

# Dignity and respect

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## OVERVIEW OF THE CHAPTER

Having discussed the importance of empathy and sensitivity in nursing care, the next challenge is to recognise the importance of treating patients and clients with the dignity and respect they deserve. Patients and clients cannot receive compassionate care without a strong focus on these essential aspects of nursing. This chapter aims to help you understand what dignity is, and is not, as well as helping you to consider other aspects of respect within your interactions and practice.

It is sometimes easier to identify when dignity is not central to nursing practice, but we need to increase our understanding of what this actually means to patients and nurses. These perspectives can be very different and can be influenced by changing healthcare priorities. The building of trusting and therapeutic, patient-centred relationships, of which non-judgemental attitude is a key component, is essential in relation to patients and clients feeling that they are being treated with respect. It is essential that dignity and respect are put at the top of the nursing agenda.

## KEY THEME ONE – DIGNITY

### CASE STUDY 3.1

Marjorie had been admitted to hospital with a urinary tract infection. Normally she managed to care for herself at home, despite the relentless advancing multiple sclerosis that affected everything she did. She hated being in hospital and found that attitudes and care varied enormously from nurse to nurse and ward to ward.

She hated being dependent on others for help, but outside her home environment with unfamiliar circumstances and more distant toilet facilities, she had to accept that receiving help was inevitable.

She woke up one night with an increasing need to go to the toilet. She rang her bell reluctantly because she knew that the nurses hated to be disturbed at night. She waited for 10 minutes, which passed like an eternity, looking at her watch more and more frequently. She rang the bell again, afraid that she would wet the bed – something she had never done in her life. Eventually a male nurse appeared and she asked him for a commode. He sighed and asked, 'Is it for number one or number two?' She answered timidly that she just wanted to pass urine. He answered brusquely, 'Then do it in your pad as the commode is only for number

two during the night.' He then walked quickly out of her bay.

Marjorie lay there for over an hour in increasing discomfort and pain, crying quietly, until she could not cope any longer and had to let go of her bladder. She was absolutely mortified as soon as she felt the relief from emptying her bladder. She lay there, awake until morning, thinking about what life had come to, that she was reduced to lying in her own urine all night. She had to get out of this place as quickly as possible and vowed not to accept being sent to hospital again, however bad her symptoms were. She did not want to feel this humiliated ever again and was so upset that she had been made to feel this way.

## Discussion

It is clear from Case study 3.1 that Marjorie's dignity was severely compromised. She was in a highly dependent situation, which was traumatic enough for such a self-sufficient woman. However, the way she was made to feel over a normal human function, which was the reason she had been admitted in the first place, made her feel devalued. Passing urine is a private and personal activity and the nurse's attitude was dismissive and demeaning, and showed no understanding of her situation, her medical condition or Marjorie as an individual. This will have a lifelong effect on her desire to accept future care.

It can sometimes be easier to identify when dignity is not central to care or communication, than to truly identify what dignity actually means. Lewis (2006) says that 'undignified care is associated with invisibility, de-personalisation and treatment of the individual as an object' (p. 2). He also says that this can involve humiliation and abuse as well as narrow and mechanistic approaches to care. He continues: 'People can't necessarily define it but they know when it isn't there' (p. 2). Michael Parkinson, Dignity Ambassador for the Dignity in Care campaign in the UK, agrees that dignity is difficult to define. He suggests, 'Dignity is a strange word, with connotations of pomp and privilege. Maybe "compassion" is a better word' (Parkinson 2008, p. 14). A definition that could be helpful is, 'a state, quality, or manner worthy of esteem or respect, and self-respect' (Merriam-Webster 2008).

It can be clearly seen that Marjorie's care did involve humiliation and abuse of her rights as an individual. She had personal needs concerning normal human activities, and at that point she was unable to function independently. The nurse involved appeared more concerned with what was easier for him, and did not see Marjorie as a person in her own right. He certainly was not treating her with compassion or respect.

Parkinson (2008) emphasises the importance of older people in stabilising society through their experience and knowledge, and the importance of this intergenerational effect. He talks about the distress of seeing how his mother, in the latter stages of dementia, was not treated with dignity by her carers. She was neglected in terms of hygiene and she was exposed to experiences that she would have found distressing. She was nursed in a mixed sex ward alongside men who were similarly disorientated and who exposed themselves on a frequent basis. He says that she was not valued as an individual nor treated with humanity by many. He sees the ultimate in respect as nursing staff that did care and took the time to attend her funeral. He says that it is important to recognise older people's knowledge and life experiences and use this as an inspiration to younger people. He says that we should be ashamed of the current lack of dignity, respect and compassion in the care of older people in the United Kingdom. Some cultures appear to treat their elders with reverence and respect, but this is not always the case. Older people can feel that society treats them as useless and invisible, a drain on the economy and a problem in terms of providing care for them. Is this the way we want people who have contributed so much throughout their lives to be treated?

