BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (http://bmjopen.bmj.com).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-059129
Article Type:	Original research
Date Submitted by the Author:	11-Nov-2021
Complete List of Authors:	E. P. Dutra, Pablo; UFRJ, INSTITUTE OF PSYCHIATRY OF UFRJ (IPUB/UFRJ) Quagliato, Laiana; UFRJ, Institute of Psychiatry of UFRJ (IPUB/UFRJ) Nardi, AE; Universidade Federal do Rio de Janeiro, Institute of Psychiatry
Keywords:	MENTAL HEALTH, MEDICAL ETHICS, MEDICAL EDUCATION & TRAINING, PSYCHIATRY, PUBLIC HEALTH, QUALITATIVE RESEARCH

SCHOLARONE™
Manuscripts

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

TITLE PAGE

Title: Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Author name:
Pablo Eduardo Pereira Dutra

Co-authors' names:
Laiana Azevedo Quagliato
Antonio Egidio Nardi

Corresponding author:
Full name: Pablo Eduardo Pereira Dutra
ORCID: 0000-0003-3970-5668
Postal address: Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro, RJ, Brazil
ZIP Code: 22.290-140
E-mail: pablo.medicinaufrj@gmail.com
Phone: +55 21 3938-0500
Fax: +55 21 3938 0500
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of UFRJ (IPUB/UFRJ)

Full names, institutions, city, and country of all co-authors:
Full name: Laiana Azevedo Quagliato
ORCID: 0000-0002-6928-5847
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Full name: Antonio Egidio Nardi
ORCID: 0000-0002-2152-4669
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Keywords (MeSH terms): Respect, Dignity, Patient rights, inpatients, privacy

Word count: 4,868

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

ABSTRACT

Objectives: The aim of this systematic review is to find international evidence to determine which strategies are effective for improving hospitalized patients' perception of respect and dignity.

Methods: A systematic review of the international literature was conducted in accordance with PRISMA 2020 guidelines and registered at PROSPERO (CRD42021241805). The MEDLINE/PubMed, PsycINFO and Cochrane Library databases were searched for observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials with interventions focused on improving respect for patients and maintaining their dignity. Studies with case report designs, editorials, opinion articles, studies <10 subjects, responses/replies to authors, and responses/replies to editors were excluded. The study population included patients admitted to hospitals, day hospitals, clinics, emergency departments, psychiatric emergencies, psychiatric hospitals, asylums, and any other places where there were inpatients. Systematic reviews were not included. Two evaluators assessed risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2: methods for allocation, methods for randomization, blinding, and evaluation of internal validity. The reviewers were blinded during the selection of studies as well as during the quality appraisal. Disagreements were resolved by consensus after the reviewers' judgment.

Results: A total of 2,515 articles were retrieved from the search to databases, and 44 articles were included in this review. We conducted a quality appraisal of the studies (27 qualitative studies, 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study and 1 convergent parallel mixed-method study).

Conclusion: There are many strategies that could be used to improve the perception of respect for and the maintenance of the dignity of the inpatient. The lack of interventional studies measuring effects in this field has led to a gap in knowledge that needs to be filled with studies with better designs and effect measurements.

Keywords: Respect, Dignity, Patient rights, inpatients, privacy

STRENGHTS AND LIMITATIONS OF THIS STUDY

- This study covers a wide range of topics related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent.
- It fills a knowledge gap in an area that lacks more research and development.
- We bring important information on medical education in order to improve medical practice.
- More studies with controlled interventions and outcomes are necessary.
- It may not be appropriate to generalize these findings to all countries and cultures.

INTRODUCTION

Dignity is a fundamental human right (1), and its maintenance is an ethical goal of care (2). The Brazilian Code of Medical Ethics (3) states that physicians must respect and act in patients' benefit. The Declaration on the Promotion of Patients' Rights in Europe (4), states that one of its objectives is "*to reaffirm fundamental human rights in health care*".

The concept of dignity is still not clearly defined (5), and it can be affected during hospitalization (6). Hospital routines are needed to promote and protect patient health, but they can be harmful when patients experience stigma (7), violation of rights, privacy, integrity, disrespect and breaches in confidentiality, and when facing unprepared and insecure professionals who cannot provide clear explanations about diagnostic and therapeutic

procedures. All of these can lead to complaints, which can be used as a tool for improving patient care (8).

OBJECTIVE

The aim of this systematic review is to evaluate worldwide evidence to determine which strategies can be used to improve inpatient patients' perception of respect and dignity.

STUDY DESIGN

A systematic review with the aim of identifying, analyzing, extracting and evaluating data from the international literature related to respect for and maintenance of the dignity of hospitalized patients. It also aims to identify knowledge gaps and relate the findings to clinical practices to improve the quality of care for all hospitalized patients worldwide.

METHODS

This study was registered at PROSPERO (CRD42021241805) and conducted following PRISMA guidelines (9). Articles were identified by searching electronic records, including the MEDLINE/PubMed, PsycINFO and Cochrane Library databases. The quoted search terms used were as follows: Patient human rights violation OR Patient disrespect OR Patient violation of dignity OR Patient rights protection OR patient intimacy violation OR patient confidentiality violation OR ethical violation OR ethics violation OR hospital violation of patients' rights OR patients' perception of rights violation OR patients' perception of disrespect. There were no restrictions on year or language of publication, and no automation tool was used. The main objective was to find any interventions and multifaceted interventions aimed at improving inpatients' perception of respect and dignity and decreasing disrespect or human/inpatient rights violations, intimacy violations, confidentiality violations, autonomy violations, etc. The search included interventions conducted in hospitals, day hospitals, clinics, emergency departments, psychiatric emergencies, psychiatric hospitals, asylums, and any other places where there are inpatients. The inclusion criteria were full text, observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials. The exclusion criteria were case reports, editorials, opinion articles, studies <10 subjects, responses/replies to authors, and responses/replies to editors.

The first author (PEPD) screened the titles and abstracts of the articles and manually excluded those articles that did not fit the inclusion criteria.

After that, two reviewers (PEPD and LAQ) independently assessed the full texts of the remaining articles for eligibility in a standardized manner: data extraction was performed independently, and disagreements between reviewers regarding the study selection or data extraction were resolved by consensus. If a consensus was not reached, the third reviewer (AEN) was consulted.

The following information was extracted from the full-text articles using an Excel spreadsheet: authors, place/year of publication, sample size, type of samples, study design, analysis, data/measure, strategies, interventions to achieve improvements, and limitations.

Two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10). Disagreements were resolved by consulting a third reviewer. The minimum number of studies for data to be pooled was 10, including any intervention that would be effective for improving the perception of respect and dignity among inpatients.

A quality appraisal of the articles was performed using the CASP Qualitative Studies Checklist (11), Specialist Unit for Review Evidence (SURE) 2018 (12), CASP Cohort Study Checklist (13), and Mays & Pope Qualitative research in health care (14).

Patient and public involvement

No patient involved.

RESULTS

Three databases were searched on March 9th, 2021: PubMed/MEDLINE, PsycINFO, and Cochrane Library. Of the 2,515 results, no article was excluded by automation tools, 3 were excluded after searching for duplicate studies using the EndnoteWeb tool, and 2,375 were excluded after title and abstract screening by the first reviewer (PEPD). In the second step, two reviewers (PEPD and LAQ) independently assessed the 121 articles for eligibility.
Thirteen references were not found. The first reviewer (PEPD) contacted by e-mail and/or via ResearchGate - more than once - authors, coauthors, and journals where they were published to try to retrieve them. Up to August 5th, 2021, 9 articles were retrieved, 3 were bought online from publishers, and 1 was not retrieved and excluded. A total of 76 articles were excluded: 50 did not include inpatients, 2 were not in the scope of this review, 4 were review/systematic review, 1 focused on health care professionals, 1 focused on the development of telehealth, 12 were essay/commentary/thoughts, 2 included less than 10 patients, 1 was a study protocol, and 3 were scale developments.
Forty-four articles were included, according to PRISMA 2020 guidelines (9) (figure 1): 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study, 1 convergent parallel mixed-method study, and 27 qualitative studies. Considering all the studies included, a total of approximately 26,626 participants were included in this review.

Table 1 shows the design and type of analysis of the qualitative and quantitative studies.

Table 1: Qualitative and quantitative studies: design and analysis

	Table 1 - Qualitative and quantitative studies: design and analysis			
	Qualitative			
Qualitative	**Design**		**Type of analysis**	
	Cross-sectional	7	Qualitative	2
			Descriptive	3
			Descriptive and inferential analysis	1
			Deductive and InductiveThematic content analysis	1
	Qualitative	27	Qualitative descriptive and inductive content analysis	2
			Thematic content analysis	1
			Phenomenological hermeneutic analysis	1
			Qualitative content analysis	3
			Qualitative	11
			Qualitative phenomenological	2
			Observational qualitative case study	1
			Qualitative interpretive study	1

			Qualitative exploratory	3
			Qualitative and quantitative	1
			Qualitative phenomenographical approach	1
Quantitative	**Design**		**Type of analysis**	
	Cross-sectional	7	Comparative	1
			Multilevel, mixed effects generalized linear regression	1
			Multivariable longitudinal regression, qualitative	1
			Bivariate and multivariate analysis	1
			Negative binomial regression	1
			Qualitative and quantitative	1
			Qualitative and quantitative (multivariate logistic regression)	1
	Quali-quantitative	1	Quali-quantitative descriptive	1
	Cohort	1	Quantitative and qualitative	1
	Convergent parallel Mixed-method	1	Qualitative and quantitative (multivariate logistic regression)	1

Privacy can be violated in many ways. Patients understood it to be a violation of privacy to provide a list of names for clerics to offer religious support and that patients were both entitled to refuse to have their names posted on a list and to receive religious support (15). For psychiatric patients, for example, it is necessary to know the individual history of each patient and their pattern of behavior, be attentive to the needs of patients during the seclusion process, explain the reasons and ensure that the patients understand the problem (16), and these experiences can be perceived as harmful, humiliating, dehumanizing, unreasonable, or distressing (17). A good communication between health professionals and patients and family members can alleviate parental and patients' anxiety and confusion (18). Likewise, low-risk emergency patients feel powerless, insulted, and humiliated because they do not understand what is happening to them, which violates their self-esteem, making them feel dependent on care, exposed, vulnerable and insecure (19). It is necessary to evaluate nursing procedures in emergencies so that patients feel more welcomed and less vulnerable. Patients of different ethnicities report similar experiences, and they considered important definitions of respect and disrespect: being treated like a person and being treated as an equal; being known as a particular individual, avoidance of stereotyping, being treated politely, honest explanations of medical issues, and how lateness is handled (20). To provide patient-centered care, it is necessary to understand how different cultures perceive respect and disrespect.

Seventeen articles focused on abuse and violation of patient rights during pregnancy, partum and postpartum. Training on respectful maternity care (RMC) should be strengthened to include greater focus on counseling skills and rapport building, and that addressing structural

issues around provider workload should complement all interventions to improve midwives' interpersonal interactions with women (21). Likewise, strategies that promote more equitable pay, offer rotational schedules with short-term respite away from providing maternity care, and increased access to mentoring and peer-to-peer learning platforms may improve RMC and uptake of facility delivery in low-resource settings and that an enhanced understanding of the relationships between patient and provider characteristics may improve the provision of quality labor and delivery services and should be considered in the design of maternity care programs, policies, and future research (22). For example, 20% of the women reported disrespect and abuse while receiving care during labor and delivery. Policies and practices aimed at ensuring universal coverage for institutional deliveries need to promote RMC for women in all health facilities. A sustainable increase in institutional delivery requires ensuring quality, compassionate and caring services in all health facilities (23,24). A good communication between mothers and providers is critical for building mothers' confidence, promoting bonding and participation of mothers in the care of their baby and may have long-term benefits for the health and well-being of the mother and her baby (25). In Jordan, the lack of privacy during labor and birth makes women pay for privacy, looking for private hospitals, although it was not always achieved at those facilities. Some simple strategies could improve privacy, such as being covered by a sheet; however, even simple practices are difficult to change (26). Likewise, weight stigma may be a common experience in pregnancy and postpartum health care and that providers need additional training to avoid stigmatizing their patients and inadvertently undermining patient-provider relationships, quality of care, and health outcomes (27). Health care providers are not aware of the most essential aspects of RMC, exposing the need to promote the RMC charter among both women who seek care and health care providers (28). Social status, level of education and age of women were perceived to influence the quality of care they received, so improving women's experience of maternal care requires targeted interventions at the interpersonal level between a woman and her health care providers (29). The absence of caring behaviors from midwives elicited distress and negative responses from women in labor (30). Disrespectful and abusive treatment during childbirth is an important factor in reducing women's confidence in health facilities, so improving interpersonal care must be an integral part of quality improvement in maternal health (31). For these reasons, providers, women and their families must be made aware of women's rights to respectful care (32). For example, women have the right to be seen as partners in the care process and not subordinate to care providers (33). Most conflicts were related to feelings of being un/misinformed by health care personnel, disrespected and objectified, lack of support, and various problems during childbirth and postpartum (34). In rural Afghanistan, the local recruitment and professional education of midwives were successful for promoting utilization and satisfaction with maternal and neonatal health services. Nevertheless, the quality of the services is still lacking, with some women complaining of disrespectful care (35). Mistreatment is experienced more frequently by women of color, when birth occurs in hospitals, and among those with social, economic or health challenges, it is exacerbated by unexpected obstetric interventions and by patient-provider disagreements (36). A study conducted in Peru to assess the prevalence of disrespect and abuse during childbirth found that the majority of participants had experienced at least one category of disrespect and abuse during childbirth care (37). All these studies are in accordance with the recommendations provided by the World Health Organization (WHO) (38,39), i.e., working to improve the quality of assistance to women during pregnancy, labor and postpartum, and their children. Understanding the roots of disrespect and lack of dignity are essential to raising the quality of care provided to women around the world. As seen in the cited articles, the treatment given to women during pregnancy, childbirth and postpartum is crucial for women to seek help when they need it. It is necessary to correct the attitude of health professionals since training so that this kind of abusive and disrespectful attitude is not perpetuated.

Among general hospitals and other health care providers, the situation is not much different. The viewpoints of nurses and patients provide knowledge of how undignified behaviors could

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

be reduced in cross-cultural health care settings. Behaviors perceived as undignified primarily by nurses or patients might result from differences in social roles and responsibilities (40). Likewise, health disparities may contribute to negative perceptions of disrespect or of receiving unfair treatment, particularly among racial/ethnic minorities (41). This indicates that almost no patient is satisfied with the quality of services, and to improve the quality of the assistance, health care professionals must be aware of the factors that violate or preserve dignity from the patient's perspective (42). Likewise, patients voiced concerns addressing interpersonal issues, which can be improved with efforts to address technology access and availability, as well as empathy and communication strategies (43). These complaints could be mitigated if health-care professionals took a more active role in identifying and responding to patients who are experiencing dissatisfaction, even when they are not actively complaining (44). These negative tensions can be mitigated by approaches that aim to push improvement in patient safety through their involvement, so a more collaborative approach, that encourages patients and health care staff to work together, is needed (45). These findings imply sensitizing managers toward providing appropriate conditions and educating nurses to observe patients' rights (46). The pilgrimage of patients among health facilities is the greatest expression of unfair inequalities, sustained by structural factors such as the precarious conditions of health services (47).

Another concern for patients is information, and medical facilities should devote every effort to alleviate patients' concerns about the invasion of their information privacy to avoid eroding the reputation of medical facilities and impeding the promotion of electronic medical records (48), because patients bring expectations for hospitals related to safety, respect, dignity, care, and information (49). For instance, small attitudes of the nursing staff, such as touching the patient's possessions without permission and exposing the patient, caused discomfort and violated patient privacy (50). It only stresses the importance to give information about ethical and legal issues related to privacy and confidentiality before and during hospitalization (51). For example, in Greece, patients were quite unaware of their rights (52). Nurses play an important role in disseminating ethical principles and establishing a respectful relationship with patients (53), and they need to improve their approaches to patient privacy (54). Likewise, patients believe that privacy is linked to dignity and respect, and that these concepts and attitudes are connected and essential to protect privacy in the hospital context (55).

A study in the intensive care unit (ICU) found that all patients recollected memories with strong feelings about the ICU environment, such as hostility and stress (56). Negative feelings were associated with violation of dignity and privacy, lack of empathy, not being understood, delays in obtaining support, and total control by the health care staff. The majority of patients are unaware of their rights, and these rights are not respected in the provision of care (57). For example, patients who had a methicillin-resistant S. aureus (MRSA) notification card felt discriminated against, making its use questionable (58). That is why it is imperative that caregivers are aware of patients' conceptions of integrity to identify and preserve it and so that they treat them in accordance with moral integrity (59). Physician behaviors should be useful in developing curricula related to professionalism, communication skills, and practice-based learning (60).

All these findings are in line with what is described in the current literature: more computerized resources will be needed to maintain the privacy of patient data (61); dignity and autonomy are intertwined and can positively impact the quality of care from the patients' point of view (62); and empathic, non possessive, respectful and authentic care has a significant effect on treatment outcomes (63). Thus, the dynamics of the provider-patient relationship is an important therapeutic factor that contributes at the clinical level to the approach and information of the patient in the area of general health and not just in mental health.

Quality appraisal

A critical appraisal of the included studies was performed, but no study was excluded based on its score, although this approach makes their analysis more robust. The instruments used for it were: CASP Qualitative Studies Checklist (11) (**Table 2**); Specialist Unit for Review Evidence

(SURE) - Questions to assist with the critical appraisal of cross-sectional Studies (12) (**Table 3**); CASP Cohort Studies Checklist (13) and the criteria put forth by Mays & Pope (2000) (14) (**Table 4**). At the bottom of each table are the scores for quality assessment.
They were scored as follows: 0 = not or inadequately addressed, 1 = partially addressed, and 2 = fully addressed criterion.
The quality assessment of the studies and of the systematic review was performed by two reviewers independently (PEPD and LAQ), who then discussed and agreed to the final rating. No study was excluded for quality reasons, but this assessment enabled a more robust review of the studies.

Table 2: CASP - Qualitative studies

	Table 2 - CASP Qualitative Studies Checklist (CRITICAL APPRAISAL SKILLS PROGRAMME)									
	Aims	**Methods**	**Design and Methods**	**Recruitment stragegy**	**Data collection**	**Bias and Reflexivity**	**Ethical issues**	**Data analysis**	**Statement of findings**	**Value and applicability**	**Score**
Tsai Y. F. et al (2020)	1	1	1	2	2	1	2	1	2	2	**15**
Beach M. C. et al (2017) (a)	1	1	1	1	1	0	1	1	1	1	**9**
Adolfsson A. et al (2012)	2	2	2	2	2	1	1	1	2	2	**17**
Torabizadeh C. et al (2012)	2	2	2	2	2	1	2	2	2	2	**19**
Pomerantz S. C. et al (2006) (a)	2	2	2	1	1	1	2	2	1	2	**16**
Faschingbauer KM et al (2013) (a)	2	2	2	1	1	1	2	2	2	2	**17**
Fleury S. et al (2013) (a)	2	2	2	1	1	1	2	1	1	1	**14**
Gebremichael M.W. et al (2018) (a)	2	1	1	1	1	1	2	2	2	2	**15**
Haskins L. et al (2019)	2	2	2	1	2	1	2	2	2	2	**18**
Howard M. et al (2013)	2	1	1	2	1	1	2	1	1	1	**13**
Evan E. E. et al (2007) (a)	2	2	2	2	1	1	2	2	1	2	**17**
Hussein S. A. A. A. et al (2019)	2	2	2	2	1	2	2	1	2	2	**18**
Aminu M. et al (2019)	2	2	2	2	2	1	2	2	2	2	**19**
Kanengoni B. et al (2019) (a)	2	2	1	2	1	1	2	2	2	2	**17**
Mohammadi E. et al (2017)	2	2	2	2	2	1	2	1	1	1	**16**
Khresheh R. et al (2019) (a)	2	2	1	2	1	1	2	2	2	2	**17**
Horwitz L. I. et al (2010)	2	2	2	2	2	1	2	2	2	2	**19**
Dzomeku V.M. et al (2017)	2	2	2	2	2	1	2	2	2	2	**19**
Wei H. et al (2019)	2	2	2	2	2	1	2	2	2	2	**19**
Pupulim J. S. L. et al (2012)	2	2	2	2	2	1	2	1	1	2	**17**
Robins C. S. et al (2005)	2	2	2	1	1	1	1	2	1	1	**14**
Hernández-Martínez A et al (2019) (a)	2	2	2	2	1	1	2	2	2	2	**18**
Wofford M et al (2004)	2	1	1	1	2	0	1	1	0	1	**10**
Thommesen T. et al (2020)	2	2	2	1	2	1	1	2	1	2	**16**
Widäng I et al (2003)	2	2	2	2	2	1	2	2	2	2	**19**

Hrisos S (2013)	2	2	1	2	2	2	2	1	2	2	**18**
Merakou K. et al (2001)	2	2	2	2	1	1	0	1	2	1	**14**
(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)	**Scores**	0–7 = low quality	8–14 = moderate quality	15–20 = high quality		0 = not or inadequately addressed or applied		1 = adequately addressed or applied		2 = well addressed or applied	

Table 3: SURE - Cross-sectional studies

	Table 3 - Specialist Unit for Review Evidence (SURE) - Questions to assist with the critical appraisal of cross-sectional studies													
	Larijani B et al (2018)	**Montesinos-Segura R et al (2017)**	**Marin CR et al (2018)**	**Ma CC (2014)**	**Dynes MM et al (2018)**	**Ring D et al (2017)**	**Lurie N *et al* (2004)**	**Gebremichael MW et al (2018)**	**Rodriguez ACI et al (2020)**	**Kujawski S et al (2015)**	**McMahon SA (2014)**	**Vedam S et al (2019)**	**Burrowes S et al (2017)**	**Óztúrk H et al (2020)**
Design	2	2	2	2	2	0	2	2	1	2	1	2	2	2
Question	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Setting/location	2	2	2	2	2	1	2	2	2	2	2	2	2	2
Selection	2	2	2	1	2	2	2	2	2	2	2	2	2	2
Characteristics	2	2	2	1	2	2	2	2	2	2	2	2	2	2
Exposure & outcomes	2	2	2	1	1	2	2	2	2	2	2	2	2	2
Study size	2	2	2	2	2	2	2	2	2	1	2	2	2	2
Statistics	2	2	1	1	2	2	1	2	2	2	2	2	1	2
Eligibility	2	1	1	1	2	2	2	2	2	2	2	2	2	2
Results	2	1	1	1	2	2	1	2	2	2	1	2	2	2
Conflict of interest	2	2	2	2	2	0	2	2	2	2	2	2	2	2
Limitations	0	2	2	2	2	2	2	2	0	2	2	2	2	1
Total	22	22	21	18	23	19	22	24	21	23	22	24	23	23
Item scores	Total scores													
0 = not or inadequately addressed or applied	0–9 = low quality													
1 = adequately addressed or applied	10–17 = moderate quality													
2 = well addressed or applied	18–24 = high quality													

Table 4: CASP - Cohort studies and Mays & Pope Criteria

CASP Cohort Studies Checklist				Critical Appraisal according to Mays & Pope (2000) Criteria		
	Skyman E et al (2014)				Santos LR *et al* (2005) (a)	Sanson G *et al* (2020)

Issue	2			**Worth or Relevance**	2	2
Recruitment	2			**Clear question**	2	2
Exposure	2			**Design**	2	2
Outcome	2			**Context**	2	2
Confounding factors identification	1			**Sampling**	1	1
Confounding factors taken into account	1			**Data collection and analysis**	2	1
Follow up complete	2			**Reflexivity**	1	2
Follow up long enough	2			**Total**	12	12
Results	2	0 = not or inadequately addressed/applied	Item score	0 = not or inadequately addressed/applied	Item score	
Precision of the results	2	1 = adequately addressed/applied		1 = adequately addressed/applied		
Believe the results	2	2 = well addressed/applied		2 = well addressed/applied		
Results applied	1	0–9 = low quality	Total score	0– 4 = low quality	Total score	
Results fit	1	10–17 = moderate quality		5–9 = moderate quality		
Implications for practice	1	18–24 = high quality		10–14 = high quality		
Total	23					

Risk of bias

To minimize bias, two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10): methods for allocation, methods for randomization, blinding, and evaluation of internal validity. The reviewers were blinded during the selection of studies to be included and excluded as well as during the quality appraisal. Disagreements were resolved by consensus after the reviewers' judgment.

DISCUSSION

These studies reveal that there are several strategies that can improve the quality of care provided to inpatients, thus improving their perception of respect and dignity. One attitude

must guide professional conduct in the health area: the Hippocratic principle "First, do no harm". This must be considered in all spheres of the provider-patient relationship. Therefore, although we did not find studies with statistically calculated interventions and effect size measurements, the quality of the studies included in this systematic review allows us to point out some strategies that can help improve patients' perceptions regarding respect for and maintenance of their dignity. Patients and health professionals around the world express the same interests and desires to have the quality of care raised to the level of excellence and the rights of patients respected.

While we tend to imagine that all patients who have a religion would like to receive visits from clergymen, even if this is true, one of the studies (15) shows that they would not want their names to be posted on visiting lists and that they consider this an invasion of your privacy. Wanting religious support does not mean wanting to be exposed. Violations of rights are also prevalent in psychiatry. Psychiatric patients demand respect even during their crisis moments, when there is psychomotor agitation. They demand more attention, and understanding at the moment of crisis[16] before thinking about isolation, considering that seclusion is a form of violation of their rights and that it often represents the unnecessary use of force to punish them. The place of care cannot become a place where rights are violated, transforming the treatment experience into a painful psychic experience (17). Likewise, the communication skills of health professionals are necessary in other fields (18), such as in pediatrics, in which parents and children demand more attention and information from physicians as a way of respecting and showing themselves capable of conducting the treatment, even in moments of the most difficult decisions. It is necessary for professionals to communicate well with patients and family members so that they can make the best decisions for the patient's quality of life. Patient care and information are also important in the emergency room (19). Patients considered to be at low risk tend to feel abandoned and "left out" when they do not receive the information they deem necessary. They do not understand why other patients receive care before them, why they have to wait for several hours, and why their illnesses are considered a low priority. Emergency room professionals need to be on the lookout for high-risk patients, but they also cannot leave low priority unattended. In addition, patients of different ethnicities, races and social groups perceive attention and respect differently (20). Professionals must be aware of these subtleties of human behavior and spend more time assisting these patients in a way that makes them feel more respected and welcomed. These small actions can make a difference when a patient seeks treatment or professional help.

One of the fields with the most studies on disrespect/respect and maintenance of dignity is the relationship between health professionals and women during pregnancy, childbirth and postpartum (21-37). Most of these studies are focused on women's rights RMC; to have a companion during childbirth, whether a family member or friend; the right not to be verbally or physically abused; the right not to have their bodies exposed in a hospital environment, where there is a large circulation of professionals; the right not to have their bodies invaded by several individuals, as in the case of teaching hospitals where a group of students or resident physicians perform a vaginal exam on the same patient; the right to receive information about prenatal care, pregnancy, childbirth, postpartum, breastfeeding, contraception and infectious-contagious diseases that can affect the mother and baby; the right of not being discriminated against because of their weight, color, race or socioeconomic status; the right to have quality and humanized care in any device in the care network, whether public or private; the right to receive analgesia or anesthesia, not having, for example, to bear the pain of an episiotomy without anesthesia; and the right to have less prolonged care, whether public or private. Obstetric violence is present in several fields of action, among the various health professionals who work in this area, from harshly speaking to or yelling at, to physically or sexually assaulting a woman. Considering the most diverse studies on the subject, it is clear that this practice is widespread in several countries around the world, and there needs to be a large investment in education and training of health professionals so that women of childbearing age can be assisted with dignity and respect.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Although nurses and patients share the same point of view regarding the recognition of what are considered inappropriate and disrespectful behaviors in multicultural contexts, the educational, cultural, social and economic foundations of patients make a difference in this perception. Health professionals must be aware of this when they care for patients from other ethnicities and from different socioeconomic levels, as this can lead to negative perceptions regarding care and complaints, for example, related to discrimination and quality of care (40 - 43). Such conflicts can be mitigated by a more conciliatory professional posture that is more active in the sense of avoiding conflicts and improving the patients' experience during the hospitalization period. The investment in training and education of health professionals is the best solution to improve the quality of care, bringing patients to a more active position in their treatment, promoting information and autonomy, providing assistance in a timely manner, respecting rights, maintaining vigilance in cases of disrespect and violations of dignity, encouraging the acceptance of differences, reducing all types of prejudice and stigma, and allowing professionals and patients to act together and not in an antagonistic way (44-47).

Small attitudes of health professionals can turn into big problems: touching personal belongings without authorization, moving objects, exposing the patient and making inappropriate comments, even though it may seem like just an innocent joke. One of the solutions may be to ask patients and family members to carry out assessments about the service, analyze complaints in the ombudsman's office, and use these data as important tools to improve the quality of the service provided. Patient concern regarding the confidentiality of their medical information is another point that deserves attention. The right to privacy and confidentiality is directly related to the respect and dignity of patients. Violations of confidentiality, in addition to being unethical, can cause moral and financial damage to patients and their families, leading to legal actions against professionals and hospitals. Another way to give patients more freedom and autonomy is to guarantee them access to their medical information, either through direct access to the system or through applications. Thus, managers and government officials must invest in information security systems, since the world is increasingly digital and the trend is to reduce the use of printed documents, ensuring the protection of data for patients and professionals. Patients must receive information about current legislation in terms of information security, their rights to privacy and confidentiality, and nursing has a fundamental role in the dissemination of ethical principles in the work environment (48-60).

The results found in the articles included in this systematic review show that there is still a long way to go in promoting more dignified and respectful care for patients admitted to health care units around the world. The innovation is in the synthesis and enumeration of these practices, which can bring a new way of dealing with information and profoundly change the way we serve and think about the care provided to hospitalized patients. Regardless of culture and nationality, studies show that there is a need to improve the quality of care, whether through improvements in education during graduation, in student training, in the use of reality data to refine professional practice, or through training of professionals when entering the labor market, offering refresher courses, recycling professionals and promoting the availability of safe means by which professionals can discuss cases and share knowledge without breaching professional secrecy.

STRENGTHS OF THIS STUDY

Our study covers a wide range of topics related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent. In addition, this systematic review fills a knowledge gap in an area that has not yet been studied, which, although gaining prominence in recent years, lacks more research and development. The fact that there is no limitation on the time researched and on the language allowed us to reach from the most recent to the oldest studies on this topic.

LIMITATIONS

Although we have tried to reach as many studies as possible, its results cannot be generalized to all cultures and countries of the world, and it does not include all specialties and their peculiarities. One study could not be retrieved, and it might have data that could be important to the results of this study. The data were not homogeneous enough to perform a meta-analysis, which would enrich the results. More studies with controlled interventions and outcomes should be carried out to measure the effect on the perception of respect for and maintenance of the dignity of hospitalized patients.

STATEMENT OF FINDINGS

Regarding clinical practice, our study brings several collaborations based on the findings of the reviewed articles. Actions to promote dignity include: providing information correctly and clearly about procedures and treatments, serving with politeness and kindness, avoiding gestures and comments that might be perceived as disrespectful, putting aside prejudices (you are not there to judge but to serve to the best of your ability and professional ethics), taking as much time to serve as necessary, adhering to confidentiality when sharing information with team members, listening to complaints and trying to resolve them, responding to timely calls, using patient complaints made as a way to improve the hospital routine, promoting improvements in the quality of the environment (including cleaning, lighting and noise control), allowing pregnant women to have companions, avoiding yelling at patients or using physical touch as a form of reprimand (which can be understood as physical aggression), avoiding unnecessary exposure of the patient's body, avoiding intimate examination by various professionals (especially in teaching hospitals), obtaining consent for diagnostic and therapeutic procedures, informing patients about the drugs that will be applied (name and what they are used for), introducing oneself to the patient, asking if the patient wants to receive visits and from whom, asking who the patient would like to share information with, calling the patient by his or her name (avoiding colloquial or derogatory language), demonstrating knowledge, showing security and professional skills, and using setbacks as opportunities for your own and for your team's collective learning.

IMPLICATIONS FOR PRACTICE

Our findings provide perspectives that could and should be used to improve patient care and education in different areas of health around the world.

IMPLICATIONS FOR RESEARCH

Virtually all studies related to the quality of care, respect, dignity, confidentiality and privacy of hospitalized patients, have a qualitative or cross-sectional design. It is necessary that future research be designed with controlled interventions and effect size measurement to bring more robustness to the findings, since this subject is gaining prominence in daily practice. Furthermore, regardless of the country, respect and dignity are universal and fundamental rights of every human being and must, therefore, be put into practice wherever patients are.

CONCLUSION

Our systematic review touches on important points of care during professional practice, with the aim of delivering truly patient-centered care to patients.

Professional practice is regulated by legal means and by professional education, but it is observed that there is a lack of training so that various everyday conflicts can be mitigated and resolved locally without harming the patient. It is inconceivable that patients need to look for another health facility because they feel mistreated at a place that should provide care. Likewise, it is unacceptable for a health professional not to be able to handle situations in their professional routine without resorting to violence or verbal aggression. When a patient goes to a health unit, he or she seeks care; therefore, we have the obligation to provide care, without prejudice, without discrimination and to the best of our technical capacity, with respect and dignity. This is the wish of all patients around the world.

REGISTRATION AND PROTOCOL

This study protocol was registered at PROSPERO (CRD42021241805 - Improving the perception of respect for and the dignity of the inpatient: A Review), and it was conducted in accordance with PRISMA 2020 guidelines (9).

