Undignifying institutions

D Seedhouse, A Gallagher

See end of article for
authors' affiliations

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Correspondence to:
Professor D Seedhouse,
Centre for Health and
Social Ethics, Auckland
University of Technology,
Akoranga Campus, Private
Bag 92006, Auckland
1020, New Zealand;
david.seedhouse@aut.ac.nz

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Declarations of the importance of dignity in health care are commonplace in codes of practice and other mission statements, yet these documents never clarify dignity's meaning. Their vague aspirations are compared to comments from staff and patients about opportunities for and barriers against the promotion of dignity in elderly care institutions. These suggest that while nurses and health care assistants have an intuitive understanding of dignity, they either do not or cannot always bring it about in practice. Thus, despite stated intentions to promote dignity, it appears that the circumstances of at least some elderly care institutions cause patients to experience avoidable indignities. Such institutions are "undignifying institutions" because they fail to acknowledge dignity's basic components, focus excessively on quantifiable priorities, and have insufficient resources available to assure consistently dignifying care. As a partial solution, we argue that health workers should be taught to understand and specify the components of dignity, which will better prepare them to challenge undignifying practices and to recognise opportunities for dignity promotion.

A pilot study into the effects on health care staff of an educational intervention (an intensive, day long seminar, conducted by a health care philosopher to explain the nature of dignity) produced a wealth of responses from interviewees. The study was undertaken at three elderly care sites in a large UK city. The intervention was offered to nursing and health care assistant staff at two of three sites (the third site was the control). Pre and postintervention structured interviews of staff, patients, and relatives were conducted. The behaviours and attitudes of staff were also observed and recorded pre and postintervention. The results were inconclusive, and will be reported in full elsewhere. (Gallagher A, Seedhouse DF. *The Practical Implications of Teaching Philosophy to Practitioners. Dignity: a Pilot Study Nursing Times*, forthcoming]). The study received approval from three local research ethics committees.

Though the study failed to prove the value of the educational intervention, it is obvious from interviewees' comments that opportunities for the promotion of dignity are not maximised in the institutions we studied—and this is plainly of ethical import. Consequently, in this paper we place the interviewees' remarks in context, discuss the nature of dignity, and speculate on the relationship between health care resources and dignity promotion. We are particularly concerned to note that at least some of the time the institutions we studied not only fail to promote dignity but actually undermine it (presumably without meaning to). Experience tells us that these institutions are typical of state funded, long stay elderly care institutions in the UK, and we consider it a matter of national importance that these ethical, institutional, and educational concerns are urgently addressed.

THE ASPIRATION—OFFICIAL DECLARATIONS ABOUT THE IMPORTANCE OF DIGNITY

References to "dignity" are commonplace in aspirational codes and policy statements for health professionals. The International Council of Nurses' (ICN) code of ethics, for example, explains that:

Inherent in nursing is respect for human rights, including the right to life, to **dignity** and to be treated with respect.¹

The Australian Nurses' Code of Conduct 1995 instructs each nurse to:

... respect the **dignity**, culture, values and beliefs of patients²

While the Nursing and Midwifery Council (NMC) (UKCC) code of professional conduct (2002) ordains that:

You are personally accountable for ensuring that you promote and protect the interests and **dignity** of patients and clients.³

The NHS plan⁴ also states an expectation that dignity will be a priority:

We will improve standards across the range of services that older people use. Wherever older people are cared for, we will expect that both they and their carers will be treated in a way which respects their **dignity**, privacy and autonomy. This is not an addition to care provision, it is an integral part of good care [emphasis in each quote is authors'].

The aspiration to "respect dignity" is virtually ubiquitous. Everyone agrees that human dignity is important and should be respected but nowhere—in any of this proliferation of codes and mission statements—is dignity defined. As with other ethical slogans in health care—for example, justice, care, advocacy, and health—unless dignity's meaning is spelt out in practical terms everyone will be unequivocally in favour of it, but no one will have clear guidance about how to achieve it.

THE REALITY—DIGNITY AND LACK OF DIGNITY IN THREE ELDERLY CARE INSTITUTIONS

As part of the pilot study 18 nurses and health care assistants at three elderly care residential institutions were asked:

- 1) To give examples of occasions when they had been able and unable to maintain dignity
- 2) To discuss opportunities for and barriers against the promotion of dignity, and

3) To suggest how dignity might be better promoted in practice.

A small sample of patients and relatives was also interviewed. According to the interviewees, the extent to which patients are dignified depends on:

- 1) Staff behaviour, attitudes, and competence
- 2) The environment
- 3) Resources available
- 4) The condition and/or behaviour of patients.