### **What does dignity mean to patients and clients?**

#### **CASE STUDY 3.2**

Constantine was feeling particularly agitated this morning. She was coping with her withdrawal from heroin and crack as well as she could and in some ways it was not as hard as she had feared. She had not felt ready to embark on the traumatic and sudden stopping of the drugs that she saw as the only way to cope with the pressures of life, and had been really afraid to take this major step. However, when she was arrested after a police raid of her boyfriend's flat, which involved an overnight stay with the police, she thought that she would at least try to stop taking drugs.

She was now in a residential substance misuse centre. The staff there were being very supportive and she was starting to feel that she might be able to manage without drugs. However, although she understood the reasons for this, she hated the restrictions on her personal independence. She knew that she did not feel safe without these restrictions at the moment, and that rules had to be obeyed in order to keep herself and others safe and as likely to succeed as possible. She also knew that she needed to be tested frequently and randomly for signs of drugs in her

system, and she did not resent this at all. What she did resent was the fact this involved testing her urine, and the passing of the sample had to be observed in order to be sure that it was genuinely hers. She knew more than most just how devious people with a drug habit could be, and that taking samples of others' urine into the toilet, so that this could be tested as their own, was very common practice. However, being watched on the toilet, often by a male nurse, was something she could not come to terms with.

Max, the male nurse who accompanied her to the toilet on this particular morning, was clearly highly uncomfortable with the process too. He was trying to give her privacy as much as was possible while still making sure that the specimen was actually hers. She told him how difficult she felt this was and how she felt that the whole process compromised her dignity and he agreed. She said that many others felt the same. He explained to her that it was possible to take saliva samples, which was less intrusive. However, these would not give immediate results as the lab they would be sent to could not send back results in much under a week. He also explained how expensive this would be.

Constantine felt that she had his support, though, when he said that he felt that her dignity and that of others was being compromised. He promised to take this forward to a management meeting and she felt confident that he would.

After she left the centre, she later found out, when she was supporting another user of the service who had recently stopped taking drugs, that the system had changed and saliva samples were now taken instead. She felt pleased to have been part of this change and was very pleased that Max had kept his word and managed to bring about this change based purely on the grounds of dignity, despite the financial pressures on the service.

## Discussion

It is important to identify what patients actually perceive as dignity, or what we ourselves would view as dignified care. Reporting on a New Zealand study, Carter, *et al.* (2004) say that dignity from a patient's perspective is perceived in terms of the relationship between the maintenance of hope, increasing dependence and the need to ask for help. The study found that the manner in which people responded to these needs was fundamental to maintaining dignity.

It is clear that Marjorie in Case study 3.1 was not responded to in a way that

promoted her dignity. However, in contrast, Constantine's situation in Case study 3.2 clearly demonstrates that nurses did respond to patients' concerns about a loss of dignity, and systems were changed as a result – even though this meant that the service had to bear additional financial costs and there had to be compromises in terms of the speed of results being available to staff.

Constantine and her fellow users of the mental health service were clear that compromising privacy was compromising their dignity and therefore this needed to be addressed. Nursing staff also took this view and took an active role in effecting a change in practice. Privacy, or the lack of it, is also discussed by Charles-Edwards and Brotchie (2005) in relation to the nursing of children. They identify three ways in which privacy can be perceived.

- 1 **Physical privacy**, which involves protecting modesty, avoiding embarrassment over bodily functions and respect when carrying out invasive procedures.
- 2 **Information privacy**, which includes confidentiality in relation to children and how this can compromise the rights of parents. Children and their parents have to be seen as separate identities, as their concerns and priorities might be different.
- 3 **Family privacy**, where the family has freedom of unwarranted interference by the State. This last point obviously has to be viewed with sensitivity and the child's well-being has to be treated as paramount. Children, traditionally, have not been seen as having their own privacy needs, and therefore their dignity, in terms of being respected in their own right, could have been compromised.

People who misuse drugs or alcohol, like Constantine, could easily be seen as people who are undeserving of respect and privacy, as could prisoners, women or men who work on the streets, or anyone else who has different priorities and lifestyles to us.

When visiting a day centre, Lewis (2006) found that older people had strong feelings about what dignity meant to them. They said that it meant being recognised as a person, being listened to and being understood when they said what was important to them. They wanted to be treated as if they were the only person in the world, with people taking time to get to know them. They wanted nurses to be flexible in allowing sufficient time and interaction to take place and for them to realise that, although they may be frail and vulnerable, they are not just someone to be 'cured' and moved on (p. 2).

Constantine, although not an older person, felt the same way. She wanted to be respected as a person and listened to in terms of what was important to

her. Although Max's presence in the toilet was compulsory, he used the time to good effect by listening to her concerns, and treating her as an individual. More than this, although he knew that she would not be with the service for very much longer, he took her concerns seriously by moving the service forward to promote a greater focus on dignity.

In studies by Walsh and Kowanko (2002) and Shotton and Seedhouse (1998), patients said that they felt their care was not dignified; not only when they were inappropriately dressed or covered, but also when there was inadequate allocation of time or resources, or acknowledgement of their views and feelings.

