Dignity in care: meanings, myths and the reality of making it work in practice

Recently there has been an increase in dignity in care campaigns but do they improve patient experience or detract from serious debate about cultural change?

INTRODUCTION

I write this article not as an expert in “dignity” but as someone struggling to find a reason and explanation as to why we have dignity in care campaigns. It is a sad indictment that we have a world class health service that is at the leading edge of scientific and technological advancements, but growing evidence that there has been an erosion of the core or primary values associated with care and caring (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010; The Prime Minister’s Commission on the Future of Nursing and Midwifery in England, 2010; Alzheimer’s society, 2009; Healthcare Commission, 2009; The Patients Association, 2009).

It may seem a little trite to say that healthcare has lost its primary values without acknowledging a broad range of factors that may have contributed to this erosion, such as the introduction of extended roles and new technologies, and a dramatic increase in the throughput of patients. These factors have all contributed to a number of significant changes in the systems and resources associated with the delivery of healthcare. In August 2008, I was appointed as professor in dignity of care for older people; this was a joint appointment between the faculty of health, Staffordshire University and Shrewsbury and Telford Hospital Trust.

I understand it is the first post of its kind and, while I am delighted and feel privileged to have been appointed to this role, I also feel a sense of sadness and unease. To appoint professors in dignity of care means something has gone fundamentally wrong in the health and social care system. When I was studying to become a registered nurse, dignity was never mentioned in my training – it was assumed to be an integral part of the caring process, something innate and intuitive, a fundamental principle of care and caring. One explanation why dignity in care has emerged now as a topic for study is that nursing’s own understanding of people and the nature of the profession have evolved. Over the last 20 years, nursing and healthcare have changed dramatically in terms of education and practice. Some of these changes have been welcomed, and offer new opportunities and challenges. Nurses are more aware and informed of the different dimensions of people’s lives. They operate more autonomously, facing challenging caring situations and responding sensitively to people from diverse cultures with diverse needs. They are working in a more complicated healthcare system where people are better informed of their rights and expectations regarding care.

The appearance of dignity in care campaigns is not, therefore, a simple case of paradise lost, but a reflection of nurses being more aware of the needs of people within society.

EMERGENCE OF DIGNITY CAMPAIGNS

The current drives for dignity in care and subsequent campaigns appear to have emerged from within older people’s services (Health Advisory Service, 1998; 1997) and have permeated the entire health and social care sectors (Royal College of Nursing, 2008; HCC, 2007; Department of Health, 2006a; 2006b; 2006c; Cardiff University, 2004).

It could be argued that these campaigns are a mask for the consumerist, bureaucratic and managerial systems that have infiltrated healthcare, deflecting from the government’s struggle to provide a cost-effective and efficient healthcare system for all.

Reviewing the emergence of these campaigns, there is clear justification for challenging and modernising the way in which older people have been cared for. Any practice that devalues and does not respect individual’s dignity should be confronted. There can be no room for complacency, age discrimination and any unfair practice (DH, 2001).

Today, “dignity in care” has become a catch all phrase within nursing and healthcare (Smith, 2008). It puts a positive spin on the issue, disguising all that has gone wrong within an ailing healthcare system.

The net effect has been the introduction of a BOX 1. DIGNITY IN HEALTHCARE

| Founding principle of healthcare |
| Historically, care and caring were better |
| Models of care delivery |
| Public expectations |
| Reflection of wider society |
number of high profile public (HCC, 2007; DH, 2006a; 2006b; 2006c) and professional campaigns (Royal College of Nursing, 2008) rallying nurses and other interested parties to sign up and be counted as dignity champions.

The aim of such campaigns is to restore dignity at the heart of nursing, health and social care. These campaigns imply that nursing and healthcare professionals may have taken their eyes off the essentials and the solution is to focus attention back on the importance of dignity.