The interviewees' observations are strikingly consistent—for example, 12 of the 18 posit a direct link between staff levels and patient dignity. Typical remarks in each category are listed below:

1) Staff behaviour, attitudes, and competence

... Yes, basically staff ... don't feel it's a priority, you know, just as long as they're washed and dressed and that's it. And like feeding a patient ... it's a task, it's a chore ... (registered nurse, site A)

... the time factor With nurses lacking a lot of time in the morning to get patients washed and dressed and things like that Forgetting to close the curtains or forgetting to put the towel on them ... (health care assistant, control site).

Older patients and their relatives also highlighted the significance of staff behaviour, attitude and competence. For example:

Well, for instance, this morning she brought me quite unnecessarily my tea without a saucer Well, I suppose it's a big place (patient, site A).

This last comment highlights a commonly overlooked aspect of seeking to promote dignity in practice. In order to maximise dignity creation, nurses must spend time getting to know the individual needs and circumstances of patients. For one patient a drink of tea without a saucer may not be an issue, while for another it may be a serious and undermining insult.

2) The environment

The environment category includes matters of privacy, safety, and aesthetic aspects of the health care environment. Inevitably, there are associated resource implications. For example:

The curtains are not very good, not very wide. They don't close properly. The windows, if you close the curtains, make it dark and the lighting is not great ... (health care assistant, site A).

Oh yes, we have a policy of the main door being closed, locked. Do we do it for our own safeguard or are we seeing to the patients' benefit? I mean ... I mean, are we right? Are we wrong? (registered nurse, site B).

... the sort of curtains on the ward and the close proximity of the beds to one another (are a cause for concern with regard to dignity). If you're moving around the bed to do a bed bath with anybody and you catch the curtains accidentally (residents can be exposed), so space between the beds (is very important). (registered nurse, control site).

3) Resources available

This was the key theme in relation to dignity promotion/diminution. The resources most commonly referred to were human (staffing), linen, and equipment. For example:

... understaffing is a big problem when it comes to time, time for people, having to skip over things. (registered nurse, site A)

Linen, towels in the morning, we haven't enough towels. We use pillowcases for drying patients and they say "where is the towel?" and we say "they didn't come yet" Patients find it really, you know, as much as us, they find it unsuitable, not very suitable. (registered nurse, site A).

And lack of resources ... certain things not working like, showers not working, call bells, the place being dirty, sometimes it looks like a pigsty. (registered nurse, control site).

... we are still acutely short of staff and you often have to choose between who needs you more ... a choice of doing say antibiotics on time or attending to someone who calls. (registered nurse, control site).

4) The condition and/or behaviour of patients

Staff also found this category problematic:

... And then sometimes it's just very difficult with some patients ... it's very hard to maintain their dignity. For example, when they have no, sort of, conception of dignity anymore ... they're confused or demented and (pause) ... also with the lady who strips herself off and you're walking past the room and you see that she's lying there exposed and, you know, it's not my fault that her dignity is not maintained right then but it's my job to give it back. (registered nurse, site A).

Sometimes they kick you, they punch you and sometimes you cannot maintain their dignity ... I know you're not supposed to force them but you have to as they're wet but don't want to be changed but we cannot leave them like that so we really have to force them to (registered nurse, site B)

These comments undoubtedly reveal:

- a) a mismatch between practice reality and the ambitions of codes and declarations,
- b) an intuitive understanding of dignity amongst staff, patients, and relatives that is as yet not concretely expressed.

Dignity has been simply and powerfully defined by various thinkers (for instance³⁻⁸) but these clarifications have not been adopted by policy-makers and managers and so are rarely accessible to or used by coalface practitioners. We believe that dignity's meaning ought to be openly and practically expressed. Furthermore, we are of the opinion that our respondents' intuitive beliefs are in keeping with the more rigorous account summarised below.

DEFINITION OF DIGNITY

The definition of dignity which guided the educational input in the pilot study has been published elsewhere⁵ and was achieved by asking: what makes people feel undignified?

Reflection on personal experience shows we tend to lack dignity when we find ourselves in inappropriate circumstances—when we are in situations where we feel foolish, incompetent, inadequate, or unusually vulnerable.

To spell this out a little more, we may lack dignity:

In circumstances ill fitted to our competencies (**Type 1**), and

In circumstances in which we are normally capable, but where we fail to achieve what we routinely would (**Type 2**)

We do not necessarily lack dignity under these conditions. And when we do experience indignities they are not always of the same magnitude.

