



UPDATE

The concept of dignity in nursing care: a theoretical analysis of the ethics of care

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Abstract

We know today that positive health outcomes derive from the intersection of various factors such as valuation and respect; involvement in decisions, positive self-esteem, and the ability to exercise control over one's own life by pointing out that the individual's perspective on dignity is a central element in high-quality care. Dignity is a complex concept, difficult to define for lack of clarity of what the concept implies, but it is fundamental in Nursing courses. This theoretical article intends to present the narrative review about the concept of dignity in Nursing care, carried out in the context of the PhD in Nursing, at Universidade de Lisboa (University of Lisbon), aiming to discuss aspects of dignity in the context of Nursing care ethics.

Keywords: Personhood. Nursing care. Ethic.

Resumo

Conceito de dignidade na enfermagem: análise teórica da ética do cuidado

Atualmente sabe-se que resultados positivos em saúde derivam de fatores como valorização e respeito, participação nas decisões, autoestima positiva e capacidade de exercer controle sobre a própria vida, indicando que a percepção do paciente sobre a própria dignidade é elemento central do cuidado. Trata-se de conceito complexo, difícil de definir por falta de clareza quanto ao que implica, mas fundamental na enfermagem. Este artigo apresenta revisão de literatura com o objetivo de discutir aspectos da dignidade no contexto da ética do cuidado.

Palavras-chave: Pessoaalidade. Cuidados de enfermagem. Ética.

Resumen

Concepto de dignidad en la enfermería: un análisis teórico de la ética del cuidado

Actualmente se sabe que los resultados positivos en salud derivan de factores como la valoración y el respeto; la participación en las decisiones, la autoestima positiva y la capacidad para ejercer control sobre la propia vida, señalando que la percepción del paciente sobre la propia dignidad es un elemento central del cuidado. Se trata de un concepto complejo, difícil de definir, por la falta de claridad respecto de lo que implica, pero fundamental en enfermería. Este artículo presenta una revisión de la literatura con el objetivo de discutir aspectos de la dignidad en el contexto de la ética del cuidado.

Palabra clave: Personeidad. Atención de enfermería. Ética.

Declaram não haver conflito de interesse.

“Dignity” occupies a prominent place in human rights, in the philosophy of the hospice movement and in various contexts. Most of the ethical-legal and deontological documents are full of allusions to this word. However, the in-depth analysis of its content brings to light the complexity of the concept and the lack of clarity in its definition. In this way, by not having evident meaning, the idea of dignity runs the risk of disappearing under more tangible priorities¹.

Various understandings have led to discussions about the meaning, content, and usefulness of the term. Many argue that the concept is empty and useless, and can be replaced by “autonomy” without loss of meaning².

Due to this lack of conceptual clarity, when accompanying a person in his or her most vulnerable moments ... we do it with the best of intentions, but each based on his or her particular way of understanding and, therefore, of caring for people, and perhaps, inadvertently, of “disregarding” it in its peculiar particularity³.

It is important to establish which aspect of the concept will be highlighted in order to avoid dogmatism in the definition. One can start with its common meaning, which in all languages is linked to the way one understands *one’s* worth. However, the term does not always refer to this human sense, and is sometimes understood as a means to a result with value in itself. Thus an abstraction (dignity) is defined by another abstraction (value), so as to ignore its clear multidimensionality.

Dignity in nursing theories

Nursing is, at the same time, discipline and “practical science”⁴⁻⁶. The latter is used to refer to philosophical systems of moderate realism, with methods of investigation and field of knowledge associated with the organization of concrete situations⁷. Therefore, as a discipline, nursing is practice-oriented.

The term “discipline” refers to the field of knowledge from an educational perspective and to the way of systematizing specific ideas and concepts. In this sense, “practical discipline” refers to the path to knowledge that has the function of explaining and describing phenomena of practice, organizing knowledge to support concrete actions⁸.

In addition to discipline, nursing is a profession with global concepts and metaparadigms

that structure its knowledge⁴. Theories formally organize this knowledge, presenting a set of interrelated concepts that form the way of seeing the world. Theorizing facilitates the understanding of reality, favours reflection and avoids the banalization of phenomena observation, including scientific elements in the understanding and analysis of reality.

