International Journal of Nursing Studies 61 (2016) 136–141

Contents lists available at ScienceDirect

International Journal of Nursing Studies

journal homepage: www.elsevier.com/ijns

In sickness and in dignity: A philosophical account of the meaning of dignity in health care

Linda Barclay *

Department of Philosophy, Monash University, Clayton Rd, Clayton, Victoria, Australia

ARTICLE INFO

Article history:
Received 22 March 2016
Received in revised form 9 June 2016
Accepted 17 June 2016

Keywords:
Dignity
Philosophical analysis
Standards and values
The Dignity Model

ABSTRACT

The meaning of dignity in health care has been primarily explored using interviews and surveys with various patient groups, as well as with health care practitioners. Philosophical analysis of dignity is largely avoided, as the existing philosophical literature is complex, multifaceted and of unclear relevance to health care settings. The aim of this paper is to develop a straightforward philosophical concept of dignity which is then applied to existing qualitative research. In health care settings, a patient has dignity when he or she is able to live in accordance with his or her standards and values. Accordingly, health care practitioners respect a patient's dignity when they refrain from transgressing the patient's standards and values, or refrain from forcing the patient to transgress his or her standards and values. This concept is shown to explain and illuminate most of the key qualitative findings. It therefore provides a more coherent and synthesised concept of dignity in health care.

What is already known about the topic

- Treating patients with dignity is an increasing priority in health care policy and practice.
- Clarifying the meaning of dignity in health care is largely explored using qualitative interviews with various patient groups.

What this paper adds

- This paper develops a philosophical concept of dignity.
- This concept of dignity is applied to existing qualitative research to clarify and synthesise the disparate factors that patients have identified as related to dignity.

1. Introduction

The importance of dignity as a value in health care is widely recognised. It is discussed extensively in palliative care, nursing, and more broadly as part of patient-centred care (Chochinov, 2012; Franklin et al., 2006; Kitson et al., 2013; Pringle et al., 2015).

The requirement to protect dignity is of limited practical guidance without a clear understanding of what is meant by 'dignity'. Despite the burgeoning literature on dignity in health care, there is no consensus on what 'dignity' means, as has been frequently noted (Pringle et al., 2015; Seedhouse and Gallagher, 2002; Walsh and Kowanko, 2002: 30). What the existing literature mainly provides is rich qualitative data based on responses of various patient groups or health care practitioners. What emerges from these studies are lists or categories of factors that informants identify as either promoting or undermining dignity. While this body of

---

* Tel.: +61 3 99054278.
E-mail address: linda.barclay@monash.edu

http://dx.doi.org/10.1016/j.ijnurstu.2016.06.010

research significantly advances understanding of how to promote dignity, it remains somewhat incomplete in two key respects.

Firstly, while lists or categories of items offer real progress, a synthesised concept has the potential to provide a much simpler and more direct clarification of what dignity means, not only in one domain, such as palliative care, but across the whole health care sector. This offers the further possibility of concrete guidance for both broader health care practice and policy development. A less 'deconstructed' account of dignity can be more useful than complex lists and multiple categories.

Secondly, the qualitative methodology favoured in most existing literature on dignity is to ask patients and health care practitioners directly to specify what they consider to be dignified care (Anderberg et al., 2007; Chochinov, 2002, 2012; Chochinov et al., 2002; Enes, 2003; Franklin et al., 2006; Joffe et al., 2003; Seedhouse and Gallagher, 2002; Woolhead et al., 2004). While patients' and practitioners' views about dignity are important in developing any account of dignified care, there are limitations to this methodology. Given that patients and practitioners are no more likely to have a clear understanding of what 'dignity' means than do researchers, asking them to report directly on their perceptions of dignified or undignified care runs the risk of collapsing the concept of dignity into the same category as 'high quality health care' or 'high quality palliative care', or simply, 'a good death'. However, if a dignified death is nothing other than a good death, or if dignified health care is nothing other than good quality health care, then 'dignity' really is "a useless concept", as Ruth Macklin has forcefully argued (Macklin, 2003). It adds nothing new: it is just a fashionable new term for existing values, such as autonomy, compassion, privacy, respect, safety, and the like.

