* identified by Nordenfelt (2003) is of questionable relevance if all patients are to be treated equally with respect for their dignity, regardless of perceived merit or moral status (Baillie, 2009). However, Nordenfelt's fourth type of dignity, dignity as *personal identity*, is readily applicable to healthcare, as illness and disability may threaten this aspect of the individual through, for example, changes in body image (Lin and Tsai, 2011) and mental and physical ability (Baillie, 2009). Age may affect personal identity, too. Reed (2011) suggested that children develop and redevelop their sense of identity as they grow up. Beliefs and culture are important to identity (Lin and Tsai, 2011), as is physical appearance (Matiti, 2002; Enes, 2003; Baillie, 2009). For example, a study by Edvardsson (2008) highlighted the fact that a person's own clothes were linked with their identity; wearing hospital clothing was depersonalising and carried a social stigma. Similarly, Reed (2011) found that children in hospital felt humiliated by being forced to wear clothes that were not their own; boys perceived hospital gowns to be 'dresses' and found them embarrassing.

The analysis by Jacobson (2007) accepted *menschenwûrde* as being the *human dignity* that all people possess, but added *social dignity* which, she argued, is experienced in a social context through interactions with others and can be 'lost or gained, threatened, violated, or promoted' (p. 295). In her view, social dignity consists of two linked elements, namely *dignity-of-self,* which includes self-confidence and self-respect and is created through social interactions, and *dignity-in-relation*, which concerns the conveyance of worth to others and is situated in time and place. Jacobson (2007) suggested that being clear about whether human or social dignity is being discussed may help to reduce some of the vagueness associated with dignity as a concept. In practice, these concepts can be applied by ensuring that healthcare workers recognise the human dignity of the people for whom they are caring, and appreciate how their interactions with them influence their social dignity.

The concept of dignity is sometimes better understood through its attributes. Following interviews

about dignity with 102 patients, Matiti (2002) identified 11 categories of attributes, namely privacy, confidentiality, need for information, choice, involvement in care, independence, form of address, decency, control, respect and nurse–patient communication. She found that patients set standards or expectations relating to each of these categories, taking into account the hospital situation. The maintenance of each of these together led to the patient feeling in control and dignified. Matiti and Baillie (2011) later suggested that each community or family sets their own standards with regard to the attributes of dignity (e.g. what constitutes respectful behaviour and privacy), and these attributes are affected by diverse factors such as culture, religion and class.

Worldwide empirical evidence confirms that, in order to have a positive healthcare experience, people need to feel that their dignity is upheld (Matiti, 2011). Beach *et al* (2005) surveyed 6722 adults in the USA and found that being treated with dignity and involved in decision making were associated with positive outcomes, such as high levels of patient satisfaction. This result was consistent across all racial and ethnic groups. In a review of the World Health Organization's general population surveys in 41 countries, Valentine *et al* (2008) noted that most of the participants selected dignity as the second most important domain in care, with only *promptness of care* being more highly rated. Likewise, healthcare professionals have expressed the view that dignity is a valuable part of their professional practice and a core ethical value (Fagermoen, 1997; Jormsri *et al*, 2005; Pang *et al*, 2009). Internationally, professional bodies have integrated dignity into their professional and ethical codes of practice (e.g. European Region of the World Confederation for Physical Therapy, 2003; International Council of Nurses, 2006; Occupational Therapy Association of South Africa, 2005). In the UK, dignity and respect are factors included in the inspections of all healthcare providers (Care Quality Commission, 2011), thus implying that dignity is considered to be an important measure of healthcare experience.

The concepts of equality and diversity and their application to healthcare

The Equalities Review Panel (2007) proposed a definition of an equal society as one that 'protects and promotes equal, real freedom and substantive opportunity to live in the ways people value and would choose, so that everyone can flourish' (p. 16). The definition goes on to emphasise that equality does not mean 'sameness' but instead acknowledges diversity in relation to equality, stating that 'An equal society recognises people's different needs, situations and goals and removes the barriers that limit what people can do and can be' (p. 16).

