

# “Teach for Dignity”: Longitudinal Evaluation of Training on Dignity-in-Care Relationships for Nursing Students

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## ABSTRACT

**Background:** Patient dignity is a critical component of health care; however, evidence suggests that it is often inadequately maintained, particularly among nursing students.

**Purpose:** To assess the impact of a dignity-in-care training intervention on nursing students' knowledge and explore how they apply it in their practice after graduation.

**Methods:** This was a mixed-methods study involving second-year nursing students with interventions provided by a psychologist. Quantitative data were collected through pre- and post-training questionnaires on dignity, while qualitative data were obtained from focus groups and semi-structured interviews conducted 1 and 2 years after the training. The analysis included McNemar's test for quantitative data and thematic analysis for qualitative results.

**Results:** Sixty-four students completed the pre- and post-training assessments. Significant improvements were observed in emotional and psychosocial dignity-related domains; however, declines were noted in procedural domains.

**Conclusions:** Future interventions should adopt a comprehensive approach, possibly co-led by nurses and psychologists, to uphold dignity in care.

**Keywords:** clinical ethics dignity in care, ethics education, mixed methods, nursing ethics

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Dignity is a comprehensive framework for patient engagement that includes respect, autonomy, empowerment, safety, communication, privacy,

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acceptance, and fairness, among other characteristics.<sup>1,2</sup> Studies on the perception of dignity have been conducted with cancer patients in the terminal stages of illness. For example, a low sense of dignity is associated with higher levels of psychological and spiritual distress, the loss of life expectancy, living in despair, and distress with adverse effects within the family.<sup>2,3</sup> Moreover, the peculiarities of dignity-related distress are also in populations of non-cancer patients and assisted in intensive and acute setting.<sup>4,5</sup> Although dignity is essential in health care, there is evidence that patients' dignity is poorly maintained.<sup>6,7</sup> For example, while patient dignity may be an assumed value among nurses, students admit to needing more clarity on fostering it in practical clinical scenarios.<sup>6,7</sup>

Authors found that nurses lacked the necessary knowledge, skill, and attitude to maintain patient dignity.<sup>6</sup> Curiously, the teaching of dignity-in-care is noticeably absent from the medical training curriculum.<sup>7</sup> The concerning aspect is the omission of dignity from medical school curricula regarding instruction and guidance on teaching associated concepts and practices. Promoting and instructing dignity-in-care poses a challenge due to the abstract nature of the concept and its lack of unequivocal definition.<sup>6</sup> In addition, culture plays a role in how one's dignity is perceived, maintained, and promoted.<sup>8</sup> Cultural values, such as dignity, evolve within society and professions. These ambiguities have substantial

consequences for training programs, as demonstrated by a recent scoping review that highlights the significance of bridging theories on dignity-centered care approaches with clinical practice, enabling students to develop specific competencies.<sup>8</sup>

Furthermore, there is a recognized need for more comprehensive and long-term evaluations to assess the impact of training on the practices and attitudes of health care professionals.<sup>8</sup> This knowledge gap underscores the importance of exploring the potential long-term effects of such training on health care professionals' practices and perspectives throughout their careers.<sup>8</sup> According to the Medical Research Council Framework for a Complex Intervention, a rigorous method is needed to prepare nursing students and evaluate the effects of a course.<sup>9</sup> In addition to assessing satisfaction and learning, other outcomes should be integrated that investigate the qualitative aspects of training.<sup>9,10</sup> Accordingly, this study aimed to evaluate, both quantitatively and qualitatively, the impact of training on the dignity-in-care relationship for nursing students in the second year of university through a longitudinal evaluation.

## Purpose

The primary aim of this study was to evaluate the effectiveness of a training intervention focused on dignity-in-care relationships for nursing students. Specifically, this objective sought to assess how much the training enhanced and modified participants' knowledge of dignity-centered care principles and practices. The secondary aim of this study was to investigate the evolving meanings of dignity-in-care during the training process and how nursing students transferred and applied these meanings over time. This exploration included an analysis of the students' approaches to integrating these concepts into clinical practice, 1 year and 2 years post-training, as they transitioned into professional roles within the health care workforce.