For these reasons, it is perilous to jettison more philosophical or theoretical analysis and clarification of the concept of dignity. Some qualitative research does incorporate philosophical analysis (Anderberg et al., 2007; Gallagher et al., 2008). However this too can be a vexed task. Much of what philosophers have historically said about dignity is abstract and extremely difficult to apply to the concrete setting of health care. Moreover, philosophers are often not discussing the same concept that is at stake in health care. 'Dignity' is a vague term, and has been used within the history of philosophical thought to refer to quite distinct concepts (Nordenfelt, 2004; Schroeder, 2008). The issue is not simply that the concept of dignity is contested: it is multifaceted. Indeed, much of this philosophical material is quite tangential to the values at stake in health care settings. What is needed is the identification of a core philosophical concept of dignity that clarifies and synthesises the disparate qualitative findings.

2. Dignity, status and standards

Philosophical analysis clearly demonstrates that dignity does add something unique and important to our ethical vocabulary. It is not a useless concept, and is especially important in health care contexts. Within the complex philosophical terrain there is a core, and quite simple, concept of dignity that offers great promise for deepening our understanding of dignity in health care.

In health care settings, a patient has dignity when he or she is able to live in accordance with his or her standards and values. Accordingly, health care practitioners respect a patient's dignity when they refrain from transgressing the patient's standards and values, or refrain from forcing the patient to transgress his or her standards and values (Killmister, 2010).

It is a uniquely human capacity to be able to shape a life in accordance with principles or standards, and thereby fill out each life with its own meaning and purpose. A large part of what it means to respect human beings, to treat them as equals, is just to respect their capacity to live according to values and principles that provide their lives with meaning and anchor their self-worth (Killmister, 2010).

These standards and values need not be particularly lofty, although they include our moral codes and perhaps religious commitments. They also include things like our cultural mores, our sense of etiquette and other beliefs we may hold about proper conduct and interpersonal interaction, including apparently trivial matters such as politeness and correct forms of address (Killmister, 2010).

The ability to realise one's values and standards can be jeopardised by a range of circumstances, including the behaviour of others, the physical setting, one's own actions, and deteriorating health. It is clearly vulnerable in situations of sickness and dependency where an individual's ability to control how well he or she can uphold his or her standards may be very limited and heavily dependent on others.

Not being able to live up to one's standards and values is often experienced as shameful and humiliating: we feel lowered in the eyes of others. David Luban demonstrates the intimate link between dignity and humiliation with the example of torture (Luban, 2009). As evidence from Abu Ghraib shows, many forms of torture were inflicted on prisoners by members of the U.S. military with the sole aim to humiliate them: "Terror makes us whimper and beg; it makes us lose control of our bowel and bladder. The Abu Ghraib dog-handlers had contests to see who could make a detainee foul himself first" (Luban, 2009: 223). According to Luban, the terror associated with the infliction of physical pain in torture also has a special connection to humiliation. He says that "the experience of acute pain is itself degrading because it collapses our world and reduces us to mere prisoners of our bodies. Pain forcibly severs our focus on anything outside of us; it shrinks our horizon to our own body" (Luban, 2009: 223). Torture makes it virtually impossible to maintain our own standards or uphold what we regard as worthy interpersonal conduct, which is why it humiliates so, just as it is designed to do (Luban, 2009). This is central to understanding why international law identifies torture as a particularly egregious threat to human dignity.

Undignified health care is not the same as torture. Nevertheless, there are some similarities in nature, if not degree. According to Suzy Killmister, at least for some of us, "part of the trauma of undergoing medical procedures is the shame we experience in having our bodies exposed, the