Dignity: not such a useless concept

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ABSTRACT
In her 2003 article in the British Medical Journal, Ruth Macklin provocatively declared dignity to be a useless concept: either a vague restatement of other more precise values, such as autonomy or respect for persons, or an empty slogan. A recent response to Macklin has challenged this claim. Doris Schroeder attempts to rescue dignity by positing four distinct concepts that fall under the one umbrella term. She argues that much of the confusion surrounding dignity is due to the lack of disambiguation among these four concepts, but that once we understand the different values in question dignity becomes a powerful tool in the fields of human rights and bioethics. It is the goal of this paper to build upon Schroeder’s insights by reconnecting the multiple strands of dignity she identifies. It will be argued that the usefulness of dignity as a guiding principle in medical ethics can be much improved by identifying the single conceptual link that ties together the various values flying under its banner. That conceptual link is provided by understanding dignity as the capacity to live by one’s standards and principles.

The concept of dignity is not, as Macklin claims,1 useless. Indeed, once the concept is disambiguated, it provides a necessary addition to other guiding principles in medical ethics. The starting point for this argument is Schroeder’s claim2 that dignity refers to four distinct concepts. Simplifying Schroeder’s four concepts, I contend that we can identify two different ways in which dignity is used in bioethics. One of these ways is, as Macklin suggests,2 largely synonymous with autonomy. Here, dignity does much the same work as it does in human rights documents, grounding the value of a human life. Nonetheless, Macklin overlooks the secondary way in which dignity is used in medical practice. This thicker usage is more closely tied to relational issues of upholding personal standards and avoiding humiliation, and thus has great relevance to medical ethics. Despite this dual usage, I argue that the two concepts are related, with the secondary usage appealing to the respect we are obliged to afford one another as bearers of dignity in its primary usage.

FOUR CONCEPTS OF DIGNITY
Both Macklin and Schroeder start from the observation that the way the term dignity gets used in normative debate—whether related to human rights or medical ethics—is unacceptably opaque. Three examples can bring out this opacity. The first example is in debates over euthanasia, whereby both sides appeal to the concept of dignity to support their conclusions: organisations such as Death With Dignity appeal to the loss of dignity in prolonged end-of-life suffering, whereas anti-euthanasia organisations appeal to respect for the inalienable dignity of a human life by refusing to foreshorten it. The second example, which Schroeder points out, is that most people have a tendency to categorise only certain exceptional individuals (she mentions Nelson Mandela and Aung San Suu Kyi) as instantiating the value of dignity, yet this is at odds with the common notion that dignity is universal. The third example is that many human rights violations, such as torture, are seen as wrong precisely because they strip us of our dignity. This seems to contradict directly the belief set forth in many human rights documents that dignity is inalienable. In all of these examples, dignity is appealed to in support of diametrically opposed positions, lending credence to Macklin’s assertion that it is a useless concept.

Schroeder nonetheless posits a solution to this problem, by identifying four different ways in which the term dignity gets utilised in public discourse. Once we see the different notions of dignity at stake in each of these examples, we can make sense of their divergences in practice. The four concepts of dignity Schroeder identifies are Kantian dignity, aristocratic dignity, comportment dignity and meritorious dignity.

To start first with Kantian dignity: putting the argument at its crudest, for Kant what makes all persons worthy of respect is our capacity for a will that operates according to our own laws of reason. We are self-legislators in the kingdom of ends:

“A rational being belongs to the realm of ends as a member when he gives universal laws in it while also himself subject to those laws. He belongs to it as sovereign when he, as legislating, is subject to the will of no other.”

For Kant, the worth of all things is conferred by law. This leads him to the conclusion that, as a rational being confers her own laws that are universal, she must have an ‘unconditional and incomparable worth’. It is this incomparable worth that he designates as dignity. Self-legislating beings such as humans have dignity, and so can never be used as a means, as if they were things with merely a price.

The crucial point is that the dignity Kant refers to is both inalienable and normatively inviolable. All rational creatures have it, by virtue of their reason, and it constrains the ways in which we can legitimately interact with one another. This universalist conception is apparent in the various international charters on human rights. The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Declaration on the
Elimination of Discrimination against Women all make reference to dignity as a foundational value. Likewise, the Declaration of Helsinki, the World Medical Association International Code of Medical Ethics and the Universal Declaration on Bioethics and Human Rights all make prominent reference to dignity as a core value underlying medical practice.

