

Age Action

IRELAND

For All Older People

Dignity in Healthcare

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Introduction

Dignity is derived from the Latin word *dignitas* (merit) or *dignus* (worthy). Associated words in English are *dignitary* and *dignify*. In the Collins English Dictionary *dignity* is defined as (i) the state or quality of being worthy of honour and (ii) a sense of self-importance (to stand on one's dignity, beneath one's dignity). Accordingly, dignity can be understood as a personal attribute that is recognised by oneself and/or others and commands respect.

In the Charter of Fundamental Rights of the European Union, the first article states that the dignity of the human person must be respected and protected. Here the understanding of dignity is that it belongs to all persons, it commands respect but it also needs protection. Dignity can be violated. Hence, its inclusion in a charter of fundamental rights.

Beyond the understanding of respect and protection of human dignity is also the notion that human dignity should be promoted. There is some evidence within healthcare that one's health can actually improve and that one can cope better with illness when one is valued and treated with respect. Therefore promoting dignity can lead to a better quality of life.

Dignity is sometimes associated with autonomy and having control over one's destiny. In terms of healthcare, and in particular in relation to older people, anecdotal evidence suggests that

- Older people's dignity and autonomy can be undermined in the health care setting.
- Many healthcare professionals hold stereotypical, negative attitudes towards older people.
- Tackling negative attitudes through exposure and education can help to preserve an older patient's dignity and autonomy.
- Giving older people and their carers adequate information for them to make informed choices about care further increases autonomy.¹

Here the notion of dignity is extended to include not only respect for the person but also for that person's decisions and the right to make choices that affect one's life.

A corollary to the understanding of dignity is that if one maintains another's dignity, then one also maintains one's own dignity; or alternatively, if one violates another's dignity, then one's own dignity is violated. This highlights the reciprocal nature of dignity.

¹ Kate Lothian, Ian Philp (2001) "Maintaining the dignity and autonomy of older people in the healthcare setting," *British Medical Journal* 322:668-670.
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What needs to be clarified, although it is alluded to in the above definitions, is that dignity is innate to the human person. So, even apart from its manifestation in the regard shown to it by others, one's dignity exists independently of others. In a sense dignity is tied to a person's very existence, what makes one human.

The Kantian maxim of treating people as ends and not, according to Utilitarian philosophy, as means, grounds the notion of human dignity on the human faculty of reason. The limitations, however, of basing human dignity on reason alone are obvious, as are the notions of dignity based on merit alone, since such grounds only apply to sectors of the human race and not to all. For many people, it is the reciprocal notion of dignity that determines their behaviour – doing unto others as you would have them do unto you. In Christian belief, all human beings have dignity by virtue of being created in the image and likeness of God.

Unfortunately, whatever basis there is for grounding dignity, there are those who will find reasons to excuse themselves from respecting another's dignity. Where there are gross violations of human rights, dignity is violated. Not so obvious, however, are the risks to dignity associated with being institutionalised, whether for criminal activity or for reasons of health care. In the case of prisons, one's autonomy is certainly curtailed for a period of time and while such action can be justified in terms of the common good, one could question whether a life sentence is a violation of human dignity. In the case of institutional health care, however, any curtailment of autonomy is open to question. Patient's involvement in the decision-making process about their care is vital and even if a patient's reason is impaired, there is still a need for someone to advocate for the patient to ensure that his or her dignity is not violated. Yet, even for an advocate to make a decision about a patient's destiny may also be a violation of the patient's human dignity.

Until now there has been very little research done which explores the views of older people as to what the concept of dignity might mean to them. There is also a large gap in the research literature as to how dignity can be promoted through health and social care. The Government health strategy, *Quality and Fairness – A Health System for You*, published in 2001 by the Department of Health and Children, included dignity as a key element. In terms of best practice in customer care, it says: "The vision adopted for the future health system places a high value on treating people with dignity and respect" (p.80). Also, in terms of staff, it says: "Strategies come and go, but the people who are an integral resource to the health system need to be appreciated, developed, motivated and effectively managed with respect and dignity if the desired vision, values, goals and objectives are to become reality" (p.53).

This report, which is based on focus group work carried out as part of a European study on Dignity and Older People funded by the European Commission Fifth Framework Quality of Life Programme, presents the views of older people and health care professionals in Ireland on their understanding of what it means to be treated with dignity. Included are the views of professionals on their experiences of working with older people and what they see as the factors within the health system impacting on their own dignity. (See Appendix)

Older People's Views on Dignity

Definitions of Dignity

The predominant interpretation of dignity by participants over 65 was “respect”. Generally, this was spoken of in terms of treating others with respect and being treated with respect by others.

Respect was something many participants learned when they were young from their parents. It presented itself as a code of conduct on how to treat others and how to behave oneself. Once appropriated, it shaped one's character and gave one a sense of one's own dignity.

Dignity is the way I was raised. We were reared with a set of codes, yes was yes and no was no. Respect, loyalty, good manners ... being straight and honest, never be afraid to say hello or a smile; your time is your character and your word is your bond, that is my dignity and I still hold it (Male, Aged 65).

The respect for others is based on their personhood, their humanity.

Respect for the human being, any human being, or a person. Respect for their way of life, for what they are no matter how old, they are still a person in God's eyes and must be shown a bit of dignity (Male, Aged 77).

And likewise, the respect due to oneself is also in recognition of one's personhood.

Dignity is respect really; respect me as a person and as an older person (Female, Aged 71).

Quite a number of participants also spoke of dignity in terms of “self-respect” (Female, Aged 70), “self-worth” (Female, Aged 66) or “self-esteem” (Male, Aged 74).

I also think it involves a feeling of self-worth, feeling good about yourself, feeling that even though you don't have the latest technological skills, you have skills and expertise that's born out of experience and that you appreciate that yourself and that other people appreciate it (Female, Aged 66).

Other people's attitude can diminish one's self-esteem but one's personal dignity is quite resilient, even in difficult circumstances.

I don't think your dignity could ever permanently be taken from you because your dignity is how you express your own inwardness, that's your dignity, but the perception of you by other people can be eroded (Male, Aged 67).

Because of its inner quality, dignity is something that is hard to lose but also something that is hard to gain if one has not been treated with respect throughout one's life.

I think if you haven't had that experience, and I think a quite a number of women haven't had that experience in Irish life, they have been dominated by bosses or husbands, it will never come and if children haven't seen their mothers being respected by fathers, it will never come, not all the loving and all the dressing up in the world will give it to them, but where you feel confident in yourself and have experience of dignity and self worth, it stays with you. It would takes a lot of bashing around I think to lose it. I am me (Female, Aged 66).