## Methods

### Study Design

We employed a mixed-method evaluation approach, incorporating concurrent qualitative and quantitative data collection, followed by separate analyses of each dataset. For the primary aim, we utilized pre- and posttests to assess students' knowledge of dignity. For the second aim, we conducted pre- and post-training focus groups (FGs) with randomly selected students. Following the analysis of the FGs, we engaged participants in a member-checking process to validate the emerging themes and corroborate the ongoing analysis. Additionally, individual semi-structured interviews were carried out 1 year and 2 years after the training to explore the sustained impact of the intervention. Supplemental Digital Content, Figure, available at: <http://links.lww.com/NE/C41>, represents the different parts of the research program.

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### Intervention

Between April and May 2021, a training on "Dignity-in-care" was conducted by a psycho-oncologist, aimed at nursing students in the second year of the University of Modena and Reggio Emilia, Reggio Emilia campus, Italy (UNIMORE). She trained at an international dignity therapy workshop held in Winnipeg, Canada (2011), conducted by the developers of dignity therapy, and she has applied a dignity-in-care approach since 2012 in different care settings.<sup>5,11,12</sup> The training included 2 meetings for a total of 7 h. The themes covered the theory of the principal Models of Dignity, in particular, related to studies of Chochinov and colleagues and the tools to understand and enhance the dignity of the patient (see Supplemental Digital Content, Appendix, available at: <http://links.lww.com/NE/C40>).<sup>13-16</sup>

### Setting and Sampling

The study was performed at UNIMORE. The quantitative evaluation sample consisted of second-year nursing students (academic year 2020/2021) who attended 100% of the course. The qualitative assessment sample consisted of second-year nursing students (academic year 2020/2021). The inclusion criterion was having attended 100% of the training. A coordinator of the University course contacted students by email or phone to arrange a meeting to explain the study's objectives. During the meeting, consent to participate was collected.

### Data Collection

For the quantitative assessment of knowledge learning, an anonymous questionnaire was administered before and after the intervention aimed at assessing prior knowledge on dignity-in-care: (1) Referring to your internship experience, how would you define dignity? (2) Referring to your internship experience, what are, in your opinion, the characteristics of a dignified approach that can enhance it? The Qualitative Research Unit experts at Azienda USL-IRCSS di Reggio Emilia conducted 2 FGs before and after training sessions, engaging a randomly selected sample of second-year students. These sessions were held 1 week before and 1 week after the intervention. After the training, participants were invited to take part in individual semi-structured interviews 1 year later and again after 2 years, when they had commenced their professional roles.

### Statistical Analysis

A framework list of mutually excluded domains related to the dimension of dignity in the care relationship was used to analyze the open-ended questions. Each domain's presence or absence in students' responses was categorized accordingly. Changes before and after the intervention

were recorded. The reliability of content analysis was ensured through a blind evaluation performed by 2 experts. Any disagreements were discussed and resolved by a third external researcher. We calculated the proportions for each domain before and after the training, along with their corresponding 95% confidence intervals (CIs), constructed using the Clopper–Pearson method. Proportion tests were performed using STATA software to assess the equality of proportions between pre- and post-training measurements. We estimated the difference between the two proportions (before and after the intervention) and its 95% CI. For paired data, the nonparametric McNemar’s test was used to assess differences in distributions. All statistical analyses were conducted using Stata/BE 17 for Mac (StataCorp, College Station, TX, USA) and MedCalc version 14 for Windows (MedCalc Software, Mariakerke, Belgium).

### Qualitative Analysis

FGs and interviews were audio-recorded, verbatim transcribed, and subsequently anonymized. The qualitative analysis adopted the framework method described by Gale and colleagues.<sup>17</sup> We analyzed the pre- and post-training FG transcripts separately by labeling relevant excerpts. Subsequently, the labels from each FG were

compared to identify any changes in the meanings attributed to the phenomenon before and after the training. From this comparison, the main themes were developed to capture the observed shifts in meaning. The refined themes served as a coding framework for analyzing the individual interviews.