LEVELS OF DIGNITY LOSS

It is helpful to distinguish different levels of dignity loss. Like the two types above, these are not absolutely separate categories, but they do begin to offer a more complete picture of dignity:

i) Dignity maintained

ii) Dignity lost in a trivial way—dignity easily restored

iii) Serious loss of dignity—substantial effort and probably help from others required to restore it

iv) Devastating loss of dignity—impossible for a person to regain dignity without help.

By combining these levels with the two general types we discover eight kinds of situation in which dignity is either at risk or lost.

Type 1i) A person is in circumstances ill fitted to her competencies, but dignity is maintained

Inappropriate circumstances are common in everyone's life, and always carry the risk of dignity loss. How we respond—or are able to respond—can make the difference between dignity maintained and dignity lost. For example:

Peter is a high-flyer. He's not yet thirty and has progressed rapidly, specialising in urology. He has been courted by two large clinical departments who would both like him to accept a post as senior theatre nurse with a view to management in a year or two. However, Peter has decided to become a nurse academic and has applied for a newly established chair in clinical nursing at the local university.

He is a clever, hard working nurse and has never failed to secure any job he's been interviewed for. The word is he will get the job, and leave his present position shortly.

His colleagues are in the middle of arranging a celebration bash (which they intend to keep secret just in case he is disappointed) when Peter walks in, looking downcast. He did not get the job. He sees what they are doing and blushes deeply.

This is a new experience for him. For a moment he doesn't know what to do. He feels like crying and is in danger of losing his dignity.

Then four pagers go off at once. There is an emergency in theatre and they need Peter immediately.

Instantly he forgets his embarrassment, regains his composure, and dashes to the theatre to change.

Peter nearly lost his dignity because he was incompetent to deal with the circumstances he found himself in. Fortunately, the circumstances changed, ensuring that his dignity was maintained.

He has learnt from the experience (his capabilities have expanded as a result of it). If he ever finds himself in a similar situation he now knows that the adage "win some lose some"

applies to everyone—even him—and he backs himself to win more than he loses. "Their loss, not mine", he'll say. He'll be hurt but he'll shrug it off and enjoy his friends.

Because he now has the capabilities to deal with such circumstances he will be able to maintain dignity if they ever occur again.

Type 2i) A person is in circumstances in which she is normally capable, fails to achieve what she routinely would, yet still maintains her dignity

We can usually excuse ourselves if we find we have bitten off more than we can chew. But if we fail to do what we have come to take for granted, that can be harder to bear.

It is possible to maintain dignity in these circumstances, but the person in the risky situation must have other useful capacities and be able to draw on them. For example:

At 72 Brian Smith had a stroke which resulted in a right-sided weakness which meant he was unable to walk unaided. Mr Smith previously had an active life and was captain of the local bowls team. For several weeks after his discharge from hospital he tried to carry on playing, and held onto the captaincy even though he was so frustrated at his reduced playing abilities that he couldn't concentrate on leadership. No one told him to give it up, but he began to notice too many pitying, embarrassed looks in his direction. Brian dug deep. He tried to look at himself from the others' point of view. He didn't like what he saw, felt profoundly sorry for himself for an hour, and then volunteered to retire from playing and offered to assist with the administrative aspects of the bowls club instead (he used to be a senior bank official). His offer was accepted with delight and relief by the rest of the team.

Brian Smith managed to maintain his dignity. He changed the prevailing circumstances as best he could. He was no longer able to play bowls properly but maintained his dignity because he had additional competencies which he could bring into play to improve his vulnerable situation.

Type 1ii) A person is in circumstances ill fitted to his competencies and loses dignity in a trivial way

Like 1i), this is a common state of affairs. The overconfident driver who has to drive a vehicle with more power than he is used to, the childless woman who thinks mothering comes naturally and who offers to take on a group of three yearolds for the morning, the student nurse who angrily challenges a senior nurse about patient care only to find that she has her facts wrong—each is at risk of at least a trivial loss of dignity.

Type 2ii) A person is in circumstances in which she is normally capable, fails to achieve what she routinely would, and loses dignity in a trivial way

This combination is likely to be tougher to deal with than situations in which one has no previous expertise, but can be solved by a dignified strategy.

An example from our study was of a normally competent nurse who was speaking with relatives about an elderly patient and realised mid-discussion that she was thinking of and referring to another patient. She was embarrassed and lost some dignity, but she could explain the lapse to others, and is generally capable, so it is likely she was able to avoid further indignity.