This sense of oneself as being important also enables one to stand up for oneself as a reasonable person. As one elderly lady put it "to fight for my dignity" (Female, Aged 63). She experienced a change of attitude by her children towards her as she got old, that they began to treat her as a child, and she had to reassert her position in the family.

Many felt that young people did not take them seriously or value their wisdom.

It's not very dignified if young people come along and say you shouldn't do this and you shouldn't do that. I mean they should give us the dignity of making our decisions while we are able to do so (Female, Aged 70).

For older people to feel that they have a contribution to make to society is very important to them.

Never feel that nobody wants you, always feel that you are you, that you have something to contribute to society in your own little way (Female, Aged 80).

Some however expressed a doubt whether they could maintain their self-worth if they developed Alzheimer's.

One participant reacted strongly to the suggestion that dying with dignity could justify euthanasia.

I don't think suffering pain will take away dignity. You may have anguish but you can have anguish and also have dignity at the same time (Female, Aged 65).

It was pointed out that dignity relates to all ages, young and old, that children also have their dignity and it too can be eroded, for example through drug abuse. To use the word dignity solely in relation to older people could segregate them out from the rest of society.

Another interpretation of dignity related it to "independence." This is something most older people value highly and is not something they would give up easily.

Independence in your life is your worth (Male, Aged 72).

Yes, I would say to be independent is the chief thing in our dignity, if we are able to lead our own lives as we want to do (Female, Aged 70).

The fact that women in particular have a pension has given them an increased sense of their independence.

Some older people wanted to be “left alone,” although others recognised that “co-dependence” (Female, Aged 68) was a better balance.

Closely associated with the idea of respect was “tolerance” (Female, Aged 74). Not only did older people expect tolerance from others, but some recognised, especially in relation to the young, that they had to try and see the world through their eyes. A certain amount of give and take was necessary to maintain civility. Thus, the reciprocal nature of dignity required that young and old each treat the other with dignity.

Another participant related the word dignity to a dignified person and went on to explain that “a person who can enjoy simple things, that to me is dignity” (Female, Aged 65). Socrates was given as an example of a person with dignity but it was suggested, “too much dignity could lead to condescension” (Female, Aged 69).

One final summing up of the work dignity by a participant,

It is such a big word dignity (Female, Aged 65).

What does it mean to be treated with dignity?

To be treated with respect is highlighted as one of the ways of treating a person with dignity. Respect can manifest itself in many ways. Some of the examples given by participants included simple things like people asking how they are, helping them with their bags, carrying out messages for them, helping them to cross the road, etc. Generally respect is manifested in the concern shown by others towards older people.

If I meet people on the street and we have a chat and they ask how I am or tell me I am looking well (even if I am not). Or, if someone helps carry my bags - that's dignity and respect. People who help; I like that (Female, Aged 63).

Showing tolerance is another way of treating older people with dignity. Again, this can be manifested in simple ways by, for example, those who provide services taking time to explain things to older people or shop assistants not rushing older people.

It is also shown in the way people speak to older people and appreciate their lives, not casting aspersions on the way they lived in their young days or making anachronistic comparisons with how people live their lives today. It is an appreciation that they are old.

Treat us with respect and realise that we're old and treat us as such (Male, Aged 70).

It is an appreciation, too, that older people have something to contribute and that their opinions are valuable. It is about taking time to listen to what they have to say. When

family members seek their advice and act on it; that is a sign of being treated with dignity. When young people especially are attentive to the needs of older people, the appreciation is strongly felt.

Being treated with dignity also means allowing one to lead one's own life in one's own way without interference. This does not mean that a helping hand would not be appreciated but it may simply mean that the older person is asked if they need a hand. Generally, older people like to be independent and to be let do things for themselves.

For older people being treated with dignity can have practical implications such as having facilities provided, like day care centres and transport, which meet their needs.

What does it mean not to be treated with dignity?

The corollary to being treated with respect is to be treated with disrespect. A number of examples presented themselves, many of which dealt with the attitude of young people who were not helpful or considerate towards older people. There were examples, too, of people who do not have patience with older people, e.g. motorists who do not allow time for older people to cross the road. One example was where a daughter and mother sold their houses and bought a house between them but after a short time the mother felt she wasn't wanted. As the person who gave the examples said:

I would prefer living on my own and be treated with dignity than living with someone else and be treated with disrespect (Female, Aged 77).

A parallel was drawn between the attitude of those who would treat older people with disrespect and those who treat the environment with disrespect.

To be left isolated or isolated from a group and not included in the conversation, that too is an example of not being treated with dignity. Again, the attitude of young people, including relatives, comes in for criticism when older people feel their views are not respected or even considered. As one woman complained:

My daughter is always saying to me, you wouldn't understand (Female, Aged 66).

The sense of being pushed aside and marginalised was resented, for example when older people were lumped together as "them auld ones" (Female, Aged 72). Some older people were literally pushed aside by young cyclists on the footpath.

Older people do recognise that they slow down as they get older, mentally as well as physically, but this fact, they said, is not recognised or respected enough in society. The sense of being talked down to was not uncommon and it was not just younger people who were at fault but those in authority, "who should know better" (Female, Aged 74).

Criticism was levied at government departments and institutions that failed older people in many respects, particularly by not having time for them. Examples include post offices where older people often feel rushed.

There were also ageist attitudes in employment and examples of older people being targeted for redundancy.

If you go into a bank and look around, I say to myself, how many people here are over 50 years of age and I don't see any, where are they all gone? I say to the people in there, do you think you are going to be here when you are 50 years of age? Where are the people 50 years of age now? Old people are invisible; they are a burden on society - that is how older people are being thought of (Male, Aged 67).

One of the more serious negativities toward older people was being burgled and for many older people security was an issue. The sense of fear endangered by such incidents, whether or not one had any first hand experience, is something older people live with, although a number have taken precautionary measures such as wearing pendant alarms around their necks.

Divergent views

As regards how older people are addressed by younger people; some older people felt that the use of first names was inappropriate while others insisted on it because it was friendlier. The use of the term "granny" (Female, Aged 88) was considered respectful but not "dear" (Male, Aged 67). Some referred to their young days when as employees they had to call their employer "master". However, the older people concerned had no desire to perpetuate such a class system today, preferring to be treated as an equal and be "recognised as a fellow human being" (Male, Aged 72). The respectful approach they said was to find out from older persons the mode of address they preferred.