The concern to develop theories is present since the beginnings of the profession. Concepts such as “care,” “well-being,” “environment,” “communication,” “safety,” and “health,” direct the practice even before being structured in a nursing theory. The journey from the times of Florence Nightingale to this day has been long and arduous. Nursing passed from a learned craft to a profession, ranging from patient subordination to responsibility and autonomy, from an exclusively practical application to scientific reasoning^{5,9}.

Although nursing experts explore metaparadigms of different models and recognize the centrality of dignity to the discipline, there is no theorizing about the concept. Some authors refer explicitly to the promotion of dignity^{10,11}, others prefer a more implicit approach to the concept⁷, and others do not even refer to it¹². Respect for such a value is considered central in the humanist approach^{10,13-17}.

Florence Nightingale¹⁸ wrote about the nurse’s work in “Notes on Nursing”, first published in 1859. Although several relevant issues are addressed, there is no specific reference to the dignity of the patient. In 1960, Virginia Henderson¹⁹, in her definition of nursing, widely cited and adopted by the International Council of Nurses (ICN), does not refer to the promotion of dignity, but in *Nature of nursing: reflections after 25 years* the term is mentioned several times²⁰.

Imogene King, in 1971, proposed that the ultimate goal of nursing is to improve the patient’s health and, where this is not possible, to allow the patient to die with dignity²¹. The author identified communication as a cornerstone to set appropriate goals and maintain realistic expectations.

They established five factors as the fundamental basis: life activities, aspects that affect life activities, life time, dependency/independence, and nursing process. They considered that while some people perform basic activities independently, others may need the assistance of the nurse. In this process, relationships of trust prepare the patient mentally, preserving their self-esteem.

Another model, Joyce Travelbee's theory of the person-to-person relationship²², was heavily influenced by Viktor Frankl's existential philosophy and ideas. The author advocates the therapeutic relationship, or "person to person," as a goal to be achieved at the end of various interactions between human beings, during which the ability to establish interpersonal ties develops. This process implies commitment among those involved, leading the subject to transcend and take an interest in the well-being of the other.

According to Travelbee²², suffering is a fundamental human experience, which affects everyone, and this way is both generalized and unique. It is related to individual values and the question of meaning: who, for example, finds meaning in illness can find meaning in life. Therefore, communication is a prerequisite of nursing care, and solidarity is built on respect and understanding. To be able to see the other person as he or she is requires a step-by-step relationship, seeing the human being behind the "labels", considering him or her as an inseparable unit composed of body and mind.

Paterson and Zderad²³, on the other hand, proposed the humanistic theory of nursing, which reveals the articulated view of scientific knowledge, the experiences of care, the existential encounter, the face to face. According to the authors, the caring person has the privilege of being with people who experience different meanings of being-in-the-world, in time and space, in the most different ages, from birth to death. The nurse seeks to know the human being through sensitivity, authentic awareness and reflection on these shared existential experiences.

Thus, it is perceived that in order to achieve the human interrelationship in care it is necessary to know oneself and the other. The opening of the authentic encounter is possible by sharing, recognizing the complexity of the individual in his / her relations with the other and with the world, understanding them as an essential and existential being in their nature, condition, experiences and in the process of "being more ". In this way, Paterson and Zderad²³ believe that in order to live and share with the other, it is necessary to know the other in his or her lived space, in a given temporality. That is, nurses should see the world through the eyes of the patient.

Going back to the concept object of this study, it is worth mentioning Watson¹⁰, who placed the preservation of human dignity as an integral part of care, proposing transpersonal relations as the nucleus of nursing science. According to the author, the nurse must stimulate these relationships to

restore the balance of the patient's mind, helping them to realize how they are and how they can come to be. This balance would ultimately lead to recovery and well-being¹⁰. Roach¹⁶ confirms Watson's perspective, considering humanity and dignity inseparable. And, in the same sense, Jacobs points out that *the central phenomenon of nursing is not health or some kind of restoration of holistic balance and harmony, but respect for human dignity*²⁴.