The report proposed 10 dimensions of equality, which include health in terms of both well-being and access to high-quality healthcare.

Diversity within healthcare implies that there are patients and healthcare workers with different characteristics and from different backgrounds (Lloyd, 2008). Narayanasamy and Narayanasamy (2012) differentiate between *visible diversity* such as *race, gender* and *physical characteristics*, and *hidden diversity* such as *sexual orientation, class* and *religion* which may not be obvious from first appearances but can affect care. The UK's Equality Act (2010) (www.legislation.gov.uk/ukpga/2010/15/contents) replaced previous anti-discrimination legislation with a single Act which established protected characteristics that cannot be used as a reason to treat people unfairly. These include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation. Each person needs to be valued as an individual (Kandola and Fullerton, 1998), and therefore protected characteristics and other individual factors should be acknowledged, understood and appreciated by those working within healthcare. Healthcare workers should be able to address barriers to healthcare that may disadvantage individuals as a result of their specific characteristics, as all individuals should experience equal satisfaction of certain common rights and needs (Malone, 2008), including dignity. However, in the UK, reports continue to highlight concerns about dignity in healthcare, and although there are various contributing factors, discriminatory behaviour by healthcare workers is one factor, and this will be focused on next.

How discriminatory behaviour affects patients' dignity

Fish and Bewley (2010) highlighted the importance of *fairness, respect, equality, dignity* and *autonomy*. They argued that, if human rights are to have any meaning or force, they are particularly relevant to vulnerable groups and small and marginalised minorities. In Canada, Jacobson (2009) identified a range of dignity-violating behaviours, including rudeness, indifference, condescension, dismissal, disregard, dependence, intrusion, objectification, restriction, labelling, contempt, discrimination, revulsion, deprivation, assault and abjection (being forced to compromise one's beliefs). If healthcare workers do not practise with respect for

diversity or provide care in ways that promote equality, their behaviour could be experienced as discriminatory and as diminishing dignity. Dignity-violating behaviours are particularly problematic when healthcare workers are dealing with members of marginalised groups; gypsies and travellers (Peters *et al*, 2009), asylum seekers (Asgary and Seger, 2011) and people who are homeless (O'Donnell *et al*, 2007; Martins, 2008) have all been found to be at risk. The loss of dignity in care that is experienced among diverse populations indicates that not all healthcare workers recognise the inherent and equal dignity of all human beings, nor do they value their diversity. Underlying their discriminatory behaviour may be ignorance; a lack of knowledge and skills may affect their ability to promote dignity (Matiti, 2002). However, other factors include different expectations and perceptions of dignity, which are influenced by an individual's socialisation.

Characteristics such as culture, level of education, and socio-economic status affect expectations in healthcare, and if expectations are not met, a person may perceive that their dignity was diminished. The diverse backgrounds of healthcare workers and people accessing healthcare have created a number of challenges. For example, patients from different backgrounds perceive their bodies and the causes of diseases in different ways, which healthcare workers may struggle to understand (Helman, 2007). Communication is important for promoting patient dignity (Matiti, 2002; Baillie, 2009), but may be challenging where one or both parties experience difficulties in understanding the language, accents and colloquial expressions used (Matiti and Taylor, 2005; Hooper, 2012). Some healthcare workers and patients want to maintain their cultural dress codes, which might conflict with organisational policies that may in turn lead to feelings of *abjection* (Jacobson, 2009).

Discriminatory behaviour within healthcare and its effects on dignity in relation to age, disability and sexual orientation will be explored next.

Discriminatory behaviour related to age

Concerns have been expressed about the human rights of older people in healthcare, particularly in relation to abuse, rough treatment, bullying, patronising and infantilising attitudes, lack of privacy, and discriminatory treatment on the grounds of age, disability and race (House of Lords/House of Commons Joint Committee on Human Rights, 2007). Ageist attitudes among hospital staff and loss of dignity in care continue to be revealed (Tadd *et al*, 2011), and the UK's Health Service Ombudsman (2011) has detailed cases of older people who suffered 'unnecessary pain, indignity and distress while in the care of the NHS [National Health Service]' (p. 7).