Type 1iii) A person is in circumstances ill fitted to her competencies, and suffers a serious loss of dignity

This state of affairs arises in various ways in hospitals and other health service settings. It can, for instance, be difficult

for even the most scrupulous health professional to remember that her familiar work setting may seem alien to a newly admitted patient. Unless the patient is told the routines, knows where the toilets are, can find a telephone, and can have privacy when she needs it she may well suffer a serious loss of dignity. If she has good personal resources available—if she is cogent, if she can walk, if she has the confidence to speak out, then she may be able to regain dignity herself. But if she does not possess these assets then she may even sink into category 1iv).

Type 2iii) A person is in circumstances in which she is normally capable, fails to achieve what she routinely would, and suffers a serious loss of dignity

Such predicaments sometimes occur in health service institutions—especially those that are under resourced. In the early 1990s in England a charge nurse called Graham Pink blew the whistle on just such a situation. He spoke out about poor conditions and lack of staff on a ward for vulnerable elderly patients. Pink referred to “avoidable injuries, infrequent washes . . . a catalogue of shame and neglect”. The elderly people’s dignity was undermined because the hospital was unable to ensure that they could do what they would normally take for granted—the hospital thus failed to provide for their dignity. Sadly, there continues to be evidence that older people in hospital suffer serious dignity loss.⁹

Type 1iv) A person is in circumstances ill fitted to her competencies and suffers a devastating loss of dignity

A person newly diagnosed with a serious disease might find herself in this unhappy state of affairs. She may be at a complete loss about what to do and will require sensitive, practical support to liberate new or latent capabilities, and so regain dignity.

Type 2iv) A person is in circumstances in which she is normally capable, fails to achieve what she routinely would, and suffers a devastating loss of dignity

Such a situation might happen—for example, following chemotherapy. At visiting time a patient might be unable to speak with her gathered family because she is constantly vomiting. If so she may require urgent help from others to rediscover her dignity. Health workers must either rapidly change her circumstances or they must equip her with new competencies to ensure that she can cope with her indignity.

GENERAL AND SPECIFIC DEFINITIONS OF DIGNITY

The above analysis suggests that dignity always has to do with being in a position where one is capable. Thus, dignity may be generally defined like this:

A person will have dignity if he is in a situation where his capabilities can be effectively applied.

Dignity may be defined more specifically like this:

This person’s capabilities are A, B, C . . . X, Y, Z. She will have dignity in situations where she can exercise these capabilities effectively.

Since ability is dependent on circumstances (it’s no use being a wonderful ball-player if you don’t have a ball) dignity promotion may best be summed up like this:

If a health worker wants to promote a person’s dignity she must either expand her capabilities or improve her circumstances.

According to this understanding of dignity, in order to maximise dignity, staff must determine what each older patient’s capabilities are and ensure that these are effectively applied. They must also understand the impact of circumstances on capabilities. Here, empirical research has an important role. Our pilot study, for example, provided important information about the circumstances which are commonly significant to older people.

Without a definition of dignity aspirations to achieve it are often toothless, and may even cause carers to assume they are dignifying patients when they are not. Armed with a definition of dignity, however, carers can immediately begin to work to make promoting dignity a practical task. Are capabilities being overlooked? Do present circumstances undermine patient capabilities? Could circumstances be altered so as to enrich patient capabilities?

THE DIGNITY/RESOURCES PATTERN

Based on the analysis of dignity provided and on our data, we claim that there is a simple and direct relationship between resource levels and dignity, such that *the better the resources (money, time, staff, energy, enthusiasm, commitment), the richer the circumstances, the more likely it is that patients will be dignified*.

As resources diminish the most obvious and quantifiable priorities (such as administering and recording medication and making sure meals are served according to the timetable) are protected at the expense of the less tangible (such as caring and promoting dignity).¹⁰ These readily quantifiable activities are often dignity promoting themselves—for example, judicious medication promotes dignity because it improves both capabilities and circumstances. If, however, the less quantifiable aspects of institutional life are neglected, as clinically dominated systems preserve their “vital functions” under pressure to maintain resource levels, significant indignities can quickly become routine.

There is a disturbing—and common—pattern here:

- a) A noble idea (such as “respect dignity”) is proclaimed (and more often than not is posted on the walls of an institution alongside other noble ideas)
- b) The idea is not given practical substance—either in practitioner training or in the institutional setting
- c) In the absence of clear definition it is:
 - i) assumed that everyone knows and agrees what the noble idea means.
 - ii) assumed that everyone knows and agrees how important it is relative to other ideas and practical priorities.
 - iii) assumed that everyone can and is applying it in their daily work, and is applying it in the same way.
- d) In practice, however, quantifiable, overt and traditional practices continue unchallenged by the noble idea, simply because they are visible habits.
- e) Some of these habits are actually counter to the noble idea, and yet they cannot be challenged by it because it is not practically specified or overt (unlike traditional practices).
- f) As resources become more stretched traditions become more entrenched and the noble idea becomes even harder to establish.
- g) Thus, despite the most explicit declarations of purpose, circumstances can force institutions to behave counter to how they intend.

