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Dignity Preservation Among Hospitalized Patient: A Case Study of Bugando Medical Centre, North-Western Tanzania

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Abstract: *Background*: Dignity preservation is regularly emphasized as one of the basic patient rights in both national and international codes of ethics in medical practices. Therefore, it is important to explore this concept based on the patient's experience to maintain and respect their dignity, improve the quality of health services, and increase patient satisfaction in health care. This was a qualitative descriptive study in which 20 hospitalized patients were recruited. Purposive sampling was used to select study participants from wards of different departments of Bugando Medical Centre (BMC). Patients were interviewed about the experience related to the preservation of their dignity during their hospital stay. Data were analyzed using qualitative content analysis. The study aimed to explore the experience of dignity preservation among hospitalized patients during their hospital stay. Four major themes emerged from the analysis of the data obtained from the interview. Patient-Provider relationship, patient involvement in medical care, Inadequate privacy and confidentiality, Accessibility and Affordability of health services. From the patient's experience, human dignity needs to be preserved and maintained in hospitals. Respect for their privacy, confidentiality, and patient involvement in the medical care should be taken into consideration.

Keywords: Dignity, Preservation, Patient, Hospitalized

1. Introduction

Respect for human dignity is a key concept in medical practices, it has been emphasized in various national and international documents and codes of medical professional ethics as a moral obligation to all healthcare workers [1]. Professional ethics require that healthcare providers should be compassionate to patients, maintain privacy, and respect their autonomy [2]. Preserving patient dignity is recognized as an essential element in patient care [3]. There is a significant relationship between dignity and hospitalization as sickness can weaken the individual's independence and jeopardize their self-identity, which in turn affects their dignity [3]. In the hospital, patients meet unfamiliar environments, and people have separated from their families and their daily social life. Under the new environment, the patient is expected to ascribe a new task assigned by healthcare providers, and all of these factors are subject to a

risk of losing their dignity [4, 5].

Maintaining patient dignity contribute to self-esteem, treatment satisfaction and trust [3]. On the other hand, violation of patient dignity may create feelings of inferiority, insecurity, mistrust and eventually affect hospital health care.

Dignity is an important component in health care delivery, it has been associated with both quality of services and quality of life among hospitalized patients [6]. The results of the study on the effect of dignity therapy on dignity, psychological well-being, and quality of life among palliative care cancer patients revealed promising findings on improving psychological well-being and quality of life [7]. However, study of cancer patients shows a positive significant relationship between patient dignity and quality of life [6] Maintaining the dignity of a patient is a critical component of high-quality healthcare delivery [8]. The studies revealed that nurses' and doctors' behaviors and responsiveness to patient's needs determine the extent to which patients feel that their dignity is preserved [9]. However, conducive hospital environments, privacy, and feeling comfortable and valued influence the patient's dignity [10]. The results of the study Manookian et al. (2013) in Iran show that communication behavior, personal beliefs and characteristics can subject a patient at risks of disrespected [9]. These factors which lies between health providers and patient interactions in health care settings include disrespect for patient preference, abusive language, failure to maintain privacy and confidentiality, failure to involve the patient in the treatment plan [11, 12].

The study of Ebrahimi H. et al (2012) in Iran show that patient was dissatisfied with the quality of service and identified some issues as an indicator of disregard for their dignity including unhygienic condition, Annoying noise in the ward, Lack of comfort, and disrespect privacy [13].

Few studies have been conducted to assess patient dignity in Tanzania, nevertheless, only a limited number of studies focused on the concept of dignity preservation from the perspectives of hospitalized patients. A study conducted in Tanzania on the disrespect and abuse during maternal care and childbirth reported that patient was felt ignored, neglected, verbally abused [14]. In the study of Margaret et al (2014) disrespectful and abusive treatments during facility delivery in Tanzania shows 19% of the 2520 women who participated in the study reported experiencing at least one form of disrespectful or abusive treatment during childbirth [15]. Gopika D. et al (2021) in a study of patient and provider perspectives on disrespect and abuse during childbirth in Tanzania reported 73.1% of women experienced at least one form of disrespect and abuse during labor [16]. Elysia L. et al (2019) reported 14.3% disrespectful care on primary health facilities [17].

