Learning to promote patient dignity: An inter-professional approach

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Abstract

The promotion of patient dignity is an important aspect of healthcare provision. However, there is evidence to suggest that patient dignity is not being promoted as expected and a number of attributing factors have been suggested in the literature. This article proposes that healthcare educators should incorporate the subject of dignity in its own right within the curriculum. Attempts in teaching the concept of dignity have tended to adopt an uni-professional approach: this paper proposes that inter-professional education (IPE) is the most suitable approach in teaching the issues relating to dignity in healthcare.

Keywords

Uni-professional; Inter-professional education (inter-professional learning); Dignity; Curriculum

Introduction

Dignity is a basic human right (WHO, 1994) and a core value within clinical practice (Fagemoen, 1997). Despite its elusiveness, scholars have attempted to define dignity within healthcare. Fenton (2002, p.2) defines dignity as ‘a state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated.’

Evidence from other countries demonstrates that patient dignity is not adequately implemented within clinical practice. The United Kingdom (Tadd et al., 2011), Norway (Slettebo et al., 2009) and Iran (Ebrahimmi et al., 2012) have all reported indignities within clinical practice. Promotion of patient dignity is a complex endeavour. First, the concept is abstract and not clear (Johnstone, 2009). In the United States, Shaw and Degazon (2008) found that, while the concept of dignity appeared to be of obvious value in nursing, undergraduate students were unaware of its implications in practice. Secondly, there is paucity of resources and, thirdly, inappropriate attitudes and behaviour amongst healthcare professionals (Baillie, 2007). Finally, the situation is compounded by the exclusion of the subject of dignity from the curriculum and the absence of collaboration among health professionals. Hence, working together is increasingly advocated as an important strategy in the promotion of patient dignity (Chadwick, 2012).

Matiti's (2002) study, revealed students' and nurses' lack of knowledge of the subject of patient dignity. Students felt unprepared for the challenges they encountered with regards to patient dignity in practice. Woogra (2004) found that both nurses and medical doctors had little awareness of the importance of government documents concerning patient dignity and privacy. He concluded that the

concept of privacy and dignity must be integrated within undergraduate and postgraduate healthcare curricula. Robbins (2012, p.28) noted the absence of the subject of dignity within the medical curriculum, stating: 'what is alarming is the absence of this subject [dignity] from medical school syllabi … effective teaching on the subject … or even evidence of research into how to teach such concepts to students'. A Canadian quantitative study by Wilson et al. (2012) found that physiotherapy students and instructors agreed that the concept of dignity should be included within their curricula. In Australia, Johnstone et al. (2004) study revealed that one of the most pressing ethical issues in nursing was the protection of patients' rights and dignity. There is sufficient evidence that, to date, the concept of patient dignity has received little attention in healthcare curricula.

However, the situation is changing and the concept of dignity is gradually being incorporated as part of the healthcare curricula for example, in the USA, Fahrenwald et al. (2005) taught nursing students the notion of dignity in their first semester as part of value-based nursing. However, Cotrel-Gibbons and Matiti (2011) have argued that the subject of dignity needs to be threaded throughout the curriculum, rather than simply being a part of value-based nursing. It should feature throughout healthcare programmes, in order to strengthen students' knowledge, skills and attitudes in the upholding of patient dignity.

Why 'dignity' should be taught in its own right

Some scholars argue that the subject of dignity cannot be taught because it is an abstract concept and is inherent within a person, interwoven into everyday learning at both family and patient levels. If dignified behaviour is learned from the family and the norms of society (Anderberg et al., 2007), it must be possible to teach it within the classroom setting and within clinical practice (Chadwick, 2012) Vezeau (2006) argued that, for students to gain an understanding of dignity within practice, they must first learn about the concept. The subject is sufficiently complex, featuring attributes such as privacy, compassion, respect, (Matiti, 2002). Therefore, it needs to be taught in its own right, not as part of another subject. The danger of teaching 'dignity' as part of other subjects is that it tends to be treated superficially and not taken seriously, thus ignoring its value and complexity. A conscious and critical exploration of the various attributes that constitute dignity helps to ascertain how each attribute operates, both in theory and in practice.

Furthermore, dignity consists of values that make up culture. Culture is a 'set of guidelines which individuals inherit as members of a particular society and that tell them how to view the world' (Helman, 2007, p.2). Culture plays a role in how one's dignity is perceived, maintained and promoted. Culture values such as dignity will evolve too within society and within professions. As McSherry (2010) asserted, dignity is a social construct that is constantly evolving, reflecting the values and norms of the society in which it is located. He further stated how 'the concept of dignity has changed and evolved across time and human history' (p.22). What this implies is that some of the indignities within healthcare settings reflect a change in cultural values and public expectations

in society. If dignity is taught as a subject in its own right, teaching will be geared towards such changes, making students aware of them.