A key time when people are deeply concerned about a potential loss of dignity is when they are nearing the end of their lives. Many people feel that they want to have some control over where and how they die, particularly if their health is deteriorating and death is inevitable. Assisted death is a very contentious subject, and one which attracts very strong views. If the patient is the central focus, their views need to be listened to and not influenced by the practitioners' beliefs and values. In Oregon, an Act was passed in 1997 called the Death with Dignity Act. The 2007 summary based on the Act (Oregon State Web site 2007) found that the most common end-of-life concerns were loss of autonomy (100%), decreasing ability to participate in activities that made life enjoyable (86%), loss of dignity (86%) and fears about inadequate pain control (33%). It would be interesting to compare the concerns these patients raised with those of patients across the world to see whether they are the same in other countries with different cultures. There are different cultural and religious views about assisted death. Many religions are not specific or divided on their views about this. For example, for Buddhists, purposely hastening death is prohibited and the emphasis would be on trying to ease the patient's transition towards death and increasing their insight into suffering and its inevitable end. Encouraging a sick person to relax their grip on life or give up the will to live would not be seen as an act of compassion. The Islamic faith categorically forbids suicide, or assisted suicide; this would be an insult to Allah and people would not even be given burial rights [http://en.wikipedia.org/wiki/Physician-assisted\\_suicide](http://en.wikipedia.org/wiki/Physician-assisted_suicide) (*Physician-Assisted Suicide* 2008).

If patients felt that their concerns about an undignified or painful death were unfounded, then they might not feel the need to resort to assisted death as a way of maintaining control, even if this means travelling to another country. Therefore nurses need to take these end-of-life concerns very seriously in order to provide realistic reassurance about the help available at the end of people's lives.

**THOUGHTS FOR YOUR PRACTICE**

- How do you ensure that privacy is respected in relation to people within your practice environment?
- Have there been times when privacy was compromised?
- If this was the case, how could you have avoided this?
- How do you maintain privacy of information when family, friends or carers are present?
- How could you use quieter times in practice to try to get to know patients better and to actively seek their views?
- Have you experienced times when a patient's death was undignified?
- How could the patient's end-of-life care been more in keeping with their wishes?
- What could you do to improve the quality of end-of-life care for patients in the future?

**How do nurses perceive dignity in their practice?****CASE STUDY 3.3**

Maisie was lying in bed wondering what life had become. She had been admitted to hospital from home the previous evening with acute retention of urine. She did not know why her bladder had stopped working, but apparently it had. A temporary catheter had been inserted to relieve the pressure and her discomfort and she had immediately felt better. However, now she was lying exposed from the waist down behind curtains in the middle of a busy ward. The reason she knew that the ward was busy was because she could see visitors, patients and nursing and medical staff bustling about through the gaps in the curtains. If she could see them, she knew that they must be able to see her, though most people tactfully kept their eyes averted.

Eventually, Kim, the nurse whom she had met for the first time on the ward round, opened the curtains and explained that she needed a more permanent catheter to solve the problem she had at the moment. Maisie had found the first catheterisation uncomfortable, but she was so relieved to feel better that she forgot about it almost immediately. However, now she could feel her anxiety building. She had not really understood anything that was said on the ward round. There were a lot of complicated

words and nobody actually spoke to her and, if they looked at her, it was if they were looking at a specimen in a jar. She used to teach biology and she knew how some of the insects felt now, that she had kept as examples.

Kim did not seem to notice that Maisie now was totally exposed and although she was trying to explain what she was about to do, all Maisie could concentrate on were the people she could see through the gaps in the curtains. At that point a male doctor came through one of the gaps she was watching and asked Kim a question about another patient. Kim answered and he went out again, leaving a larger gap in the curtains. As Kim was about to start, another nurse came through the other gap in the curtains and asked for the drug keys. She detached them from Kim's belt and went out again leaving a larger gap in those curtains. Kim was obviously very keen to get this over and done with and Maisie said nothing, although Kim was obviously trying to put her at ease by asking her questions about herself and explaining her actions.

A male nurse then came through the first gap and said he was going on his break. As he left, increasing the size of gap in the curtains still more, Maisie burst into tears.

## Discussion

Having discussed what dignity means to patients and clients, it is important to compare this with nurses' perceptions of dignity, and how this can be compromised within healthcare settings.

In the UK, Charlotte Potter, of the charity 'Help the Aged', emphasised the importance of establishing and maintaining dignity for patients as an issue of paramount importance. She says that 'nurses are key to ensuring dignity through care, but they do not work in a vacuum. If they do not receive appropriate support, patients will lose out'. (BBC News 2008). In response to this, Care Services Minister, Ivan Lewis, said, 'Nurses, like other NHS professionals, have a duty to treat patients with dignity at all times; however they also have a right to expect the necessary support and resources to make this possible.' (BBC News, 2008). This has been taken forward since then and respect and dignity are now one of the top priorities for the National Health Service (NHS), and will be high on the agenda for every hospital, care home and healthcare provider in the UK.

