Defining the concept of dignity and developing a model to promote its use in practice

Dignity is a complex and multifaceted concept. This article offers a definition and a model to help nurses promote it in practice and make decisions about care.
In the perspectives of dignity discussed so far, it has been reduced to a single concept, which has failed to account for its complexity. This article proposes that dignity needs to be defined in a broader and more inclusive way, which incorporates the ideas that it can refer to a right, an experience and something that can be bestowed on others.

**Dignity as a multifaceted concept**
Spiegelberg (1970) distinguished between “dignity in general”, which is a matter of degree and is subject to gain or loss, and “human dignity”, which belongs to every human being and cannot be gained or lost.

Similarly, Gallagher (2004) proposed that dignity in nursing practice should be considered both objectively and subjectively. Dignity as an objective concept is the basis of human rights, where it is seen as a “value”, which a person has purely because they are human, and is therefore stable and enduring. Dignity as a subjective concept includes the idea that it can be experienced and allows for individual differences.

Subjective dignity includes Gallagher’s (2004) and Spiegelberg’s (1970) conceptions of “self regarding” and “other regarding” dignity. The former refers to how a person feels about themselves and how they perceive themselves to be treated by others, whereas the latter refers to how others perceive and treat a person.

Therefore, dignity can refer to an objective concept to which everyone has a right and a subjective concept that is socially constructed and made up of values and feelings that can be bestowed on others and experienced (Fig 1).

**DEFINING DIGNITY FOR PRACTICE**
The DH’s Dignity in Care campaign aims to create a common understanding of what dignified health and social care services look like (see tinyurl.com/dignity-site). To do this, defining dignity is essential.

In the SCIE’s (2006) guide, a provisional meaning based on the dictionary definition was used, which describes dignity in relation to respect. The problem with this is that respect is equally abstract and as difficult to define as dignity.

This article offers a clearer definition, modified from Haddock (1996) and based on a systematic review of the literature:

“Dignity is a fundamental human right. It is about feeling and/or being treated and regarded as important and valuable in relation to others. Dignity is a subjective, multidimensional concept, but also has shared meaning among humanity.”

Under this definition, dignity is both an objective “right” and a subjective concept that can be experienced. Its definition as having a shared meaning among humanity suggests that it is also an intersubjective concept (see Fig 2). This assertion is based on research that shows, despite individual variations, a generally high level of agreement between care recipients about what constitutes dignified care (SCIE, 2006).

This shared meaning can be seen as resulting from the establishment of social norms which are learned and acquired through socialisation. Intersubjective ideas about dignity are therefore largely culturally dependent, and cannot be applied across different cultural groups. This has important implications for practice, discussed later.

**A MODEL OF DIGNITY**
A model of dignity was constructed to represent the ideas presented in the definition. In this model, as suggested by Gallagher (2004) and Spiegelberg (1970), dignity has two dimensions: “self regarding” and “other regarding”. Both are subjective because they are about how an individual interprets either their own or someone else’s dignity to have been affected.

Shotton and Seedhouse (1998) suggested that dignity has different levels, from “dignity maintained” to “devastating loss of dignity”. These levels are included in the model because they show that dignity can be lost to a greater or lesser extent in relation to both self regarding and other regarding dignity.

**The right to dignity**
The model is underpinned by the idea that every law abiding person has the right to dignity purely because they are human. Including other regarding dignity in this model is valuable for practice because it illustrates that dignity can be lost, even when a person is not aware of it being violated, for example if they have a severe learning disability. In such instances, it may only be other people who regard a person’s dignity as having been violated. Health and social care providers and workers have a duty to maintain dignity, even if there is a question mark about a person’s capacity or awareness about what is happening to them.

This is because the right to dignity is enshrined in the Human Rights Act 1998, which includes the right to freedom from degrading treatment and the right to respect for privacy. The Nursing and Midwifery Council’s (2008) code of conduct places responsibility on nurses to “make the care of people your first concern, treating them as individuals and respecting their dignity”.

Where a person is not able to communicate how they would like care to be delivered, caregivers must maintain dignity by drawing on social and cultural norms that apply to the person for whom they are caring. This is represented in the model’s third column and is referred to as intersubjective dignity (Fig 2).

