

# Dynamics of dignity and safety

## Citation for published version (APA):

Goodwin, D., Mesman, J., Verkerk, M., & Grant, S. (2018). Dynamics of dignity and safety: a discussion. *BMJ Quality & Safety*, 27(6), 488-491. <https://doi.org/10.1136/bmjqs-2017-007159>

## Document status and date:

Published: 16/01/2018

## DOI:

[10.1136/bmjqs-2017-007159](https://doi.org/10.1136/bmjqs-2017-007159)

## Document Version:

Publisher's PDF, also known as Version of record

## Document license:

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# Dynamics of dignity and safety: a discussion

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Received 13 July 2017

Revised 5 December 2017

Accepted 18 December 2017

Published Online First

13 January 2018

## INTRODUCTION

‘Do no harm’ is an enduring principle of medicine, yet people continue to be harmed in the process of being ‘cared for’. Before the 1990s, there was very little understanding that poor quality might be inherent in the structures and processes of the healthcare system.<sup>1</sup> Now, as a result of considerable research investment, a great deal is known about, for example, hospital-acquired infection, surgical error, medication error, and the systems and processes that predispose practitioners towards error. Nevertheless, what it means to ‘care’ and how this might carry threats to safety has recently been exemplified by events at Mid Staffordshire NHS Foundation Trust in the UK. Here, there were consistently higher than average mortality rates and poor standards of care in which patients’ most basic needs were routinely overlooked; personal hygiene, nutrition and hydration were not maintained, and patients were treated without compassion or respect for their dignity.<sup>2,3</sup> Describing a pervasive culture of indifference to suffering and tolerance of poor standards of care, the public inquiry explicitly aligned a culture of staff disregard for patients’ dignity with threats to patient safety and drew attention to the value of compassion, kindness and respect for dignity.<sup>3</sup> The emphasis the ‘culture’ of healthcare work received as a result of events such as these further stimulated efforts to understand and, where necessary, change healthcare cultures.

So although the scope of what is now considered to fall within the remit of ‘safety’ research has expanded to include concepts like culture, still things fall out of view. It has been suggested that the current emphasis of patient safety initiatives on ‘technical errors’ such as surgical mishaps and medication errors means that other harms are overlooked and that ‘emotional distress’ should be considered

a legitimate harm on the grounds that it is ‘unwise to ignore the frustrating and dehumanizing experiences that erode a relationship which has caring as its imperative’.<sup>4</sup> Entwistle *et al* likewise argue that emotional harms are significant and point to the connection between emotional and physical harm when they highlight how negative staff responses to patients who raise safety concerns ‘appeared to contribute to various forms of harm’, ‘undermining their confidence, and depressing their inclination and ability to contribute to their care in future’.<sup>5</sup> Potentially, the need to quantify harm and measure the success of interventions to reduce it has channelled what is meant by ‘care’ and ‘harm’ in safety discourses to emphasise protocolised care and to focus on physical harm. It is a view difficult to escape when hospitals are obliged to demonstrate their awareness of safety by measurement and monitoring of such harms and to discharge their governance responsibilities through the development of safety policies and procedures. There is, of course, a growing body of qualitative research that questions whether safety policies and formal measures, however strictly they are followed, are enough to secure safety.<sup>6,7</sup> Building on this impetus to conceptualise safety more broadly, we argue that there is a need to open up what is meant by care and harm, to explore a particular aspect of care and how it affects safety that (with some exceptions discussed below) does not feature largely in discourses on safety, that is, dignity.

Although there is lively debate about dignity in bioethics, with some dismissing it as a ‘useless concept’, meaning ‘nothing more than a capacity for rational thought and action’,<sup>8</sup> and others seeing dignity as a foundational principle, an innate quality possessed by individuals, an inalienable right and of intrinsic value,<sup>9</sup> it is mostly treated as something separate, unrelated



**To cite:** Goodwin D, Mesman J, Verkerk M, *et al*. *BMJ Qual Saf* 2018;**27**:488–491.

even, to safety. What is more, the philosophical meanings of dignity are not very well connected to the empirical work on dignified and safe care. Even in nursing studies, the philosophical and ethical notion of dignity has been stressed without connecting it to more empirical issues on safety.<sup>10</sup> Here, as elsewhere, dignity is positioned as an ethical value important in its own right,<sup>11</sup> integral to high-quality care, professional education and training.<sup>12</sup> Consequently, the connections with safety remain undeveloped.