The second concept of dignity Schroeder distinguishes is aristocratic dignity. In the pre-modern era, dignity was associated with rank rather than a universal quality of human kind. To be dignified, in this account, is to act in accordance with the demands of one’s position. For example, a priest might act with dignity by officiating at a service with solemnity, or a queen might act with dignity by refraining from displays of emotion in front of her subjects.

The third concept of dignity identified is comportment dignity. This concept is related to the second, in that it concerns outward displays of appropriate behaviour, but it differs in that the determining factor of the behaviour’s appropriateness is not rank, but rather adherence to social norms and expectations. Comportment dignity is most easily grasped in the negative. For example, an individual would display a distinct lack of comportment dignity if she urinated in public, or threw food at her companion in a restaurant.

The final concept is classified as meritorious dignity. Building upon Aristotle, Schroeder identifies a strand of thinking on dignity that associates it with virtue. Dignity, in this conception, is something that is deserved rather than inherent, and one deserves it through being honourable. In particular, dignity is instantiated through facing adversity with the cardinal virtues of temperance, courage and justice, as well as a sense of self-worth. Nelson Mandela thus displayed meritorious dignity throughout his imprisonment on Robben Island, and the lone student who confronted the tank during the Tiananmen Square protests likewise displayed meritorious dignity. Those who are cowardly, intemperate or unjust, on this account, do not have dignity.

Schroeder maintains that disentangling these four competing concepts of dignity casts light on those cases in which dignity appeared to be too opaque to be of assistance. For example, in the right to life argument we can now see that the two sides appeared to be too opaque to be of assistance. For example, in over-crowded wards complain that their dignity is being violated. It is not merely an inability to conform to social norms that may be experienced in situations of medical dependency, but also an inability to realise one’s values of, perhaps, self-reliance, grace, courage, or even basic personal hygiene. Situations that constrain the individual to act in ways they find abhorrent or demeaning will undermine that individual’s ability to live according to their own standards.

This reconfiguring of comportment dignity brings it sufficiently closely in line with meritorious dignity that greater clarity is achieved through combining them. In collapsing comportment and meritorious dignity into one category, we arrive at the following definition: aspirational dignity is the quality held by individuals who are living in accordance with their principles.

One of the advantages of this concept of dignity, which neither Macklin nor Schroeder acknowledge, is its applicability to the biomedical context. The rapid responses to Macklin’s paper were replete with examples from medical practitioners of situations that they saw as paradigmatically dignity compromising, and which they felt Macklin’s collapsing of dignity into autonomy failed to capture. Importantly, many of those responders made reference, either explicitly or implicitly, to the notion of shame or humiliation. In particular, it was shame or humiliation experienced through the inability to uphold personal standards.

Seeing the connection between dignity and humiliation unites the discussion of bio-ethics with broader concerns. In a recent article, David Luban has discussed the relationship between US interrogation methods and the concept of dignity, arguing for a conception of dignity as non-humiliation. According to Luban, techniques such as the stripping of detainees, terrifying them into fouling themselves, and sexually taunting them, epitomise the loss of dignity that accompanies deliberate humiliation. Although hospitalisation is a far cry from torture, there are a number of relevant similarities. For most of us, at least part of the trauma of undergoing medical procedures is the shame we experience at having our bodies exposed, the public nature of otherwise deeply private bodily functions, and the childlike dependence to which we are reduced. While such situations are not deliberately inflicted upon the patient, they can nonetheless be experienced as humiliation. This is when the definition of aspirational dignity as the upholding of one’s standards becomes crucial. The reason why, for example, being left semi-naked on a hospital trolley is experienced as humiliation, and thus as a violation of dignity, is that the patient has standards of public
To overcome this impasse, I argue that it is necessary to reunite the competing concepts of dignity. In order to understand dignity as both inalienable and aspirational—a move that must be made if dignity is going to provide guidelines for ethical action towards patients—it is necessary to see it as a capacity. Understood in this way, dignity’s inalienability comes from the fact that the potential for principled action grounds at least in part the moral worth of all persons. This keeps it well within the realm of the Kantian concept, in which we saw that the moral worth, or dignity, of all rational individuals came from their capacity to self-legislate. (It also aligns it almost completely with the concept of autonomy, as Macklin notes.) Dignity’s aspirational sense, however, now comes from the fact that the realisation of these principles can indeed be thwarted. Under certain conditions, it will be (virtually) impossible for an individual to act in accordance with their values. There is thus an aspect of dignity, its active side, that can be lost. This united conception therefore provides content to dignity as a medical value that is missing from the thin Kantian concept. As the realisation of dignity can be lost or denied, medical practitioners have reason to be attuned to the potential for their actions to undermine the standards and principles of their patients, and in particular the potential for their actions to cause humiliation.