Older people with dementia have been found to face even more discriminatory attitudes in healthcare. The guidelines issued by the British Psychological Society and the Royal College of Psychiatrists (2007) for the care of people with dementia warned against such discrimination, stating that these individuals should not be excluded from any services because of their diagnosis, age or coexisting learning disabilities. A recent UK Commission to investigate dignified care for older people highlighted the fact that they continue to experience discrimination despite being the major group of health service users (Commission on Dignity in Care, 2012). The Commission report asserted that 'Undignified care of older people does not happen in a vacuum; it is rooted in the discrimination and neglect evident towards older people in British society' (p. 8).

Ageism is not confined to the UK. For example, in New Zealand, Neville (2008) found a pervasive culture of ageism towards older people with delirium. Horton and Johnson (2010) gave a detailed account of the barriers that uninsured older people encountered when attempting to access healthcare in the USA. A paper by Minichiello *et al* (2012) revealed sexual ageism across North America, Australia, China and Korea, which affected older people's access to education and health programmes.

Still focused on discrimination and age, but at the other end of the spectrum, Reed (2011) asserted that the dignity of children is often overlooked and is sometimes considered of less value or relevance than the dignity of adults. The United Nations (1989) Convention on the Rights of the Child emphasised the inherent dignity of the child, and specifically highlighted that their age should be considered: 'Children should be treated with humanity and respect for the inherent dignity of the human person and in a manner which takes into account the needs of persons of his or her age' (Article 37).

The Convention also recognised, in Article 23, the effect of disability on the dignity of children and demanded that they should be able to enjoy a full and decent life with their dignity ensured.

Discriminatory behaviour related to disability

Deal (2007, p. 93) suggested that overt prejudice towards people with disabilities seems to be disappearing, but that subtle forms continue, to the detriment of the vision of people with disabilities being 'respected and included as equal members of society.' People with certain forms of disability experience particular difficulties in accessing healthcare, and when they do access it, they encounter more

obstacles (Bollard, 2009). People with learning disabilities are particularly vulnerable in this respect, and there is evidence of persistent stigmatisation of and discrimination towards members of this particular group (While and Clark, 2010). Evidence of such discrimination includes the findings which emerged from a BBC *Panorama* programme in 2011 that exposed a hospital for people with learning disabilities in which nursing staff goaded and tortured the residents. Following this broadcast, the Care Quality Commission (2012), after a programme of unannounced inspections, confirmed that there was discrimination towards people with learning disabilities, and outlined the improvements required. Despite such actions, people with learning disabilities continue to experience direct discrimination from NHS staff who fail to treat them with dignity and respect, which reflects the lack of value afforded to the life of individuals with a learning disability (Mencap, 2012).

Discriminatory behaviour related to sexual orientation

A systematic review by Pennant *et al* (2009) highlighted the fact that healthcare workers require a better understanding of the needs of people who are lesbian, gay or bisexual. Fish and Bewley (2010) reported a lack of understanding about lesbian and bisexual women as a 'marginalised sexual minority who experience discrimination' (p. 358) within healthcare. The women wanted dignity, which they perceived as freedom from thoughtless or degrading treatment, such as questions about contraception during their smear tests. Fish and Bewley (2010) concluded that lesbian and bisexual women are 'unrecognised as users of healthcare.' Cant (2005) found that gay men preferred to attend clinics where they felt that they were treated humanely and with respect. However, he highlighted inequalities of access to respectful sexual health clinics, indicating that a person's characteristics combine to increase their inequitable healthcare experiences. He found that gay men who were less articulate and more socially disadvantaged were not aware of their right to choose a clinic to attend.