There were some divergent views, too, on things like giving an older person a seat on a bus. Some felt embarrassed if, for instance, a man with a child in his arms gave up his seat. Another person gave an example of not being helped into a taxi and yet felt her dignity was respected because she wasn't treated as if she was incapable (the driver did hold the door open for her). Yet another person commended a bus driver who got down from the bus to help an older person board.

Relationships with family members varied. On the whole older people felt cared for and appreciated. Some, however, felt their relatives wanted nothing to do with them, that they did not want to assume any responsibility for their care and that their only interest in them was the inheritance they hoped to get after they died.

Hospital Experiences

On the whole, older people were very positive in their views on how they were treated in hospital. Ambulance staff, doctors, nurses and paramedics were all commended.

I come out of there feeling somebody is looking after me so I don't mind in the least going in (Male, Aged 77).

Taking time for their patients is particularly appreciated.

The nursing staff up here work very, very hard. They do. But I always find time to talk to them or they to me and they have always treated me with dignity, it didn't matter whether they were just passing, you were acknowledged and you were treated like the person you are (Male, Aged 73).

Some recognised that nurses are not always treated with dignity by patients, but the most common experience of not being treated with dignity by patients was when hospital staff ignored them. There were times when specialists not only talked above their heads in terms of the jargon used but literally talked over their heads to other members of staff or relatives as if the patient/older person was not present in the room.

I went into this particular specialist and he had an assistant, instead of talking to me he was writing all the time, I could have been an elephant. He said take her in there and tell her to strip down and I just said, "am I invisible?" (Female, Aged 66).

Some were of the opinion that if they were younger and richer they would get a better service (Female, Aged 76).

The issue of meeting different doctors on different visits to the hospital was a problem as patients had to repeat their story over and over again. Another difficulty was the lack of information received about one's complaint.

Some older people were not happy about being sent far away from their locality for treatment and others worried about being sent home from hospital before they were ready or if they did not know who would care for them on discharge.

The waiting time for treatment was also highlighted, but this is not something that is peculiar to older people in Irish hospitals.

One participant, who described dignity as "self-worth" gave her impression of hospitals in these words:

Well if you have it [*feeling of self-worth*] for years, from you're experiences in the work place and in family circle, that you felt respected and you felt good about yourself, that stays with you and it will help you through even the worst and most humiliating circumstances and I am thinking of occasions in hospital when you're just like a bit of meat on a bed, as it were, and you are being punched and probed and all the rest, but you still felt, where I am today, these people who are looking me over and talking about me and ignoring me will be there in 20 years time or whatever; their day will come. I am the sample specimen today; they will be the sample or specimen (Female, Aged 66).

Nursing Homes

There was general praise for nursing homes by the majority of participants. Unlike in the past when older people were sometimes institutionalised against their will, today people

had choices and going into a nursing home was not seen as something negative because of the quality of life afforded to the residents. As one participant said on visiting a friend in a home:

They treated her with respect and she looked it, always beautifully dressed (Male, Aged 75).

Nevertheless, the prospect of being “shoved” into a nursing home by family members and being “forgotten” was still feared by some older people (Female, Aged 76). Indeed, some patients in nursing homes had the experience of only one of their children coming to visit them while the rest of the family stayed away.

Having choices about one’s care remains important, even when one has made the decision to go into residential care. In one instance a patient’s room was being painted and she had to go out of her room, which she wasn’t happy about.

We weren’t asked, we were just told to get out (Female, Aged 77).

While the loss of a certain amount of independence did result from being in an institution, e.g. one could not always make a cup of tea when one wished, there was also a realisation that if one remained with relatives (depending on how well one was treated) one could also lose a lot of independence and have to put up with noisy children and not being able to watch what TV programme one wanted.

Adjusting to life in a home can however be difficult, especially for those who lived for a long time on their own.

It is hard to change or adapt. You are away from home. Your friends are gone. That is what I find hard. I can’t get out or move about. The visitors get fewer the longer you are away (Male, Aged 82).

After a period of time, older people generally settle in and the positive aspects of being in a home, being cared for and having company, are better appreciated. But, that is not to say that being in a home is a return to life as it was before.

I remember visiting a woman in a home about 30 years ago and I asked would you rather be here or at home and she said, “sure this is not like home, I don’t own anything here.” That’s what she found hard (Male, Aged 82).

It was noted that sometimes agency nurses and attendants do not always have the same interest in patients as permanent staff. It was also remarked that as nursing becomes more professional, there has been a loss in the vocational element of the work that is now seen as a job.

The question of affordability of nursing care was an issue and while some had the means to meet the costs, others worried about the type of care they would get if they needed

long-term care because of a lack of means. No one wished to be a burden on their sons or daughters, neither in terms of being cared for by them or having to depend on them to pay for a nursing home.

GP's

Family doctors deserve special mention as many participants look to them when in need. Not only are they regarded as physicians for their ills but many older people view them as confidants for their general well-being.

If you are worried about something, the doctor is your only friend (Female, Aged 77).

One thing older people do not want to be told is, "it's your age," which they find most disconcerting.

Every time I went to him with a little complaint he would say sure aren't you very well considering what age you are. That was all the sympathy I got (Male, Aged 76).

But, more than curing their illnesses, many older people want their GP to have more time for them, making house calls and "popping in" (Female, Aged 74) to see that they are OK, especially if they live alone.

Professionals' Views on Dignity

Definition of Dignity

As was the case with the older people's focus groups, the preferred word by professionals as a substitute for the word "dignity" was "respect". Other words used were "empathy," "freedom," and "individuality."

In terms of defining "dignity" the most common understanding was in terms of "treating someone with respect". Examples included respecting the patient's wishes, responding to their needs, treating them as individuals. The basis for this understanding relies on the reciprocal nature of respect, which can be summarised using the biblical quotation: "Do unto others as you would have them do unto you." Other variations on this was, "treating others the way you want to be treated, regardless of age," or "treating others as you would want your parents to be treated".

Another understanding of treating someone with respect was to define this, not in terms of the reciprocal nature of respect but as something inherent in the persons to whom respect is being shown because they deserve respect, because they are human beings. This understanding is akin to recognising a person's individuality.

Some maintained that the concept of dignity is rooted in Christianity and that treating someone with respect goes beyond what one sees as a recognition of the intrinsic value of the person, regardless of their physical or mental state. It is a recognition, too, that even as an older person one is still growing. This understanding is akin to recognising a person's uniqueness.

Treating someone with dignity was also understood as something that enhances self-respect. People feel valued if they are treated with dignity and this feeling is a very positive experience.

