Dignity violations as a cause of conflict in the health care setting.

"Leave your dignity at the door."

It was one of the first things said to me by a midwife on a labour ward tour during my first pregnancy.

I didn't belong in that harsh, alien landscape with its eye-scorching light and sensible surfaces. I had no identity, status or power. Dignity, my inherent human value, was the only thing I had to entitle me to be respected and cared for. And I was to leave it at the door?

What I felt next; unsafe, angry, in emotional freefall; was inexplicable to me until I learned about the importance of dignity, and how dignity violations trigger conflict.

Dr. Donna Hicks is a conflict resolution specialist and was Deputy Director of the Program on International Conflict Analysis and Resolution (PICAR) at the Weatherhead Centre for International Affairs, Harvard University. In her work as third-party facilitator in intractable conflict zones such as Israel-Palestine and Northern Ireland she discovered that dignity is so important to us that we perceive a threat to our sense of worth as if it is a physical threat, a threat to our survival[i].

And it once was. Our dignity signalled our value to our social group and indicated whether we were worthy of saving from famine, disasters, predators, or indeed other humans. We are primed to feel as if our lives depend on being treated respectfully[ii] and when we aren't, the negative feelings are intense and painful.

In the short term, dignity violations and the intense emotions they trigger lead to anger and withdrawal. Research has shown that chronic dignity violations can lead to isolation, avoidance of treatment, chronic mental and physical ill health and cycles of victimisation and abuse.[iii] Extreme dignity violations have resulted in suicide and, at the opposite extreme, murder.[iv]

Health care procedures and settings amplify the potential for dignity violations. Patients are often vulnerable, afraid, weak and/or ashamed, submitting to handling and invasive procedures, supine when everyone else is standing, disrobed. The environment is frequently what dignity research defines as harsh; that is, hierarchical and rigid; hectic, stressful and requiring urgent action but seriously under-resourced[v]. And harried staff may be perceived as arrogant, hostile and impatient, and can perceive non-compliance or questioning as violations of their own dignity. The interplay of these factors can create a spiral where each participant violates the other's dignity and triggers sensations of threat and anger on both sides of the interaction.

Despite feeling threatened and angry I didn't become aggressive in my encounter with the midwife, I simply left.

But not all patients walk away from healthcare settings when they feel threatened or angry. Some strike out.

In fact, violence against clinicians and support staff in clinical settings worldwide is increasing[vi] and widespread[vii], [viii]. This violence includes verbal abuse (the most commonly experienced violence), insults, swearing, racial or gender slurs, aggressive gestures and physical violence.

In Australia, nationwide surveys of clinicians and support staff conducted in 2010[ix] and 2015[x] found that perpetrators of violence in health care settings were most frequently patients, followed by patients' carers, and then colleagues.

The impacts of this violence include poor job satisfaction, high staff attrition, psychological trauma and reluctance to engage with the abuser[xi], [xii] ultimately threatening the safety and quality of patients care[xiii], [xiv].

Despite health departments and clinician organisations around the globe implementing preventative programs for patients and their carers, and training for staff in aggression defusion and response[xv], a 2020 Cochrane systematic review[xvi] concluded that there was little robust evidence that initiatives to prevent and minimise patient aggression actually work.

A need to be wary of patient aggression, and goals of respecting patient dignity may seem like dissonant concepts for clinicians and support staff confronted frequently by abuse. Perhaps part of the solution lies in understanding that some patient aggression is inextricably linked with their dignity. If staff can recognise anger and withdrawal as natural responses to dignity violation, to recognise themselves as unwitting dignity violators, as well as the violated, they may, in fact intuitively prevent and defuse aggression while restoring dignity for some of their most marginalised and vulnerable patients.

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[xv] ACT Government ibid

[xvi] Spelten et al ibid