However, this refocusing should also encourage campaigners to discuss and explore the changing context in which dignity needs to be reinstated. The DH has already begun reviews into the effectiveness of the dignity in care campaign and the role of the dignity champion (DH, 2009).

The utmost care and attention should be taken to prevent the violation of any patient, service user or, indeed, any healthcare professional’s dignity.

By exploring the premises of dignity outlined in Box 1, we can try to explain the origins of these campaigns and why calls for restoring or reintroducing dignity in care have arisen.

### DIGNITY DEFINED

Before exploring the premise of dignity, it is important to define it. Dignity is a subjective, complex and difficult concept to pin down.

Nordenfelt and Edgar (2005) present a theoretical model of dignity created within the Dignity and Older Europeans project. This suggests that there are four types of dignity, which are outlined in Box 2.

Fenton and Mitchell’s (2002) definition seems to capture the four types of dignity and offers a way of understanding and engaging with the concept within nursing and healthcare.

They state: “Dignity is a state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated. Dignity is promoted when individuals are enabled to do the best within their capabilities, exercise control, make choices and feel involved in the decision making that underpins their care.”

These definitions imply that nursing and healthcare professionals can undertake activities that promote and preserve dignity. However, they also suggest that these practitioners have the potential to rob or violate a person’s sense of identity and dignity.

The latter has certainly been referred to in a number of recent reports asserting that healthcare does not always preserve and uphold patient dignity but actually leads to violations (Alzheimer’s Society, 2009; Healthcare Commission, 2009; The Patients Association, 2009).

### BOX 2. TYPES OF DIGNITY

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
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<tbody>
<tr>
<td>Personal dignity inherent within every human being.</td>
<td></td>
</tr>
<tr>
<td>Dignity as merit: either formal or official – this kind of dignity is conferred upon someone either as a result of merit or rank. Some people may inherit titles. However, in this classification, dignity is usually earned or conferred by others because of deeds or actions.</td>
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</tr>
<tr>
<td>The dignity of moral stature: refers to one’s own moral identity and stature and how an individual may lose this if they fail to act according to their guiding principles and values.</td>
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<tr>
<td>The dignity of personal identity: concerns a person’s identity. An individual can be robbed or violated by physical assault or humiliation. The notion of integrity and personal identity, autonomy and inclusion are all important aspects of the person’s identity.</td>
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### PREMISES ON WHICH DIGNITY IN CARE IS BASED

#### Founding principle

One premise is that dignity in care has never been a central or founding principle of our healthcare system. Therefore, historically, dignity in care has not been a reality.

Many nurses talk about the “olden days”, seeing them through a nostalgic set of lenses that have perhaps become distorted over time.

Was nursing or healthcare any better then than it is today? Were patients treated with more dignity than they are today? My first instinct is to say “no”. I can recall many incidents from my clinical practice working as an auxiliary nurse in a psychogeriatric hospital where patients were subject to many indignities: queuing up in toilets before mealtimes; wearing outdated, ill-fitting hospital clothes and being restrained by a number of means, both chemical and physical.

These widespread practices seemed to be the norm and, in hindsight, would now constitute institutional and personal abuse. Thankfully, they are no longer tolerated in the healthcare system because they represent a violation of dignity. These examples of poor practice bring into question the relationship between dignity in care and caring values. Campaigns for dignity in care may not necessarily result in the change of values, attitudes and beliefs that are perceived to be lacking in nursing (Maben and Griffiths, 2008).

One positive aspect of being a nurse years ago was that there seemed to be time to care. Nurses were visible and at the bedside. While there was still good and bad practice, dignity in care was not really a word used in the vocabulary of nurses or patients, since nursing care seemed to encompass all of this in an integral and intuitive way.

#### Historical perspective

My second premise stems from the first. If dignity in care did exist historically, then where and why has it gone from caring in contemporary nursing?

One of the reasons could be the perceived erosion in or loss of care and caring (Corbin, 2008), caused in part by the delegation of fundamental caring skills to unqualified staff, while qualified practitioners undertake roles and duties once performed primarily by medical staff.