Dignity as an ethical imperative in health care

Dignity is very important for all those involved in care^{25,26}. So far, few studies have attempted to define the concept or demonstrate its extension in clinical practice. Therefore, it is concluded that to define its meaning is a challenge, since it is an abstract and subjective term, difficult to measure^{25,27-30}, although it has been studied by many^{25,29-39}.

Concern about promoting dignity in care seems to have begun in the context of palliative care⁴⁰⁻⁴², broadening its scope to include discussions on health and social services provided to a wide range of vulnerable or marginalized individuals, such as the elderly, homeless, the poor, the mentally ill etc⁴³⁻⁴⁹.

In an article on the subject, Mairis recognizes the importance of dignity, but realizes that the concept has different meanings for each person. The author interviewed 20 nursing students in order to investigate their perception of the concept. Three essential attributes stood out among the results: 1) maintaining self-respect; 2) maintaining self-esteem; and 3) valuation of individual standards. Respondents considered dignity as a personal attribute to which little value is given, unless the individual is vulnerable, feeling that he or she may lose it³¹.

Defining it as a shared belief among humanity, Haddock²⁵ states that its effect affects the ability to maintain or promote the dignity of the other. For the author, this concept allows the person to feel important and valuable in the relationship with others, being respected even in situations of threat. Haddock also emphasizes the distinction between having, being treated with and giving dignity to other people, emphasizing the subjective and dynamic dimensions of the concept and emphasizing the importance of relationships²⁵.

In nursing, the Haddock study identified the importance of self-awareness, countertransference, adequate and thorough patient assessment, and a deeper understanding of cultural values and meanings. It also described the power of nurses to

maintain and promote dignity, understanding the patients and treating them with attention when they feel vulnerable²⁵. This idea was systematically emphasized by later studies^{26,28,50-52}.

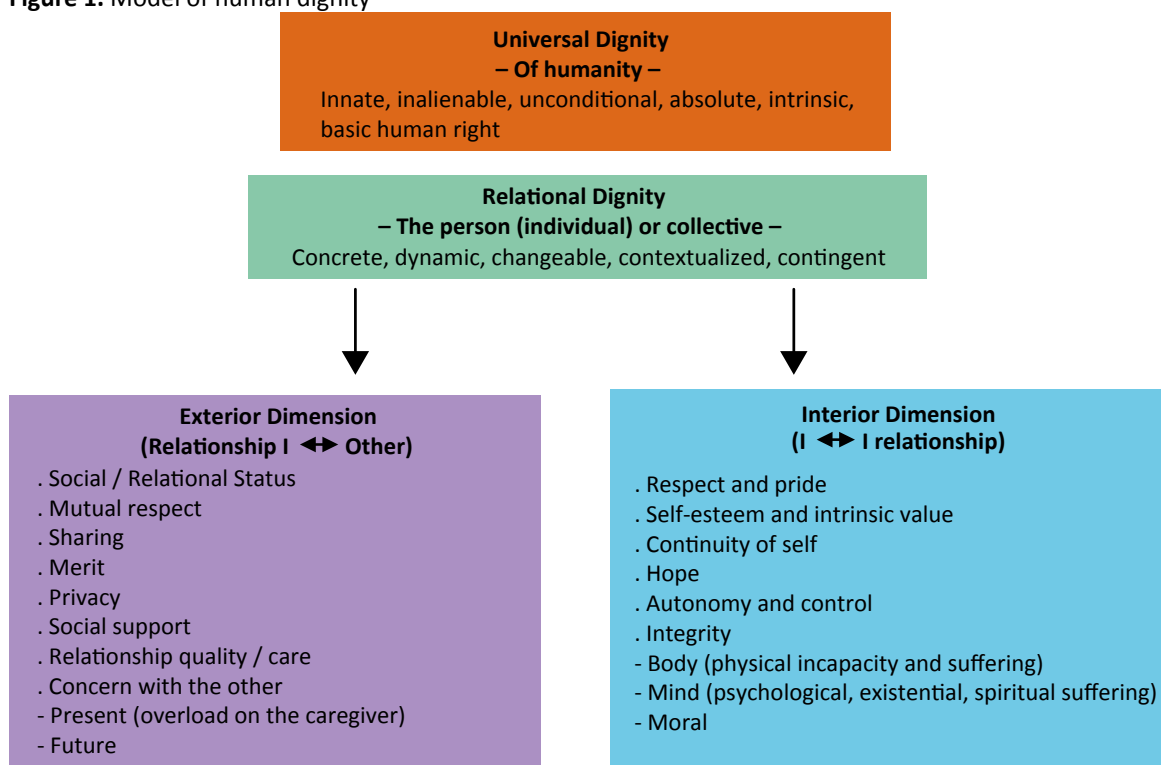
In nursing, one of the first philosophical analyses of dignity was published in 1998 by Leila Shotton and David Seedhouse¹, who saw it as the ability of the person to exercise his or her abilities or, in particular conditions, to receive help for the task. According to them, dignity is directly related to the dynamic interaction between circumstances and capabilities. There is a lack of dignity when the individual feels incompetent, inadequate or extraordinarily vulnerable¹.