### Results

One hundred twenty-one students attended the first meeting and 100 in the second. Eight of these participated in the pre-training FGs and 7 in the post-training FGs, with 15 students participating. Not all the students who participated in the training submitted their tests. We collected 64 pre- and post-training questionnaires from the same participants who filled out both questionnaires. Five students participated in the individual interviews after 1 year (May 2022) and 8 after 2 years (May 2023).

### Quantitative Results

The open-ended questionnaire administered before and after the intervention collected 67 students’ responses (134 evaluations by 2 raters), with 64 students’ responses (128 evaluations by 2 raters) for the pre- and post-training assessments, evaluating multiple domains

**Table 1.** According to the Model of Chochinov et al (\*), the Distribution of Domains of the Definition of Dignity Before and After Training

All Domain	Domains of Dignity, According to the Model of Chochinov	Before	After	p-Value <sup>a</sup>	Paired	
		Percentage With Confidence Interval n = 134% (95% CI)	Percentage With Confidence Interval n = 128% (95% CI)		Differences n = 128% (95% CI)	p-Value <sup>b</sup>
D01	Recognize the person and not just the disease	70.9 (62.6-78.0)	82.0 (74.3-87.8)	0.034	11.7 (2.0-19.3)	0.018
D02	Convey listening, attention, empathy, respect, understanding, esteem, interest, humanity	52.9 (44.4-61.3)	88.3 (81.4-92.8)	<0.001	35.2 (26.3-39.7)	<0.001
D03	Growth/self-awareness	7.5 (4.0-13.4)	30.5 (23.1-39.1)	<0.001	24.2 (15.2-29.4)	<0.001
D04	Physical symptom management	26.9 (19.9-35.1)	39.1 (30.9-47.8)	0.035	11.7 (-0.6-22.7)	0.063
D05	Psychological distress management	29.1 (21.9-37.4)	54.7 (45.9-63.2)	<0.001	25.0 (12.6-34.9)	<0.001
D06	Support for residual physical autonomy	9.7 (5.7-16.1)	8.6 (4.8-14.9)	0.756	0.8 (-6.3-7.6)	1.000
D07	Acknowledge and take interest in those aspects of the patient’s life that he/she most values	23.9 (17.4-31.9)	46.1 (37.6-54.8)	<0.001	22.7 (10.9-31.9)	<0.001
D08	Encourage and enable the patient to participate in meaningful or purposeful activities	6.7 (3.5-12.5)	2.3 (0.7-7.1)	0.090	4.7 (-1.3-8.3)	0.146
D09	Respect silences	3.0 (1.1-7.7)	6.2 (3.1-12.1)	0.206	3.1(-2.8-7.5)	0.387
D10	Referral to specialist healthcare professional (psychiatric, psychotherapist, spiritual care)	-	-	-	-	-
D11	Ask permission to examine patient/ Proper draping to safeguard and respect privacy	43.3 (35.1-51.9)	26.6 (19.6-34.9)	0.004	17.9 (5.2-28.9)	0.005
D12	Families support	3.7 (1.6-8.7)	5.5 (2.6-11.1)	0.501	1.6 (-4.2-6.5)	0.774
D13	Encourage the settling of affairs, preparation of an advanced directive, making a will, funeral planning	1.5 (0.4-5.8)	-	0.165	1.5 (-1.1-1.5)	0.500

\*Chochinov HM. Dignity-conserving care—a new model for palliative care: helping the patient feel valued. JAMA. 2002;287(17):2253.