The NHS next stage review (DOH 2008) focused primarily on the importance of the patients' experience in terms of quality of care and quality of

caring. This was seen as involving 'compassion, dignity and respect with which patients are treated' (p. 47). Patient satisfaction is now a major quality indicator and patient feedback needs to be actively sought and responded to by nurses. Patients who are not treated with dignity and respect will clearly be dissatisfied with the care they have received, and this is now seen as unacceptable. Nurses are now charged with leading practice, challenging unacceptable standards in practice and changing healthcare systems as necessary.

Kim might well have been very surprised by Maisie's tears, as she had her back to the gaps in the curtains and was focusing on the task in hand, communicating with Maisie as she felt appropriate at the time. To Kim, it perhaps felt normal to be interrupted in the middle of providing intimate care in the environment she was working in. However, Maisie was used to being treated with respect in her previous job and in life in general. She was certainly not used to lying exposed on a hospital bed, where people could see parts of her that should not be in the public domain. She accepted that Kim needed to access intimate areas of her body, but was very distressed by the fact that she was seen as an object that did not need to be respected by others who came into her bedspace, without even understanding her need for privacy, dignity or respect.

In order to promote dignity, Sturdy (2007) says that healthcare professionals need to 'protect those who are exposed to the alien, and often frightening, environment of care services' (p. 9). Kim needed to take an active role in protecting Maisie from having her privacy and dignity invaded in this alien environment in which she found herself. The culture of the ward needed to change so that nurses and other healthcare practitioners did not see it as acceptable to walk in on patients, who might be in a compromised state. In addition, the right equipment needed to be available to ensure that curtains fitted well, and perhaps that there was some indicator of the fact interruptions were to be avoided because of the nature of the care being undertaken. There have been examples of coloured pegs being used to close curtains, which give an indication of the importance of privacy. These would have helped in this situation, both by discouraging the interruptions in the first place, and by ensuring that there were no gaps in the curtains. Maisie's needs should have been seen as paramount and advanced planning could have avoided the need for handover of keys, or discussion of break times or another patient.

Ill-fitting curtains have been raised as a concern in terms of providing dignified care, but other examples are insufficient washing and toilet facilities, mixed sex wards, which can be distressing to both genders, and a lack of specialist lifting equipment, which can mean that people are being moved and

handled inappropriately. In addition, some hoists can make people feel very vulnerable, particularly when they are used in a common area. This can be difficult to avoid, but a greater awareness by nursing staff of the importance of maintaining dignity wherever possible, and the recognition of how vulnerable they would feel if they were that patient, is an important cultural shift that needs to take place in many care environments. Kim certainly would not have wanted to be in Maisie's situation, and neither would any of the other healthcare professionals who interrupted her care.

Nurses in the UK have raised concerns about being unable to provide dignified care. In a poll of more than 2000 nurses, 8 out of 10 nurses said that they have left work distressed because they have been unable to treat patients with the dignity they deserve (BBC News 2008). Washing and privacy were cited as common issues of concern, as well as staff shortages and not being able to provide non-emergency patients with single-sex accommodation. One nurse said: 'Patients seem to be becoming numbers not people. I am having to fight against what the system wants in order to provide dignified care to my patients.' In total, 81% of those quizzed said they sometimes, or always, left their workplace feeling distressed or upset because they had not been able to give patients the kind of dignified care that they would want. In addition, 86% of the nurses polled said dignity should be a higher priority (Royal College of Nursing [RCN] 2008).

The RCN poll (RCN 2008) cited several issues that prevented dignified care:

- overcrowded wards;
- the layout of the clinical area;
- the curtains around the beds;
- noisy and disruptive environments;
- mixed sex wards.

Organisationally, these included:

- resources and staffing levels;
- overwhelming paperwork;
- targets and statistics;
- a lack of leadership on these issues.

Maisie would certainly have felt that her dignity was being compromised by the apparent busyness of the ward, the lack of effective curtaining and the mixed sex environment. She would have been unaware of the paperwork and the need to meet targets. However, she might have suspected that there were

problems on this ward with staffing levels and a lack of leadership on issues that encouraged dignity. However, Kim and the other practitioners should have been aware of the impact of these factors and their influence on maintaining patient dignity. They also need to take a lead in challenging such practice and the organisational issues that can adversely affect the care given.

In the UK nurses are being given more responsibilities, particularly in relation to enhanced technology and the meeting of targets, which increases the amount of paperwork and computer orientated work that they need to do. In addition, enhanced roles can make nurses more task-orientated and focused on advanced skills. This can detract from them taking an active part in the fundamental care needs that people have, or at least supervising the quality of care that is required. Nurses need to take a lead in ensuring that patients' fundamental care needs are met. For example, patients might need to be encouraged to eat and helped with eating and drinking, if necessary. Systems need to be in place to ensure that nurses know when this is not happening. Coloured meal trays for those with particular nutritional needs have been used in some places to highlight when adequate nutrition is being compromised.