Street and Kissane⁵³ broaden the comprehension of the idea by understanding it as embodied and socially constructed, being subjective, multidimensional, situational, and contextual. In the same way, in exploring dignity in the context of palliative care, Street and Love⁵⁴ showed the importance of listening to people's needs and desires, demonstrating that privacy does not only mean having a private room, but respect and recognition of the psychological, social and spiritual development of the patient.

Since 1995 Chochinov⁵⁵ has studied the dignity of people with terminal illnesses, having grouped the questions asked by patients into three categories: 1) *illness-related issues*, ie how the illness affects personal dignity; 2) *personal dignity-preserving repertoire*, the impact of personal perspectives and experiences on dignity; and 3) *social dignity inventory*, or how the quality of interaction with others influences dignity (Figure 1). The themes in each category provided the basis for the current model (*dignity model*)⁵⁵ and the dignity in care movement, which gives therapeutic guidance to health professionals, highlighting physical, psychological, social and spiritual / existential aspects that can affect the patient.

In 2008, following the work developed, Chochinov and colleagues⁵⁶ presented an instrument composed of 25 items that allowed the evaluation of the feeling of dignity in end-of-life patients. The patient dignity inventory was adapted to Portuguese in 2009, by António Gonçalves⁵⁷ and named *escala da dignidade do doente* (scale of the dignity of the sick) (Table 1). The instrument assesses the presence of symptoms, existential suffering, inner peace, dependence, social support and other indicators related to activities of daily living, such as a sense of control, ability to "fight" and ability to accept⁵⁷.

Figure 1. Model of human dignity



Source: Adapted from Julião e Barbosa⁵⁸

Table 1. Patient dignity inventory

| Concerns related to the disease | Personal dignity resources | Social resources of dignity |
|---|---|---|
| Level of independence Cognitive acuity Functional capacity | Perspectives protecting dignity Continuity of the self Role preservation Legacy elaboration Keeping self pride Keeping hope Autonomy and control | Privacy Borders Social support Care's tuning up |
| | | |
| | Practices Protecting Dignity Live in the moment Maintenance of normality Seeking spiritual comfort | Overload on carers Concerns about the future |

Source: Adapted from Julião e Barbosa ⁵⁸

For Fenton and Mitchell²⁸, dignity is relatively little addressed in the nursing literature despite essential in care. The authors emphasise the professional obligation not to ignore the needs of the individual in the midst of the demands of nursing practice. However, in contrast to Fenton and Mitchell, Jacelon et al⁵² argue that the topic is often discussed in the health care literature, although its significance is not always clear. By conceptual analysis, using the literature and data from five focus groups with a diversified sample of the elderly, the researchers concluded that *dignity is an inherent characteristic of the human being, which can be felt as an attribute of the self, and manifests itself through behaviour that shows respect for the self and for others*⁵⁹.

