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Dignity-centered Care Model: an Attempt to Maintain Mutual Dignity Between the Patient and the Health System

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Abstract

Dignity-centered care model has recently attracted attentions in the literature. The International Council of Nurses emphasizes the provision of dignity-centered care coupled with ethic, and the World Health Organization asserts that access to dignified care must get an upper hand in the world. The present study aims to propose a model for dignity-centered care. In this study, a hybrid model was used as the research method. The research protocol included literature review, field study, analysis, and model development strategy. Dignity-centered care is associated with the maintenance of mutual dignity between the patient and the health system. We found, by maintaining mutual dignity between the patient and care providers, dignity-centered care increases mutual trust and satisfaction, mutual understanding, effective communication and also improves the quality of care-taking.

Introduction:

Dignity-centered care model has recently been considered in the literature. The International Council of Nurses emphasizes the provision of dignity-centered care coupled with ethic, and the World Health Organization asserts that access to dignified care is the right of all people in the world. Michael (2014) stated that dignity is a common concept in society and involves items such as human rights and medical ethics and maintaining dignity is one of the primary principles of human rights, especially in the right to freedom and equality. Jackson & Irwin (2011) argued that dignity means - how people feel and behave, and dignity is also to respect one's values and norms. They also stated that dignified behavior results in sense of worthwhileness, sense of usefulness, trust, and freedom in decision-making. In addition, the results of undignified behavior include a sense of worthlessness, lack of control and trust, lack of freedom in decision-making, and sense of shamefulness. However, a dignified behavior is necessary at all stages of providing care even after death.

As per Gallagher (2004) dignity is a twofold issue and a foundation for human rights, although it is different among individuals with different characteristics. He believes that dignity is a value that each person should consider for others. Despite the emphasis on maintaining

dignity and respectful behavior, few studies have been conducted on the process of dignity-centered care and its concepts have remained unknown (Schwartz-Barcott *et al.*, 2002). Hence, the present study aims to provide a model of dignity-centered care using a hybrid method.

The hybrid model for concept development is one of the methods of conceptual evolution and theorizing. This model aims to resolve the ambiguity of concepts and studies a concept in its relevant context. In addition, this method brings it possible to propose a model through achieving a deeper and more complete understanding of the concept in the context of the study and identifying the relationship between features, effective factors, antecedents, and implications of the desired concept (Bousso *et al.*, 2009).

Methodology:

The present study was based on a hybrid model. In this method, firstly the desired concept was proposed in three steps of literature view, field study, and analysis and then the model was developed through one of the three strategies of choice, consensus, and creation. In the present study, the creation strategy was used for model development. According to this strategy, after identifying the features, antecedent, and implications of the concept, the factors affecting the concept were extracted and then

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the model statements were developed by completing the relationship between concepts. Finally, the model was developed by organizing the concepts and statements (Schwartz-Barcott *et al.*, 2002).

Literature review: keywords as; dignity-centered care, patient dignity, dignity in the health system, care, and dignity were searched on PUBMED database and 143 articles were obtained. After removing the duplicates, 112 articles were selected for the study. Then, the abstracts of the articles were analyzed in terms of the inclusion criteria and 65 articles were selected. In the next step, out of the selected articles, 31 Persian or English articles based on dignity-centered care published in the period 1990-2017 were selected for finally analyses. Fig.-1 shows the process of articles selection. The data were analyzed by using the content analysis method (Elo & Kyngäs, 2008) in order to identify the features, antecedents, and implications of the desired concept. The articles relevant to features, antecedents, and implications of dignity-centered care have been presented in Table 1.

Figure 1: The pattern of dignity maintenance

Table 1: Articles relevant to features, antecedents, and implications of dignity-centered care

Category	Concept	Articles
Features	Interpersonal process	Gallagher, 2004; Lam, 2007; Johnston <i>et al.</i> , 2012
Antecedents	Respect	Michael, 2014; Jackson & Irwin, 2011; Lam, 2007; Lohne <i>et al.</i> , 2014; Kwak & Lee, 2013; Baertschi, 2014
Implications	Mutual understanding (empathy)	Jackson & Irwin, 2011; Lam, 2007; Ho <i>et al.</i> , 2013; Hamooleh <i>et al.</i> , 2013; Baillie, 2009; Necek, 2014
	Sense of mutual trust	Jackson & Irwin, 2011; Baillie, 2009; Lohne <i>et al.</i> , 2014
	Sense of satisfaction (worthwhileness)	Jackson & Irwin, 2011; Stoecker, 2014; Ho <i>et al.</i> , 2013; Baillie, 2009
	Effective communication	Jackson & Irwin, 2011; Baillie, 2009; Johnston <i>et al.</i> , 2012; Stoecker, 2014

A literature review has concluded that dignity-centered care is associated with the maintenance of mutual dignity between the patient and the health system. Dignity-centered care is an interpersonal process whose most

important antecedent is the maintenance of intrinsic dignity, that is realized through mutual respect, and its outcomes include increased trust and satisfaction, mutual understanding, and effective communication also and improved the quality of care.

