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Respect for Human Dignity in Nursing: Philosophical and Practical Perspectives

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Perdrai-je ma dignité?
Quelqu'un se souciera-t-il de mon sort?
Me réveillerai-je demain
De ce cauchemar?

(tiré de la comédie musicale *Rent*,
paroles et musique de Jonathan Larson)

Depuis sa première publication en 1976, le *Code for Nurses with Interpretive Statements* [Code des infirmières, accompagné d'énoncés explicatifs] a servi de cadre permettant d'expliciter les « obligations morales » des infirmières et infirmiers professionnels (American Nurses Association [ANA], 1985). Une refonte de ce code est actuellement en préparation (ANA, Code of Ethics Project Task Force, 1999). Tel qu'exposé dans l'un et l'autre de ces documents, le premier devoir moral de toute infirmière est le respect de la dignité humaine (ANA, 1999) : les infirmières doivent faire preuve de compassion dans toutes leurs interactions professionnelles et respecter la dignité, la valeur intrinsèque et la spécificité de chaque personne, sans égard aux considérations d'ordre social, économique ou personnel, ou liées à la nature des problèmes de santé. (p.4)

Dans les cinq énoncés servant à traduire la portée de ce devoir, on a recours à un certain nombre d'expressions clés, dont, en premier lieu, « le respect de la dignité humaine »; cette notion sous-entend à la fois le respect de la valeur intrinsèque de chaque personne et des droits humains. Issues de la philosophie morale, ces expressions sont couramment utilisées dans d'autres disciplines, notamment en droit, en religion, en médecine et en sciences humaines. La définition même du terme de « dignité » demeure limitée en regard de l'interprétation et de l'utilisation qui en est faite. Cet article propose donc d'étudier cette notion à la lumière de quelques approches choisies en philosophie morale, de définitions tirées des dictionnaires et d'essais contemporains, ainsi que de l'interprétation qu'en font les étudiantes et étudiants inscrits au baccalauréat, à la maîtrise ou au doctorat en sciences infirmières. Ces quatre sources différentes nous servent ici de fondement pour argumenter que l'analyse scientifique seule ne peut que limiter la portée de la notion de dignité. Le respect de la dignité humaine, en conclusion, doit être considéré comme un art qui s'alimente par la praxis et suscite le dialogue entre professionnels des soins infirmiers; sa portée est beaucoup plus large, tant sur le plan ontologique et épistémologique, que celle d'un simple principe énoncé dans un code déontologique.

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Will I lose my dignity
Will someone care
Will I wake tomorrow
From this nightmare?

– Music and lyrics by Jonathan Larson
from the musical comedy *Rent*

Introduction

Since its first publication in 1976, the *Code for Nurses with Interpretive Statements* has provided guidelines for explicating the "moral obligations" of professional nurses (American Nurses Association [ANA], 1985). The American Nurses Association is currently drafting a new version of the code (ANA, Code of Ethics Project Task Force, 1999). In both documents the first ethical duty of all nurses in the profession is to show respect for human dignity (ANA, 1999):

> The nurses, in all professional relationships, practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. (p. 4)

A number of phrases are used in the five interpretive statements of this duty, the first of which is "respect for human dignity." Inherent in this phrase is respect for *worth* and *human rights*. Such phrases are replete within moral philosophy yet can also be found in other disciplines, including jurisprudence, religion, medicine, and the humanities. The actual definition of a word such as *dignity* is often not as meaningful as how it is perceived and used. The purpose of this paper is to discuss the use of the word *dignity* by examining selected moral philosophical epistemologies, dictionary meanings, current literature, and perceptions of students in nursing programs at the baccalaureate, master's, and doctoral levels. Based on the discussion of these four sources of ethical knowing, possibilities for future analysis of respect for human dignity are offered that suggest that this concept is underdeveloped if investigated only scientifically. It is concluded that such respect for human dignity can be viewed as a practical art, enhanced through praxis, conducive to dialogue among nursing professionals, and broader both ontologically and epistemologically than a principle in a code of ethics.