In order to make sense of this united conception of dignity, a distinction must be made between capacity and ability. A capacity is a latent potential, whereas ability refers to the immediate possibility of action. As such, we can say that an infant has the capacity for language, but that in their present state of development they do not have the ability to realise that capacity. By contrast, an inanimate object such as a stone has neither the capacity nor the ability for language. Similarly, an athlete with an injury may lose the ability to compete, yet the capacity remains—given the appropriate remedial therapy, the individual can regain her ability. To see dignity as the capacity for principled action, therefore, is to recognise that there is a latent potential in all persons so to act. Even if events make an instance of virtue impossible—an individual does not have the ability to remain courageous under conditions of torture, for example, or to uphold their standards of personal hygiene in substandard hospital care—their capacity remains intact.

The definition of dignity would thus be as follows: dignity is the inherent capacity for upholding one’s principles. In this definition, we can understand what is wrong with certain acts as being due to the creation of a fracture between the capacity and the ability for principled action. Let us see how this definition fares at bringing clarity to the claims being made on behalf of dignity described above.

One of the core problems with dignity seemed to be that it could be utilised on either side of bio-ethics debates such as euthanasia. It is clear that many advocates of euthanasia are appealing to a concept strikingly similar to the one I have developed. Death With Dignity, for example, describe their campaign as founded on the belief that ‘the greatest human freedom is to live, and die, according to one’s own beliefs.’ More surprisingly, perhaps, we can also make sense of at least some of the opposition to euthanasia with reference to the same concept. Schroeder draws attention to this passage:

>“We want our deaths to be free from pain, mess, embarrassment. But there is a long Christian tradition of ‘holy death’, that is, of allowing even a hard death to be witness to God’s grace. We’re nowhere invited to bring down the curtain early to preserve our pride. How dignified did Jesus look on the way to the cross? Spattered with blood and spit, despised and rejected, he carried his own instrument of torture up a hill. Was this a death with dignity? Ironically, it was.”

decency that they strive to maintain in their daily lives, and which they are here being forced to abandon.

Before turning to the key question of how the Kantian and the aspirational concepts of dignity can be reunited, we must first see if either could stand alone as a core principle for medical ethics. If either alone were capable of providing the necessary content and justification for medical guidelines, the connection between them would prove redundant. As we shall see, however, taken in isolation these two concepts are deeply problematical.

If the Kantian concept of dignity were to underpin bio-ethics, we would immediately encounter a significant problem: if dignity were inalienable, we would have nothing to fear from those acts that are sometimes said to threaten it. For example, it is often claimed that what is wrong with torture is that it strips the victim of her dignity. Similarly, it is often claimed that prolonging the life of a terminally ill patient in chronic pain and without control of her bodily functions strips her of her dignity. If the Kantian concept holds true, these claims must be false. As dignity is an inalienable property held by all rational creatures, being subject to such situations cannot strip an individual of her dignity. It thus provides little in the way of guidelines for action: at most, we could claim that the possession of dignity entitles its bearers to a certain standard of treatment—in Kantian terms, because of our dignity we must be treated as ends rather than means. Indeed, this is the approach taken by most human rights documents, whereby our dignity is held to be inviolable. Nonetheless, this approach leaves us with such a thin conception that its utility for medical practice is questionable (and given Macklin’s interpretation of dignity in these terms, her dismissal of the concept is understandable). As Luban points out, ‘the term “human dignity” is really a kind of placeholder—an uncontroversial, neutral-sounding term for the unknown X that anchors human rights.’ If all we mean by dignity is the fact that human life has value, we have few resources from which to argue that dignity requires a certain standard of treatment, or a particular type of interaction, beyond the bare necessities.

