

Development and Validation of the Scale of Perception of Respect for and Maintenance of the Dignity of the Inpatient [CuPDPH]

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Abstract

Background. Dignity is a fundamental concept that is affected and altered in the course of hospitalization by professional's behaviour. Despite the importance of respect and the maintenance of dignity, there are few instruments to evaluate the perception of a dignified attention. Our objective is to develop and determine the psychometric properties of a questionnaire for evaluating the perception of respect for and preservation of the dignity of the hospitalized patient.

Methods. From the review of the literature of patients' contributions, a theoretical definition of the concept was generated, which served as the basis for the construction of a self-administered questionnaire. The preliminary items were submitted for expert opinion. Subsequently, their comprehensibility, feasibility and execution time were verified by conducting a pilot study. The definitive questionnaire was administered to a sample of patients hospitalized in two units of a third-level hospital in Barcelona.

Results. The final sample consisted of 289 patients. The analysis of internal consistency through the Cronbach alpha coefficient was 0.76. In the factorial analysis of the main components of the oblique rotation, six factors named "privacy", "identity", "integrity", "information", "respect" and "consideration" emerged; together, they explain a total variance of 61.06%. The assignment of the statements to each of the factors was consistent with the initial definition.

Conclusions. The proposed theoretical model considers the perception of dignity as the sum and interrelation of diverse factors based on personal and professional values that must precede and accompany any care activity. The constructed questionnaire demonstrated acceptable indices of validity and reliability in all its facets.

Background

The concept of human dignity has a long philosophical tradition. Its empirical study in the field of health is much more recent [1] and is very rare in Spain. Dignity refers to fundamental rights to be respected in any vital context [2]. The ethical and deontological codes of health professionals, as well as the vision and mission of hospitals, include values of respect, dignity and autonomy.

Human dignity is related to self-esteem, personal worth, self-respect and consideration [3]. Although it is present in our popular vocabulary, it unclear whether we understand its meaning and implications [2,4]. Marley [3] notes that dignity is a concept whose definition includes many nuances and is extraordinarily difficult to explain; we recognize behaviours that respect dignity, although we perceive the absence of dignity much more easily. Camps [2] indicates that dignity, respect and autonomy form part of a conglomerate of meanings that is enriched by the conjunction of all three values and is impoverished if we reduce the concept to only one of them.

The first empirical studies on perceptions of respect and maintenance of dignity in hospitalized people appeared in approximately 1960 [6] in psychiatric patients. Other areas of care, such as geriatrics, surgical medical care, palliative care, intensive care, rehabilitation or obstetrics, were incorporated later and included patients from different age groups and life situations. The majority of studies have been carried out in the nursing discipline using qualitative methodologies to deepen the knowledge of the experiences and perceptions of the participants on the subject, starting from direct observations and semi-structured interviews with patients and professionals.

Studies have been developed in several countries with different societies, professional development programmes and health structures [7]. Despite this, we have observed, as we will explain later, that the identified experiences and values share common territories. The experience of the dignity of hospitalized patients includes many nuances that contribute to individual well-being; however, they are shared by people when they have the same experiences at a similar time in their lives, such as being involved in common scenarios such as illness and hospitalization and sharing similar states of fragility and vulnerability [8].

People yearn for healing; however, the evolution of some diseases confronts us with the request for dignified care as an expression of a balance between the use of resources provided by advances and technologies and respect for the integrity of the person. The imbalance between the two generates most bioethical conflicts, which affect the principles of non-maleficence, beneficence and autonomy [9]. Chochinov [10] argues that attention and care must go hand in hand. That is, the greater the technological development, the more skills and abilities that reconcile goodness, respect and compassion must be developed. However, practices are moving away from such person-centred skills.

During the period of hospitalization, the physical structure of the institution, the complex processes of care, procedures, activities, routines and professionals are organized as factors and agents that modify the feeling that people may have about their dignity [11]. In the context of illness - hospitalization - the person continuously experiences losses and modifications of their roles, functions, space, integrity, identity, intimacy and privacy [12].

To feel that their dignity is respected or promoted, patients need to perceive a balance between their losses and positive perceptions of the responses of others [in this case, any health professional] in the hospital setting. It is, therefore, the responsibility of all health professionals to

be aware of and sensitive to this situation and to act according to their professional and ethical responsibility [13].

It should be noted that only two questionnaires exploring dignity in the hospitalization process have been identified. In the first, based on a review of the literature and the Italian code of ethics for nurses, Ferri [5] identifies three facets: intimacy, information-autonomy and respectful interaction between nurse and patient. The questionnaire contains 15 items in question format with dichotomous answers. A study of the validity of the content was carried out by eight experts; no other psychometric properties were evaluated. The items whose positive responses obtained higher scores were those referring to the tone with which the nurses addressed patients [with respect and without using nicknames], efforts to minimize body exposure and privacy in the bathroom. The lowest scores were obtained for items related to privacy in the use of wedges or bottles and in decision-making.