Another significant factor is the study of dignity as a cultural value benefits from the diverse backgrounds of both students and teachers within healthcare. Students and educators from different backgrounds bring diverse perceptions of dignity to training and teaching. They enrich the definition of dignity, its teaching and practice and the structure of its development within the curriculum.

Content and strategies of teaching dignity

Gallagher (2004) suggested that the notion of dignity should be considered as a two-pronged professional value, encompassing respect for the dignity of others and respect for one's own dignity. Thus, the promotion of self-dignity and the dignity of patients and others should be at the centre of healthcare teaching and practice. Watson (1996) argues that professionals should feel valued in order to value others: this implies that students must learn how to deal with situations in which their dignity is breached in order for them to understand how other people's dignity may be breached or protected.

Students require specific skills to promote their own and other people's dignity. The skills already inherent in training programmes, such as interpersonal skills and assertiveness skills, will be exploited in this. Students' knowledge, skills and appropriate attitudes should be transferrable, in dealing with other students, staff and patients; thus, they will develop an ability to reflect upon ‘dignity’ early in their professional journey. They will also take into account the factors that influence the promotion of patient dignity, including government policies relating to dignity in practice. Factors such as gender, resources, age and technology are critical to the promotion of dignity within healthcare.

As part of their training, students must also be able to challenge bad practice in healthcare (Webster, 2007). Bellefontaine's (2009) qualitative study found that student nurses did not always report potentially unsafe practices that they had witnessed. The students' own confidence, professional knowledge base and fear of failing clinical placements were critical factors in this. Students must be empowered to identify bad situations, reporting them when necessary and dealing with the aftermath without fear of repercussions.

Various teaching approaches have been suggested in the literature. The ‘Becoming Excellent Students in Transition to Nursing’ (BEST) programme, introduced by Shaw and Dezagon in 2008, demonstrated the benefit of exploring real-life situations within the classroom. Students asserted that the integration of core values (such as human dignity) created a shared culture and deepened

their commitment to the nursing profession. Similarly, Jacelon et al. (2004) stated that the creation of situations in the classroom in which nursing students can learn to interact in ways that enhance dignity encourages nurses to digest such values. Beth Perry (2009) advocated role modelling within clinical practice. The involvement of service users is also crucial, in that students learn to understand situations from the perspective of patients.

Inter-professional education (IPE)

The inclusion of dignity within uni-professional education has been promoted, in which 'students learn within their own specific health professional programs, with minimal contact with other students' (Oandasan and Reeves, 2005, p.24). However, Charles et al. (2010) asserted that, in uni-professional education, students see the world through the eyes of their own profession, decreasing the likelihood of seeing it through the eyes of other professions. The knowledge and practices gained from their professional training has its own way of impacting upon the care and treatment of patients and clients (D'amour and Oandasan, 2005). These authors argued that the division of professional responsibilities is rarely or cohesively integrated in a manner that meets the needs of clients, largely because of poor communication and misunderstanding (Charles et al., 2010).

The phrase 'inter-professional education' has been used interchangeably with inter-professional learning because the words are connected. Inter-professional education refers to when 'two or more professions learn from and about each other, in order to improve collaboration and quality of care' (Barr and Goosey, 2002, p.2), leading to inter-professional learning (IPL). IPE fosters good communication and collaboration between different professions (WHO, 2010) and enables students to acquire knowledge, skills and attitudes that they could not acquire within uni-professional education (Hallin et al., 2008). Thus, IPE is an appropriate approach in the teaching of 'dignity', as the concept transcends the work of all healthcare professionals. As stated by the WHO (2010, p.20): 'inter-professional education and collaborative practice are not panaceas for every challenge the health system may face. However, when appropriately applied, they can equip health workers with the skills and knowledge required to meet the challenges of an increasingly complex global health system' (i.e., the concept of dignity). In learning about the concept of dignity collectively, students will realise the complexities surrounding the concept and how a health professional's activities may compromise the good practice of other health professionals. In order to promote patient dignity, healthcare workers must possess an understanding of each other's roles and the expectations of each profession also need to be explored. Such inter-professional discussions within practice will enable students to critically reflect on their day-to-day interactions with other professionals and develop practical solutions collaboratively, hopefully fostering mutual respect amongst team members.

To date, reports indicate that participants benefit from the various methods of teaching dignity. However, research is required to evaluate the effectiveness of these teaching methods and to

determine changes in knowledge, skills and attitude and practical ways of assessing students. This paper has not considered how to assess the effectiveness of evaluation in the teaching of dignity.

Conclusion

This paper has argued for inclusion of the concept of dignity within healthcare curricula and has proposed IPE as the most effective approach in the teaching of patient dignity. Students require exposure to both uni-professional education and IPE, in order to provide a holistic foundation of dignity in training and in practice. Students are the workforce of tomorrow and thus the future of patient or client dignity is in their hands.

Conflicts of interest

None.

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