In contrast to the idea of dignity as an abstract value, we propose to define dignity as a social practice as something that requires a certain sort of action: as something that can be threatened or promoted by caring practices. Pols *et al* explain that dignity may also be understood as a state that can be violated, for example, when patients are not assisted to the toilet in a timely manner and soil themselves. In such cases, the lack of dignity is often used to expose poor care situations.<sup>13</sup> In countering these indignities, dignity is often promoted by encouraging practitioners to adopt a more attentive attitude towards patients and clients. For example, the ‘Dignity Challenge’, aimed to promote more dignified care by developing particular attitudes within the practitioners in their daily behaviour with their patients.<sup>14</sup> However, dignified care is not simply attentive care, but is in itself a contested and social practice that asks sometimes for difficult moral weighing of conflicting values. Introducing dignity as a social practice, we emphasise the comparative, contingent and ambivalent dimensions.<sup>9</sup> The idea that dignity can be seen as something to be understood and managed in a uniform, transparent and even measurable way is too simplistic. In developing this idea of dignity as a social practice, we make room for other, sometimes conflicting, values and dimensions of care, such as safety. Therefore, in this paper, we argue for the need to bring these two concepts together and that their relationship deserves more attention in research, policies and practice.

### OPENING UP THE DYNAMICS OF THE DIGNITY–SAFETY RELATIONSHIP

Exploring the relationship between dignity and safety requires a close look at how these concepts are understood and enacted in everyday healthcare practices. In practice, dignity and safety shape each other in ways that as yet are poorly understood; sometimes there are trade-offs where prioritising safety might come at the cost of a person’s dignity, but sometimes there are mutualities where caring about a person’s dignity also results in safer care. Therefore, the ways dignity and safety are configured in situated practices hold consequences for both the quality and safety of care.

Hillman *et al*<sup>15</sup> describe a situation in which safety was traded against dignity. They illustrate how a falls reduction target on an elderly care ward promoted a culture of restriction of patients and defensive nursing

practices. To reduce the risk of falling, patients were encouraged to remain in their beds and chairs and to use commodes and bedpans instead of walking to the toilet. These measures safeguard a certain level of safety but brought with them a reduction in dignified care. Staff, on the other hand, felt under threat of complaints and protected themselves by record-keeping, paradoxically at the expense of caregiving. When enacted this way, safety came at the cost of dignity. Because healthcare organisations are complex sociotechnical systems where cause and effect are not related in a linear way, there is far more to patient safety and quality of care than the following of measurable policies and interventions with predetermined definitions of safety. Pols *et al*<sup>13</sup> describe a complex situation wherein different versions of dignity aligned with or threatened safety. A man insisted he be allowed to die at home despite poor economic circumstances which meant electricity and gas supplies had been terminated. Without electric to light the property, and to move the electric bed (to which he was at this point bound), and without gas to heat the property, community nurses were not permitted to attend. Lacking nursing care, proper heating and lighting, it was neither a safe nor dignified environment for a man to die in, yet to move the man to an inpatient setting would override his most vehement wish. By adhering to his wishes, rather than prioritising his safety and physical comfort, the man maintained a situated, although imperfect, form of dignity. This example demonstrates why, as Aranda and Jones argue, simplistic, uniform or formulaic practices of respecting dignity are inadequate.<sup>9</sup> In addressing undignified care—whether as a threat to safety (as detailed in the Mid Staffordshire case outlined above) or as a consequence of interventions to improve safety (as in the case of the falls reduction target discussed above)—the complexity of care should be recognised, including the contingency, inherent conflicts of value and sometimes the impossibility of achieving an outcome that satisfies the demands of differing understandings of dignity and safety and their priority.

Therefore, we propose to move from dominant discourses of safety and dignity that limit exploration of the relationship between these two concepts and towards an understanding that is rooted in their co-creation through practices of healthcare delivery. Within safety discourses, there already exists the argument to view safety as a practice, paying close attention to the circumstances of its production. Dekker and Hollnagel<sup>16</sup> argue that safety should be seen as ‘dynamic, interactive, communicative acts that are created as people conduct work (...) and gather experiences from it’. Likewise, for us, dignity involves recognition of the person that you are, and it should be seen as contingent and experienced, bestowed or earned through *interaction* in social settings.<sup>9</sup> Dignity is therefore to be seen as a social and contested practice in which respecting the dignity of a person does not involve valuing and

treating her as a case of generic personhood, but more as the concretely particular person she is.<sup>17</sup> As such, we suggest that greater emphasis should be paid to examining personhood as a holistic concept that incorporates a range of key dimensions including the physical, relational, emotional and spiritual aspects of people and their social interactions. In short, dignified and safe care is an experienced and embodied practice that implies moral work with its own complexities, including, sometimes, moral trade-offs.

