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Learning and unlearning dignity in care: Experiential and experimental educational approaches

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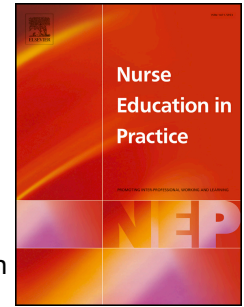
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ORIGINAL RESEARCH

TITLE

Learning and unlearning dignity in care: experiential and experimental educational approaches

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REVISED TITLE:**Learning and unlearning dignity in care: experiential and experimental educational approaches****ABSTRACT**

Guarding against loss of human dignity is fundamental to nursing practice. It is assumed in the existing literature that 'dignity' as a concept and 'dignity in care' as a practice is amenable to education. Building on this assumption, a range of experiential and experimental educational approaches have been used to enhance students' understanding of dignity. However, little is known about student nurses' views on whether dignity is amenable to education and, if so, which educational approaches would be welcomed. This mixed-methods study used an online questionnaire survey and focus groups to address these questions. Student nurses in Scotland completed online questionnaires (n=111) and participated in focus groups (n=35). Students concluded that education has transformative potential to encourage learning around the concept of dignity and practice of dignity in care but also believed that dignity could be unlearned through repeated negative practice exposures. Experiential and experimental educational approaches were welcomed by student nurses, including patient testimony, role-play, simulation, and empathy exercises to step into the lives of others. Nurse educators should further integrate experiential and experimental educational approaches into undergraduate and postgraduate nursing curricula to guard against the loss of learning around dignity students believed occurred over time.

Key words: Human Dignity; Nursing Students; Nursing Education; Role Play; Testimony; Experience.

INTRODUCTION

Guarding against loss of patient dignity is enshrined in codes that guide and govern nurses' practice around the globe (e.g., United Kingdom Nursing and Midwifery Council 2015, Nursing Council of New Zealand 2012, Nursing and Midwifery Board of Australia 2008, Canadian Nurses Association 2008). Nurse educators are charged with encouraging their students to become confident with dignity as a concept and competent to deliver dignity in the care of patients and their families. Over the past two decades a range of experiential and experimental educational approaches have been used to challenge student nurses' knowledge and understanding of the concept of dignity and practice of dignity in care, including: patient narratives (Raholm, 2008), photo-elicitation (Brand and McMurray 2009), drama (McGarry and Aubeeluck 2013) and discussion (Goodman 2013). This shows that nurse educators believe that dignity as a concept and dignity in care as a practice are amenable to education. It is not known if student nurses agree. Also, with the notable exception of Goodman (2013), spaces for educators and students to come together and discuss and decide upon the educational approaches most likely to result in this conceptual confidence and practical competence around dignity have rarely been created. This paper draws on a study that co-designed dignity education with student nurses to answer two key questions: (1) Do student nurses think that dignity is amenable to education?; and, if so; (2) what educational approaches do student nurses think should be used? In doing so, the paper examines the educational approaches that might enhance students understanding of the theory and practice of dignity to enable them to meet their obligations set out in international codes of practice.

BACKGROUND

Dignity

Debates around the substance and implications of the idea of dignity take place across a spectrum of international and local contexts, both theoretical and practical. These debates appear to have gained renewed vigour since the idea's inclusion, most prominently, in the founding document of the international human rights regime, the Universal Declaration of Human Rights. This Declaration, in response to the extreme violations of dignity witnessed during the Second World War, recognised the "inherent dignity and [...] equal and inalienable rights of all members of the human family" (United Nations [UN], 1948: Preamble). Discussing dignity in this human rights context, international lawyer Oscar Schachter aptly stated, "I know it when I see it even if I cannot tell you what it is" (Schachter 1983: 849). This characteristic feature of the dignity idea – that it is at once abstract yet recognisable in its violation (Kaufman et al. 2010) – motivates a rich and diverse conversation in contemporary scholarship about the dignity idea's origins and implications (for example, Düwell et al. 2014, McCrudden 2013). The practical implications of this abstract idea are paramount, because dignity is both promoted and undermined in concrete local, social interactions, including those interactions in the context of healthcare in general, and nursing in particular (Munoz et al, in press). Recognising this, nurse educators have advocated for different forms of pedagogy around the idea of dignity.