In response to this problem, we may wish to turn to the alternative, aspirational, concept of dignity. Understanding dignity as connected to upholding aspired-to values helps to explain why an act such as torture is a violation of dignity: it is an act that makes it virtually impossible to maintain one’s values. Honesty, compassion and bravery are all broken down through acts of torture. Similarly, insufferable pain and loss of control over bodily functions are seen to compromise the ability of the individual to maintain the standards that they have sought to uphold throughout their life. Under these conditions, persons are reduced to their most base level—their ability to act in accordance with their principles is stunted.

This concept suffers, however, from the inverse problem to the Kantian concept. Whereas in the Kantian conception we saw that dignity’s inalienability made it impossible to lose, within the aspirational concept it seems that dignity may well be appealed to in such situations, as it stands this is not a form of dignity that is even close to universal, and so cannot be utilised as a guiding principle in medical ethics. (Unless, that is, we are content to say that medical practitioners should treat patients differently in accordance with the degree to which they display such standards.)
If we interpret this passage in light of the definition given above, we can see it as a claim that it is precisely through upholding one’s principles under the hardship of suffering that dignity is achieved. The debate can then be seen as between the argument that end-of-life suffering goes beyond what humans can endure while upholding their principles, and the counter-claim that it is only through such suffering that our commitment to principles can be demonstrated. Once the two sides are seen to be disagreeing over the application of a single concept, we can hope at the very least for mutual understanding: it is much easier to have a debate when both sides are appealing to the same concept.

Likewise, this concept enables us to untangle the seeming contradiction of the common claim that substandard medical care violates dignity, which is wrong because dignity is an inviolable quality of all human beings. We can see now that the inviolability being invoked refers to the capacity for upholding principles and standards, whereas the violation being criticised refers to the ability to do so.

REMAINING CHALLENGES

Before concluding, I shall consider how well the definition of dignity I have developed can address three remaining challenges. First, if the universality of dignity is circumscribed by the capacity for conceiving of principles and standards, does it exclude individuals for whom such reasoning is impossible (dementia patients, the mentally disabled, those in an irreversible coma)? If so, does this invalidate the argument? Second, if dignity is the capacity to uphold personal principles and standards, is it really a value medical practitioners should be striving to defend? Finally, has the definition of dignity I have developed merely collapsed into an account of agency, thus confirming Macklin’s original objection?

In terms of the first challenge, there are two directions in which we could go. The first would be to concede that certain individuals (namely those incapable of conceiving of or understanding principles and standards) do not have dignity, but that this is less problematical than commonly thought once we acknowledge that dignity is not the only, or even the most, important guiding value for medical practice. Simply because certain individuals do not have dignity does not mean that other considerations—susceptibility to pain, a general ethic of care—should not come into play. Furthermore, there is still one way in which dignity itself can play a guiding role in these cases. This is because the dignity of the practitioner is also at stake, and sets limits on how one can act towards other individuals. For medical practitioners in particular, the profession presupposes commitment to certain principles. It is only through acting in accordance with these principles that the medical practitioner acts with dignity. As such, acknowledging that certain individuals lack dignity would not be a carte blanche for medical mistreatment.

The second direction (about which I have some doubts) would be to attempt to incorporate all or most individuals within the concept of dignity outlined above. This could involve the claim that our interest in upholding principles and standards may extend beyond the timeframe in which we are cognisant of those standards and principles. In other words, I have an ongoing interest in whether I am humiliated, even if I am asleep, comatose—or even dead—and will thus never subjectively experience the shame. It is easiest to understand this interest extending into the future, for cases in which capacity is lost, but we could also conceive of it extending into the past. As I consider my identity to be continuous with who I was as an infant, to have been humiliated would be a violation of my dignity. In this understanding, dignity would extend to all individuals who had experienced even a fleeting moment of self-awareness, sufficient to be able to conceive of shame.

We should note that this second direction could be used to supplement the first, extending the concept of dignity without necessarily making it universal. Nonetheless, it must be conceded that even with this strategy, certain individuals will be excluded—individuals who have never, nor will ever, experience self-consciousness, for example, would not be considered to have dignity in this account.

Medical practitioners are understandably reluctant to endorse a conception of a principle that validates differential treatment for patients. To claim that there are some individuals who do not have dignity may strike some as repugnant. The alternative, however, is to cling to a conception of dignity that has no content. It is only by refusing to articulate what dignity is and why we have it—or claiming simply that we have it on religious grounds—that we can extend it to all irrespective of capacities. As soon as we bring content to the notion of dignity, for example by pointing to a reason for which human life has value, we risk excluding those who do not share that property.