Having discussed some of the challenges that nurses face in ensuring that their patients or clients receive dignified care, it is important to develop strategies to support practitioners in their role in promoting dignity. The UK, Dignity Challenge and dignity champions (web site Dignity in Care) suggest various ways in which nurses can develop high quality services that respect people's dignity. These could include:

- having a zero tolerance of all forms of abuse;
- supporting people with the same respect you would want for yourself or a member of your family;
- treating each person as an individual by offering a personalised service;
- enabling people to maintain the maximum possible level of independence, choice and control;
- listening and supporting people to express their needs and wants;
- respecting people's right to privacy;
- ensuring that people feel able to complain without fear of retribution;
- engaging with family members and carers as care partners;
- assisting people to maintain confidence and a positive self-esteem;
- acting to alleviate people's loneliness and isolation.

By looking at this list of suggestions, it is easy to see the ways in which Maisie's dignity was not being protected, and the lack of leadership ensuring that dignity issues were seen as a priority.

Nurses need to understand and agree on what dignity means to patients and clients (Hunt 2008). They also need to develop influencing skills to make sure that the appropriate resources are available to allow dignified care to take place. Nurses also need to be assertive enough to take a zero tolerance approach to colleagues who treat patients disrespectfully. This could be in their role as practitioners or managers. Nurses need to be active listeners and use their verbal and non-verbal communication skills in order to really hear what patients actually need from the service they are providing.

#### THOUGHTS FOR YOUR PRACTICE

- How do you prevent interruptions to care that might compromise patients' dignity?
- How do you ensure that you have adequate resources and equipment in your practice environment to ensure that people have the best care possible in the circumstances?
- How would you take an active leadership role in challenging undignified practice?
- How could you start to influence changes in systems that do not promote patient dignity?
- How do you ensure that patients' fundamental care needs are met within your practice area?

## KEY THEME TWO – RESPECT

### CASE STUDY 3.4

Helen had been having a bad night shift on the Intensive Therapy Unit (ITU). The patient she was looking after, Omar, was deteriorating fast, despite the whole team's efforts to stabilise him. His young wife, Misha, was at his bedside, quietly crying, and she knew that their baby son was being looked after by his mother in the waiting room. It was so unfair. He had only been going to the late night shop to get some formula milk for the baby because they had run out. He was brutally attacked outside the shop by a young man who had been shouting racist insults as he carried on kicking and stamping on his head. Helen knew that Omar's head injury was too severe for him to survive and he had been unconscious since

the attack. However, it had been established that he wanted his organs to be used for others, if such a situation arose. Helen listened as the transplant nurse discussed with Misha what organs could be retrieved, and she thought of the various people whose lives would be enhanced by the use of these organs.

In the next bed was a 50-year-old man who had been an alcoholic most of his life. His oesophageal varices were now starting to heal, but he was very jaundiced and was on the liver transplant list. When he had been admitted she had called him Mike, when apparently he was always called Mick, and he had been cross for her assumption that Mike was his name. She felt that he had overreacted because, after all, how was she to know his name? On the admission information it just said that his name was Michael. She knew that she should treat him with as much respect as any other patient, but she just could not respect his lifestyle choices. If Mick, or someone like him, received Omar's liver she felt it would be a betrayal of Omar's generosity and care for others. Omar had done nothing to deserve his untimely death; whereas Mick was lucky to have lived so long and his health problems were clearly of his own making. She knew that nobody would receive Omar's liver if they were continuing to drink, but she also knew of another patient who had stopped drinking for a year, had a transplant and then started drinking again and had died six months later. Helen felt this was such a waste of a precious organ.

She knew that she should be non-judgemental, but felt that she could identify more with younger people who had a lot to give and who had not made dubious life choices. The elderly, who had lived their lives, drunks, or those who had harmed others, she found much more difficult to nurse.

## Discussion

It is clear that, while Helen obviously respects and values Omar, she has little time for Mick and his lifestyle choices. If respect is seen as treating others as you would want to be treated yourself – which is one of the basic tenets of compassion – she is finding this very difficult in her relationship with Mick. She is failing to acknowledge his worth or to respect and value him as an individual.

We have already discussed the importance of dignity and privacy, in terms of respect, but there are other elements of respect, which are of equal importance. Helen seemed surprised that Mick has responded badly to calling him

by the wrong derivation of his name. Nurses are more informal nowadays and many patients are happier to be called by their first names. However, this is not always the case and people should be given a real choice about what they want to be called, whether this is Mr Lewis, Michael, Mike or Mick. Helen made the assumption that he was happy to be called by his first name and then compounded this error of judgement by assuming that he would be called by a shortened version, and that shorter version was Mike. This negative start to their relationship might have been avoided if she had genuinely asked him what he liked to be called.