The second questionnaire consisted of 16 open-ended and closed-ended questions administered to a convenience sample of 40 patients. Given the characteristics of the questionnaire, the researchers did not perform any psychometric analyses. The information collected from the answers to the open-ended questions was the object of subsequent content analysis. The patients showed strong opinions on privacy and dignity and the ways in which they may be compromised by the clinical environment or the behaviour of professionals [14].

In our context, periodic surveys on patient satisfaction are carried out in health centers to collect data that identify aspects of care that are elements of dignity, but these surveys do not contemplate dignity in all its facets. At this point, we ask ourselves the following questions: What do patients in our society, in our hospital structure, express about dignity? How is dignity promoted? How is dignity weakened? What do we do or fail to do professionally that endangers or compromises the dignity of hospitalized patients? What practices can we improve, and which should we discard?

The lack, in our environment, of a questionnaire that assesses the dignity perceived by patients opens up a field of research in which reflection on the results can undoubtedly generate a further line of research whose benefits will apply to both professionals and the people we serve and will improve professional excellence by defending not only high technical competence but also ethical competence.

Our purpose is to build an instrument that explores inpatient perceptions of the behaviours observed in the professionals who care for them. As an interdisciplinary group, we consider this an opportunity to explore the perception of care and respect for dignity and to consider their limits.

Methods

Aim

This study aimed to develop and test the psychometric properties of the scale of perception of respect for and maintenance of the dignity of the inpatient [CUPDPH].

Study Design

A cross-sectional, psychometric validation study is proposed.

The study was carried out in two phases: *Phase I: Item generation and scale development. Phase II: Validation and interpretation of the questionnaire*

Phase I: Item generation and scale development

1. Item generation. Based on a review of the literature on the perceptions of inpatients about the concept of respect for dignity, a definition was proposed that was empirically verified with the questionnaire. The objective was to generate preliminary items referring to the defined domain that would allow, through the appropriate analysis, the items for inclusion in the definitive scale to be selected. To guarantee the representativeness and relevance of the generated items, we returned repeatedly to the initial definition.

For the construction of the items, the recommendations of the psychometric texts referring to the structure, language and length of the items [15–17] were taken into account.

Each item was considered in light of the following questions: Does its content have to do with dignity? Is its contribution relevant?

The same number of items was temporarily established for each of the theoretical facets to guarantee, a priori, that all aspects of dignity were considered in an equitable way [16,18].

To avoid response biases, which are characterized by a greater tendency to give answers to the left or the right and to promote the balance of the questionnaire, the items were formulated positively and negatively [17].

A Likert-type response model was adopted, with five options: 5 = Strongly agree, 4 = Agree, 3 = Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree. These scores were reversed for negatively formulated items.

2. Validity of content. A group of 10 members of the Clinical Ethics Committee of the Hospital Santa Creu i Sant Pau constituted by doctors, nurses, an epidemiologist, a chaplain and a patient representative was established as a panel of experts to validate the content of the questionnaire. They were asked to evaluate the appropriateness of the proposed affirmations with the following criteria: 1 = very inadequate for evaluating the perception of the dignity of the hospitalized patient; 2 = inadequate for evaluating the perception of dignity; 3 = moderately adequate for evaluating the perception of the patient's dignity; 4 = considerably adequate for evaluating the perception of dignity; and 5 = very adequate for evaluating the perception of the hospitalized patient's dignity. They were also asked to make comments or grammatical corrections and to indicate whether the items were easily understandable.

The selection of the items was made through the methodology proposed by Fehring [19]. It consists of weighting the scores obtained by the items, where 5 = 1; 4 = 0.75; 3 = 0.50; 2 = 0.25; 1 = 0. The sum of the weighted ratios is calculated for each of the items, and the Content Validity Index [CVI] is determined by adding the weighted ratios obtained for the items and dividing the result by the total number of items.

The readability and comprehensibility of the questionnaire were also calculated through the INFLESZ v1® program.

3. Pilot study. The final questionnaire was given to twenty patients in the study hospital units. The questionnaires included instructions that reinforced the importance of answering all questions. To avoid the fear of being evaluated, we reinforced the idea of preserving confidentiality and emphasized that "*there are no correct or incorrect answers; rather, responses are expressions of agreement or disagreement with the statements that are presented*". The patients were asked to indicate the time they needed to complete the questionnaire, the difficulty of understanding the statements, and any suggestions regarding language, form, etc.