FUNDING

This study has no external funding source.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

CORRESPONDING AUTHOR:

Pablo Eduardo Pereira Dutra, MD
ORCID: https://orcid.org/0000-0003-3970-5668
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of UFRJ (IPUB)
Federal University of Rio de Janeiro (UFRJ)
Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro/RJ
Phone: +55 21 3938-0500
E-mail: pablo.medicina@ufrj.br

AUTHORS AND AFFILIATIONS

Pablo Eduardo Pereira Dutra, MD
ORCID: https://orcid.org/0000-0003-3970-5668
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
Federal University of Rio de Janeiro (UFRJ)
Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro/RJ
Phone: +55 21 3938-0500
E-mail: pablo.medicina@ufrj.br

Laiana Azevedo Quagliato, MD, MSc
ORCID: https://orcid.org/0000-0002-6928-5847
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
Federal University of Rio de Janeiro (UFRJ)
Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro/RJ
Phone: +55 21 3938-0500

Antonio Egidio Nardi, MD, PhD
ORCID: https://orcid.org/0000-0002-2152-4669
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
Federal University of Rio de Janeiro (UFRJ)
Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro/RJ
Phone: +55 21 3938-0500

ORCid

Pablo Eduardo Pereira Dutra - https://orcid.org/0000-0003-3970-5668

Laiana Azevedo Quagliato - https://orcid.org/0000-0002-6928-5847
Antonio Egidio Nardi - https://orcid.org/0000-0002-2152-4669

REFERENCES

1) United Nations. Universal Declaration of Human Rights | united nations. [cited 2021 June 8]; Available from: https://www.un.org/en/about-us/universal-declaration-of-human-rights

2) Ferri P, Muzzalupo J, Di Lorenzo R. Patients' perception of dignity in an Italian general hospital: a cross-sectional analysis. BMC Health Serv Res. 2015;15(1):41-48.

3) Conselho Federal de Medicina. Código de Ética Médica [Internet]. Conselho Federal de Medicina. 2019 [cited 2021 June 8]. Available from: https://portal.cfm.org.br/images/PDF/cem2019.pdf

4) World Health Organization (WHO). A Declaration on the Promotion of Patients Rights in Europe. [Internet] 1994. [cited 2021 June 08]. Available from: https://www.who.int/genomics/public/eu_declaration1994.pdf

5) Bagheri A. Elements of human dignity in healthcare settings: the importance of the patient's perspective. J Med Ethics. 2012;38(12):729–30.

6) Campillo B, Corbella J, Gelpi M, Martinez E, Viciana MA, Alonso M. Development and validation of the scale of perception of respect for and maintenance of the dignity of the inpatient [CuPDPH]. Ethics Med Public Health. 2020;15(100553):100553.

7) Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity: Obesity stigma and patient care. Obes Rev. 2015;16(4):319–26.

8) Mirzoev T, Kane S. Key strategies to improve systems for managing patient complaints within health facilities - what can we learn from the existing literature? Glob Health Action. 2018;11(1):1458938.

9) Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. Syst Rev. 2021;10(1):89.

10) Chapter 7: Considering bias and conflicts of interest among the included studies [Internet]. Cochrane.org. [cited 2021 June 8]. Available from: https://training.cochrane.org/handbook/current/chapter-07

11) Critical Appraisal Skills Programme. CASP Qualitative Studies Checklist [Internet]. B-cdn.net. [cited 2021 Jul 6]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

12) Specialist Unit for Review Evidence (SURE). Questions to assist with the critical appraisal of cross-sectional studies [Internet]. Cardiff.ac.uk. 2015 [cited 2021 Jul 9]. Available from: https://www.cardiff.ac.uk/__data/assets/pdf_file/0006/212775/SURE_Qualitative_checklist_2015.pdf

13) Critical Appraisal Skills Programme. CASP Cohort Study Checklist [Internet]. B-cdn.net. [cited 2021 Jul 26]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Cohort-Study-Checklist-2018_fillable_form.pdf

14) Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. BMJ. 2000;320(7226):50–2.

15) Erde E, Pomerantz SC, Saccocci M, Kramer-Feeley V, Cavalieri TA. Privacy and patient-clergy access: perspectives of patients admitted to hospital. J Med Ethics. 2006;32(7):398–402.

16) Faschingbauer KM, Peden-McAlpine C, Tempel W. Use of seclusion: finding the voice of the patient to influence practice. J Psychosoc Nurs Ment Health Serv. 2013;51(7):32–8.

17) Robins CS, Sauvageot JA, Cusack KJ, Suffoletta-Maierle S, Frueh BC. Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatr Serv. 2005;56(9):1134–8.

18) Hsiao JL, Evan EE, Zeltzer LK. Parent and child perspectives on physician communication in pediatric palliative care. Palliat Support Care. 2007;5(4):355–65.

19) Adolfsson A, Dahlén, Westin. Experience of being a low priority patient during waiting time at an emergency department. Psychol Res Behav Manag. 2012;5:1-9.

20) Beach MC, Branyon E, Saha S. Diverse patient perspectives on respect in healthcare: A qualitative study. Patient Educ Couns. 2017;100(11):2076–80.

21) Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017;17(1):263-74.

22) Dynes MM, Twentyman E, Kelly L, Maro G, Msuya AA, Dominico S, et al. Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016. Reprod Health [Internet]. 2018;15(1):41-64.

23) Gebremichael MW, Worku A, Medhanyie AA, Berhane Y. Mothers' experience of disrespect and abuse during maternity care in northern Ethiopia. Glob Health Action. 2018;11(sup3):1465215.

24) Gebremichael MW, Worku A, Medhanyie AA, Edin K, Berhane Y. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective. BMC Pregnancy Childbirth. 2018;18(1):392-97.

25) Horwood C, Haskins L, Luthuli S, McKerrow N. Communication between mothers and health workers is important for quality of newborn care: a qualitative study in neonatal units in district hospitals in South Africa. BMC Pediatr. 2019;19(1):496-508.

26) Hussein SAAA, Dahlen HG, Ogunsiji O, Schmied V. Uncovered and disrespected. A qualitative study of Jordanian women's experience of privacy in birth. Women Birth. 2020;33(5):496–504.

27) Incollingo Rodriguez AC, Smieszek SM, Nippert KE, Tomiyama AJ. Pregnant and postpartum women's experiences of weight stigma in healthcare. BMC Pregnancy Childbirth. 2020;20(1):499-508.

28) Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision" - knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC Pregnancy Childbirth. 2019;19(1):42-9.

29) Kanengoni B, Andajani-Sutjahjo S, Holroyd E. Women's experiences of disrespectful and abusive maternal health care in a low resource rural setting in eastern Zimbabwe. Midwifery. 2019;76:125–31.

30) Khresheh R, Barclay L, Shoqirat N. Caring behaviours by midwives: Jordanian women's perceptions during childbirth. Midwifery. 2019;74:1–5.

31) Kujawski S, Mbaruku G, Freedman LP, Ramsey K, Moyo W, Kruk ME. Association between disrespect and abuse during childbirth and women's confidence in health facilities in Tanzania. Matern Child Health J. 2015;19(10):2243–50.

32) McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy Childbirth. 2014;14:268-80.

33) Millicent Dzomeku V, van Wyk B, Lori JR. Experiences of women receiving childbirth care from public health facilities in Kumasi, Ghana. Midwifery. 2017;55:90–5.

34) Rodríguez-Almagro J, Hernández-Martínez A, Rodríguez-Almagro D, Quirós-García JM, Martínez-Galiano JM, Gómez-Salgado J. Women's perceptions of living a traumatic

childbirth experience and factors related to a birth experience. Int J Environ Res Public Health. 2019;16(9):1654-66.

35) Thommesen T, Kismul H, Kaplan I, Safi K, Van den Bergh G. "The midwife helped me ... otherwise I could have died": women's experience of professional midwifery services in rural Afghanistan - a qualitative study in the provinces Kunar and Laghman. BMC Pregnancy Childbirth. 2020;20(1):140-56.

36) Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019;16(1):77-94.

37) Montesinos-Segura R, Urrunaga-Pastor D, Mendoza-Chuctaya G, Taype-Rondan A, Helguero-Santin LM, Martinez-Ninanqui FW, et al. Disrespect and abuse during childbirth in fourteen hospitals in nine cities of Peru. Int J Gynaecol Obstet. 2018;140(2):184–90.

38) The White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women [Internet]. Healthpolicyproject.com. [cited 2021 Aug 22]. Available from: http://www.healthpolicyproject.com/pubs/46_FinalRespectfulCareCharter.pdf

39) WHO Statement. The prevention and elimination of disrespect and abuse during facility-based childbirth [Internet]. Who.int. [cited 2021 Aug 22]. Available from: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

40) Asmaningrum N, Kurniawati D, Tsai Y-F. Threats to patient dignity in clinical care settings: A qualitative comparison of Indonesian nurses and patients. J Clin Nurs. 2020;29(5–6):899–908.

41) Blanchard J, Lurie N. R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care. J Fam Pract. 2004;53(9):721–30.

42) Ebrahimi H, Torabizadeh C, Mohammadi E, Valizadeh S. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. J Med Ethics. 2012;38(12):723–8.

43) King JD, van Dijk PAD, Overbeek CL, Hageman MGJS, Ring D. Patient complaints emphasize non-technical aspects of care at a tertiary referral hospital. Arch Bone Jt Surg. 2017;5(2):74–81.

44) Howard M, Fleming ML, Parker E. Patients do not always complain when they are dissatisfied: implications for service quality and patient safety. J Patient Saf. 2013;9(4):224–31.

45) Hrisos S, Thomson R. Seeing it from both sides: do approaches to involving patients in improving their safety risk damaging the trust between patients and healthcare professionals? An interview study. PLoS One. 2013;8(11):e80759.

46) Khademi M, Mohammadi E, Vanaki Z. On the violation of hospitalized patients' rights: A qualitative study. Nurs Ethics. 2019;26(2):576–86.

47) Fleury S, Bicudo V, Rangel G. Reacciones a la violencia institucional: estrategias de los pacientes frente al contraderecho a la salud en Brasil. Salud Colect. 2013;9(1):11–25.

48) Kuo K-M, Ma C-C, Alexander JW. How do patients respond to violation of their information privacy? Health Inf Manag. 2014;43(2):23–33.

49) Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. J Hosp Med. 2010;5(9):514–20.

50) Marin CR, Gasparino RC, Puggina AC. The perception of territory and personal space invasion among hospitalized patients. PLoS One. 2018;13(6):e0198989.

51) Mohammadi M, Larijani B, Emami Razavi SH, Fotouhi A, Ghaderi A, Madani SJ, et al. Do patients know that physicians should be confidential? study on patients' awareness of privacy and confidentiality. J Med Ethics Hist Med. 2018;11:1-7.

52) Merakou K, Dalla-Vorgia P, Garanis-Papadatos T, Kourea-Kremastinou J. Satisfying Patients' Rights: a hospital patient survey. Nurs Ethics. 2001;8(6):499–509.

53) Ming Y, Wei H, Cheng H, Ming J, Beck M. Analyzing patients' complaints: Awakening of the ethic of belonging: Awakening of the ethic of belonging. ANS Adv Nurs Sci. 2019;42(4):278–88.

54) Öztürk H, Torun Kılıç Ç, Kahriman İ, Meral B, Çolak B. Assessment of nurses' respect for patient privacy by patients and nurses: A comparative study. J Clin Nurs. 2021;30(7–8):1079–90.

55) Pupulim JSL, Sawada NO. Percepção de pacientes sobre a privacidade no hospital. Rev Bras Enferm. 2012;65(4):621–9.

56) Sanson G, Lobefalo A, Fascì A. "Love can't be taken to the hospital. If it were possible, it would be better": Patients' experiences of being cared for in an intensive care unit. Qual Health Res. 2021;31(4):736–53.

57) Santos LR, Beneri RL, Lunardi VL. Ethical questions in the work of the health team: the (dis)respect to client's rights. Rev Gaucha Enferm. 2005;26(3):403–13.

58) Skyman E, Bergbom I, Lindahl B, Larsson L, Lindqvist A, Thunberg Sjöström H, et al. Notification card to alert for methicillin-resistant Staphylococcus aureus is stigmatizing from the patient's point of view. Scand J Infect Dis. 2014;46(6):440–6.

59) Widäng I, Fridlund B. Self-respect, dignity and confidence: conceptions of integrity among male patients: Conceptions of integrity among male patients. J Adv Nurs. 2003;42(1):47–56.

60) Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviors: a qualitative study. Acad Med. 2004;79(2):134–8.

61) Kayaalp M. Patient privacy in the era of big data. Balkan Med J. 2018;35(1):8–17.

62) Rodríguez-Prat A, Monforte-Royo C, Porta-Sales J, Escribano X, Balaguer A. Patient perspectives of dignity, autonomy and control at the end of life: Systematic review and meta-ethnography. PLoS One. 2016;11(3):e0151435.

63) Kallergis G. The contribution of the relationship between therapist-patient and the context of the professional relationship. Psychiatrike. 2019;30(2):165–74.

COPYRIGHT/LICENSE FOR PUBLICATION

“The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution, iii) create any other derivative work(s) based on the Contribution, iv) to exploit all subsidiary rights in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above."

Figure caption:

Figure 1: PRISMA flow diagram

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

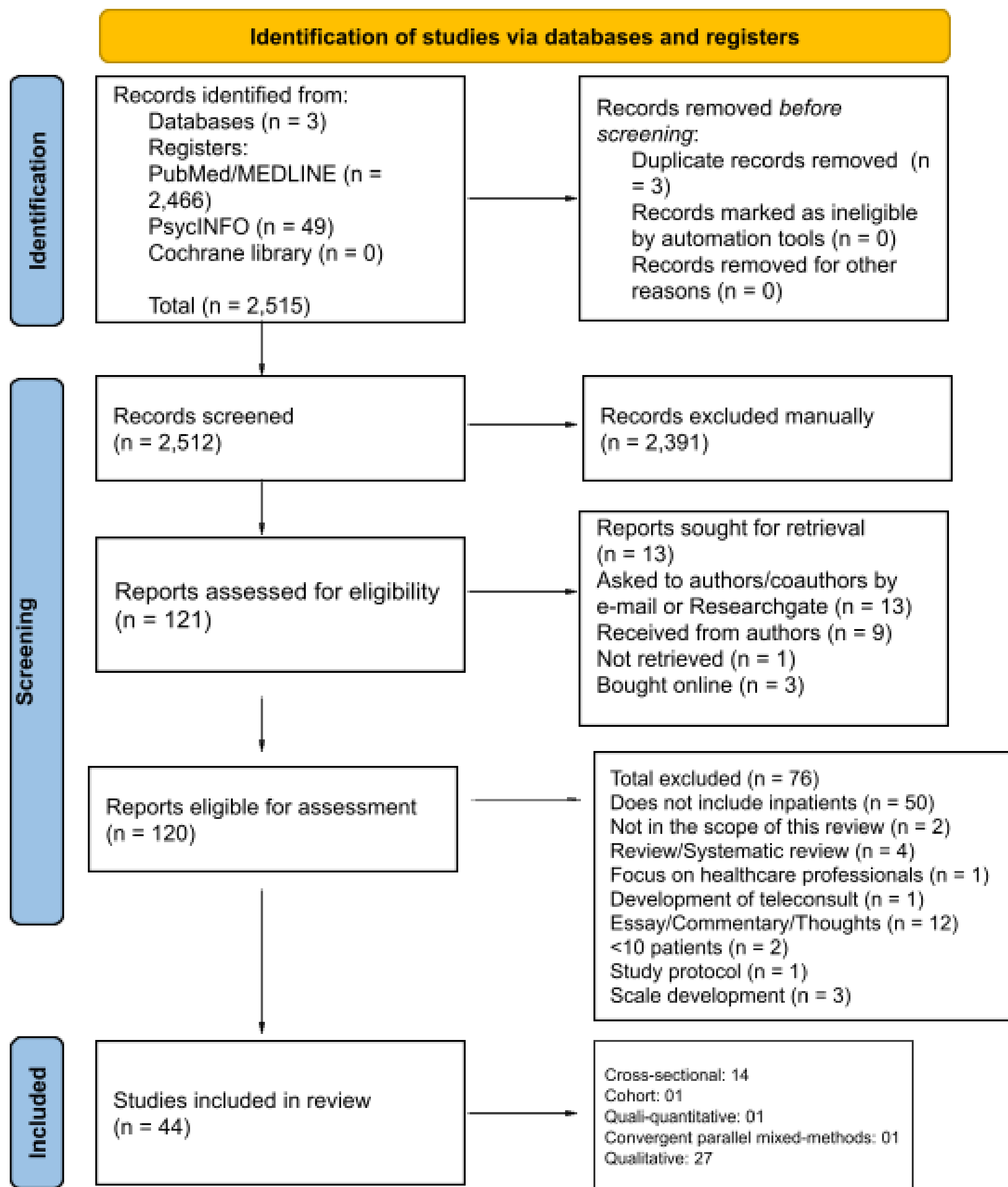

Figure 1: PRISMA flow diagram

PRISMA 2020 for Abstracts Checklist

Section and Topic	Item #	Checklist item	Reported (Yes/No)
TITLE			
Title	1	Identify the report as a systematic review.	Page 2 - Yes
BACKGROUND			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Page 2 - Yes
METHODS			
Eligibility criteria	3	Specify the inclusion and exclusion criteria for the review.	Page 2 - Yes
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	Page 2 – Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies.	Page 2 – Yes
Synthesis of results	6	Specify the methods used to present and synthesise results.	Page 2 – Yes
RESULTS			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	Page 2 – Yes
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Page 2 – Yes
DISCUSSION			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Page 2 – Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Page 2 – Yes
OTHER			
Funding	11	Specify the primary source of funding for the review.	Page 2 – Yes
Registration	12	Provide the register name and registration number.	Page 2 - Yes

For peer review only

PRISMA 2020 for Abstracts Checklist

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 2
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Page 2-3
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 3
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 3
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 3
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Page 3
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Page 3
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 3
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Page 3
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Page 3
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 3 and 11
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Not applicable
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 3
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 3
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 3
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Pages 3-6, and pages 8-11
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Pages 3-4
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Pages 3, 4, 8
Reporting bias	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Pages 3, 11

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
assessment			
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Page 8
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Pages 3,4
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Page 4
Study characteristics	17	Cite each included study and present its characteristics.	Page 4-6
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Page 11
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Pages 3-8
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Page 11
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Not applicable
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Page 13
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Pages 8-11
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Page 4, 13
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Pages 8-11
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 11-13
	23b	Discuss any limitations of the evidence included in the review.	Page 13
	23c	Discuss any limitations of the review processes used.	Page 13
	23d	Discuss implications of the results for practice, policy, and future research.	Pages 13, 14
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Pages 2, 3, 14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	PROSPERO
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	None
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Page 14
Competing interests	26	Declare any competing interests of review authors.	Page 14

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Not applicable

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only

BMJ Open

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-059129.R1
Article Type:	Original research
Date Submitted by the Author:	22-Feb-2022
Complete List of Authors:	E. P. Dutra, Pablo; UFRJ, Institute of Pyschiatry of UFRJ (IPUB/UFRJ) Quagliato, Laiana; UFRJ, Institute of Psychiatry of UFRJ (IPUB/UFRJ) Nardi, Antonio; UFRJ, Institute of Psychiatry of UFRJ (IPUB/UFRJ)
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Mental health, Medical education and training, Global health, Ethics, Public health
Keywords:	MENTAL HEALTH, MEDICAL ETHICS, MEDICAL EDUCATION & TRAINING, PSYCHIATRY, PUBLIC HEALTH, QUALITATIVE RESEARCH

SCHOLARONE™
Manuscripts

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

TITLE PAGE

Title: Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Author name:
Pablo Eduardo Pereira Dutra

Co-authors' names:
Laiana Azevedo Quagliato
Antonio Egidio Nardi

Corresponding author:
Full name: Pablo Eduardo Pereira Dutra
ORCID: 0000-0003-3970-5668
Postal address: Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro, RJ, Brazil
ZIP Code: 22.290-140
E-mail: pablo.medicina@ufrj.br
Phone: +55 21 3938-0500
Fax: +55 21 3938 0500
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of UFRJ (IPUB/UFRJ)

Full names, institutions, city, and country of all co-authors:
Full name: Laiana Azevedo Quagliato
ORCID: 0000-0002-6928-5847
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Full name: Antonio Egidio Nardi
ORCID: 0000-0002-2152-4669
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Keywords (MeSH terms): Respect, Dignity, Patient rights, inpatients, privacy

Word count: 4,583

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

ABSTRACT

Objectives: The aim of this systematic review is to find international evidence to determine which strategies are effective for improving hospitalized patients' perception of respect and dignity.

Methods: A systematic review of the literature was conducted in accordance with PRISMA 2020 guidelines and registered at PROSPERO (CRD42021241805). The MEDLINE/PubMed, PsycINFO and Cochrane Library databases were searched for observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials with interventions focused on improving respect for patients and maintaining their dignity. Studies with case report designs, editorials, opinion articles, studies <10 subjects, responses/replies to authors, and responses/replies to editors were excluded. The study population included patients admitted to hospitals, day hospitals, clinics, emergency departments, psychiatric emergencies, psychiatric hospitals, asylums, and any other places where there were inpatients. Systematic reviews were not included. Two evaluators assessed risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2: methods for allocation, methods for randomization, blinding, and evaluation of internal validity. The reviewers were blinded during the selection of studies as well as during the quality appraisal. Disagreements were resolved by consensus after the reviewers' judgment.

Results: A total of 2,515 articles were retrieved from the search to databases, and 44 articles were included in this review. We conducted a quality appraisal of the studies (27 qualitative studies, 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study and 1 convergent parallel mixed-method study).

Conclusion: There are many strategies that could be used to improve the perception of respect for and the maintenance of the dignity of the inpatient. The lack of interventional studies measuring effects in this field has led to a gap in knowledge that needs to be filled with studies with better designs and effect measurements.

Keywords: Respect, Dignity, Patient rights, inpatients, privacy

STRENGHTS AND LIMITATIONS OF THIS STUDY

- This study covers a wide range of topics related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent.
- It fills a knowledge gap in an area that lacks more research and development.
- We bring important information on medical education in order to improve medical practice.
- More studies with controlled interventions and outcomes are necessary.
- It may not be appropriate to generalize these findings to all countries and cultures.

INTRODUCTION

Dignity is a fundamental human right (1), and its maintenance is an ethical goal of care (2). The Brazilian Code of Medical Ethics (3) states that physicians must respect and act in patients' benefit. The Declaration on the Promotion of Patients' Rights in Europe (4), states that one of its objectives is "*to reaffirm fundamental human rights in health care*".

The concept of dignity is still not clearly defined (5), and it can be affected during hospitalization (6). Hospital routines are needed to promote and protect patient health, but they can be harmful when patients experience stigma (7), violation of rights, privacy, integrity, disrespect and breaches in confidentiality, and when facing unprepared and insecure professionals who cannot provide clear explanations about diagnostic and therapeutic

procedures. All of these can lead to complaints, which can be used as a tool for improving patient care (8).
One may think that dignity and respect violations are restricted to low-income countries or to people of low socioeconomic status, but it is a worldwide phenomenon, and it is not directly related to wealth, but to culture and professional education. Several studies suggest that patients' rights are violated daily in practically all scenarios of practice of health-related activities. However, its results are sparse and there is no systematization of what can improve patients' perception of receiving respectful and dignified care.
Published studies, as we will see later, address specific specialties in isolation and few address this important topic comprehensively. The strategies used to improve the quality of care and the perception of respect and dignity from the patients' point of view may seem obvious, but they are not observed in practice in several countries and continents. Thus, it is necessary to review the current literature in search of strategies that can positively impact patients' perception of respect and dignity.

OBJECTIVE

The aim of this systematic review is to evaluate worldwide evidence to determine which strategies can be used to improve inpatient patients' perception of respect and dignity.

STUDY DESIGN

A systematic review with the aim of identifying, analyzing, extracting and evaluating data from the literature related to respect for and maintenance of the dignity of hospitalized patients. It also aims to identify knowledge gaps and relate the findings to clinical practices to improve the quality of care for all hospitalized patients worldwide.

METHODS

This study was registered at PROSPERO (CRD42021241805) and conducted following PRISMA guidelines (9). Articles were identified by searching electronic records, including the MEDLINE/PubMed, PsycINFO and Cochrane Library databases. The quoted search terms used were as follows: Patient human rights violation OR Patient disrespect OR Patient violation of dignity OR Patient rights protection OR patient intimacy violation OR patient confidentiality violation OR ethical violation OR ethics violation OR hospital violation of patients' rights OR patients' perception of rights violation OR patients' perception of disrespect. There were no restrictions on year or language of publication, and no automation tool was used. The main objective was to find any interventions and multifaceted interventions aimed at improving inpatients' perception of respect and dignity and decreasing disrespect or human/inpatient rights violations, intimacy violations, confidentiality violations, autonomy violations, etc. The search included interventions conducted in hospitals, day hospitals, clinics, emergency departments, psychiatric emergencies, psychiatric hospitals, asylums, and any other places where there are inpatients. The inclusion criteria were full text, observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials. The exclusion criteria were case reports, editorials, opinion articles, studies <10 subjects, responses/replies to authors, and responses/replies to editors.
The first author (PEPD) screened the titles and abstracts of the articles and manually excluded those articles that did not fit the inclusion criteria.
After that, two reviewers (PEPD and LAQ) independently assessed the full texts of the remaining articles for eligibility in a standardized manner: data extraction was performed independently, and disagreements between reviewers regarding the study selection or data extraction were resolved by consensus. If a consensus was not reached, the third reviewer (AEN) was consulted.
The following information was extracted from the full-text articles using an Excel spreadsheet: authors, place/year of publication, sample size, type of samples, study design, analysis, data/measure, strategies, interventions to achieve improvements, and limitations.

Two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10). Disagreements were resolved by consulting a third reviewer. The minimum number of studies for data to be pooled was 10, including any intervention that would be effective for improving the perception of respect and dignity among inpatients.
A quality appraisal of the articles was performed using the CASP Qualitative Studies Checklist (11), Specialist Unit for Review Evidence (SURE) 2018 (12), CASP Cohort Study Checklist (13), and Mays & Pope Qualitative research in health care (14).

Patient and public involvement
No patient involved.

Quality appraisal
A critical appraisal of the included studies was performed, but no study was excluded based on its score, although this approach makes their analysis more robust. The instruments used for it were: CASP Qualitative Studies Checklist (11) (**Table 1) (See supplementary 1)**; Specialist Unit for Review Evidence (SURE) - Questions to assist with the critical appraisal of cross-sectional Studies (12) (**Table 2) (See supplementary 2)**; CASP Cohort Studies Checklist (13) (**Table 3) (See supplementary 3)** and the criteria put forth by Mays & Pope (2000) (14) (**Table 4) (See supplementary 4)**.
They were scored as follows: 0 = not or inadequately addressed, 1 = partially addressed, and 2 = fully addressed criterion. Critical appraisal scores are described below each table.
The quality assessment of the studies and of the systematic review was performed by two reviewers independently (PEPD and LAQ), who then discussed and agreed to the final rating. No study was excluded for quality reasons, but this assessment enabled a more robust review of the studies.

Risk of bias
To minimize bias, two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10): methods for allocation, methods for randomization, blinding, and evaluation of internal validity. The reviewers were blinded during the selection of studies to be included and excluded as well as during the quality appraisal. Disagreements were resolved by consensus after the reviewers' judgment.

RESULTS
Three databases were searched on March 9th, 2021: PubMed/MEDLINE, PsycINFO, and Cochrane Library. Of the 2,515 results, no article was excluded by automation tools, 3 were excluded after searching for duplicate studies using the EndnoteWeb tool, and 2,375 were excluded after title and abstract screening by the first reviewer (PEPD). In the second step, two reviewers (PEPD and LAQ) independently assessed the 121 articles for eligibility.
Thirteen references were not found. The first reviewer (PEPD) contacted by e-mail and/or via ResearchGate - more than once - authors, coauthors, and journals where they were published to try to retrieve them. Up to August 5th, 2021, 9 articles were retrieved, 3 were bought online from publishers, and 1 was not retrieved and excluded. A total of 76 articles were excluded: 50 did not include inpatients, 2 were not in the scope of this review, 4 were review/systematic review, 1 focused on health care professionals, 1 focused on the development of telehealth, 12 were essay/commentary/thoughts, 2 included less than 10 patients, 1 was a study protocol, and 3 were scale developments.
Forty-four articles were included, according to PRISMA 2020 guidelines (9) (**Figure 1**): 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study, 1 convergent parallel mixed-method study, and 27 qualitative studies.

The results of articles classified as high-quality in the quality assessment receive more emphasis than those with a lower classification. They were divided according to the main themes.

Religion, emergency, psychiatric and pediatric patients

Violations of patients' dignity and privacy are almost routine. The simple act of providing a patient list to third parties for religious visits without consent is considered a violation of privacy (15). Likewise, the seclusion to which psychiatric patients in agitation are subjected, often as a form of punishment, also constitutes a violation of dignity, as they are often not offered liquids and food, which makes them feel humiliated (16, 17).

In all cases, there is a fundamental element missing, communication. In pediatrics, for example, the lack of communication between doctors and parents and patients produces anxiety and confusion (18), which could be avoided if the professional talked to families in an open and understanding way, demonstrating knowledge and security in their work. This same feeling of vulnerability and powerlessness is experienced by emergency patients, considered of low priority, as they feel insecure, exposed and violated in their self-esteem, as they wait for professional attention for several hours in some cases (19). When the patient is of a different ethnicity from that of the doctor, this feeling of inferiority increases, as patients feel the need to be treated as equals, as people, as being important and want to have their complaints heard, receive polite, timely and with clear explanations (20).

Obstetric patients

The feeling of invasion of privacy and lack of respect and dignity is common among obstetric patients from the first contact with obstetricians, as there is a lack of training in Respectful Maternity Care (RMC), counseling skills, in building a good physician-patient relationship (21). Professionals allege overwork, low and inadequate remuneration, lack of training, precarious and inadequate working conditions, overload due to lack of professionals (22), which can improve with investment in training, in more dignified working conditions, in improving of remuneration, in the availability of contact with other professionals for learning and consultations, as well as with a better understanding of the cultural context of the patient and the professional (23,24). Better communication between professionals and pregnant women and mothers can contribute to building a relationship of trust, promoting their engagement in breastfeeding and baby care (25).

The female body undergoes several transformations during pregnancy, such as weight gain. Some pregnant women feel embarrassed by their doctors, due to stigma related to their weight gain, which can undermine the doctor-patient relationship (26). In Jordan, for example, women end up seeking private assistance in search of a little more respect for their privacy, since public hospitals lack sheets to cover themselves, leaving their bodies and intimacy exposed (27).

The promotion of RMC among women and health professionals can improve the quality of care provided (28), reduce social stigma, as women with lower levels of education and lower socioeconomic status feel stigmatized and perceive that they are treated with less quality than than others with better economic and social status (29). Disrespectful, unkind, rude and negativistic behaviors only contribute to increase the level of stress and generate distrust in the parturient, who has often denied her right to a companion, feeling uninformed, abandoned, neglected and objectified during childbirth and postpartum (31-34).

In rural Afghanistan, the training of professionals had a positive impact on the satisfaction of pregnant women in relation to health services, although there are still complaints (35), related to disrespect, low quality of services, maltreatment and disagreements between doctors and patients (36), as well as in Peru, where most research participants had already suffered at least one episode of disrespect and abuse during pregnancy and childbirth (37). The World Health Organization (WHO) recommends improvements in the quality of treatment and care for women to reduce stigma and poor care and to promote respect and dignity (38,39).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

General hospital patients

Cultural and ethnic differences between nurses and patients can contribute to negative perceptions of disrespectful and unfair treatment, particularly among ethnic minorities (40,41). Thus, it is necessary for health professionals to be attentive to recognize factors that violate or preserve dignity from the patient's point of view (42), such as interpersonal problems, professional availability and lack of empathy in communication (43), even when the patient does not actively complain, the professional must take a more proactive stance to identify and respond to the patient's needs in a timely manner, with strategies to improve patient safety, promoting their involvement in the care of their health (44,45). To this end, managers need to be sensitized to invest in professional education, in order to keep professionals attentive to patients' rights, reducing treatment inequities that lead patients to pilgrimage through health services in search of more dignified treatment (46,47).

Professional development should also promote strategies that ensure patients' privacy, not only of their personal and health information (48), since a leak can undermine the reputation of a health facility, as patients bring to the hospital expectations of receive security, respect, dignity, information and care (49). Touching patients' personal objects or moving them can be perceived as an invasion of territory and privacy, causing discomfort (50), reinforcing the need to provide information about privacy and confidentiality before and during hospitalization (51). A Greek study showed that patients had little idea of their rights (52) and nursing has a very important role in disseminating this knowledge and ethical principles, establishing a relationship of respect for patients' rights and privacy (53-55). Intensive care unit (ICU) patients often have memories of the environment as hostile and stressful, generating negative feelings of violation of their rights to dignity and privacy, lack of empathy, not being understood, delay in getting help and be subject to full control by health professionals (56).

Most patients are unaware of their rights (57); a study with the distribution of information cards to patients with methicillin-resistant S. aureus (MRSA) infection, which should be presented to the professionals with whom they would consult, showed that these patients are subject to discrimination and lack of knowledge, which makes its use questionable (58). It is therefore imperative that healthcare professionals keep the concept of integrity in mind and that this knowledge be used to train healthcare professionals with more professionalism, communication skills, and practice-based learning (59, 60). In an increasingly digital age, resources for preserving information and privacy are essential, since patients' autonomy is closely intertwined with their dignity (61-63), which can positively impact the quality of empathic, non-possessive care, authentic and respectful, with positive results in treatment outcomes (64).

DISCUSSION

These studies reveal that there are several strategies that can improve the quality of care provided to inpatients, thus improving their perception of respect for and the maintenance of their dignity. There is a Hippocratic principle that guides the medical profession, “first, do no harm” and that must be considered in all spheres not only of the doctor-patient relationship, but of any relationship between health professionals and patients. Therefore, although we did not find studies with statistically calculated interventions and effect size measurements, the quality of the studies included in this systematic review allows us to point out some strategies that can help improve patients' perceptions regarding respect for and maintenance of their dignity. Patients and health professionals around the world express the same interests and desires to have the quality of care raised to the level of excellence and the rights of patients respected.

It is necessary to keep in mind that minor violations of patients' rights happen daily, even when it is considered to have good intentions, as in the case of visits by religious to patients. Their names cannot be placed on a list without consent, as this constitutes an invasion of privacy. Likewise, when a patient needs mechanical restraint or seclusion due to aggressiveness, it is necessary to offer fluids, food and attention, to understand why the patient acted that way, as

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

many see this attitude as a violation of human rights or as punishment, so that the experience fulfills its therapeutic goals and does not become a source of trauma for the patient or a painful psychic experience.