Reducing discriminatory behaviour and promoting dignity in healthcare

Discriminatory behaviour diminishes dignity (Jacobson, 2009). Therefore each individual healthcare worker should practise in a non-discriminatory manner and promote dignity equally with respect for each person's differences. In the UK, the Equality and Human Rights Group (2007) argued for a human rights-based approach to healthcare, to improve the quality of patients' experiences and develop a person-centred approach to health service design and delivery. Promoting dignity is about responding to the individual needs of each patient during healthcare activities, recognising that these needs vary due to that person's characteristics. A person-centred or family-centred approach enables healthcare workers to consider each person (or family) and their dignity needs on an individual basis. Being person-centred may also be encapsulated by the phrase 'seeing the person in the patient' (Goodrich and Cornwell, 2008). Organisational culture influences the application of a person-centred approach (Kirkley *et al*, 2011), and indeed Manley and McCormack (2008) argued that patients will not experience dignified, compassionate person-centred care unless the culture of care in the workplace is changed. The workforce survey by Baillie *et al* (2008) highlighted the importance of organisational culture in promoting dignified approaches to care and how the culture influences the behaviour of healthcare workers. As a specific example, the Royal College of Psychiatrists (2011) recommended a whole team and organisational approach to enable all healthcare workers to engage more positively with people with dementia, as individual staff on their own cannot provide person-centred care.

We propose that healthcare organisations are responsible for promoting a culture that values *equality, diversity* and *dignity*, and for providing resources to meet the needs of a diverse population. According to the Operating Framework for the NHS in England 2011/12 (Department of Health, 2010), NHS organisations should maintain progress with regard to equality by fulfilling statutory duties under the Equality Act (www.legislation.gov.uk/ukpga/2010/15/contents) in order to deliver high-quality care for all patients. Organisations require policies and practices that allow the diverse needs of patients to be met within the framework of *respect, flexibility* and *dignity* (Lloyd, 2008). Organisations should consider whether there are enough resources to meet the needs of all diverse groups and ensure that access to healthcare is equitable, for example, by providing interpreting services for those who cannot speak English, appropriate facilities for people with disabilities, and care environments that meet the needs of people with dementia. Although each person who accesses healthcare has their own individual needs and expectations, an organisation should have a broad appreciation of these needs within its local population (American Medical Association, 2008). Healthcare system designs must ensure that patients are fully informed, retain control and participate in care delivery whenever possible, and receive care that is respectful of their values and preferences (American Medical Association, 2008).

Narayanasamy and Narayanasamy (2012) suggest that developing anti-discriminatory practices requires an awareness of diversity legislation and personal and professional development for individuals that includes increasing self-awareness about values, promoting critical thinking, challenging assumptions and analysing misunderstandings. Organisations are responsible for ensuring that members of the workforce at all levels are educated about dignity through a structured programme which includes diversity issues, thus equipping the workforce with the appropriate knowledge and attitudes (American Medical Association, 2008).

Conclusion

Dignity is a complex and multi-faceted concept that has an important influence on patients' healthcare experiences and is a core principle in professional healthcare practice. Human dignity applies to all people equally. However, in healthcare, reports of loss of dignity continue unabated, and healthcare workers' behaviour can contribute to loss of dignity. If they do not appreciate the diversity of patients and their individual differences, discriminatory behaviour may result and lead to undignified care. All healthcare workers should understand how dignity, diversity and equality interrelate, and how they can preserve the dignity of each individual. Adopting a person-centred approach to each patient and their family will help people to feel that they are valued and that their particular characteristics are respected during care delivery. Organisations should support the provision of equality and respect for diversity and dignity within healthcare services, which includes addressing the educational needs of healthcare workers.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Lesley Baillie, Florence Nightingale Foundation Chair of Clinical Nursing Practice, Faculty of Health and Social Care, London South Bank University and University College London Hospitals, 103 Borough Road, London South Bank University, London SE1 0AA, UK. Email: baillil2@lsbu.ac.uk

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