

Beholding & Upholding Human Dignity in the Nursing Profession

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This work highlights the absence and need for a nursing conceptualization of dignity, including how gaps in the nursing literature inadequately equip the profession to articulate and defend dignity. Essays by the President's Council for Bioethics show how Ruth Macklin's claims of the uselessness of dignity can be compellingly contested with the position that human dignity is greater than, and certainly not interchangeable with, the principle of respect for autonomy. Of these essays, Daniel P. Sulmasy's, Leon R. Kass's, and Edmund D. Pellegrino's theories present a conceptualization of dignity that is truthful, substantive, and defensible for nursing. Sulmasy offers a practical guide which can facilitate the upholding of dignity by nurses at the bedside. This guide aligns with Kass's insight into upholding dignity in the form of reverence in the face of vulnerability, as well as admiration in the face of excellence. Sulmasy's guide supports the intersubjective notion of dignity presented by Pellegrino by listing the guide as moral imperatives, or duties. Pellegrino's understanding of dignity as a lived, intersubjective experience fully encompasses the nursing profession's idea of human dignity by showing the fullness of human nature, the reverence owed to vulnerability as well as excellence, and the recognition of dignity in the realities of daily life. This work situates the intersubjectivity of the nurse-patient interaction in a highly technical setting in light of this conception of dignity, arguing that the more intensively technological the medical setting, the more imperative it is to respond to the dignity that is discussed.

Introduction: The Inquiry into Dignity

As a nursing student, I have had the privilege of bearing witness to patients' moments of raw, profound vulnerability. Each time I witnessed vulnerability, it spoke to the deeper nature of being human. I found questions prompted by my patients' realities to be inevitable. What do I owe my patient? What do human beings owe one another? How can we honor the nature of human beings, in all its finitude? These questions led to the larger inquiry into human dignity. Specifically, the nursing profession asked that I guard human dignity, but no one communicated a clear conceptualization of what it or its theoretical foundation is.

When I turned to the nursing literature, I found that the factually rich yet distant content of my textbooks did not address my questions. My experiences in various clinical settings showed me that many nurses recognize the dignity of their patients. They sense intuitively that being a nurse implies proximity to the unfolding fundamental truths regarding the beginning, the middle, and the end of human life – including the indomitable dignity throughout these stages.

In one clinical experience, the nurse I shadowed in an intensive care unit demonstrated this intuitive recognition as we took care of the most critically ill patient I had seen as a student. This patient was connected to a bundle of transparent intravascular tubing that infused medications emboldened with the words, "HIGH ALERT." She had an arterial line inserted into

her femoral artery, located in the groin, which allowed the nurse to monitor and pharmacologically manipulate her blood pressure when the patient's body became too unstable to regulate its own basic cardiovascular system. Since the patient's renal function had deteriorated, she was also undergoing continuous dialysis, which meant all her blood was being filtered outside of her body for twenty-four hours a day. The patient's respiratory ability had been compromised as well, which necessitated a tracheal tube and ventilator set carefully to deliver the correct amount of air pressure to simulate normal breathing. Due to her dependence on the ventilator, she was in a state of medically induced paralysis and sedation in order keep her oxygen demand, physical comfort level, and emotional state stable. Despite the importance of proper nutritional intake, she could only receive total parenteral nutrition – a bag of liquefied macronutrients formulated for delivery directly into the bloodstream.

The unconscious person lying before me depended on numerous different machines outside of her body to take the place of her heart, her kidneys, her lungs, and her experience of eating. The room was quiet and dark, with the blinds closed and the lights dimmed, in order to promote better rest. The most vibrant part of the room was the light emitted by each machine to signify its proper functioning – the lights on the machines that sustained the patient seemed more alive to me than the patient herself. This stirred uncertainty within me about the meaning of what I was seeing. However, what

emerged as the most significant part of this scene was what the nurse did next. After she finished teaching me the importance of calibrating the arterial line, she paused for a moment. She gazed at the patient and tenderly squeezed the patient's hand. "Breaks my heart," she said with a gravity that transcended her words. Then, she stroked the patient's head, carefully smoothing out some messy hair. She took another reverent moment to stare at the patient's face in silence and sincerity, then she motioned for me to follow her out of the room. Amidst the medicalized, technology-laden sight I had witnessed, the nurse saw beyond the interventions. Squeezing an unconscious patient's hand as a sign of deep care and fixing her hair out of an inarticulable consideration were testaments to the acknowledgment of something greater than the capacities the patient could not exercise.

The nurse upheld the dignity of the patient, by virtue of the patient's full, irreducible humanity – and I began to ask myself why this act of good nursing care was not shown or expected more universally, since dignity is a familiar term in the profession. Evidence-based literature primes me to be a competent nurse, but the underlying philosophical dimension of the job that I encounter powerfully is not discussed by the kinds of research and knowledge that is emphasized by the profession as a science. The aim of this research is to explore and articulate the philosophical convictions about dignity that form the edifice of nursing.

Part 1: The State of Dignity

Dignity in the Nursing Profession

The nursing profession introduces the notion of dignity early on to its students, at the point when nursing is still a nascent concept in their minds and not yet a practice. At Villanova University's Fitzpatrick College of Nursing, students are taught the importance of holistic care and of treating patients with dignity throughout their education. Once students begin their clinical courses in various hospitals, they are graded on their performances based on the objectives in the Clinical Evaluation Instrument (CEI). These CEIs outline dignity as a competency within the objective of providing good care, specifically "safety, dignity, and quality patient-centered care," (Nursing Leadership Course 4117 CEI Objective II 2). Students are also expected to treat "...all patients, family and members of the interprofessional team... with dignity and respect," (CEI Objective II 4).

Dignity is never explicitly defined, though it is used regularly to convey a recognition of something about the patient that is greater than their health condition. Dignity seems to be a subjective concept that every

nurse interprets for herself and incorporates into nursing practice, based on the patient-care anecdotes of the nurses who came before them. It appears that for health care professionals, "treating patients with dignity seems to be part of their character, as well as their sense of professional integrity," (Dresser 511). In nursing, treatment of patients with dignity is likely driven by intuitive acknowledgment and assumption of duty rather than robust theoretical conceptualization as in bioethics or philosophy. It is a term that is believed to be clear upon casual consideration yet is not elaborated upon or considered more deeply. When asked to maintain the dignity of patients, nursing students understand that there is an expectation of general respectfulness, conduct with a sense of propriety, preserving some sense of control for the patient, and protecting the patient's pride. Nursing students are taught in deed, yet not in word, how to defend dignity. Thus, the search for an exactness of the term yields no answer.

In the review of the literature on CINAHL, the database of scholarly nursing work and evidence for practice, dignity is identified in relation to specific conditions or health care issues. When 'dignity AND nursing' were searched, thirteen of these generated results were about dementia patients or individuals with some cognitive disability, seventeen related to critical care, end of life, or hospice, and nine focused on the older adult population. The results suggest that the body of literature does not understand dignity in its fullness, but rather pairs it as 'dignity and dementia,' 'dignity and disability,' 'death with dignity,' or 'dignity and aging.'