Dignity education

Surveying recent scholarship, Matiti (2015) notes that student nurses lack knowledge about dignity and have little awareness of government documents promoting dignity in care. She argues that despite the considerable definitional complexity surrounding the use of the term, dignity can be influenced through education and should be taught in its own right (Matiti 2015):

“The danger of teaching ‘dignity’ as part of other subjects is that it tends to be treated superficially and not taken seriously, thus ignoring its value and complexity. A conscious and critical exploration of the various attributes that constitute dignity helps to ascertain how each attribute operates both in theory and in practice.” (Matiti 2015: 2).

She suggests that to date “the concept of patient dignity has received little attention in healthcare curricula” and is only now “gradually being incorporated” (Matiti, 2015: 1) and several experiential and experimental approaches have been developed. For example, Raholm (2008) argued that the use of patient narratives, especially those exploring the ethics of human suffering, can affirm dignity and called for nurse educators to develop learning environments that encourage students to listen to patients’ narratives. Brand and McMurray (2009) evaluated the use of photo-elicitation that enabled students to reflect on care delivered to older adults and found that the experience encouraged students to reflect on dignity as a core nursing value and called for closer engagement with arts-based approaches in nurse education. McGarry and Aubeeluck’s (2013) evaluation of a drama-based educational initiative designed to enable students to explore the core concepts of dignity and communication found that the experience enhanced students’ understanding of the concept of dignity and deepened their appreciation of different perspectives on dignity. However, despite repeated calls for dignity education to be integrated into nurse education (Matiti 2002, Cotrel-Gibbons and Matiti 2011, Matiti 2015) and development of educational techniques to enhance students’ conceptual confidence and practical competence around dignity, only rarely has dignity education been designed *with* student nurses.

Co-designing dignity education

Co-design processes are increasingly prominent in healthcare, especially to ensure services and interventions are appropriate and designed in partnership with service users (Munoz, 2013). However, co-design has only recently been embraced within dignity education. Goodman (2013) describes the development of a five-step approach to enhance appreciation of dignity designed with UK nursing students. This framework involved: 1) using real-life case studies to illustrate and reflect; 2) discussing and exchanging different perspectives; 3) reviewing literature, codes of practice and policy; 4) contrasting the different nursing models that do/do not incorporate dignity; 5) analysing practice (Goodman 2013). Our study was designed to harness this potential for co-design to create innovative educational interventions.

During 2013-14 a collaborative interdisciplinary project involving nurse educators, legal academics and health geographers was conducted. The aim of the project was to co-design dignity education with student nurses. The first step of this co-design process was, however, to address the gap in evidence around whether student nurses believed that dignity as a concept and dignity in care as a practice were amenable to education. This paper reports the findings from this first step. Student nurses' perceptions of dignity revealed through the co-design process and a suggested typology for integration of the specific educational approaches identified here is described in detail elsewhere (Munoz et al, in press).

METHODS**Study design**

A mixed-methods study was conducted, including an online questionnaire survey and focus groups. In line with established mixed-methods research practice (Creswell 2003), questionnaires were used to gather a broad overview of the educational approaches that

might enable learning around the concept of dignity and practice of dignity in care. Focus groups with a sample of questionnaire respondents enabled these issues to be discussed in greater depth.