of dignity according to Chochinov's Model. Table 1 shows the percentages for each domain, both before and after the intervention, along with the corresponding confidence intervals, McNemar test, and *p*-values for each domain. The most significant improvement was observed in D03 (*Growth/self-awareness*), with an increase from 7.5% before the intervention to 30.5% post-intervention, yielding a paired difference of 24.2% and a *p*-value <.001. Similarly, D02 (*Convey listening, attention, empathy, respect, understanding, esteem, interest, humanity*) improved significantly, from 52.9% to 88.3%, with a paired difference of 35.2% and a *p*-value <.001. In D05 (*Psychological distress management*), an increase from 29.1% to 54.7% was observed, with a paired difference of 25.0% and a *p*-value <.001. D07 (*Acknowledge and take interest in those aspects of the patient's life that he/she most values*) also saw a notable increase from 23.9% to 46.1%, with a paired difference of 22.7% and a *p*-value <.001.

Despite showing significant trends, other domains like D01 (*Recognize the person and not just the disease*) and D04 (*Physical symptom management*) did not achieve statistical significance. For D01, the percentage rose from 70.9% to 82.0%, with a paired difference of 11.7% and a *p*-value of .018. D04 increased from 26.9% to 39.1%, with a paired difference of 11.7% and a *p*-value of .063. Conversely, domains related to more task-oriented interventions showed reductions. D08 (*Encourage the patient to participate in meaningful or purposeful activities*) decreased from 6.7% to 2.3%. In comparison, D11 (*Ask permission to examine patient/ Proper draping to safeguard and respect privacy*) decreased significantly from 43.3% to 26.6%, with a paired difference of 17.9% and a *p*-value of .005.

### Qualitative Findings

The qualitative analysis identified four main themes regarding the students' perspectives and meaning making, which illustrate the impact of the training and its evaluation: Defining Dignity, Acting as Professionals, Communicating Dignity, and Evaluating the

Training. Within the first 3 themes, we developed an interpretation of how the initial meanings evolved, resulting in a shift in meaning Table 2.<sup>18</sup> The participants demonstrated active engagement and participation throughout the entire training and research process. Regarding the acquisition of new knowledge, the qualitative results, supported by quantitative data, confirmed that participants' understanding of dignity in care expanded to include psychological dimensions, as well as a greater level of introspection and awareness.

### Defining Dignity

Before the training, participants provided varied definitions of dignity. Afterward, their understanding coalesced around personalizing the patient relationship and emphasizing respect for autonomy. In the workplace, former students recognized the need to embody dignity, transitioning from theoretical discussions to practical applications and relating these discussions to real-world situations, and sharing experiences and examples instead of abstract ideas.

### Acting as Professionals

On entering the training, participants demonstrated prior knowledge and skills. After the training, students emphasized the professional responsibility to uphold patient dignity not only in one-on-one interactions but also within the broader clinical context, including interactions with colleagues. In the post-training FGs, participants reported feeling committed to defending patients from undignified actions by colleagues, viewing advocacy as a key professional role. In the final interviews, former students described professionalism as respecting the dignity of all members of the care community—patients, caregivers, and colleagues—through conflict resolution and efforts to improve care.

### Communicating Dignity

Before training, students were aware of the importance of communication in patient relationships, showing

**Table 2. Qualitative Findings and Meaning Shift**

Theme	Pretraining	Post-training	1-2 Years After the Training
Defining dignity	From a plurality of definitions...	to an agreement on the term ...	... to embodying dignity (dependent on one's professional behaviors)
		<i>Meaning shift: Grounded the semantics</i>	
Acting as professionals	Individual actions...	... are accompanied by advocacy within the broader professional context ...	... and target all members of the care community (patients, caregivers, colleagues)
		<i>Meaning shift: Interpreting oneself from an advocacy prospective</i>	
Communicating dignity	The centrality of communication with the patient ...	... is enriched with broader repertoires and actors ...	... and becomes an act of care itself
		<i>Meaning shift: Expanding the range of communication tools</i>	
Evaluating the training			

prior knowledge of its centrality in care. Training reinforced their skills and expanded their communicative repertoire, including the use of silence, explaining procedures to put patients at ease, avoiding dismissive behavior, and transparently managing time constraints.