Dignity is closely intertwined with vulnerable groups or examined as a call for health care professionals to behave with general regard for it. Dignity is often explored within a qualitative research design in the nursing literature, meaning interpretations or subjective insights are the avenues for conceptualizing dignity. Dignity is discussed in the context of older adults describing their experiences living with schizophrenia (Robison 23), or by clinicians from nursing homes "to denote an overall value, aim or goal in...daily work with dying elderly patients" (Brodtkorb 79). It is considered in themes related to palliative care such as the beneficence of revealing diagnoses to patients, quality care at the end of life, and respectful care (Korhan 76). It is discussed in terms of student nurses' perceptions that dignity can be taught and practiced through nursing education (Kyle 54).

Other sources in the nursing literature indicate that family members of dementia patients perceive dignity as the opposite of suffering, since that state of physical suffering is "undignified," (Dekker 326). Family members also believe that health care professionals preserve dignity when they adopt the approach of "caring with

pleasure” and focus on the interpersonal relationship with the patient (Diaz-Cortes 26). It was also perceived that empathetic behavior by health care professionals preserved dignity while indifference toward the patient violated it (Slettebo 2430-2431). There is also an idea of “humiliated dignity,” which occurs when the patient is failed, disrespected, or ignored of preserved dignity, which occurs when the nurse “respects the patient’s will, and protects the patient’s body from the gaze of others” (Abelsson and Lindwall 277).

These qualitative methodologies in the nursing literature begin the pursuit of understanding dignity. This particular strategy and the intuition of those interpreting this term can be helpful in trying to understand dignity or inform guidelines for generally and specifically doing good for the patient. However, the meaning of dignity is circumnavigated – it is not directly addressed. Even when dignity itself as a concept is the feature of an article, this method of grappling with it emphasizes the fragmentation of the term, rather than arriving at a unified, synthesized conception that can guide the profession collectively. The insights of various individuals, even when they reach a saturation point, cannot encompass all aspects of the term or satisfyingly occupy the space of an absent theoretical foundation. Further, when individuals, patients and health care professionals alike, are asked to speak about dignity within a specific context such as palliative care or care for the elderly, an incomplete and situational account of it is inevitable. Since questions of dignity arise collaterally within the practicalities of patient care and other health-related circumstances, this may explain the specificity and concreteness of dignity described in the nursing literature. It may be inevitable for the nursing conceptualization of dignity to be context-specific, since there is a necessarily task-oriented, outcome-focused component of the job.

The literature offers and appraises a plethora of tools that preserve the dignity of patients (Johnston 1748-1764). However, many such tools that claim to measure dignity instead measure general patient satisfaction or inquire into singular elements related to the patient’s dignity, which begs the question of how reliable these metrics are if a consensus cannot be reached on one robust conceptualization of what we are measuring. If the nursing profession’s idea of dignity is never fully articulated, what can it expect to see with the instruction to preserve dignity? How can defending a patient’s dignity be held to any standard? Further, why is it that vulnerable groups such as the ones discussed in the literature should have their dignity defended?

The nursing literature also focuses on singular aspects of dignity at a time, such as allowing nursing home residents *more personal influence* and

acknowledging individuals through the method of slow caring (Lohne 786). Further, “self-management” (Slettebo 2429) is described as vital to the idea of dignity. When individuals in the palliative care setting are asked to convey what they believe dignity is, the greatest number of responses include, “Respect for decisions” or “Respect for opinions,” and when asked which terms they associate with dignity at the end of life, “Respect,” “Rights,” and “Autonomy” are among the most popular (Rudilla 101). This indicates that the preservation of personal powers, primarily the capacity for autonomy, is the most concrete understanding of dignity.

As seen from the review of the nursing literature, dignity is used as vague terminology to convey different facets of holistic patient care and is often paired with other terms that hyper-specify the scope of dignity or render an inconsistent, incomplete conceptualization of it. This results in the narrowing of dignity to its associated term. Dignity becomes nothing more than a rhetorical supplement to enhance the idea already conveyed by its pairing. Specifically, the dignity to which the nursing literature refers often conveys the idea of increased ability for the patient to control their circumstances or the power to make decisions. Based on the current body of nursing literature, the following question arises: Can dignity be understood as the bioethics principle of respect for autonomy? Some individuals, such as bioethicist Ruth Macklin, argue that respect for autonomy is all dignity means.

Macklin and Useless Dignity

In “Dignity is a Useless Concept,” Macklin discusses the deficiencies of the term dignity. She states that “... appeals to dignity are either vague restatements of other, more precise, notions or mere slogans that add nothing to an understanding of the topic,” (1419). She denies the substance of dignity with the claim that the principle of respect for persons, or respect for autonomy, in bioethics more precisely conveys the intended idea. In one example, she denies that dignity can belong to a deceased person by pointing out that “the object is no longer a person but a cadaver,” (1420). Proper treatment of the dead body, she claims, has to do with the respect for the autonomy of the living relatives rather than of the body which is lifeless and no longer capable of forming or communicating its wishes.

The autonomous, rational capacity of human beings is, indeed, a distinct and powerful aspect. Prominent moral theories, including natural law, natural rights, and Kantianism, build upon the basis of a reason-governed being to guide the “doing good” and doing right by these beings. However, to presume that this rational capacity is all there exists to consider about human beings

is an egregious underestimation of human nature. Recognition of dignity relies on the understanding of the richness and complexity of human nature, which suggests that an incomplete appraisal of human nature results in a devaluation of the concept of human dignity.

While Macklin's criticism of the term's lack of specification in some contexts can be conceded, it strikes many as fundamentally incorrect that human dignity is nothing beyond an empty, replaceable, rhetorical concept especially in moments – such as those leading up to and following death – that carry such significance. In addition, it seems that Macklin's specific example of the cadaver and her general claim connote more fear than true respect for autonomy. For instance, she implies an apprehension of the consequences of wronging an autonomous individual, namely the deceased person's living, capable family members, as the driving force for specific treatment of the cadaver. This not only fails to deem the value of a human being as separate from the capacity for reason, but it also begs the question: What if the cadaver had no living, autonomous family members to instill the sense of "respect" that is, indeed, due in the treatment of deceased individuals?

Furthermore, Macklin uses the principle of respect for autonomy interchangeably with respect for persons. By equating the value of the human person to that person's capacity for rationality, she wrongly reduces the fullness of being human to a singular aspect of humanity. When autonomy is deemed the main criterion for proper treatment of humans, this proper treatment becomes reserved for only those who have certain capacities. It is not the foundation of proper treatment based on a recognition of the complete, intrinsic value of a human being, but rather a conditional obligation toward others; and oftentimes, it is not the autonomous and capable individual whose dignity is most in need of guarding.