One of the keys to good relationships with patients is communication. Parents of pediatric patients, as well as patients themselves, need clear information, which gives them a sense of confidence and security. Professionals need to demonstrate skill, knowledge and confidence during their interventions, in order to guarantee the best treatment for their patients and to allow patients and their parents to make the best decisions for the quality of life of their children.

Feelings of humiliation, impotence and being “left aside” affect emergency patients, with lower risk conditions, which makes them wait for care for long periods. These patients need to receive information about their conditions and the functioning of the emergency department, they must receive information and attention from the nursing staff, as their condition can progress to more serious situations or death, if they are not checked frequently. When patients have different ethnicities than professionals, the asymmetry of the relationship seems to be exacerbated by the behavior of some professionals, leading patients to feel discriminated against, treated in a dehumanized and disrespectful way. Allowing the patient to speak, listening to the patient carefully and valuing their complaints and opinions gives them the feeling of being respected and seen as an equal person. Professionals must be aware of these subtleties of human behavior and spend more time assisting these patients in a way that makes them feel more respected and welcomed. These small actions can make a difference when a patient seeks treatment or professional help.

The field of obstetrics is one of the fields that has more studies on the respect and dignity of patients, including the prepartum, pregnancy and postpartum periods. It is necessary for professionals in the field to be trained regarding Respectful Maternity Care (RMC). It is a woman's right to receive clear information; respectful and dignified treatment; to hug and breastfeed her child in the immediate postpartum period; to have her intimacy and privacy preserved; not being subjected to episiotomy without consent or without anesthesia; having a family member accompanying them; not being discriminated against because of their weight, ethnicity, color, race, sexuality, religion, socioeconomic status, place of residence, state or country of origin; to have a companion during childbirth, whether a family member or friend; the right not to be verbally or physically abused (not to be cursed or verbally humiliated; not to be slapped during childbirth, for example); the right not to have their bodies exposed in a hospital environment, where there is a large circulation of professionals (to be covered by a sheet); the right not to have their bodies invaded by several individuals (not being exposed to frequent vaginal examinations by various professionals, especially in teaching hospitals); the right to receive information about prenatal care, pregnancy, childbirth, postpartum, breastfeeding, contraception, vaccination and infectious-contagious diseases that can affect the mother and baby; the right to have quality and humanized care in any device in the care network, whether public or private; the right to receive analgesia or anesthesia; and the right to have less prolonged care, whether public or private.

Obstetric violence is present in several fields of action, among the various health professionals who work in this area, from harshly speaking to or yelling at, to physically or sexually assaulting a woman. Considering the most diverse studies on the subject, this practice is widespread in several countries around the world, from the U.S. to Asian countries, and there needs to be a large investment in education and training of health professionals so that women of childbearing age can be assisted with dignity and respect.

Professionals should be aware of the cultural subtleties of the patients they serve, as many behaviors may seem inappropriate in multicultural contexts, as the patient's education, culture, socioeconomic level and religion produce different perceptions about the professionals' conduct. This can lead to negative perceptions and complaints, for example regarding discrimination and quality of care.

A conciliatory and more proactive attitude towards avoiding conflicts can improve patients' perception of the professional and the health facility during the hospitalization period. The

investment in training and education of health professionals is the best solution to improve the quality of care, bringing patients to a more active position in their treatment, promoting information and autonomy, providing assistance in a timely manner, respecting rights, maintaining vigilance in cases of disrespect and violations of dignity, encouraging the acceptance of differences, reducing all types of prejudice and stigma, and allowing professionals and patients to act together.

Small attitudes of health professionals can turn into big problems: touching personal belongings without authorization, moving objects, exposing the patient and making inappropriate comments, even though it may seem like just an innocent joke. One of the solutions may be to ask patients and family members to carry out assessments about the service, analyze complaints in the ombudsman's office, and use these data as important tools to improve the quality of the service provided. Patient concern regarding the confidentiality of their medical information is another point that deserves attention. The right to privacy and confidentiality is directly related to the respect and dignity of patients. Violations of confidentiality, in addition to being unethical, can cause moral and financial damage to patients and their families, leading to legal actions against professionals and hospitals. Another way to give patients more freedom and autonomy is to guarantee them access to their medical information, either through direct access to the system or through applications. Thus, managers and government officials must invest in information security systems, since the world is increasingly digital and the trend is to reduce the use of printed documents, ensuring the protection of data for patients and professionals. Patients must receive information about current legislation in terms of information security, their rights to privacy and confidentiality, and nursing has a fundamental role in the dissemination of ethical principles in the work environment.

The results found in the articles included in this systematic review show that there is still a long way to go in promoting more dignified and respectful care for patients admitted to health care units around the world. The innovation is in the synthesis and enumeration of these practices, which can bring a new way of dealing with information and profoundly change the way we serve and think about the care provided to hospitalized patients. Regardless of culture and nationality, studies show that there is a need to improve the quality of care, whether through improvements in education during graduation, in student training, in the use of reality data to refine professional practice, or through training of professionals when entering the labor market, offering refresher courses, recycling professionals and promoting the availability of safe means by which professionals can discuss cases and share knowledge without breaching professional secrecy.

STRENGTHS OF THIS STUDY

Our study covers a wide range of topics related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent. In addition, this systematic review fills a knowledge gap in an area that has not yet been studied, which, although gaining prominence in recent years, lacks more research and development. The fact that there is no limitation on the time researched and, on the language, allowed us to reach from the most recent to the oldest studies on this topic.

LIMITATIONS

Although we have tried to reach as many studies as possible, its results cannot be generalized to all cultures and countries of the world, and it does not include all specialties and their peculiarities. One study could not be retrieved, and it might have data that could be important to the results of this study. The data were not homogeneous enough to perform a meta-analysis, which would enrich the results. More studies with controlled interventions and outcomes should be carried out to measure the effect on the perception of respect for and maintenance of the dignity of hospitalized patients.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

STATEMENT OF FINDINGS

Regarding clinical practice, our study brings several collaborations based on the findings of the reviewed articles. Actions to promote dignity include: providing information correctly and clearly about procedures and treatments, serving with politeness and kindness, avoiding gestures and comments that might be perceived as disrespectful, putting aside prejudices (you are not there to judge but to serve to the best of your ability and professional ethics), taking as much time to serve as necessary, adhering to confidentiality when sharing information with team members, listening to complaints and trying to resolve them, responding to timely calls, using patient complaints made as a way to improve the hospital routine, promoting improvements in the quality of the environment (including cleaning, lighting and noise control), allowing pregnant women to have companions, avoiding yelling at patients or using physical touch as a form of reprimand (which can be understood as physical aggression), avoiding unnecessary exposure of the patient's body, avoiding intimate examination by various professionals (especially in teaching hospitals), obtaining consent for diagnostic and therapeutic procedures, informing patients about the drugs that will be applied (name and what they are used for), introducing oneself to the patient, asking if the patient wants to receive visits and from whom, asking who the patient would like to share information with, calling the patient by his or her name (avoiding colloquial or derogatory language), demonstrating knowledge, showing security and professional skills, and using setbacks as opportunities for your own and for your team's collective learning.

IMPLICATIONS FOR PRACTICE

Our findings provide perspectives that could and should be used to improve patient care and education in different areas of health around the world.

IMPLICATIONS FOR RESEARCH

Virtually all studies related to the quality of care, respect, dignity, confidentiality and privacy of hospitalized patients, have a qualitative or cross-sectional design. It is necessary that future research be designed with controlled interventions and effect size measurement to bring more robustness to the findings, since this subject is gaining prominence in daily practice. Furthermore, regardless of the country, respect and dignity are universal and fundamental rights of every human being and must, therefore, be put into practice wherever patients are.

CONCLUSION

Our systematic review touches on important points of care during professional practice, with the aim of delivering truly patient-centered care to patients.

Professional practice is regulated by legal means and by professional education, but it is observed that there is a lack of training so that various everyday conflicts can be mitigated and resolved locally without harming the patient. It is inconceivable that patients need to look for another health facility because they feel mistreated at a place that should provide care. Likewise, it is unacceptable for a health professional not to be able to handle situations in their professional routine without resorting to violence or verbal aggression. When a patient goes to a health unit, he or she seeks care; therefore, we have the obligation to provide care, without prejudice, without discrimination and to the best of our technical capacity, with respect and dignity. This is the wish of all patients around the world.

REGISTRATION AND PROTOCOL

This study protocol was registered at PROSPERO (CRD42021241805 - Improving the perception of respect for and the dignity of the inpatient: A Review), and it was conducted in accordance with PRISMA 2020 guidelines (9).

FUNDING

This study has no external funding source.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

CONTRIBUTORSHIP STATEMENT

The study concept was developed by PEPD. The manuscript of the protocol was drafted by PEPD and critically revised by LAQ and AEN. PEPD developed and provided feedback for all sections of the review protocol and approved the final manuscript. The search strategy was developed by PEPD and LAQ. Study selection was performed by PEPD and LAQ. Data extraction and quality assessment was performed by PEPD and LAQ, with AEN as a third party in case of disagreements. All authors have approved the final version of the manuscript.

DATA AVAILABILITY STATEMENT

No additional data available.

REFERENCES

1) United Nations. Universal Declaration of Human Rights | united nations. [cited 2021 June 8]; Available from: https://www.un.org/en/about-us/universal-declaration-of-human-rights

2) Ferri P, Muzzalupo J, Di Lorenzo R. Patients' perception of dignity in an Italian general hospital: a cross-sectional analysis. BMC Health Serv Res. 2015;15(1):41-48.

3) Conselho Federal de Medicina. Código de Ética Médica [Internet]. Conselho Federal de Medicina. 2019 [cited 2021 June 8]. Available from: https://portal.cfm.org.br/images/PDF/cem2019.pdf

4) World Health Organization (WHO). A Declaration on the Promotion of Patients Rights in Europe. [Internet] 1994. [cited 2021 June 08]. Available from: https://www.who.int/genomics/public/eu_declaration1994.pdf

5) Bagheri A. Elements of human dignity in healthcare settings: the importance of the patient's perspective. J Med Ethics. 2012;38(12):729–30.

6) Campillo B, Corbella J, Gelpi M, Martinez E, Viciana MA, Alonso M. Development and validation of the scale of perception of respect for and maintenance of the dignity of the inpatient [CuPDPH]. Ethics Med Public Health. 2020;15(100553):100553.

7) Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity: Obesity stigma and patient care. Obes Rev. 2015;16(4):319–26.

8) Mirzoev T, Kane S. Key strategies to improve systems for managing patient complaints within health facilities - what can we learn from the existing literature? Glob Health Action. 2018;11(1):1458938.

9) Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. Syst Rev. 2021;10(1):89.

10) Chapter 7: Considering bias and conflicts of interest among the included studies [Internet]. Cochrane.org. [cited 2021 June 8]. Available from: https://training.cochrane.org/handbook/current/chapter-07

11) Critical Appraisal Skills Programme. CASP Qualitative Studies Checklist [Internet]. B-cdn.net. [cited 2021 Jul 6]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

12) Specialist Unit for Review Evidence (SURE). Questions to assist with the critical appraisal of cross-sectional studies [Internet]. Cardiff.ac.uk. 2015 [cited 2021 Jul 9]. Available from: https://www.cardiff.ac.uk/__data/assets/pdf_file/0006/212775/SURE_Qualitative_checklist_2015.pdf

13) Critical Appraisal Skills Programme. CASP Cohort Study Checklist [Internet]. B-cdn.net. [cited 2021 Jul 26]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Cohort-Study-Checklist-2018_fillable_form.pdf

14) Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. BMJ. 2000;320(7226):50–2.

15) Erde E, Pomerantz SC, Saccocci M, Kramer-Feeley V, Cavalieri TA. Privacy and patient-clergy access: perspectives of patients admitted to hospital. J Med Ethics. 2006;32(7):398–402.

16) Faschingbauer KM, Peden-McAlpine C, Tempel W. Use of seclusion: finding the voice of the patient to influence practice. J Psychosoc Nurs Ment Health Serv. 2013;51(7):32–8.

17) Robins CS, Sauvageot JA, Cusack KJ, Suffoletta-Maierle S, Frueh BC. Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatr Serv. 2005;56(9):1134–8.

18) Hsiao JL, Evan EE, Zeltzer LK. Parent and child perspectives on physician communication in pediatric palliative care. Palliat Support Care. 2007;5(4):355–65.

19) Adolfsson A, Dahlén, Westin. Experience of being a low priority patient during waiting time at an emergency department. Psychol Res Behav Manag. 2012;5:1-9.

20) Beach MC, Branyon E, Saha S. Diverse patient perspectives on respect in healthcare: A qualitative study. Patient Educ Couns. 2017;100(11):2076–80.

21) Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017;17(1):263-74.

22) Dynes MM, Twentyman E, Kelly L, Maro G, Msuya AA, Dominico S, et al. Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016. Reprod Health [Internet]. 2018;15(1):41-64.

23) Gebremichael MW, Worku A, Medhanyie AA, Berhane Y. Mothers' experience of disrespect and abuse during maternity care in northern Ethiopia. Glob Health Action. 2018;11(sup3):1465215.

24) Gebremichael MW, Worku A, Medhanyie AA, Edin K, Berhane Y. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective. BMC Pregnancy Childbirth. 2018;18(1):392-97.

25) Horwood C, Haskins L, Luthuli S, McKerrow N. Communication between mothers and health workers is important for quality of newborn care: a qualitative study in neonatal units in district hospitals in South Africa. BMC Pediatr. 2019;19(1):496-508.

26) Incollingo Rodriguez AC, Smieszek SM, Nippert KE, Tomiyama AJ. Pregnant and postpartum women's experiences of weight stigma in healthcare. BMC Pregnancy Childbirth. 2020;20(1):499-508.

27) Hussein SAAA, Dahlen HG, Ogunsiji O, Schmied V. Uncovered and disrespected. A qualitative study of Jordanian women's experience of privacy in birth. Women Birth. 2020;33(5):496–504.

28) Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision" - knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC Pregnancy Childbirth. 2019;19(1):42-9.

29) Kanengoni B, Andajani-Sutjahjo S, Holroyd E. Women's experiences of disrespectful and abusive maternal health care in a low resource rural setting in eastern Zimbabwe. Midwifery. 2019;76:125–31.

30) Khresheh R, Barclay L, Shoqirat N. Caring behaviours by midwives: Jordanian women's perceptions during childbirth. Midwifery. 2019;74:1–5.

31) Kujawski S, Mbaruku G, Freedman LP, Ramsey K, Moyo W, Kruk ME. Association between disrespect and abuse during childbirth and women's confidence in health facilities in Tanzania. Matern Child Health J. 2015;19(10):2243–50.

32) McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy Childbirth. 2014;14:268-80.

33) Millicent Dzomeku V, van Wyk B, Lori JR. Experiences of women receiving childbirth care from public health facilities in Kumasi, Ghana. Midwifery. 2017;55:90–5.

34) Rodríguez-Almagro J, Hernández-Martínez A, Rodríguez-Almagro D, Quirós-García JM, Martínez-Galiano JM, Gómez-Salgado J. Women's perceptions of living a traumatic childbirth experience and factors related to a birth experience. Int J Environ Res Public Health. 2019;16(9):1654-66.

35) Thommesen T, Kismul H, Kaplan I, Safi K, Van den Bergh G. "The midwife helped me ... otherwise I could have died": women's experience of professional midwifery services in rural Afghanistan - a qualitative study in the provinces Kunar and Laghman. BMC Pregnancy Childbirth. 2020;20(1):140-56.

36) Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019;16(1):77-94.

37) Montesinos-Segura R, Urrunaga-Pastor D, Mendoza-Chuctaya G, Taype-Rondan A, Helguero-Santin LM, Martinez-Ninanqui FW, et al. Disrespect and abuse during childbirth in fourteen hospitals in nine cities of Peru. Int J Gynaecol Obstet. 2018;140(2):184–90.

38) The White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women [Internet]. Healthpolicyproject.com. [cited 2021 Aug 22]. Available from: http://www.healthpolicyproject.com/pubs/46_FinalRespectfulCareCharter.pdf

39) WHO Statement. The prevention and elimination of disrespect and abuse during facility-based childbirth [Internet]. Who.int. [cited 2021 Aug 22]. Available from: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

40) Asmaningrum N, Kurniawati D, Tsai Y-F. Threats to patient dignity in clinical care settings: A qualitative comparison of Indonesian nurses and patients. J Clin Nurs. 2020;29(5–6):899–908.

41) Blanchard J, Lurie N. R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care. J Fam Pract. 2004;53(9):721–30.

42) Ebrahimi H, Torabizadeh C, Mohammadi E, Valizadeh S. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. J Med Ethics. 2012;38(12):723–8.

43) King JD, van Dijk PAD, Overbeek CL, Hageman MGJS, Ring D. Patient complaints emphasize non-technical aspects of care at a tertiary referral hospital. Arch Bone Jt Surg. 2017;5(2):74–81.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

44) Howard M, Fleming ML, Parker E. Patients do not always complain when they are dissatisfied: implications for service quality and patient safety. J Patient Saf. 2013;9(4):224–31.

45) Hrisos S, Thomson R. Seeing it from both sides: do approaches to involving patients in improving their safety risk damaging the trust between patients and healthcare professionals? An interview study. PLoS One. 2013;8(11):e80759.

46) Khademi M, Mohammadi E, Vanaki Z. On the violation of hospitalized patients' rights: A qualitative study. Nurs Ethics. 2019;26(2):576–86.

47) Fleury S, Bicudo V, Rangel G. Reacciones a la violencia institucional: estrategias de los pacientes frente al contraderecho a la salud en Brasil. Salud Colect. 2013;9(1):11–25.

48) Kuo K-M, Ma C-C, Alexander JW. How do patients respond to violation of their information privacy? Health Inf Manag. 2014;43(2):23–33.

49) Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. J Hosp Med. 2010;5(9):514–20.

50) Marin CR, Gasparino RC, Puggina AC. The perception of territory and personal space invasion among hospitalized patients. PLoS One. 2018;13(6):e0198989.

51) Mohammadi M, Larijani B, Emami Razavi SH, Fotouhi A, Ghaderi A, Madani SJ, et al. Do patients know that physicians should be confidential? study on patients' awareness of privacy and confidentiality. J Med Ethics Hist Med. 2018;11:1-7.

52) Merakou K, Dalla-Vorgia P, Garanis-Papadatos T, Kourea-Kremastinou J. Satisfying Patients' Rights: a hospital patient survey. Nurs Ethics. 2001;8(6):499–509.

53) Ming Y, Wei H, Cheng H, Ming J, Beck M. Analyzing patients' complaints: Awakening of the ethic of belonging: Awakening of the ethic of belonging. ANS Adv Nurs Sci. 2019;42(4):278–88.

54) Öztürk H, Torun Kılıç Ç, Kahriman İ, Meral B, Çolak B. Assessment of nurses' respect for patient privacy by patients and nurses: A comparative study. J Clin Nurs. 2021;30(7–8):1079–90.

55) Pupulim JSL, Sawada NO. Percepção de pacientes sobre a privacidade no hospital. Rev Bras Enferm. 2012;65(4):621–9.

56) Sanson G, Lobefalo A, Fascì A. "Love can't be taken to the hospital. If it were possible, it would be better": Patients' experiences of being cared for in an intensive care unit. Qual Health Res. 2021;31(4):736–53.

57) Santos LR, Beneri RL, Lunardi VL. Ethical questions in the work of the health team: the (dis)respect to client's rights. Rev Gaucha Enferm. 2005;26(3):403–13.

58) Skyman E, Bergbom I, Lindahl B, Larsson L, Lindqvist A, Thunberg Sjöström H, et al. Notification card to alert for methicillin-resistant Staphylococcus aureus is stigmatizing from the patient's point of view. Scand J Infect Dis. 2014;46(6):440–6.

59) Widäng I, Fridlund B. Self-respect, dignity and confidence: conceptions of integrity among male patients: Conceptions of integrity among male patients. J Adv Nurs. 2003;42(1):47–56.

60) Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviors: a qualitative study. Acad Med. 2004;79(2):134–8.

61) Kayaalp M. Patient privacy in the era of big data. Balkan Med J. 2018;35(1):8–17.

62) Rodríguez-Prat A, Monforte-Royo C, Porta-Sales J, Escribano X, Balaguer A. Patient perspectives of dignity, autonomy and control at the end of life: Systematic review and meta-ethnography. PLoS One. 2016;11(3):e0151435.

63) Kisvetrová H, Tomanová J, Hanáčková R, Greaves PJ, Steven A. Dignity and predictors of its change among inpatients in long-term care. Clin Nurs Res. 2021;10547738211036968.

64) Kallergis G. The contribution of the relationship between therapist-patient and the context of the professional relationship. Psychiatrike. 2019;30(2):165–74.

COPYRIGHT/LICENSE FOR PUBLICATION

"The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution, iii) create any other derivative work(s) based on the Contribution, iv) to exploit all subsidiary rights in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above."

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

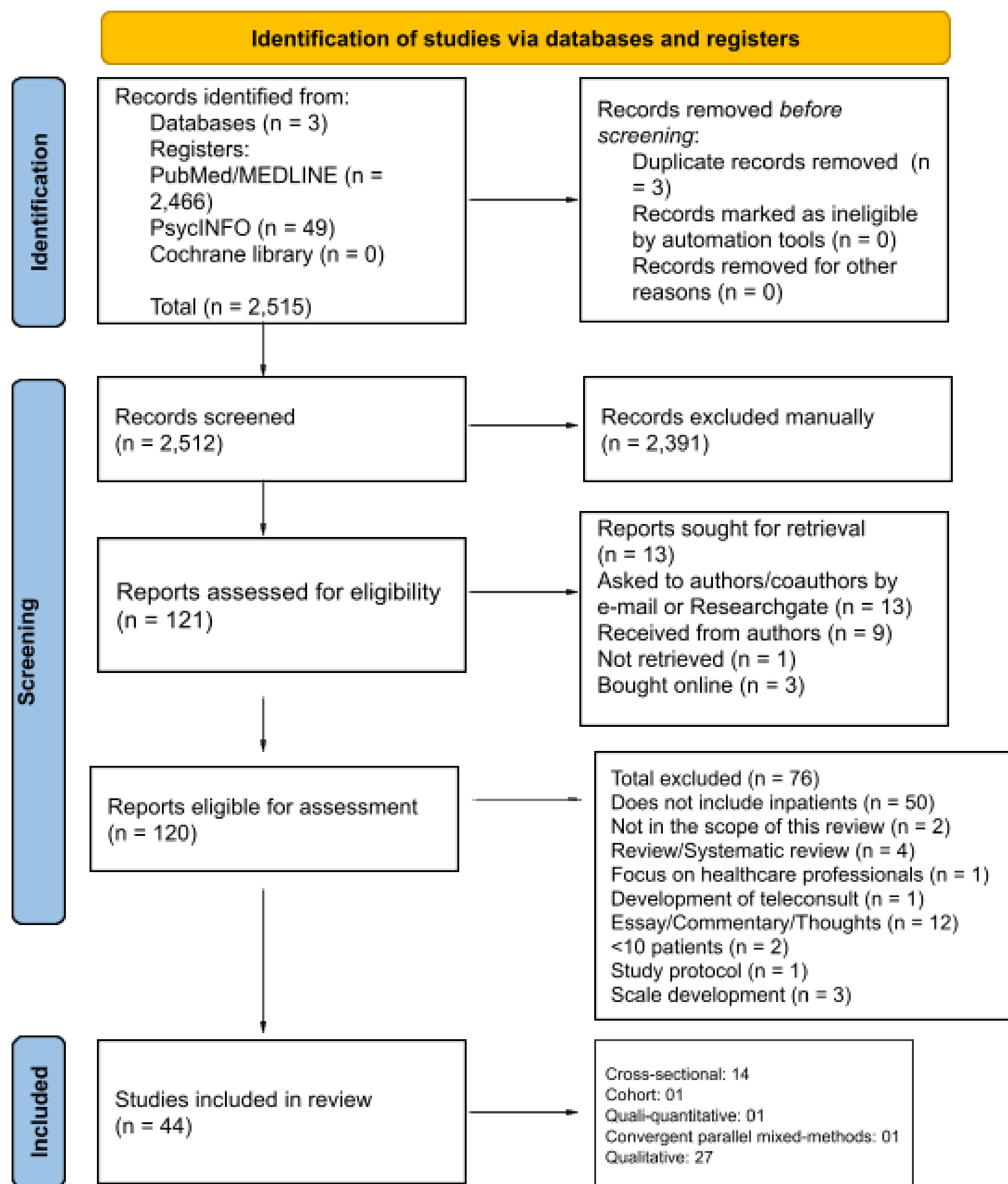

Figure 1: PRISMA flow diagram

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Author (year of publication)	Torabizadeh C. et al (2012)	Aminu M. et al (2019)	Horwitz L. I. et al (2010)
Aims	2	2	2
Methods	2	2	2
Design and Methods	2	2	2
Recruitment stragegy	2	2	2
Data collection	2	2	2
Bias and Reflexivity	1	1	1
Ethical issues	2	2	2
Data analysis	2	2	2
Statement of findings	2	2	2
Value and applicability	2	2	2
Total	**19**	**19**	**19**
Country (year of research and data collection)	Iran (2010/2011)	Malawi (2016)	USA (2007/2008)
Sample size	20	73	976
Type of samples	20 patients (12 women, 08 men; aged 21-78yr)	64 women (33 in antenatal care; 09 in intrapartum care; 22 in postnatal care); 09 healthcare providers (01 in antenatal care; 02 in intrapartum care; 06 in postnatal care)	976 postdischarge patients from medical, surgical, gynecology-oncology, neurology, neurosurgery, or Intensive care unit

For peer review only

CASP Qualitative Studies Checklist (Critical Appraisal Skills Programme)			
STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To improve ways to reduce devaluation and to promote patients' dignity; to create organizations to promote and to protect patient dignity	Staff behaviour; Good communication; Consent and decidion-making; Privacy and confidentiality	Safety, treatment with respect and dignity, prompt and efficient care, successful exchange of information, enrironmental control and autonomy, high-quality amenities
INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Provide adequate supplies and necessary facilities; environmental sanitation and cleanliness; loudness at night; avoid unpleasant tasks to be done by companions, not allowing companions to get involved in private issues; provide comfort to companions; avoid unnecessary undressing or body exposure, medical or nurse rounds while changing or using bed pans, avoid presence of members of opposite sex, try to provide care by same sex staff, male and female staff should be available on shifts; provide clear, effective and friendly verbal and gestural communication; try to minimize the cultural clash between patients and staff	Staff behaviour that showed commitment and empathy and was non-judgmental; to allow women to express concerns and ask questions, give information, educational talks, counselling sessions; involve women and family in decisions; avoid breach in confidentiality, respect women's privacy	Improve safety (diet, medication administration, patient identification, and equipment); improve staff knowledge and skills; improve cleanliness and environmental control; ethical, respectful, warmth, attentive to privacy and confidentiality, and dignifying staff attitudes; reduce waiting times for admission, transport, discharge, and staff responses to patients' needs; improve provider-patient and provider-provider communication; improve invironmental control (noise, cleanliness, smells, pain, interruption, food, smoking, lighting, temperature, humidity)

For peer review only

RESULTS	Lack of facilities and equipment: Shortage of facilities and equipment is an obstacle to dignity. Unhygienic conditions: cleaning of their environment was necessary for them to feel dignity. Annoying noise: Crowded wards annoyed the majority of patients preventing peace and tranquillity. Compulsory companionship: not only does the patient want to have a companion, the staff expects them to have one. Lack of companion's comfort: They believe that their dignity is not maintained if their companions are not appreciated by the healthcare system. Indecent body exposure: being exposed to others shows disregard for their dignity. Mixed-gender situations: Patients felt uncomfortable when they were left with patients of the opposite sex in rooms or wards. Inadequate verbal and gestural communication: patients were dissatisfied with ineffective communication from healthcare providers. Cultural and social gap: as patients normally have no choice about roommates, some consider that they are not given as much respect as they should be in accordance with their social class.	Important themes that emerged included: the importance of a valued patient-provider relationship as determined by a good attitude and method of communication, the need for more education of women regarding the stages of pregnancy and labour, what happens at each stage and which complications could occur, the importance of a woman's involvement in decision-making, the need to maintain confidentiality when required and the problem of insufficient human resources. Prompt and timely service was considered a priority. Neither women accessing maternity care nor trained healthcare providers providing this care were aware of the respectful maternity care (RMC) Charter.	Six major domains of dissatisfaction were identified: ineptitude, disrespect, waits, ineffective communication, lack of environmental control, and substandard amenities. These domains corresponded to six implicit expectations for quality hospital care: safety, treatment with respect and dignity, minimized wait times, effective communication, control over physical surroundings, and high-quality amenities.

For peer review only

LIMITATIONS	Small sample, limited to a single geographic region	Due to differences in cultural practices and beliefs, perceptions and experiences of those in more rural and/or more traditional areas would need further exploration	Patients' perceptions were not compared to chart data; Caregivers were allowed to participate in lieu of patients, which may have reduced identification of some dissatisfying events; patients who did not speak English or Spanish were excluded and could have different experiences; it did not explore dissatisfaction in detail; patients may have been reluctant to report dissatisfaction to a member of hospital staff; there may have been other dissatisfying events
Author (year of publication)	**Khresheh R. et al (2019) (a)**	**Pupulim J. S. L. et al (2012)**	**Pomerantz S. C. et al (2006) (a)**
Aims	2	2	2
Methods	2	2	2
Design and Methods	1	2	2
Recruitment stragegy	2	2	1
Data collection	1	2	1
Bias and Reflexivity	1	1	1
Ethical issues	2	2	2
Data analysis	2	1	2
Statement of findings	2	1	1
Value and applicability	2	2	2
Total	**17**	**17**	**16**
Country (year of research and data collection)	Jordan (?)	Brazil (2007)	USA (?)
Sample size	21	34	179

CASP Qualitative Studies Checklist (Critical Appraisal Skills Programme)

Type of samples	21 postpartum inpatients	34 (15 male and 19 female inpatients)	179 inpatients
STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To improve women's feelings during childbirth (felling frightened and losing control over birth process, feeling disrespected by staff, being treated as ignorant and feeling humiliated)	1) To see the patient as a person, as a human being; 2) to respect patients' autonomy, to minimize feelings of objectification; 3) to respect the need for a place of their own	To assess the patient's willingness to have religious visits, to obtain consent to list a patient's religion to clergy; to assess the patient's sense of privacy violation
INTERVENTIONS TO ACHIEVE IMPROVEMENTS	To be attentive and available to women; to avoid unnecessary exposure of genitals; to avoid examination by different staff; to help changing position; to assist with walking to the bathroom; not leaving women alone; to help reducing pain; adoption of respectful manners by staff	1) To respect patients' feelings, reactions, and privacy, to care for and to treat them well; maintenance of dignity and privacy are seen as markers of a good quality of assistance; to respect patients' self-determination; 2) to ask permission to examine, to touch the patients' body or to perfom any procedure, to allow patients' decision about when to be touched, to give choices; 3) to allow seclusion and tranquility, an attemp to preserve and rescue individuality, to respect privacy when using the barhroom, to guarantee confidentiality	To respect patient's rights and desires; to respect patient privacy; not to address a patient's religion without consent; to ask for patient's consent to allow religious visits; no to list a patient's religion unless consented

For peer review only

RESULTS	Three main themes were identified: (1) Women's feelings during childbirth: they felt frightened, humiliated, ignored, and disrespected. Negative actions in term of tangible or physical non-caring behaviours and emotional behaviours were reported. (2) Women's perceptions of the caring behaviours of midwives during childbirth: women had negative experiences during childbirth, they reported disrespectful manners and physical and empathetic abandonment by midwives during childbirth. (3) Women's preferred caring behaviours: women wanted the midwives to listen to what they say, to demonstrate respect for them, and be truly 'present' for women when they needed them.	The subjects pointed out behavioral factors, which contribute or not for the protection and maintenance of the privacy in the hospital, highlighting respect as the most important aspect, followed by personal control over situations that violate privacy. Patients believe that privacy is linked to dignity and respect, depends on the demarcation of the personal/territorial space and the autonomy's security; and that these concepts and attitudes are connected and essential to protect privacy in the hospital context.	Most respondents were women, had a high-school education or less and almost half had not been admitted to hospital previously, were part of an organised religion and described themselves as somewhat or very religious, would not want to be listed by religion and did not think hospitals should give lists to the clergy without their consent. In all, 84% would welcome a visit by their own clergy even if it were triggered by the list. Only 47% thought their sense of privacy would be violated by the hospital disclosing their name, whereas most thought disclosure violated patients' privacy rights; of those who wanted their name listed by religion, 17% thought their sense of privacy would be violated by the hospital disclosing their admission and religion to clergy without their permission and 35% thought the hospital giving clergy the list of names without permission was a violation of patients' rights to privacy
LIMITATIONS	Only one hospital, cannot reflect the perceptions of women all over Jordan; did not include women who had emergency caesarean birth; women who did not participate may have different experiences, did not cite data collection time frame	Patients' perceptions may vary among different regions, and cultures	The sample may not be representative of the patients admitted to the hospital, as those who consented to be interviewed may be biased towards those who are more religious and, therefore, more interested in this issue; key questions regarding privacy rights were asked at the end of a long interview. It is not clear whether fatigue influenced those responses

For peer review only

Dzomeku V.M. et al (2017)	Wei H. et al (2019)	Widäng I et al (2003)	Haskins L. et al (2019)
2	2	2	2
2	2	2	2
2	2	2	2
2	2	2	1
2	2	2	2
1	1	1	1
2	2	2	2
2	2	2	2
2	2	2	2
2	2	2	2
19	**19**	**19**	**18**
Ghana (2014-2015)	China (2015-2017)	Sweden (2000-2001)	South Africa (2015-2016)
56	127	17	44
56 antenatal and postanal women	127 (49.6% males, 45.7% females, 4.7% unsure)	17 patients (10 in the surgical ward and 7 in the medical ward)	24 mothers, 20 healthcare providers

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Disrespectful care; inadequate communication and involvement in decision-making; experiences of empathetic support; experiences of continuous labour support and attenttion	Uncompassionate attitudes, unprofessional communication, disrespect of patients rights, unsatisfactory quality of nursing care	**Self-respect** (having control over yourself and the situation; having the courage to set boundaries; being alone; having self-belief); **Dignity** (being seen as a whole person; being respected; being seen as trustworthy); **Confidence** (keeping information confidential; trusting the professionals; having a balance between one's own desires and those of others; participating; being free)	Provide timely care; communicate clearly, friendly and respectfully; to stimulate women to participate in care
Ability to understand life experiences; demonstration of concern and empathy; to be with mothers throughout their labour period; to have spouses and relatives with mothers; emotional and comforting measures, information and advocacy; improve communication, involve patients and families in decision-making; to institute quality assurance methods; education of healthcare professionals on patient-centred care	To be constructive and helpful; to show respect for humanity and ethics; to maintain a positive and compassionate attitude and respect patient humanity; to be fair to all patients, respect human dignity, and explain information understandably and respectfully; to fully inform patients about his/her treatment plans and the medications and procedures given and undergoing; to be competent and empathetic in nursing care; improve nursing education	Allow patients to gain control; to tell a caregiver that one's feeling at risk of having his/her integrity violated; to allow patients to be alone, in privacy; to allow the patient to be responsible for himself; to see patients as a whole person; not to objectify patients; to respect patients' wishes and follow their instructions; to respect confidentiality; to show a high level of knowledge, be involved, have good communication skills and show empathy; to balance demands from patients with those from health care; to involve patients in the decision-making process; recognise patients' independence and allow them to take care of themselves	To be attentive to patients needs; to be friendly, to provide clear information, to clear mothers' doubts, to listen to mothers' concerns; to include mothers in decision-making process; to ask for consent; to involve women by allowing them to ask questions, to care for their babies, to give clear instructions about infections and protocols for infectious diseases in neonatal units; to stimulate women to be actively caring for their babies

For peer review only

Mothers had both encouraging and discouraging experiences during care, which influenced their willingness to seek assisted health care during childbirth in the future. Participants who had experiences of empathetic support and continuous labour support and attention reported these to be encouraging. Other participants reported discouraging experiences such as disrespectful care and inadequate communication and involvement in care decisions.	Uncompassionate attitudes were categorized when patients/families did not feel that nurses showed empathy or concerns for patients, or when patients/families felt that nurses treated them in a way that was negative, destructive, or aggressive; nurses' attitude and demeanor directly affect patients' perceptions of the quality of patient care and the kindness—benevolence—of the organization; unprofessional communication was characterized when patients/families perceived that nurses lacked the use of proper language, tone, choice of words, or facial/body expressions when talking to patents and families; patients felt that being able to understand a procedure and make an informed decision was a critical patient right; when incongruency occurs between patients' expectations for care and the care that they receive, patients are dissatisfied, and patients' complaints may occur; most of the times patients' complaints are not triggered by their perceptions of substandard care, but by nurses' uncompassionate attitudes or unprofessional communication skills.	To develop emotion-focused coping-strategies, which might transform negative events into positive ones, minimizing the risk of perceiving events as violating, problem-focused coping-strategies, like creating alternative solutions or considering alternatives in terms of their costs and benefits, can be found in different actions (seeking more information and support from caregivers or other patients or selecting the caregiver who best suits the patient); to allow withdrawing in a physical as well as psychological sense; to treat the patients in a way that he can feel his integrity is being preserved, to respect him a whole person; to improve mutual confidence between patient and caregiver, to maintain a high level of confidentiality, increasing patients' trust in caregivers; to allow patients to set boundaries during diagnostic or therapeutic procedures to balance patients' and caregivers desires; to allow patients to participate in decision-making process, to allow patients to be free	The importance of information sharing between healthcare workers (HWs) and mothers of babies, contrasting the positive communication reported by many mothers which led to them feeling empowered and participating actively in the care of their babies, with incidents of poor communication; poor communication, rudeness and disrespectful behavior of HWs was frequently described by mothers, and led to mothers feeling anxious, unwilling to ask questions and excluded from their baby's care; poor communication and misunderstandings led to serious mismanagement of babies with HWs delaying or withholding care, or to mothers putting their babies at risk by not following instructions.