A Moral-Philosophy View

Dignity has no physical properties that natural science can observe or identify, a fact that may contribute to its ineffability. As a concept,

dignity and its attributes may be identified by what human beings experience and the perceptions that the human mind subsequently formulates (Chinn & Kramer, 1999). Because there is no way to directly measure or observe it, dignity is a "relatively abstract" concept that is known through more indirect methods of observation and experience (Chinn & Kramer). Epistemology and knowledge of concepts in the world has been the pursuit of philosophers for centuries. Two epistemologic views, one empirically based and one rationally based, are presented as a philosophical preamble to the concepts of respect and moral agency in explicating an understanding of human worth and dignity within the context of moral principles.

Knowledge and John Locke

In the 17th century, the British empiricist John Locke (1632–1704) believed that a human being is born with a mind that is a blank slate, a *tabula rasa*. The knowledge that eventually fills the slate is derived from experiences. Locke focuses primarily on "objects" in the world using such examples as a rose, ice, and sugar. However, it is, along with other sensations, the smell of the rose, the feel of the ice, and the taste of the sugar that fill the mind with perceptions and ultimately knowledge about these objects (Locke, 1689/1998).

In his *Essay on Human Understanding*, Locke (1689/1998) extends his philosophical thinking about how one knows the world beyond objects to such ideas as pleasure, delight, pain, and power. The posited, empirical belief of how humans come to know these concepts and ideas is still based on the experiences of sensation and reflection. Once the senses provide the brain with information, the mind reflects on the perceptions. Locke states, "we can have knowledge no farther than we have ideas" and "we can have knowledge no farther than we can have perceptions of that agreement or disagreement" (Book IV, Chapter 3, Sections 1 & 2). Perceptions and ideas, Locke believed, are derived from intuition, sensation, and reason.

It would seem reasonable to believe that dignity is a concept guided by intuition. To respect another person's dignity would appear obvious to most moral agents. However, using the senses to garner knowledge regarding dignity may prove perplexing. Locke believed that senses have external causes, an assumption that was later refuted by the Scottish philosopher David Hume. The basis of the refutation is that if the senses are experienced and the external causes are not, then the knowledge derived from the senses could be due to spontaneity and not really experienced at all. Of the three Lockean knowledge

forms, it is reason that was pursued by the next philosopher to be discussed, Immanuel Kant.

Rationality (Reason) and Immanuel Kant

The Lockean belief that knowledge is *a posteriori*, or based on experiences and subsequent perceptions, was counter to the older philosophical belief that innate ideas are known *a priori*. Immanuel Kant, a German philosopher born almost a century after Locke, believed that all knowledge *begins with* experiences but does not necessarily *arise from* experiences (Kant, 1781/1990). The distinction between the two is most relevant to understanding the philosophical and metaphysical bases of morality and respect for human dignity. The most significant insight can be drawn from Kant's (1785/1997) *Foundations of the Metaphysics of Morals*.

Reason or rational knowledge is pivotal to Kantian moral philosophy. Kant describes two forms of rational knowledge, material and formal. Ethics, he believed, is material philosophy in that it is based on a moral philosophy that formulates laws not of nature (as in physics) but of the Will of man as affected by nature. In other words, when philosophy deals with material knowledge regarding objects of understanding (such as dignity and morality) it is termed the Metaphysics of Morals and is known through reason. While Locke was an empiricist, Kant was an idealist. Kant believed that sources of moral knowledge are not individual "feelings or sentiments" based on some nature of the human being, and that moral duty is based on reason (Kant, 1785/1997; Pojman, 1998).

Because moral knowledge is derived from reason, Kant postulates that an unconditional imperative, which he terms categorical, is indeed the imperative that guides moral duty: "...the first proposition of morality is that to have genuine moral worth, an action must be done from duty" (Kant, 1785/1997, pp. 15–16). He also believed that it is "out of love for humanity" that actions are connected to the concept of duty.

Respect

Although dignity is the focus of this paper's discourse, it appears that respect is just as important as dignity since dignity is rather void and moot unless it is respected by another person in a community. The whole idea that practical morality is community-based is credited to Aristotle and reiterated in the following passage from the United States

Catholic Conference of Bishops (1986), as cited in Ashley and O'Rourke (1997, p. 8):

> Human dignity can be realized and protected only in community. In our teaching, the human person is not only sacred but also social. How we organize our society directly affects human dignity and the capacity of individuals to grow in community.