Challenging Macklin

As I consider Macklin's claims, I find them fundamentally incomplete compared to my experiences at the bedside. For instance, the nurse I shadowed in the medical intensive care unit demonstrated a respect for something greater than autonomy – she showed respect of the unchanged nature of the critically ill patient, and in so doing, she upheld the patient's dignity. If dignity were truly an empty, rhetorical concept that could be replaced by respect for autonomy, the nurse's actions could not be considered logical or, perhaps, even contextually appropriate. The patient was unconscious, surrounded by no relatives whose autonomy could have been "respected" through those actions. Indeed, if the nurse functioned on solely that principle, she

would have perceived the kindness of therapeutic touch and the decency of helping the patient appear more presentable to be fruitless efforts since neither would have restored the patient's autonomy. A nurse who intuitively recognizes human dignity, however, would have thought otherwise.

The reduction of dignity to the concept of autonomy is, in and of itself, problematic for the sake of discussing dignified patient care, but it also does not justly represent the way by which clinical nurses – including the nurse I shadowed – intuitively regard their patients' dignity. The nursing literature's usage of dignity makes it prone to the pitfalls discussed by Macklin, giving undue credibility to her argument that respect for autonomy can take the place of dignity since it is merely an empty term. These factors contribute to and perpetuate the grounds on which Macklin's criticisms of the term dignity stand, and the nursing profession is left unequipped to compellingly rebut these arguments. Thus, a clear philosophical conceptualization of dignity, including a theoretical foundation and framing for the clinical setting, is imperative for the nursing literature and the nursing profession in order to represent and encourage congruence with the way it is nobly upheld by nurses at the bedside. In searching for an articulation and defense of dignity that aligns with nursing, the profession can look toward the rich literature of philosophy and bioethics.

Part 2: Conceptualizations of Human Dignity

In 2001, the President of the United States created the President's Council on Bioethics, which aimed "to develop a deep and comprehensive understanding of the issues that it considers," (Executive Order 13237, Sec. 2. c). Further, the Executive Order states that this Council "shall be guided by the need to articulate fully complex and often competing moral positions on any given issue, rather than by an overriding concern to find consensus," (Sec. 2. c). The Council, therefore, is committed to presenting differing views in its pursuit of discernment in bioethical matters. Council members are "drawn from the fields of science and medicine, law and government, philosophy and theology, and other areas of the humanities and social sciences," (Sec. 3. a.). Those who contribute to the work of the Council are not only chosen for their credibility and expertise in various relevant disciplines, but they are also equipped to speak about the unique, contemporary contexts in which bioethical issues may arise.

In March 2008, the Council released a collection of essays specifically to philosophically contest Macklin's claims and to expand on the meaning that the word dignity carries. The Council's essays were,

therefore, selected as sources for my research seeking a theoretical, philosophical, and health care-oriented conceptualization of human dignity. The essays arranged by the President's Council on Bioethics offer various arguments by which to make sense of dignity as more than autonomy, as well as effectively refuting Macklin's claims from several different points. Since the current gaps in the nursing literature on dignity make it susceptible to Macklin's claims, despite the fundamentally opposing philosophies, experts who can rebut Macklin and lend a robust theory of nursing-applicable dignity will contribute greatly to the nursing profession. The contributors to the essays in *Human Dignity and Bioethics* address the importance of the term human dignity in various ways, articulating some among the myriad of facets belonging to human dignity.

These thinkers present a considerable range by which to understand dignity, and despite – or, perhaps, due to – some conflicting ideas, the shared conviction proves to be compelling: Macklin's claims are not compelling, and dignity is, indeed, a significant and substantive concept. Adam Schulman speaks about the far-reaching origins and roots of the term dignity that still hold influence on its conceptualizations, then ultimately defends a dignity that is seen as humanity. F. Daniel Davis refutes Macklin's interchanging of respect for persons, which later shifted to respect for autonomy and led to the standard of voluntary consent, with dignity, which emerge from a fairly new bioethical context, by showing how the historical backgrounds of the two concepts make them distinct in meaning as well as application. Holmes Rolston III raises the idea that human beings are individually unique rather than solely shaped by their biology and distinct from animals due to their capacity to create culture. Susan M. Shell understands dignity in Kantian terms, holding that rationality and moral capacity are what found dignity. Nick Bostrom describes dignity as a quality and speaks in favor of transhumanism, which holds that human beings have dignity because of their ability to improve or perfect their own natures. He suggests that human dignity will be honored, preserved, and even upheld as a moral organizational guide in a posthuman society, ultimately divorcing dignity from humanity. Charles Rubin, on the other hand, argues against transhumanism, championing human nature as something that has dignity already and does not need to be perfected, despite its finitude. Rebecca Dresser provides an account of dignity based on her experiences as a cancer patient, focusing on the centrality of dignity in patient experiences.

In selecting the most suitable sources among these essays, I first determined how compelling and logical the argument itself was, then determined its relevance

to the nursing profession in terms of how frequently and significantly these ideas were encountered in my time at the bedside. Given my limited clinical experience at the time of this documentation, the sources were chosen based on how philosophically aligned they were to the examples of dignity that I witnessed in nurses who taught me both in the classroom and in clinical.

In my analysis, I found that many of these discussions do not facilitate a philosophically relevant or adequately robust conceptualization of dignity for the nursing profession. Specifically, Schulman and Davis supply informative context, etymological and historical, respectively, but these are not relevant for philosophical nursing application. Rolston delivers a thorough argument for the distinct humanness of dignity by distinguishing the ability for culture and collaboration, which no other animal possesses. This argument, however, does not fully address what human beings might owe one another within those cultures and collaborations, which is the primary area of concern for nursing care. In addition, Shell's conceptualization does not align with the profession's values since nursing, and health care as a whole for that matter, does not exclude nonrational human beings from receiving care. Though Bostrom's and Rubin's ideas refute one another, both can be considered irrelevant to our purposes as well, because nursing care does not significantly revolve around transhumanism as much as it does around the process of recovering from a disease or other threat to health. Lastly, Dresser's account, though powerful, communicates an anecdotal quality more than robust philosophical theory which the nursing profession may adopt.

The most representative philosophical theories must be synthesized in order to articulate and defend the idea of dignity in the nursing profession, as well as address the gaps in the nursing literature. Of the essays, the theories of Leon R. Kass, Daniel P. Sulmasy, and Edmund D. Pellegrino specifically can impart insights that will articulate a theoretical foundation, robust conceptualization, and practical guide for the profession.