Data Collection

Online questionnaire survey

Between October 2013 and June 2014, all 303 undergraduate student nurses across adult and mental health fields of practice at two campuses of a Scottish university were invited to participate in an online survey created using Bristol Online Surveys; 111 (36.6%) students completed the questionnaire. Invitations were sent to students via a message on the virtual learning environment (VLE) used to support education in the institution and a description of the study was presented to each cohort face-to-face, where information sheets and consent forms were also made available to interested participants. The questionnaire included 18 questions with a combination of Likert-scale and free-text response options, designed to be completed in 15-20 minutes. Questions gathered data on socio-demographic characteristics (including age, gender, stage in their studies, and previous care and practice placement experience) and asked students questions about their knowledge and understanding of dignity and how dignity education might best be designed. Computer facilities on campus were made available for a one-hour period to enable students to participate. Participation was voluntary and students did not need to attend the computer facilities at this time or to complete the questionnaire.

Focus groups

Focus groups were conducted with 35 students in each cohort of the three-year undergraduate programme at one campus (Year 1: n=13; Year 2: n=9; Year 3: n=13). Focus groups were an hour in duration and structured by asking students: (1) if they thought that

dignity was amendable to education; and, (2) if so, what educational approaches did they think should be used? Initial discussion in smaller groups was followed by whole-group discussion. Focus groups were facilitated by two researchers; one researcher moderated discussions with a second acting as observer and note-taker. One researcher in each focus group was not involved in undergraduate teaching. Discussions were audio-recorded and transcribed verbatim.

Data Analysis

Quantitative data from questionnaires were analysed descriptively using SPSS v19.0 and reported as n (%). Content analysis was used to analyse free-text responses from questionnaires. To ensure rigour, focus groups data were analysed thematically through a three-stage process. First, each author read all transcripts independently to become familiar with the data and identify initial codes. Second, a data workshop was held at which the data and initial codes were discussed by all authors. Finally, the agreed codes were applied to the data. Data across cohorts were integrated prior to analysis, although the point a student had reached in their programme is noted in reporting to contextualise their response.

Ethics

The study was approved by the Research Ethics Committee of the University [anonymised for review]. All students provided written informed consent prior to questionnaire completion and focus group participation. Due to the assurance of anonymity for questionnaire participants it was not possible to link questionnaire responses with focus group comments. Quotations from questionnaire data are indicated by single quotation marks ('...'), with double quotation marks used for focus group/workshop comments ("..."). Anonymity is preserved through the use of a unique participant number to identify each student's focus group comments (e.g., Student 1 / Year 1 [S1/Y1]).

RESULTS

Sample

Nine in ten questionnaire respondents were female (91.0%) and in the adult nursing field of practice (87.4%), and half (54.1%) were aged 18-24 years, reflecting the profile of the nursing programme in the institution (Table 1). Four in ten (40.5%) students had care experience prior to entering their undergraduate programme.

[Insert Table 1 here]

Learning and unlearning dignity

Most students (83.7%) 'disagreed' or 'strongly disagreed' with the following negatively worded statement on the survey: 'health professionals cannot be taught about human dignity' (Figure 1).

[Insert Figure 1]

Focus group participants, however, voiced certain limits to the extent to which dignity could be learned during nurse education. Some suggested that education could only enhance innate characteristics or understandings of dignity that were modelled during childhood – most often by parents/carers. For example:

“I think it’s definitely a skill that can half be taught but I think it’s also something that needs to be within us as care providers and it needs to be a side of us that needs to show compassion and knows and wants to show compassion and that needs to be

nurtured with further education about dignity and understanding people and empathy and things like that.” (S3/Y2)

“I would say that is already taught to you by your parents so yeah dignity is completely a taught thing it’s not something to be honest you are born with and you are not born with this idea of dignity it’s something you would learn, it’s a concept that you have to be taught what it means as well.” (S5/Y2)

Dignity was understood as a *learned* behaviour and attitude amenable to change through positive and negative external influences. Collegial and contextual influences were central. Practice placements were key places where understanding of the concept of dignity and practice of dignity in care was developed and maintained, mainly through mirroring behaviours modelled by qualified nursing and medical staff. For example:

“I would like to think that I didn’t need to come to University to know how to speak to somebody properly and show somebody some respect and respect their privacy. Not getting away from the fact that there is so much to learn and when you’re in a practice placement I think you learn from the members of staff who are positively promoting people’s dignity.” (S4/Y1)