Dignity is a complex and multidimensional concept, and involve sociocultural aspects, deeper understanding of this concept particularly in the health care deliveries will allow healthcare providers to understand people from different cultural backgrounds and maintain dignity during the hospital stay. Therefore, the findings of this study are important because will inform the policymakers, Healthcare providers, patients and other stakeholders of the importance of preserving the dignity of patients in hospitals.

2. Material and Methods

2.1. Study Design

The researchers adopted a qualitative descriptive (QD) design. We interviewed hospitalized patients, recorded their observations, then reviewed and coded the data for analysis. The qualitative descriptive approach was appropriate because it involves a naturalistic inquiry [18, 19]. We developed an interview guide with open-ended questions formulated from research objectives. The interviews lasted from 30-45 minutes. To ensure confidentiality, the interviews were conducted in a room separate from but adjoining the wards or by screening the beds for immobile patients. Purposive sampling was used to identify study participants, all of whom were hospitalized patients.

2.2. Sampling and Setting

The study was conducted at BMC, BMC is a tertiary referral, consultant, and teaching Hospital in the Lake and Western zones of the United Republic of Tanzania. It is located along the shores of Lake Victoria in the City of Mwanza. BMC has 950 beds and 1500 employees. It is a referral hospital with various specializations.

A purposive sampling of 20 twenty admitted patients was recruited into the study. The participants were selected from various medical and surgical wards. The inclusion criteria for participation were age over 18 years, adequate mental capacity and the ability to describe experience, and willingness to participate.

2.3. Data Collection

The study was conducted between June and August 2022. Interviews were conducted among hospitalized patients. Along with demographic information, including age, department, ward of admission, duration of hospitalization, frequency of hospitalization, marital status, employment status, insurance coverage, and education level, interviewers asked participants about their experience in dignity preservation during their hospital stay; how long have you been admitted in this hospital; What can say about your relationship with healthcare workers during the hospital stay; What are your views concerning your dignity preservation during your hospital stay? Subjects were asked to share their experience on factors that hinder dignity preservation; maintenance of your dignity during your hospital stay; What are your suggestions to improve human dignity preservation among hospitalized patients, and their thoughts about dignity preservation in hospitals (see attached interview guide). The study was intended to interview 25 respondents, there was no refusal of participation from the study participants. The study participants were purposely selected depending on the length of hospitalization. Those above one to seven days post-

admission were included. The interviews were conducted with trained research assistants and lasted 30 to 45 minutes. After interviewing twenty participants, information saturation was achieved and data collection was suspended.

2.4. Data Analysis

The Audio recorded interviews were transcribed verbatim and then translated from Swahili to English. The interviews were analyzed using qualitative content analysis [20]. The qualitative content analysis enables the researcher to develop categories from the text data inductively [21]. These help the capturing of the participant's experience of dignity preservation. The full transcript and field notes were read by the authors to become familiar with the data and context. The experience of hospitalized patients was condensed through data reductions. The condensing unit was discussed by the authors, and they reached a consensus on the final codes. Similar codes were grouped to form subcategories. Subcategories were further analyzed to distinguish their similarities and differences whereby the similar ones were sorted to form categories that reflected the content of the text [22].

2.5. Ethical Consideration

This study was approved by BMC/CUHAS ETHICS COMMITTEE and granted an ethical certificate approval, Ref. No CREC/556/2022. Permission for conducting the research was granted by the Director of Bugando Medical Centre. The consent was also sought from the participants before recruitment.

3. Results

3.1. Demographic Characteristics

A total of 20 participants were interviewed from different departments of BMC including surgical, Internal Medicine, Oncology, and Orthopedics from respective admitted wards. The majority of the patient was admitted for the first time, 14 (70%) between 1-7 days 8 (40%), and 11 (55%) were females. The greatest number of the patient was aged between 18-39, 10 (50%) followed by 40-49 (45%), and most of them were admitted to general wards, 15 (75%). Among the participants, only 4 (20%) were having health Insurance. (Table 1).