Field study: the data were collected by using qualitative approaches (Bouso *et al.*, 2009; Schwartz-Barcott *et al.*, 2002). The required data were collected and analyzed through semi-structured interviews. We included 3 nurses, 3 physicians, and 3 patients for interviews. After each interview, recorded data were transcribed, analyzed using the conventional content analysis method, and finally organized with MAXQDA 10.

The interviewees emphasized the indiscriminate maintenance of mutual respect. For example, one of them stated, "We should not insult or disrespect others just because having a higher position or more work experience". Another interviewee, emphasizing the mutuality of dignity maintenance, said, "This is a two-way process. I should respect the dignity of others and then I can expect them to respect my dignity. This is also true in the relationship between patients and the medical staff. Any of them who do not respect the dignity of the other side cannot expect other to do so." In terms of implications, interviewees stated that observance of mutual respect and dignity leads to mutual understanding, increased satisfaction and trust, and effective communication.

Results:

At the stage of integration and analysis, common points of data obtained from the first and second stages were identified and the findings of both stages were integrated (Bouso *et al.*, 2009). Comparison of the results of the two stages in this study showed that maintaining dignity is a two-way interactive process that results in mutual understanding, increased satisfaction and trust, and effective communication.

Analysis of the concept of dignity-centered care model: by integrating the data obtained from two stages of literature review and field study, we attempted to identify the main concepts and the relationship between them. Further, the relationship between concepts was completed and the model statements were developed by identifying the factors affecting this concept and considering the relevant features, antecedents, and implications. Finally, these concepts and statements were organized to develop a dignity-centered care model.

The study findings revealed that dignity-centered care is an interpersonal process and maintenance of mutual dignity ensures its stability. Developed based on the study findings, Fig.-1 shows that dignity maintenance is an interpersonal process and maintaining the inherent dignity of oneself and others cause its stability and continuity.

Figure 2: The pattern of maintaining mutual dignity between individuals in the process of care (dignity-centered care)

Figure 3: Dignity-centered care model with regard to factors affecting it and also its features and implications

In the process of care, the patients are in contact with the staff appointed for the health system, and, in fact, they have an interpersonal communication network with health system staff which includes nurses, physicians, paramedics, etc. Conditions of each of these individuals affect and the relationship between them affect the whole network. To achieve dignity-centered care in all interactions, it is necessary to maintain mutual dignity. Figure 2 shows the process of maintaining mutual dignity between patients and the health staff.

Discussion:

Dignity-centered care is associated with the maintenance of mutual dignity between the patient and the health system. Dignity-centered care is an interpersonal process whose most important antecedent is the maintenance of intrinsic dignity, that is realized through mutual respect, and its outcomes include increased trust and satisfaction, mutual understanding, and effective communication also and improved the quality of care.

Michael (2014) states that dignity is a common concept in society and involves items such as human rights and medical ethics. He identified two levels of inherent and non-inherent dignity. Maintaining inherent dignity involves equality of all people to all ethical issues independent of conditions. Maintaining inherent dignity

is one of the primary principles of human rights, especially in the right to freedom and equality. These are consistent with the findings of the present study.

Baillie (2009) argued that human dignity includes feelings (sense of calm in control and values) reflect in mutual behavior. The environment, behavior of nurses, and characteristics of patients, including age and behavior, influence human dignity, and failure to comply with privacy is a threat to human dignity. These results also corroborate the findings of the present study. Sabatino *et al.* (2014) asserted that individual characteristics and environmental elements are two main dimensions of dignity maintenance. The results of the present study also indicated that individual characteristics and environmental factors were effective on the maintenance of dignity.

Tranvag *et al.* (2014) stated that three main dimensions of patient dignity include previous dignity experiences, individual dignity, and interpersonal dignity. Chochinov *et al.* (2002) stated that the main classes of the concept of dignity are “concerns about the disease”, “disrespect for dignity”, and “social dignity interventions”. The findings of these studies also indicate that mutual respect is a pivotal element in dignity-centered care, and personal and interpersonal factors and underlying conditions affect it.

Hack *et al.* (2010) believed that dignified behavior includes an effective approach to the reduction of sufferings, quality improvement, and enhancement of the sense of dignity in dying patients, which lead to the provision of a safe and effective treatment environment. Lohne *et al.* (2014) stated that maintaining dignity means to treat others the same you with they treat you. In addition, Jackson & Irwin (2011) reiterates that dignified behavior is necessary at all stages of providing care even after death and dignified behavior of nurses towards patients results in the sense of worthwhileness, sense of usefulness, trust, and freedom in decision-making. The present study strengthened the findings of above-mentioned studies in terms of the implications of dignity-centered care. Conclusively, by maintaining mutual dignity between the patient and care providers, dignity-centered care increases mutual trust and satisfaction, mutual understanding, and effective communication and also improves the quality of provided care.

Recommendations:

Since dignity-centered care was defined in this study and the factors affecting it was identified, the present study can be a basis for further research in this regard with more and more participations of the subjects (interviewees) and also be dealing with issues related to dignity-centered care.

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