Phase II: Validation and interpretation of [CuDPH]"

1. Setting and sample. The project was carried out at the Hospital de la Santa Creu i Sant Pau [HSCSP]. With a total of 619 hospital beds, the HSCSP serves a reference population of 300,000 inhabitants [20% of the population of Barcelona].

A convenience sample was of patients hospitalized in the Short Stay and a General Surgery unit was selected.

The sample size was estimated based on the number of items used to construct the questionnaire and the psychometric criteria, which recommend a minimum of 5 participants per item or a minimum of 100 participants when performing a factor analysis[15]. The sample size was also revised so that, taking into account the maximum indetermination [$p = q = 0.5$] and a 95% confidence interval, significant differences could be found. Given these considerations, it was necessary to include 278 patients in the study [an additional 10% was added to compensate for loss].

Patients over 18 years of age who were conscious and oriented, able to read and respond to the form and voluntarily agreed to participate were included. Patients who were not conscious and oriented, had cognitive disability, were not able to give a written response to the form or who did not agree to participate were excluded.

Recruitment of participants was carried out in the hospitalization units before discharge to avoid participants' fears of repercussions for the answers they provided.

Data were collected between June 2018 and March 2019. Each patient was given a document explaining the objective and the purpose of the study and what their participation consisted of. They were given the informed consent document and a form with the study questionnaire and questions about socio-demographic variables. Given that no other questionnaire is available to establish convergent validity, a question was added to the questionnaire for each proposed facet or theoretical to allow the patients to provide a general evaluation.

2. Metric analysis.

Analysis of the discriminant capacity of the items. Subjects scoring at the 25th and 75th percentiles were identified. We then calculated the discrimination index by applying the following formula: $D = [\text{number of subjects obtaining the highest score} / \text{total number of subjects}] - [\text{total number of subjects obtaining the lowest score} / \text{total number of subjects}]$.

Reliability. The reliability of the questionnaire was studied through the measurement of internal consistency using Cronbach's alpha. The items were revised to discard those whose elimination implied an increase in the value of Cronbach's α .

Internal structure. Starting with the items remaining after the analysis of internal consistency, the adequacy of the data was first checked using the Kaiser-Meyer-Olkin [KMO] test and the Bartlett sphericity test. For the study of the internal structure of the questionnaire, a factorial analysis of main components with oblimin oblique rotation was carried out because based on the theoretical assumptions; a certain relationship between the appeared factors was hypothesized. We determined to eliminate from the matrix the items whose coefficients obtain absolute values lower than 0.40.

The data were analysed using the statistical package SPSS 25.0.

Ethical considerations. The Clinical Research Ethics Committee of the Hospital de la Santa Creu i Sant Pau approved this study, code: [IIBSP-CUP-2017-76]. A trained research assistant provided all participants with a detailed explanation of the purpose of this study prior to obtaining written informed consent. In addition, all participants were informed of their right to withdraw from the study. The questionnaires were collected anonymously.

The implementation of the project began after notification and approval of the Department of Medicine and Nursing.

Results

Phase I: Item generation and scale development

1. *Item generation.* Based on review of literature, from the collected elements, the following definition was proposed:

"Perceived dignity is the sum of perceptions that the patient has in relation to the behaviours of the professionals who attend to him or her. It integrates values of respect and integrity to the individual's person, identity, space and the information that he or she receives, allowing him/her to exercise autonomy".

The review of the qualitative studies generated 348 items, which, after successive revisions and the identification of similar topics, were reduced to 267, 162, 121 and finally 111 items. This first version of the questionnaire was sent to the six members of research group. They reviewed the content of each of the items and ranked them from 1 to 5 according to their adequacy for evaluating the perception of dignity. Items with CVI of less than 0.50 were eliminated. Through this process, they reduced the number of items to 57.

2. *Validity of content.* These 57 items were given to the group of experts to assess. Items with CVI > 0.86 were considered optimal. Once the calculations were completed, the items were reviewed again in light of the theoretical assumptions to verify that each item included was consistent and meaningful.

The index of legibility of Fernandez Huerta with a result of 70.06 and Inflesz @65,26 indicate the easiness of the legibility of the questionnaire. The comprehension of the text was also measured through the Gutierrez index whose result: 43.34 reveal a normal comprehension. The necessary training for the comprehension of the questionnaire was also calculated through Crawford Grade Level: 4.8 (school years necessary to understand it). Estimated reading time: 1.3 minute(s).

3. *Pilot study.* The average time collected for the execution of the form did not exceed 7 minutes. The participants did not express any difficulties in carrying it out.

Phase II: Validation and interpretation of [CuPDPH]"

1. Characteristics of the participants.

To determine the psychometric properties of the questionnaire, 301 forms were given to patients in two settings: a surgical unit and a short stay unit in the emergency department. Twelve questionnaires were discarded as incomplete [more than three unanswered items]. The final sample consisted of 289 patients: 148 men [50.9%] and 138 women [47.4%]. The mean age of the participants was 62.5 years [SD = 17.72], with a range of 18 to 98 years.