Some studies have brought specific contributions to understanding the patient's dignity. The qualitative work of Woolhead et al⁶⁰ identified several topics related to the theme, such as identity, self-esteem, integrity, trust, human rights, equality, autonomy, independence and control. The study by Black and Dobbs⁶¹ explored elderly people's understanding of the sense of dignity by identifying three fundamental components: (1) dignity as autonomy, understood as the ability to make decisions in all aspects of life (this was the most prevalent idea); 2) relational dignity, which describes the importance of interactions; and 3) dignity of self-identity, which includes pride, personal acceptance, and appreciation of the self.

Jacelon's study⁴⁹ examined how the elderly perceive the concept while hospitalized. Interviews were performed at admission, during hospitalization and at discharge. In the early stages of hospital admission, participants agreed that getting

treatment to go home was more important than maintaining dignity. However, during hospitalization, participants reported that they felt negatively affected by the procedures to which they were subjected and by the way they were treated by the team. It was found that the longer the hospitalization time, the more emphasis the elderly gave to respect for dignity⁴⁹.

There are two different dimensions when talking about the subject: the concrete, essential and absolute; and the relative, or internal. The first is associated with the body, which carries the dignity and freedom of the human being. The second refers to how reality itself is perceived. The essential and absolute dignity is inviolable and is characterized by freedom, responsibility, duty, service, pride, respect, honor and independence. These values, not always directly visible, are influenced by the dominant culture. When carelessly handled or unsecured, there is a violation of dignity. In order to reestablish it, it is necessary to change the context in order to highlight these values³⁸.

Human vulnerability becomes obvious when meaningful values can no longer be guaranteed, and concrete solutions to preserve dignity seem unavailable. In the specific context of the elderly, one can experience situations where important abilities, such as "taking care of oneself", can no longer be exercised. In simple tasks such as bathing, washing clothes, or tidying up, the patient depends on someone's help. "Being worthy of this help" then moves to the top of the hierarchy of values, restoring the experience of possible dignity³⁸. The internal hierarchy of values alters the external one, limiting itself to what can be achieved in context. Life can gain new meaning, and dignity can be restored³⁸.

Woolhead *et al*⁶⁰ studied elderly people from different socioeconomic backgrounds and levels of health and disability in institutional and community contexts. The sample included 72 participants aged over 65 years. The results indicated that dignity was perceived as identity, human right and autonomy⁶².

Gallagher³³ identifies two fundamental values in nursing: self-respect, which refers to personal dignity, and respect for the other. Both are subjectively experienced as the achievement of one's own dignity, revealed by behaviour toward oneself and others. The author recommends a comprehensive view of ethical competence, which includes seeing, reflecting, knowing, doing, and being³³.

Confirming the aforementioned work of Haddock²⁵, Griffin-Heslin²⁹ identified dignity as fundamental in nursing care, emphasising the importance of respect, autonomy, empowerment and communication. Going beyond that, the author expanded the understanding of the concept by highlighting its complexity, formed by several attributes that can be portrayed in different ways²⁹.

Tadd's study⁶³, the most comprehensive European research on the subject, considered the point of view of the elderly and health professionals and social service. The author also established three dimensions for this concept: identity, human rights and autonomy. The data suggested that each of them can be maintained or compromised by the behaviour of the person or team and by the context⁶³.

Arino-Blasco, Tadd and Boix-Ferrer⁶⁴ investigated the moral implications of human dignity from the perspective of health professionals. This broad survey, which involved 85 focus groups with 424 health professionals in six European countries, identified key factors for care delivery: promotion of autonomy and independence; holistic and person-centred approach; maintaining identity and encouraging involvement in care; participation and capacity building; effective communication and respect. Also identified are circumstances that constitute unworthy care: invisibility; depersonalisation; humiliation and abuse; and mechanistic approaches to caring⁶⁴.

In a literature review, Franklin, Ternstedt and Nordenfelt⁶⁵ reported that none of the 14 studies that formed the corpus of their research adequately represented the complexity of the concept, although all had something to offer as part of the emerging picture. It seems that it is easier to identify when dignity is not central to care than to identify its meaning⁶⁵. For the authors, *unworthy*

*care is associated with invisibility, depersonalisation and treatment of the individual as an object*⁶⁶, and may involve humiliation and abuse, as well as mechanistic approaches to care, *so that people may not be able to define "dignity" (...), but know when it is not present*⁶⁷.