Leon R. Kass elaborates on the idea that dignity must be accounted for in the context of shared, full human nature even in imperfection or vulnerability. He first claims that "...the dignity of rational choice pays no respect at all to the dignity we have through our loves and longings – central aspects of human life ...Not all of human dignity consists in reason or freedom," (313). He then provides a robust account of dignity by delineating the interconnectedness and intricacy of the "basic dignity of human *being*" with the "full dignity of being (actively) *human*..." (299). He defines basic dignity as the passive living, or simple existence, of the human person including organ functions, fundamental needs,

and growth. This basic dignity must be honored by being protected. Full dignity, on the other hand, is that of active living in pursuit of flourishing and intellectual and moral excellence. This full dignity dignifies; that is, dignity manifests itself when the capacities upon which it is constructed are fulfilled according to a standard of excellence. Kass then discusses the two concepts of dignity in relation to one another. The basic dignity of human being is what allows the very possibility of full dignity – the capacities for excellence or virtue are potentiated by simple existence. Without existence, an active and flourishing life is impossible. Correspondingly, the full dignity of being human is what justifies, broadens, and deepens basic dignity. The capabilities implied by full dignity make meaningful the existence aspect of humans. Therefore, Kass argues that all human persons must be treated with the recognition of both aspects of human dignity. This speaks to the fundamental purpose of the nursing profession as well and offers a compelling theoretical basis for dignity.

Daniel P. Sulmasy expands on this connection between human nature and human dignity. He offers an account of dignity as the intrinsic, distinct value of human beings and discusses a tripartite conception of human dignity: intrinsic dignity, attributed dignity, and inflorescent dignity. Intrinsic dignity is possessed by all humans simply by virtue of being human. Attributed dignity, he says, “always involves a choice...[and] is, in a sense, created” (473), since it is the dignity that one recognizes in others. Inflorescent dignity is identified in those who are realizing and expressing their intrinsic dignity through active excellence. Sulmasy presents a compelling axiological argument to show, in terms of value, how intrinsic dignity specifically builds the foundational understanding of human dignity. He states that, “One defines attributed and inflorescent dignity in terms of intrinsic dignity,” (476). According to Sulmasy, intrinsic dignity is the distinctly human value.

It is “the intrinsic value that belongs to members of natural kinds that have specific capacities for language, rationality, love, free will, moral agency, creativity, aesthetic sensibility, and an ability to grasp the finite and the infinite,” (476). The capacities and experiences that constitute human life are what give humans a value that is unique and intrinsic to their very natures. He suggests also that this dignity is the reason why “interpersonal morality” (484) exists at all. To bolster his ideas, he makes another argument, noting inconsistencies in various human properties that dignity has been conceptually reduced to, including utilitarian pleasure and pain calculus, the Hobbesian economic quantification of human beings, the freedom to actively choose, and subjective ideologies for each individual. These inconsistencies indicate the incorrectness of these

conceptualizations of human dignity. Furthermore, Sulmasy says that “...it is because of the intrinsic value of the sick that health care professionals serve them... intrinsic human dignity is the foundation of health care,” (478). He holds that dignity is not only useful in a myriad of health care topics, including just access to healthcare, euthanasia, treatment of the disabled, embryonic stem cell research, human cloning, and care of comatose or post-comatose individuals, but is the very basis of healthcare and bioethics.

Sulmasy thus addresses the question of why every human being has dignity. He argues that dignity is the value human beings possess by virtue of their very nature. This elaborates on the idea that dignity is had by each individual as part of a membership of the collective; this, it appears, is why human beings have dignity – not dignities – just as they share a nature, not different human natures. Dignity is inherent in all human beings by the nature they possess. This is the very foundation of health care – a view which seems to align with the nursing profession. Furthermore, human dignity is the very basis of health care – the reason why vulnerable human beings are owed human aid.

Edmund D. Pellegrino further contextualizes human dignity through the examination of the “lived experience” (516). He holds that dignity, as encountered in everyday life, is the way it most authentically and deeply manifests and, thus, may contribute to an authentic and deep understanding of it. One way he vivifies the experience of dignity is by showing how dignity is necessarily tied to relationships and interactions with others. “Assessment of my own dignity is disclosed in the personal encounter with another. The experience of dignity is inescapably a phenomenon of intersubjectivity,” (521) he says. Pellegrino also claims that perceived dignity, especially as experienced by a patient, is affected by factors associated with hospitalization and illness, such as atypical vulnerability, guilt, shame, and spiritual crisis, that can lead to a decreased perception of self-worthiness.

Pellegrino expands on dignity by situating it specifically in the medical setting. He states that though the experiential aspect of human dignity is significant, it does not exclude those individuals who cannot experience dignity consciously or have diminished cognitive faculties. These individuals still possess an inherent dignity. Further, Pellegrino argues that the “preservation of human dignity and the prevention of indignity are obligations built into the ends of medicine ... [which] are focused on the good of the patient as a human person,” (530). The question of human dignity in medicine and bioethics addresses the fundamental mission of those fields, which are to safeguard the dignity and good of the patient.

Part 3: The Conceptualization of Dignity for Nursing

The theories contributed by Leon R. Kass, Daniel P. Sulmasy, and Edmund D. Pellegrino provide particularly robust, original conceptualizations and defenses of human dignity that align with the values of nursing. The synthesized conceptualizations of their theories will fill the gaps in the nursing literature to adequately articulate and defend dignity's place in the profession. Sulmasy, Kass, and Pellegrino together provide a robust theoretical foundation for dignity by addressing the relationship dignity has to humanity, or human nature: The fullness of human nature includes both higher capacities and instances of vulnerability, which are owed the same reverence. This interpersonal recognition of full humanity is potentiated in the interactions of daily life, meaning that in the realm of health care bedside nurses especially have a prominent role. The synthesized theories also elaborate on the obligation of nurses and health care professionals to uphold the dignity of their patients, thereby articulating the place dignity has in the clinical setting.

Theoretical Foundation of Human Dignity for Nursing

Despite imparting a quality education about the anatomical, physiological workings of the human body and a rich theological culture of acknowledging each human being as a child of God, a purely philosophical account of human nature is not outlined in the M. Louise Fitzpatrick College of Nursing. This is true of the entire profession. Indeed, the absent articulation of the very nature of the beings entrusted to nurses' care contributes greatly to the lack of a satisfying conceptualization of human dignity. When there is a faith-based understanding of the human person, there is a faith-based understanding of dignity which can provide some guidance for nursing practice. However, the profession faces a problem when it must – without appeals to religion – articulate why vulnerability demands upheld dignity. What is it about human beings that nurses so intuitively value? The following synthesis of bioethical theories will empower the voice of the nursing profession as it responds to this inquiry.

In nursing, the pursuit of understanding dignity commonly stagnates with the idea that vulnerability, for its own sake, is owed an act of goodness. Though this idea reflects a kind principle held by many nurses, it does not address the matter. Further, this idea is challenged in Kass's theory as he notes:

If there is dignity to be found in the vicinity of

suffering, it consists either in the purpose for which suffering is borne or in the manner in which it is endured... Dignity with respect to suffering, like dignity with respect to rights, is a matter of virtue or strength of soul. Not everyone has it, and it therefore cannot be the basis of equal dignity of human being. (318-319)

Vulnerability, specifically suffering, does not reveal the integrity or value of what is most human. Therefore, there must be some other reference point within human beings for which we must “do good” and by which we must do right. This reference point is what we can identify as human dignity.