2. Metric Analysis

Item analysis. Most of the items were answered with each of the response options, except items 1, 2, 5, 11, and 12. The mean of the item scores was 4.51 [SD 0.34]. The median was 4.58. Nine of the 19 items scored below the median. The item with the highest score was "I was called by name". The item with the lowest score was "I was asked with whom I wanted to share information," followed by "They knocked on the door". Table 1 shows the mean item scores and the standard deviation for each item. *Insert table 1.*

Discriminant capacity of the items. In the study of the discriminant capacity of the questionnaire items, 19 items had discrimination indices higher than 0.40.

Reliability. The internal consistency of the questionnaire, as measured by the Cronbach's alpha coefficient, was 0.76. No element was detected whose elimination resulted in an increase in the alpha value.

Internal structure. The Kaiser-Meyer-Olkin test [KMO = 0.76] and Bartlett's sphericity analysis [$p < 0.000$] reported the suitability of the data for continued inclusion in the factor analysis. In the analysis of the main components with oblimin rotation, we found 6 components with a proper value > 1 that explained a total variance of 61.02%.

The sedimentation graph shows the changes in the curve from component 4 [see Figure 1]. *Insert figure 1 file.*

Starting from the sedimentation graph, the Kaiser criterion of eigenvalues equal to or greater than 1 and the explained variance, an analysis of the main components was carried out, forcing the structure into 2, 3 and 4 factors to explore the most coherent factorial solution. The most satisfactory result was obtained with the initial solution of 6 factors with factorial loads between 0.43 and 0.84.

Seven items obtained factorial loads in two factors; they were assigned to factor in which they showed the greater factorial load. Table 2 contains the rotated factor structure of the questionnaire with saturation greater than 0.40 as well as Cronbach's alpha for each of the factors and for the full scale.

Factor 1, with an eigenvalue of 4.54 and an explained variance of 23.9%, was labelled "privacy" and had the highest factorial load for the item "If I had to undergo a procedure, the companions of the other patient were asked to leave the room": 0.789.

Factor 2 was tagged as "integrity". It had an eigenvalue of 2.184, explained 11.5% of the total variance and obtained the highest factorial load for the item "I felt invisible": 0.816.

Factor 3, with an eigenvalue of 1.415, explained 7.45% of the total variance and was labelled "identity". It had the highest factorial load for the item "I was called by my name": 0.837.

Factor 4, with an eigenvalue of 1.285, was labelled "information", and explains 6.767% of the total variance. It had the highest factorial load for the item "They provided me with clear answers": 0.786.

Factor 5, with an eigenvalue of 1.152, explained 6.06% of the total variance. The item with the highest weight was "I felt that my rights were protected": 0.735.

Factor 6 was labelled "consideration". It had an eigenvalue of 1.017 and explained 5.35% of the variance. It had the highest factorial load for the item "I was asked with whom I wanted to share information": 0.80.

The correlations of the items with the total questionnaire scores were higher than 0.30 in all cases as present table 3. *Insert table 3.*

The factors correlated poorly among one another in most cases and correlated strongly with the total scores. The correlations between the factors obtained and the total questionnaire scores were significant and higher than $r = 0.40$. All the results are presented in Table 4, which shows that the majority correlations between items was low, but some higher and significant correlations appear.

Discussion

Phase I: Item generation and scale development

The set of preliminary items was based on observable behaviours of health professionals collected from qualitative studies about patients' perceptions and the theoretical definitions generated from these studies. Expert judgement and posterior psychometric analyses determined the final composition of the questionnaire.

The proposed questionnaire was easy to apply. This is evidenced by the low rate [4%] of null questionnaires. On the other hand, the analysis of the Crawford and Martinez Huerta index carried out prior to the pilot study indicated that sufficient adjustments had been made to ensure the readability and comprehensibility of the proposed text [20].

Phase II: Validation and interpretation of [CuDPH]"

The analysis of the items of our scale indicated a satisfactory discriminant capacity. All the items differentiated well between the subjects who obtained a high score and those who obtained a low score on the total questionnaire. Once again, there are no other similar validated existing scales, so this factor also favours our instrument.

The questionnaire presented an internal consistency evaluated through the Cronbach alpha coefficient of 0.76, which indicates that the items refer to a common construct. Given the characteristics of the questionnaire, it was not possible to establish its temporal stability.

In relation to factor analysis, the resulting structure is significant and coherent with the constitutive elements proposed in the definition and assumed in the theoretical approach: "*the sum and interrelation of respect, intimacy, integrity, the maintenance of the identity of the person as an individual and recognition*". All the aspects add up, and the relationship among them further increases their meaning.