The word "dignified" was also used as an attribute associated with certain people and "very old people from the Church of Ireland" sprung to mind as an example of the type of person being referred to (Social Worker).

To "die with dignity" also came up as a usage of the word dignity and when this notion was explored it appeared that what it refers to is a person dying mentally competent up until the time of their death.

Some professionals thought the word was overused and had become something of a cliché. Others found it easier to come to an understanding of the term through its negative sense, i.e. not treating someone with dignity. Reference was made to the "indignities" of old age and the loss of competencies associated with ageing. However, what were sometimes referred to as indignities, such as drooling, could be attributes that were somehow culturally defined. Such "indignities" may not be universally recognised

outside a particular culture and certainly in a Western culture, drooling would not be considered undignified if one was referring to a baby.

As a concept, “dignity” was seen as taking in many areas of life – physical, psychological, sexual, spiritual – such that it was difficult to settle for any one definition.

What does it mean to treat someone with dignity?

Treating people with dignity implies treating them with courtesy and kindness, but it also means:

- Respecting their rights
- Giving them freedom of choice
- Listening and taking into consideration what they say and
- Respecting their wishes and decisions, even if one disagrees.

Treating people with dignity implies being sensitive to people’s needs and doing one’s best for them, but it also means:

- Involving them in decision making
- Respecting their individuality
- Allowing them to do what they can for themselves and
- Giving them privacy and their own personal space

Treating an older people with dignity implies treating them as a person, but it also means:

- Treating them the same as everyone else
- Treating them as an adult, not as a child, and
- Treating them as part of the community

Some of the practical implications of treating an older person with dignity include, for example, taking time to explain things to older patients.

It is their life, so they should be told everything (Care Attendant).

You actually explain to somebody with dementia what is happening to them everytime you do, every time they are going to be moved into a hoist, instead of just doing it to them and frightening them (Social Worker).

How one addresses an older person is important, whether by their first name or as Mr. or Mrs. How medical teams relate to the patient is also important, whether they stand at the foot of the bed or sit beside the patient. Sometimes two staff members when making the bed an older person is lying in talk over the person rather than include him/her in the conversation.

One of the worse things is people in wheelchairs, we can talk over them and not to them and it’s one of the worse things that you can do. Also to get down at their level, they are in a wheelchair and physically get down beside them and talk to them, it’s so important (Physiotherapist).

One last thing it's very important when you are talking, to listen to them and give them time to speak to you because very often you finish a sentence off for them and that's all they wanted to say in the first place you know. Just to give them time to get the words out (Physiotherapist).

Another common occurrence when relatives are present is a tendency to address the relative rather than the patient, especially if the patient has a hearing difficulty or is cognitively impaired.

Even for someone who is cognitively impaired, they will understand somewhat. They will get more suspicious if they think they are being spoken of behind their back. We do try and focus on the patient but it isn't always the case (Nurse Manager).

And for those with cognitive impairments, it is important that the preferences they had, such as the food they liked, is still acknowledged at meal times, even though they may no longer be able to express their preferences.

It is important not to disenfranchise them – “Does he take sugar syndrome” (Social Worker) – and allow them make decisions for themselves. So it is not just a matter of telling the patient what you are going to do but to ask them do they want it.

It is the simple things again that make all the difference, like when you are getting a resident up in the morning, to give them the choice of what they would like to wear, what would you like to put on you today, as opposed to just pulling something over their head (Activity Staff Nurse).

One of the most important things for professionals working with older people is to preserve their independence. In terms of practical care for patients this involves motivating them to do as much as possible for themselves, concentrating on their abilities and not their disabilities.

There is a danger of families or services stepping in and taking over the decision-making.

It never ceases to amaze me how older people have been doing great, then they get sick and suddenly there's a big hoo haa because they never had hot water or they can't go home because the house is dingy. Even family members start this carry on, oh she can't go home because of the bed, that mattress is you know, and the sinks are a bit cracked. It's a complete over emphasis. There's no dignity in not being allowed to live with a cracked sink or the way you always lived. If the older person wanted something done about it, if they really did, they would have done it. If the reason is poverty, we can do something about that with the consent of the older person. But there is an awful lot of stuff about hygiene and safety and ways of life and what they eat and wear. I think we have to be very delicate about the fact that we can explore people's lives to the most intimate degree, where they sleep, who they sleep with, and how they get into bed and how they get out of

bed, how they use the toilet and what they do at night. I sometimes wonder how can you preserve people's dignity when they can't even hide their frailties and they can't even hide their quirks (Social Worker).

Certainly, to have enough food, heat and comfort for the rest of their days and medical services is seen as their due, if not their right. If help is needed, then this should not take away the respect shown to them.

If they need help going to the bathroom just to say to them, "will I stay with you or will I go outside?" (Carer).

To treat them as a whole person, not just because they have got Alzheimer's disease or whatever, they are a person with a past and a future, even though their future has altered but to treat them as a whole person and with respect (Nurse).

Again, understanding how worthy they are, they have worked all their life, they have reared their families, they have worked hard and now they deserve to be looked after (Nurse).

Despite being old, older people can still contribute to society. They have years of experience. They should be seen as part of the community.

No old person should ever feel that they are a burden on society (Director of Nursing).

Barriers to enhancing dignity in a care setting

Time and timetables are two of the most common factors affecting quality patient care. Staff do not always have enough time to spend with patients which can result in difficulties meeting patients' individual needs and having to conform to schedules can compromise patients' individuality.

While there may never be enough time in the day to do everything one would wish for a patient, staff shortages increase the possibility of putting a patient's dignity at risk. An extreme case, but one which is known to occur, is the use of restraints on patients simply because there is not enough staff to mind them. Staff might also be more aggressive towards patients because they are under pressure. Stress for staff is also an issue.

Striking the correct balance between the patient's wishes and staff's schedules is not always easy. Flexibility is key and many institutions caring for the elderly nowadays allow a fair degree of freedom for patients to do as they will, provided other patients are not adversely affected. At times staff find themselves in the unenviable position of being the arbitrator between two patients, each patient feeling that their dignity would be affected if the other had their way.

One of the frustrations for staff in delivering quality patient care is lack of resources. This situation is quite common, within institutional settings and in the community. It

affects staffing levels but it also limits what can be done for patients and the amount of activities that can be provided. Individualised care is certainly compromised by the lack of resources.

Another common limitation on quality care has to do with the buildings the patients are accommodated in. Even some of the newer buildings are inadequate. Privacy cannot always be guaranteed since there may not be sufficient private rooms or private spaces.