Sustained practice exposure did, however, also lead students to conclude that dignity could be *unlearned* over time. For example, one student struggled to understand how dignity could be depleted if it had been reinforced through education:

“I’ve worked alongside nurses and for the life of me I can’t figure out why they are a nurse and if it isn’t there then I don’t know why, you know, if you’ve come through

University, they've come through University and they are working on the job and they are working beside other nurses and sometimes it's just not there and that makes me wonder if it is something that can be taught." (S4/Y1)

Others stressed the potential deleterious influence of repeated exposure to practice cultures:

"Dignity can be affected by who you are with and the way you treat people is important as well in line with teaching dignity then seeing even the nicest person whose had a really good upbringing always polite can be that other person on the ward when they're surrounded by that kind of environment and it's not always a comment on the person." (S9/Y1)

In short, students suggested that dignity in care could be *learned* through education and positive practice exposure, but it could also be *unlearned* through the influence of negative practice culture.

Education approaches to enhance dignity

Content analysis of free-text questionnaire responses identified that the most commonly suggested educational approach to enhance understanding of dignity and practice of dignity in care was 'role play/simulation' (23.4%), followed by 'patient experience' (19.8%), 'case studies/scenarios' (19.8%) and 'empathy exercises' (13.5%) (Table 2). Students' views on each are discussed in turn.

[Insert Table 2 here]

Role play / simulation

Students noted that ‘although most people hate role play, it is a good way to learn’, ‘practic[ing] being patients on each other’ and simulating examples of situations where dignity in care was and was not evident would enhance students’ awareness of the consequences of undignified care during routine tasks, such as moving and handling and feeding. Although in general, ‘assessment’ did not feature prominently in questionnaire responses (only 7.2% of students noted that assessments, mainly essays, could encourage learning about dignity), focus group participants suggested that aspects of dignity in care practiced through role play or simulation could be assessed through an Objective Structured Clinical Examination (OSCE).

Patient experience

Students suggested that teaching should incorporate listening to patients’ stories, either in person or via video-recordings, as well as engagement with patients’ written accounts. Specifically, students welcomed opportunities to have discussions with patients where they reflected on care experiences that they perceived to be dignified and undignified.

Focus group participants reinforced the importance of patient experience, but encouraged educators to ask service users to reflect on the positive experiences of dignified care as a counterbalance to the perceived over-emphasis on examples of care that fall short of expected standards of dignity that were more frequently described in the classroom:

“I also feel like they should bring like the positive experiences like patients and stuff on how they did get treated with dignity because I think a lot of the time as nurses and nursing students we are all taught “oh look at how we’ve done all this wrong and we need to be better” but maybe we should be taught about the good experiences

because there is maybe one in ten that gets a good experience and maybe more that get bad experience but that's all we learn and do we really know whether we are doing good or bad because we are only taught about the bad stuff." (S5/Y2)

Case studies / scenarios

Students felt case studies and scenarios could enable them to better understand the impact of care that is perceived by patients as undignified and equip them to deal appropriately with undignified care when encountered in practice.

"Scenarios/case studies of undignified care. Videos of undignified care as this is what people remember the most and they will recognise these situations in care and hopefully step in." (S4/Y3)

"Showing case studies of when dignified care was not carried out to help us understand what is not acceptable and why." (S2/Y3)

Specifically, students requested inclusion of video recordings and documentaries based on investigative journalism that presented balanced accounts of care that was considered by patients as dignified and undignified care. This revealed a desire for realistic insight into dignity in care and echoes students' views on how patient experience could best be incorporated into education.

"Videos of good and bad practice. Not just the extremes of both though. Practice which on the surface seems ok but is not great should be shown and also from the nurse's point of view so students understand why less dignified care takes place."
(S5/Y2)

Also, in both questionnaire responses and focus groups, students frequently stated that case studies and scenarios should be followed by small group discussions.