This is particularly true with older people who might feel much more comfortable being called by their last name. In fact, they might feel that it is disrespectful to be called by their first name by someone much younger than they are. Their identity is influenced by the person they are, but also by the generation they belong to. It is important to understand how our parents and grandparents might feel and to be careful with our use of language and ensure that we communicate in a respectful manner. Overall, a lack of formality can cause concern for older people but could reassure younger people. Informality and professionalism can coexist, but this has to be carefully managed.

It is apparent that Helen is not only judgemental, although she appreciates the need for her not to be in her role as a nurse, she is also stereotyping people as 'the elderly' and 'drunks'. Holt (2000) discusses this in relation to older people and suggests that the use of collective terms and group labelling such as 'elderly' imply the merging of millions of people whose lives have spanned four decades of human life and history into a single homogeneous group, which reveals a pitiful disregard for individual diversity. Holt continues by suggesting that 'there is a distinct need for care philosophies to embrace the heterogeneity of ageing and recognise each individual as an individual, not merely as a unit to be classified by age' (p. 56). Both these attitudes, which were displayed by Helen, form a real barrier to building a trusting relationship. These points will be discussed further in this chapter.

### **How do we build person-centred relationships?**

#### **CASE STUDY 3.5**

Josh was very clear that he did not want to be here outside the school nurse's drop in room at all, but he knew he had to discuss this with someone. Whenever he had seen Becky around the school, she had always smiled and he felt that she was someone he would be able to talk to. So

he took a deep breath and knocked on the door. When he heard her voice he almost bottled out and walked away. He made himself go in then sat on the chair at the side of her desk, facing her. Immediately she smiled and he felt himself relax a little. It was going to be difficult to know how to begin though.

He heard her say that it was nice to see him and she knew that, as a nurse, he could trust her to be confidential with whatever he told her. He started to try to say what he had come to talk about, but heard himself stammering. She said that it was good that he had come to see her now as she had plenty of time because nobody else was booked for the rest of the session. That helped him to realise that he did not need to say everything in a rush. She asked him what he most enjoyed doing and he heard himself say that he enjoyed rugby and wanted to do sports sciences at university. He was in his final year of school, so making choices about university courses seemed to be taking on a life of its own. As Becky started to ask about his rugby, Josh suddenly blurted out his innermost thoughts. He was a respected sportsman within the school and his macho image was well intact and he felt that he was constantly gently repelling advances from girls at the school. However, he had known for some time now that he was not interested in girls and he was pretty sure that he was gay.

Becky asked him what had made him think that he was gay initially, and he said that he found that he was attracted to the male form rather than the female pictures that his friends found attractive. He had not really taken this seriously at the time, but here he was, three years later, and he knew that his attraction for men was increasing rather than diminishing. He was really worried about how his parents and his friends would react, but firstly he was concerned about how Becky would react. Would she feel repulsed? Would she tell him it was just a phase? Would she laugh at him?

He didn't have the courage to look directly at her, but he heard her say gently that she knew how hard it was for him to tell anyone this and how glad she was that he had been brave enough to tell her. He looked up and saw the concern in her eyes and the steady way she met his gaze and knew that this was just the beginning of the discussions that he would have with her.

## Discussion

This was a very traumatic situation for Josh. He had been keeping this very personal part of himself completely secret for some years, and now felt that it was time to discuss it with someone. He had seen Becky around the school and the fact that she had always smiled and seemed friendly had obviously made an impact on him. However, it was a new relationship that was being built at a time when he was trying to discuss very personal matters. His initial trust of her was as a nurse, who he saw as being a professional and who would respect him and his confidentiality.

This is borne out in a Canadian study by Trojan and Yonge (1993), who found that trusting, caring relationships were built on general trust, acceptance, respect and confidence in professional skills. They found that nurses were initially trusted because of their nursing qualification and expertise, but that the interaction that took place after the initial meeting was crucial to whether trust disappeared or developed. A nurse in the study says that:

People are usually quite receptive as soon as you identify yourself, but it would depend a lot on how they interact with you on your initial visit whether or not the trust would stay there, or whether it is something that you are going to have to work on as the visits continue. (Trojan and Yonge 1993, p. 1905)

This study was carried out in relation to older people but it clearly is transferable to the building of any trusting relationship.

Becky had appeared to Josh as someone who was approachable and genuine and, therefore, he felt that he could trust her. Genuineness can be seen as being 'free from hypocrisy and dishonesty, actual, real, sincere or being yourself, honest and unpretentious' (Web site of The Free Dictionary). Becky exhibited all of these attributes, which drew Josh to her as someone he could confide in and trust. Rungapadiachy (1999) defines trust as being honest, open, sincere, supporting and dependable, genuine, warm and accepting. Again Becky demonstrated all of these traits.

