

# Dignity in surgical care: how little we really know

There is currently public and professional concern that dignity may be compromised during care in the NHS. The definition of dignity is complex, it is a concept with significant and variable content and little is known about measuring dignity and its impact on treatments and outcomes. There is currently an organizational drive to improve the dignity of care within the NHS, but how well are the implications of patient dignity really understood?

## What is dignity?

The precise definition and interpretation of the term dignity is not widely agreed (Pinker, 2008), despite the first article of the United Nations Declaration on Human Rights stating that everyone is born free and equal in dignity and rights (UN General Assembly, 1948). A significant problem is that dignity is difficult to quantify, measure or investigate.

A European Department of Education study identified four components of dignity: merit, moral status, identity and autonomy, and universal human worth (Dignity and Older Europeans Project, 2004). It is often easier to identify and define the absence of dignity rather than its presence and it is not constrained by mortality; it exerts an even greater influence and salience on the intricate processes and respect afforded to the dead and dying (Glahn, 2009).

Several sources discuss the concept of human dignity as synonymous with 'finding a person's actions, thoughts and concerns worthy of intrinsic respect' (Macklin, 2003).

Dignity of an obtunded, cognitively impaired or dying patient can still be perceived or appreciated by others, for example visiting relatives who may consider a patient's dignity. Hence clinicians should consider a measurement and an effect of dignity beyond the individual patient. The Royal College of Surgeons (2014a) allude to this in their guidance on good surgical

practice, highlighting the need to respect dignity at all times, particularly with unconscious patients.

The ethical acceptability of any proposed management for the benefit of the patient may become a complex consideration of all invested parties' interests. However, delivering treatments that maximize dignity may have complex ramifications for health economists and policy makers. This is especially true if guidelines are developed using quality-adjusted life years and utilitarian principles of maximizing dignity in the whole population (Dolan, 2001).

## Measuring dignity

The Department of Health (2010) defines dignity as 'respect for the individual' and defines seven areas in which this can be implemented (Table 1). Most of these factors refer to basic eating standards, prevention and treatment of pressure ulcers, and provision of single-sex bays on hospital wards. However, other aspects such as clear communication with the patient, patient involvement in treatment decisions, and patients feeling that they are treated as a individual all directly involve clinicians. These elements of care are much more frequently asserted (e.g. 'You should treat each patient as an individual') or even decreed (e.g. 'I treat each patient as an

individual') rather than measured from the perspective of the patient (e.g. 'I felt as if I was treated as an individual').

'Dignity therapy' has been developed in the field of palliative care. An initial study of dignity therapy (Chochinov et al, 2005) used a dignity inventory to measure dignity before and after 'dignity therapy', demonstrating significant improvements. This is one of the first examples of the quantification of patient dignity. While the dignity inventory is an extensive tool it may pave the way for the development of brief, effective outcome measures to quantitatively assess dignity in patient care (Chochinov et al, 2011).

## The effect of dignity on outcomes of surgical treatment

When assessed, dignity is considered a surgical outcome measure and is clearly desirable in health care. In addition, as the measurement of dignity becomes increasingly sophisticated it may allow comparative analysis of the interactions between dignity and other treatment outcomes (Oosterveld-Vlug et al, 2014). Thus, dignity may become an independent variable providing an insight into the effects that 'undignified' care can have on patients.

Patients' previous emotional experiences can affect the outcomes of their care, with

**Table 1. Dignity benchmarks**

Factor	Best practice
Attitudes and behaviours	People and carers feel that they matter all of the time
Personal world and personal identity	People experience care in an environment that encompasses their values, beliefs and personal relationships
Personal boundaries and space	People's personal space is protected by staff
Communication	People and carers experience effective communication with staff, which respects their individuality
Confidentiality	People experience care that maintains their confidentiality
Privacy – modesty	People's care ensures their privacy and protects their modesty
Privacy – private area	People and carers can access an area that safely provides privacy

From Department of Health (2010)

low preoperative SF-12 quality of life questionnaires independently correlating with postoperative dissatisfaction among patients undergoing total knee replacement (Scott et al, 2010). Quality of life is a different measure to dignity, and the principle that patients' emotional response to their care might affect their outcomes from surgery remains largely untested (Khatib and Armenian, 2010). If the effects of undignified care on patients are better understood it may become easier to ensure that the moral obligation of dignified care is met.

## Dignity and the NHS

Dignified care is clearly of paramount importance to patients and health-care professionals (World Medical Association, 2006) and has repeatedly been identified as a core NHS value. Whenever a health-care professional interacts with patients, notions of dignity underpin the concept of caring (Goodman, 1983). Following the publication of the Francis report in February 2013, focus turned to compliance with fundamental standards. One of the many pre-existing national projects was 'Essence of care', developed by the Department of Health (2010) with the goal of increasing quality of care and patient experience. It explicitly suggests practice should be underpinned by research that supports its continual development (Department of Health, 2010). These guidelines allow staff to assess their practice against twelve agreed benchmarks, one being 'respect and dignity for all patients and staff'. Following public consultation, dignity concerns were comprehensively addressed in the *Delivering Dignity* document released by the NHS Confederation (2012), an independent body that represents different organizations providing and commissioning NHS services. *Delivering Dignity* specifies that treating those in your care with respect, dignity and courtesy is an 'always event', necessary in any type of patient care (NHS Confederation, 2012)

Dignity is at particular risk during the care of surgical patients with limited capacity to act as their own advocate, in particular children, the physically or mentally disabled, and the elderly. Such patients have higher rates of traumatic injuries and constitute a substantial caseload for surgi-

cal and trauma services (Royal College of Surgeons, 2014b). If respect and dignity are considered integral to an improved surgical patient experience, they should be quantified, measured, evaluated and auditing to enhance surgical care. Such data and analysis have not been published.

## Conclusions

Given the importance of dignity to patients and clinicians, developments are needed in both the science of dignity measurement and in assessing the effect that dignified care has on clinical outcomes. **BJHM**

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## KEY POINTS

- Patient dignity during care in the NHS is an escalating public and professional concern. The time has come to clarify exactly how we define and measure dignity as we strive for compliance with this fundamental standard of care.
- If we are to measure the input or processes of dignity, we should also consider measuring its corresponding impacts on treatments and outcomes.
- Dignity could prove to be an important surgical outcome measure and the science of assessing its effects needs research and development.