For peer review only

Small sample, limited geographic area	Limited understanding of patients' complaints in depth; limited geographic area	Only men were included, small sample	Exclusion of very small hospitals for logistic reasons; did not conduct observation during evening or night shifts or observe healthcare workers on duty after hours; fathers were not included; the presence of the observer may have changed the behavior of the participants; mothers may have avoided to criticise the care received while their babies were still admitted in the unit; healthcare workers may not have felt able to speak about colleagues and managers
Mohammadi E. et al (2017)	**Thommesen T. et al (2020)**	**Tsai Y. F. et al (2020)**	**Gebremichael M.W. et al (2018) (a)**
2	2	1	2
2	2	1	1
2	2	1	1
2	1	2	1
2	2	2	1
1	1	1	1
2	1	2	2
1	2	1	2
1	1	2	2
1	2	2	2
16	**16**	**15**	**15**
Iran (2009-2012)	Afghanistan (2017)	Indonesia (2016-2017)	Ethiopia (?)
29	39	75	62

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

18 patients, 11 members of their families	25 postpartum patients, 11 mothers-in-law, 3 community midwives	35 inpatients (18 male, 17 female); 40 registered nurses (17 male, 23 female)	62 women post-delivery
Deprivation of the caregiver's presence; delay/lack of appropriate responses to the needs; receiving mechanical care (superficiality, lack of affection, failure to understand the situation); being disrespected (humility, aggression)	Decisions on where to give birth, access to health facilities, and receiving and evaluating midwifery care	Discrimination, negligence, impoliteness, dismissal, inattentiveness	To be friendly, polite, avoid disrespect, to avoid abandonment, to avoid junior providres to performe unsupervised, to treat as adult, to allow women to have privacy, to avoid worries about pregancy outcomes, to avoid unnecessary vaginal examinations, to avoid shortages, avoid abandonment and neglect, cultural respect, avoid dirt
Provision of timely and appropriate needs, provide genuine care (knowledge, attention, emotion, and understanding), know the patient well, alleviate suffering, find appropriate ways to communicate, to show compassion, provide emotional support, to be respectful	Education to women, information about pregnacy and birth; improve access to basic and emergency obstetric care; integrate cultural sensitivity and respect for privacy and intimacy into health profesionals' education; environmental control (hygiene and cleanliness); respect for privacy and intimacy; promote early breastfeeding; promote communication between women and midwives; provide familiar professional midwife care; provision of cheap equipment (e.g. curtains), ensuring a minimum level of comfort, privacy and dignity; provide resources (drugs and equipment) and human resources; train professionals on empathic and respectful communication	Improve responsiveness time; improve communication skills in order to provide compatssionate care; avoid harm to a patient during treatments and interventions; encourage exchange of nurse-patient information; treat patients equally/do not discriminate; show attentiveness	To be supportive, friendly, polite, to stay for patients needs, to communicate results of examinations, to avoid infantilization, to respect privacy, to give clear information, to examine in private and not that frequently, to avoid shortages of consumable materials, staff and water, to avoid verbal and physical abuse, to be attentive, to allow companionship, to respect cultural practices, improve cleanliness

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

The patients' rights were violated in a variety of ways. There were three main dimensions to this issue: (a) care recession including deprivation of the caregiver's presence and the delay/lack of needed responses; (b) receiving mechanical care including superficiality, lack of emotion, and failure to understand the situation; and (c) being disrespected including humility and aggression.	Whilst most of the women were aware of the benefits of midwifery care, it turned out that not all of them used such a service; a number of women managed to look after themselves during labour and childbirth, and stated that they did not need or want midwifery care; most of the older informants stated during the focus-group discussions that it is best to give birth at home, and that giving birth in a health facility is a modern practice they did not feel confident with; some women, regardless of their age, felt confident about coping with childbirth on their own; such cultural attitudes may on the one hand reflect resilience, but on the other hand represent barriers to safe childbirth in the event of unexpected problems and emergencies; some women expressed that they would have opted for the clinic but were not allowed to do so by their husbands or in-laws; according to Islamic tradition Afghan women need permission from and accompaniment by a close male family member – a Mahram – in order to seek professional health care and to go to a health facility, husbands and in-laws did not consent to women giving birth in a clinic	**Similarities of viewpoints between nurses and patients**: Negligence: prolonged wait times for care, which they perceived as unresponsive; nurses as being disrespectful, which caused pain and suffering. Impoliteness: use of a loud, high-pitched voice by Indonesian nurses was considered yelling; both nurses and patients interpreted this as impolite and inappropriate; nurses administered treatments roughly and without regard for the discomfort they might be causing the patient. Dismissal: patients were not provided with information or explanations they required. **Dissimilarities of viewpoints between nurses and patients**: Discrimination: patients perceived they were being treated less than equal to other patients, which threatened their dignity; they worried that being admitted to the hospital and paying with healthcare insurance resulted in a poorer quality of care than for patients able to pay privately. Inattentiveness: perceived by nurses to be disrespectful to patients.	The study participants described disrespect and abuse as serious obstacles to utilization of maternal health services. Women reported experiencing feelings of being infantilized, losing self-control, being overlooked, being informed bad news without proper preparation, repeated examination without being properly communicated/ informed, disallow companions, and left unattended during labor. Facility related issues include women's perception of incompetence of professionals attending delivery, unhygienic facilities, and unavailability of basic supplies.
The patterns are dependent on the context in a qualitative research	Main researcher could not run the interviews herself for security reasons; use of local research assistants with limited experience in qualitative research; women in this study could be more in favor of the program than others; data collectors may have been biased in their choice of respondents; details may have been lost in translation from Dari/Pashto into English; female data collectors had issues with transport, security and limited time frame	Design of the study; did not employ in-depth interviews for data collection; did not quantify the frequency of disrespectful behaviors	Cannot be generalized, did not cite data collection time frame

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Hussein S. A. A. A. et al (2019)	**Hernández-Martínez A et al (2019) (a)**
2	2
2	2
2	2
2	2
1	1
2	1
2	2
1	2
2	2
2	2
18	**18**
Jordan and Australia (2017/2018)	Spain (?)
27	32
27 Jordanian women (Recent Mothers, RM; Experienced Mothers, EM; Australian Jordanian Mothers, AJM) (12 RM, 08 EM, 07 AJM)	32 women

For peer review only

To improve privacy and dignity	Birth plan compliance, obstetric problems, mother-infant bond, emotional wounds, perinatal experiences
One professional to examine patients during labor and birth; female professionals, especially during vaginal examination; to address women's needs for respect and privacy; not having doors opened directly into the birthing room; using physical barriers when the door is opened; to cover with a simple sheet; shielding women from visitors; limiting the number of attendants present; train professionals to protect and maintain women's privacy	Give explanation and medical reasons why; introduce oneself, look patients in the eyes, explain the procedures; make sure women are properly informed; wait the correct time for medication to take full efect; reiforce breastfeeding over artificial feeding; pregnancy and breastfeeding support groups; focus on giving more information on the processes; focus on training women, their partners and close family; obtain consent, be attentive and supportive

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Seeking a birth in a private hospital in Jordan was one of the strategies that women used to gain privacy, although this was not always achieved; women were surprised and distressed that in public hospitals, and at times in private hospitals in Jordan, they were expected to share a room with other women during labour and birth; privacy was afforded when birthing at home; women felt exposed, and embarrassed and complained of not being covered with a sheet; participants were distressed by, and critical of, the number of doctors that came in and out of their rooms, the most distressing part of having to deal with many different health professionals was during vaginal examinations, participants discussed their preference for having a female health professional care for them during labour, and birth, and in particular to perform vaginal examinations.	Data analysis revealed five major themes—“Birth Plan Compliance”, “Obstetric Problems”, “Mother-Infant Bond”, “Emotional Wounds” and “Perinatal Experiences”—and 13 subthemes. The majority of responses mentioned feelings of being un/misinformed by healthcare personnel, being disrespected and objectified, lack of support, and various problems during childbirth and postpartum. Fear, loneliness, traumatic stress, and depression were recurrent themes in participants’ responses. As the actions of healthcare personnel can substantially impact a birth experience, the study findings strongly suggest the need for proper policies, procedures, training, and support to minimise negative consequences of childbirth.

For peer review only

Study conducted in Irbid (Jordan) and Sydney (Australia) and at the same place, which can not be representative of other women in Jordan; small sample (only 27 Jordanian women); participants self-select, other women may have different stories to tell; participants may not have felt comfortable enough to discuss everything they have experienced or thought	Cannot pinpoint a specific geographic area for future policy recommendations; not generalisable;
Fleury S. et al (2013) (a)	**Robins C. S. et al (2005)**
2	2
2	2
2	2
1	1
1	1
1	1
2	1
1	2
1	1
1	1
14	**14**
Brazil (?)	USA (2002-2004)
285	27

For peer review only

190 users and/or their companions, 90 professionals directly involved in providing health care and 5 hospital administrators	27 psychiatric patients (11 female, 16 male)
Denial, submission, naturalization, individual resistance, collective resistance	Threat of physical violence and arbitrary nature of the rules; not knowing the consumers as individuals, perceived lack of fairness, experiencing disrespect or embarrassement
Not to naturalize the disrespectful and oppressive treatment; not to discriminate; to educate patients to identify discrimination and mistreatment; to resort the mechaminsm of denouncement	Efforts to reduce the incidence of traumatic and harmful events in psychiatric settings; revise hiring practices; improve staff training; changes to policies and procedures

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Professionals that have less contact with patients tend to be given an even more favorable position; it was not possible to prove the hypothesis that a higher position increases the chances of discriminatory behavior; concerning the institutional culture and management, there is a trivialization of the injustices and rationalization of the inadequate conditions and precariousness present in the public healthcare services; the lack of effective channels for filing grievances and punishing mistreatment and discrimination is made worse by a predominant attitude that perceives any complaint as disrespectful on the part of patients; the absence of clear rules, procedures and norms related to the referral of patients and the selection of those that will be assisted increases the discretionary power of professionals that are not trained for these tasks; the structural aspect of inequality showed the precariousness of the public healthcare services, thus generating a pilgrimage in users to different health units in search of care; the existence of stigmatizing characteristics increases the likelihood of the user being discriminated against	Eighteen of 27 interviewees described harmful incidents that they had witnessed or experienced directly, many of which evoked strong emotional responses by consumers during their narration. Nearly all incidents described were hospital based and were clustered around two sets of themes. The first set related to the hospital setting, including the fear of physical violence and the arbitrary nature of the rules. The second set related to the narrators' interactions with clinical staff, including depersonalization, lack of fairness, and disrespect.
Cannot be generalized, limited geographic area, did not cite data collection time frame	Did not interview staff

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Hrisos S (2013)	Adolfsson A. et al (2012)
2	2
2	2
1	2
2	2
2	2
2	1
2	1
1	1
2	2
2	2
18	**17**
England (2010)	Sweden (2007)
59	14
16 patients (10 female, 6 male) and 4 relatives (2 female, 2 male), 39 healthcare staff (9 pharmacists, 11 doctors, 12 nurses and 7 health care assistants)	14 inpatients, Two lowest priority groups in the Emergency Department who eventually wait for the longest period of time to receive treatment (at Skaraborg area, a district in the Västra Götaland area)

For peer review only

Perceived advantages of patient involvement in improving their own safety; Concerns about involving patients in improving their own safety; Risk of damage to the patient-provider relationship; Staff may treat the patient “differently”; Behavioural implications of service-user fears; Behavioural implications of healthcare professional fears	To manage patients' feelings of being dependent on care, exposed, vulnerable, and secure; create conditions that enhance well being
To address patients concerns about their safety; to involve patients in the decision-making process; to improve staff communication skills; to train professionalism in patient-provider relationship; to engage patients proactively in aspects of their care and work issues that they perceive that might impact negatively their care; not to avoid patient-provider prolonged contact; to stimulate patients to share their concerns	To listen to patients' history and to ask question about it, to be available/attentive (diminishes helplesness and insecurity); to manage basic needs (food, water, pain relief) (diminishes feelings of not being treated respectfully and that their symptoms were not taken seriously); to give clear information about risk classification (diminishes patients' discomfort and mental suffering); to show understanding and compassion (makes patients feel secure), effective communication

Patients were generally positive towards the notion of patient involvement in improving their safety and identified potential advantages; to be able to ask questions or have their concerns addressed, since this provided them with reassurance and a better understanding of what was happening to them and what to expect; perceived advantages expressed by staff were improved adherence to treatment and greater patient satisfaction with care, achieved through better understanding; pushing improvement through patient-mediated intervention, pointing out potential errors or oversights in care provision was felt to be "questioning" or challenging the professionalism of healthcare staff; other actions perceived by patients and relatives as "challenging" or as "criticising" included overtly or explicitly checking that the correct medicines had been administered during drug rounds and asking about alternative treatment options to those recommended by their doctor; patients may experience a loss of trust in the competency or integrity of their care providers, if they feel that they "have to" ask or tell them about potential lapses in their care, because they are not doing the job properly; healthcare providers were expected to always remain "professional" in their dealings with patients and their families, regardless of the situation, and there appeared to be a general consensus amongst both patients and healthcare professionals that most would; being rebuffed or chastised was a very real fear for many patients, and a key barrier to them speaking up; the perceived consequences of upsetting staff, and disrupting relationships, were so powerful that they admitted not sharing potentially serious queries or concerns even with their relatives, who they knew would immediately raise them with staff; staff suggested that they and their colleagues could become guarded in their interactions with certain patients and their relatives, therefore distancing themselves from being the potential target of a complaint.	To allow patients to express their symptoms and feelings freely, they had a sense that they were being acknowledged and taken seriously; to know what the nurses were documenting in their files, when patients are assigned a low priority in the emergency department (ED); to give them adequate attention; to help patients not to feel helpless and overlooked; to give adequate attention; to explain levels of priority in the ED so that patients do not feel insecure; to be available, attentive, and responding appropriately to the patient's needs; to provide adequate food, drink and pain relief; to show understanding and compassion for the patient's situation.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Not generalisable beyond the sample studied; small sample, limited geographic area	
Merakou K. et al (2001)	**Howard M. et al (2013)**
2	2
2	1
2	1
2	2
1	1
1	1
0	2
1	1
2	1
1	1
14	**13**
Greece (1996)	Australia (1997-2007)
600	16

For peer review

600 patients (49,8% men; 50.2% women)	16 patients
Knowledge of the law on patient's rights; the right to information; the right to decision making; the right to confidentiality; the right to object, mechanism of protection of patients' rights	Ineffective communication; Standard of care is not acceptable; Treated with disrespect; Ineffective complaints handling systems; Perceptions of negligence
To inform patients during the course of their admission; to train healthcare professionals on patients' rights; to provide full information about diagnostic; to improve communication with patients and families; to take the time to attend; to obtain consent; to involve patients in decision-making process; to respect privacy and confidentiality; to establish a complaints management system	Complaint management needs to be redressed; the paradigm shift must go beyond regurgitating complaint data metrics in percentages per patient contact, toward a concerted effort to evaluate what the complaint data are really saying; the voices of the taciturn dissatisfied patients need to be encouraged so that their complaints are heard at the time they are experiencing dissatisfaction; to use this opportunity to identify a more positive and proactive approach in encouraging patients to complain when they are dissatisfied; to influence real-time improvements and patient safety

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Patients most inclined to complain were male, young people, urban residents, people with a low income, and those experiencing a short hospital stay; 94.2% answered they do not claim for their rights, 71.6% replied they did not claim because they were satisfied with hospitalization, 9.7% were afraid of doctors reactions, 9.2% believed that the outcome would not be in their favor, 5.5% reported they were not aware of their rights; 44.4% answered that the patients' rights would be better respected if a committee or an expert were available at the hospital setting, and other mechanisms woud be staff education in medical ethics (22.4%), giving patients information about their rights as soon as they were hospitalized 21.4%), introduction of new legislation (5.3%)	15 of the 16 participants did not voice their complaint at the time of the event, when they experienced dissatisfaction with service delivery; the most significant theme that emerged from the narratives was the issue of the participants feeling that they were not being listened to nor supported to voice their concerns or complaints; patients articulated the need for health-care system reform; they primarily wanted to be listened to, to be acknowledged, to be believed, for people to take ownership if they had made a mistake, for mistakes not to occur again, and to receive an apology
Small sample, limited geographic area	The sample size was limited in terms of location and the fact that there was no culturally and linguistically diverse (CALD) or indigenous representation; limited geographic area

For peer review only

Faschingbauer KM et al (2013) (a)	Evan E. E. et al (2007) (a)	Kanengoni B. et al (2019) (a)
2	2	2
2	2	2
2	2	1
1	2	2
1	1	1
1	1	1
2	2	2
2	2	2
2	1	2
2	2	2
17	**17**	**17**
USA (?)	USA (?)	Zimbabwe (?)
12	40	20
06 men, 06 women	20 pairs of parent and children	20 pregnant and postpartum

Individual it
0 = not or inadequately addressed or applied
Tot
Qualitativ
Cross-sectio
Cohort
Quali-quant convergent pa method

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1) Patientt hope for respect and open communication; 2) Patient emotional response to the seclusion process; 3) Patient insight into behavior and the importance of positive coping skills	Relationship building, demonstration of effort and competence, information exchange, availability, and appropriate level of child and parent involvement	Abandonment of care and neglect; non-consented care, lack of information;
To discuss the patients' behavior, to give a chance to calm down before seclusion, to look for alternatives to seclusion, to ask patient to do something instead of telling him what to do, not to ignore the patient during seclusion, to explain the reason for seclusion, to treat patient as an individual, to improve staff communication skills, to know patients' prior history and behavior patterns; 2) To offer fluids and food during seclusion, to manage environment (temperature, cleanliness, noise), not to use seclusion as a punishment, no to mock/laugh at/talk about patients in a negative way, not to disrespect, mistreat or hurt patients, to be attentive to patients' needs; 3) to talk about the reasosn for seclusion, to give patient time to talk, to allow patients to obtain social support from peers, behavior management classes, to debrief after seclusion	To improve communication skills with children and their parents; to be attentive; to be avalilable; to provide clear explanations; to consider the level of involvement of children and parents	To be attentive, to reduce wating times, to provide adequate health information

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To provide open communication about patients' individual needs, talking about their feelings and individual problem before his or her behavior escalated and could not be controlled; to discuss their inappropriate behavior; to give a chance to calm down before seclusion; to ask patients to do something instead of telling them what to do; to offer as-needed medications earlier to control behaviors; to know specific medical and psychiatric background and history in order to understanding their personal needs and idiosyncrasies; to check on them while in the seclusion room, to pay attention to unmet patients' needs (to offer fluids, blankets, bathroom, cleanliness etc); not to mock them or laugh at; not to use seclusion as a form of punishment; to talk over the incident leading to seclusion after the episode; to give them time to talk; to provide family and social support.	To take the time to get to know the patients as individuals and develop a friendship with the patients; to be respectful; to inquire about personal or social concerns in addition to treating physical symptoms; to believe the children's words; to provide relational continuity; to help build trust; to demonstrate the best efforts and exhibit competence and knowledge about the child's care; to talk in an understandable, straightforward manner, give clear explanations, and provide complete information	Multifaceted and interconnected factors contribute to midwives' attitudes and behaviours towards their clients. Midwives' subjective perceptions, women's social status, and health system constraints (i.e., availability of trained midwives and quality of midwifery training) in rural and poorly resourced community, often result in inappropriate services, negative attitudes, abusive treatment, and disrespectful behaviour towards women. Poor treatment in maternity care directly contribute to adverse health outcomes and women's satisfaction with services.

For peer review only

Limited to one hospital, can not be transfered to other hospitals, unit cultures and different psychiatric units, difficulty of inpatient psychiatric patients to express theirs feelings and thoughts	Exclusion of non-English speakers, because families that have a language barrier may have different needs when it comes to communicating with their physician; modest sample size, limiting generalizability; limited geographical, ethnic, and religious variation in the patient population; self-selection bias may also have been a factor because those subjects who chose to participate may be more open to communicating with unfamiliar people than those who refused to be contacted; recruitment of patients through health care providers who may have differing opinions on whether a patient fits the prognosis criteria, especially given the difficulty in predicting length of life for many of the childhood diseases that result in premature death	Limitations noted include complexities in accessing participants, lack of privacy, silencing or limiting some participants replies and lack of re- peat interviews due to hard to reach sample populations.
Wofford M et al (2004)	**Beach M. C. et al (2017) (a)**	
2	1	
1	1	
1	1	
1	1	
2	1	
0	0	
1	1	
1	1	
0	1	
1	1	
10	**9**	
USA (1999-2000)	USA (?)	
222	156-260	

For peer review only

222 complaints (from patients [111], patient's wife [27], husband [6], child [52], parents [50], other relative of friends [15] or a health care professional)	26 focus groups of men and women, 6-10 patients each group (African americans, latinoes, whites)
Perceived unavailability, Disrespect, Inadequate information, Disagreement about expectations of care, Distrust, Interdisciplinary miscommunication, Misinformation	1) Definitions of respect; 2) Specific behaviors that convey respect or dignity
To use patients complaints to improve physicians' communication skills, to avoid disrespectful behavior, to make communication a high priority, to improve interdisciplinary communication	To treat like a person, to treat like an equal, to hear what patient has to say, to respect the patient's knowledge of him/herself, to ask questions about the condition (demonstration of concern), to give honest explanations of medical issues, to avoid stereotyping, to allow patient input into treatment choices, to handle lateness

For peer review only

Complaints were most commonly lodged by a patient (111), followed by a patient's spouse (33), child (52), parent (50), relative/friend (15), or health care professional (2). The most commonly identified category was disrespect (36%), followed by disagreement about expectations of care (23%), inadequate information (20%), distrust (18%), perceived unavailability (15%), interdisciplinary miscommunication (4%), and misinfor- mation (4%). Multiple categories were identified in 42 (19%) complaints. Examples from each category provide adequate detail to develop instructional modules.	Autonomy: clearly expressed by participants in the themes of wanting honest and clear explanations, and in wanting input into treatment plans. Dignity: treating people equally; asking questions about medical conditions, might be interpreted as a sense of caring or investment in the value of the patient as person through concern about medical issues. Integrity: to listen to the patient's narrative, knowing the patient as a unique person, and the avoidance of stereotyping. Trusting patients' self-knowledge: is of particular interest because of its prominence among African American participants, and because it perhaps pushes the conceptualization of respect into new territory. Vulnerability: respect for vulnerability was not explicitly mentioned by any participants. Yet vulnerability emerges as present when viewing the corpus of participant comments as a whole in particular, vulnerability to mistreatment.
Not generalizable, because many patients leave silently and do not register complaints	Imprecise number of participants, time frame of data collection is missing

CRITICAL APPRAISAL SCORES			
tem score (color and value)		(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)	
1 = adequately addressed or applied	2 = well addressed or applied		
al Score Appraisal by study design, color and value			
	Low quality	**Moderate quality**	**High quality**
e studies	0-7	8-14	15-20
onal studies	0-9	10-17	18-24
t study	0-9	10-17	18-24
titative and arallel mixed- studies	0-4	5-9	10-14

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

		Gebremichael MW et al (2018)
	Design	2
	Question	2
	Setting/location	2
	Selection	2
	Characteristcs	2
	Exposure & outcomes	2
	Study size	2
	Statistics	2
	Eligibility	2
	Results	2
	Conflict of interest	2
	LImitations	2
	Total	**24**
	Country (year of research and data collection)	Ethiopia (2015)
	Sample size	1.125
	Type of samples	1,125 women post-delivery

For peer review only

or Review Evidence (SURE) - Questions to assist with the critical appraisal of cross-sectional studies

STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To increase respect and reduce abuse
INTERVENTIONS TO ACHIEVE IMPROVEMENTS	To avoid shouting, scolding, ignoring, to offer adequate information, to obtain consent, to avoid breaching in confidentiality and privacy, to avoid leaving women unattended, to allow women to participate in decision-making

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Specialist Unit fo		
	RESULTS	**More D and A**: Disrespect and abuse (D and A) during delivery services was reported more among: women residing in urban compared with rural areas and women educated to grade 9 or above; women in the age groups 20–34, and 35 or above, compared to those below the age of 20 years, women who were heads of households reported more incidents of D and A compared with women living in a household headed by a male; women who spent longer hours in labour in health facilities, compared with women who spent less than 1 hour in labour; women who were not permitted to have support persons/relatives in the delivery room also reported a significantly higher rate of D and A during labour and delivery compared with those women who were allowed to have support persons. **Less D and A**: Women who had 3–5 births experienced fewer incidents of D and A than women with more than 5 births.
	LIMITATIONS	Recall period of one year after delivery can be too long to remember details; there may be sampling bias due to focus on a single encounter in the previous year; excluded stillbirths, neonatal and infant deaths; underreporting by rural women due to their lack of awareness of their rights; did not include economic status in the analysis; information about facilites were not included

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

onal studies		Montesinos-Segura R et al (2017)
	Design	2
	Question	2
	Setting/location	2
	Selection	2
	Characteristcs	2
	Exposure & outcomes	2
	Study size	2
	Statistics	2
	Eligibility	1
	Results	1
	Conflict of interest	2
	LImitations	2
	Total	**22**
	Country (year of research and data collection)	Peru (2016)
	Sample size	1.528
	Type of samples	1,528 women who delivered in 14 regional hospitals located in nine urban Peruvian cities
	STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	Interventions to reduce the prevalence of disrespect and abuse should be promptly implemented, with different approaches in each region

For peer review only

e (SURE) - Questions to assist with the critical appraisal of cross-secti	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Face-to-face and virtual training might be used to enhance the capability of healthcare workers, and the importance of education to empower women should be emphasized; human resource centers for women to make complaints of disrespect and abuse safely and comfortably might be implemented; to measure the prevalence of disrespect and abuse at various time intervals; approaches specific to each setting are required; these problems should not be uniformly addressed throughout the country, and that each hospital and geographic region should prioritize interventions according to their particular context; to promote participation of a companion chosen by the pregnant woman throughout their labor

For peer review only

Specialist Unit for Review Evidence		
	RESULTS	1488 women experienced abuse; the most prevalent form of disrespect and abuse was non-dignified care, followed by non-consented care, and non-confidential care; the number of women who experienced two or more categories of disrespect and abuse concurrently was 1358, whereas that of women who experienced four or more categories concurrently was 850; women who delivered by cesarean had a higher prevalence of abandonment of care and a lower prevalence of physical abuse as compared with women who delivered vaginally; women referred from other health facilities had a lower prevalence of abandonment of care, non-consented care, discrimination, and non-confidential care as compared with women who were not referred; abandonment of care was significantly more common in the coastal region than in the jungle, whereas discrimination was significantly more common in the jungle than at the coast
	LIMITATIONS	The aim was to generate a validated survey of disrespect and abuse suitable for all Peruvian hospitals; however, each geographic region has its own unique cultural features and traditions; it is possible that some of the items listed in the survey were not part of the disrespect and abuse construct in some contexts; the length of the survey was a limiting factor; the participants might have felt intimidated by the hospital environment, which in turn might have influenced their responses; only women who had delivered in the past 48 hours were surveyed; this population of women could have been affected by immediate distressing factors related to labor, which might have influenced their answers

For peer review only

Vedam S et al (2019)
2
2
2
2
2
2
2
2
2
2
2
2
24
USA (2010-2016)
2.138
2138 women who experienced at least one pregancy in the US, including those currently pregnant

For peer review only

Physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, health system conditions and constraints
Development of several new patient-designed indicators of mistreatment in maternity care; to prevent mistreatment, health care providers need to first consider how they can meet women's socio-cultural, emotional and psychological needs; building collaborations to address factors that maintain racial and ethnic disparities; creating a culture of equity and individualized care and routine training around issues of structural racism and intersectionality of multiple drivers of disadvantage; moving to the development of multidisciplinary teams; addressing issues of access to high quality care across communities and settings for care; equitable application of evidence-based interventions that are responsive to patient reported outcomes and priorities; training for care providers in promoting respectful care including values clarification and attitude transformation (VCAT), training on VCAT based on providers' and clients' rights and obligations, and revision of professional ethics and practices; strengthening facility quality improvement systems for monitoring, reporting, addressing, and resolving disrespect and abuse cases; Mentorship and on-the-job role-modeling by identified champions within the facility as part of routine continuous professional education; civic education about patient rights and avenues for redress may be needed to ensure accountability even in high resource countries

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1 in 6 women experienced more than one type of mistreatment (being shouted at; ignored by healthcare providers/refusing request for help/failing to respond request; violation of physical privacy; healthcare providers threatening to withhold treatment or forcing them to accept treatment they did not want; physical abuse [aggressive physical contact, inappropriate sexual conduct, refusal to provide anesthesia for an episiotomy, etc.]; any mistreatment [one or more above]. Indigenous, Hispanic, Black, White, White women with White partners, White women with Black partner experienced one type of mistreatment; Bi-racial couples experienced less mistreatment when women were White; White women with Black partners were twice likely to report mistreatment than White women with White partners; women who were born in the US reported similar rates of mistreatment compared to women who were not born in the US; recent immigrants were more likely to report mistreatment; younger women were more likely to report physical abuse; first-time mothers were twice as likely to report mistreatment; women who reported low socioeconomic status (SES) were twice as likely to report mistreatment compared to women with moderate or high SES; 1 in 3 women with pregnancy complications or with social risk (substance use, incarceration, domestic violence) reported mistreatment (shouted at, scolded, violation of physical privacy); mistreatment was higher in hospital than in other settings
The sample is voluntary and not population-based; oversampling of communities that are often underrepresented in national studies on experience of care; women were more educated, older, and more likely to have been born in the US; samples of women from Hispanic, Asian, and other communities of color were lower than the national reported rates; lower representation from women who had more routine or simply “satisfactory” experiences that might not be characterized as either particularly empowering nor traumatizing; sample might have a ‘higher’ socioeconomic status population than is representative of the US childbearing population which would decrease rates of reported mistreatment, and potentially underestimate mistreatment in the US population at large; the study's national sample is not representative of the lived experience of many subgroups including undocumented immigrants, incarcerated pregnant parents, and families located in rural settings with limited options for maternity care; each person will have their own sense of bodily/self autonomy and human rights, placed within the cultural context of each environment

For peer review only

Lurie N et al (2004)
2
2
2
2
2
2
2
1
2
1
2
2
22
USA (2001)
6.722
6,722 adults, age >18yr, living in the US, who speak English, Spanish, Mandarin, Cantonese, Vietnamese, or Korean
Random phone interview