In searching for the basis of human dignity, we can eliminate those specific attributes and powers that not all humans share. After all, if it is not common to all human beings, the search for the very meaning of the term would become null. Dignity would be divorced from the idea of intrinsic human worth, and instead be reserved for those who exercise more exclusive capacities. This already draws a clear distinction between the concepts of dignity and autonomy, but Sulmasy offers further insight into what autonomous capacity, or rationality, is in relation to the broader basis of dignity: “It is not the expression of rationality that makes us human, but our belonging to a kind that is capable of rationality that makes us human,” (478). This poses the idea that it is our very identity – the fact that we are human – that indicates our status rather than the individual exercising of autonomy or any other ability.

Further, Sulmasy discusses dignity as intrinsic to the nature of the being that is human. Human nature is marked, among other things, by the capabilities of “language, rationality, love, free will, moral agency, creativity, aesthetic sensibility, and an ability to grasp the finite and the infinite,” (477). His tripartite conceptualization speaks of intrinsic dignity, inflorescent dignity, and attributed dignity, in which “... intrinsic dignity is the fundamental notion of dignity. One defines attributed and inflorescent dignity in terms of intrinsic dignity,” (476). He describes the universality of this type of dignity:

So, if there is such a thing as intrinsic value in the world, then intrinsic dignity is the name we give to the value of all the individual members of any and all kinds that, as kinds, share the properties we think essential to the special value we recognize in the human. (478)

The identification of another being as one who shares the same complex and irreducible nature implies the value – the dignity – all humans share as well. If the understanding can be established that human nature

is constant and shared among all such beings at any stage or circumstance of life, it can be articulated why an embryo, a human adult, a comatose patient, and a cadaver are owed the same regard for their own sakes. To recognize human nature implies the duty to uphold human dignity.

Kass builds upon this theory with the conceptualization of dignity as the interconnectedness of the passivity of human being, or basic dignity, and the activity of being human, or full dignity. He highlights the relationship between basic human existence as what potentiates higher excellences innate to human beings, as well as the higher capacities that justify basic human existence:

...just as the higher human powers and activities depend upon the lower for their existence, so the lower depend on the higher for their standing; they gain their worth or dignity mainly by virtue of being integrated with the higher – because the nature of the being is human. What I have been calling the basic dignity of human being – sometimes expressed as the ‘sanctity of human life,’ or the ‘respect owed to human life’ as such – in fact depends on the higher dignity of being human. (322)

Kass suggests that the phenomenon of an individual’s dignity remains unchanged by their circumstances, but rather, the beholding and upholding of it may be different. Based on this theory, it can be said that vulnerability is owed reverence, just as excellence is owed admiration. Only the intention to uphold dignity amid vulnerability, excellence, or a state in between, can determine which is owed – and how – in each situation.

Pellegrino holds a similar belief and states that all humans share one nature which informs their dignity, no matter what their state of autonomy may be:

Our focus on the experiential dimensions of human dignity must not lead to the erroneous conclusions that dignity and indignity are irrelevant for those who cannot consciously experience them. Those in comatose states, in states of total or partial brain damage, those with various forms of dementia, the mentally retarded, as well as the infant and the very young child, all retain their inherent dignity. The concept of dignity to which I subscribe assigns an inalienable, inherent dignity to all human beings simply by virtue of being the kinds of beings they are. None of the patho-physiological mechanisms that impair the human capacity for conscious experience can alter dignity. (528)

He elaborates on what is rightfully owed by

illustrating dignity as a lived, intersubjective experience. He discusses the priority to “understand human dignity not only abstractly as a concept and an idea, but also as an experience, a lived reality of human life,” (515). Pellegrino states that dignity lies in the interactions between human beings, even and especially in the daily lives of these beings. Human dignity, as inherent as it is as having human nature, is still relational:

What is most significant for our understanding of our own or another’s dignity is that we experience them only in community with others. Assessment of my own dignity is disclosed in the personal encounter with another. The experience of dignity is inescapably a phenomenon of intersubjectivity. Only in the encounter with others do we gain knowledge of how we value each other and ourselves. (521)

Thus, the context of dignity is redefined, not making dignity less extraordinary, but rather making the extraordinariness of dignity visible in ordinary, everyday encounters.

Dignity’s Place in Nursing

Pellegrino’s idea of dignity as a lived experience, dependent on the relationality of human beings, shows the significance of nursing as the health care profession that tends to the patient each hour of the day. Since the primary component of nurses’ jobs is the constant presence at the patient’s bedside, which implies considerable participation in the ordinary realities of the patient’s experience, Pellegrino’s theory describes and justifies dignity upheld by nurses. This relational honoring of the human being shows the relevance of dignity in nursing. Kass adds to this idea by elaborating on the simplicity, fullness, and community of being human:

Beyond the dignity of virtue and the dignity of endurance, there is also the simple but deep dignity of human activity – sewing a dress, throwing a pot, building a fire, cooking a meal, dressing a wound, singing a song, or offering a blessing made in gratitude. There is the simple but deep dignity of intimate human relation – bathing a child, receiving a guest, embracing a friend, kissing one’s bride, consoling the bereaved, dancing a dance, or raising a glass in gladness. And there is the simple but deep dignity of certain ennobling human passions – hope, wonder, trust, love, sympathy, gratitude, awe, and reverence for the divine. No account of the dignity of being human is worth its salt without them. (314-315)

Kass describes the fullness of dignity in the daily,

perhaps even mundane, activities of living. While a patient remains under nursing care, the accomplishment of activities of daily living become the nurse's concern as well as the patient's; and in these moments of interaction are the opportunity and duty to honor the patient's dignity. The intersubjectivity Pellegrino and Kass discuss is a central aspect of dignity. Though the dignity itself of an individual cannot truly be changed due to its inherence to the individual's very nature, that dignity can be either upheld or offended.

Indeed, this creates a *moral imperative* for nurses to see patients as more than their current states and instead as beings whose natures and identities intrinsically make possible the full experiences of human life. Pellegrino develops this moral imperative:

The clinical encounter is a confrontation, a face-to-face encounter between someone who professes to heal and someone in need of healing. Its locus is the doctor-patient, or nurse-patient, relationship. It is a phenomenon of intersubjectivity, and it is in this sense that it is a locus for the experience of human dignity and its loss. The... relationship is paradigmatic for other "healing" relationships, those that involve humans in states of need and vulnerability. (522)

In the alternative understanding that the defining characteristic of the human being is some powerful capacity of that being, the intrinsic respect that all humans are owed is reserved for only the powerful. However, the tenets of nursing and of health care understand and declare the duty to care for the vulnerable – those whose capacities have been compromised, or perhaps, never been enjoyed by the individual. Sulmasy describes the basis of this duty:

Thus, because a sick individual is a member of the human natural kind, we recognize that this individual has the intrinsic value we call dignity. It is in the recognition of that worth that we have established the healing professions as our moral response to those of our kind who are suffering from disease and injury. (478)