Table 1. *Showing participants demographic characteristics.*

	Frequency	Percent
Department		
Surgery	10	50
Internal Medicine	3	15
Oncology	3	15
Orthopedics	4	20
Duration of Hospitalization		
1-7	8	40
7-14	4	20
14-21	4	20
>21	4	20
Frequency of Hospitalization		
First time	14	70
Second time	4	20
> three times	2	10
Sex		
Male	9	45
Female	11	55
Employment status		
Unemployed	8	40
Employed	2	10
Retired	2	10
Housewife	1	5
Peasant	7	35
Education level		
Illiterate	3	15
Primary education	13	65
Secondary education	2	10
>Secondary education	2	10
Admitted ward		
Private	3	15
VIP	2	10
General ward	15	75
Age of the patient		
18-39	10	50
40-59	9	45
>60	1	5
Insurance coverage		
Yes	4	20
No	16	80

	Frequency	Percent
Religion		
Islamic	6	30
Catholic	9	45
Protestant	1	5
Others	4	20

The analysis of the interview documents and categories show patient was dissatisfied with how their dignity was preserved during their hospital stay. However, there is considerable diversity of experience among patients. Verbal abuse, disregard, and inadequate privacy were among the factors which hinder dignity preservation. Four major categories emerged from the analysis of the data obtained from the interview. Patient-Provider relationship, patient involvement in medical care, Inadequate privacy and confidentiality, Accessibility and Affordability of health services. (Figure 1)

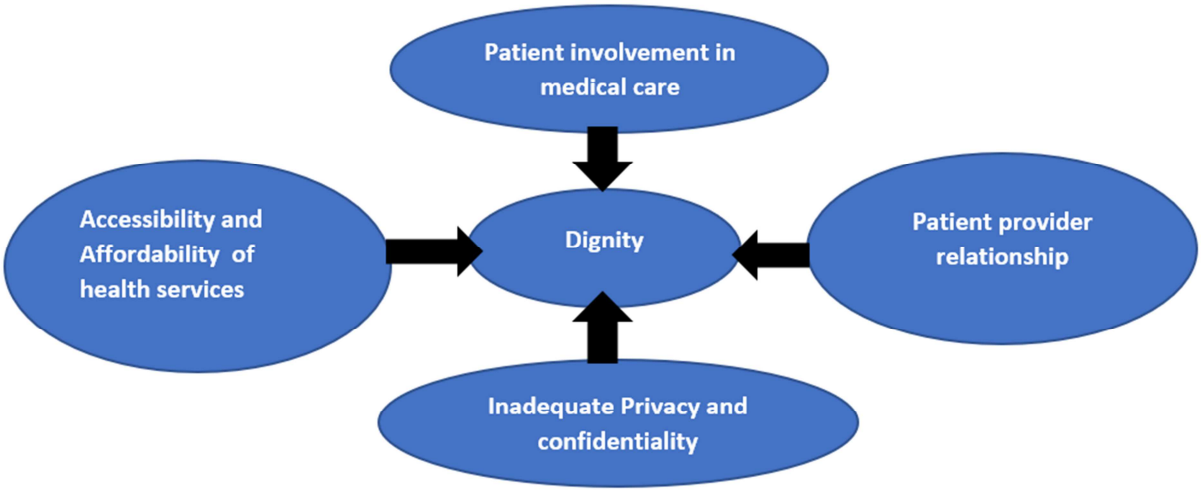

Figure 1. *Summary of findings showing four major categories, and their relationship.*

3.2. Patient-Provider Relationship

The patient-provider relationship is the foundation of creating trust within the context of care [23, 24]. It is among the indicators of measuring dignity preservation, it involves how the patient is spoken with providers, and the type of language used during communication in the wards or health facilities. Verbal abuse, disrespect, bribery, humiliation, scolding, and blaming would be considered a non-dignified relationship. "Patients were asked about their relationship with healthcare provides during their hospital stay" The responds were as follows with the respective quotes

[…Some healthcare providers respond the call when you need help. But others do not respond, for example, yesterday I had a problem, I called them, they didn't come, later on a woman came to help me, but after struggling for a long time. (Male, Surgery, General Ward).]