Kant postulates that respect is *a priori*. In other words, if respect is *a priori* it is not inductively inferred, may be determined by experience, but does not necessarily require experience to be known and may be known by some other knowledge form (Russell, 1945). Sherman (1997) highlights important Kantian connections between practical reason, emotion, and respect and explains Kant's view this way:

> If there are a priori practical principles (by which rational agents, such as ourselves, are capable of being moved), and if in addition to being rational agents, we are also affective agents so constituted that we have desires that can always conflict with those principles, then there will always be present the ingredients for respect. Put more simply, respect is just the affective side of our ever available capacity to be moved by practical reason. Respect is not itself a separate sort of motivation. Rather, it is the effect of moral motivation on feeling. In a sense, it is a kind of epiphenomenon. (p. 176)

If intuition, reason, and sensations are knowledge forms of dignity, then Aristotelian and Kantian philosophy become a little clearer. Aristotle believed that emotions "transformed by revisions of our beliefs" subsequently "embrace more adequately our judgments of what is overall good" (Sherman, 1997, p. 178). On the other hand, Kant did not believe in the Aristotelian "connection of emotion with cognition" but did believe that emotions are "sensations." Kant believed that practical reason is the knowledge used for motivational agency but because man is "affective" he is *not motivated* by respect (an emotion) per se but respect is an effect of a moral motivation (Sherman). "But though respect is a feeling, it is not one received through any outer influence...thus respect can be regarded as the effect of the law on the subject and not as the cause of the law" (Kant, 1785/1997, p. 17).

Noggle (1999) states that "a person enters the moral realm when she affirms that other persons matter in the same way that she does" and that respect is a way to manifest such "mattering" (p. 449). Some would say we owe respect to other persons (Buss, 1999). A deontological view of respect is based on the belief that persons, because of their moral autonomy (not their individual autonomy) have value, therefore dignity, and thus ought to be respected for that special value

(Beauchamp, 1991). Respect for persons is based on their worthiness to be respected (Buss).

Moral Principles

The connection of the sources of knowledge regarding dignity to actual moral behaviour, according to Chinn and Kramer (1999), "can be reduced to principles and codes, which are shorthand ways of expressing ethical knowing" (p. 163). The most contemporary ethical principles guiding moral behaviour are those of beneficence, nonmaleficence, justice, and respect for autonomy. These four principles are the basis for applied ethics as espoused by such leading ethicists as Tom Beauchamp and James Childress (Beauchamp & Childress, 1994).

Principles may not be sufficient to guide one's moral behaviour, and this applied-ethics method has been questioned. Knowledge about human dignity is one example that Meilander (1995) cites as a concept that may not be addressed solely through the application of principles, since there are disagreements and questions about our self-knowledge regarding human dignity. Meilander believes that a focus on principles does not offer enough "substantive guidance" and is ultimately "deceptive in its clarity — leaving unaddressed the most pressing questions" (p. 19). Pondering the issue of assisted suicide or pondering the issue of abortion are just two examples of how the complexities of respect for human dignity have eluded universality in public opinion, public policy, and the law. If respect for dignity were grounded in moral principles, it would seem that knowledge about dignity would be more universally apparent. However, views concerning the dignity and sanctity of life can be extraordinarily bipolar in certain circumstances, making nurses' moral obligation in the *Code of Ethics* questionable and perplexing.

Principlism (a somewhat negative term used to refer to the four principles cited above) and codes of ethics may have the same goal — that is, "social consensus." Meilander (1995) suggests that this goal is equated with the development of public policy. In 1973 the United States Supreme Court voted to legalize abortion in the famous case of Roe v. Wade. This case is an example of how public policy (law) focuses the issues of privacy and the right to reproductive choice in the cloak of respect for autonomy. Such a principle-based, right-based ruling, however, did not take into account "protection for prenatal life" (Devettere, 2000, p. 351) and could be in opposition to persons' self-knowledge regarding the dignity of a potential human life.

The ANA, through its *Code of Ethics*, suggests that dignity has universality, neutrality, and consensus, a suggestion that requires further explication of the meaning of dignity. The focus on dignity in this context perhaps obscures the rich robustness of such a concept in the minds (self-knowledge) of nurses, who view respect for human dignity from other moral perspectives such as relational caring, virtue, feminism, or the Aristotelian perspective of *eudaimõn* and *eupraxia*, meaning, respectively, happiness and living the good life (Aristotle, 1892/1962).