### Evaluating the Training

Participants provided insights into the impact of the training, which can be categorized into 3 sub-themes:

- (1) *Reflections on the Training Received*: Key aspects of the training, such as sharing personal experiences and fostering self-reflection, were particularly appreciated. However, some participants voiced criticism of their broader educational experience, particularly regarding perceived power imbalances during internships and insufficient institutional support, which they identified as barriers to fostering dignity in care, including toward themselves. These critical reflections came from the last interviews so facilitated by the fact that the interviewees had completed their studies and, no longer facing contextual pressures or fears of negative repercussions, could express themselves more freely, highlighting various problematic aspects of the institution that trained them.
- (2) *Impact on Professional Practice*: Participants adapted the concepts learned to their clinical contexts, with practical applications including respectful communication, using touch as a form of care, maintaining dialogue with patients regardless of their level of consciousness, and personalizing care based on patients' characteristics and preferences.
- (3) *Proposals for Improvement*: Participants suggested several enhancements to the training, including introducing it early in the curriculum, repeating it annually, and expanding the training to include a broader range of health care professionals.

### Discussion

The findings of this study highlight significant changes in the perception and application of dignity-related domains following the training intervention. The most substantial improvements were observed in domains tied to the "emotional and psychological" aspects of dignity-in-care. In particular, the improvement of management of psychological distress underscores the enhanced capacity of the participants to recognize and address psychological suffering, aligning with the global care model emphasized in palliative care practices. Similarly, the participants became more attuned to conveying empathy, respect, and understanding, essential qualities in fostering a dignified care environment.

The data suggested that students became more adept at recognizing the importance of a patient's narrative and values after undergoing training. The students were able to support the narrative of the patient as a person, with their knowledge of new tools, such as the Patient Dignity Question, which asks, "What do I need to know about you as a person to give you the best care possible."<sup>15</sup> Especially for students who need to acquire ways to construct conversations with patients to enhance their dignity, knowing simple questions can support them in feeling more secure in the care relationship. Students reported a deeper awareness of personal growth and self-awareness during care. Self-reflection and self-care are essential for health care professionals to avoid "the risk of undignified actions," as suggested by other studies.<sup>19,20</sup> Self-care requires health care professionals to be mindful of their emotional responses, vulnerability, and fears.<sup>21</sup> We hypothesize that the significant increase in this domain has provided a solid basis for improving the management of the emotional dimension in the care relationship with patients.

However, not all domains showed positive changes, for example, *Ask permission to examine patient/Proper draping to safeguard privacy*. We hypothesized that the training conducted by a psycho-oncologist may have emphasized the psychological elements of valuing dignity within the care relationship. On the other hand, the possibility to safeguard the privacy of the patients is directly connected to the hospital system. Many wards are organized in rooms with 3 patients, and these structural aspects do not always guarantee respect for privacy during visits or hygiene. Consequently, students may have implemented their relationship and emotional support skills precisely to make up for these aspects that currently cannot be changed. Similarly, data may indicate that the training program did not sufficiently address strategies for engaging patients in meaningful activities or that structural barriers in clinical practice make such engagement difficult. On the other hand, nursing students may not always have the autonomy to propose activities to patients during their internship, except under the close supervision of their tutors.

Finally, the training was conducted during the COVID-19 pandemic, which reduced many activities in the hospital. The increase observed in the *physical symptom management* was positive, although not statistically significant. It may be difficult for nursing students to propose therapies for symptom management because they are not yet integrated into teams or experienced in administering therapies. Moreover, the significant statistical improvements in *conveying listening and empathy*, *psychological distress management*, and *take interest in the patient's life* showed that in general, the students acquired more skills in the dimension related to the person and not only to the disease.