Clark³⁶ refers to the issue both as objective right, which can be granted, and as subjectively experienced feeling. The researcher considers dignity the fundamental human right in order to highlight its importance and value.

Periyakoil, Noda and Kraemer³⁷ investigated the maintenance of dignity at the end of life through themes that emerged from data and existing literature. The study concluded that: 1) everyone has intrinsic dignity; and 2) extrinsic dignity remains outside the person, being influenced by the way it is treated by others. The sub-themes of intrinsic dignity included autonomy, self-esteem and spirituality, all of them, when present, capable of arousing a sense of hope. The extrinsic dignity was observed when physical and emotional needs were met, there was respect, and privacy and confidentiality were treated as a priority³⁷.

Julião and Barbosa⁵⁸ present a model based on the integration of ideas and concepts of Nordenfelt³², Jacobson³⁴ and Chochinov⁵⁵. For the authors, the concept encompasses universal and relational dignity - the latter consisting of two *complementary, dynamic and interconnected dimensions*⁶⁸ that are from the universal.

Edlund and collaborators³⁸ attempted to arrive at a deeper understanding of the concept, from its meaning, scope, and nature. Researchers have identified values of absolute dignity, which involve everything that belongs to human beings as such, such as holiness, freedom, responsibility, and duty to serve others.

For the authors, the absolute value of the person is constant, and can not be questioned or withdrawn. "Relative dignity" mirrors the absolute, but is changeable, shaped by the values embodied by humans, including the moral and cultural traits that attach importance and significance to actions and phenomena in the environment. These traits serve as symbols of the dignity that is experienced in relation to someone or something. When someone acts on these symbols, the human being can interpret this action as a threat or violation. The mutability of this dimension is a process by which dignity can be destroyed, but also reestablished³⁸.

Sulmasy³⁹ presents three types of dignity: intrinsic, attributed and *inflorescent*. The intrinsic refers to innate dignity; the attributed is the value, the moral stature that people grant each other by acts of attribution; and, finally, *inflorescent* defines individuals who “bloom”, living their lives according to the inherent dignity of the human being³⁹.

Van Gennip *et al*⁶⁹ indicate that conditions related to illness do not directly affect the dignity of patients, but the way they are perceived. The authors proposed the model of dignity in illness, composed of three elements that shape self-perception: the individual, relational and social self. The individual *self* refers to the internal, private self-assessment made by an autonomous individual based on his or her own perception of value and experiences. The relational refers to the dignity formed in dynamic and reciprocal interactions, and the social refers to the dimension of the subject as a social object, defined by the collective discourse on the disease⁶⁹.

Final Considerations

At present, the concept of dignity is considered multidimensional, influenced by the socio-cultural environment and personal history^{25,28,31-33,50,53-56}, including internal dimensions, such as valuing oneself, and external dimensions, such as valuing by others^{32,33,50,53,56}. And, to be socially constructed,

dignity becomes difficult to define. As a result, it is also complicated to establish how to keep dignity explicit in patient-centred explicit interventions, especially the elderly⁵². Thus, although much is debated on the subject, there is a lack of practical answers on how to promote and maintain it.

Considering its importance, it is surprising that, until now, the concept has been neglected in empirical research, lacking a solid basis for nurses' daily practice. It is the responsibility of professionals to describe or define concepts in an operational way. Ambiguity and confusion are generated without understanding on the part of its practitioners, as the lack of orientation creates inconsistency in practice and incompatibility between the professional and the patient's point of view. Dignity is interpreted in various ways²⁸ even though is often considered inherent in nursing care⁴¹ and, by its lack of definition, runs the risk of having its meaning diluted, becoming a word emptied of importance.

The study and promotion of dignity by health professionals - and particularly by nurses - must be reformulated. The review presented here shows the great complexity of the theme, which is in the essence of nursing, with its very different factors and dimensions that intertwine and influence each other. Therefore, it is important to develop studies that refer to care promoting dignity, seeking to understand how the nurse, the patient and other actors develop the care process.

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