賽馬會安寧頌
JCECC
Jockey Club End-of-Life Community Care Project

Dignified Care
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Over the past few months, media has revealed several incidents with senior citizens not being treated in proper ways. For example, elderly residents were left naked while awaiting their bath, they were being neglected, and there were even instances where they were being scold and hit because they were "not behaving well"[1]. In health care there are many concerns about something beyond basic physical and daily care, namely, the preservation of dignity.

While dignity seems to be the basis for human rights, it is an abstract concept which can be difficult to comprehend, and the discussion about dignity seems to be focusing mainly on a philosophical level. When looking up the word dignity in any dictionary, it refers to the quality or state of being worthy, as well as to being worthy of esteem or respect. What does it entail to be worthy of esteem or respect? What makes people feel being worthy of esteem or respect, and what does the word mean in the health and social work context?

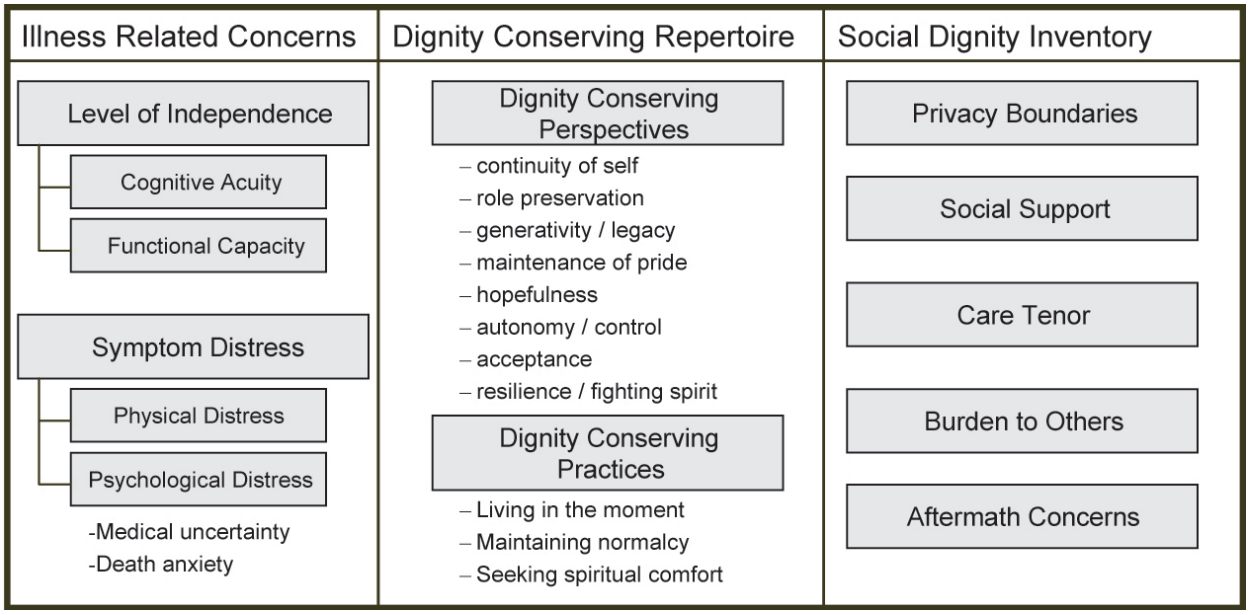
To answer these questions, a Canadian research team, led by Harvey Max Chochinov (2002), conducted a study with 50 advanced terminal cancer patients over a 15-month period. Analysis from semi-structured interviews gave rise to an interesting dignity model which provide us with some insights as to how we should provide dignified care to care recipients. In this model, patients' dignity constitutes of: 1) illness related concerns, 2) dignity conserving repertoire, and 3) social dignity inventory. Illness related concerns are issues related to the illness itself which may threaten ones' sense of dignity. These can include cognitive acuity and functional capacity, and the physical and psychological distress associated with symptoms. Dignity conserving repertoire is certain qualities, self-view and practices that can conserve ones' dignity in the process of illness. These could be a continuity of self, role preservation, generativity and legacy, sense of pride, maintaining hope, autonomy and control, acceptance and resilience, or living in the moment, maintaining normalcy and seeking spiritual support. Social dignity inventory refers to

[1] See, for example: http://www.scmp.com/news/hong-kong/law-crime/article/1856845/caretaker-hong-kong-nursing-home-which-left-elderly or http://news.mingpao.com/pns/%E9%95%B7%E8%80%85%E9%81%AD%E8%84%AB%E5%85%89%E9%9C%B2%E5%A4%A9%E7%AD%89%E5%86%B2%E6%B6%BC-%E8%AD%B7%E8%80%81%E9%99%A2%E5%89%B5%E8%BE%A6%E4%BA%BA%E8%AA%8D%E6%90%8D%E5%B0%8A%E5%9A%B4%20%E7%A4%BE%E7%BD%B2%E6%A5%B5%E5%BA%A6%E9%97%9C%E6%B3%A8/web_tc/article/20150526/s00001/1432577551357

social interactions that may enhance, or detract, the sense of dignity, which include privacy boundaries, social support, care tenor, burden to others and aftermath concerns.

Whereas the model may look complex, it provides some clear directions for health and social care, not only for cancer patients, but for all elderly and patients. These directions are: 1) Treating illness and physical can be important, but it is also essential to ensure care recipients' cognitive functioning and functional capacity while also addressing psychological distress; 2) Although care recipients may need others' help in daily care, they need to be reassured that they can still be themselves, having their own self-value, roles and contributions and live a positive and normal live; 3) The need for being care does not deprive their rights to privacy and being respect.

Conclusively, despite the abstract definition of "dignity", researchers are taking great initiatives to clarify the concept. With studies like Chochinov, scenarios as discussed above, in which elderly people are treated with a tremendous lack of dignity, will hopefully fade away from our society soon.



Reference

Chochinov, H. M., Hack, T., McClement, S., Kristjanson, L., & Harlos, M. (2002). Dignity in the terminally ill: a developing empirical model. *Social science & medicine*, *54*(3), 433-443.