Moral Agency

The view that ethics (and ultimately respect for human dignity) is more than principles and universal codes is reflective in such ethical theories as care ethics (Groenhout, 1998), virtue ethics (Sherman, 1997), and Christian ethics (Ashley & O'Rourke, 1997). A personal ethic or morality need not be limited to one view or theory. Such philosophers as Aristotle, St. Thomas Aquinas, and Kant (known as the duty-based or deontology-based moral philosopher) stressed the importance of the character and virtue of the moral agents themselves.

Moral agency is a person's property of being able to reason, self-determine, and ultimately act or be moral. MacIntrye (1999) offers three characteristics of moral agency. In this discussion the nurse as agent has: (1) qualities of mind and character that are hers as an individual, not necessarily as a nurse; (2) confidence in her rational moral judgements; and (3) accountability to herself not only as a nurse but also as an individual. These characteristics suggest that if nurses recognize and accept the attributes of their own moral agency they will be directed to free moral agency, even in environments that by their very structure are "compartmentalized" in their social order because they have accountability in that order.

How one chooses, evaluates, decides to execute moral agency (in this discussion how to respect dignity) is a complex process. However, the ANA has chosen to view dignity as a concept that is a "fundamental principle" and therefore uses principles as its moral compass (ANA, 1985; ANA, Code of Ethics Project Task Force, 1999). The difficulty arises, for example, when nurses disagree with what is birth or death with dignity. Some may hold the belief that withholding nutrition and fluids is respecting dignity, while others may hold a belief that it is just the opposite. Reckling (1997), in her study, found that nurses played a passive role in making decisions about withholding or withdrawing life support from patients in intensive-care units. Numerous reasons for such passivity were cited, including "a combination of their profes-

sional expectations and the situational constraints they face" (p. 43). But could it be that nurses in their obligation to respect human dignity are torn between their own moral, religious, and virtuous beliefs and those beliefs that are saturated with principlism, whose very foundation is respect for patient autonomy and family wishes?

Gadow (1999) posits that because nursing is a profession it has moral ends. She articulates three levels of ethics relevant to nursing. The first is non-discursive immediacy, the "subjective certainty" one derives from family, religion, tradition, and community. The second is ethical universalism, an "objective certainty" based on principles, theories, codes, and laws. The third is ethical engagement, an "intersubjective contingency" derived from existential relational narratives. These levels, which correspond to premodern, modern, and postmodern ethics, are philosophically laden but, most importantly, although they appear as historically hierarchical Gadow insists they can coexist.

In conclusion, dignity and respect are two concepts that have philosophical underpinnings, underpinnings that do have some universality of belief. This means not that there cannot be varying beliefs concerning dignity and respect, but that if they are held as *codes* of moral comportment for all nurses perhaps there needs to be considerable concept clarification for them to stand as the basis for a universal moral code of ethics. There is considerable controversy as to the meaning of the two words, their sources of knowledge, and the ultimate utilization of this knowledge in determining moral obligations and judgements.

Dictionary Definitions

Dictionary definitions provide the lexical meanings of words (Pedhauzer & Schmelkin, 1991). Another form of definition is stipulation — that is, a word means whatever its user stipulates it to mean. For example, the word *toilet* in the phrase *pulmonary toilet* certainly does not have the lexical meaning of a bathroom fixture but refers to the medical regimen of managing a patient's pulmonary problems. Words or phrases may also serve as euphemisms for concepts that appear too harsh or blunt. The ethical, legal, medical, and nursing literature is replete with the phrase *death with dignity,* which may be a euphemism for dying without suffering, dying at home, or dying with some sense of human worth. Although the phrase is used commonly, the moral behaviour that demonstrates respect for human dignity is not limited to the end of life but spans persons' entire lifetimes.