“In a small group everyone tends to participate and you get different ideas and people’s opinions come out and it’s a better way of learning than just sort of all being sat with someone talking to you which is so easy to just go “oh” and ignore them so I think small groups is definitely the way to do it.” (S3/Y1)

Empathy exercises

Empathy exercises were conceived by students as opportunities for students to “put themselves in patients’ shoes” (S1/Y3). Such exercises often involved individual visualisation to imaginatively access vicarious experience of dignity in care. Often, reflecting on the experiences of family members provided the entry-point for such thought experiments:

“Encourage students to think about how they would like their loved ones to be treated while receiving care.” (S3/Y1)

Empathy exercises were distinct from group-based approaches such as role play where nursing tasks, such as hoisting or feeding, could be simulated with or without due regard to patient dignity to gain insight. Indeed, students reflected on the way in which ‘empathy exercises’ shifted emphasis away from nursing skills, toward the emotions experienced by patients.

“Don't know if this something you could teach but trying to get students to empathise with their patients - to put themselves in their position and consider

what might make them feel their dignity was being compromised - perhaps encouragement of more reflection with a particular emphasis on dignity rather than practical nursing skills.” (S3/Y2)

Moreover, such exercises were considered to encourage an empathetic, non-judgemental stance towards patients by understanding the values and experiences that shape individuals' attitudes and actions.

DISCUSSION

Most students in our study thought that dignity as a concept and dignity in care as a practice was amenable to education through the nursing curriculum. However, students also believed that nurse education could build upon existing values shaped through early life experiences and reinforced through positive relational influences and environments thereafter. Considerable attention has already been paid to the recruitment of potential nursing students based on sets of attributes that disclose underlying values, behaviours and personality traits. Policy-makers and educators are increasingly placing importance on the values that are required to be evidenced on entry to nursing programmes in the UK, and a focus on values-based recruitment features prominently in workforce strategy in Scotland (Scottish Government, 2015) and England (Health Education England, 2015) in response to recent care scandals across the NHS (Francis, 2013; Department of Health, 2013). For example, Waugh et al (2014) discuss a person-specification for caring nurses and midwives drawn up between students and practising nurses. Our study found, however, that while students perceive their underlying values as important, they also consider them amenable to change through education. Thus, greater emphasis may need to be placed on the value of education and its transformative potential to enhance students' understanding of dignity and practice of dignity in care.

In our study, educational approaches welcomed by students focused on *experiencing* the embodied and relational dimensions of dignity, in line with their perceptions of dignity revealed through the co-design process (Munoz et al, in press). For example, experiencing dignified care either vicariously through patient experience or case scenarios, or directly through role-play or simulation. Blomberg et al (2014) discuss the behaviours that student nurses in perioperative care encounter and emphasise the embodied nature of dignity in care evident through the behaviour of staff towards each other and people in their care. Hence, it is important that embodied understandings of dignity in care are integrated into nurse education. Similarly, *experimenting* through empathy exercises that transported students into the lives of often older family members were also vital. Students stressed the importance of *experiential* and *experimental* educational approaches that take seriously the embodiment and relationships at the core of dignity in care, thereby marking a shift away from didactic approaches to education. Currie et al (2015) observe that students are often preoccupied with learning about what nurses do (suggestive of a didactic learning experience) and not necessarily how that practice is experienced by patients which might be better understood through, for example, reading case-notes and care-plans, having spaces and time for reflection, and facilitated engagement with patients. Students in our study desired similar approaches. It is doubtful that didactic approaches can adequately enhance students understanding and practice of human dignity. Although students did acknowledge the importance of lectures and assessments, far more frequently students' responses and discussions were educational approaches that rely on small group teaching. This may present a direct challenge to the present mode (and out-moded) model of nurse education relying on large lecture sessions as part of an overly-crowded curriculum (Taylor et al 2010). However, our findings suggest that carving open spaces for small group teaching is critical.

Creative solutions to the challenges of delivering small group teaching in the face of diminishing resources and increased demand for nursing education should be sought.