A similar stance is presented by Pellegrino: The preservation of human dignity and the prevention of indignity are obligations built into the ends of medicine. The ends of medicine are focused on the good of the patient as a human person...Ultimately, medicine aims to restore health; its intermediate aim is to cure, ameliorate, or prevent illness. Most proximately, it is to make a right and good healing decision, for a particular patient in a particular clinical encounter. Any behavior that frustrates those

ends or causes suffering is a violation of the moral trust patients must place in physicians if they are to be helped. This is the trust physicians implicitly or explicitly promise to live up to when they offer to be of assistance. It is the source of physicians' obligation to be faithful to their promise to help. (530)

It appears, then, that the moral imperative to uphold dignity upon recognition of humanity delineates the very fundament of the nurse-patient relationship. The nursing profession is built upon the belief that human beings have a dignity – a worth – greater than their current state of suboptimal health. Human beings have within them a dignity that their fellow humans must, by duty, behold and uphold, and nursing as a profession is one collective, unique response to that duty. In other words, the nursing profession itself exists for the purpose of upholding human dignity intersubjectively, or relationally, in a health-oriented context.

Sulmasy, Kass, and Pellegrino present harmonious philosophical accounts of what human beings are and what human nature involves. They define, without appeals to anatomy or theology, the beings which the nursing profession cares for in the clinical setting. In addition, full humanity, in all its vulnerability and potential for excellence, is owed regard for its intrinsic worth – that is, dignity. The interconnectedness of basic dignity (Kass), also understood as intrinsic dignity (Sulmasy), with full dignity (Kass), also understood as inflorescent dignity (Sulmasy), is why vulnerability demands compassionate care and the aid of fellow humans. Attributed dignity (Sulmasy), also conveyed by the idea of dignity as fundamentally intersubjective or relational (Pellegrino), articulates the moral imperative of human beings, in daily life as well as in specific contexts such as the clinical setting, to properly regard dignity. Also, as Sulmasy claims, the health care professions, including nursing, are founded upon the very concept of intrinsic dignity. The professional purpose of restoring the health of fellow human beings is a unique response to the moral imperative to defend dignity, in that human flourishing is promoted as the proper acknowledgment of the intrinsic value of humans.

Part 4: The Obligation to Uphold Dignity

The relationship between dignity and human beings is not only that every human possesses and shares it, but also that every human being is able to properly interact with it. The robust bioethical conceptualization of dignity that have been synthesized in the previous section aligns with the profession of nursing, but how

can this conceptualization be applied? In the clinical setting and more broadly in human interactions, how can the proper interaction with dignity occur?

According to the Oxford English dictionary, to *behold* means “I. 2. To hold by some tie of duty or obligation, 6. To regard (with the mind), have regard to, attend to, consider, 7a. To hold or keep in view, to watch; to regard or contemplate with the eyes, to look upon, look at (implying active voluntary exercise of the faculty of vision),” (“behold”). To *uphold* means “2d. To sustain spiritually, 4a. To support by advocacy or assent; to sustain against objection or criticism, 5. To raise or lift up; to direct upwards,” (“uphold”). Based on these definitions, to behold is to regard or conceptualize either through articulation or intuition; to uphold is to defend, guard, or preserve. Thus, dignity is witnessed – or beheld – internally in one’s mind to prompt the moral imperative for action. The only action that can be taken regarding dignity is to defend – that is, uphold – it. Dignity is not something that is able to be violated or changed, due to its intricate derivation from human nature itself, and further, it is something that can only be properly or improperly beheld and upheld.

The nurse I shadowed on the medical intensive care unit clearly provided higher quality care, which lay in her recognition of the patient’s full, vibrant humanity, even in a state of such vulnerability. In the time she took to gaze at the patient, and with the words, “Breaks my heart,” she *properly beheld* the patient’s dignity. When she held the unconscious patient’s hand and smoothed out her hair (out of no preoccupation with concepts such as autonomy), she *properly upheld* the patient’s dignity. Thus, the College of Nursing’s CEI correctly associates dignity with patient centered care. However, rather than categorizing dignity with safety and quality care, it must reflect the understanding that dignity is the very foundation of patient-centeredness – human dignity is why we deliver safe, quality care.

In response to Macklin’s claim that “dignity is a useless concept,” (1419), perhaps the actions of the nurse were, in fact, “useless” or unnecessary. It may be argued that this upholding, let alone beholding, is not useful, since it has no bearing on the technical care the nurse provides. However, on what grounds could one claim that this was unimportant and did not enrich the very nature of the nurse-patient relationship? In the context of one human being caring for another, it seems that usefulness is altogether the wrong measure by which to conceptualize dignity. Upon consideration of the nursing profession’s purpose, which is to facilitate the health and general well-being – that is, the flourishing – of human beings, it is evident that the profession is deeply aligned with the fundamental philosophy that each human being has intrinsic dignity. Otherwise,

no physically, mentally, or otherwise ill individual would be worth nursing interventions. Thus, from the moral perspective of properly interacting with dignity, beholding is necessary for upholding, and upholding dignity is an obligation to which the nursing profession responds. Based on this, Macklin’s argument denying the substance of dignity appears impoverished especially in terms of the nursing profession and all other health care professions.

One nursing article by Abelson and Lindwall which was previously discussed in the review of the literature explains the concept of “humiliated dignity” compared to preserved dignity, which occurs when the nurse “protects the patient’s body from the gaze of others” in pre-emergency room settings (277).¹ This raises an insight about the phenomenon of the gaze, which I witnessed when I shadowed the nurse in the critically ill patient’s room. It seems that the gaze discussed in both the article and in my clinical experience describes a significant component of beholding and upholding dignity. The importance of the gaze is, indeed, a rich topic in a philosophical branch called phenomenology:

“What I thus meet is the mental glance or consciousness of the other directed through his eyes...But I may direct my attention to the gaze of the other in a particular mode: with affection or hostility, with scrutiny or an attitude of self-revelation, and so on. Here the gaze becomes the bearer of a meaning that is taken up also by the whole of the look,” (Heron 260)

The gaze is laden with meaning and depth in the interactions between human beings. It is, furthermore, the way one is witnessed – or beheld – in all the fullness of one’s existence by another human being. “According to Husserl, I become aware of myself specifically as a human person only in such intersubjective relations,” (qtd. in Gallagher & Zahavi, “Phenomenological Approaches to Self-Consciousness”).¹

For nursing, this indicates that gazing is necessary to properly behold a patient’s dignity, even – or especially – for unconscious patients. If gazing is meant to meet the consciousness of another human being, then all those who have the nature of a conscious being are owed the proper gaze. The gaze can be directed impersonally, with indifference, or with full recognition of the potentials and truths implied by the patient’s human nature. The proper gaze enriches the nurse-patient relationship, as a

¹ This article does not refer to the gaze as a philosophical concept, but rather as a theme that emerged as a result of the qualitative analysis of perceptions of dignity. However, the trend of the word in relation to dignity pointed toward relevance to the philosophical concept.