The *Oxford English Dictionary* (1971) accords dignity eight significations (sematology) and two morphologies, one French and one Latin. The French word *digneté* was first used in the 12th century; the Latin word *dignitatem* refers to worth or merit (p. 726). The eight significations are:

1. the quality of being worthy or honourable; worthiness, worth, nobleness, and excellence;
2. honourable high estate, position, or estimation; honour; degree of estimation or rank;
3. an honourable rank, office, or title; a high official or titular position;
4 nobility or befitting elevation of aspect, manner or style;
5. [in astrology] the situation of a planet in which its influence is heightened;
6. a company of canons;
7. [in algebra] power;
8. [in German] honour and worth

The index to Beauchamp's (1991) *Philosophical Ethics* gives three locations for dignity in the text, but it also instructs the reader to "see Moral worth" (p. 426). It is interesting that Beauchamp chooses to paraphrase Kant when describing the source of one's dignity. "The person's dignity — indeed, 'sublimity' — comes not from subjection to the law but rather from being the lawmaker — that is, from being autonomous" (p. 181). Beauchamp admits that "dignity can be defined in several ways, but perhaps the best definition treats dignity in terms of free rational agents who are ends in themselves" (p. 198). However, this definition is not particularly relevant for nurses when caring for patients who, because of their physiologic or mental states, are not free rational agents. In an attempt to respect the dignity and worth of free rational agency, the federal government in the United States has legislated self-determination (related to choices involved in medical care) in the form of advanced directives as a proxy for individual autonomy. But in the absence of such pre-articulated values, respect for autonomy can be evoked if the nurse is able to re-embody herself, experience her own subjectivity, then subsequently experience the patient's subjectivity as a form of existential advocacy (Gadow, 1989). How does the nurse who cannot assume the existential advocate role, for whatever reason, respect the patient's worth? It might be that worth is unconditional (Feinberg, 1973). It would appear that this is the belief of the ANA Task Force when it refers to dignity that is "unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (ANA, Code of Ethics Project Task Force, 1999, p. 4).

The fact remains that there are those with restricted social status — for example, prisoners in hospital-based prison wards, combative patients tied in four-point restraints, or persons stripped of moral personhood status because of their lack of sentience or cortical function. The relationship of human worth and dignity to the ability of persons to execute moral agency through moral motivation and subsequent judgement is the basis for respecting such worth in others. However, it is clear that nurses are sometimes in a position in which moral personhood is not the focus of their respect for others; in such circumstances nurses respect not moral personhood but moral standing. Moral standing does not require the characteristics of moral personhood (agency, motivation, judgement) but does indicate that persons in such positions have a *capacity* for pain, suffering, or emotional deprivation (Beauchamp, 1999).

Nursing Views

Three different levels of nursing students were asked to provide an example of code-of-ethics use in respecting a patient's dignity. Four doctoral students responded. Three cited calling patients by name and providing patients with privacy and "covering" their bodies. One student wrote: "I maintained her dignity by providing privacy, recognizing her discomfort and fear, and meeting her educational and emotional needs, and cultural awareness." One student described her beliefs in more detail. She felt that patients fear losing their dignity if they envision being ashamed, naked, vulnerable, or weak or having to beg for something. Running counter, then, to losing dignity is maintaining pride, protection, strength, self-sufficiency through being valued, and feeling valuable. This same student believed that respecting patients' choices concerning medical treatments is another way of respecting dignity.

Five nursing students in a master's program responded. Two equated respect for patients with keeping the body covered. One student stated that she respected a patient's dignity by honouring her decision to die of cancer at home, providing comfort measures, and comforting the family by providing information and support. Two students felt that when physicians asked for their opinions the physicians were respecting nurses' dignity. When describing a combative, rude gunshot victim, one student said, "I treated him with dignity by appreciating who he was at that moment in his life."

Thirty-eight baccalaureate nursing students enrolled in an ethics class responded to the question "what is dignity?". Their responses centred on the following:

- pride, self-confidence, self-esteem, self-respect, and values
- what makes one human — part of the inner being, defines character
- worth and uniqueness
- trustworthy, solemn, earnest, reverent
- being respectful of others — for example, upholding patient confidentiality, protecting privacy
- an absolute moral right, a prima facie right
- stronger than pride, fosters autonomous choices
- respect for and honouring of others
- to act in a dignified manner
- dignity is spiritual — a birthright, not an earned right

Eighteen of these students shared their experiences of respecting patients' privacy. The experiences were related to actual patient encounters. Themes in the descriptions were: referring to patients by name, covering patients with bed linens, providing information to help patients make choices, not talking about patients in front of them, respecting religious beliefs, being there for comfort and support, listening, and promoting personal privacy. The most chilling example was the following:

> *A few years ago, EMS brought in a man in his 60s who had been found unresponsive by his wife in the early hours of the morning. A CAT scan determined he had a cerebral hemorrhage that was incompatible with life. His family came in later, and refused to go in and see him. His wife stated he was an alcoholic and had abused her for a very long time. She said discontinue everything and let him go. Some of the nurses remembered him and agreed that he had not been a nice man. So, the triage nurse decided to use his room for the next patient and get this guy down to the morgue. She wanted me to put his body into a morgue bag while his heart was still beating! I felt that no matter what he had done in this life he didn't deserve that type of treatment from me in his dying moments. I refused to put him in a morgue bag until his heart stopped. I hope this was a little more dignified for him.*

This incredible story is antithetical to any concept of dignity or any other professional code of ethics. It was the student who recognized that such action and behaviour were disrespectful and violated all principles and beliefs related to human dignity. Six students interpreted the question about dignity as it specifically related to death. Death with dignity for these students meant that the dying person not be left alone, that the dying person be free of pain, that the death have meaning, that

a patient who decides to forgo treatment be respected for their decision, that patients be viewed as persons whose lives have value, that patients be cared for as more than objects, and that washing patients who have died before the family sees them is a way of according dignity post-death.

Review of the Literature

Searching the *Bioethicsline* through the National Library of Medicine Internet Grateful Med Search using *dignity* as the search word yielded 717 citations. Searching *dignity* through CINAHL for the years 1989–1999 yielded 81 citations. One concept clarification was found. Mairis (1994), a nurse from England, interviewed nursing students and concludes that there are three attributes of dignity: "maintenance of self-respect, maintenance of self-esteem, and appreciation of individual standards." She also describes four antecedents or prerequisites for dignity as a concept: "dignity is a human quality, self-advocacy promotes dignity, dignity may be demonstrated by behavior, speech, conduct and dress, and dignity is developed by individual life experiences" (p. 931). Mairis posits that a Kantian view of one of his categorical imperatives ("act only according to that maxim by which you can at the same time will that it should be a universal law") (Kant, 1785/1997, p. 38) is "insufficient" to promote a patient's dignity. It is her belief that dignity "is acquired through life experiences" (Mairis, p. 952), a belief that she supports by listing eight ways that dignity can be maintained — for example, feeling valued — and eight ways that it can be lost — for example, feeling disregarded.

In a phenomenological-hermeneutic research study, Söderberg, Lundman, and Norberg (1999) interviewed 14 women with fibromyalgia. They conclude from their three major themes (loss of freedom, threat to integrity, and a struggle to achieve relief and understanding) that the overall experience of having this illness is struggling for dignity. Their interpretation of dignity is derived from the Latin words *dignitus* and *dignus*, meaning, respectively, equivalence and credibility. These two meanings are quite different from those of English versions of dignity and may represent the authors' Swedish interpretations. The authors do posit, however, that dignity has an internal dimension (credibility and honour) and an outer dimension (reputation, nobility, and status).

"Death with Dignity" is the title of a number of published works (Hayslip, 1998; Madan, 1992; Parry, 1998; Quill, 1992). Madan, in particular, suggests that the spread of Western medical culture with its

technological advances may be "regrettable" in that prolonging life through the use of technology runs counter to the beliefs of some cultures. The author believes that such prolongation of life could result in a failure to respect dignity. Ganzini et al. (2000) report on physicians' experiences with the Oregon *Death with Dignity Act*. Since 27 October 1997, physician-assisted suicide in the American state of Oregon has been legal. Since this law came into force, 57 persons have been prescribed lethal medications and their cases reported to the Oregon Health Division. Of these, 43 (75%) died from the prescribed medications. In a previous study of the Oregon *Death with Dignity Act*, researchers concluded that the reasons for requesting assisted suicide were not uncontrollable pain or financial concerns but loss of autonomy and loss of control over bodily functions (Chin, Hedberg, Higginson, & Fleming, 1999). Could it be that fear of the loss of autonomy, the loss of being a free rational agent — not whether the patient is physically exposed or is called by name — is really at the core of dignity? As Kant (1785/1997) said, "Autonomy is thus the basis of the dignity of both human nature and every rational nature" (p. 53). Kant's view of dignity, and its relationship to reason and autonomy, is the thrust of respect for persons in community, not only when death is near but throughout their lives.