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To avoid negative perceptions of minority groups (low-income, low educational level, different races); to focus on approaches that can best improve the perceptions of respect

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Over 14% of blacks, 19% of Hispanics, and 20% of Asians reported they have been treated with disrespect by their doctor. Men (15.9%) were more likely than women (11.6%) to perceive being treated with disrespect by their doctor. Asian (24%) and Hispanic (23%) men were more likely than black (17%) and white (11%) men to perceive being treated with disrespect. 18% of persons without a college education believed they have been treated with disrespect versus only 10% of those with college education. 29% of Asians, 22% of Hispanics, and 19% of blacks without a college education reported being treated with disrespect or being looked down upon, versus 13% of whites; 32.3% of those who felt being treated with disrespect or being looked down upon did not follow doctors advice, and 31.1% put off needed care. Among those who felt treated unfairly because of race, 46.5% did not follow doctors advice, and 40.8% put off needed care. Among those who felt treated unfairly because of their language, 37.5% put off needed care. Among those who felt they would have been treated better had they been of a different race, 33.8% did not follow doctors' advice or put off care.
Relying on self-report, may not be accurate; could not disentangle how general life experiences influcence perceptions; could not examine ohter minorities; had insufficient number of native americans to analyse separately; lack of agreement on the definition of age-appropriate cancer screening

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Dynes MM et al (2018)
2
2
2
2
2
1
2
2
2
2
2
2
23
Tanzania (2016)
1.184
249 providers, 935 post-delivery clients

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Friendliness, comfort, and attention; information and consent; non-abuse and kindness
Not to treat patients of different ages differently, not to discriminate, to avoid ageism; to respect confidentiality; to manage complications in labor and delivery; to allow companionship; to give information clearly; to give friendly, comforting and attentive care; to be patient; to provide mentoring for providers; strategies to reduce workplace stress, training on respectful maternity care,

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Receipt of respectful maternity care dimension 1 (RMC-D1) (friendliness, comfort, and attention): clients aged 30-39 and 40-49 years had signifcantly higher RMC-D1 scores than clients aged 15-19 years. Clients who experienced delivery complications had significantly lower RMC-D1 scores compared to those who did not report complications. Clients of providers who perceived they were paid fairly for ther job duties had signifcantly higher RMC-D1 scores compared with clients of providers who felt they were not paid fairly. Clients of nurses/midwives had significantly lower RMC-D1 scores compared to clients of clinicians. Clients of providers who reported attending 11-20 deliveries in the last month had signifcantly lower RMC-D1 scores compared to clients of providers who attended 1-10 deliveries. **Receipt of respectful maternity care dimension 2 (RMC-D2) (information and consent)**: clients who had a birth companion had signifcantly higher scores compared to clients who did not have a companion in labor. Clients who reported attending to religious services at least weekly had signifcantly lower RMC-D2 scores compared to those who reported less than weekly attendance. Clients of providers who perceived they were paid fairly for their job duties had significantly higher RMC-D2 scores compared to clients of providers who perceived they are not paid fairly. Clients of providers who reported working more hours per week had significantly higher scores compared to clients of providers who work fewer hours. Clients of providers aged 30-39 and 40-49 years had significantly lower RMC-D2 scores compared to clients of providers aged 20-29 years. **Receipt of respectful maternal care dimension 3 (RMC-D3) (non-abuse and kindness)**: clients of providers who were aged 50 years or more had signifcantly higher RMC-D3 scores compared to clients of providers in the 20-29 year age group. Clients of providers who reported access to two types of electronic mentoring had significantly higher RMC-D3 scores compared to clients of providers with no access to mentoring opportunities.
No differenciation in degree of disrespect; no random sampling, cannot make causal inferences and generalize findings; limited ability to identify all risk factors

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

McMahon SA (2014)
1
2
2
2
2
2
2
2
2
1
2
2
22
Tanzania (2011)
112
49 women, 27 male partners, 20 community health workers, 5 community leaders, 11 religious leaders
Feeling ignored or neglected, monetary demands or discriminatory treatment, verbal abuse, physical abuse

For peer review only

Patients may be made aware of women's rights; include providers in participatory trainings; trainings must be supported by health system; improve the working environment (general infrastructure, human resource shortages, deficiencies in supervision and skills training); inclusion of family members during labour and childbirth

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Women recounted events or circumstances that are described as abusive in maternal health literature: feeling ignored or neglected; monetary demands or discriminatory treatment; verbal abuse; and in rare instances physical abuse. As a response to abuse, women described acquiescence or non-confrontational strategies: resigning oneself to abuse, returning home, or bypassing certain facilities or providers. Male respondents described more assertive approaches: requesting better care, paying a bribe, lodging a complaint and in one case assaulting a provider.
Rely on reports, not on direct observation; abuse was not evenly probed in each interview; captured insights of women who delivered several months earlier and may have a recall bias; did not reach data saturation; did not interview providers; did not identify and interview escorts

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Kujawski S et al (2015)
2
2
2
2
2
2
1
2
2
2
2
2
23
Tanzania (2011-2012)
1.388
1,388 postpartum

Satisfaction with delivery, perceived quality of care for delivery, intention to delivery to the same facility for the next birth
Providers empathy; reduce Caesarian sections and financial burden on women and their families; provide information and education; privacy to complain

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Women who reported any disrespectful and abusive treatment during childbirth were less likely to be very satisfied with delivery, were less likely to rate the quality of care for delivery as excellent or very good, and were also less likely to plan to deliver at the same facility with their next child. Women were less likely to be very satisfied with their delivery if they had at least a secondary education, had a Ceaesarean section, and reported extreme pain during labor and delivery. The oldest participants, aged 35-48, were also less likely to be very satisfied with their delivery, compared to the youngest group, aged 15-19. Those who rated their health as very good or good were more likely to rate satisfaction and quality of care positively and were more likely to intend to deliver at the same facility in the future. Women who were married and for whom this delivery was their first birth were less likely to intend to deliver their next child at the same facility.
Lack of a gold standard to measure disrespect and abuse; did not include some aspects of health system; unable to discern causality

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Marin CR et al (2018)
2
2
2
2
2
2
2
1
1
1
2
2
21
Brazil (2015)
300
300 patients from a university hospital
Touching the patient's possessions without permission, changing the bed side table to a position that cannot be reached, and raising or lowering the window blinds without consulting the patient; Performing a technical procedure in an intimate area and changing the patient's clothes without a screen; Embarrassment due to exposure of the body, lack of intimacy and disrespectful behavior by nursing professionals

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To be more attentive to the patient's space and respect the territoriality established by them, often with their personal objects and possessions. Small actions, such as changing the place of the cell phone or slippers, can symbolize the removal of territory and generate strong feelings of discomfort; nudity in front of strangers can be deeply iatrogenic. Within this context, the age, gender and culture of the affected subjects can directly affect the communication dynamics; The patients reported that requesting permission to manipulate their body, to examine them or to perform other care/procedure shows consideration and attention on the part of the professional, which makes the patient feel valued and in control of the situation. This approach may minimize the effects of the invasion and the feeling of being seen as an object; The respect of territory and personal space represents an ethical and respectful approach to patients, which can permit to maintain their dignity even under vulnerable conditions, favouring their recovery; Healthcare should respect the individuality and dignity of the patient, not only including changes in the physical space, but also in the actions and behavior of healthcare providers regarding patient privacy.

For peer review only

The perception of invasion of territorial space was greater than that of personal space; the participants reported that touching their personal possessions without permission, changing the bedside table to a position that cannot be reached, and raising or lowering the window blinds without consulting the patient were attitudes of the nursing staff that annoyed them and caused a feeling of invasion; embarrassing attitudes occur when the nursing staff conduct a technical procedure in an intimate area or change the patient's clothes without a screen; patients who had no children and those living with only one people in the residence perceived greater invasion of their territorial space; patients who shared the room or were hospitalized in the maternity ward felt less personal space invasion
Non-random selection of the participants, the fact that it was performed in only one public hospital in Brazil, which serves predominantly the maternal and child public and, consequently, the significant number of female participants, unbalancing the sample with respect to gender. The cross-sectional nature of our study can only provide associations, the study evaluated only self-reported perceptions of patients and not actual practice by healthcare staff and the sample is not representative of other settings in the country.

Burrowes S et al (2017)
2
2
2
2
2
2
2
1
2
2
2
2
23
Ethiopia (2015)
45
45 (23 women who gave birth attended by a midwife, 3 women who had given birth at home, 15 3rd-year bachelor's degree midwifery students, and 4 practicing midwives)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Increase midwifery training in patient's rights and autonomy
To strengthen professional ethics, communication skills, patients' rights, patient's choice, and patients' autonomy training; to explore ways to structure birh experiences in order to empower women; women-centered care

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The quality of care offered at the facility seemed to be a factor in women's choice of home rather than facility birth; patients and providers first, and most frequently, mentioned verbal abuse; patients mention denial of preferred birth position, while providers report verbal abuse as the leading type of violation. Patients reported that providers often shouted at them or at other patients, mocked them, or spoke to them in harsh tones; the most common type of physical abuse witnessed was slapping patients on the legs in order to get them to comply with midwives' instructions for vaginal exams or for positioning for labor; patients were allowed to drink liquids during labor, but food was frequently denied; most patients were not allowed to give birth in their desired position, and a large minority were not permitted to have family members or friends accompany them during delivery; midwives and midwifery students mentioned observing practices such as stitching episiotomies without anesthesia, performing procedures without informing the patient, and denial of follow-up care to patients who had previously refused services; patients complained frequently about the lack of privacy on the wards due to the lack of screens or curtains and also due to the large number of students who observe deliveries as part of their training
Small sample; limited to a single geographic region; based on interview and not to direct observation

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Rodriguez ACI et al (2020)
1
2
2
2
2
2
2
2
2
2
2
0
21
USA (2017)
501
143 pregnant; 358 postpartum
Negative attitudes and unkind or disrespectful treatment; comments about weight; intense focus on high-risk status and potential negative outcomes based on woman's weight; inapropriate comments

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Individualize approach to each woman's weight; take in mind the potential negative consequences of stigmatizing mothers for weight; compassionate care, free from stigma; stimulate breastfeeding, reduce negative expectations about breastfeeding; investigate postpartum depression symptoms

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Participants who reported having changed their provider had a significantly higher pre-pregnancy BMI (M = 42.79 ± 10.89) than those who did not (M = 32.92 ± 10.91), $F(1, 478) = 28.02$, $p < 0.001$. There was a significant difference in pre-pregnancy BMI among women who reported that too little (M = 31.29 ± 9.19), the right amount (M = 32.97 ± 11.07), and too much (M = 40.69 ± 11.58) attention was paid to their weight, $F(2, 478) = 13.73$, $p < .001$. Post-hoc analyses revealed those reporting too much attention had a significantly higher pre-pregnancy BMI than others. Those reporting that they could not trust their provider because of weight-related treatment also had significantly higher pre-pregnancy BMIs (M = 40.67 ± 10.64) than those who did not (M = 32.78 ± 10.97), $F(1, 479) = 24.95$, $p < 0.001$. Pregnant participants who expected that they would feel uncomfortable seeking help with breastfeeding had a marginally significantly higher pre-pregnancy BMI (M = 40.28 ± 11.84) than those who did not (M = 34.20 ± 12.46), $F(1, 128) = 3.73$, $p < 0.056$. For postpartum participants, those who had felt uncomfortable seeking help with breastfeeding had significantly higher pre-pregnancy BMIs (M = 36.01 ± 11.76) than those who had not (M=32.28±10.20), $F(1, 282)= 6.68$, $p = 0.010$.
Sample was primarily white of higher socioeconomic status, large proportion from California, did not investigate other samples (low-income and racial/ethnic minority mothers), cannot be generalized

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Öztürk H et al (2020)
2
2
2
2
2
2
2
2
2
2
2
1
23
Turkey (2019)
707
357 patients, 350 nurses

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Application of Patient Privacy Scale (PPS)
To bring the discussion of patient privacy into light

For peer review only

Nurses and the patients in the public hospitals had statistically significantly higher overall privacy scores than those in the training and research hospitals. The overall privacy scale scores were higher and more statistically significant in the patients hospitalized in surgical clinics than those hospitalized in clinics for internal diseases and in single compared to married patients.
The current study was limited only to the opinions of nurses working in public hospitals in a city in Turkey and patients receiving inpatient treatment in these hospitals

For peer review only

Ring D et al (2017)
0
2
1
2
2
2
2
2
2
2
0
2
19
USA (1997-2013)
1.118
1,118 patients complaints
Access and availability, humaneness and disrespect, communication, expectations of care and treatment, distrust and billing

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

Improve patients' experiences (optimal communication strategies and costumer service), increase availability by phone or e-mail of the staff, improve communication strategies and empathy, to listen to, to respect, to make patients feel appreciated for who they are,

For peer review only

22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Women reported more complaints in access and availability, humaneness and disrespect, and billing; patients aged 40 to 60 years were more likely to file a complaint in all categories except distrust (most common in patients over age 80) and research; most complaints concerned the surgeon (58%) or the administrative assistant (32%). Over half of all complaints were related to interpersonal issues [humaneness/ disrespect (20%), expectation of care and treatment (20%), communication (14%) and distrust (3.6%)]; the most common type of complaint per year from 1997 to 2012 was access and availability except during 2004 when it was humaneness/disrespect. In the access and availability category, accessibility via telephone and e-mail (34%), wait time (24%), and physical absence of clinician/cancellation of appointment (18%) were the three most common sources of complaint. Regarding the category of humaneness/ disrespect, the most common description was unprofessional (38%), then rudeness (34%), and condescending (15%). 76% of communication category complaints were attributed to miscommunication between the patient and surgeon, while care and treatment complaints involved disputes about treatment, followed by diagnostic issues, and referrals. Many treatment-related complaints addressed medication (most often opioids) and dissatisfaction with the outcome of surgery.
Limited to one hospital; underreporting of complaints, variability of complaints may be due to variability in ombusperson, patient may have the ideia that complaint would not be addressed, differences in reporting by age may be due to more treating patients that ages, complaints addressed only in major negative experiences

For peer review only

Larijani B et al (2018)
2
2
2
2
2
2
2
2
2
2
2
0
22
Iran (2010)
200
200 patients from two hospitals in Tehran

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Two-part questionnaire administered by two interviewers
Train and observe confidentiality and privacy issues, to promote the observance of patients' rights; both healthcare providers and recipients be informed about these issues; education may be provided upon admission or at any other appropriate time via provision of oral explanation as well as written media such as pamphlets, brochures, booklets, etc.; Health policy makers should develop and implement a plan for raising patients' awareness of privacy and confidentiality to improve physician-patient relationships;

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

153 patients provided a correct definition of privacy, and 161 patients were aware of instances of privacy violation; 77 patients had good awareness of physician confidentiality, 46 patients believed that physicians could disclose patients' information to reduce or eliminate a significant risk of serious harm to others, 47 patients did not think it was necessary for physicians to obtain patients' consent before consulting with their families, 105 patients did not believe that physicians needed patients' permission to consult with their colleagues or other members of the medical team in cases of multidisciplinary diagnosis and treatment, 28 patients were aware that disclosing patient's information is unethical, against religion, and illegal, 113 patients had previously known that medical information pertaining to mentally retarded patients should be recounted to their parents or guardians, 39 patients did not consider the results of medical examinations and tests as confidential in cases where patient security, employment, insurance issues and legal competency were concerned, and 47 patients were not aware that in research studies it is essential not to disclose patients' identity, 158 patients had good awareness of the confidentiality of examination results and medical consultations; 15 patients were not aware that in case of patients' decision to commit suicide or homicide, physicians must inform the relevant authorities; whether male physicians should be allowed to perform physical examinations on female patients, 81 patients answered that they should, where it was a matter of saving lives. It may therefore be concluded that they had a good level of awareness in this regard
The authors did not state the limitations of this study

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Ma CC (2014)
2
2
2
1
1
1
2
1
1
1
2
2
18
Taiwan (2012)
204
204 patients > 18 years-old
To evaluate patient's concerns about privacy of EMRs data; to evaluate patient's behavioural responses of patients to their perception of information privacy concerns resulting from information practices of medical facilities

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Institutions and governments need to ensure data protection to each individual; to protect data from use without patient's consent; to develop privacy protection policies to reduce patient's privacy information concerns

For peer review only

Collection of information, secondary use of information and errors in data collection were primary factors in arousing patients' information privacy protective responses toward electronic medical records (EMRs); governments and medical facilities should focus on these findings and develop EMR privacy protection policies to reduce people's information privacy concerns; patients took protective responses towards EMRs when their information privacy concerns were invaded; the lack of attention to these relationships in the healthcare context is problematic because of the influence of these relationships on the promotion of EMRs in the future; the development of EMRs by those responsible for formulating and implementing information-privacy protection procedures in organisational and societal contexts is needed.
This study only looked at people who access Electronic Medical Records (EMRs) without authorisation as staff at the medical facility, which might ignore other unauthorised access by individuals not associated with the medical facility. Further, the external validity of the findings may be limited as the sample was collected from one hospital in Taiwan only. Consequently, inferences to other populations cannot be made safely. However, the collected sample possessed certain demographic characteristic (e.g. gender) in the same proportion as the Taiwanese population, although there were some differences in age and education, meaning that these results may be generalisable to other Taiwanese hospitals. Future research could expand on the present study's findings by using a more representative sample in other geographical settings.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

CRITICAL APPRAISAL SCORES			
Individual item score (color and value)			(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)
0 = not or inadequately addressed or applied	1 = adequately addressed or applied	2 = well addressed or applied	
Total Score Appraisal by study design, color and value			
	Low quality	**Moderate quality**	**High quality**
Qualitative studies	0-7	8-14	15-20
Cross-sectional studies	0-9	10-17	18-24
Cohort study	0-9	10-17	18-24
Quali-quantitative and convergent parallel mixed-	0-4	5-9	10-14

For peer review only

raisal Skills Programme)	
	Issue
	Recruitment
	Exposure
	Outcome
	Confounding factors identification
	Confounding factors taken into account
	Follow up complete
	Follow up long enough
	Results
	Precision of the results
	Believe the results
	Results applied
	Results fit
	Implications for practice
	Total
	Country (year of research and data collection)
	Sample size
	Type of samples

For peer review only

Table 3 - CASP Cohort Studies Checklist (Critical Appı

RESULTS	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	STRATEGIES, BEHAVIORS AND/OR OUTCOMES OF INTEREST

For peer review only

LIMITATIONS

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Skyman E et al (2014)
2
2
2
2
1
1
2
2
2
2
2
1
1
1
23
Sweden (2004/2011)
202
2004: 92 patients (Card: 71, No card: 21); 2011: 110 patients (Card: 91, No card: 19)

only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Disrespect and humiliation, Lack of knowledge, Unprofessionalism, Responsability not to spreading MRSA
To reduce uncertainty, offence, anger and discrimination; to educate patients and healthcare workers; to inform patients and health care providers; to manage patients fellings ; to preserve patients' dignity; to educate health care providers
Patients felt pointed out in a negative way by receiving a notification card; a majority reported that they always or almost always had shown the card when seeking hospital or outpatient care, and for dental care the number was signifcantly higher in 2011 (57.14%) than in 2004 (30.98%) (p=0.004); 81% stated that it is good to have a card in 2004, and 62% in 2011; 38% reported health care workers (HCW) were familiar with the card in 2004, and it increased signifcantly (45%) in 2011 (p=0.036); patients reporting HCW took no notice of the card (21% in 2004, 11% in 2011, p=0.004). Very few actively stated that the HCW were unfamiliar with the card (15.5% in 2004, 5.5% in 2011, p=0.036). Almost half of the patients indicated positive reactions when presenting the notification card (45% in 2004, 47.2% in 2011, p=0.445). A higher number however, responded that they were met with despair and fear (9.86% in 2004, 34% in 2011, p=0.052). Patients claimed unknown acquisition (70% in 2004), of whom 75% believed wrongly that they had been inffected in the hospital. In 2011, there was a tendency towards increased unawareness (47.27%), as compared to 2004, but the difference was not significant. The dominant misconception was still hospital acquisition (81%), even though the perceived hospital acquired-MRSA rate decreased signifcantly (19% in 2011, 42.4% in 2004, p<0.001). Few stated community acquisition in both groups (5% and 21%).

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Low response rates, patients with negative experiences may be more willing to to respond

For peer review only

<table>
<tr><th colspan="4">CRITICAL APPRAISAL SCORES</th></tr>
<tr><th colspan="3">Individual item score (color and value)</th><td rowspan="2">(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)</td></tr>
<tr><td>0 = not or inadequately addressed or applied</td><td>1 = adequately addressed or applied</td><td>2 = well addressed or applied</td></tr>
<tr><th colspan="4">Total Score Appraisal by study design, color and value</th></tr>
<tr><th></th><th>Low quality</th><th>Moderate quality</th><th>High quality</th></tr>
<tr><th>Qualitative studies</th><td>0-7</td><td>8-14</td><td>15-20</td></tr>
<tr><th>Cross-sectional studies</th><td>0-9</td><td>10-17</td><td>18-24</td></tr>
<tr><th>Cohort study</th><td>0-9</td><td>10-17</td><td>18-24</td></tr>
<tr><th>Quali-quantitative and convergent parallel mixed-method studies</th><td>0-4</td><td>5-9</td><td>10-14</td></tr>
</table>

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

...ia (Quali-quantitative and convergent parallel mixed-method studies)

	Sanson G *et al* (2020)
Worth or relevance	2
Clear question	2
Design	2
Context	2
Sampling	1
Data collection and analysis	1
Reflexivity	2
Total	**12**
Country (year of research and data collection)	Italy (2015)
Sample size	100
Type of samples	100 Intensive Care Unit (ICU) patients
STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To identify perceptions about the ICU environment; to reduce discomfort of tubes and procedures, room temperature, position

For peer review only

Critical Appraisal according to Mays & Pope (2000) Criter		
	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Environmental control to reduce disstress, to allow more time for family visits for some patients and less for ohers, clock visible to all patients, windows (daylight and night), to explain ICU bans and rules to patients; Pain control, change positions, manage visual fields
	RESULTS	Patients resported that they had a clear remembrance of their ICU stay; the patients with no clear memory of their ICU stay had significantly worse, and a longer lenght of mechanical ventilation and ICU stay; intrusive memories related to their stays in the ICU.
	LIMITATIONS	Using a data saturation method has been questioned, because it could introduce a certain degree of uncertainty and ambiguity when it tries to find the unobserved on the basis of what is observed. The study enrolled vulnerable participants, some of which had a partial recollection of their ICU experiences. The interviews were carried out in hospital and the interviewer was a health care professional; this situation may have influenced the participants' answers.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Santos LR *et al* (2005) (a)
2
2
2
2
1
2
1
12
Brazil (??)
73
73 general hospital inpatients
Satisfaction with the service provided; Requesting authorization for adminstering medication and carrying out exams, as well as providing prior information; communication of tests results; clarification about the diagnosis; participation in the choice of treatment; problems experienced or observed in the institution

CRITICAL APPRAISAL S		
Individual item score (color and value)		
0 = not or inadequately addressed or applied	1 = adequately addressed or applied	2 = well addressed or applied
Total Score Appraisal by study desi		
	Low quality	
Qualitative studies	0-7	
Cross-sectional studies	0-9	
Cohort study	0-9	
Quali-quantitative and convergent parallel mixed-method studies	0-4	

For peer review only

To ask for patients' authorization to examine them, to touch; to explain the procedure/exam; to discuss its indications, options, and risks; to give information about the patients' rights, conditions, the function of medications, to clarify their doubts; to allow patients to decide what is best for them; to use clear and undertandable language when talking to patients
Patients who were interviewed did not receive information about the function of the medication they were given; they were not asked to or were not informed about procedures; they did not receive any information about consent and were not asked to consent; they were not asked about the route of administering their medication by the physician
Small sample, limited geographic area, data collection time frame not cited

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

SCORES

(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)

ign, color and value

Moderate quality	**High quality**
8-14	15-20
10-17	18-24
10-17	18-24
5-9	10-14

For peer review only

PRISMA 2020 for Abstracts Checklist

Section and Topic	Item #	Checklist item	Reported (Yes/No)
TITLE			
Title	1	Identify the report as a systematic review.	Page 2 - Yes
BACKGROUND			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Page 2 - Yes
METHODS			
Eligibility criteria	3	Specify the inclusion and exclusion criteria for the review.	Page 2 - Yes
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	Page 2 – Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies.	Page 2 – Yes
Synthesis of results	6	Specify the methods used to present and synthesise results.	Page 2 – Yes
RESULTS			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	Page 2 – Yes
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Page 2 – Yes
DISCUSSION			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Page 2 – Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Page 2 – Yes
OTHER			
Funding	11	Specify the primary source of funding for the review.	Page 2 – Yes
Registration	12	Provide the register name and registration number.	Page 2 - Yes

PRISMA 2020 for Abstracts Checklist

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 2
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Page 2-3
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 3
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 3
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 3
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Page 3
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Page 3
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 3
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Page 3
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Page 3
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 3 and 11
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Not applicable
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 3
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 3
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 3
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Pages 3-6, and pages 8-11
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Pages 3-4
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Pages 3, 4, 8
Reporting bias	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Pages 3, 11

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

PRISMA 2020 Checklist

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Section and Topic	Item #	Checklist item	Location where item is reported
assessment			
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Page 8
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Pages 3,4
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Page 4
Study characteristics	17	Cite each included study and present its characteristics.	Page 4-6
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Page 11
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Pages 3-8
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Page 11
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Not applicable
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Page 13
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Pages 8-11
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Page 4, 13
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Pages 8-11
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 11-13
	23b	Discuss any limitations of the evidence included in the review.	Page 13
	23c	Discuss any limitations of the review processes used.	Page 13
	23d	Discuss implications of the results for practice, policy, and future research.	Pages 13, 14
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Pages 2, 3, 14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	PROSPERO
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	None
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Page 14
Competing interests	26	Declare any competing interests of review authors.	Page 14

For peer review only

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Not applicable

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only

BMJ Open

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-059129.R2
Article Type:	Original research
Date Submitted by the Author:	12-Apr-2022
Complete List of Authors:	E. P. Dutra, Pablo; UFRJ, Institute of Pyschiatry of UFRJ (IPUB/UFRJ) Quagliato, Laiana; UFRJ, Institute of Psychiatry of UFRJ (IPUB/UFRJ) Nardi, Antonio; UFRJ, Institute of Psychiatry of UFRJ (IPUB/UFRJ)
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Mental health, Medical education and training, Global health, Ethics, Public health
Keywords:	MENTAL HEALTH, MEDICAL ETHICS, MEDICAL EDUCATION & TRAINING, PSYCHIATRY, PUBLIC HEALTH, QUALITATIVE RESEARCH

SCHOLARONE™
Manuscripts

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

For peer review only

1

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

TITLE PAGE

Title: Improving the perception of respect for and the dignity of inpatients: A Systematic Review

Author name:
Pablo Eduardo Pereira Dutra

Co-authors' names:
Laiana Azevedo Quagliato
Antonio Egidio Nardi

Corresponding author:
Full name: Pablo Eduardo Pereira Dutra
ORCID: 0000-0003-3970-5668
Postal address: Av. Venceslau Brás, 71, Botafogo, Rio de Janeiro, RJ, Brazil
ZIP Code: 22.290-140
E-mail: pablo.medicina@ufrj.br
Phone: +55 21 3938-0500
Fax: +55 21 3938 0500
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of UFRJ (IPUB/UFRJ)

Full names, institutions, city, and country of all co-authors:
Full name: Laiana Azevedo Quagliato
ORCID: 0000-0002-6928-5847
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Full name: Antonio Egidio Nardi
ORCID: 0000-0002-2152-4669
Institution:
Federal University of Rio de Janeiro (UFRJ)
Laboratory of Panic and Respiration (LABPR)
Institute of Psychiatry of the UFRJ (IPUB)
City: Rio de Janeiro
Country: Brazil

Keywords (MeSH terms): Respect, Dignity, Patient rights, inpatients, privacy

Word count: 4,583

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Improving the perception of respect for and the dignity of inpatients: A Systematic Review

ABSTRACT

Objectives: The aim of this systematic review is to find evidence to determine which strategies are effective for improving hospitalized patients' perception of respect and dignity.

Methods: A systematic review of the literature was conducted in accordance with PRISMA 2020 guidelines. The MEDLINE/PubMed, PsycINFO and Cochrane Library databases were searched on March 9, 2021. Observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials with interventions focused on improving respect for patients and maintaining their dignity were included. Case reports, editorials, opinion articles, studies <10 subjects, responses/replies to authors, responses/replies to editors, and review articles were excluded. The study population included inpatients at any health facility. Two evaluators assessed risk of bias according to the Cochrane Handbook of Systematic Reviews of Interventions criteria: allocation, randomization, blinding, and internal validity. The reviewers were blinded during the selection of studies as well as during the quality appraisal. Disagreements were resolved by consensus.

Results: 2,515 articles were retrieved from databases, and 44 articles were included in this review. We conducted a quality appraisal of the studies (27 qualitative studies, 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study and 1 convergent parallel mixed-method study).

Discussion: a limitation of this study is that it may not be generalizable to all cultures. Most of the included studies are of good quality according to the quality appraisal. To improve medical and hospital care in most countries, it is necessary to improve the training of doctors and other health professionals.

Conclusion: many strategies that could improve the perception of respect for and of the dignity of the inpatient. The lack of interventional studies in this field has led to a gap in knowledge to be filled with better designed studies and effect measurements.

Funding: this study has no external funding sources.

Registration: PROSPERO (CRD42021241805).

Keywords: Respect, Dignity, Patient rights, inpatients, privacy

STRENGHTS AND LIMITATIONS OF THIS STUDY

- The review protocol was registered at PROSPERO and PRISMA guidelines were followed in this systematic review.
- A comprehensive search strategy was employed to locate studies related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent.
- The data were not homogeneous enough to perform a meta-analysis, which could enrich the results.
- One study could not be retrieved, and it might have data that could be important to the results of this study.
- Some studies presented qualitative data which were difficult to determine their validity in different cultures.

INTRODUCTION

Dignity is a fundamental human right (1), and its maintenance is an ethical goal of care (2). The Brazilian Code of Medical Ethics (3) states that physicians must respect and act in patients' benefit. The Declaration on the Promotion of Patients' Rights in Europe (4), states that one of its objectives is "*to reaffirm fundamental human rights in health care*".

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The concept of dignity is still not clearly defined (5), and it can be affected during hospitalization (6). Hospital routines are needed to promote and protect patient health, but they can be harmful when patients experience stigma (7), violation of rights, privacy, integrity, disrespect, and breaches in confidentiality, and when facing unprepared and insecure professionals who cannot provide clear explanations about diagnostic and therapeutic procedures. All of these can lead to complaints, which can be used as a tool for improving patient care (8).

One may think that dignity and respect violations are restricted to low-income countries or to people of low socioeconomic status, but it is a worldwide phenomenon, and it is not directly related to wealth, but to culture and professional education. Several studies suggest that patients' rights are violated daily in practically all scenarios of practice of health-related activities. However, its results are sparse and there is no systematization of what can improve patients' perception of receiving respectful and dignified care.

Published studies, as we will see later, address specific specialties in isolation and few address this important topic comprehensively. The strategies used to improve the quality of care and the perception of respect and dignity from the patients' point of view may seem obvious, but they are not observed in practice in several countries and continents. Thus, it is necessary to review the current literature in search of strategies that can positively impact patients' perception of respect and dignity.

OBJECTIVE

The aim of this systematic review is to evaluate worldwide evidence to determine which strategies can be used to improve inpatient patients' perception of respect and dignity.

STUDY DESIGN

A systematic review with the aim of identifying, analyzing, extracting, and evaluating data from the literature related to respect for and maintenance of the dignity of hospitalized patients. It also aims to identify knowledge gaps and relate the findings to clinical practices to improve the quality of care for all hospitalized patients worldwide.

METHODS

This study was registered at PROSPERO (CRD42021241805) and conducted following PRISMA guidelines (9). Articles were identified by searching electronic records, including the MEDLINE/PubMed, PsycINFO and Cochrane Library databases. The quoted search terms used were as follows: Patient human rights violation OR Patient disrespect OR Patient violation of dignity OR Patient rights protection OR patient intimacy violation OR patient confidentiality violation OR ethical violation OR ethics violation OR hospital violation of patients' rights OR patients' perception of rights violation OR patients' perception of disrespect. There were no restrictions on year or language of publication, and no automation tool was used. The main objective was to find any interventions and multifaceted interventions aimed at improving inpatients' perception of respect and dignity and decreasing disrespect or human/inpatient rights violations, intimacy violations, confidentiality violations, autonomy violations, etc. The search included interventions conducted in hospitals, day hospitals, clinics, emergency departments, psychiatric emergencies, psychiatric hospitals, asylums, and any other places where there are inpatients. The inclusion criteria were full text, observational studies, prospective studies, retrospective studies, controlled trials, and randomized controlled trials. The exclusion criteria were case reports, editorials, opinion articles, studies <10 subjects, responses/replies to authors, and responses/replies to editors.

The first author (PEPD) screened the titles and abstracts of the articles and manually excluded those articles that did not fit the inclusion criteria.

After that, two reviewers (PEPD and LAQ) independently assessed the full texts of the remaining articles for eligibility in a standardized manner: data extraction was performed

independently, and disagreements between reviewers regarding the study selection or data extraction were resolved by consensus. If a consensus was not reached, the third reviewer (AEN) was consulted.
The following information was extracted from the full-text articles using an Excel spreadsheet: authors, place/year of publication, sample size, type of samples, study design, analysis, data/measure, strategies, interventions to achieve improvements, and limitations.
Two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10). Disagreements were resolved by consulting a third reviewer. The minimum number of studies for data to be pooled was 10, including any intervention that would be effective for improving the perception of respect and dignity among inpatients.
A quality appraisal of the articles was performed using the CASP Qualitative Studies Checklist (11), Specialist Unit for Review Evidence (SURE) 2018 (12), CASP Cohort Study Checklist (13), and Mays & Pope Qualitative research in health care (14).

Patient and public involvement
No patient involved.