Just as students perceived that dignity could be learned through education, equally importantly, our study found that students believed that dignity could be unlearned through repeated negative practice exposure. Importantly, the experimental and experiential educational approaches most welcomed by students in our study were those that enabled students to physically or figuratively practice dignity in care through role play/simulation, patient experience, case studies/scenarios and empathy exercises, rehearsing clinical situations they may encounter in practice to steel their resolve to ensure that they delivered dignity in care and stand up to situations where standards of dignity fell short of those expected by patients. Thus, while our study has confirmed that the experiential and experimental educational approaches that have been used in nurse education to date (Raholm, 2008; Brand and McMurray 2009; McGarry and Aubeeluck 2013; Goodman 2013) are welcomed by students, it goes one step further and suggests that these approaches are vital to guard against the perceived loss of conceptual confidence and practical competence around dignity that (potentially) comes after qualification once students are working in not always positive practice environments. Our findings also suggest that students could be given the opportunity, through the use of such diverse, critique-based educational approaches to engage with the complexities of human dignity. Students' responses to the broadly-designed question indicated unarticulated assumptions about the nature and 'location' of dignity within nursing interactions. Responses suggest different perspectives on what dignity is (for example, a skill, an outlook, a particular need for privacy, and so on) and whether dignity inheres in the care-giver, and/or in the care-recipient, and how these perspectives might inter-relate. This observation supports that of Matiti (2015: 2) that a "conscious and critical exploration" of the challenging concept of human dignity is a valuable

educational goal. Hence, our findings strengthen previous calls for dignity to be a core component of pre-registration nurse education (Cotrel-Gibbons and Matiti 2011, Matiti 2015) and suggests that this could best be achieved by further embedding experiential and experimental educational approaches in nursing curricula. Such approaches can enable students to learn the theory and practice of dignity in care and, more importantly, guard against unlearning of dignity over time.

Strengths and limitations

To our knowledge, this is the first study to assess whether student nurses perceive dignity to be amenable to education. It is timely due to renewed emphasis on guarding against loss of dignity in care settings following care scandals in the United Kingdom, as well as on-going international debate around educational approaches to enhance values-based nursing practice. Our findings therefore inform development of nursing curricula both in the United Kingdom and internationally and offer educators insight into the approaches that are likely to be welcomed by student nurses.

However, our study has a number of limitations. First, research was conducted on two campuses in a single university in Scotland. The experiences and attitudes of study participants may not reflect the wider student nurse population in Scotland or elsewhere. Further large-scale comparative studies across institutions both in the UK and internationally are needed to understand potential variation in attitudes toward dignity education and acceptable educational approaches across regions and countries. This is especially important given potentially different cultural understandings of dignity. Second, the questionnaire response rate was relatively low (37%). Findings may not therefore be representative of the three cohorts of nursing students in this institution, and may be prone to selection bias, as those most interested in the concept and practice of dignity or

educational innovation would have been more likely to participate in the questionnaire and subsequent focus groups. Future studies should attempt to develop strategies to elicit a wider range of views in order to inform curriculum design and give educators increased confidence that particular approaches will be welcomed by student nurses.

CONCLUSION

Students concluded that education has transformative potential to encourage learning around the concept of dignity and practice of dignity in care. However, students also believed that dignity could be unlearned through repeated negative practice exposures. Experiential and experimental educational strategies, including hearing patient testimony, engaging in role play and simulation, and conducting empathy exercises to step into the lives of others, were welcomed by students as approaches to enhance their understanding and practice of dignity in care. Nurse educators should find ways to further integrate experiential and experimental educational approaches into pre-registration nursing curricula and continuing professional development to enhance students' conceptual confidence with dignity and practical competence in delivering dignity in care and guard against students' unlearning dignity over time.