Husserl is a major contributor to phenomenology philosophy. This establishment of the relevance and existence of the gaze sets the stage for an in-depth phenomenology analysis, especially on the lived experience for the nurses. However, such is beyond the scope of this work as its goal is primarily to establish the grounding of dignity and its importance for the nurse-patient relationship.

form of the dignified intersubjective human encounters discussed by Pellegrino. It seems, therefore, that the gaze is part of beholding and prompting the moral imperative of upholding human dignity.

Considering the conceptualization of dignity, clinical settings such as highly technical critical care units that pose greater challenges to beholding the full human nature of the patient and upholding dignity also face a greater moral imperative. The nurse I shadowed on the intensive care unit undertook the greater duty of the whole profession by counteracting the technology with a more humanistic approach to her nursing care. As the nurse demonstrated, this conceptualization of dignity can be operationalized into nursing practice. Dignity is something that is upheld in a fundamentally proper and complete intersubjective human experience. In the health care setting, nurses are the prominent figures at the interface of human contact and medical intervention, which makes operationalizing this concept of dignity greatly important for this profession.

However, the current nursing literature does not offer many guides to operationalizing this conceptualization of dignity. Often, the tools used to promote dignity are unfounded on robust theoretical understandings or on philosophical articulation. This gap in the literature is veiled by the moral intuition nurses follow in practice or by the impulse to simply be kind. However, it remains problematic in terms of offering a practical, consistent guide. For instance, the guidelines that exist for unconscious patients such as the one I witnessed on the intensive care unit focus on each bodily system or major issue (neurologic, respiratory, cardiovascular, immobility, pain, renal, nutrition and hydration, gastrointestinal, hygiene), but the aspects of care that relate to dignity are merely tangential and are categorized as communication or psychosocial (Geraghty 62-63). Even in terms of trying to understand the phenomenon of the patient's general consciousness, the focus in caring for a patient who is comatose are the "mechanisms by which the nursing profession may contribute to a patient's recovery from coma," and how the nursing profession does not have enough research on coma stimulation (Olson & Graffagnino 451).

This evidences a need for a practical guide that can be used in the nursing profession, especially in operationalizing dignity in practice. Sulmasy offers such a guide derived from a robust account of dignity. These duties communicate not only the intrinsic value of the human being, but also the moral imperative. Sulmasy presents:

All members of a natural kind that has intrinsic dignity and are, as individual members of that natural kind, capable of exercising the moral agency that in part constitutes their

intrinsic dignity, have the following duties: P-I. A duty of perfect obligation to respect all members of natural kinds that have intrinsic dignity. P-II. A duty of perfect obligation to respect the capacities that confer intrinsic dignity upon a natural kind, in themselves and in others. P-III. A duty to comport themselves in a manner that is consistent with their own intrinsic dignity. P-IV. A duty to build up, to the extent possible, the inflorescent dignity of members of natural kinds that have intrinsic dignity. P-V. A duty to be respectful of the intrinsic value of all other natural kinds. P-VI. A duty of perfect obligation, in carrying out PP-I-V, never to act in such a way as directly to undermine the intrinsic dignity that views the other duties their binding force. (483)

The duties outlined by Sulmasy are a realistic, valuable guide firstly because they form the edifice built upon a robust theoretical foundation that contributes to the deeper understanding of human beings. By emphasizing the inherence of dignity to human nature and by accounting for human nature as an infinitely complex yet finite entity, he places centrality on the identity humans have by their very blueprint – not on the expressions of that identity which may vary. Therefore, the nature of humans grants everyone an equally shared intrinsic dignity, part of which is the potential for inflorescent dignity. Each individual sharing in this nature, thus, is worthy of aid that will sustain and/or further potentiate or realize inflorescent dignity. This is the philosophical rudiment of the nursing profession, which – like dignity itself – is essentially relational.

Sulmasy's duties can also be a practical guide in health care, and more generally, since they obligate both proper beholding and proper upholding of dignity. Upon consideration, duties P-IV to build up, as much as possible, other humans' inflorescent dignity and P-VI to never act in opposition to humans' intrinsic dignity are action-oriented obligations. Duties P-IV and P-VI provide instruction and structure for the interactions between human beings, including the nurse-patient dynamic, to uphold – and never to undermine – both the intrinsic and inflorescent dignity of others. P-III is also action-oriented in terms of pertaining more to the upholding rather than beholding of dignity, but P-III articulates the obligation to uphold one's own dignity – we are, therefore, obligated to treat ourselves in recognition of intrinsic dignity as well.

The other duties, P-I, P-II, and P-V, speak of obligations to respect or be respectful. This certainly contributes to the upholding aspect of interacting with dignity, but it more strongly obligates proper beholding.

To be respectful is not necessarily an instruction for action, but rather a call for correct conceptualization. The respect one demonstrates may or may not be through action, but rather, through a moral shift – an interaction such as a gaze that communicates proper, full recognition of another human being’s dignity. Those who are asked to respect the intrinsic dignity of other human beings may respond with the question of how. The gaze can be one concrete interaction signifying the broader duty to properly behold patients’ intrinsic worth, regardless of the condition by which they are temporarily or permanently stricken. This includes the condition of death – for a being who is dead does not lose their identity or the recognition of their nature. Therefore, Sulmasy’s duties provide practical, thought-provoking prompts to both think and act with full regard for human dignity, especially in health care settings where nurses encounter patients at all points of life, with various health conditions. Based on Sulmasy’s guide, I argue that as long as a being can be identified as having a human nature, that being is deserving of proper beholding and upholding of their human dignity. Furthermore, this guide can be operationalized by nurses in the clinical setting, as seen in the example of the nurse I shadowed on the medical intensive care unit.

Specifically, the nurse fulfilled P-I by respecting the member of the natural kind that has intrinsic dignity, P-III by conducting herself as a human being who recognizes her own intrinsic dignity, and P-V by being respectful of the intrinsic value of the other member of the natural kind. She was reverent in the face of vulnerability, because she recognized the nature of potential excellence. In other words, she beheld that dignity as the witness to the entirety and complexity of human nature, while the respect for autonomy that Macklin discusses witnesses only the capacity for reason, which is a governing yet incomplete component to human nature. The nurse treated the patient respectfully, regarding the full capacities implied by and intrinsic to her human nature, despite the patient’s impaired capacity for consciousness or reason. In so doing, she fulfilled duties P-I and P-V, because she did not reduce the patient to the capacity for autonomy and instead saw the patient for her intrinsic dignity or value, concomitant with human nature.

Conclusion

Dignity is owed regard, whether it is the regard specific to vulnerability, the regard specific to excellence, or the regard specific to daily intersubjective life. Dignity is the inviolable truth of the nature of human being which is obligated to be upheld. It must be made clear that in the clinical setting, the ideas of dignified

care and indignity are not true devaluations of the being who possesses dignity, since the dignity reflects a nature that is as unchangeable and fundamental as it is complex, but rather a fault on the part of the one who incorrectly beholds it. Proper beholding of dignity, therefore, precedes and potentiates proper upholding of it.