I don't know how many of us could use a commode knowing that others were just outside the curtain (Nurse).

The actual space around each bed can be too little to allow staff to work comfortably with the patients and there may be no space for patients to put their personal belongings.

It does mean an awful lot to the residents to have a few familiar things around them because they have given up an awful lot to come into a home (Care Attendant).

Some buildings restrict free movement on the inside and inhibit access to the outside. This applies particularly to patients suffering from a disability for which the buildings were never intended in the first place. Many of the health care professionals (doctors, nurses, attendants) complained that they should have been involved in the design stages of nursing and hospital facilities and that this should not have been left to architects and planners alone. Occupational therapists and patient resident committees it was felt should also be included.

Even where resources are up to standard, there are still ongoing problems such as staff turnover, which can affect continuity of care. There is not always the remuneration incentive for staff to remain. There can also be problems of communication between management and staff or between staff and patients.

There are, however, a number of improvements that could be made without additional resources. The layout of day rooms, for example, do not have to have all the chairs arranged along the walls; they could be put together in circles to facilitate better communication between patients/clients. Having chairs with arm rests in casualty and other waiting areas would also assist an older person getting to their feet.

Something that is quite new in the Irish context is staff from different countries working on the wards or in the nursing homes. A language barrier can exist and this can create problems although sometimes the problem is one of racial prejudice by patients. Even for the foreign nationals themselves who come from countries where older people are normally taken care of in their own homes, there can be quite an adjustment to be made to the Irish situation of institutionalised care for older people.

Another barrier to quality care, which impacts on the dignity of patients, is ageism. Ageism exists in society but it is also evident where services for older people are under-

funded or where, it appears, other areas are always given priority. Some staff commented that older people are not given the same level of care in casualty as younger people and on the wards a negative attitude by staff towards older people can sometimes be detected.

Enhancers

Apart from the personal qualities required by those working with the elderly, there are a number of ways of working that can preserve dignity on the ward.

Where time is a barrier, one can still give quality time, which may simply involve holding someone's hand while talking with them. How dignity is preserved may come down to the way an older person is addressed.

Sometimes we might be very casual about calling older people by their first names, instead of Mr. & Mrs., the old fashioned way. All those things have gone for us, but not necessarily for them (Care Assistant).

More and more it is recognised among health care professionals that a holistic approach to care is very important and that meeting the psycho-social needs of a patient is equally important as meeting their medical needs. Indeed, satisfying the former can reduce the need of the latter and result in a happier and less demanding patient. That is why activities for the elderly in an institutional setting are seen as so important for their well-being. Reminiscence is seen as particular helpful.

Another factor that is generally recognised as promoting well-being is maintaining a person's independence for as long as possible. Ideally this would be in the person's own home. Yet, even in an institution, allowing them to do as much as possible for themselves and concentrating on their abilities rather than their disabilities is seen as best practice.

Individualised care is seen as the most appropriate and best for preserving dignity, even though limited resources can be an impediment.

We have been involved in a project to try and look at a needs responsive package of care for older people which will occur outside of office hours, seven days a week. It is a model of care for looking after older people at home that can work. It is not new as a concept, it is new in this country, but it is difficult to move from a fixed style of approach to a needs response care package (Doctor).

For those who care for older people, simply putting oneself in their shoes serves as a guide for how to treat them.

Also, the hospital or nursing home environment should be as homely as possible. Patients dressing in their own clothes, for example, not only maintains their sense of dignity but helps staff to treat them as individuals. Patients having their own space which they can personalise with photos, etc. does likewise. Other little things that help maintain a patient's dignity include having proper cutlery at meal times, sitting at a table with others and not rushing patients through their meal times. Even for someone with

Alzheimer's who has a hand tremor, there is special weighted cutlery that can make feeding oneself easier.

Allowing patients to have a say in their care is seen as promoting their dignity as well.

We try to maximise the level of the person's involvement, whether it is maintaining their independence in dressing or involving them in the decisions that affect their lives. We have had to have a few team discussions about some difficult scenarios but generally we don't meet without the person involved because it affects their life and they are central to that discussion, they are central to planning. So involving and maximising the involvement of the older person is a preservation of dignity (Senior Social Worker).

What can be a help to staff in knowing the type of person they are dealing with and their preferences, even if the person suffers from dementia and cannot communicate verbally, is a "Life History Book". This records the person's own story, their history, their likes and dislikes, in words and photographs, something which may be put together at a time when the person was reasonably well. It is something which staff and relatives can be involved in and can be included in the activities of a day care centre or residential home.

It enables staff to get a more whole view of what people were like and to enable the resident to take more ownership of their whole person (Social Worker).

Other aspects of care include taking time to explain things to patients. Even if it appears that they do not understand; it can still reassure them.

Also, as far as possible, involving the wider community outside the institution is important in helping the elderly feel that they belong and have something to contribute. Intergenerational activities are particularly helpful.

I read of a nursing home in England and there was quite high levels of depression among the elderly and a play school opened up in the basement of the building and the children began to come up and mix and associate with the elderly and it was noticed that the levels of depression decreased (Nurse).

Mention was also made of an organisation that brought in pets to a nursing home for patients to pet and it made a great difference to the patients, many of whom would have had pets at one time in their lives.

There are many other organisations of volunteers who befriend older people and make a huge difference to their well-being. One thing older people do not want to feel is that they are a burden on others.

Working With Older People

Views of Professionals of Older People

The views of professionals who work with older people, especially in hospitals or long stay facilities, can be coloured by the fact that the older people they come in contact with on a regular basis have various levels of dependency, which really represents only about 15% of the older population. The other 85% of older people would be relatively fit and well.

I suppose we are all guilty in one sense that we can sometimes see the disability in the person and not the actual person's dignity or individuality (Assistant Manager).

Staff have to remind themselves from time to time that they are dealing with real people.

I am constantly visually surprised when I see somebody standing up at my own height; they become reframed in my own way (Social Worker).

When you look at our own residents and begin to say "housewife, father, farmer, city counsellor, legal secretary, ward sister" – that sometimes works for me to remind me that these were people like me a few years ago doing certain things with the titles and we need to be careful that because they are old not to lump them together under one title. They are still the ward sister retired, the judge retired, the city counsellor retired. That is a preservation of dignity to see them as people rather than groups (Senior Social Worker).

For those who work in day care settings, it is somewhat easier for them to view older people the same as everyone else. This is also the experience of those who are involved in activity departments of hospital.

