

Letter

From the struggle of defining to the understanding of dignity: A commentary on Barclay (2016) “In sickness and in dignity: A philosophical account of the meaning of dignity in health care”

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Dear Editor,

We were pleased to see that [Barclay \(2016\)](#) very recently addressed the important issue of dignity in health care. In the paper entitled “In sickness and in dignity: A philosophical account of the meaning of dignity in health care”, the author ([Barclay, 2016:136](#)) promotes an understanding and sensitivity for patients’ dignity as ‘core’ outlining critical responsibilities of health care practitioners. This enticing title left us very curious to know more about the philosophical perspective of dignity in health care that the paper purports to offer. The paper provides a very comprehensive and detailed review of key aspects of health care that may preserve or violate human dignity. They also draw upon some of the pioneering theories, models that seek to conserve dignity. For this reason the paper makes a significant contribution to these debates.

[Barclay \(2016\)](#) draws our attention to the fact that dignity is a nebulous term and there is little consensus regarding definitions. Indeed [Barclay \(2016\)](#) calls for a more coherent and synthesized concept of dignity in health care suggesting that a less deconstructed account and the “identification of a core philosophical concept of dignity that clarifies and synthesises the disparate qualitative findings may be helpful” (p. 137). However we would question, while offering a detailed discussion on the concept whether or not the paper delivered on its aims.

We are not certain that, after reading the paper (on multiple occasions), nurses would have a more thorough grasp of the meaning of the concept of dignity. Additionally, while there seems to be a call for a broad understanding of the term, we would hold that the meaning of dignity within the nursing profession may have particular importance and relevance that could overlap but not necessarily fully concur with the interpretations of other disciplines. The particular professional lens that is used to understand dignity will ultimately affect understandings. For example, looking at dignity from a psychoanalytic perspective ([Akhtar, 2015](#)) differs widely from the perspective of a nurse.

When reading [Barclay’s \(2016\)](#) paper, the main argument put forward is that the meaning of dignity used in health care has been derived from a limited philosophical background. Thus the paper aims to

provide a more coherent and synthesised concept of dignity in health care, which is defined as “in health care settings, a patient has dignity when he or she is able to live in accordance with his or her standards and values” (Barclay, 2016; p. 137). A final definition is also provided reading “...it [dignity] refers to upholding the patient’s standing as an equal, especially by respecting her capacity to live in accordance with her standards and values.” (Barclay, 2016; p. 140). Interestingly Barclay (2016) use the phrase ‘standards and values’ on 35 occasions affirming the importance of these to her philosophical understanding of dignity. One area that is only fleetingly addressed is how these attributes of dignity relate to individuals living with profound intellectual impairment – raising the question is the development of dignity and dignity preservation a purely conscious, intellectual activity? How can one live in accordance with his or her standards and values if they do not have the capacity or rationality to know what these are? This then raises the question that dignity is then conferred and the dignity of the individual is preserved and upheld according to the standards and values of those charged and ultimately responsible for their care?

While we agree with Barclay’s understanding of dignity, however, to provide care based on respect and dignity, nurses need to understand patients’ individual perspectives or ‘standards and values’ in various settings. In particular, there is a focus within the paper (Barclay, 2016), in the title at least, on ‘sickness’. However there should also be a commitment to promote dignity not just in sickness, but in times of health and wellbeing especially relevant in the fields of health promotion and rehabilitation. Indeed labelling patients as ‘sick’ creates a paradoxical situation. Patients often don’t feel ‘sick’, and thus treating them as such could serve to compromise their dignity.

Barclay’s (2016) also criticizes the ability for qualitative research on dignity to inform this concept. However we question if there is any other research paradigm more appropriate to understanding perspectives of such an individual phenomenon? Isn’t this what is expected in providing evidence-based care? Nurses have a responsibility to nurture the dignity of patients and have been involved in several studies to develop a concept of dignity, some based on a generic approach (Griffin-Heslin, 2005), and other in specific contexts, as in older adults (Coventry, 2006; Jacelon et al., 2004), palliative care (Brennan, 2014), dying patients (Hemati et al., 2016), and also in young child (Popovich, 2003).

At the same time relevant nursing diagnosis (within NANDA-I, an international classification of nursing diagnoses) already includes a nursing diagnosis entitled “risk for compromised human dignity”, which is defined as “risk of perceived loss of respect and honour, which may compromise health” (Herdman and Kamitsuru, 2014: 267). When looking at this classification, specific risk factors need to be taken into consideration: cultural incongruence, dehumanizing treatment, disclosure of confidential information, exposure of the body, humiliation, insufficient comprehension of health information, intrusion by clinician, invasion of privacy, limited decision-making experience, loss of control over body function, and stigmatization. Any of these risk factors can contribute to poor health care experiences. These are etiological factors that place patients’ at risk of feeling disrespected or having their dignity compromised.

Ultimately while conceptual clarity is useful, and a philosophical concept of dignity is extremely helpful and welcome bringing new insight and understanding to the debate we question the usefulness of this exercise for nurses especially those working in frontline care.

Clearly nursing diagnosis already exists, and from a practical health care provider point of view, the struggle of having to have a definition is overcome by the need to understand what dignity is for each patient. A one size fits all approach to dignity is not always appropriate when caring for diverse groups of people.

Uncited reference

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