Some studies represent the concept of dignity of the hospitalized patient as the perceived balance between control and choice in the different aspects that make up dignity and that health professionals can encourage or limit [21,22]. Other studies indicate the influence that self-esteem, modified by the illness, has on the person's perception of him- or herself [23]. These aspects complete the meaning of the proposed definition.

A detailed analysis of the factorial load structure [Table 2] allows us to appreciate the coherence of the grouping of items and to justify the labels assigned to the elements of the factorial solution.

In the factorial structure, the highest percentage of variance [23.90%] was explained by factor 1, which was called "privacy". It is made up of six items whose meanings relate to respect for the individual's privacy and includes physical aspects that refer to their body and space: "privacy when using the wedge", "not exposing my body".

Hospitalization implies a modification of personal spaces that allows professionals to enter intimate spaces that in any other context would be unacceptable [4]. This new space is mainly a room that in most cases is shared with a stranger 24 hours a day and in which all the activities of daily life take place: dining, hygiene, rest, treatment, and visits from doctors, nurses and friends. Staff enter and leave this space and sometimes do not promote the maintenance of this personal space by knocking on the door or indicating the entry [24].

The most intimate circle of personal space is the body, to which professionals also have access. Hospitalized patients understand that their bodies are accessed for necessary treatments; however, they feel humiliated when professionals do not close the curtains completely, do not access their bodies delicately or do not avoid total exposure [9,25].

This factor also includes intimacy in encounters with professionals, which is considered through statements such as "they looked me in the eyes" or "I was able to speak to staff privately", representing social and emotional aspects of privacy.

It should be noted that the item "they looked me in the eyes" obtained a factorial weight of 0.48 in factor 5, "respect". This result is not inconsistent because looking someone directly in the eyes can be considered an act of both intimacy and respect. In fact, this item established significant correlations with the items of factor 5.

Factor 2, "perception of integrity", is composed of three items that were negatively constructed: "they show superiority", "they treat me like an object", and "I feel invisible". The strong cohesiveness of the scores for these three items was evidenced by the non-inclusion of any other item and by extraordinarily low correlations with the rest of the items. Patients understand that it is the duty of professionals to preserve innate human dignity, to respect everyone equally without discrimination, and to treat patients as people with inherent value and not as objects [26,27]. One of the most negative experiences was being part of the doctors' rounds [11] when the team does not present itself and patients feel that they are viewed more as an "organ" [object] than as a person [9,24].

Factor 3, labelled identity, perception of maintenance of and respect for, consists of two items: "I was called by my name" and "I did not feel discriminated against because of my condition, gender or illness". During a hospital admission, options related to the patient's daily routine are altered by the introduction of depersonalization elements [4]. As a result of the deterioration caused by the illness and, as Bayés [28] points out, the perception that one's resources are inferior one's capacities, suffering occurs.

When a patient is hospitalized, they are labelled with an identification bracelet that they voluntarily accept in the name of safety. The patient goes from having a name to having a bed or room number [26]. In some centres, when the patient is admitted, they change into pyjamas or an institutional nightdress, which diminishes some of the identity individuals derive from the ornaments and clothing they choose [9,24], which often provides a senses of well-being and security. The horizontal position some patients must maintain and being prostrate in front of the verticality of the others, modifies the patient's perception of his or her image [26]; this self-perception is modified again when the patient recovers verticality. All these factors, once again, contribute to the reality of having acquired the trademark characteristics of a patient.

Factor 4 is comprised of two items that refer to the provision of information to professionals and the clarity of information. It should be noted that the scores obtained for these two items were high, indicating satisfaction in this area.

The aspect of choice in this context also appears linked to the information the patient receives about what is happening and the related feelings of control and autonomy [22,26]. During hospitalization, patients need to be made aware of what is going to happen that day or in the future and to be informed before an activity, an examination, or a test is performed [12]. Not being allowed to communicate or verbalize their needs produces anguish and irritation [11], and these results are extrapolated to any clinical circumstance that occurs without communication.

Factor 5 consists of four items that address the patient's perceptions of aspects of respect, such as efforts to maintain his or her image, the use of respectful language and tone by staff that does not infantilize the patient, or the use of affective expressions that are not appropriate for the time or place. Respect is fundamentally materialized in "being treated as people" [29].

Other items refer to professionals not always addressing patients, not respecting their individuality, calling them by name without their permission or using terms such as "loved" or "love"[12,24] and not treating them as adults [25].

The patients were extraordinarily sensitive to detecting non-verbal expressions of disregard for the ravages caused by the disease [11] or for their condition [26] on the faces of professionals.