Quality appraisal
A critical appraisal of the included studies was performed, but no study was excluded based on its score, although this approach makes their analysis more robust. The instruments used for it were: CASP Qualitative Studies Checklist (11) (**Table 1) (See supplementary 1)**; Specialist Unit for Review Evidence (SURE) - Questions to assist with the critical appraisal of cross-sectional Studies (12) (**Table 2) (See supplementary 2)**; CASP Cohort Studies Checklist (13) (**Table 3) (See supplementary 3)** and the criteria put forth by Mays & Pope (2000) (14) (**Table 4) (See supplementary 4)**.
They were scored as follows: 0 = not or inadequately addressed, 1 = partially addressed, and 2 = fully addressed criterion. Critical appraisal scores are described below each table.
The quality assessment of the studies and of the systematic review was performed by two reviewers independently (PEPD and LAQ), who then discussed and agreed to the final rating. No study was excluded for quality reasons, but this assessment enabled a more robust review of the studies.

Risk of bias
To minimize bias, two reviewers assessed the risk of bias using the following criteria from the Cochrane Handbook of Systematic Reviews of Interventions version 6.2 (10): methods for allocation, methods for randomization, blinding, and evaluation of internal validity. The reviewers were blinded during the selection of studies to be included and excluded as well as during the quality appraisal. Disagreements were resolved by consensus after the reviewers' judgment.

RESULTS
Three databases were searched on March 9th, 2021: PubMed/MEDLINE, PsycINFO, and Cochrane Library. Of the 2,515 results, no article was excluded by automation tools, 3 were excluded after searching for duplicate studies using the EndNote Web tool, and 2,375 were excluded after title and abstract screening by the first reviewer (PEPD). In the second step, two reviewers (PEPD and LAQ) independently assessed the 121 articles for eligibility.
Thirteen references were not found. The first reviewer (PEPD) contacted by e-mail and/or via ResearchGate - more than once - authors, coauthors, and journals where they were published to try to retrieve them. Up to August 5th, 2021, 9 articles were retrieved, 3 were bought online from publishers, and 1 was not retrieved and excluded. A total of 76 articles were excluded: 50 did not include inpatients, 2 were not in the scope of this review, 4 were review/systematic

review, 1 focused on health care professionals, 1 focused on the development of telehealth, 12 were essay/commentary/thoughts, 2 included less than 10 patients, 1 was a study protocol, and 3 were scale developments.

Forty-four articles were included, according to PRISMA 2020 guidelines (9) (**Figure 1**): 14 cross-sectional studies, 1 cohort study, 1 quali-quantitative study, 1 convergent parallel mixed-method study, and 27 qualitative studies.

The results of articles classified as high-quality in the quality assessment receive more emphasis than those with a lower classification. They were divided according to the main themes.

Religion, emergency, psychiatric and pediatric patients

Violations of patients' dignity and privacy are almost routine. The simple act of providing a patient list to third parties for religious visits without consent is considered a violation of privacy (15). Likewise, the seclusion to which psychiatric patients in agitation are subjected, often as a form of punishment, also constitutes a violation of dignity, as they are often not offered liquids and food, which makes them feel humiliated (16, 17).

In all cases, there is a fundamental element missing, communication. In pediatrics, for example, the lack of communication between doctors and parents and patients produces anxiety and confusion (18), which could be avoided if the professional talked to families in an open and understanding way, demonstrating knowledge and security in their work. This same feeling of vulnerability and powerlessness is experienced by emergency patients, considered of low priority, as they feel insecure, exposed, and violated in their self-esteem, as they wait for professional attention for several hours in some cases (19). When the patient is of a different ethnicity from that of the doctor, this feeling of inferiority increases, as patients feel the need to be treated as equals, as people, as being important and want to have their complaints heard, receive polite, timely and with clear explanations (20).

Obstetric patients

The feeling of invasion of privacy and lack of respect and dignity is common among obstetric patients from the first contact with obstetricians, as there is a lack of training in Respectful Maternity Care (RMC), counseling skills, in building a good physician-patient relationship (21). Professionals allege overwork, low and inadequate remuneration, lack of training, precarious and inadequate working conditions, overload due to lack of professionals (22), which can improve with investment in training, in more dignified working conditions, in improving of remuneration, in the availability of contact with other professionals for learning and consultations, as well as with a better understanding of the cultural context of the patient and the professional (23,24). Better communication between professionals and pregnant women and mothers can contribute to building a relationship of trust, promoting their engagement in breastfeeding and baby care (25).

The female body undergoes several transformations during pregnancy, such as weight gain. Some pregnant women feel embarrassed by their doctors, due to stigma related to their weight gain, which can undermine the doctor-patient relationship (26). In Jordan, for example, women end up seeking private assistance in search of a little more respect for their privacy, since public hospitals lack sheets to cover themselves, leaving their bodies and intimacy exposed (27).

The promotion of RMC among women and health professionals can improve the quality of care provided (28), reduce social stigma, as women with lower levels of education and lower socioeconomic status feel stigmatized and perceive that they are treated with less quality than others with better economic and social status (29). Disrespectful, unkind, rude, and negativistic behaviors only contribute to increase the level of stress and generate distrust in the parturient, who has often denied her right to a companion, feeling uninformed, abandoned, neglected, and objectified during childbirth and postpartum (30-34).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

In rural Afghanistan, the training of professionals had a positive impact on the satisfaction of pregnant women in relation to health services, although there are still complaints (35), related to disrespect, low quality of services, maltreatment and disagreements between doctors and patients (36), as well as in Peru, where most research participants had already suffered at least one episode of disrespect and abuse during pregnancy and childbirth (37). The World Health Organization (WHO) recommends improvements in the quality of treatment and care for women to reduce stigma and poor care and to promote respect and dignity (38,39).

General hospital patients

Cultural and ethnic differences between nurses and patients can contribute to negative perceptions of disrespectful and unfair treatment, particularly among ethnic minorities (40,41). Thus, it is necessary for health professionals to be attentive to recognize factors that violate or preserve dignity from the patient's point of view (42), such as interpersonal problems, professional availability and lack of empathy in communication (43), even when the patient does not actively complain, the professional must take a more proactive stance to identify and respond to the patient's needs in a timely manner, with strategies to improve patient safety, promoting their involvement in the care of their health (44,45). To this end, managers need to be sensitized to invest in professional education, to keep professionals attentive to patients' rights, reducing treatment inequities that lead patients to pilgrimage through health services in search of more dignified treatment (46,47).

Professional development should also promote strategies that ensure patients' privacy, not only of their personal and health information (48), since a leak can undermine the reputation of a health facility, as patients bring to the hospital expectations of receive security, respect, dignity, information, and care (49). Touching patients' personal objects or moving them can be perceived as an invasion of territory and privacy, causing discomfort (50), reinforcing the need to provide information about privacy and confidentiality before and during hospitalization (51). A Greek study showed that patients had little idea of their rights (52) and nursing has a very important role in disseminating this knowledge and ethical principles, establishing a relationship of respect for patients' rights and privacy (53-55). Intensive care unit (ICU) patients often have memories of the environment as hostile and stressful, generating negative feelings of violation of their rights to dignity and privacy, lack of empathy, not being understood, delay in getting help and be subject to full control by health professionals (56).

Most patients are unaware of their rights (57); a study with the distribution of information cards to patients with methicillin-resistant S. aureus (MRSA) infection, which should be presented to the professionals with whom they would consult, showed that these patients are subject to discrimination and lack of knowledge, which makes its use questionable (58). It is therefore imperative that healthcare professionals keep the concept of integrity in mind and that this knowledge be used to train healthcare professionals with more professionalism, communication skills, and practice-based learning (59, 60). In an increasingly digital age, resources for preserving information and privacy are essential, since patients' autonomy is closely intertwined with their dignity (61-63), which can positively impact the quality of empathic, non-possessive care, authentic and respectful, with positive results in treatment outcomes (64).

DISCUSSION

These studies reveal that there are several strategies that can improve the quality of care provided to inpatients, thus improving their perception of respect for and the maintenance of their dignity. There is a Hippocratic principle that guides the medical profession, “first, do no harm” and that must be considered in all spheres not only of the doctor-patient relationship, but of any relationship between health professionals and patients. Therefore, although we did not find studies with statistically calculated interventions and effect size measurements, the quality of the studies included in this systematic review allows us to point out some strategies

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

that can help improve patients' perceptions regarding respect for and maintenance of their dignity. Patients and health professionals around the world express the same interests and desires to have the quality of care raised to the level of excellence and the rights of patients respected.

It is necessary to keep in mind that minor violations of patients' rights happen daily, even when it is considered to have good intentions, as in the case of visits by religious to patients. Their names cannot be placed on a list without consent, as this constitutes an invasion of privacy. Likewise, when a patient needs mechanical restraint or seclusion due to aggressiveness, it is necessary to offer fluids, food, and attention, to understand why the patient acted that way, as many see this attitude as a violation of human rights or as punishment, so that the experience fulfills its therapeutic goals and does not become a source of trauma for the patient or a painful psychic experience.

One of the keys to good relationships with patients is communication. Parents of pediatric patients, as well as patients themselves, need clear information, which gives them a sense of confidence and security. Professionals need to demonstrate skill, knowledge, and confidence during their interventions, to guarantee the best treatment for their patients and to allow patients and their parents to make the best decisions for the quality of life of their children.

Feelings of humiliation, impotence and being “left aside” affect emergency patients, with lower risk conditions, which makes them wait for care for long periods. These patients need to receive information about their conditions and the functioning of the emergency department, they must receive information and attention from the nursing staff, as their condition can progress to more serious situations or death, if they are not checked frequently. When patients have different ethnicities than professionals, the asymmetry of the relationship seems to be exacerbated by the behavior of some professionals, leading patients to feel discriminated against, treated in a dehumanized and disrespectful way. Allowing the patient to speak, listening to the patient carefully and valuing their complaints and opinions gives them the feeling of being respected and seen as an equal person. Professionals must be aware of these subtleties of human behavior and spend more time assisting these patients in a way that makes them feel more respected and welcomed. These small actions can make a difference when a patient seeks treatment or professional help.

The field of obstetrics is one of the fields that has more studies on the respect and dignity of patients, including the prepartum, pregnancy and postpartum periods. It is necessary for professionals in the field to be trained regarding Respectful Maternity Care (RMC). It is a woman's right to receive clear information; respectful and dignified treatment; to hug and breastfeed her child in the immediate postpartum period; to have her intimacy and privacy preserved; not being subjected to episiotomy without consent or without anesthesia; having a family member accompanying them; not being discriminated against because of their weight, ethnicity, color, race, sexuality, religion, socioeconomic status, place of residence, state or country of origin; to have a companion during childbirth, whether a family member or friend; the right not to be verbally or physically abused (not to be cursed or verbally humiliated; not to be slapped during childbirth, for example); the right not to have their bodies exposed in a hospital environment, where there is a large circulation of professionals (to be covered by a sheet); the right not to have their bodies invaded by several individuals (not being exposed to frequent vaginal examinations by various professionals, especially in teaching hospitals); the right to receive information about prenatal care, pregnancy, childbirth, postpartum, breastfeeding, contraception, vaccination and infectious-contagious diseases that can affect the mother and baby; the right to have quality and humanized care in any device in the care network, whether public or private; the right to receive analgesia or anesthesia; and the right to have less prolonged care, whether public or private.

Obstetric violence is present in several fields of action, among the various health professionals who work in this area, from harshly speaking to or yelling at, to physically or sexually assaulting a woman. Considering the most diverse studies on the subject, this practice is

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

widespread in several countries around the world, from the U.S. to Asian countries, and there needs to be a large investment in education and training of health professionals so that women of childbearing age can be assisted with dignity and respect.

Professionals should be aware of the cultural subtleties of the patients they serve, as many behaviors may seem inappropriate in multicultural contexts, as the patient's education, culture, socioeconomic level, and religion produce different perceptions about the professionals' conduct. This can lead to negative perceptions and complaints, for example regarding discrimination and quality of care.

A conciliatory and more proactive attitude towards avoiding conflicts can improve patients' perception of the professional and the health facility during the hospitalization period. The investment in training and education of health professionals is the best solution to improve the quality of care, bringing patients to a more active position in their treatment, promoting information and autonomy, aiding in a timely manner, respecting rights, maintaining vigilance in cases of disrespect and violations of dignity, encouraging the acceptance of differences, reducing all types of prejudice and stigma, and allowing professionals and patients to act together.

Small attitudes of health professionals can turn into big problems: touching personal belongings without authorization, moving objects, exposing the patient, and making inappropriate comments, even though it may seem like just an innocent joke. One of the solutions may be to ask patients and family members to carry out assessments about the service, analyze complaints in the ombudsman's office, and use these data as important tools to improve the quality of the service provided. Patient concern regarding the confidentiality of their medical information is another point that deserves attention. The right to privacy and confidentiality is directly related to the respect and dignity of patients. Violations of confidentiality, in addition to being unethical, can cause moral and financial damage to patients and their families, leading to legal actions against professionals and hospitals. Another way to give patients more freedom and autonomy is to guarantee them access to their medical information, either through direct access to the system or through applications. Thus, managers and government officials must invest in information security systems, since the world is increasingly digital and the trend is to reduce the use of printed documents, ensuring the protection of data for patients and professionals. Patients must receive information about current legislation in terms of information security, their rights to privacy and confidentiality, and nursing has a fundamental role in the dissemination of ethical principles in the work environment.

The results found in the articles included in this systematic review show that there is still a long way to go in promoting more dignified and respectful care for patients admitted to health care units around the world. The innovation is in the synthesis and enumeration of these practices, which can bring a new way of dealing with information and profoundly change the way we serve and think about the care provided to hospitalized patients. Regardless of culture and nationality, studies show that there is a need to improve the quality of care, whether through improvements in education during graduation, in student training, in the use of reality data to refine professional practice, or through training of professionals when entering the labor market, offering refresher courses, recycling professionals and promoting the availability of safe means by which professionals can discuss cases and share knowledge without breaching professional secrecy.

STRENGTHS OF THIS STUDY

Our study covers a wide range of topics related to the respect and dignity of inpatients, reaching many countries around the world on virtually every continent. In addition, this systematic review fills a knowledge gap in an area that has not yet been studied, which, although gaining prominence in recent years, lacks more research and development. The fact that there is no

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

limitation on the time researched and, on the language, allowed us to reach from the most recent to the oldest studies on this topic.

LIMITATIONS

Although we have tried to reach as many studies as possible, its results cannot be generalized to all cultures and countries of the world, and it does not include all specialties and their peculiarities. One study could not be retrieved, and it might have data that could be important to the results of this study. The data were not homogeneous enough to perform a meta-analysis, which would enrich the results. More studies with controlled interventions and outcomes should be carried out to measure the effect on the perception of respect for and maintenance of the dignity of hospitalized patients.

STATEMENT OF FINDINGS

Regarding clinical practice, our study brings several collaborations based on the findings of the reviewed articles. Actions to promote dignity include: providing information correctly and clearly about procedures and treatments, serving with politeness and kindness, avoiding gestures and comments that might be perceived as disrespectful, putting aside prejudices (you are not there to judge but to serve to the best of your ability and professional ethics), taking as much time to serve as necessary, adhering to confidentiality when sharing information with team members, listening to complaints and trying to resolve them, responding to timely calls, using patient complaints made as a way to improve the hospital routine, promoting improvements in the quality of the environment (including cleaning, lighting and noise control), allowing pregnant women to have companions, avoiding yelling at patients or using physical touch as a form of reprimand (which can be understood as physical aggression), avoiding unnecessary exposure of the patient's body, avoiding intimate examination by various professionals (especially in teaching hospitals), obtaining consent for diagnostic and therapeutic procedures, informing patients about the drugs that will be applied (name and what they are used for), introducing oneself to the patient, asking if the patient wants to receive visits and from whom, asking who the patient would like to share information with, calling the patient by his or her name (avoiding colloquial or derogatory language), demonstrating knowledge, showing security and professional skills, and using setbacks as opportunities for your own and for your team's collective learning.

IMPLICATIONS FOR PRACTICE

Our findings provide perspectives that could and should be used to improve patient care and education in different areas of health around the world.

IMPLICATIONS FOR RESEARCH

Virtually all studies related to the quality of care, respect, dignity, confidentiality, and privacy of hospitalized patients, have a qualitative or cross-sectional design. It is necessary that future research be designed with controlled interventions and effect size measurement to bring more robustness to the findings, since this subject is gaining prominence in daily practice. Furthermore, regardless of the country, respect and dignity are universal and fundamental rights of every human being and must, therefore, be put into practice wherever patients are.

CONCLUSION

Our systematic review touches on important points of care during professional practice, with the aim of delivering truly patient-centered care to patients.

Professional practice is regulated by legal means and by professional education, but it is observed that there is a lack of training so that various everyday conflicts can be mitigated and resolved locally without harming the patient. It is inconceivable that patients need to look for another health facility because they feel mistreated at a place that should provide care.

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

Likewise, it is unacceptable for a health professional not to be able to handle situations in their professional routine without resorting to violence or verbal aggression. When a patient goes to a health unit, he or she seeks care; therefore, we have the obligation to provide care, without prejudice, without discrimination and to the best of our technical capacity, with respect and dignity. This is the wish of all patients around the world.

REGISTRATION AND PROTOCOL

This study protocol was registered at PROSPERO (CRD42021241805 - Improving the perception of respect for and the dignity of the inpatient: A Review), and it was conducted in accordance with PRISMA 2020 guidelines (9).

FUNDING

This study has no external funding source.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

CONTRIBUTORSHIP STATEMENT

The study concept was developed by PEPD. The manuscript of the protocol was drafted by PEPD and critically revised by LAQ and AEN. PEPD developed and provided feedback for all sections of the review protocol and approved the final manuscript. The search strategy was developed by PEPD and LAQ. Study selection was performed by PEPD and LAQ. Data extraction and quality assessment was performed by PEPD and LAQ, with AEN as a third party in case of disagreements. All authors have approved the final version of the manuscript.

DATA AVAILABILITY STATEMENT

No additional data available.

REFERENCES

1) United Nations. Universal Declaration of Human Rights | united nations. [cited 2021 June 8]; Available from: https://www.un.org/en/about-us/universal-declaration-of-human-rights

2) Ferri P, Muzzalupo J, Di Lorenzo R. Patients' perception of dignity in an Italian general hospital: a cross-sectional analysis. BMC Health Serv Res. 2015;15(1):41-48.

3) Conselho Federal de Medicina. Código de Ética Médica [Internet]. Conselho Federal de Medicina. 2019 [cited 2021 June 8]. Available from: https://portal.cfm.org.br/images/PDF/cem2019.pdf

4) World Health Organization (WHO). A Declaration on the Promotion of Patients Rights in Europe. [Internet] 1994. [cited 2021 June 08]. Available from: https://www.who.int/genomics/public/eu_declaration1994.pdf

5) Bagheri A. Elements of human dignity in healthcare settings: the importance of the patient's perspective. J Med Ethics. 2012;38(12):729–30.

6) Campillo B, Corbella J, Gelpi M, Martinez E, Viciana MA, Alonso M. Development and validation of the scale of perception of respect for and maintenance of the dignity of the inpatient [CuPDPH]. Ethics Med Public Health. 2020;15(100553):100553.

7) Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity: Obesity stigma and patient care. Obes Rev. 2015;16(4):319–26.

8) Mirzoev T, Kane S. Key strategies to improve systems for managing patient complaints within health facilities - what can we learn from the existing literature? Glob Health Action. 2018;11(1):1458938.

9) Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. Syst Rev. 2021;10(1):89.

10) Chapter 7: Considering bias and conflicts of interest among the included studies [Internet]. Cochrane.org. [cited 2021 June 8]. Available from: https://training.cochrane.org/handbook/current/chapter-07

11) Critical Appraisal Skills Programme. CASP Qualitative Studies Checklist [Internet]. B-cdn.net. [cited 2021 Jul 6]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

12) Specialist Unit for Review Evidence (SURE). Questions to assist with the critical appraisal of cross-sectional studies [Internet]. Cardiff.ac.uk. 2015 [cited 2021 Jul 9]. Available from:
https://www.cardiff.ac.uk/__data/assets/pdf_file/0006/212775/SURE_Qualitative_checklist_2015.pdf

13) Critical Appraisal Skills Programme. CASP Cohort Study Checklist [Internet]. B-cdn.net. [cited 2021 Jul 26]. Available from: https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Cohort-Study-Checklist-2018_fillable_form.pdf

14) Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. BMJ. 2000;320(7226):50–2.

15) Erde E, Pomerantz SC, Saccocci M, Kramer-Feeley V, Cavalieri TA. Privacy and patient-clergy access: perspectives of patients admitted to hospital. J Med Ethics. 2006;32(7):398–402.

16) Faschingbauer KM, Peden-McAlpine C, Tempel W. Use of seclusion: finding the voice of the patient to influence practice. J Psychosoc Nurs Ment Health Serv. 2013;51(7):32–8.

17) Robins CS, Sauvageot JA, Cusack KJ, Suffoletta-Maierle S, Frueh BC. Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatr Serv. 2005;56(9):1134–8.

18) Hsiao JL, Evan EE, Zeltzer LK. Parent and child perspectives on physician communication in pediatric palliative care. Palliat Support Care. 2007;5(4):355–65.

19) Adolfsson A, Dahlén, Westin. Experience of being a low priority patient during waiting time at an emergency department. Psychol Res Behav Manag. 2012;5:1-9.

20) Beach MC, Branyon E, Saha S. Diverse patient perspectives on respect in healthcare: A qualitative study. Patient Educ Couns. 2017;100(11):2076–80.

21) Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017;17(1):263-74.

22) Dynes MM, Twentyman E, Kelly L, Maro G, Msuya AA, Dominico S, et al. Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016. Reprod Health [Internet]. 2018;15(1):41-64.

23) Gebremichael MW, Worku A, Medhanyie AA, Berhane Y. Mothers' experience of disrespect and abuse during maternity care in northern Ethiopia. Glob Health Action. 2018;11(sup3):1465215.

24) Gebremichael MW, Worku A, Medhanyie AA, Edin K, Berhane Y. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective. BMC Pregnancy Childbirth. 2018;18(1):392-97.

25) Horwood C, Haskins L, Luthuli S, McKerrow N. Communication between mothers and health workers is important for quality of newborn care: a qualitative study in neonatal units in district hospitals in South Africa. BMC Pediatr. 2019;19(1):496-508.

26) Incollingo Rodriguez AC, Smieszek SM, Nippert KE, Tomiyama AJ. Pregnant and postpartum women's experiences of weight stigma in healthcare. BMC Pregnancy Childbirth. 2020;20(1):499-508.

27) Hussein SAAA, Dahlen HG, Ogunsiji O, Schmied V. Uncovered and disrespected. A qualitative study of Jordanian women's experience of privacy in birth. Women Birth. 2020;33(5):496–504.

28) Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision" - knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC Pregnancy Childbirth. 2019;19(1):42-9.

29) Kanengoni B, Andajani-Sutjahjo S, Holroyd E. Women's experiences of disrespectful and abusive maternal health care in a low resource rural setting in eastern Zimbabwe. Midwifery. 2019;76:125–31.

30) Khresheh R, Barclay L, Shoqirat N. Caring behaviours by midwives: Jordanian women's perceptions during childbirth. Midwifery. 2019;74:1–5.

31) Kujawski S, Mbaruku G, Freedman LP, Ramsey K, Moyo W, Kruk ME. Association between disrespect and abuse during childbirth and women's confidence in health facilities in Tanzania. Matern Child Health J. 2015;19(10):2243–50.

32) McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy Childbirth. 2014;14:268-80.

33) Millicent Dzomeku V, van Wyk B, Lori JR. Experiences of women receiving childbirth care from public health facilities in Kumasi, Ghana. Midwifery. 2017;55:90–5.

34) Rodríguez-Almagro J, Hernández-Martínez A, Rodríguez-Almagro D, Quirós-García JM, Martínez-Galiano JM, Gómez-Salgado J. Women's perceptions of living a traumatic childbirth experience and factors related to a birth experience. Int J Environ Res Public Health. 2019;16(9):1654-66.

35) Thommesen T, Kismul H, Kaplan I, Safi K, Van den Bergh G. "The midwife helped me ... otherwise I could have died": women's experience of professional midwifery services in rural Afghanistan - a qualitative study in the provinces Kunar and Laghman. BMC Pregnancy Childbirth. 2020;20(1):140-56.

36) Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019;16(1):77-94.

37) Montesinos-Segura R, Urrunaga-Pastor D, Mendoza-Chuctaya G, Taype-Rondan A, Helguero-Santin LM, Martinez-Ninanqui FW, et al. Disrespect and abuse during childbirth in fourteen hospitals in nine cities of Peru. Int J Gynaecol Obstet. 2018;140(2):184–90.

38) The White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women [Internet]. Healthpolicyproject.com. [cited 2021 Aug 22]. Available from: http://www.healthpolicyproject.com/pubs/46_FinalRespectfulCareCharter.pdf

39) WHO Statement. The prevention and elimination of disrespect and abuse during facility-based childbirth [Internet]. Who.int. [cited 2021 Aug 22]. Available from: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

40) Asmaningrum N, Kurniawati D, Tsai Y-F. Threats to patient dignity in clinical care settings: A qualitative comparison of Indonesian nurses and patients. J Clin Nurs. 2020;29(5–6):899–908.

41) Blanchard J, Lurie N. R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care. J Fam Pract. 2004;53(9):721–30.

42) Ebrahimi H, Torabizadeh C, Mohammadi E, Valizadeh S. Patients' perception of dignity in Iranian healthcare settings: a qualitative content analysis. J Med Ethics. 2012;38(12):723–8.

43) King JD, van Dijk PAD, Overbeek CL, Hageman MGJS, Ring D. Patient complaints emphasize non-technical aspects of care at a tertiary referral hospital. Arch Bone Jt Surg. 2017;5(2):74–81.

44) Howard M, Fleming ML, Parker E. Patients do not always complain when they are dissatisfied: implications for service quality and patient safety. J Patient Saf. 2013;9(4):224–31.

45) Hrisos S, Thomson R. Seeing it from both sides: do approaches to involving patients in improving their safety risk damaging the trust between patients and healthcare professionals? An interview study. PLoS One. 2013;8(11):e80759.

46) Khademi M, Mohammadi E, Vanaki Z. On the violation of hospitalized patients' rights: A qualitative study. Nurs Ethics. 2019;26(2):576–86.

47) Fleury S, Bicudo V, Rangel G. Reacciones a la violencia institucional: estrategias de los pacientes frente al contraderecho a la salud en Brasil. Salud Colect. 2013;9(1):11–25.

48) Kuo K-M, Ma C-C, Alexander JW. How do patients respond to violation of their information privacy? Health Inf Manag. 2014;43(2):23–33.

49) Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. J Hosp Med. 2010;5(9):514–20.

50) Marin CR, Gasparino RC, Puggina AC. The perception of territory and personal space invasion among hospitalized patients. PLoS One. 2018;13(6):e0198989.

51) Mohammadi M, Larijani B, Emami Razavi SH, Fotouhi A, Ghaderi A, Madani SJ, et al. Do patients know that physicians should be confidential? study on patients' awareness of privacy and confidentiality. J Med Ethics Hist Med. 2018;11:1-7.

52) Merakou K, Dalla-Vorgia P, Garanis-Papadatos T, Kourea-Kremastinou J. Satisfying Patients' Rights: a hospital patient survey. Nurs Ethics. 2001;8(6):499–509.

53) Ming Y, Wei H, Cheng H, Ming J, Beck M. Analyzing patients' complaints: Awakening of the ethic of belonging: Awakening of the ethic of belonging. ANS Adv Nurs Sci. 2019;42(4):278–88.

54) Öztürk H, Torun Kılıç Ç, Kahriman İ, Meral B, Çolak B. Assessment of nurses' respect for patient privacy by patients and nurses: A comparative study. J Clin Nurs. 2021;30(7–8):1079–90.

55) Pupulim JSL, Sawada NO. Percepção de pacientes sobre a privacidade no hospital. Rev Bras Enferm. 2012;65(4):621–9.

56) Sanson G, Lobefalo A, Fascì A. "Love can't be taken to the hospital. If it were possible, it would be better": Patients' experiences of being cared for in an intensive care unit. Qual Health Res. 2021;31(4):736–53.

57) Santos LR, Beneri RL, Lunardi VL. Ethical questions in the work of the health team: the (dis)respect to client's rights. Rev Gaucha Enferm. 2005;26(3):403–13.

58) Skyman E, Bergbom I, Lindahl B, Larsson L, Lindqvist A, Thunberg Sjöström H, et al. Notification card to alert for methicillin-resistant Staphylococcus aureus is stigmatizing from the patient's point of view. Scand J Infect Dis. 2014;46(6):440–6.

59) Widäng I, Fridlund B. Self-respect, dignity and confidence: conceptions of integrity among male patients: Conceptions of integrity among male patients. J Adv Nurs. 2003;42(1):47–56.

60) Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviors: a qualitative study. Acad Med. 2004;79(2):134–8.

61) Kayaalp M. Patient privacy in the era of big data. Balkan Med J. 2018;35(1):8–17.

62) Rodríguez-Prat A, Monforte-Royo C, Porta-Sales J, Escribano X, Balaguer A. Patient perspectives of dignity, autonomy and control at the end of life: Systematic review and meta-ethnography. PLoS One. 2016;11(3):e0151435.

63) Kisvetrová H, Tomanová J, Hanáčková R, Greaves PJ, Steven A. Dignity and predictors of its change among inpatients in long-term care. Clin Nurs Res. 2021;10547738211036968.

64) Kallergis G. The contribution of the relationship between therapist-patient and the context of the professional relationship. Psychiatrike. 2019;30(2):165–74.

COPYRIGHT/LICENSE FOR PUBLICATION

"The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution, iii) create any other derivative work(s) based on the Contribution, iv) to exploit all subsidiary rights in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above."