However, another patient from surgical ward respond to this question said that

[Yes, as I told you at the beginning. you find yourself calling someone to help but he doesn't come, or he pretends not to heard, the language used is sometimes not polite. you came here to treat a patient, you are given the complaint but you don't respond. The needs are not fulfilled in a timely manner while the patient is struggling, that is not good service (Male, Surgery, General Ward).]

The theme indicates that patients are thought to be neglected and disrespected, especially when they need help from healthcare providers. Dependency and a changing environment have caused them to lose their dignity. As quoted from one of the participants

[…I agree, that is different when you are at home and hospital. May be because of dependency, when someone is sick they loss ability of performing their routine activities, and therefore need assistance frequently (Female, Orthopedic, General ward).]

Another female patient from the Internal medicine was also agreed that, illness can subject a patient to depend on others, this might subject him/her to a loss of dignity. As quoted below

[The patient's loss their dignity or are not respected when they are admitted to the hospital is due to dependence, sometimes patients are very serious ill and therefore depends on health care providers for everything. Unfortunately, sometimes healthcare providers get tired (Female, Internal medicine, Private ward).]

3.3. Patient Involvement in Medical Care

Shared decision-making remains one of the core principles of good clinical practices; respecting patients' right to know their informed preferences should be the foundation of professional decisions [25]. Patient involvement in decision-

making is recognized as a quality of care; this has been emphasized in various medical councils, including medical and nurses' councils. This enables the patient's participation in their care and treatment, giving them greater control over their health. When asked if they had been involved in the treatment plan, the patient had a diverse opinion. Some responded that they were involved; others did not. As quoted from one of the participants

["…Yes, I had been told everything, if there is any problem, for instance there is something I don't understand they clarifying accordingly. I am satisfied with response and the way I have been treated. (Male, Internal Medicine, General ward)"]

When asked if they had given the chance to ask questions, the patient said that

[I did not get time for asking questions, they are always busy, it is difficult to get that chance, when they came, they are so many and talking themselves then move to another patients (Female, Orthopedic, General ward)]

Another patient from surgical ward responded that

["… I did not be involved because If I will get involved I could be aware to understand if my CT scan CD will remain here or else. Because my colleague given their CDs. Myself I don't know why did not give the CD. (Male, surgery, General ward)."]

The results indicated that participants had diverse experiences regarding shared decisions on treatment plans. However, patients need to be respected and get involved in treatment decisions.

3.4. Inadequate Privacy and Confidentiality

The common theme that emerged from the data analysis was inadequate privacy and confidentiality. In some wards, participants insisted that covering with curtains their beds during an examination or any other procedures was necessary for dignity preservation. Their narratives revealed their concerns about privacy and confidentiality

["Confidentiality is not a problem for me. There is no day that have exposed my secrets parts and always done everything to me. it has never happened to kept me in a place that does not have privacy. In terms of confidentiality and privacy it is there as usual. (Female, Internal medicine, Private ward)."]

However, another patient responds that, the environment is not adequately support their privacy.

["… But our environment is not good for patient privacy and confidentiality, there is no curtains but some time they are using screen some time not. But what is needed is services, if it is given we thanks them" (Male, surgery, General ward).]

3.5. Accessibility and Affordability of Health Services

The majority of the patient was not having health insurance; therefore, they were not able to afford treatment costs. This led to remaining in the hospital even after treatment completion to wait until the payment is completed. As one of the participants responded below

[… "Sometime patients don't have enough money to buy medicines or some time they are treated and don't have money to pay. Therefore, staying in hospital for long time because they don't have money to pay…" (Male, surgery, General ward).]

However, another patient from the orthopedics ward responded they were not allowed to leave the hospital until he made the payments.

["… I had given a bill but I failed to pay, I am still looking for money. My relative talked to doctors and allowed to pay in installments. So, I am still in debt my mother promises to pay next month. (Male, Orthopedics, General ward)]

4. Discussion

Exploration of dignity preservation among patients who had been admitted to hospitals has little been done in Tanzania. Several factors that hinder dignity preservation in healthcare settings were identified in this study. These factors suggest that improving provider–patient relationships, patient privacy and confidentiality, involvement of patients in their own care, and improving accessibility and affordability of health services should be considered in the provision of dignified health care. These factors had also been mentioned in previous studies as an important element for patient dignity preservation in the hospital's settings [26–28].