Likewise, they perceived as violations the feeling of not being seen or heard, professionals being slow to respond, and professionals responding with indifference or with condescending or minimizing attitudes. Patients understand that in order to feel respected, it is essential for care professionals to spend time with them and to feel that there is someone who at a given moment will speak up on their behalf [11,25].

Factor 6 comprised three items: "privacy to discuss my situation with the staff", "being allowed to express feelings and worries", and "being asked with whom I wanted to share information". The patients noted the capacity of professionals to intuit what they needed, sometimes without asking, and above all, they appreciated the constant presence [11] and the rapid response to their needs [21]. The patients were able to identify those professionals who, in their care, provided an "extra something" that not all professionals had and that increased the patient's feeling of receiving good and dignified care [30].

As bodily functions and daily activities decrease, the sensation of loss of control, integrity, self-esteem and identity increases [9,31], at which time the behaviour of professionals is fundamental. Bayés [32] refers to how patients' perception of time changes and how professionals should be sensitive to this circumstance in relation, for example, to waiting times or the time they dedicate to attending to the patient.

The analysis of the items shows that they contain principles and values. The answers delimit how the relationship between the professional and the patient should be. Therefore, we can say that the questionnaire can be examined in light of principles, virtues or care, in line with the proposal by Tschudin et al [33] that in care, it is not only possible but even necessary and beneficial to incorporate interpretations from different ethical sources.

The concept under study is presented as the sum and interrelation of different facets of respect in caring for human beings that makes us perceive the individual's needs and concerns while imploring us to provide answers from a place of respect, responsibility and commitment to people and the profession.

Limitations

It should be considered that the items of the questionnaire were constructed based on a review of studies that reported the experiences of hospitalized patients and on a preliminary theoretical definition and review by experts, which added objectivity to the process.

The participants' answers were subjective expressions of their values and attitudes in relation to the concept studied, but they were valid nonetheless.

The fact that the participants were recruited from only one institution constitutes a limitation to the generalization of the results presented. This fact encourages us to propose future studies in other care settings and different centers.

Conclusion

The theoretical model proposed in the research considers dignity as the sum and interrelation of fundamental aspects of patient care: privacy, integrity, information, identity, respect and consideration.

The questionnaire created proved to be feasible, easy to complete, and understandable. The analysis of internal consistency showed that the questionnaire truly measured what it aimed to measure. The analysis of the internal structure of the questionnaire indicated that it was coherent and consistent with the theoretical model proposed. The results obtained encourage us to continue working along these lines, with the aim of going deeper into the subject and introducing interventions that maintain and promote inpatient dignity.

Declarations

Ethical considerations. The Clinical Research Ethics Committee of the Hospital de la Santa Creu i Sant Pau approved this study, code: [IIBSP-CUP-2017-76]. A trained research assistant provided all participants with a detailed explanation of the purpose of this study prior to obtaining written informed consent. In addition, all participants were informed of their right to withdraw from the study. The questionnaires were collected anonymously.

Consent for publication. Not applicable.

Availability of data and materials. The datasets during and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests. The authors declare that they have no competing interests.

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Authors' contributions. BC conducted a literature review on the topic, wrote and edited the survey, analysed the survey data, wrote the first draft, and helped edit and format other drafts. MV, JC, MG, and EM helped design the survey and edit drafts of the manuscript. MA helped review the literature, design the survey, analyse the data, and write and edit drafts of the manuscript. All authors read and approved the final manuscript.

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Tables

Table 1 Descriptive statistics of item scores [Mean, Standard Deviation SD, Option Answer, Frequency N, %]

	Mean	SD	Option	N	%
I have been informed	4.69	0.63	1	3	1
			3	8	2.8
			4	61	21
			5	217	74.8
They provided me with clear answers	4.72	0.54	1	1	0.3
			3	7	2.4
			4	64	22.1
			5	217	74.8
They asked me who I wanted to share information with	3.5	1.46	1	49	16.9
			2	11	3.8
			3	79	27.2
			4	35	12.1
			5	108	37.2
They showed superiority	4.23	1.32	1	26	9
			2	15	5.2
			3	18	6.2
			4	33	11.4
			5	190	65.5
They called me by my name	4.87	0.49	1	3	1
			4	24	8.3
			5	260	89.7
They used respectful language [they did not call me love, honey, darling...]	4.65	0.77	1	6	2.1
			2	1	0.3
			3	12	4.1
			4	51	17.6
			5	218	75.2
I felt like I was treated like an object	4.59	1.05	1	18	6.2
			2	3	1
			3	7	2.4
			4	23	7.9
			5	236	81.4
They preserved my image	4.49	0.94	1	10	3.4
			2	3	1
			3	22	7.6
			4	53	18.3
			5	201	69.3
I felt invisible	4.41	1.18	1	20	6.9
			2	13	4.5

