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.”

![Figure 1: Objective and Subjective Dignity](image)

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; Widäng 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...