Sulmasy, Kass, and Pellegrino present conceptualizations of dignity that are substantive, defensible, and valuable to the profession of nursing. The theoretical foundation of human dignity as being tied to human nature allows for an explanation of the fullness of humanity, of why vulnerability warrants reverence, and how articulating dignity also articulates a moral imperative to uphold it. The synthesized theories contribute a significant insight that aligns with the mission of the nursing profession. Furthermore, the synthesized conceptualization of dignity articulates and enhances the intuitive understanding by which nurses can behold human dignity. Beholding human dignity as the intrinsic value informed by human nature creates a moral imperative to uphold dignity. Thus, the human relationship to dignity is not only that all humans possess it by nature, but also that they must behold and uphold it properly.

Moreover, usefulness is not the correct lens through which to view dignity, in health care and otherwise, but rather it is the richness of the human-to-human, nurse-patient relationship that must be the measure of dignity. As emphasized by the branch of phenomenology in philosophy, the significance of the gaze in the process of beholding, and thus upholding, must not be underestimated. The correct gaze can enrich the human-to-human, nurse-patient relationship and help fulfill the intersubjective requirement in properly orienting oneself to human dignity. With the robust theoretical foundation, I have discussed, nursing can defend dignity and address the gap in its literature, which inadvertently conveys dignity as respect for autonomy. Sulmasy offers a practical guide which can facilitate the upholding of dignity by nurses at the bedside. This guide aligns with Kass’s insight into upholding dignity in the form of reverence in the face of vulnerability, as well as admiration in the face of excellence. Sulmasy’s guide also supports the intersubjective notion of dignity presented by Pellegrino by listing the guide as moral imperatives, or duties. These duties are thorough in obligating both proper beholding and upholding of human dignity; all beings who can be identified as having a human nature are deserving of human dignity, and this includes those at the beginning of life, with various health conditions, those at the end of life, and those who no longer have life. The nursing profession is a health-oriented response to the obligation of upholding

human dignity. Thus, to speak in terms of performing nursing tasks with dignity is to greatly misunderstand the gestalt of dignity. It is imperative for nursing practice to reflect the understanding that the nursing profession itself stands on for the purpose of upholding dignity in its unique way.

The Operationalization of Dignity

In preparation for the national board certifying nurse licensure exam, called the NCLEX-RN, nursing students are given practice questions throughout their education. Recently, on one of these nursing exams I was asked what differentiates an intensive care nurse from a medical-surgical floor nurse. I thought back to my experiences at clinical, especially to the nurse on the medical intensive care unit who took care of the most critically ill patient I had ever seen. I recall thinking none of the answer choices truly reflected my own personal response, but I chose with relative confidence. I remember this question distinctly not only because I discovered I had chosen the incorrect answer, but also because I was astounded by the correct one. The correct answer, it turned out, was that intensive care nurses are higher level technicians than medical surgical floor nurses.

Based on my experiences, I could not have answered that question correctly, because I understood the technology as an important yet instrumental part of the larger goal I perceived as the job. The technology in the ICU exists to help sustain patients who are in highly critical conditions – that is, in Kass's terms the technology helps uphold the basic dignity of these patients with the hope of restoring their full dignity of active excellence. In Sulmasy's terms, this technology helps the nurses and health care team uphold P-IV, the duty to build up, as much as possible, the inflorescent dignity of human beings, who all share intrinsic dignity.

The highly technical setting of the intensive care unit calls for a greater need for the correct gaze, the proper beholding and upholding of human dignity. The setting that renders correct gazing and recognition of the relational, or intersubjective, dimension of dignity more challenging is the very setting that risks improper beholding and upholding. The moral imperative to uphold dignity, therefore, is in direct opposition with the view that the intensive care nurse can be defined by the technology she must use. Can the job be reduced to the technology?

Operationalizing the dignity that has been discussed may or may not change the technical practices of nursing. The scientific interventions and technicality of the profession, especially on highly critical units, may remain as they currently are, with only the moral

shift upon realizing what dignity is. It is the approach, the formative outlook, with which the nurse enters a patient's room that matters most. However, if studies can show that acts of upheld dignity, of unnecessary "kindness" can improve patient outcomes, could technical practices indeed stay the same?

The newly articulated moral perspective can empower the voice of nursing in defending dignity. It allows the profession to speak in a deeper philosophical realm, in addition to the scientific. This philosophical understanding of human beings and nurses' roles in caring for them can help frame the expectations that may inevitably arise. The clear articulation of the nurse-patient relationship may be effective in alleviating nurse burnout, since articulation and understanding of sensitive situations in the clinical setting will help nurses make sense of intense emotions. For instance, if a nurse understands that her obligation is to practice with competency and uphold the intrinsic dignity of her patients, she will remove herself from the perceived emotional obligations that may be misconstrued, including shared pain, fear, and loss. Nursing, I argue, is a profession of reverence but it is not a profession of emotionality. Understanding the place of dignity and their place in upholding it will benefit nurses greatly in drawing the boundaries that are often nebulous in situations where a caring person is asked to care professionally.

The M. Louise Fitzpatrick College of Nursing can be a pioneer in implementing the philosophical-nursing hybrid conceptualization of human dignity which I have discussed. To be equipped with philosophy as well as science and theological roots will allow Villanova nurses to defend dignity compellingly against views such as Macklin's. Moreover, it will instill a sense of clear purpose, providing nurses with the articulation of what it is they are experiencing. The CEI is an effective and thorough instrument for clinical evaluations of nursing students. That it includes dignity as an objective of patient-centered care is already a testament to the depth of this nursing education. However, to include the following would further enhance the intellectual and holistic well-being of students as they navigate their nursing practices:

Upholding dignity is the fundament and mission of the nursing profession. Dignity is the intrinsic value of human beings, inviolably and inextricably tied to their full, vivid nature. Dignity is owed regard, whether it is reverence in the face of vulnerability, admiration upon seeing excellence, or relational confirmation amid everyday reality. Nursing is a prominent profession in the clinical setting charged with the obligation to behold patients' full humanity and uphold patients' intrinsic dignity in the unique health-oriented approach. Dignity,

though it cannot be devalued by other humans, is essentially intersubjective, and therefore must be upheld by nurses through the witnessing of full humanity in every intersubjective encounter.

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Mentor

Thomas W. Smith

Dr. Thomas W. Smith was the Anne Quinn Welsh Endowed Chair and Director Emeritus of the Honors Program at Villanova University until 2020. Dr. Smith was the founding chair of the Department of Humanities at Villanova. He received his undergraduate degree from Georgetown University and his Ph.D. from the University of Notre Dame. He was awarded Villanova's Lindback Award for Teaching Excellence in 2001. His scholarship focuses on the history of political thought and the intersection of faith and public life. Dr. Smith is currently the Dean of the School of Arts and Sciences at the Catholic University of America.