Dowling (2006) says that respect is about building up an intimate relationship that involves a reciprocity and self-disclosure, getting to know the patient and allowing them to get to know the nurse as well. However, decreased hospital stays and resource reductions makes nursing more task orientated and this limits the opportunities for intimacy. Building relationships can be seen as a reasonable sacrifice in resource-limited organisations. Becky would have been busy, but she saw it as paramount that she gave the impression that her time was not limited in any way. Nurses need to try to develop this ability

to seem as if they have sufficient time, regardless of their many demands, otherwise people will not disclose things to them and they will not see the true picture in relation to the individual's situation.

Trusting relationships allow people to disclose highly sensitive information that needs to be shared in order for optimal situations to develop. Difficult issues, such as abuse of older people, child protection, anger, domestic abuse, stress as a carer, inability to cope, fear of losing control or being hospitalised need to be understood in order to try to help those involved. These can only be divulged when there is trust between those involved and where there is privacy and confidentiality. However, as nurses we have a responsibility to ensure that patients and clients understand in advance the point at which confidentiality cannot be maintained. Illegal or damaging behaviour and abuse can not be kept confidential, because this involves the safety of others. However, other situations help the nurse to understand the stress that someone is feeling so that she can offer other solutions, which might prevent future harm.

For example, a man with paraplegia who was so terrified of being readmitted to hospital was unable to tell a community nurse who he trusted that he had deteriorating sacral sores. He did not tell her until the point where hospitalisation was inevitable and, actually, by that point he had septicaemia and was unlikely to survive. This could have been prevented, but the nurse involved had to conform to time-limited visits, which were less frequent than were needed, due to time constraints, an under-resourced team and frequent staff turnover. She was also new to the community and less experienced at identifying such matters. All of these issues can impact negatively on the ability to focus on therapeutic relationships and make building intimate relationships more difficult. Nurses need to be empowered to challenge resource constraints that make the building and maintaining of trusting relationships almost impossible. Holistic care and problem solving are severely compromised if resource constraints are negatively affecting trusting relationships.

Ensuring confidentiality can be very difficult within many practice environments. Breaches of confidentiality are not only unprofessional, but also severely damage trusting relationships with patients. Within a hospital setting, conversations behind curtains can be overheard. In any setting, a person could ask for someone else to be present, not realising the potential topics that could be covered during the ensuing conversation. Some communities are very close-knit and confidentiality can be more or less impossible to maintain; for example in schools, small villages and isolated communities where the nurse might live and work within the same community. The nurse may be totally confidential, but people might fear that she or he might not be. It is up to the

nurse to raise confidentiality as an issue early in the relationship to reassure patients and clients that this is absolute, except in situations where there is a risk of harm to themselves or others, as discussed above.

#### THOUGHTS FOR YOUR PRACTICE

- How do you feel that you could give the impression of approachability to patients and clients before you actually build relationships with them?
- What do you do in your first contact with patients and clients to initiate a trusting relationship?
- How do you broach the subject of confidentiality at the start of your relationships?
- How do you ensure that your conversations are confidential?
- How do you balance resource constraints with building a trusting relationship with patients and clients?

### Do we understand the importance of non-judgemental attitude?

#### CASE STUDY 3.6

##### Real life patient experience

Recently I had to have stitches removed from my arm that were needed after a self-inflicted injury.

I had to go to St Helens Walk-in Centre to have this done, as it was the weekend. I was not looking forward to it. Being somebody who self-injures, it meant I would have had to show my whole arm to this nurse and I wondered how they would react.

I don't know the name of the person I saw, but he asked me the dreaded question before I rolled my sleeve up: 'How did you do it?' I replied, 'Self-harm.' He encouraged me to roll my sleeve up.

He clearly picked up on my anxiety and reluctance to remove the dressing that would reveal yet more scars and the stitched wound. In a calm and gentle manner, he simply said, 'Go on, it's okay', and suddenly, I felt okay. Those few words just let me know that he wasn't going to ridicule me or treat me any differently.

He was gentle in removing the very awkward stitches and was clear in giving me information about aftercare (i.e. no perfumed products on it for at least three days, etc).

This nurse could not have done a better job – not just at removing the stitches, but at making me feel at ease and not making me feel ashamed or guilty. There are nurses out there who could take a leaf out of his book and understand a little more about self-harm. In this instance, I was treated like a respected and valued human being – not some useless waste of space who didn't deserve the time of day because I'd hurt myself. (Web Site on Patient Opinion, ID 7908)

## Discussion

In the example above, which comes from a patient opinion web site, the person involved is clearly highly anxious about having their stitches removed because of the fact that they are there because of a self-inflicted injury. The nurse involved is very sensitive and his non-judgemental approach is the most important part of the consultation. He makes the patient feel accepted and respected, rather than ashamed and guilty. People who exhibit behaviour that is not readily accepted by society; for example, self-harming, parasuicide, alcohol or drug misuse, are used to being treated with disdain and are very skilled at seeing when there is an underlying judgemental attitude, even if nothing is actually said to this effect.