Hendin (1995) puts an interesting marketing slant on *death with dignity*, implying that it is a "selling slogan" for supporters of euthanasia and assisted suicide. He suggests that instead of as a slogan the phrase should be used as confirmation of the value and meaning of the life lived.

In a study by Söderberg, Gilje, and Norberg (1997), the core theme of *dignity* was found in 85 different stories of intensive-care nurses who were asked to describe scenarios of ethical difficulty. From these stories, the authors identified the "demands" of respecting patients' dignity: "attentiveness, awareness, personal responsibility, engagement, fraternity, and active defense of dignity," and equated such demands with the philosophies of Marcel, Ricoeur, and Weil. The authors also formulated three dignity-related meanings to the nurses' stories: "transforming disrespect into respect for the inviolable value of the human being, transforming ugly situations into beautiful ones, transforming discord of death into togetherness."

Although the concept of dignity runs through the literature, two studies illustrate the confusion that surrounds its meaning. Johnson (1998) analyzes the clinical and philosophical use of the term *dignity*, especially as it relates to dying. He notes its ambiguity and concludes

by suggesting that *death with dignity* should be viewed not as an isolated concept but as "an interactive process among the dying and their caretakers. Together this interdependent amalgam engages in humanizing communication toward understanding the final needs and wants of the patient." This suggestion is again reminiscent of the philosophical connection of dignity with the special features of humanity and free rational agency that often define a human as a person. Shotton and Seedhouse (1998) review the meanings that dignity can have in different disciplines, such as bioethics, nursing, and studies concerned with human rights. Their fear is that if dignity is not more clearly defined it will "disappear beneath more tangible priorities."

Conclusion and Possibilities for Future Analysis

Dignity as a concept is ripe for clarification and analysis. Although Morse (1995) raises questions about the appropriate method for concept analysis, the continued growth of bioethics, the advancement of reproductive technology, and the implications of genetic research are just three reasons why *dignity* needs to be more robustly defined. Morse posits that methods of concept analysis derived from Wilson (1969) have certain flaws, such as the use of single cases; the absence of context, which can contribute to practical application; and the identification of fairly obvious results. Morse suggests the use of six different approaches to explain concepts:

- concept development to describe a concept that is unclear
- concept delineation to demonstrate differences between two "merged" concepts
- concept comparison to describe different, often competing, concepts
- concept clarification to reduce the confusion of certain assumptions about a concept
- concept correction to rectify the lack of fit between a concept and its clinical application
- concept identification to define a new concept.

The word *dignity* is unclear (concept development); dignity has been merged with worth and respect (concept delineation); dignity is often compared with respect for autonomy (concept comparison); assumptions of dignity such as free rational agency may obfuscate the concept (concept clarification); dignity in clinical practice in prisons and mental-health units may be in jeopardy (concept correction); and finally dignity in nursing practice may prove to be an altogether different concept

(concept identification). It appears that dignity requires considerable further research if its meaning is to be understood.

Morse (1995) suggests that qualitative research methods, beginning with a literature review and progressing to data analyses from observation, interviews, and secondary data analyses, are a way of using "rules of relation to identify the attributes of a concept, to delimit the concept, and to document the various forms that the attributes manifest" (p. 36). These methods are a useful means of better defining dignity, yet we must go beyond science (whether using qualitative or quantitative methods) to *knowing* respect for human dignity as an art and as a moral imperative. Ethics is conducive to *phronesis* (an Aristotelian term for the cultivation of praxis or "doing" through an understanding of what ought to be done in certain situations), places respect for human dignity in the realm of what Aristotle refers to as the practical arts, and does not limit the concept development of dignity to science (Carr & Kemmis, 1986).

Locke, as previously mentioned, was an empiricist who believed "morality being [is] capable of demonstration" in a scientific sense: "...measures of right or wrong, I cannot see why they should not also be capable of demonstration, if due methods were thought on to examine or pursue their agreement or disagreement" (*Essay Concerning Human Understanding*, Book IV, Chapter III, Section 18, as cited in Russell, 1945). More contemporary philosophical beliefs would view an understanding of respect for human dignity in realms other than science. As eventually scientism may be a threat to the fullest explanation of dignity, it is clear that dignity/human worth is a moral concept with roots in philosophy and other disciplines such as religion and art. The sources of knowledge to better explicate dignity are numerous. Science, whether achieved through quantitative or qualitative methodology, may not be the most appropriate search engine — and it is certainly not the only one — to validate and clarify the role of respect for human dignity in the nursing profession.