Maben and Griffiths (2008) write: “Some of the enduring qualities of nursing such as care and compassion are thought to have been lost and not demonstrated by some nurses.”

This seems to have been compounded by a bureaucratic agenda in terms of unfunded risk assessments and form filling – meaning nurses do not have the time to care. It is not that bureaucracy is unnecessary – on the contrary, inspections, satisfaction surveys and documentation are all important and valuable. But the emphasis on the importance of bureaucratic tasks seems to be detracting from the provision of fundamental nursing care.

Another position is that dignity is a social construct; one that is constantly evolving reflecting the values and norms of the society in which it is located. Roman history tells us that dignity or dignitas was not conferred to all members of society in equal measures. Dignity, then, was associated with rank and merit, and the authority and command a person held over others, through wealth, power or status.

Similarly, a review of some of the Victorian novelists reveals that not all sections within society were treated with dignity.
The concept of dignity has changed and evolved across time and human history. This is certainly reflected in the four types of dignity noted in Box 2, where the emphasis in modern society is not so much on status and power but on integrity, values and the practice of actions and attitudes that preserve and uphold the identity and uniqueness of each person.

The point is that dignity campaigns reflect the time and social context. Their emergence mirrors the values and discomforts that nurses and healthcare professionals are experiencing, such as a reduction in the amount of time available to spend with patients.

The desire to restore dignity to the heart of nursing is an attempt to challenge and redress some of the delegation and overspecialisation that has occurred over the past decade, which have perpetuated the perceived erosion of care (Scott, 2000). Nursing and healthcare must learn from the past. However, nostalgia alone will not restate care and caring at the heart of our healthcare system, since nostalgia can be just as destructive as overspecialisation.

Too much bureaucracy prevents innovation and development. We all need to be vigilant and prepared to challenge bad practice in whatever form it takes, rather than just going with the flow or blending in with the status quo. Socialisation and “wanting to fit in” are powerful suppressors, which can silence the best and most well intentioned nurse.

**Organisation of care**

Premise three explores the organisational and operational models of care delivery. The phrase “holistic” care has been a popular mantra for the nursing profession, which challenged the apparent domination of the medical model of care (Paley, 2002; Thorne, 2001). This means providing individualised, person-centred care addressing all dimensions of the individual – physical, social, psychological and spiritual.

However, nurses have not always provided holistic care. For example, my own work reveals that the holistic revolution within nursing has not really succeeded and lip service is paid to only some of the dimensions – for example spirituality and spiritual care (McSherry, 2007; 2006). Fenton and Mitchell’s (2002) definition underlines that we cannot provide dignified care to patients unless we attend to the spiritual dimension.

It would appear that the language and rhetoric associated with holistic care has been replaced by dignity in care. While holistic care was an attempt to remove some of the dehumanising, medicalisation and fragmentation of care, dignity in care could be interpreted as an attempt to challenge the managerial and bureaucratic influences that prevent nurses from caring for patients.

**Public expectations**

There have been many drives to ensure that the voices of the public inform and direct developments within our health and social care systems. This inclusive partnership working is to be applauded and strengthened but it is impossible to ignore a political agenda that seeks to deflect or divert attention from some of the fundamental issues that have led to the perceived erosion in care.

The result of this inclusive approach is that the public’s awareness and expectations have dramatically increased in terms of how they believe they should be treated within health and social care. This is perhaps so much so that public demand and expectation now far outweigh what can actually be delivered within current economic constraints imposed on the NHS.

Has the bar been falsely raised in terms of the public’s awareness and expectations? This premise may be at the heart of the problem of dignity – not that nurses are less caring.

The issue may be that, while dignity is valued by nurses, the economic and political constraints imposed on the delivery of healthcare prevent dignified care from being provided. This phenomenon is evident in recent investigations and inquiries (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010; Healthcare Commission, 2009).