To explore the nature of subjective and intersubjective dignity further, concept analysis was carried out, from which a number of properties were identified.

**PROPERTIES OF DIGNITY**
The sources of these properties come from existing research and theoretical papers, including patient reports about what dignity means to them (Clark, 2008; Franklin et al, 2006; Nordenfelt, 2004; Widang and Fridlund, 2003; Fenton and Mitchell, 2002; Jacobs, 2001; Shotton and Seedhouse, 1998; Haddock, 1996; Dworkin, 1995; Mairis, 1994).

The method of concept analysis involved putting together a list of all ideas about what dignity encompasses, grouping them together conceptually, and cross referencing them. Properties and ideas supported by more than one source were retained, and those that only appeared once were discarded. These properties help to describe what is involved in promoting dignity and therefore go a step towards putting dignity into practice.

Research has suggested that although there is some general agreement about the kinds of things considered to be dignified, there are also individual differences. This is why it is important, when possible, to consult people receiving care individually about how they would like their care to be delivered.

**Subjective dignity – rushing and efficiency**
Individual perceptions of what causes dignity to be violated depend on personal values and preferences. The extent to which each property of
dignity is prioritised may be different for different people. For example, research shows that there are variations in how people like intimate and personal care to be carried out. Mirfin-Velitch et al (2004) found that people with intellectual disabilities wanted caregivers to take time during intimate care to interact with them. However, as a wheelchair user, Vassey (1996) described how she liked intimate care to be completed quickly and efficiently. This shows how some people may find the experience of relying on others to provide such care degrading and want it to be over as soon as possible, while others may feel valued if caregivers take their time, and as though they are being treated as a person rather than an object.

These accounts suggest the amount of time taken for intimate care is important for maintaining dignity, but whether it is more dignified to carry it out quickly or slowly depends on individual preferences. It is probably not just speed but also the manner that is important; there is a difference between efficiency and rushing, and the latter is probably less likely to maintain dignity.

An added complication is that if people prefer an aspect of care, such as brushing teeth, to be carried out quickly, this might have a detrimental effect on their health and hygiene. This also has implications for maintaining dignity, because of the way that other people regard someone who does not have a clean, healthy and hygienic mouth.

Because dignity is a multidimensional concept comprised of different properties, a single interaction could maintain dignity in some ways but not others. Caregivers must consult those receiving care and weigh up the advantages and disadvantages of various courses of action, and find a solution that meets health needs while maintaining dignity as far as possible.

Dignity and dependency
There is significant variation in what people regard as undignified in relation to dependency. Some people who are disabled have said they experienced indignity and shame in having to depend on others (Buckley et al, 2007; Franklin et al, 2006). However, Rock (1988) found from her own experience as a disabled person, and from discussion with other disabled people, that independence can be seen as a variable self concept that relates to control and choice rather than any absolute measure of competence. It might therefore be concluded that loss of dignity is not an inevitable consequence of dependency; this is because dignity can be maintained by providing opportunity for control and choice.

Humour and dignity
Those providing care need to consider that an action perceived as maintaining self regarding dignity may not maintain other regarding dignity. For example, while the positive value of humour for relieving anxiety and discomfort in nurse–patient interactions has been documented, White et al (2003) pointed out that joking and teasing may be misunderstood by recipients and cause distress and humiliation. Therefore, carers must consider the impact of their actions from recipients’ perspective, and not make assumptions without checking with them.

Why is dignity so important?
As service providers and caregivers can give priority to dignity, they should be aware of the devastating impact that its loss can have. Studies on dignity in healthcare settings have given some indications about the kinds of emotional reactions people experience when their dignity is compromised, including anger, anxiety, humiliation and embarrassment (Lundqvist and Nilstum, 2007; Franklin et al, 2006).

Another study showed that faecal and urinary incontinence affected emotional wellbeing, and the authors argued that the negative impact should not be underestimated (Buckley et al, 2007).