Admittedly, this may be an area where theory and practice must part ways. Even if we concede that, from a theoretical perspective, dignity is held by virtue of certain capacities and thus only extends to those who hold them, we may legitimately worry about our ability to discern the appropriate individuals. A solution may be to assume the capacity grounding dignity for all homo sapiens. Acting on the assumption that all do in fact hold dignity may be a way to reconcile the theoretical grounding of dignity with the practical difficulties facing medical practitioners.

The second challenge facing the conceptualisation of dignity I have defended lies in its normative appeal. Why should medical practitioners be concerned with allowing patients to uphold personal standards? More worryingly, what if those standards are in some way obnoxious? The answer to the first question returns us to the connection between dignity and humiliation: to be denied the ability to uphold one’s personal standards is experienced as humiliation, with deep consequences for one’s self-respect.

The subjectivity of this response may, however, cause concern. It is not difficult to think of examples of patients who would experience a certain form of treatment as compromising their standards, when this goes against deeply held principles: for example, a racist patient might find the experience of being treated by a black doctor or nurse to be humiliating; likewise a sexist patient may feel the same about being treated by a woman. Does this mean that we should concede to the patients’ demands, in the name of their dignity? The first point that needs to be made in response to this problem is again to stress that dignity is not the only principle guiding medical practice. In these instances, I would argue, the dignity of the patient is indeed compromised, but to concede to their wishes would compromise the values of equality and respect for persons, not to mention the dignity of the medical practitioners themselves. We need not see the dignity of the patient as trumping these other concerns.

The second point that needs to be made is that subjectivity is an essential part of the concept. If we were to assume that dignity could be maintained simply through adherence to the norms of the society in which the action took place, we would quickly encounter the problem of cross-cultural differences. To assume an objective (or culturally specific) standard would constrain us to
say that there is no loss of dignity experienced by a patient who is treated in a way that violates her most deeply held cultural norms. There is thus good reason to maintain the position that the standards and principles that must be upheld to maintain dignity are the patient’s own, conceding that dignity is not always the highest principle at stake in a given situation.

The final challenge was to see whether the definition of dignity I have developed does more than merely restate the value of autonomy. It must be conceded at the outset that both concepts share a foundation. Given that the capacity I refer to is concerned with developing principles and upholding standards, it clearly intersects with autonomy. Both are ways of articulating a capacity that gives value to a human life. Nonetheless, I contend that dignity is conceptually distinct from autonomy. This is primarily because the way in which dignity is respected differs from the way in which autonomy is respected. This makes it a vital distinction for medical ethics, in which the question of what each principle demands drives the enquiry into the principle’s meaning.

The difference between what autonomy demands and what dignity demands can be drawn out thus: to respect an individual’s autonomy requires respect for their self-governance. This is why the connection between autonomy and informed consent is so tight. To respect an individual’s dignity, meanwhile, requires respect for their self-worth. Admittedly, as this self-worth can be undermined through failing to uphold principles, there is an overlap with autonomy. Nonetheless, there are numerous ways in which failure to respect self-worth is not synonymous with failure to respect self-governance. For example, when patients recount the experience of overcrowding as a violation of dignity, it is difficult to read this as a violation of self-governance, except in the thinnest possible sense that it goes against her wishes. Similarly, certain procedures can either be experienced as humiliating or not, without the difference being traceable in any way to greater control being granted to the patient. The only discernable difference lies in whether or not the patient feels her standards have been maintained (perhaps through being shielded from public view). Recognising this admittedly subtle distinction between the demands of autonomy and the demands of dignity is, contra Macklin, of great importance to medical practice.

CONCLUSION
To summarise, I have argued that Macklin’s assessment of dignity as a useless concept was premature. Building upon the disambiguation put forward by Schroeder, I have laid out a definition of dignity that makes sense of both its universal application and its violability. I see dignity as playing two roles: it is both a (near) universal capacity that grounds the value of human life, thus making it an appropriate basis for human rights and bioethics documents in general; and it serves to articulate which actions are required for that capacity to be met, in particular the absence of humiliation. In essence, the mistake Macklin makes is to focus solely on the first of these roles, thus overlooking a vital aspect of dignity’s relevance to medical ethics. The mistake Schroeder makes, meanwhile, is to recognise the distinct roles, but fail to connect them. The concept of dignity so disambiguated can continue to serve as a guiding principle in medical ethics.

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