Does the Concept of Dignity Warrant Further Research, and Can the Work be Moved Forward?

Dignity is not earned—it is deserved by every human being. That statement resonates with most of us, and it is consistent with the belief that one does not need to be seen as worthy to have dignity. Dignity is not associated with autonomy, as proposed by Mairis (1994); nor is it entirely an inherent right, as it can be lost and one’s dignity can be violated. According to Clark (2010), dignity is experienced both objectively and subjectively, and it is defined as self-regarding and other-regarding; that is, dignity is self-confirming and indicates self-confidence and positive self-esteem, whereas the loss of dignity may be associated with anger, embarrassment, anxiety, and humiliation (Lundqvist & Nilstun, 2007).

Previous research has focused on dignity as a complex concept that is difficult to define and measure. It is similar to spirituality, an area of research with which I am very familiar. I believe that spirituality exists, I can experience its presence and notice its absence, and I believe it is critical to the provision of holistic nursing care. It is from this perspective that I offer my thoughts about the significance of dignity in older adults and the importance of nursing efforts to provide care that promotes human dignity in those we serve. Approaches to enhancing individuals’ dignity occur in our communication with others, our promotion of comfort and relief of pain, and our engagement in relationships with shared respect. These moments are just a few examples of nursing interventions that I believe are crucial to holistic care.

If we believe that dignity exists, then we must include research on dignity in gerontological nursing and health care research. If dignity is multidimensional, then a multidimensional research approach is warranted. The qualitative research being conducted initially on the topic is the beginning of the process of exploration of the concept and illuminates its dimensions. This type of research is worthy of the effort and may be a necessary part of the research trajectory. However, researchers who want to relate dignity to interventions and, ultimately, measure its impact on outcomes need to determine which elements of dignity can be operationalized and thereby tested in research protocols. We can quantify an individual’s level of involvement in decision making or level of satisfaction as an affirmation of the quality of care or human interactions. Research methods are not confined to qualitative descriptions of experience; in fact, quantitative measurement tools can be developed.

The two articles on dignity included in this issue of Research in Gerontological Nursing used qualitative interviewing techniques to more clearly understand the experience of dignity. The study by Lohne et al. (pp. 265-272) explored family caregivers’ experiences in nursing homes and used a phenomenological-hermeneutic approach. In the study by Jacelon (pp. 273-283), a grounded theory approach was used to identify the types of strategies used by community-dwelling and hospitalized older adults. Both studies contribute to the field and bring an understanding of experience that may lead to the development of nursing interventions.

In any research study, dignity may not be the only variable to affect patient outcomes and cost of care, and it may serve as a mediating or confounding factor. Concepts such as respect and ethical treatment, along with dignity, have a positive effect on outcomes. Reducing the length of the inpatient stay or improved adherence to health care treatments will ultimately have an impact on patient outcomes and cost of care.

Knowledge of dignity needs to be generated from a variety of perspectives. A global view of the concept and types of interventions is critical. Our colleagues in Europe, as well as others outside of the continental United States,
seem to have a greater interest in conducting this research and moving the science forward.

As the older adult population increases in the United States, most European nations, Japan, and even less developed countries, a critical need exists for research on the topic. The World Health Organization (WHO; 2014) reports that the proportion of the world’s population 60 and older will increase from approximately 11% to 22% from 2000 to 2050. In this period, the absolute number of individuals 60 and older is expected to increase from 605 million to 2 billion (WHO, 2014).

Aging is no longer the sole province of more developed countries. Longer life expectancy at birth and lower fertility have sharply increased the proportion of elderly in less developed countries. In 1950, 4 percent of the population in less developed countries was ages 65+. Today, that proportion has risen to nearly 6 percent but is projected to reach nearly 15 percent by mid-century (Haub, 2011, para. 7).

It is thought that 4% to 6% of older adults in high economy countries experience some level of maltreatment (WHO, 2011). A lack of the violation of dignity and respect for older adults may incur serious consequences for this growing population, as well as social, moral, and economic costs. Research on dignity in older adults and interventions that can be standardized across the age spectrum and modified for cultural variations are critical.

REFERENCES

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