Figure 1: PRISMA flow diagram

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

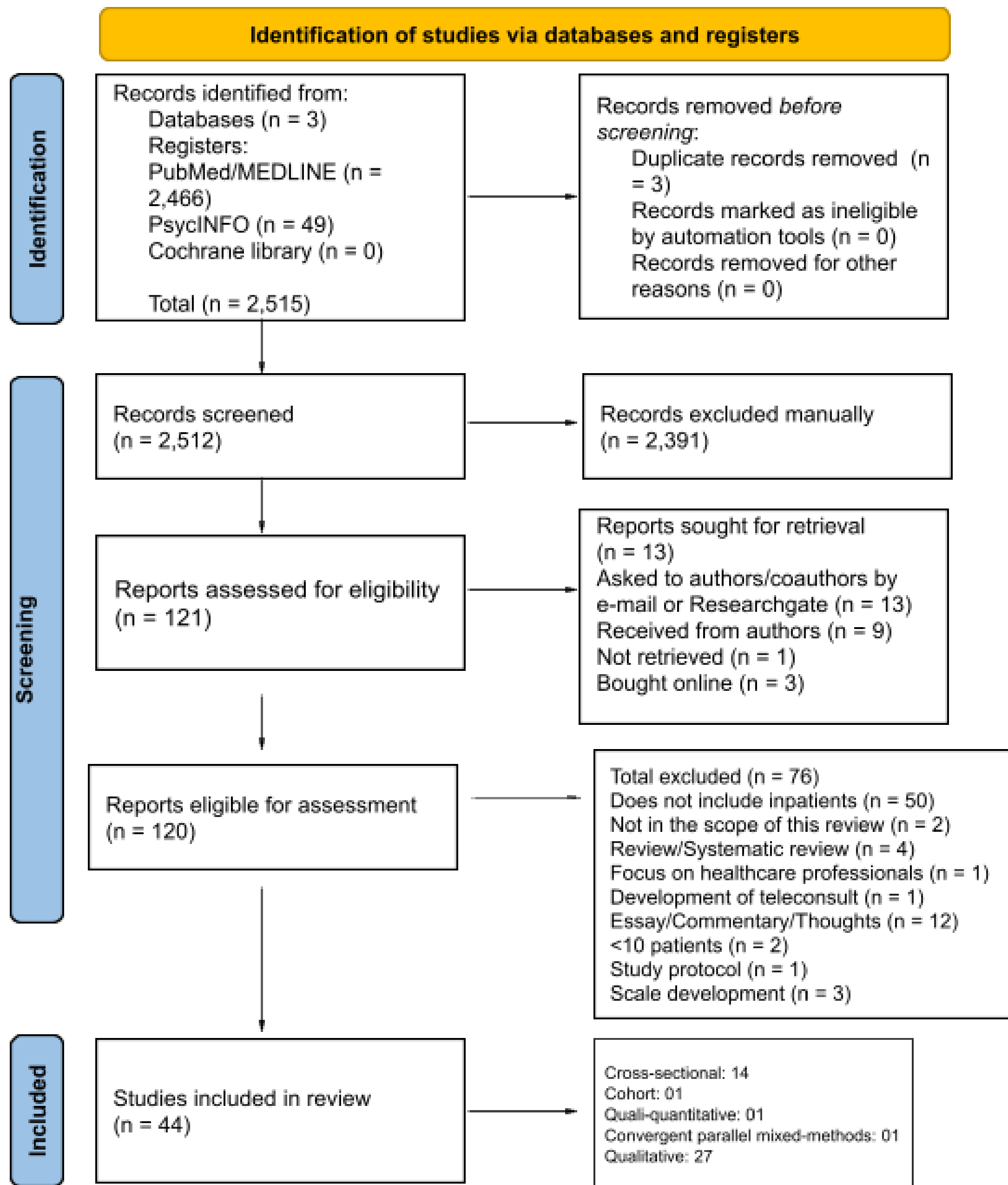

Figure 1: PRISMA flow diagram

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Author (year of publication)	Torabizadeh C. et al (2012)	Aminu M. et al (2019)	Horwitz L. I. et al (2010)
Aims	2	2	2
Methods	2	2	2
Design and Methods	2	2	2
Recruitment stragegy	2	2	2
Data collection	2	2	2
Bias and Reflexivity	1	1	1
Ethical issues	2	2	2
Data analysis	2	2	2
Statement of findings	2	2	2
Value and applicability	2	2	2
Total	**19**	**19**	**19**
Country (year of research and data collection)	Iran (2010/2011)	Malawi (2016)	USA (2007/2008)
Sample size	20	73	976
Type of samples	20 patients (12 women, 08 men; aged 21-78yr)	64 women (33 in antenatal care; 09 in intrapartum care; 22 in postnatal care); 09 healthcare providers (01 in antenatal care; 02 in intrapartum care; 06 in postnatal care)	976 postdischarge patients from medical, surgical, gynecology-oncology, neurology, neurosurgery, or Intensive care unit

For peer review only

CASP Qualitative Studies Checklist (Critical Appraisal Skills Programme)				
	STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To improve ways to reduce devaluation and to promote patients' dignity; to create organizations to promote and to protect patient dignity	Staff behaviour; Good communication; Consent and decidion-making; Privacy and confidentiality	Safety, treatment with respect and dignity, prompt and efficient care, successful exchange of information, enrironmental control and autonomy, high-quality amenities
	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Provide adequate supplies and necessary facilities; environmental sanitation and cleanliness; loudness at night; avoid unpleasant tasks to be done by companions, not allowing companions to get involved in private issues; provide comfort to companions; avoid unnecessary undressing or body exposure, medical or nurse rounds while changing or using bed pans, avoid presence of members of opposite sex, try to provide care by same sex staff, male and female staff should be available on shifts; provide clear, effective and friendly verbal and gestural communication; try to minimize the cultural clash between patients and staff	Staff behaviour that showed commitment and empathy and was non-judgmental; to allow women to express concerns and ask questions, give information, educational talks, counselling sessions; involve women and family in decisions; avoid breach in confidentiality, respect women's privacy	Improve safety (diet, medication administration, patient identification, and equipment); improve staff knowledge and skills; improve cleanliness and environmental control; ethical, respectful, warmth, attentive to privacy and confidentiality, and dignifying staff attitudes; reduce waiting times for admission, transport, discharge, and staff responses to patients' needs; improve provider-patient and provider-provider communication; improve invironmental control (noise, cleanliness, smells, pain, interruption, food, smoking, lighting, temperature, humidity)

For peer review only

RESULTS	**Lack of facilities and equipment**: Shortage of facilities and equipment is an obstacle to dignity. **Unhygienic conditions**: cleaning of their environment was necessary for them to feel dignity. **Annoying noise**: Crowded wards annoyed the majority of patients preventing peace and tranquillity. **Compulsory companionship**: not only does the patient want to have a companion, the staff expects them to have one. **Lack of companion's comfort**: They believe that their dignity is not maintained if their companions are not appreciated by the healthcare system. **Indecent body exposure**: being exposed to others shows disregard for their dignity. **Mixed-gender situations**: Patients felt uncomfortable when they were left with patients of the opposite sex in rooms or wards. **Inadequate verbal and gestural communication**: patients were dissatisfied with ineffective communication from healthcare providers. **Cultural and social gap**: as patients normally have no choice about roommates, some consider that they are not given as much respect as they should be in accordance with their social class.	Important themes that emerged included: the importance of a valued patient-provider relationship as determined by a good attitude and method of communication, the need for more education of women regarding the stages of pregnancy and labour, what happens at each stage and which complications could occur, the importance of a woman's involvement in decision-making, the need to maintain confidentiality when required and the problem of insufficient human resources. Prompt and timely service was considered a priority. Neither women accessing maternity care nor trained healthcare providers providing this care were aware of the respectful maternity care (RMC) Charter.	Six major domains of dissatisfaction were identified: ineptitude, disrespect, waits, ineffective communication, lack of environmental control, and substandard amenities. These domains corresponded to six implicit expectations for quality hospital care: safety, treatment with respect and dignity, minimized wait times, effective communication, control over physical surroundings, and high-quality amenities.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

LIMITATIONS	Small sample, limited to a single geographic region	Due to differences in cultural practices and beliefs, perceptions and experiences of those in more rural and/or more traditional areas would need further exploration	Patients' perceptions were not compared to chart data; Caregivers were allowed to participate in lieu of patients, which may have reduced identification of some dissatisfying events; patients who did not speak English or Spanish were excluded and could have different experiences; it did not explore dissatisfaction in detail; patients may have been reluctant to report dissatisfaction to a member of hospital staff; there may have been other dissatisfying events
Author (year of publication)	**Khresheh R. et al (2019) (a)**	**Pupulim J. S. L. et al (2012)**	**Pomerantz S. C. et al (2006) (a)**
Aims	2	2	2
Methods	2	2	2
Design and Methods	1	2	2
Recruitment stragegy	2	2	1
Data collection	1	2	1
Bias and Reflexivity	1	1	1
Ethical issues	2	2	2
Data analysis	2	1	2
Statement of findings	2	1	1
Value and applicability	2	2	2
Total	**17**	**17**	**16**
Country (year of research and data collection)	Jordan (?)	Brazil (2007)	USA (?)
Sample size	21	34	179

For peer review

CASP Qualitative Studies Checklist (Critical Appraisal Skills Programme)

Type of samples	21 postpartum inpatients	34 (15 male and 19 female inpatients)	179 inpatients
STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To improve women's feelings during childbirth (felling frightened and losing control over birth process, feeling disrespected by staff, being treated as ignorant and feeling humiliated)	1) To see the patient as a person, as a human being; 2) to respect patients' autonomy, to minimize feelings of objectification; 3) to respect the need for a place of their own	To assess the patient's willingness to have religious visits, to obtain consent to list a patient's religion to clergy; to assess the patient's sense of privacy violation
INTERVENTIONS TO ACHIEVE IMPROVEMENTS	To be attentive and available to women; to avoid unnecessary exposure of genitals; to avoid examination by different staff; to help changing position; to assist with walking to the bathroom; not leaving women alone; to help reducing pain; adoption of respectful manners by staff	1) To respect patients' feelings, reactions, and privacy, to care for and to treat them well; maintenance of dignity and privacy are seen as markers of a good quality of assistance; to respect patients' self-determination; 2) to ask permission to examine, to touch the patients' body or to perfom any procedure, to allow patients' decision about when to be touched, to give choices; 3) to allow seclusion and tranquility, an attemp to preserve and rescue individuality, to respect privacy when using the barhroom, to guarantee confidentiality	To respect patient's rights and desires; to respect patient privacy; not to address a patient's religion without consent; to ask for patient's consent to allow religious visits; no to list a patient's religion unless consented

For peer review only

RESULTS	Three main themes were identified: (1) Women's feelings during childbirth: they felt frightened, humiliated, ignored, and disrespected. Negative actions in term of tangible or physical non-caring behaviours and emotional behaviours were reported. (2) Women's perceptions of the caring behaviours of midwives during childbirth: women had negative experiences during childbirth, they reported disrespectful manners and physical and empathetic abandonment by midwives during childbirth. (3) Women's preferred caring behaviours: women wanted the midwives to listen to what they say, to demonstrate respect for them, and be truly 'present' for women when they needed them.	The subjects pointed out behavioral factors, which contribute or not for the protection and maintenance of the privacy in the hospital, highlighting respect as the most important aspect, followed by personal control over situations that violate privacy. Patients believe that privacy is linked to dignity and respect, depends on the demarcation of the personal/territorial space and the autonomy's security; and that these concepts and attitudes are connected and essential to protect privacy in the hospital context.	Most respondents were women, had a high-school education or less and almost half had not been admitted to hospital previously, were part of an organised religion and described themselves as somewhat or very religious, would not want to be listed by religion and did not think hospitals should give lists to the clergy without their consent. In all, 84% would welcome a visit by their own clergy even if it were triggered by the list. Only 47% thought their sense of privacy would be violated by the hospital disclosing their name, whereas most thought disclosure violated patients' privacy rights; of those who wanted their name listed by religion, 17% thought their sense of privacy would be violated by the hospital disclosing their admission and religion to clergy without their permission and 35% thought the hospital giving clergy the list of names without permission was a violation of patients' rights to privacy
LIMITATIONS	Only one hospital, cannot reflect the perceptions of women all over Jordan; did not include women who had emergency caesarean birth; women who did not participate may have different experiences, did not cite data collection time frame	Patients' perceptions may vary among different regions, and cultures	The sample may not be representative of the patients admitted to the hospital, as those who consented to be interviewed may be biased towards those who are more religious and, therefore, more interested in this issue; key questions regarding privacy rights were asked at the end of a long interview. It is not clear whether fatigue influenced those responses

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Dzomeku V.M. et al (2017)	**Wei H. et al (2019)**	**Widäng I et al (2003)**	**Haskins L. et al (2019)**
2	2	2	2
2	2	2	2
2	2	2	2
2	2	2	1
2	2	2	2
1	1	1	1
2	2	2	2
2	2	2	2
2	2	2	2
2	2	2	2
19	**19**	**19**	**18**
Ghana (2014-2015)	China (2015-2017)	Sweden (2000-2001)	South Africa (2015-2016)
56	127	17	44
56 antenatal and postanal women	127 (49.6% males, 45.7% females, 4.7% unsure)	17 patients (10 in the surgical ward and 7 in the medical ward)	24 mothers, 20 healthcare providers

For peer review only

Disrespectful care; inadequate communication and involvement in decision-making; experiences of empathetic support; experiences of continuous labour support and attenttion	Uncompassionate attitudes, unprofessional communication, disrespect of patients rights, unsatisfactory quality of nursing care	**Self-respect** (having control over yourself and the situation; having the courage to set boundaries; being alone; having self-belief); **Dignity** (being seen as a whole person; being respected; being seen as trustworthy); **Confidence** (keeping information confidential; trusting the professionals; having a balance between one's own desires and those of others; participating; being free)	Provide timely care; communicate clearly, friendly and respectfully; to stimulate women to participate in care
Ability to understand life experiences; demonstration of concern and empathy; to be with mothers throughout their labour period; to have spouses and relatives with mothers; emotional and comforting measures, information and advocacy; improve communication, involve patients and families in decision-making; to institute quality assurance methods; education of healthcare professionals on patient-centred care	To be constructive and helpful; to show respect for humanity and ethics; to maintain a positive and compassionate attitude and respect patient humanity; to be fair to all patients, respect human dignity, and explain information understandably and respectfully; to fully inform patients about his/her treatment plans and the medications and procedures given and undergoing; to be competent and empathetic in nursing care; improve nursing education	Allow patients to gain control; to tell a caregiver that one's feeling at risk of having his/her integrity violated; to allow patients to be alone, in privacy; to allow the patient to be responsible for himself; to see patients as a whole person; not to objectify patients; to respect patients' wishes and follow their instructions; to respect confidentiality; to show a high level of knowledge, be involved, have good communication skills and show empathy; to balance demands from patients with those from health care; to involve patients in the decision-making process; recognise patients' independence and allow them to take care of themselves	To be attentive to patients needs; to be friendly, to provide clear information, to clear mothers' doubts, to listen to mothers' concerns; to include mothers in decision-making process; to ask for consent; to involve women by allowing them to ask questions, to care for their babies, to give clear instructions about infections and protocols for infectious diseases in neonatal units; to stimulate women to be actively caring for their babies

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Mothers had both encouraging and discouraging experiences during care, which influenced their willingness to seek assisted health care during childbirth in the future. Participants who had experiences of empathetic support and continuous labour support and attention reported these to be encouraging. Other participants reported discouraging experiences such as disrespectful care and inadequate communication and involvement in care decisions.	Uncompassionate attitudes were categorized when patients/families did not feel that nurses showed empathy or concerns for patients, or when patients/families felt that nurses treated them in a way that was negative, destructive, or aggressive; nurses' attitude and demeanor directly affect patients' perceptions of the quality of patient care and the kindness—benevolence—of the organization; unprofessional communication was characterized when patients/families perceived that nurses lacked the use of proper language, tone, choice of words, or facial/body expressions when talking to patents and families; patients felt that being able to understand a procedure and make an informed decision was a critical patient right; when incongruency occurs between patients' expectations for care and the care that they receive, patients are dissatisfied, and patients' complaints may occur; most of the times patients' complaints are not triggered by their perceptions of substandard care, but by nurses' uncompassionate attitudes or unprofessional communication skills.	To develop emotion-focused coping-strategies, which might transform negative events into positive ones, minimizing the risk of perceiving events as violating, problem-focused coping-strategies, like creating alternative solutions or considering alternatives in terms of their costs and benefits, can be found in different actions (seeking more information and support from caregivers or other patients or selecting the caregiver who best suits the patient); to allow withdrawing in a physical as well as psychological sense; to treat the patients in a way that he can feel his integrity is being preserved, to respect him a whole person; to improve mutual confidence between patient and caregiver, to maintain a high level of confidentiality, increasing patients' trust in caregivers; to allow patients to set boundaries during diagnostic or therapeutic procedures to balance patients' and caregivers desires; to allow patients to participate in decision-making process, to allow patients to be free	The importance of information sharing between healthcare workers (HWs) and mothers of babies, contrasting the positive communication reported by many mothers which led to them feeling empowered and participating actively in the care of their babies, with incidents of poor communication; poor communication, rudeness and disrespectful behavior of HWs was frequently described by mothers, and led to mothers feeling anxious, unwilling to ask questions and excluded from their baby's care; poor communication and misunderstandings led to serious mismanagement of babies with HWs delaying or withholding care, or to mothers putting their babies at risk by not following instructions.

For peer review only

Small sample, limited geographic area	Limited understanding of patients' complaints in depth; limited geographic area	Only men were included, small sample	Exclusion of very small hospitals for logistic reasons; did not conduct observation during evening or night shifts or observe healthcare workers on duty after hours; fathers were not included; the presence of the observer may have changed the behavior of the participants; mothers may have avoided to criticise the care received while their babies were still admitted in the unit; healthcare workers may not have felt able to speak about colleagues and managers
Mohammadi E. et al (2017)	**Thommesen T. et al (2020)**	**Tsai Y. F. et al (2020)**	**Gebremichael M.W. et al (2018) (a)**
2	2	1	2
2	2	1	1
2	2	1	1
2	1	2	1
2	2	2	1
1	1	1	1
2	1	2	2
1	2	1	2
1	1	2	2
1	2	2	2
16	**16**	**15**	**15**
Iran (2009-2012)	Afghanistan (2017)	Indonesia (2016-2017)	Ethiopia (?)
29	39	75	62

For peer re

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

18 patients, 11 members of their families	25 postpartum patients, 11 mothers-in-law, 3 community midwives	35 inpatients (18 male, 17 female); 40 registered nurses (17 male, 23 female)	62 women post-delivery
Deprivation of the caregiver's presence; delay/lack of appropriate responses to the needs; receiving mechanical care (superficiality, lack of affection, failure to understand the situation); being disrespected (humility, aggression)	Decisions on where to give birth, access to health facilities, and receiving and evaluating midwifery care	Discrimination, negligence, impoliteness, dismissal, inattentiveness	To be friendly, polite, avoid disrespect, to avoid abandonment, to avoid junior providres to performe unsupervised, to treat as adult, to allow women to have privacy, to avoid worries about pregancy outcomes, to avoid unnecessary vaginal examinations, to avoid shortages, avoid abandonment and neglect, cultural respect, avoid dirt
Provision of timely and appropriate needs, provide genuine care (knowledge, attention, emotion, and understanding), know the patient well, alleviate suffering, find appropriate ways to communicate, to show compassion, provide emotional support, to be respectful	Education to women, information about pregnacy and birth; improve access to basic and emergency obstetric care; integrate cultural sensitivity and respect for privacy and intimacy into health profesionals' education; environmental control (hygiene and cleanliness); respect for privacy and intimacy; promote early breastfeeding; promote communication between women and midwives; provide familiar professional midwife care; provision of cheap equipment (e.g. curtains), ensuring a minimum level of comfort, privacy and dignity; provide resources (drugs and equipment) and human resources; train professionals on empathic and respectful communication	Improve responsiveness time; improve communication skills in order to provide compatssionate care; avoid harm to a patient during treatments and interventions; encourage exchange of nurse-patient information; treat patients equally/do not discriminate; show attentiveness	To be supportive, friendly, polite, to stay for patients needs, to communicate results of examinations, to avoid infantilization, to respect privacy, to give clear information, to examine in private and not that frequently, to avoid shortages of consumable materials, staff and water, to avoid verbal and physical abuse, to be attentive, to allow companionship, to respect cultural practices, improve cleanliness

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The patients' rights were violated in a variety of ways. There were three main dimensions to this issue: (a) care recession including deprivation of the caregiver's presence and the delay/lack of needed responses; (b) receiving mechanical care including superficiality, lack of emotion, and failure to understand the situation; and (c) being disrespected including humility and aggression.	Whilst most of the women were aware of the benefits of midwifery care, it turned out that not all of them used such a service; a number of women managed to look after themselves during labour and childbirth, and stated that they did not need or want midwifery care; most of the older informants stated during the focus-group discussions that it is best to give birth at home, and that giving birth in a health facility is a modern practice they did not feel confident with; some women, regardless of their age, felt confident about coping with childbirth on their own; such cultural attitudes may on the one hand reflect resilience, but on the other hand represent barriers to safe childbirth in the event of unexpected problems and emergencies; some women expressed that they would have opted for the clinic but were not allowed to do so by their husbands or in-laws; according to Islamic tradition Afghan women need permission from and accompaniment by a close male family member – a Mahram – in order to seek professional health care and to go to a health facility, husbands and in-laws did not consent to women giving birth in a clinic	**Similarities of viewpoints between nurses and patients**: Negligence: prolonged wait times for care, which they perceived as unresponsive; nurses as being disrespectful, which caused pain and suffering. Impoliteness: use of a loud, high-pitched voice by Indonesian nurses was considered yelling; both nurses and patients interpreted this as impolite and inappropriate; nurses administered treatments roughly and without regard for the discomfort they might be causing the patient. Dismissal: patients were not provided with information or explanations they required. **Dissimilarities of viewpoints between nurses and patients**: Discrimination: patients perceived they were being treated less than equal to other patients, which threatened their dignity; they worried that being admitted to the hospital and paying with healthcare insurance resulted in a poorer quality of care than for patients able to pay privately. Inattentiveness: perceived by nurses to be disrespectful to patients.	The study participants described disrespect and abuse as serious obstacles to utilization of maternal health services. Women reported experiencing feelings of being infantilized, losing self-control, being overlooked, being informed bad news without proper preparation, repeated examination without being properly communicated/ informed, disallow companions, and left unattended during labor. Facility related issues include women's perception of incompetence of professionals attending delivery, unhygienic facilities, and unavailability of basic supplies.
The patterns are dependent on the context in a qualitative research	Main researcher could not run the interviews herself for security reasons; use of local research assistants with limited experience in qualitative research; women in this study could be more in favor of the program than others; data collectors may have been biased in their choice of respondents; details may have been lost in translation from Dari/Pashto into English; female data collectors had issues with transport, security and limited time frame	Design of the study; did not employ in-depth interviews for data collection; did not quantify the frequency of disrespectful behaviors	Cannot be generalized, did not cite data collection time frame

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Hussein S. A. A. A. et al (2019)	**Hernández-Martínez A et al (2019) (a)**
2	2
2	2
2	2
2	2
1	1
2	1
2	2
1	2
2	2
2	2
18	**18**
Jordan and Australia (2017/2018)	Spain (?)
27	32
27 Jordanian women (Recent Mothers, RM; Experienced Mothers, EM; Australian Jordanian Mothers, AJM) (12 RM, 08 EM, 07 AJM)	32 women

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To improve privacy and dignity	Birth plan compliance, obstetric problems, mother-infant bond, emotional wounds, perinatal experiences
One professional to examine patients during labor and birth; female professionals, especially during vaginal examination; to address women's needs for respect and privacy; not having doors opened directly into the birthing room; using physical barriers when the door is opened; to cover with a simple sheet; shielding women from visitors; limiting the number of attendants present; train professionals to protect and maintain women's privacy	Give explanation and medical reasons why; introduce oneself, look patients in the eyes, explain the procedures; make sure women are properly informed; wait the correct time for medication to take full efect; reiforce breastfeeding over artificial feeding; pregnancy and breastfeeding support groups; focus on giving more information on the processes; focus on training women, their partners and close family; obtain consent, be attentive and supportive

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Seeking a birth in a private hospital in Jordan was one of the strategies that women used to gain privacy, although this was not always achieved; women were surprised and distressed that in public hospitals, and at times in private hospitals in Jordan, they were expected to share a room with other women during labour and birth; privacy was afforded when birthing at home; women felt exposed, and embarrassed and complained of not being covered with a sheet; participants were distressed by, and critical of, the number of doctors that came in and out of their rooms, the most distressing part of having to deal with many different health professionals was during vaginal examinations, participants discussed their preference for having a female health professional care for them during labour, and birth, and in particular to perform vaginal examinations.	Data analysis revealed five major themes—“Birth Plan Compliance”, “Obstetric Problems”, “Mother-Infant Bond”, “Emotional Wounds” and “Perinatal Experiences”—and 13 subthemes. The majority of responses mentioned feelings of being un/misinformed by healthcare personnel, being disrespected and objectified, lack of support, and various problems during childbirth and postpartum. Fear, loneliness, traumatic stress, and depression were recurrent themes in participants’ responses. As the actions of healthcare personnel can substantially impact a birth experience, the study findings strongly suggest the need for proper policies, procedures, training, and support to minimise negative consequences of childbirth.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Study conducted in Irbid (Jordan) and Sydney (Australia) and at the same place, which can not be representative of other women in Jordan; small sample (only 27 Jordanian women); participants self-select, other women may have different stories to tell; participants may not have felt comfortable enough to discuss everything they have experienced or thought	Cannot pinpoint a specific geographic area for future policy recommendations; not generalisable;
Fleury S. et al (2013) (a)	**Robins C. S. et al (2005)**
2	2
2	2
2	2
1	1
1	1
1	1
2	1
1	2
1	1
1	1
14	**14**
Brazil (?)	USA (2002-2004)
285	27

For peer review only

190 users and/or their companions, 90 professionals directly involved in providing health care and 5 hospital administrators	27 psychiatric patients (11 female, 16 male)
Denial, submission, naturalization, individual resistance, collective resistance	Threat of physical violence and arbitrary nature of the rules; not knowing the consumers as individuals, perceived lack of fairness, experiencing disrespect or embarrassement
Not to naturalize the disrespectful and oppressive treatment; not to discriminate; to educate patients to identify discrimination and mistreatment; to resort the mechaminsm of denouncement	Efforts to reduce the incidence of traumatic and harmful events in psychiatric settings; revise hiring practices; improve staff training; changes to policies and procedures

Professionals that have less contact with patients tend to be given an even more favorable position; it was not possible to prove the hypothesis that a higher position increases the chances of discriminatory behavior; concerning the institutional culture and management, there is a trivialization of the injustices and rationalization of the inadequate conditions and precariousness present in the public healthcare services; the lack of effective channels for filing grievances and punishing mistreatment and discrimination is made worse by a predominant attitude that perceives any complaint as disrespectful on the part of patients; the absence of clear rules, procedures and norms related to the referral of patients and the selection of those that will be assisted increases the discretionary power of professionals that are not trained for these tasks; the structural aspect of inequality showed the precariousness of the public healthcare services, thus generating a pilgrimage in users to different health units in search of care; the existence of stigmatizing characteristics increases the likelihood of the user being discriminated against	Eighteen of 27 interviewees described harmful incidents that they had witnessed or experienced directly, many of which evoked strong emotional responses by consumers during their narration. Nearly all incidents described were hospital based and were clustered around two sets of themes. The first set related to the hospital setting, including the fear of physical violence and the arbitrary nature of the rules. The second set related to the narrators' interactions with clinical staff, including depersonalization, lack of fairness, and disrespect.
Cannot be generalized, limited geographic area, did not cite data collection time frame	Did not interview staff

For peer review only

Hrisos S (2013)	Adolfsson A. et al (2012)
2	2
2	2
1	2
2	2
2	2
2	1
2	1
1	1
2	2
2	2
18	**17**
England (2010)	Sweden (2007)
59	14
16 patients (10 female, 6 male) and 4 relatives (2 female, 2 male), 39 healthcare staff (9 pharmacists, 11 doctors, 12 nurses and 7 health care assistants)	14 inpatients, Two lowest priority groups in the Emergency Department who eventually wait for the longest period of time to receive treatment (at Skaraborg area, a district in the Västra Götaland area)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Perceived advantages of patient involvement in improving their own safety; Concerns about involving patients in improving their own safety; Risk of damage to the patient-provider relationship; Staff may treat the patient “differently”; Behavioural implications of service-user fears; Behavioural implications of healthcare professional fears	To manage patients' feelings of being dependent on care, exposed, vulnerable, and secure; create conditions that enhance well being
To address patients concerns about their safety; to involve patients in the decision-making process; to improve staff communication skills; to train professionalism in patient-provider relationship; to engage patients proactively in aspects of their care and work issues that they perceive that might impact negatively their care; not to avoid patient-provider prolonged contact; to stimulate patients to share their concerns	To listen to patients' history and to ask question about it, to be available/attentive (diminishes helplesness and insecurity); to manage basic needs (food, water, pain relief) (diminishes feelings of not being treated respectfully and that their symptoms were not taken seriously); to give clear information about risk classification (diminishes patients' discomfort and mental suffering); to show understanding and compassion (makes patients feel secure), effective communication

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Patients were generally positive towards the notion of patient involvement in improving their safety and identified potential advantages; to be able to ask questions or have their concerns addressed, since this provided them with reassurance and a better understanding of what was happening to them and what to expect; perceived advantages expressed by staff were improved adherence to treatment and greater patient satisfaction with care, achieved through better understanding; pushing improvement through patient-mediated intervention, pointing out potential errors or oversights in care provision was felt to be "questioning" or challenging the professionalism of healthcare staff; other actions perceived by patients and relatives as "challenging" or as "criticising" included overtly or explicitly checking that the correct medicines had been administered during drug rounds and asking about alternative treatment options to those recommended by their doctor; patients may experience a loss of trust in the competency or integrity of their care providers, if they feel that they "have to" ask or tell them about potential lapses in their care, because they are not doing the job properly; healthcare providers were expected to always remain "professional" in their dealings with patients and their families, regardless of the situation, and there appeared to be a general consensus amongst both patients and healthcare professionals that most would; being rebuffed or chastised was a very real fear for many patients, and a key barrier to them speaking up; the perceived consequences of upsetting staff, and disrupting relationships, were so powerful that they admitted not sharing potentially serious queries or concerns even with their relatives, who they knew would immediately raise them with staff; staff suggested that they and their colleagues could become guarded in their interactions with certain patients and their relatives, therefore distancing themselves from being the potential target of a complaint.	To allow patients to express their symptoms and feelings freely, they had a sense that they were being acknowledged and taken seriously; to know what the nurses were documenting in their files, when patients are assigned a low priority in the emergency department (ED); to give them adequate attention; to help patients not to feel helpless and overlooked; to give adequate attention; to explain levels of priority in the ED so that patients do not feel insecure; to be available, attentive, and responding appropriately to the patient's needs; to provide adequate food, drink and pain relief; to show understanding and compassion for the patient's situation.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Not generalisable beyond the sample studied; small sample, limited geographic area	
Merakou K. et al (2001)	**Howard M. et al (2013)**
2	2
2	1
2	1
2	2
1	1
1	1
0	2
1	1
2	1
1	1
14	**13**
Greece (1996)	Australia (1997-2007)
600	16

For peer review

600 patients (49,8% men; 50.2% women)	16 patients
Knowledge of the law on patient's rights; the right to information; the right to decision making; the right to confidentiality; the right to object, mechanism of protection of patients' rights	Ineffective communication; Standard of care is not acceptable; Treated with disrespect; Ineffective complaints handling systems; Perceptions of negligence
To inform patients during the course of their admission; to train healthcare professionals on patients' rights; to provide full information about diagnostic; to improve communication with patients and families; to take the time to attend; to obtain consent; to involve patients in decision-making process; to respect privacy and confidentiality; to establish a complaints management system	Complaint management needs to be redressed; the paradigm shift must go beyond regurgitating complaint data metrics in percentages per patient contact, toward a concerted effort to evaluate what the complaint data are really saying; the voices of the taciturn dissatisfied patients need to be encouraged so that their complaints are heard at the time they are experiencing dissatisfaction; to use this opportunity to identify a more positive and proactive approach in encouraging patients to complain when they are dissatisfied; to influence real-time improvements and patient safety

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Patients most inclined to complain were male, young people, urban residents, people with a low income, and those experiencing a short hospital stay; 94.2% answered they do not claim for their rights, 71.6% replied they did not claim because they were satisfied with hospitalization, 9.7% were afraid of doctors reactions, 9.2% believed that the outcome would not be in their favor, 5.5% reported they were not aware of their rights; 44.4% answered that the patients' rights would be better respected if a committee or an expert were available at the hospital setting, and other mechanisms woud be staff education in medical ethics (22.4%), giving patients information about their rights as soon as they were hospitalized 21.4%), introduction of new legislation (5.3%)	15 of the 16 participants did not voice their complaint at the time of the event, when they experienced dissatisfaction with service delivery; the most significant theme that emerged from the narratives was the issue of the participants feeling that they were not being listened to nor supported to voice their concerns or complaints; patients articulated the need for health-care system reform; they primarily wanted to be listened to, to be acknowledged, to be believed, for people to take ownership if they had made a mistake, for mistakes not to occur again, and to receive an apology
Small sample, limited geographic area	The sample size was limited in terms of location and the fact that there was no culturally and linguistically diverse (CALD) or indigenous representation; limited geographic area

For peer review only

Faschingbauer KM et al (2013) (a)	Evan E. E. et al (2007) (a)	Kanengoni B. et al (2019) (a)
2	2	2
2	2	2
2	2	1
1	2	2
1	1	1
1	1	1
2	2	2
2	2	2
2	1	2
2	2	2
17	**17**	**17**
USA (?)	USA (?)	Zimbabwe (?)
12	40	20
06 men, 06 women	20 pairs of parent and children	20 pregnant and postpartum

Individual it
0 = not or inadequately addressed or applied
Tot
Qualitativ
Cross-sectio
Cohort
Quali-quanti convergent pa method

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1) Patientt hope for respect and open communication; 2) Patient emotional response to the seclusion process; 3) Patient insight into behavior and the importance of positive coping skills	Relationship building, demonstration of effort and competence, information exchange, availability, and appropriate level of child and parent involvement	Abandonment of care and neglect; non-consented care, lack of information;
To discuss the patients' behavior, to give a chance to calm down before seclusion, to look for alternatives to seclusion, to ask patient to do something instead of telling him what to do, not to ignore the patient during seclusion, to explain the reason for seclusion, to treat patient as an individual, to improve staff communication skills, to know patients' prior history and behavior patterns; 2) To offer fluids and food during seclusion, to manage environment (temperature, cleanliness, noise), not to use seclusion as a punishment, no to mock/laugh at/talk about patients in a negative way, not to disrespect, mistreat or hurt patients, to be attentive to patients' needs; 3) to talk about the reasosn for seclusion, to give patient time to talk, to allow patients to obtain social support from peers, behavior management classes, to debrief after seclusion	To improve communication skills with children and their parents; to be attentive; to be availlable; to provide clear explanations; to consider the level of involvement of children and parents	To be attentive, to reduce wating times, to provide adequate health information

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To provide open communication about patients' individual needs, talking about their feelings and individual problem before his or her behavior escalated and could not be controlled; to discuss their inappropriate behavior; to give a chance to calm down before seclusion; to ask patients to do something instead of telling them what to do; to offer as-needed medications earlier to control behaviors; to know specific medical and psychiatric background and history in order to understanding their personal needs and idiosyncrasies; to check on them while in the seclusion room, to pay attention to unmet patients' needs (to offer fluids, blankets, bathroom, cleanliness etc); not to mock them or laugh at; not to use seclusion as a form of punishment; to talk over the incident leading to seclusion after the episode; to give them time to talk; to provide family and social support.	To take the time to get to know the patients as individuals and develop a friendship with the patients; to be respectful; to inquire about personal or social concerns in addition to treating physical symptoms; to believe the children's words; to provide relational continuity; to help build trust; to demonstrate the best efforts and exhibit competence and knowledge about the child's care; to talk in an understandable, straightforward manner, give clear explanations, and provide complete information	Multifaceted and interconnected factors contribute to midwives' attitudes and behaviours towards their clients. Midwives' subjective perceptions, women's social status, and health system constraints (i.e., availability of trained midwives and quality of midwifery training) in rural and poorly resourced community, often result in inappropriate services, negative attitudes, abusive treatment, and disrespectful behaviour towards women. Poor treatment in maternity care directly contribute to adverse health outcomes and women's satisfaction with services.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Limited to one hospital, can not be transfered to other hospitals, unit cultures and different psychiatric units, difficulty of inpatient psychiatric patients to express theirs feelings and thoughts	Exclusion of non-English speakers, because families that have a language barrier may have different needs when it comes to communicating with their physician; modest sample size, limiting generalizability; limited geographical, ethnic, and religious variation in the patient population; self-selection bias may also have been a factor because those subjects who chose to participate may be more open to communicating with unfamiliar people than those who refused to be contacted; recruitment of patients through health care providers who may have differing opinions on whether a patient fits the prognosis criteria, especially given the difficulty in predicting length of life for many of the childhood diseases that result in premature death	Limitations noted include complexities in accessing participants, lack of privacy, silencing or limiting some participants replies and lack of re- peat interviews due to hard to reach sample populations.
Wofford M et al (2004)	**Beach M. C. et al (2017) (a)**	
2	1	
1	1	
1	1	
1	1	
2	1	
0	0	
1	1	
1	1	
0	1	
1	1	
10	**9**	
USA (1999-2000)	USA (?)	
222	156-260	

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

222 complaints (from patients [111], patient's wife [27], husband [6], child [52], parents [50], other relative of friends [15] or a health care professional)	26 focus groups of men and women, 6-10 patients each group (African americans, latinoes, whites)
Perceived unavailability, Disrespect, Inadequate information, Disagreement about expectations of care, Distrust, Interdisciplinary miscommunication, Misinformation	1) Definitions of respect; 2) Specific behaviors that convey respect or dignity
To use patients complaints to improve physicians' communication skills, to avoid disrespectful behavior, to make communication a high priority, to improve interdisciplinary communication	To treat like a person, to treat like an equal, to hear what patient has to say, to respect the patient's knowledge of him/herself, to ask questions about the condition (demonstration of concern), to give honest explanations of medical issues, to avoid stereotyping, to allow patient input into treatment choices, to handle lateness