The introduction of the dignity campaigns can be viewed from different perspectives. The optimist within me sees them as a genuine attempt to improve care and the caring experience. The cynic views them as a political and professional ploy to delude the public that something is being done, and deflect from some serious debate about the nature and structure of nursing and healthcare.

Ultimately, are these campaigns attempting to restore fundamental elements of care that have been eroded?

My reason for asking this is that one drawback of these campaigns is that dignity champions tend to adopt an “opt in” mentality, where people sign up or register their interest. This approach places sole responsibility on the shoulders of interested parties, asking them to challenge bad practice and instigate change without providing infrastructure or support.

It is my belief that, although these campaigns generate awareness of the importance of dignity in care, they will not result in the cultural change that is necessary within the health and social care sectors.

The difficulty with campaigns is they are short lived, have a limited shelf life and, once the immediate interest and enthusiasm has dwindled, they fade out.

Campaigns are also aimed at engaging particular groups within the health and social care sectors – primarily nursing – and will not resolve some of the issues that seem to be operating around respect and dignity within the wider society.

**Reflection of wider society**

The fifth premise develops the point about the perceived erosion or loss of respect and dignity within society at large. I feel that what happens within our healthcare system is a reflection of what is happening within society and we cannot look at dignity in care without looking at the wider context.

While one must treat with caution the way in which the media captures and presents news, there does appear to be a devaluing of the person.

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**BOX 3. DEPARTMENT OF HEALTH’S (2006c) 10 POINT DIGNITY CHALLENGE**

High quality care services that respect people’s dignity should:

1. Have a zero tolerance of all forms of abuse;
2. Support people with the same respect you would want for yourself or a member of your family;
3. Treat each person as an individual by offering a personalised service;
4. Enable people to maintain the maximum possible level of independence, choice and control;
5. Listen and support people to express their needs and wants;
6. Respect people’s right to privacy;
7. Ensure people feel able to complain without fear of retribution;
8. Engage with family members and carers as care partners;
9. Assist people to maintain confidence and a positive self esteem;
10. Act to alleviate people’s loneliness and isolation.
Perhaps a solution would be to define what is meant by dignity within society and, crucially, how to capture and clarify this so that its place, relevance and meaning within the social order are known.

There is certainly, an increased awareness within nursing and healthcare of the importance of preserving patient dignity. However, the challenge for all of us is to ensure dignified care happens (Magee et al, 2008).

Perhaps a starting point for those working within health and social care is to ask themselves some pertinent questions. What do I value? Why did I enter the caring profession? A useful exercise is to look at the 10 point dignity challenge (DH, 2006c) outlined in Box 3 and ask: “How do I measure up?”

My simple and perhaps naive philosophy is that, if we start challenging our own prejudices, attitudes and behaviours, this will have an impact on our nursing practice and interaction with patients and our colleagues.

Jacelen et al (2004) support this process of self reflection and introspection when they write: “We concluded that learning about dignity was an antecedent to behaving with dignity.”

CONCLUSION

Not everything in nursing and healthcare is bad – on the contrary. Dignity in care is a matter of perspective. For some, it may be the reality they seek, while for others it may always remain a myth – something from a bygone age which is now unattainable.

Regardless of which perspective we adopt, dignity in care campaigns and dignity champions will only go a little way towards restoring some of the fundamental principles associated with the perceived erosion of care and caring.

While I support and have registered as a dignity champion, I feel a more strategic approach is required to bring about the desired effect. The “opt in” mentality and registering to be a dignity champion alone will not bring about the sustained cultural shift that is required within the whole health and social care system.

All health and social care professionals need to be working as dignity champions as dignity in care is not the sole responsibility of one professional group – namely nurses – but everyone working and employed within the health and social care sectors.

See opinion on page 24 for a discussion on how time constraints and staffing levels threaten patient dignity.

REFERENCES


The Patients Association (2009) Patients Not Numbers, People Not Statistics. tinyurl.com/patientsnumbers