Trojan and Yonge (1993) say that 'If a nurse cannot accept the client and their values, the development of a trusting nurse-patient relationship is impeded' (p. 1905). Without a non-judgemental attitude, a trusting relationship cannot develop. In a Welsh study, De Raeve (2002) says that 'trust between people as individuals may emerge and increase, as people become more revealed and known to each other' (p. 161). In Case study 3.4, Helen would have been unable to build a trusting relationship with Mick because her judgemental attitude would have been in the way. However, in Case studies 3.5 and 3.6, it is clearly apparent that neither person was being judged by the nurses involved.

An English study written by Repper, Ford and Cooke (1994), concerning mental health clients, also emphasises the importance of a non-judgemental attitude in building a trusting relationship. They say that trust needs to develop in order for clients to feel able to show their vulnerability. Clients had to feel that they could expose these parts of themselves in the safe and sure knowledge that they would not be judged, or the information used to refer them elsewhere or to discharge them from care.

It is important that nurses really change their biases and prejudices so that they can practise in a non-judgemental manner. For example, in a community

setting Trojan and Yonge (1993) talk about the importance of acceptance and non-judgemental attitude 'as one nurse stated "my feeling is that I am a guest in their homes. If I can't accept what they have got in their homes, their living conditions, then that is my problem, not their problem"' (p. 1905).

Cultural norms and values can play a part in whether nurses can accept a person or patient's situation or lifestyle. In a study of Egyptian caregivers, Boggatz and Dassen (2006), found that carers had to overcome fear, disgust, repetition and sexual taboo in their care of older people. They had to challenge their traditional values to care for their patients in the Egyptian care home in which they worked.

McHarg (2008) reports from the perspective of a friend on the care of a patient in hospital shortly before his death. The friend was a man with advanced Alzheimer's disease and his friend says:

The condition was irreversible; he'd lost his memory and could be difficult. But the nurses always treated him as the gentleman he had been, not the awkward child he sometimes became. They never laughed at him. They allowed him his dignity. The Max I knew would have appreciated that. (p. 14)

The patient in this situation was never mocked or denigrated. He was respected in his changed circumstances, and that would have been important not only to him, but to his friends and relatives.

If nurses do not get this right then the impact on care is clearly inadequate and damaging.

Nurses say that patients become distressed and confused if they are not treated with respect and if clinicians fail to communicate properly with them, which means the onus is on nurses to ensure their interpersonal skills are polished. Patients who feel they are not receiving the right levels of service may become angry and emotional . . . If you don't treat them right, they may become aggressive. (Staines 2008, p. 15)

This is understandable as nobody would want to be treated without dignity and respect. The person in Case study 3.6, who had self-harmed, might well have reacted in this way as they were expecting the staff to have a negative attitude. People who are continually treated without respect by practitioners who 'judge' them become angry or disempowered as a result, and can be reluctant to seek help.

**THOUGHTS FOR YOUR PRACTICE**

- Have you ever judged somebody, based purely on their appearance, life choices or circumstances?
- In your practice, how can you challenge these attitudes in yourself and others?
- Are you aware of your own biases and prejudice?
- How do you stop these impacting on your role as a nurse?

**SUMMARY – LINKS TO COMPASSION AND CARING**

We do not believe that compassionate care can exist without dignity and respect being central to the relationship between nurse and patient or client. Dignity has to be considered primarily from the patient's or client's perspective. People need to be listened to and understood in terms of what is important to them. They want to be treated as individuals, as we would ourselves. They want their privacy to be respected and time to build relationships with nursing staff. Nurses can find it difficult to meet these needs in the current healthcare environment, with a potential focus on targets rather than quality of care. Nurses need to take a lead in challenging undignified care in themselves and others, and in challenging systems that compromise their ability to provide dignified care.

The importance of trust in building respectful relationships cannot be underestimated. People need to feel that their confidentiality is not being compromised and that their care is individualised and based around their specific circumstances. They also need to feel that they are accepted and valued, regardless of their life situation or lifestyle choices. Without these important components of respect and dignity, compassionate care is absent.

When dignity and respect are absent from care, people feel devalued, lack control and comfort. They may also lack confidence, be unable to make decisions for themselves, and feel humiliated, embarrassed and ashamed. Providing dignity in care centres on three integral aspects: respect, compassion and sensitivity. In practice this means:

**Respecting** patients' and clients' diversity and cultural needs; their privacy – including protecting it as much as possible in large, open-plan hospital wards; and the decisions they make;

Being **compassionate** when a patient or client and/or their relatives

need emotional support, rather than just delivering technical nursing care;  
 Demonstrating **sensitivity** to patients' and clients' needs, ensuring their comfort' (Royal College of Nursing 2008).

Peter Carter, general secretary of the RCN, says, 'Dignity should not be an after-thought or an optional extra. Each and every patient – whether they are in a hospital, a GP's surgery, in the community or in a care home – deserves to be treated with dignity and respect' (BBC News 2008).

In addition, the Chief Nursing Officer for England, Christine Beasley, says, 'I believe strongly that dignity, respect, care and compassion are at the heart of good nursing care whenever and wherever it takes place' (BBC News 2008).

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