In our study, we found that patients' involvement in their treatment plan, effective patient-provider relationship, respect for privacy and confidentiality were essential for dignified care. Most of the participants did not involve in their care, leading to a lack of awareness of their treatment plan which reduce their sense of self-worth. However, few patients were informed about their diagnosis and their plan of care. These patients felt valuable and respected. These findings support the previous research on the importance of effective provider - relationship in dignity preservation [29]. Another study conducted by Virdun et al (2015) revealed the importance of effective communication on dignity preservation [30]. A study by Mandu Stephen et al (2021) also identified the importance of an effective patient-provider relationship [31].

Participants also associated a lack of money to afford treatment costs with a loss of dignity. Some patients completed their treatments and were still detained in the ward due to failure to payment of hospital bills. Our study However, some participants in our study addressed the issue of inadequate privacy and confidentiality as barriers to dignity preservation, the findings of this study show patients admitted to the private's wards had their privacy maintained. Different from those admitted to general wards. An inadequate number of curtains and mobile screens to protect privacy during care compromised their dignity, this study is congruent to the study conducted by Marianne et al (2023) which revealed the importance of privacy and confidentiality in maintaining patient dignity [32]. The study conducted in Cyprus on nursing students' perceptions of patient dignity

also discovered that the need of respecting privacy and confidentiality in maintaining dignity is crucially important in patient care [33]. Physicians' and nurses' views on privacy and confidentiality to dignified care pointed out that awareness of healthcare providers about patient dignity, rights and communication has to be raised [34]. A report exploring the evidence for disrespect and abuse in facility-based childbirth mentioned lack of respect, non-confidential care, detention in facilities, and non-consented care as among the contributors to non-dignified care [35]. Paudel et al (2021) reported a high prevalence of disrespect and abuse during labor and delivery [36].

Revealed most of the patients were not having health insurance, therefore they were unable to manage the hospital cost. Bhoomadevi et al (2019) reported financial constraints as one of the factors influencing most of the patients seeking discharge against medical advice [37]. Another study conducted in Iran revealed that financial problems lead to poor access to health services [38]. The study conducted in Iran shows financial constraint was a source of patient abuse [39]. The financial implications for our study participants of the current study was some did afford the cost of medication, diagnostic and other surgical and medical procedures that were ordered by the healthcare professionals.

Study Limitation

The participants were recruited from a single hospital in the northern part of Tanzania, and this may affect the generalizability of these findings. The experienced shown in our study cannot reflect other patients as dignity is perceived in different cultural norms.

5. Conclusion

The study recognized several factors that hinder dignity preservation in hospital settings. Dignity is preserved when the patients are treated with compassion, respect their privacy, and are involved in treatment plans and decision-making. Barriers to dignity were inadequate privacy and confidentiality, lack of involvement in care, poor patient-provider relationship and lack of accessibility and affordability of health services.

List of Abbreviation

BMC: Bugando Medical Centre
QD: Qualitative Descriptive
CUHAS: Catholic University of Health and Allied Science
CREC: CUHAS Research Ethics Committee

Declaration

Ethics Approval and Consent to Participate

All methods were carried out in accordance with relevant guidelines and regulations, informed consent was obtained from all subjects and/or their legal guardian(s).

This study was approved by BMC/CUHAS ETHICS COMMITTEE and granted an ethical certificate approval, Ref. No CREC/556/2022. Permission for conducting the research was granted by the Director of Bugando Medical Centre. The consent was also sought from the participants before recruitment.

Consent for Publication

All authors read the manuscript and approved it for

Publication

Availability of Data and Materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Authors' Contributions

NG – Conceptualization, proposal writing, data collection, analysis and manuscript writing.

HM- Data collection and manuscript writing

GP- Conceptualization, designing of data collection tools and analysis

LA- Proposal writing, data collection, analysis and manuscript writing

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Conflicts of Interest

The authors declare that they have no competing interests.

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