We are very fortunate in the activities department because we get to take the patients out on outings and to different places and it is when you see them away from the bed, especially in the outside world, you see them as real people (Activity Staff Nurse).

Photographs on the ward of the older person when they were younger are also a good reminder to staff that they are dealing with real people. One participant who spoke about reminiscence as an excellent way to stimulate older people, when asked what reminiscence does for their dignity, responded:

It makes them feel like real people, they are telling you about themselves when they were younger, you know all the different stages of life and it makes them feel real, but apart from that it makes us as staff look on them as real people (Activity Staff Nurse).

Some staff reflected a view of older people that would not see them the same as everyone else.

There are a lot of them timid because that generation, they didn't answer back (Nurse).

Younger people have higher expectation, they want to know every tablet, everything, whereas older people say, "if the nurse said it, that's grand," "if the doctor said it, I will take his advice". It was sort of instilled in the older people to conform, that this was their role. Maybe the future older people will want to be more active in their health care but definitely the present generation of older people kind of take the doctor's word (Nurse Manager).

GPs came in for criticism for their attitude, although those who specialise in work with the elderly received a more positive reaction.

Four years ago next weekend my mother died, the Lord have mercy on her, but six or eight months before that she just wasn't well, she was in her nineties you know, so I got the doctor out one day to see her and he said, "there is nothing wrong with her, what do you expect anyway?" he say, "what can you expect anyway of a woman of her age?" And I think that sums up a lot of the attitudes towards the older person (Assistant Director of Nursing).

I would agree with No. 2. GPs, not all of them now but the majority of them, would have that attitude, "it's your age," whereas if you have an elderly person referred to the gerontologist there is a whole different attitude, they look at the whole patient, they don't put age up as number one factor, it's a whole different approach (Nurse).

A similar negative attitude was also picked up by some geriatricians from their colleagues on other wards. Especially in casualty it was noted that up to a third of older people being admitted get a label of not being able to cope or manage at home when in fact it is the physical ailment that brought them to the hospital that has rendered them unable to cope and once that is treated they are fine.

Even the phone call you get is negative. "Oh we have so and so, it is an absolute mess." They put on the sign, "acopia" (not being able to cope). If this was written beside the name of a member of my family, I would be really ashamed (Doctor).

It is like, they are old, they cannot manage any more. And they could be really sick but they are just given this label. They are seen almost as a nuisance. If there is a general medical team on call they may be giving out about that everyone we got in was elderly as if they were less entitled to medical care than if they were younger (Doctor).

Views regarding work with older people

While those who work with older people regard their work as rewarding and challenging. Many expressed the view that their peers who work in other specialties regard their work as un-specialised and not very demanding. It is seen as the “Cinderella” of the nursing profession (Nurse). This attitude, however outdated, still persists within the nursing profession and even among social workers.

It’s not the kind of sexy end of social work, and people say, “Ah yeah, you work with old people, well I work with Aids” and all these other scenarios that seem to be better (Social Worker)

About 10 years ago in terms of care of the elderly it was seen as one of the worst areas to work in. I mean you were basically feeding, toileting and that was practically it. Now the whole care of the elderly has completely changed. You do maintain a lot more dignity. There is a lot more activities and a lot more going on and it’s not just the same as it was (Nurse Manager).

As far as those who work with older people are concerned, the work is very demanding.

And yet you really need more skills because if they have dementia and are cognitively impaired you have to anticipate a lot of things. Young people can tell you what’s wrong with them in acute hospitals. And you have all the family issues as well, so it is more challenging (Staff Nurse).

People think it’s real cushy and easy but it’s not a bit because it goes into such questions about your life (Social Worker).

Even though the attitude towards work with the elderly is improving, there are still nursing shortages. Young people are not entering this field of work in sufficient numbers and even though placements in the area of care of the elderly had a positive effect on attitudes, there was a recognition that younger people may not want to remain in one area of work all their lives and that they would naturally want to move. However, as a result of staff shortages, there is also an increase in stress levels among those who have to carry on with reduced numbers and this can have a knock on effect on patients too who sense the pressure nurses are under.

I think working with the elderly is probably more stressful than working with younger people, they kind of seem to pull out of you more. I think stress amongst staff is probably higher working with the elderly (Physiotherapist).

A somewhat more optimistic note was struck by one geriatrician who saw a greater number of interns choosing to work with the elderly as their speciality. From his own point of view, what attracted him to care of the elderly was the holistic approach to patient care and working as part of a multi-disciplinary team.

Not everyone, it would be argued, is cut out for working with the elderly. Some of the attributes seen as necessary for this work include patience, empathy and commitment. It was also seen by some that the work might be more suitable for middle-aged people who bring to their work their own life experiences that helps them empathise more with the older people in their care.

I think even people who are not qualified, if they have their own life experiences, middle aged, they tend to be much, much better even those that wouldn't be as qualified as some of us (Nurse).

The question of professionalism does, however, raise its head within the sphere of care for the elderly and that attitudes of superiority within the speciality can actually create problems.

I think carers because they have firsthand experience with the elderly, because they are in communication with them on a daily basis, they know a lot but because we are not classed as professionals, we are sometimes not heard or we don't have a voice. That's a problem (Care Attendant).

On the whole, those who work regularly with older people appreciate very much the people they are dealing with and find their work rewarding.

I notice that if their basic needs are being met and they are beginning to feel comfortable and secure, they have an awful lot to offer (Care Attendant).

The elderly have a lot to teach us and a lot to give, you know they really have, I mean even the bed bound ones you can learn from them, you know. They have so much to relate back to the past and they can fill in so many gaps that you mightn't have known about (Nurse).

Older people will always thank you, they really will thank you (Carer).

You know they are so appreciative and it's just wonderful to see, as someone said to me, how do you measure a smile (Activity Staff Nurse).

Working in an institutional setting

One problem that arises for staff in an institutional setting is how familiarity with their caring role can sometimes desensitise them to how the person being cared for actually feels about having their personal needs met by someone else. Staff can become so used to toileting and bathing patients that they could overlook the need for privacy, as was the case in the scenario of the older woman being bathed with the door open, or become insensitive to patients who may be embarrassed being cared for by persons of the opposite sex.

I think sometimes when we are working with care of the elderly all of the time, I think without realising it, we can get blasé and it becomes, not unfeeling, but routine (Staff Nurse).

With regard to routine, the expectation of relatives can have an influence.

They, the families, want the routine too. We had one patient and he wanted to go to bed and it was dinnertime and we kept the food for him but when the relative came in, she said, “why was he not being fed” (Care Assistant).