Critical social theory holds promise as a way to "preserve the concerns of classical practical philosophy with the qualities and values inherent in human life" (Carr & Kemmis, 1986, p. 133). The use of scientific research methods alone may not be amenable to such preservation. Is respect for dignity a *classical practical philosophy*? Is it a value *inherent in human life*? The answers to both these questions appear to be prima facie positive. The fit of dignity (respect for) in a practical arts paradigm, its clear value in human life, and its rich ontologic and epis-

temologic history are three reasons for suggesting a different existential clarification of its meaning.

Carr and Kemmis (1986) suggest that critical social science lies somewhere between philosophy and science, after reflecting on a question posed by Habermas about how the preservation cited above might be achieved: "...can we obtain clarification of what is practically necessary and at the same time objectively possible?" (p. 133). Critical social science affirms that "science should be justified by epistemology and not vice versa" (Carr & Kemmis). The suggestion that there is not one knowledge form that defines dignity means that epistemology should not justify the science that analyzes dignity as if it were even measurable (a suggestion of Mairis, 1994). If dignity could be measured and if one's knowledge interest could determine some causal explanation for dignity, then perhaps an empirical-analytical approach would be useful. On the other hand, dignity in the ethical sense is practical philosophy with the knowledge interest of understanding, knowledge that could be gained from hermeneutic or other interpretive sciences. If the knowledge guiding interest to understand dignity were an emancipatory one, then critical social science would be ideal. Why critical social science as a means of garnering knowledge about dignity? It would appear that those persons for whom dignity is not respected, for whom worth is not recognized, for whom respect is not afforded, are indeed oppressed. Such oppression is often justified by meeting the interests of others. The following scenario exemplifies oppression and lack of respect for worth and dignity.

> *In the emergency department at 6am, Jan, an experienced emergency-department nurse, called the local taxi company to take a 48-year-old patient named Ian home after a 4-hour stay following a seizure. This patient with Down syndrome had been admitted via ambulance from a group home 30 minutes away from the hospital. He was alert, no longer post-ictal, and anxious to go home in time to get to work. Jan had not called Ian's legal guardian/family since she thought that consent for treatment was understood, given that the group-home staff had called for the ambulance and therefore, in essence, consented to treatment, and given that the family had previously written their blanket permission for emergency treatment. The sole staff member at the group home could not leave the other two clients to pick Ian up, so Jan and the physician concluded that a taxi was the most appropriate mode of transport. Ian was a Medicare beneficiary. He did not qualify for ambulance transport home since Medicare rules do not allow non-emergency ambulance or wheelchair transport for patients who can walk. With discharge instructions pinned to his pyjamas, Ian was put into the back of a taxicab, destination instructions were given to the driver, and Jan's encounter with Ian was over.*

This true story illustrates how a critical definition of dignity and its analogous concepts of worth and honour could benefit a nurse's decision-making. The ANA *Code of Ethics* suggests that respect for human dignity is the top priority of professional nursing in a moral sense. Critical social science holds promise as a means of describing knowledge about dignity that extends beyond its subjective meaning and describes an "objective framework within which communication and social action occur" (Carr & Kemmis, 1986, p. 137). This is based on the belief that dignity is moot if it is not considered within the framework of a moral community and that such moral community may distort the understanding of dignity. Habermas (1984), through his ideal speech situation with its four validity claims of truth, comprehension, sincerity, and rightness, suggests that his theory of communicative competence is a collaboration of theory and practice — a collaboration that would serve to emancipate those oppressed by disregard for their dignity, worth, and honour. Harmony of theory and practice is pivotal to nursing as a profession that is both an art and a science.

Dignity appears to be a conceptual something that all persons have and therefore can lose. Dignity is a conceptual something that persons are born with and want to die with. As ubiquitous as it is, dignity deserves to be defined so that it can be understood theoretically and practically within the nursing discipline. Philosophy (theories and principles), science, lived experiences, and the art of moral agency are all contributors to the respect for human dignity that human beings show in community.

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