Healthcare practices, however, are shaped in important ways by the context in which they are enacted. Indeed, 'shaped' is perhaps understating the matter. Cultures of healthcare work inform and are informed by practices in a reciprocal and continually evolving way. Drawing on social and anthropological understandings, culture should be viewed, not as 'a thing', 'out there'<sup>18</sup> but as historically contingent local practices that interact in complex ways with external bodies and discourses outside the workplace such as shifting policy contexts,<sup>19</sup> the standards, norms and values of professional bodies,<sup>20</sup> the politics and hierarchies within and between different staff groups.<sup>21</sup> Therefore, in the context of healthcare work, we understand 'culture' as the dynamic, contestable and emergent configuration of values, competencies and practices, through which dignity and safety are enacted. Safety and dignity are thus intertwined and practised relationally within particular social and cultural contexts. It is through this safety–dignity co-shaping that dynamic trade-offs are created both within and across different healthcare contexts. By way of example, Tadd *et al*<sup>22</sup> explain how financial incentives and targets (eg, of 97% bed occupancy) work against patient-centred care central to treating people with dignity (when it results in repeatedly relocating patients so that it disorients or exacerbates confusion). They argue that practices such as these 'results in a culture that is risk averse and often defensive, where care is undervalued; a culture where professional accountability and discretion is replaced by standardised checklists, pathways and audits resulting in the view that if an aspect of care can't be measured it doesn't matter; a culture where getting the job done matters more than how the job is done, so that the focus is primarily on the tasks rather than seeing the people who matter'. Such an understanding of dignity and safety as culturally embedded practices is thereby sensitive to the macro-level, meso-level and micro-level characteristics of particular organisational settings and the impact of issues such as interprofessional power dynamics, professional–patient–family relationships, and formal and informal communication on the potential to enact safe dignity and dignified safety in particular ways.

#### CONCLUSION: RESEARCHING DIGNITY AND SAFETY AS CULTURALLY EMBEDDED PRACTICES

We have argued that the relationship between dignity and safety is underexplored and that the effects of the various dignity–safety configurations are currently poorly

understood. Research is needed to explore the complex web of relations between safety and dignity—the way practices of safety and dignity are embedded within, and informed by, local healthcare contexts and the actions and understandings of professionals, patients and families. This is important as sometimes interventions to improve safety can have unintended consequences that are counterproductive or that can detract from the quality of care by overriding concerns for patients' dignity. To explore the various dignity–safety configurations and their effects, we suggest that a critical and reflexive approach to quality and safety research and improvement is necessary. This approach requires listening to different participants in care as they are invited to reflect on their moral understandings about their identities and practices as people, professionals, carers and so forth, what is valued in relationships and how this informs healthcare practices. Importantly, reflection and discussion are also necessary to analyse the inherent complexities and trading off that occur between the different values involved, such as safety and dignity. Likewise, it requires uncovering local everyday interprofessional practices by which inevitable, often less predictable risks are managed and mitigated by practitioners using their tacit knowledge, innovation and flexibility.<sup>23</sup> In this reflection, to normatively evaluate practices, we endorse an empirically nourished ethics that is acutely aware of its situatedness, that is, ethics is the practice of particular people in particular times, places, cultures and professional environments.<sup>24</sup> We propose that the methodologies best suited to accessing practices that secure and threaten dignity and safety across different organisational settings, and to facilitating empirically nourished ethics, are research methodologies such as ethnography, video reflexive ethnography (VRE) and participatory action research.

Ethnography is an established research approach, well attuned to the close and detailed study of cultures. Its objective is 'to describe the lives of people other than ourselves, with an accuracy and sensitivity honed by detailed observation and prolonged first-hand experience'.<sup>25</sup> Ethnography focuses on local knowledge and is sensitive to the intricacies of micro-level processes and practices. Pink and Morgan<sup>26</sup> advocate a short, intensive form of ethnography using video. They argue that it maintains the first-hand involvement of the ethnographer as a core way to learn about other people's lives, practical activity and the unspoken, sensory and tacit elements of everyday life. Moreover, video not only provides rich visual data but reviewing the recordings works as an ongoing intensive form of engagement with the field. This intensity becomes part of the way the researcher comes to understand and empathise with participants. An approach that capitalises on the benefits of video-ethnography and couples it with a collaborative and interventionist approach is VRE.<sup>27</sup> In addition to the methods described above, VRE requires participants and researchers to work in productive partnership and reflexively analyse video footage of practitioners' own practice.<sup>28</sup> Such analyses produce nuanced

understandings of practice in all its complexity, aspects of which might otherwise be taken for granted, and provide the basis for practitioner-led interventions to enhance practice.<sup>28</sup> Participatory action research is another research approach defined by its involvement of participants and interventionist design. Participatory action research is usually multimethod, often mixed method, multiperspectival, and 'seeks change in what people do, how they interact with the world and with others, what people mean, what they value, and the discourses in which people understand and interpret their world'.<sup>29</sup> The added value of these latter two approaches lies in their collaborative and interventionist nature. For these approaches, research into practice is not a further step after publication, rather participant-led change is an integral step in the research and a way of fulfilling the potential for improvement made possible through the research process. Importantly, both participatory action research and the VRE method provide the actual means for practitioners to tap into group wisdom and explore the way dignity and safety are practised relationally within the particularities of their own organisational setting.

**Contributors** All authors have contributed to the development of ideas expressed in this article and to the drafting and editing of the article.

**Competing interests** None declared.

**Provenance and peer review** Not commissioned; externally peer reviewed.

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