Another said, “Why are you changing my mammy’s clothes so often. Every time I come in there is a big bag of laundry.” Another will say, “My mother’s clothes haven’t been changed for two whole days.” You can’t win (Nurse).

Institutions can also have the tendency towards conformity such that treating patients as individuals can be compromised. An example, again in relation to a patient screaming when being showered:

I know someone who went into a nursing home and was very cross, which was out of character, but it turned out they were trying to give him a shower every day and this man was never fond of water. The nursing home wanted him spick and span but his life history would show that he never was (Nurse Manager).

As one participant remarked:

It is like when they get to 65 they cannot make decisions for themselves and they all start playing bingo (Doctor).

Another problem with institutional settings, at least according to some staff, is that older people in such settings tend to become institutionalised very quickly and their dependency increases.

They expected the nurses to do things for them, they said, “that is what they are paid for”(Nurse Manager).

This can have a detrimental effect too on those who go for respite care and end up more dependent after their stay. While some patients do want to be pampered, and some demand the same level of attention as more dependent patients, there is a question regarding to what extent the increased dependency is attributable to the staff.

Most of them who come into a nursing home, they may be walking and doing things for themselves but what I have observed is that we take them to be old and they need to be helped and we help them so much. We dress them up in the morning and then they stop dressing themselves. They would get out of bed on their own, but we help them and then they stop helping themselves. We need to

give them the chance to do what they are able to do and that will keep them going. They just need to be encouraged and they will do it themselves (Care Assistant).

A problem in this regard is having enough staff to afford enough time to the patients and this is seldom the case. It is quicker to do things for patients than to wait for them to do things for themselves. Some staff would argue that even with the best intentions in the world, institutions, because they operate to a certain timetable, creates a passivity among patients no matter how flexible the timetable may be.

Even in regard to nursing homes, which may have better staff-to-patient ratios, the general view by professionals of them is that they can never really be a home. However, staff do try to make the environment approximate as much as possible to “normal life” (Dietician). Sometimes the building décor or the music played is not what the residents would be used to from their homes and this needs to be borne in mind. It is a good discipline, too, for staff to realise that this is home for the patients in their care and issues, such as privacy, should be treated in a similar way as to the home environment where people do not walk in and out of bathrooms indiscriminately when they are in use.

There was a view among some staff that increased dependency of itself takes away a certain amount of a person’s dignity. It was also held that a person who chooses to come into a nursing home forfeits a certain amount of freedom, which again is seen as a loss of dignity. What can sometimes happen to patients as a result of this loss is a growing anger or resentment, sometimes directed against family who “left” their parent in a home, but more often than not the anger is taken out on staff. This is a problem staff face and they say it can take some time before a client/patient settles. (Is this another way of saying that the person becomes institutionalised?) One social worker commented that it is so much easier to treat a person with dignity when they conform than to treat them with dignity when they question and challenge the system in which they (the social workers) operate.

We work within a system particularly in a hospital and for that to be functioning as everybody would like, everybody is very good here, comes in on time, doesn’t query, doesn’t question but to treat that person with dignity is to say they have a right to question, they have a right to ask, they have a right to challenge, they have a right to come in twenty minutes late (Medical Social Worker).

Ensuring Best Practice

Training

While there are things that can be taught, it is not altogether certain that what one teaches will be put into practice. This may be especially true in relation to treating older people with dignity. Most professionals said that dignity did feature during their training, though not as a specific course. It was only afterwards, when they were actually in the workplace, that the real learning took place. Most credit was given to good mentors on the ward and the example they set for what was learned about treating people with dignity. For the most part, it was assumed that a professional had the skills for the job they were undertaking. Often carers had the least amount of training, but that is not to say that they were less well versed in dignity.

What was taught in college included: treating everyone as an individual, explaining all procedures to the patient, drawing curtains, keeping the patient covered, respecting patient's wishes, care for the dying, etc. Dignity was not the focus of such training. In the past dignity probably featured more. A nurse who was qualified for 38 years remarked,

I would say dignity was a very important issue during my training across the board and I would say it has slipped in recent years. Before if a male doctor was examining a female patient there was always a chaperone. That has slipped a good bit (Nurse).

One change that has come about in the last 10 years or so, what might be regarded as a breakthrough in nursing as far as dignity is concerned, is the move away from being task orientated to taking a more holistic approach to patient care. To what extent this is implemented in practice may, however, be conditioned by available resources. The other major change today is the emphasis on people's rights. Patients and their relatives are now more conscious of their rights and this is something that has helped to preserve dignity. Because of litigation, it is something staff need to keep in mind.

For social workers, their training always included the social dimension, so they never really felt themselves to be task orientated. Emphasis would have been placed on treating people as individuals, being non-judgemental and promoting self-determination. Nevertheless, care for the elderly would have only been a small part of their initial training. Child-care would have featured more. Social workers would be quite conscious of their role as advocates for patients in upholding their rights. This is something nurses and doctors who work with the elderly now see as a role for them too, both within the hospital and outside.

For occupational therapists (OTs), care for the elderly would have occupied a much greater part of their training, including their placements. There was an emphasis on empathising with their clients rather than sympathising with them. In terms of relating to clients, they were taught how to address them. Also, in terms of how OT's should

present themselves, since they did not wear uniforms, they were taught not to overdress as they could be going into the homes of people who may not be well off; yet they should be professional.

Doctors did not have a specific course on dignity either. Again it was assumed that they would approach patients in a professional manner and that they would learn how to handle patients on the wards. The issue of dress came up for one doctor who was constantly being asked her age. For her, dressing professionally preserved her position of authority, although she was slow to admit this. It was admitted, however, that many patients in geriatrics are two or three times older than the person caring for them and as such it could be difficult for the patient to accept the advice of someone much younger than them.

Training in communication was mentioned as something important for staff so that they could pick up on the non-verbal signs of patients with dementia. Communication was also mentioned as important in relaying information to patients, especially those with hearing or cognitive impairments. Problems of cross-cultural communication was also mentioned as today more and more staff come from overseas. However, courses in communication did not usually feature on the syllabus of health care professionals.

Another area where staff felt they could benefit from training was in handling abusive or difficult patients.

One of the big gaps is the overlap between services for the elderly and psychiatry. Some of our patients with, for example, personality disorders who are beginning to dement because of alcohol or other addiction problems, they have turned out to be the most difficult patients for new staff to deal with. Sometimes it was seen initially as a personality conflict but on mature reflection, training would really help and it's not very much training, it is just to get people to slow down and to be aware. If our client has racist viewpoints, you are aware of that and there is a way to deal with that and get round it. With almost every patient there is a way around whatever psychological block is presenting you (Social Worker).