For example, if a patient’s call for attention is not responded to due to short staffing, the patient may feel a consequent lack of control and self worth, in which case an institution has created a dignity undermining circumstance. Similarly, when patients are dried with pillowcases rather than towels, when staff do not know their patients because they are from an agency, when showers are not repaired, or when patients are left sitting in a place they don’t want to be simply because no one has asked if they would like to be moved, the institutional practice has itself undermined patients’ capabilities.

Though staff and patients reported many examples of dignifying circumstances (and we observed many instances of exemplary practice during our pilot study) their examples of undignifying situations show there is much that might yet be

done both to enhance the capabilities of patients and to improve the circumstances in which they are cared for.

CONCLUSIONS AND RECOMMENDATIONS

We do not think staff deliberately seek to undignify patients—for the most part staff do remarkably well to uphold patient dignity in demanding circumstances, and we have particular respect for the hard-pressed health professionals we met during our study.

We are arguing, however, that long established traditions and cultures embedded within institutions sometimes render it impossible for staff to promote dignity, even though they want to. Thus we suggest that if dignity truly is a priority, and especially if its achievement is considered to be of equal importance to clinical goals (which according to hundreds of codes and mission statements it is) then there must be extensive, well funded and systematic reviews of dignity promotion, meant to identify and remedy mismatches between circumstances and capabilities. In particular we make the following recommendations:

We suggest that all health care institutions and educational establishments:

- a) explain dignity's components to their staff
- b) set up education programmes to encourage reflection on less tangible health care goals
- c) facilitate the reporting of bad practice
- d) establish good role models
- e) continually stress the importance of seeking to understand patients in order to have the clearest possible grasp of their actual and potential capabilities
- f) carry out further empirical work to determine how and what circumstances impact on dignity in practice.

Whilst we have identified and discussed current key circumstances, we acknowledge that our study was small in scale and also that other factors—for example, technological developments may also constitute a circumstance which promotes or inhibits dignity in a changing health care environment.

The institutional environment and its resource levels affect patient capabilities—the richest environments tend to reveal and release the most positive potentials while the poorest do the opposite. Therefore, we suggest that all institutions establish efficient reporting procedures to enable patients and relatives to complain when the environment causes them indignity. We also suggest that older patients and relatives should be involved in the design and monitoring of older person care facilities.

Sometimes patients' capabilities are so severely compromised that they do not experience dignity or indignity themselves. In practice, however, it is best—for patients, relatives, and staff—to assume that a patient can experience dignity.

We acknowledge that on this view, dignity must be a subjective experience. Consider a case in which a person under anaesthetic is left naked on an operating table in public view, but never knows it. At first sight it seems natural to say that the person suffered an indignity—but in truth he or she did

not suffer anything. Only if he finds out what happened could he possibly feel undignified.¹¹ There is indignity here, but it is experienced vicariously. The doctor or nurse who finds the patient unnecessarily exposed will likely think either that Mr X would not wish to be seen like this, I would not wish to be seen like this, or most people would not wish to be seen like this. Strictly speaking, in such cases we rightly apply a generally held understanding of dignity to prevent what would be indignities, were they actually experienced by the subject. Our own sense of dignity is protected as we act in what we assume to be another person's interests, when he cannot act for himself.

Given this assumption, when working with patients who are incompetent due to physical or mental illness, staff should try to discover past preferences, interests, priorities, and capabilities and aim to provide for these, as far as possible. For example, if it used to be important for a person to have her hair done regularly and to dress well then every effort should be made to ensure that this continues to be so.

In short, if dignity matters then it is essential to specify what it is and what is necessary to ensure it. If an institution does not have sufficient resources to promote dignity consistently then it will inevitably be an undignifying institution. And if one believes that dignity is a human priority then undignifying institutions are simply unacceptable.

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Authors' affiliations

D Seedhouse, Centre for Health and Social Ethics, Auckland University of Technology, Auckland, New Zealand

A Gallagher,* Centre for Professional Ethics, University of Central Lancashire, UK

*At the time of writing A Gallagher was a Research Assistant at the former School of Health, Biological and Environmental Sciences, Middlesex University, London, UK

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