According to Haddock (1996), dignity is connected to the self concept and self esteem, and Burns (1979) suggested self esteem can be measured as an indication of whether a person possesses dignity. The extent to which a person is treated with dignity can therefore not only give rise to an immediate emotional response but also have a more profound and enduring effect. This means the subjective experience of dignity includes how the person is made to feel at the time, as well as how they are made to feel on a longer term basis.

Dignity, self esteem and health
The impact of dignity on self esteem is important because the latter is thought to

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**FIG 2. MODEL OF DIGNITY**

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Self regarding dignity</th>
<th>Intersubjective dignity</th>
<th>Other regarding dignity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw upon the preferences and wishes of the patient to maintain self regarding dignity</td>
<td>Feeling like a person, not an object</td>
<td>Feeling like a whole person</td>
<td>Feeling seen as a person, not an object</td>
</tr>
<tr>
<td></td>
<td>Feeling like an individual</td>
<td>Feeling like a whole person</td>
<td>Feeling seen as a whole person</td>
</tr>
<tr>
<td></td>
<td>Having a sense of equal worth</td>
<td>Having a sense of belonging</td>
<td>Having seen as equal</td>
</tr>
<tr>
<td></td>
<td>Having control and autonomy</td>
<td>Having a sense of competencies being realistically acknowledged</td>
<td>Having seen as an individual</td>
</tr>
<tr>
<td></td>
<td>Having a sense of belonging</td>
<td>Not feeling foolish, embarrassed, degraded</td>
<td>Being regarded as having equal worth</td>
</tr>
<tr>
<td></td>
<td>Having a state of physical, emotional and spiritual comfort</td>
<td>Having a state of physical, emotional and spiritual comfort</td>
<td>Being regarded as having control and autonomy</td>
</tr>
</tbody>
</table>

**LEVELS OF DIGNITY**
- Maintained
- Lost in a trivial way
- Lost in a serious way
- Lost in a devastating way

- Positive experience
- Positive effect on self esteem
- Negative experience
- Negative effect on self esteem

With acknowledgements to Gallagher (2004) and Shotton and Seedhouse (1998)
underpin psychological and physical health (MacInnes, 1999). Low self-esteem is associated with negative emotional effects (Smith and Petty, 1996) and can lead to depression and anxiety.

Symbolic interactionism is a theoretical perspective of social psychology in which the self is a process, rather than a structure, that develops through interaction. Self and other are sustained by interactive relations, and it is within and through these relations that concepts of self and other evolve (Carpendale and Müller, 2004). Therefore, we see ourselves as others see us, and symbolic interactionism the way others see is called the “ascribed status”. This suggests that individuals experience a positive sense of self worth if they are thought about or treated positively by others. Self esteem is therefore raised if others regard us with high esteem and treat us with dignity, whereas it is lowered if we are regarded without esteem and treated without dignity.

REFERENCES


Erlbaum Associates.


IMPLICATIONS FOR PRACTICE

This article has implications for practice for any service providing health and social care. For frontline staff to be able to deliver care with dignity, their employer must support them, which means that appropriate training and policies need to be in place. When planning and delivering care, staff should consider individual preferences regarding how care is delivered and, where possible, discuss these preferences with patients/clients. The properties of dignity in this model can be used to help service users articulate what is important to them in relation to maintaining dignity. The assessment of dignity should be integral to care planning and person centred planning.

Where clients are unable to inform staff of how they would like care to be delivered, staff must draw on their own understanding of intersubjective dignity and apply their knowledge of cultural and social norms. Maintaining dignity is not a science, but relies on understanding, empathy and compassion.

Caregivers may need to make judgements, sometimes in difficult and challenging circumstances, so it is essential they have knowledge and skills to help them in this. The notion of dignity as an intersubjective concept is important here because it suggests that a set of social and cultural norms could be developed from which caregivers can learn generally accepted ways of promoting dignity.

At times, some aspects of dignity may be compromised because of a need to provide urgent or necessary care. There may also be conflict between self regarding and other regarding dignity. As far as possible, this should be dealt with through multidisciplinary team working and by developing care plans and procedures.

CONCLUSION

This article provides a definition of dignity and a starting point from which healthcare professionals can begin to understand how they can promote it. It also proposes a model that nurses and others can apply in practice.