			3	7	2.4
			4	38	13.1
			5	211	72.8
I did not feel discriminated against	4.82	0.61	1	4	1.4
			2	2	0.7
			3	1	0.3
			4	29	10
			5	253	87.2
I felt my rights were protected	4.82	0.44	3	6	2.1
			4	41	14.1
			5	241	83.1
They took the time to assist me	4.77	0.54	2	3	1
			3	7	2.4
			4	43	14.8
			5	236	81.4
They allowed me to express my feelings	4.43	0.89	1	4	1.4
			2	6	2.1
			3	35	12.1
			4	59	20.3
			5	182	62.8
They looked me in the eyes	4.7	0.65	1	2	0.7
			2	1	0.3
			3	15	5.2
			4	45	15.5
			5	226	77.9
I had privacy when using the wedge or the bottle	4.57	0.82	1	5	1.7
			2	2	0.7
			3	21	7.2
			4	48	16.6
			5	195	67.2
They knocked on the door	3.89	1.23	1	16	5.5
			2	24	8.3
			3	62	21.4
			4	53	18.3
			5	126	43.4
They made the companions of the other patient leave the room	4.5	0.91	1	9	3.1
			2	2	0.7
			3	22	7.6
			4	57	19.7

			5	198	68.3
They avoided unnecessary exposure of my body	4.61	0.80	1	6	2.1
			2	2	0.7
			3	15	5.2
			4	52	17.9
			5	212	73.1
I was able to talk to them privately about my feelings and worries	4.37	1.01	1	9	3.1
			2	8	2.8
			3	33	11.4
			4	55	19
			5	181	62.4

Table 2: Analysis of Principal Components with Oblimin Rotation

		Privacy	Integrity	Identity	Information	Respect	Consideration
1	They looked me in the eyes	0.576				-0.476	
2	I had privacy when using the wedge or the bottle.	0.629					
3	They knocked on the door	0.533					0.41
4	If I had to undergo a procedure, they asked the other patient's visitors to leave the room.	0.789					
5	They avoided unnecessary exposure of my body	0.73					
6	I was able to discuss my situation privately with the staff.	0.615					0.589
7	They showed superiority		0.775				
8	I felt like I was treated like an object		0.84				
9	I felt invisible		0.816				
10	They called me by my name.			-0.837			
11	I did not feel discriminated against.			-0.701			
12	I was informed			-0.564	0.672		
13	They provided me with clear answers				0.786		
14	They used respectful language [they did not call me love, honey, darling...]					-0.53	0.515
15	They preserved my image					-0.678	
16	I felt my rights were protected	0.431				-0.735	
17	They took the time to assist me					-0.734	
18	They allowed me to express my feelings and worries				0.436		0.567
19	They asked me who I wanted to share information with.						0.802

Table 3: Item correlation and item correlation total scores

Table 4: Inter-factor correlation and correlation total scores

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1	1.00																		
2	.49**	1.00																	
3	.16**	.23**	1.00																
4	.17**	.09	.05	1.00															
5	.38**	.29**	.13*	.05	1.00														
6	.12*	.17**	.22**	-.02	.36**	1.00													
7	.17**	.10	-.11	.47**	.11	.08	1.00												
8	.21**	.22**	.10	.06	.40**	.34**	.20**	1.00											
9	.11	.05	.03	.42**	.07	.01	.54**	.14*	1.00										
10	.30**	.11	.13*	.11	.32**	.17**	.11	.15**	.173**	1.00									
11	.16**	.30**	.18**	.08	.11	.23**	.18**	.35**	.145*	.20**	1.00								
12	.28**	.31**	.12*	.04	.15*	.18**	.15**	.27**	.10	.15*	.44**	1.00							
13	.25**	.23**	.25**	.09	.07	.10	.01	.16**	.07	.12	.29**	.36**	1.00						
14	.18**	.20**	.16**	.17**	.15*	.15*	.18**	.32**	.151*	.17**	.44**	.31**	.32**	1.00					
15	.06	.08	.17**	.01	.02	.18**	.02	.24**	-.01	.12	.30**	.15*	.25**	.30**	1.00				
16	.14*	.16**	.24**	.00	.08	.10	.05	.21**	-.01	.10	.27**	.27**	.35**	.33**	.25**	1.00			
17	.10	.17**	.25**	.01	.20**	.17**	.08	.22**	.150*	.20**	.26**	.22**	.21**	.39**	.31**	.42**	1.00		
18	.13*	.20**	.14*	.07	.06	.126*	.03	.25**	.07	.20**	.35**	.17**	.18**	.30**	.38**	.20**	.47**	1.00	
19	.22**	.24**	.34**	-.03	.130*	.210**	.07	.17**	.06	.16**	.36**	.25**	.41**	.32**	.33**	.38**	.50**	.36**	1.00