## Qualitative Findings

The qualitative study highlights the transformative impact of dignity-focused training on participants' understanding and practice of dignified care. Participants demonstrated active engagement, with qualitative and quantitative data confirming an expanded knowledge of dignity that included psychological dimensions and greater introspection. The training reinforced communication as a cornerstone of dignified care, with participants expanding their repertoire to include non-verbal cues, transparency, and dialogue, reflecting its role as both a skill and an ethical obligation. These findings underscore the potential of dignity-focused training to foster a more compassionate health care culture, highlighting the need for institutional reforms to sustain its impact.

## Educational Relaunches

The training course topics elicited numerous comments and reflections that extended beyond the 2 afternoon training modules. The data analysis suggested the importance of offering subsequent integration for the future dignity-in-care training at UNIMORE (academic years 2023-2024). On the one hand, we arranged new modules with a nurse expert in the Dignity Approach in the hospital.<sup>22</sup> We have also proposed additional activities in small groups to encourage a structured comparison that students often lack because they are involved in various internships. A third meeting focused on supervising the emotional aspects related to the care relationship was offered. Finally, we proposed a new training program for nurse tutors, those who are in charge of training students during their internship, to support them in evaluating proposals and ideas from students more effectively (who often do not feel confident sharing new activities for patients in a professional setting).

## Limitations

This is a 1-group pretest–posttest design study, whose internal validity depends on the degree of control that researchers have over potential methodological issues such as secular trend, regression of the mean, selection, measurement bias, and confounding. Moreover, owing to the lack of a control group, researchers were unable to define whether other events took place at the time of the intervention, which might have informed observed changes. Concerning the measurement bias, validated assessment tools were unavailable; we therefore developed ad hoc measurement instruments for students.

The qualitative study's sampling was conveniently selected, and participation was voluntary. This may have introduced selection bias by involving more engaged participants in the training. Furthermore, the data collection conducted at the university might have influenced the information due to the potential for desirability bias. Nonetheless, a more open environment was established during the final interviews. The sampling of the qualitative study was conveniently selected, and

participation was voluntary. This could have introduced a selection bias by involving more engaged participants in the training. Furthermore, the data collection conducted during the university may have influenced the information, as a desirability bias could have been at play. Nonetheless, a freer environment was set during the last interviews.

## Conclusions

The study demonstrates that a focused training intervention can significantly improve health care professionals' awareness and application of dignity-related domains, particularly those concerning the psychological and emotional aspects of care. The most significant improvements were observed in areas related to psychological support, empathy, growth, and self-awareness—critical components of the dignity-in-care approach.

However, the reduction observed in domains associated with physical privacy and patient engagement in meaningful activities suggests that these areas may require further attention in future training interventions. Future training programs should address these gaps, ensuring that health care professionals are equipped to deliver care that fully respects and upholds patient dignity in all its dimensions, as interventions co-led by psychologists and nurses.

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## TEACHING TIPS

### Teaching Time Management as a Self-Care Strategy

When talking to students and faculty as part of a new student success initiative, self-care and time management were identified as 2 pressing concerns. Discussion centered around how self-care was the first thing fall to the wayside for students as they struggled to meet the demand of balancing complex didactic, lab, clinical, and study schedules with personal commitments. Faculty, peer, and professional tutors made themselves available to work with students during the first month of the nursing program to help facilitate creating a personalized time management system. Students engaged 1-on-1 or in small groups with tutors to discuss their current time management practices. They discussed the merits of the different types of planner systems (hourly, daily, weekly, monthly) and strategies for prioritizing school and personal demands, such as creating a visual 4-quadrant matrix to sort tasks by both degree of urgency (columns – urgent/less urgent) and importance (rows – important/less important). This instruction emphasized the importance of scheduling self-care alongside study, time management as a trial-and-error process, and how time management skills are directly applicable to the bedside, particularly when nurses have 12 hours to complete a litany of urgent and non-urgent tasks for multiple patients. Instruction then culminated in application, as students were challenged to create their own personalized calendars. Electronic and paper versions of different planner and time management systems were provided, and students were encouraged to return to review the calendars and receive constructive feedback. By framing time management as self-care, we can teach translatable nursing skills and promote well-being.

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