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TABLES

Table 1: Questionnaire sample characteristics

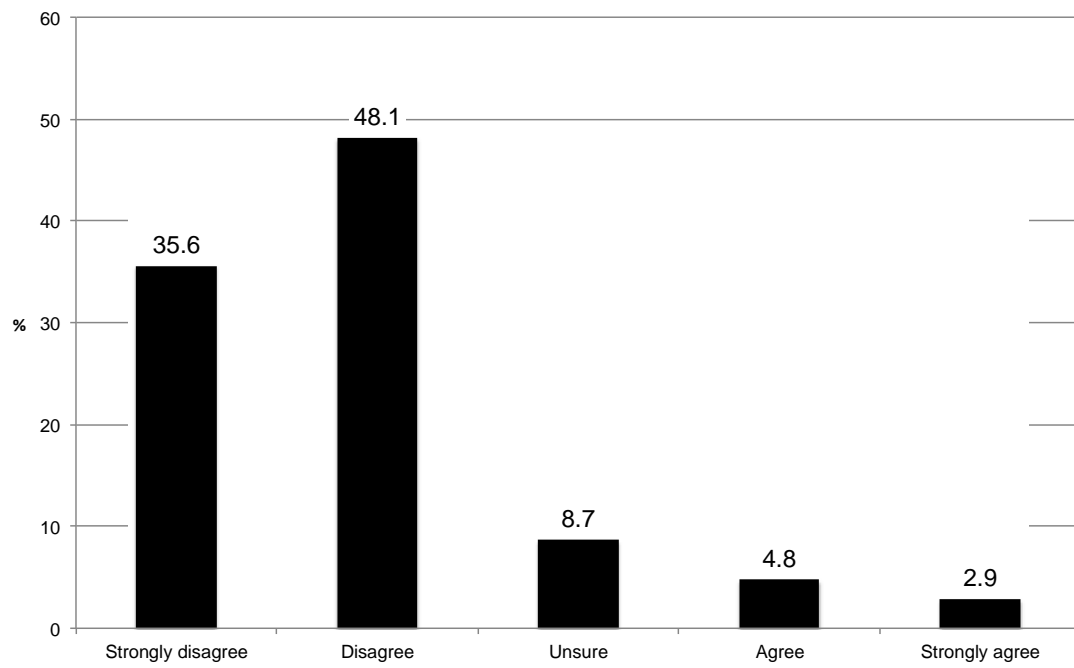
	%	(n)
Gender		
Female	91.0	(101)
Male	9.0	(10)
Age		
18-24	54.1	(60)
25-29	16.2	(18)
30-39	18.0	(20)
40-49	9.0	(10)
50-59	2.7	(3)
Year of study		
1st	44.1	(49)
2nd	14.4	(16)
3rd	41.4	(46)
Field of practice		
Adult	87.4	(97)
Mental Health	12.6	(14)
Previous care experience		
Yes	40.5	(45)
No	59.5	(66)

Table 2: Suggested pedagogical approaches to promote dignity

Rank	Approach	%	(n)
1	Role Play / Simulation	23.4	(26)
2=	Patient Experience	19.8	(22)
2=	Case studies / Scenarios	19.8	(22)
4	Empathy exercises	13.5	(15)
5	Reflection	12.6	(14)
6	Lectures	11.7	(13)
7=	Placement Experience	9.0	(10)
7=	Role Modelling	9.0	(10)
9	Practical Sessions ¹	8.1	(9)
10	Assessments	7.2	(8)
11	Communications Workshop	5.4	(6)
12	Workshops ¹	2.7	(3)

Note: ¹ Unspecified content.

FIGURE

Figure 1: Statement: 'Health professionals **cannot** be taught about dignity'.

Highlights

- Guarding against loss of dignity in care is enshrined in international nursing codes of practice.
- Nurse educators have developed educational approaches to challenge student nurses' knowledge and understanding of dignity.
- Student nurses' views on whether dignity is amenable to education and the educational approaches most welcomed are not known.
- Student nurses concluded that dignity could be learned but also unlearned through negative practice experiences.
- Experiential and experimental educational approaches including patient testimony, role-play, simulation and empathy exercises were welcomed by students and should be further embedded in nursing curricula.

Conflict of Interest Statement

The authors declare that they have no conflict of interest.

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