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Complaints were most commonly lodged by a patient (111), followed by a patient's spouse (33), child (52), parent (50), relative/friend (15), or health care professional (2). The most commonly identified category was disrespect (36%), followed by disagreement about expectations of care (23%), inadequate information (20%), distrust (18%), perceived unavailability (15%), interdisciplinary miscommunication (4%), and misinfor- mation (4%). Multiple categories were identified in 42 (19%) complaints. Examples from each category provide adequate detail to develop instructional modules.	Autonomy: clearly expressed by participants in the themes of wanting honest and clear explanations, and in wanting input into treatment plans. Dignity: treating people equally; asking questions about medical conditions, might be interpreted as a sense of caring or investment in the value of the patient as person through concern about medical issues. Integrity: to listen to the patient's narrative, knowing the patient as a unique person, and the avoidance of stereotyping. Trusting patients' self-knowledge: is of particular interest because of its prominence among African American participants, and because it perhaps pushes the conceptualization of respect into new territory. Vulnerability: respect for vulnerability was not explicitly mentioned by any participants. Yet vulnerability emerges as present when viewing the corpus of participant comments as a whole in particular, vulnerability to mistreatment.
Not generalizable, because many patients leave silently and do not register complaints	Imprecise number of participants, time frame of data collection is missing

For peer review only

CRITICAL APPRAISAL SCORES			
tem score (color and value)		(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)	
1 = adequately addressed or applied	2 = well addressed or applied		
al Score Appraisal by study design, color and value			
	Low quality	**Moderate quality**	**High quality**
ve studies	0-7	8-14	15-20
onal studies	0-9	10-17	18-24
t study	0-9	10-17	18-24
titative and arallel mixed- studies	0-4	5-9	10-14

For peer review only

	Gebremichael MW et al (2018)
Design	2
Question	2
Setting/location	2
Selection	2
Characteristcs	2
Exposure & outcomes	2
Study size	2
Statistics	2
Eligibility	2
Results	2
Conflict of interest	2
LImitations	2
Total	**24**
Country (year of research and data collection)	Ethiopia (2015)
Sample size	1.125
Type of samples	1,125 women post-delivery

For peer review only

or Review Evidence (SURE) - Questions to assist with the critical appraisal of cross-sectional studies

STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To increase respect and reduce abuse
INTERVENTIONS TO ACHIEVE IMPROVEMENTS	To avoid shouting, scolding, ignoring, to offer adequate information, to obtain consent, to avoid breaching in confidentiality and privacy, to avoid leaving women unattended, to allow women to participate in decision-making

For peer review only

Specialist Unit fo		
	RESULTS	**More D and A**: Disrespect and abuse (D and A) during delivery services was reported more among: women residing in urban compared with rural areas and women educated to grade 9 or above; women in the age groups 20–34, and 35 or above, compared to those below the age of 20 years, women who were heads of households reported more incidents of D and A compared with women living in a household headed by a male; women who spent longer hours in labour in health facilities, compared with women who spent less than 1 hour in labour; women who were not permitted to have support persons/relatives in the delivery room also reported a significantly higher rate of D and A during labour and delivery compared with those women who were allowed to have support persons. **Less D and A**: Women who had 3–5 births experienced fewer incidents of D and A than women with more than 5 births.
	LIMITATIONS	Recall period of one year after delivery can be too long to remember details; there may be sampling bias due to focus on a single encounter in the previous year; excluded stilbirths, neonatal and infant deaths; underreporting by rural women due to their lack of awareness of their rights; did not include economic status in the analysis; information about facilites were not included

onal studies		Montesinos-Segura R et al (2017)
	Design	2
	Question	2
	Setting/location	2
	Selection	2
	Characteristcs	2
	Exposure & outcomes	2
	Study size	2
	Statistics	2
	Eligibility	1
	Results	1
	Conflict of interest	2
	LImitations	2
	Total	**22**
	Country (year of research and data collection)	Peru (2016)
	Sample size	1.528
	Type of samples	1,528 women who delivered in 14 regional hospitals located in nine urban Peruvian cities
	STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	Interventions to reduce the prevalence of disrespect and abuse should be promptly implemented, with different approaches in each region

For peer review only

e (SURE) - Questions to assist with the critical appraisal of cross-secti

INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Face-to-face and virtual training might be used to enhance the capability of healthcare workers, and the importance of education to empower women should be emphasized; human resource centers for women to make complaints of disrespect and abuse safely and comfortably might be implemented; to measure the prevalence of disrespect and abuse at various time intervals; approaches specific to each setting are required; these problems should not be uniformly addressed throughout the country, and that each hospital and geographic region should prioritize interventions according to their particular context; to promote participation of a companion chosen by the pregnant woman throughout their labor

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Specialist Unit for Review Evidenc		
	RESULTS	1488 women experienced abuse; the most prevalent form of disrespect and abuse was non-dignified care, followed by non-consented care, and non-confidential care; the number of women who experienced two or more categories of disrespect and abuse concurrently was 1358, whereas that of women who experienced four or more categories concurrently was 850; women who delivered by cesarean had a higher prevalence of abandonment of care and a lower prevalence of physical abuse as compared with women who delivered vaginally; women referred from other health facilities had a lower prevalence of abandonment of care, non-consented care, discrimination, and non-confidential care as compared with women who were not referred; abandonment of care was significantly more common in the coastal region than in the jungle, whereas discrimination was significantly more common in the jungle than at the coast
	LIMITATIONS	The aim was to generate a validated survey of disrespect and abuse suitable for all Peruvian hospitals; however, each geographic region has its own unique cultural features and traditions; it is possible that some of the items listed in the survey were not part of the disrespect and abuse construct in some contexts; the length of the survey was a limiting factor; the participants might have felt intimidated by the hospital environment, which in turn might have influenced their responses; only women who had delivered in the past 48 hours were surveyed; this population of women could have been affected by immediate distressing factors related to labor, which might have influenced their answers

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Vedam S et al (2019)
2
2
2
2
2
2
2
2
2
2
2
2
24
USA (2010-2016)
2.138
2138 women who experienced at least one pregancy in the US, including those currently pregnant

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, health system conditions and constraints
Development of several new patient-designed indicators of mistreatment in maternity care; to prevent mistreatment, health care providers need to first consider how they can meet women's socio-cultural, emotional and psychological needs; building collaborations to address factors that maintain racial and ethnic disparities; creating a culture of equity and individualized care and routine training around issues of structural racism and intersectionality of multiple drivers of disadvantage; moving to the development of multidisciplinary teams; addressing issues of access to high quality care across communities and settings for care; equitable application of evidence-based interventions that are responsive to patient reported outcomes and priorities; training for care providers in promoting respectful care including values clarification and attitude transformation (VCAT), training on VCAT based on providers' and clients' rights and obligations, and revision of professional ethics and practices; strengthening facility quality improvement systems for monitoring, reporting, addressing, and resolving disrespect and abuse cases; Mentorship and on-the-job role-modeling by identified champions within the facility as part of routine continuous professional education; civic education about patient rights and avenues for redress may be needed to ensure accountability even in high resource countries

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1 in 6 women experienced more than one type of mistreatment (being shouted at; ignored by healthcare providers/refusing request for help/failing to respond request; violation of physical privacy; healthcare providers threatening to withhold treatment or forcing them to accept treatment they did not want; physical abuse [aggressive physical contact, inappropriate sexual conduct, refusal to provide anesthesia for an episiotomy, etc.]; any mistreatment [one or more above]. Indigenous, Hispanic, Black, White, White women with White partners, White women with Black partner experienced one type of mistreatment; Bi-racial couples experienced less mistreatment when women were White; White women with Black partners were twice likely to report mistreatment than White women with White partners; women who were born in the US reported similar rates of mistreatment compared to women who were not born in the US; recent immigrants were more likely to report mistreatment; younger women were more likely to report physical abuse; first-time mothers were twice as likely to report mistreatment; women who reported low socioeconomic status (SES) were twice as likely to report mistreatment compared to women with moderate or high SES; 1 in 3 women with pregnancy complications or with social risk (substance use, incarceration, domestic violence) reported mistreatment (shouted at, scolded, violation of physical privacy); mistreatment was higher in hospital than in other settings

The sample is voluntary and not population-based; oversampling of communities that are often underrepresented in national studies on experience of care; women were more educated, older, and more likely to have been born in the US; samples of women from Hispanic, Asian, and other communities of color were lower than the national reported rates; lower representation from women who had more routine or simply “satisfactory” experiences that might not be characterized as either particularly empowering nor traumatizing; sample might have a ‘higher’ socioeconomic status population than is representative of the US childbearing population which would decrease rates of reported mistreatment, and potentially underestimate mistreatment in the US population at large; the study's national sample is not representative of the lived experience of many subgroups including undocumented immigrants, incarcerated pregnant parents, and families located in rural settings with limited options for maternity care; each person will have their own sense of bodily/self autonomy and human rights, placed within the cultural context of each environment

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Lurie N et al (2004)
2
2
2
2
2
2
2
1
2
1
2
2
22
USA (2001)
6.722
6,722 adults, age >18yr, living in the US, who speak English, Spanish, Mandarin, Cantonese, Vietnamese, or Korean
Random phone interview

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To avoid negative perceptions of minority groups (low-income, low educational level, different races); to focus on approaches that can best improve the perceptions of respect

For peer review only

Over 14% of blacks, 19% of Hispanics, and 20% of Asians reported they have been treated with disrespect by their doctor. Men (15.9%) were more likely than women (11.6%) to perceive being treated with disrespect by their doctor. Asian (24%) and Hispanic (23%) men were more likely than black (17%) and white (11%) men to perceive being treated with disrespect. 18% of persons without a college education believed they have been treated with disrespect versus only 10% of those with college education. 29% of Asians, 22% of Hispanics, and 19% of blacks without a college education reported being treated with disrespect or being looked down upon, versus 13% of whites; 32.3% of those who felt being treated with disrespect or being looked down upon did not follow doctors advice, and 31.1% put off needed care. Among those who felt treated unfairly because of race, 46.5% did not follow doctors advice, and 40.8% put off needed care. Among those who felt treated unfairly because of their language, 37.5% put off needed care. Among those who felt they would have been treated better had they been of a different race, 33.8% did not follow doctors' advice or put off care.
Relying on self-report, may not be accurate; could not disentangle how general life experiences influcence perceptions; could not examine ohter minorities; had insufficient number of native americans to analyse separately; lack of agreement on the definition of age-appropriate cancer screening

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Dynes MM et al (2018)
2
2
2
2
2
1
2
2
2
2
2
2
23
Tanzania (2016)
1.184
249 providers, 935 post-delivery clients

For peer review only

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Friendliness, comfort, and attention; information and consent; non-abuse and kindness
Not to treat patients of different ages differently, not to discriminate, to avoid ageism; to respect confidentiality; to manage complications in labor and delivery; to allow companionship; to give information clearly; to give friendly, comforting and attentive care; to be patient; to provide mentoring for providers; strategies to reduce workplace stress, training on respectful maternity care,

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Receipt of respectful maternity care dimension 1 (RMC-D1) (friendliness, comfort, and attention): clients aged 30-39 and 40-49 years had signifcantly higher RMC-D1 scores than clients aged 15-19 years. Clients who experienced delivery complications had significantly lower RMC-D1 scores compared to those who did not report complications. Clients of providers who perceived they were paid fairly for ther job duties had signifcantly higher RMC-D1 scores compared with clients of providers who felt they were not paid fairly. Clients of nurses/midwives had significantly lower RMC-D1 scores compared to clients of clinicians. Clients of providers who reported attending 11-20 deliveries in the last month had signifcantly lower RMC-D1 scores compared to clients of providers who attended 1-10 deliveries. **Receipt of respectful maternity care dimension 2 (RMC-D2) (information and consent)**: clients who had a birth companion had signifcantly higher scores compared to clients who did not have a companion in labor. Clients who reported attending to religious services at least weekly had signifcantly lower RMC-D2 scores compared to those who reported less than weekly attendance. Clients of providers who perceived they were paid fairly for their job duties had significantly higher RMC-D2 scores compared to clients of providers who perceived they are not paid fairly. Clients of providers who reported working more hours per week had significantly higher scores compared to clients of providers who work fewer hours. Clients of providers aged 30-39 and 40-49 years had significantly lower RMC-D2 scores compared to clients of providers aged 20-29 years. **Receipt of respectful maternal care dimension 3 (RMC-D3) (non-abuse and kindness)**: clients of providers who were aged 50 years or more had signifcantly higher RMC-D3 scores compared to clients of providers in the 20-29 year age group. Clients of providers who reported access to two types of electronic mentoring had significantly higher RMC-D3 scores compared to clients of providers with no access to mentoring opportunities.
No differenciation in degree of disrespect; no random sampling, cannot make causal inferences and generalize findings; limited ability to identify all risk factors

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

McMahon SA (2014)
1
2
2
2
2
2
2
2
2
1
2
2
22
Tanzania (2011)
112
49 women, 27 male partners, 20 community health workers, 5 community leaders, 11 religious leaders
Feeling ignored or neglected, monetary demands or discriminatory treatment, verbal abuse, physical abuse

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Patients may be made aware of women's rights; include providers in participatory trainings; trainings must be supported by health system; improve the working environment (general infrastructure, human resource shortages, deficiencies in supervision and skills training); inclusion of family members during labour and childbirth

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Women recounted events or circumstances that are described as abusive in maternal health literature: feeling ignored or neglected; monetary demands or discriminatory treatment; verbal abuse; and in rare instances physical abuse. As a response to abuse, women described acquiescence or non-confrontational strategies: resigning oneself to abuse, returning home, or bypassing certain facilities or providers. Male respondents described more assertive approaches: requesting better care, paying a bribe, lodging a complaint and in one case assaulting a provider.
Rely on reports, not on direct observation; abuse was not evenly probed in each interview; captured insights of women who delivered several months earlier and may have a recall bias; did not reach data saturation; did not interview providers; did not identify and interview escorts

For peer review only

Kujawski S et al (2015)
2
2
2
2
2
2
1
2
2
2
2
2
23
Tanzania (2011-2012)
1.388
1,388 postpartum

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Satisfaction with delivery, perceived quality of care for delivery, intention to delivery to the same facility for the next birth
Providers empathy; reduce Caesarian sections and financial burden on women and their families; provide information and education; privacy to complain

For peer review only

Women who reported any disrespectful and abusive treatment during childbirth were less likely to be very satisfied with delivery, were less likely to rate the quality of care for delivery as excellent or very good, and were also less likely to plan to deliver at the same facility with their next child. Women were less likely to be very satisfied with their delivery if they had at least a secondary education, had a Ceaesarean section, and reported extreme pain during labor and delivery. The oldest participants, aged 35-48, were also less likely to be very satisfied with their delivery, compared to the youngest group, aged 15-19. Those who rated their health as very good or good were more likely to rate satisfaction and quality of care positively and were more likely to intend to deliver at the same facility in the future. Women who were married and for whom this delivery was their first birth were less likely to intend to deliver their next child at the same facility.
Lack of a gold standard to measure disrespect and abuse; did not include some aspects of health system; unable to discern causality

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Marin CR et al (2018)
2
2
2
2
2
2
2
1
1
1
2
2
21
Brazil (2015)
300
300 patients from a university hospital
Touching the patient's possessions without permission, changing the bed side table to a position that cannot be reached, and raising or lowering the window blinds without consulting the patient; Performing a technical procedure in an intimate area and changing the patient's clothes without a screen; Embarrassment due to exposure of the body, lack of intimacy and disrespectful behavior by nursing professionals

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To be more attentive to the patient's space and respect the territoriality established by them, often with their personal objects and possessions. Small actions, such as changing the place of the cell phone or slippers, can symbolize the removal of territory and generate strong feelings of discomfort; nudity in front of strangers can be deeply iatrogenic. Within this context, the age, gender and culture of the affected subjects can directly affect the communication dynamics; The patients reported that requesting permission to manipulate their body, to examine them or to perform other care/procedure shows consideration and attention on the part of the professional, which makes the patient feel valued and in control of the situation. This approach may minimize the effects of the invasion and the feeling of being seen as an object; The respect of territory and personal space represents an ethical and respectful approach to patients, which can permit to maintain their dignity even under vulnerable conditions, favouring their recovery; Healthcare should respect the individuality and dignity of the patient, not only including changes in the physical space, but also in the actions and behavior of healthcare providers regarding patient privacy.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The perception of invasion of territorial space was greater than that of personal space; the participants reported that touching their personal possessions without permission, changing the bedside table to a position that cannot be reached, and raising or lowering the window blinds without consulting the patient were attitudes of the nursing staff that annoyed them and caused a feeling of invasion; embarrassing attitudes occur when the nursing staff conduct a technical procedure in an intimate area or change the patient's clothes without a screen; patients who had no children and those living with only one people in the residence perceived greater invasion of their territorial space; patients who shared the room or were hospitalized in the maternity ward felt less personal space invasion
Non-random selection of the participants, the fact that it was performed in only one public hospital in Brazil, which serves predominantly the maternal and child public and, consequently, the significant number of female participants, unbalancing the sample with respect to gender. The cross-sectional nature of our study can only provide associations, the study evaluated only self-reported perceptions of patients and not actual practice by healthcare staff and the sample is not representative of other settings in the country.

For peer review only

Burrowes S et al (2017)
2
2
2
2
2
2
2
1
2
2
2
2
23
Ethiopia (2015)
45
45 (23 women who gave birth attended by a midwife, 3 women who had given birth at home, 15 3rd-year bachelor's degree midwifery students, and 4 practicing midwives)

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Increase midwifery training in patient's rights and autonomy
To strengthen professional ethics, communication skills, patients' rights, patient's choice, and patients' autonomy training; to explore ways to structure birh experiences in order to empower women; women-centered care

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The quality of care offered at the facility seemed to be a factor in women's choice of home rather than facility birth; patients and providers first, and most frequently, mentioned verbal abuse; patients mention denial of preferred birth position, while providers report verbal abuse as the leading type of violation. Patients reported that providers often shouted at them or at other patients, mocked them, or spoke to them in harsh tones; the most common type of physical abuse witnessed was slapping patients on the legs in order to get them to comply with midwives' instructions for vaginal exams or for positioning for labor; patients were allowed to drink liquids during labor, but food was frequently denied; most patients were not allowed to give birth in their desired position, and a large minority were not permitted to have family members or friends accompany them during delivery; midwives and midwifery students mentioned observing practices such as stitching episiotomies without anesthesia, performing procedures without informing the patient, and denial of follow-up care to patients who had previously refused services; patients complained frequently about the lack of privacy on the wards due to the lack of screens or curtains and also due to the large number of students who observe deliveries as part of their training
Small sample; limited to a single geographic region; based on interview and not to direct observation

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Rodriguez ACI et al (2020)
1
2
2
2
2
2
2
2
2
2
2
0
21
USA (2017)
501
143 pregnant; 358 postpartum
Negative attitudes and unkind or disrespectful treatment; comments about weight; intense focus on high-risk status and potential negative outcomes based on woman's weight; inapropriate comments

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Individualize approach to each woman's weight; take in mind the potential negative consequences of stigmatizing mothers for weight; compassionate care, free from stigma; stimulate breastfeeding, reduce negative expectations about breastfeeding; investigate postpartum depression symptoms

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Participants who reported having changed their provider had a significantly higher pre-pregnancy BMI (M = 42.79 ± 10.89) than those who did not (M = 32.92 ± 10.91), $F (1, 478) = 28.02$, $p < 0.001$. There was a significant difference in pre-pregnancy BMI among women who reported that too little (M = 31.29 ± 9.19), the right amount (M = 32.97 ± 11.07), and too much (M = 40.69 ± 11.58) attention was paid to their weight, $F (2, 478) = 13.73$, $p < .001$. Post-hoc analyses revealed those reporting too much attention had a significantly higher pre-pregnancy BMI than others. Those reporting that they could not trust their provider because of weight-related treatment also had significantly higher pre-pregnancy BMIs (M = 40.67 ± 10.64) than those who did not (M = 32.78 ± 10.97), $F (1, 479) = 24.95$, $p < 0.001$. Pregnant participants who expected that they would feel uncomfortable seeking help with breastfeeding had a marginally significantly higher pre-pregnancy BMI (M = 40.28 ± 11.84) than those who did not (M = 34.20 ± 12.46), $F (1, 128) = 3.73$, $p < 0.056$. For postpartum participants, those who had felt uncomfortable seeking help with breastfeeding had significantly higher pre-pregnancy BMIs (M = 36.01 ± 11.76) than those who had not (M=32.28±10.20), $F (1, 282)= 6.68$, $p = 0.010$.
Sample was primarily white of higher socioeconomic status, large proportion from California, did not investigate other samples (low-income and racial/ethnic minority mothers), cannot be generalized

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Öztürk H et al (2020)
2
2
2
2
2
2
2
2
2
2
2
1
23
Turkey (2019)
707
357 patients, 350 nurses

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Application of Patient Privacy Scale (PPS)
To bring the discussion of patient privacy into light

For peer review only

Nurses and the patients in the public hospitals had statistically significantly higher overall privacy scores than those in the training and research hospitals. The overall privacy scale scores were higher and more statistically significant in the patients hospitalized in surgical clinics than those hospitalized in clinics for internal diseases and in single compared to married patients.
The current study was limited only to the opinions of nurses working in public hospitals in a city in Turkey and patients receiving inpatient treatment in these hospitals

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Ring D et al (2017)
0
2
1
2
2
2
2
2
2
2
0
2
19
USA (1997-2013)
1.118
1,118 patients complaints
Access and availability, humaneness and disrespect, communication, expectations of care and treatment, distrust and billing

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Improve patients' experiences (optimal communication strategies and costumer service), increase availability by phone or e-mail of the staff, improve communication strategies and empathy, to listen to, to respect, to make patients feel appreciated for who they are,

For peer review only

Women reported more complaints in access and availability, humaneness and disrespect, and billing; patients aged 40 to 60 years were more likely to file a complaint in all categories except distrust (most common in patients over age 80) and research; most complaints concerned the surgeon (58%) or the administrative assistant (32%). Over half of all complaints were related to interpersonal issues [humaneness/ disrespect (20%), expectation of care and treatment (20%), communication (14%) and distrust (3.6%)]; the most common type of complaint per year from 1997 to 2012 was access and availability except during 2004 when it was humaneness/disrespect. In the access and availability category, accessibility via telephone and e-mail (34%), wait time (24%), and physical absence of clinician/cancellation of appointment (18%) were the three most common sources of complaint. Regarding the category of humaneness/ disrespect, the most common description was unprofessional (38%), then rudeness (34%), and condescending (15%). 76% of communication category complaints were attributed to miscommunication between the patient and surgeon, while care and treatment complaints involved disputes about treatment, followed by diagnostic issues, and referrals. Many treatment-related complaints addressed medication (most often opioids) and dissatisfaction with the outcome of surgery.
Limited to one hospital; underreporting of complaints, variability of complaints may be due to variability in ombusperson, patient may have the ideia that complaint would not be addressed, differences in reporting by age may be due to more treating patients that ages, complaints addressed only in major negative experiences

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Larijani B et al (2018)
2
2
2
2
2
2
2
2
2
2
2
0
22
Iran (2010)
200
200 patients from two hospitals in Tehran

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Two-part questionnaire administered by two interviewers
Train and observe confidentiality and privacy issues, to promote the observance of patients' rights; both healthcare providers and recipients be informed about these issues; education may be provided upon admission or at any other appropriate time via provision of oral explanation as well as written media such as pamphlets, brochures, booklets, etc.; Health policy makers should develop and implement a plan for raising patients' awareness of privacy and confidentiality to improve physician-patient relationships;

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

153 patients provided a correct definition of privacy, and 161 patients were aware of instances of privacy violation; 77 patients had good awareness of physician confidentiality, 46 patients believed that physicians could disclose patients' information to reduce or eliminate a significant risk of serious harm to others, 47 patients did not think it was necessary for physicians to obtain patients' consent before consulting with their families, 105 patients did not believe that physicians needed patients' permission to consult with their colleagues or other members of the medical team in cases of multidisciplinary diagnosis and treatment, 28 patients were aware that disclosing patient's information is unethical, against religion, and illegal, 113 patients had previously known that medical information pertaining to mentally retarded patients should be recounted to their parents or guardians, 39 patients did not consider the results of medical examinations and tests as confidential in cases where patient security, employment, insurance issues and legal competency were concerned, and 47 patients were not aware that in research studies it is essential not to disclose patients' identity, 158 patients had good awareness of the confidentiality of examination results and medical consultations; 15 patients were not aware that in case of patients' decision to commit suicide or homicide, physicians must inform the relevant authorities; whether male physicians should be allowed to perform physical examinations on female patients, 81 patients answered that they should, where it was a matter of saving lives. It may therefore be concluded that they had a good level of awareness in this regard

The authors did not state the limitations of this study

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Ma CC (2014)
2
2
2
1
1
1
2
1
1
1
2
2
18
Taiwan (2012)
204
204 patients > 18 years-old
To evaluate patient's concerns about privacy of EMRs data; to evaluate patient's behavioural responses of patients to their perception of information privacy concerns resulting from information practices of medical facilities

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Institutions and governments need to ensure data protection to each individual; to protect data from use without patient's consent; to develop privacy protection policies to reduce patient's privacy information concerns

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Collection of information, secondary use of information and errors in data collection were primary factors in arousing patients' information privacy protective responses toward electronic medical records (EMRs); governments and medical facilities should focus on these findings and develop EMR privacy protection policies to reduce people's information privacy concerns; patients took protective responses towards EMRs when their information privacy concerns were invaded; the lack of attention to these relationships in the healthcare context is problematic because of the influence of these relationships on the promotion of EMRs in the future; the development of EMRs by those responsible for formulating and implementing information-privacy protection procedures in organisational and societal contexts is needed.

This study only looked at people who access Electronic Medical Records (EMRs) without authorisation as staff at the medical facility, which might ignore other unauthorised access by individuals not associated with the medical facility. Further, the external validity of the findings may be limited as the sample was collected from one hospital in Taiwan only. Consequently, inferences to other populations cannot be made safely. However, the collected sample possessed certain demographic characteristic (e.g. gender) in the same proportion as the Taiwanese population, although there were some differences in age and education, meaning that these results may be generalisable to other Taiwanese hospitals. Future research could expand on the present study's findings by using a more representative sample in other geographical settings.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

CRITICAL APPRAISAL SCORES			
Individual item score (color and value)			(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)
0 = not or inadequately addressed or applied	1 = adequately addressed or applied	2 = well addressed or applied	
Total Score Appraisal by study design, color and value			
	Low quality	**Moderate quality**	**High quality**
Qualitative studies	0-7	8-14	15-20
Cross-sectional studies	0-9	10-17	18-24
Cohort study	0-9	10-17	18-24
Quali-quantitative and convergent parallel mixed-	0-4	5-9	10-14

For peer review only

raisal Skills Programme)	
	Issue
	Recruitment
	Exposure
	Outcome
	Confounding factors identification
	Confounding factors taken into account
	Follow up complete
	Follow up long enough
	Results
	Precision of the results
	Believe the results
	Results applied
	Results fit
	Implications for practice
	Total
	Country (year of research and data collection)
	Sample size
	Type of samples

For peer review only

Table 3 - CASP Cohort Studies Checklist (Critical Appr

RESULTS	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	STRATEGIES, BEHAVIORS AND/OR OUTCOMES OF INTEREST

For peer review only

LIMITATIONS

For peer review only

Skyman E et al (2014)
2
2
2
2
1
1
2
2
2
2
2
1
1
1
23
Sweden (2004/2011)
202
2004: 92 patients (Card: 71, No card: 21); 2011: 110 patients (Card: 91, No card: 19)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Disrespect and humiliation, Lack of knowledge, Unprofessionalism, Responsability not to spreading MRSA
To reduce uncertainty, offence, anger and discrimination; to educate patients and healthcare workers; to inform patients and health care providers; to manage patients fellings ; to preserve patients' dignity; to educate health care providers
Patients felt pointed out in a negative way by receiving a notification card; a majority reported that they always or almost always had shown the card when seeking hospital or outpatient care, and for dental care the number was signifcantly higher in 2011 (57.14%) than in 2004 (30.98%) (p=0.004); 81% stated that it is good to have a card in 2004, and 62% in 2011; 38% reported health care workers (HCW) were familiar with the card in 2004, and it increased signifcantly (45%) in 2011 (p=0.036); patients reporting HCW took no notice of the card (21% in 2004, 11% in 2011, p=0.004). Very few actively stated that the HCW were unfamiliar with the card (15.5% in 2004, 5.5% in 2011, p=0.036). Almost half of the patients indicated positive reactions when presenting the notification card (45% in 2004, 47.2% in 2011, p=0.445). A higher number however, responded that they were met with despair and fear (9.86% in 2004, 34% in 2011, p=0.052). Patients claimed unknown acquisition (70% in 2004), of whom 75% believed wrongly that they had been inffected in the hospital. In 2011, there was a tendency towards increased unawareness (47.27%), as compared to 2004, but the difference was not significant. The dominant misconception was still hospital acquisition (81%), even though the perceived hospital acquired-MRSA rate decreased signifcantly (19% in 2011, 42.4% in 2004, p<0.001). Few stated community acquisition in both groups (5% and 21%).

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Low response rates, patients with negative experiences may be more willing to to respond

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

CRITICAL APPRAISAL SCORES			
Individual item score (color and value)			(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)
0 = not or inadequately addressed or applied	1 = adequately addressed or applied	2 = well addressed or applied	
Total Score Appraisal by study design, color and value			
	Low quality	**Moderate quality**	**High quality**
Qualitative studies	0-7	8-14	15-20
Cross-sectional studies	0-9	10-17	18-24
Cohort study	0-9	10-17	18-24
Quali-quantitative and convergent parallel mixed-method studies	0-4	5-9	10-14

For peer review only

ia (Quali-quantitative and convergent parallel mixed-method studies)		Sanson G *et al* (2020)
	Worth or relevance	2
	Clear question	2
	Design	2
	Context	2
	Sampling	1
	Data collection and analysis	1
	Reflexivity	2
	Total	**12**
	Country (year of research and data collection)	Italy (2015)
	Sample size	100
	Type of samples	100 Intensive Care Unit (ICU) patients
	STRATEGIES/BEHAVIORS/OUTCOMES OF INTEREST	To identify perceptions about the ICU environment; to reduce discomfort of tubes and procedures, room temperature, position

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Critical Appraisal according to Mays & Pope (2000) Criter		
	INTERVENTIONS TO ACHIEVE IMPROVEMENTS	Environmental control to reduce disstress, to allow more time for family visits for some patients and less for ohers, clock visible to all patients, windows (daylight and night), to explain ICU bans and rules to patients; Pain control, change positions, manage visual fields
	RESULTS	Patients resported that they had a clear remembrance of their ICU stay; the patients with no clear memory of their ICU stay had significantly worse, and a longer lenght of mechanical ventilation and ICU stay; intrusive memories related to their stays in the ICU.
	LIMITATIONS	Using a data saturation method has been questioned, because it could introduce a certain degree of uncertainty and ambiguity when it tries to find the unobserved on the basis of what is observed. The study enrolled vulnerable participants, some of which had a partial recollection of their ICU experiences. The interviews were carried out in hospital and the interviewer was a health care professional; this situation may have influenced the participants' answers.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Santos LR *et al* (2005) (a)
2
2
2
2
1
2
1
12
Brazil (??)
73
73 general hospital inpatients
Satisfaction with the service provided; Requesting authorization for adminstering medication and carrying out exams, as well as providing prior information; communication of tests results; clarification about the diagnosis; participation in the choice of treatment; problems experienced or observed in the institution

CRITICAL APPRAISAL S

Individual item score (color and value)		
0 = not or inadequately addressed or applied	1 = adequately addressed or applied	2 = well addressed or applied
Total Score Appraisal by study desi		
		Low quality
Qualitative studies		0-7
Cross-sectional studies		0-9
Cohort study		0-9
Quali-quantitative and convergent parallel mixed-method studies		0-4

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

To ask for patients' authorization to examine them, to touch; to explain the procedure/exam; to discuss its indications, options, and risks; to give information about the patients' rights, conditions, the function of medications, to clarify their doubts; to allow patients to decide what is best for them; to use clear and undertandable language when talking to patients
Patients who were interviewed did not receive information about the function of the medication they were given; they were not asked to or were not informed about procedures; they did not receive any information about consent and were not asked to consent; they were not asked about the route of administering their medication by the physician
Small sample, limited geographic area, data collection time frame not cited

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

SCORES

(a) Did not cite explicitly the data collection date/time frame (e.g. month/year)

ign, color and value

Moderate quality	High quality
8-14	15-20
10-17	18-24
10-17	18-24
5-9	10-14

For peer review only

PRISMA 2020 for Abstracts Checklist

Section and Topic	Item #	Checklist item	Reported (Yes/No)
TITLE			
Title	1	Identify the report as a systematic review.	Page 2 - Yes
BACKGROUND			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Page 2 - Yes
METHODS			
Eligibility criteria	3	Specify the inclusion and exclusion criteria for the review.	Page 2 - Yes
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	Page 2 – Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies.	Page 2 – Yes
Synthesis of results	6	Specify the methods used to present and synthesise results.	Page 2 – Yes
RESULTS			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	Page 2 – Yes
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Page 2 – Yes
DISCUSSION			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Page 2 – Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Page 2 – Yes
OTHER			
Funding	11	Specify the primary source of funding for the review.	Page 2 – Yes
Registration	12	Provide the register name and registration number.	Page 2 - Yes

PRISMA 2020 for Abstracts Checklist

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 2
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Page 2-3
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 3
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 3
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 3
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Page 3
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Page 3
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 3
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Page 3
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Page 3
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 3 and 11
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Not applicable
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 3
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 3
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 3
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Pages 3-6, and pages 8-11
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Pages 3-4
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Pages 3, 4, 8
Reporting bias	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Pages 3, 11

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
assessment			
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Page 8
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Pages 3,4
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Page 4
Study characteristics	17	Cite each included study and present its characteristics.	Page 4-6
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Page 11
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Pages 3-8
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Page 11
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Not applicable
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Page 13
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Pages 8-11
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Page 4, 13
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Pages 8-11
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 11-13
	23b	Discuss any limitations of the evidence included in the review.	Page 13
	23c	Discuss any limitations of the review processes used.	Page 13
	23d	Discuss implications of the results for practice, policy, and future research.	Pages 13, 14
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Pages 2, 3, 14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	PROSPERO
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	None
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Page 14
Competing interests	26	Declare any competing interests of review authors.	Page 14

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Not applicable

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

For peer review only