Correlation

total scores	.47**	.43**	.43**	.40**	.320**	.356**	.420**	.53**	.43**	.41**	.55**	.48**	.52**	.57**	.45**	.52**	.57**	.51**	.57**
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* p<0.05 **p>0.01

	Total scores	1	2	3	4	5	6
Total scores	1						
Privacy	.740**	1					
Integrity	.512**	.075	1				
Identity	.441**	.211**	.168**	1			
Information	.518**	.240**	.169**	.374**	1		
Respect	.676**	.438**	.164**	.417**	.355**	1	
Consideration	.662**	.504**	.04	.191**	.330**	.351**	1

**p>0.01

Figures

SCREE PLOT

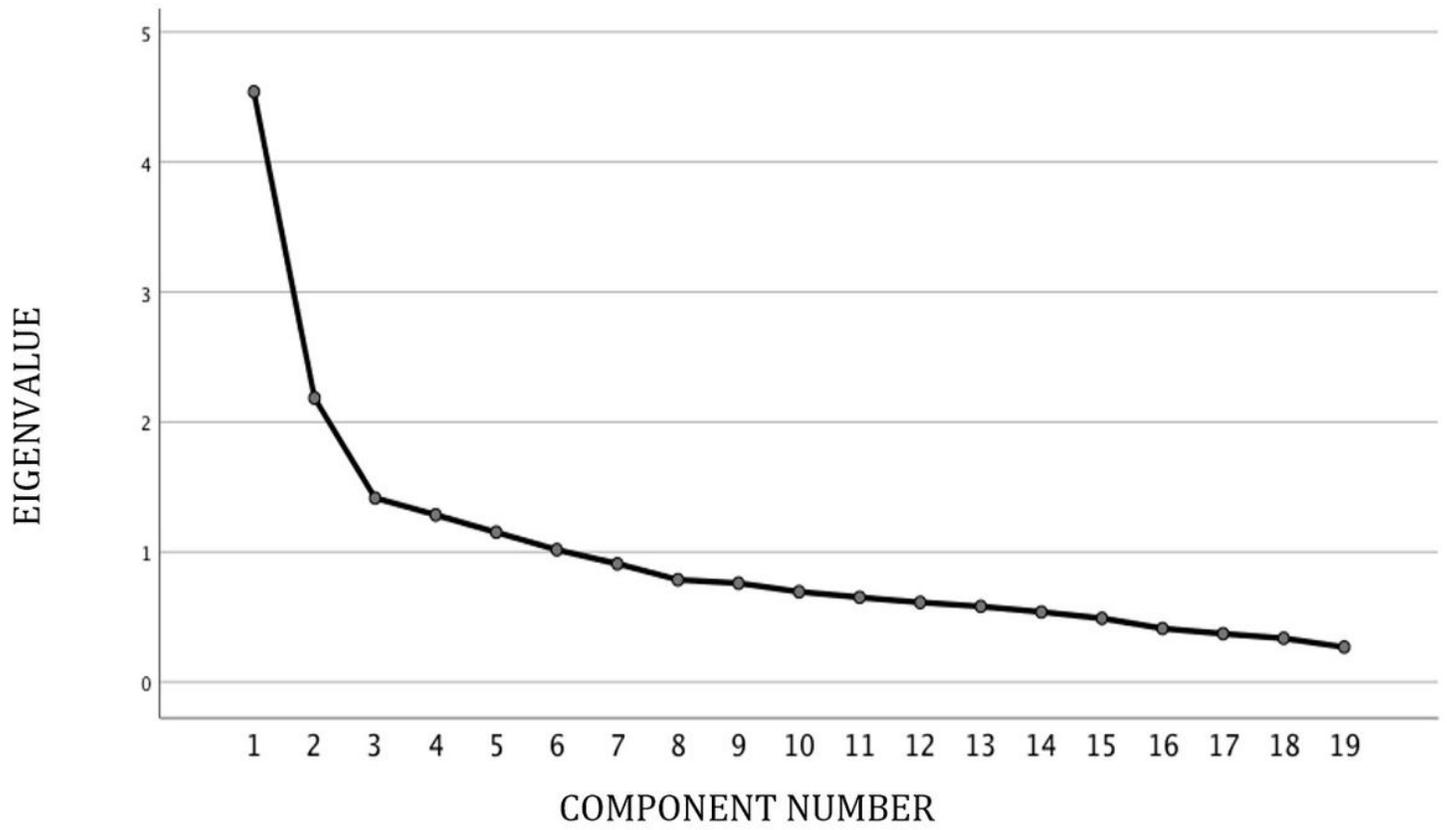


Figure 1

Scree Plot