More could be done too to overcome ageist attitudes among staff if all spent some time in care of the elderly or if they did projects or research in this area. What could be learned on a geriatric ward in terms of dignity could be brought back to the other wards, where it was often the case that many patients were older people. Education for staff concerning what is possible with care of the elderly was also felt to be important, especially for those treating patients suffering from stroke. For those who specialised in the area of care for the elderly there was an emphasis on rehabilitation and enabling patients to return to their own homes, whereas on other wards older people were often seen as "bed-blockers" if they were on the ward for more than three weeks. Sometimes problems arose where managers came from acute wards into geriatrics without specific training in this area. It is not so high tech, but requires more of the human touch. Indeed everyone working on a geriatric ward, including domestics, should be given basic training in care for the elderly.

Some staff felt that there should be a specific course on dignity, although others felt that it would be very hard to change some people's attitudes if they were the type that did not show respect to patients. This raised the question whether such people should be working in a caring role; the answer to which is probably, "no." Nevertheless, to have a course on dignity might not be a bad idea if it heightened awareness, as everyone at times can be lax in treating patients with respect. And for those who were not beyond redemption, it may actually help them to be better carers.

Essentially treating someone with respect was something learned from home. Staff were sure that if someone was lax and was pulled up, for example if they had to be told to cover up the patient or keep their voice down, the person would not object as they would know instinctively that they were not respecting the patient. Having grandparents at home was seen as an added advantage for those coming into the profession of caring for the elderly. However, to assume that those coming into the profession in the future would have a similar background may be a presumption not warranted by changes now taking place in Irish society.

It [dignity] wasn't touched on in my training but again it was assumed. It does concern me though when you think about society. I was getting a bus into town a few weeks ago and this old man stepped off the bus and these youngsters were shouting at him and jostling him and it was horrible. It does concern me how it will be in 20 or 30 years time. It is just lack of respect in general out there (Therapist).

As well as training for staff, it was also felt that some training or education was necessary for family members too. An example would be in the area of incontinence. Remarks such as, "my mother is being very difficult, she is soiling herself and she just won't call" are heard and the relative is unaware that his/her parent cannot help herself (Doctor).

We have all heard of so many people being admitted to psychiatric hospitals just because their families or people couldn't deal with them (Care Attendant).

Dealing with the families of older people is a major part of the work of professionals, something for which they are not always well trained. Families can sometimes have unrealistic expectations, but when staff take time to explain the situation they are usually reassured.

A broader education for the public may be required around such issues as dying with dignity and understanding dementia. Certainly, there has been very little public debate on the issue of advanced directives.

The issue of training for family carers was also raised, not only to cope with their present situation but also to prepare them for the future and to plan ahead with other family members so that issues of inheritance, for example, do not create huge problems for families down the line, something which health care staff feel the effects of sometimes.

Codes of Practice

All the health care professions would have their own professional codes as well as ethical standards of practice. Many of the hospitals and nursing homes would also have mission statements. Not all of them would make specific reference to dignity but many of the concepts associated with dignity, such as empowerment, would be included. The Health Boards produced a Charter of Rights for Older People with a specific section on Dignity and Respect. There are also sections on Privacy and Control of Environment, Access to Information & Services and Personal Responsibility. Under Respect & Dignity, the Charter states:

You have the right to:

- Have recognition as an individual, including the right to be addressed in a form you are happy with.
- An equal partnership relationship between yourself and your carers.
- Freedom of expression in language, dress, religious belief and sexuality.
- Maintain family, social and peer group relationships outside the care setting.
- Be free from undue stress and worry.
- Have choice in activities of living when appropriate.

It was suggested that for individual professional health care workers it was not altogether necessary to have a specific code on dignity.

If you are a qualified person and at this stage do not know how to treat a person with dignity, you really shouldn't be in the job (Nurse Manager).

Nevertheless, the idea of institutions having something that enshrines what patients might reasonably expect with regard to their care may not be a bad idea. It was noted that in relation to childcare there were much more protocols whereas in eldercare there was nothing as yet on elder abuse and in many instances formal complaints procedures did not exist. Notional rights existed that did not have the force of law. With the changing face of health care workers, many coming from countries where care for the elderly in institutional settings scarcely exists, it was felt that certain policies regarding care of older people should be in place.

Especially with agency staff and staff from overseas, you need to have the policies in place, on the wards so people can refer to them (Nurse).

There are sheets given to you about infection control, disposal of sharps, your salary but nothing about the dignity of patients (Doctor).

Some institutions did espouse a certain religious ethos. A nursing home run by the St. John of God professed such values as hospitality, which were enshrined in the induction given to new staff.

The hospitality we profess means that we must defend and keep watch over the rights of the individual to be born, to live in a decent manner, to be helped in sickness, to die with dignity (Director of Nursing).

As regards best practice on the ward there are certain agreed procedures, although their enforcement may depend somewhat on the direction given by management. Staff would normally be pulled up for not treating a patient with respect for example and most nursing homes would operate flexible arrangements that preserve individuality. However, there were no specific best practice guidelines on dignity.

There is dignity in dying guidelines but not dignity in living (Doctor).

Conclusion

Respect is the key word used to describe dignity by older people. The three things that stand out in relation to treating older people with respect are: Equality, Choice and Belonging. Older people want to be treated the same as everyone else, they want to have choices about their care and they want to feel that they have something to contribute to society. They do not want to be discriminated against, have their independence undermined or be thrown out on the scrap heap.

In terms of health care, they would like their sicknesses treated seriously and not to be discounted because of their age. For those living alone, they would like more visits, as they often feel isolated and alone. Many in fact look to the professional services of GPs and the police to check in on them. The expectations placed on the medical profession may be misplaced but meeting this need is a real quality of life issue for older people.

Health care professionals tended to emphasis independence as one of the most important aspects of dignity. This is possibly due to their training in a holistic approach to care of the elderly and their professional role of promoting patient autonomy. Respect was the word most often used in regard to patient management.

The views of the health care professionals reinforced rather than contradicted many of the views expressed by older people. It must be remembered, however, that the professionals who took part in the study worked almost 100% of their time with older people. They were people who had chosen to work with older people because they had a high regard for older people or loved the medicine associated with care of the elderly. Many of them were acutely aware of the deficiencies in the health care system and were critical of it. They were also aware of their own shortcomings, but on the whole saw themselves as doing a good job.

Within the health care system there is the perennial problem of matching services to meet needs, with the issue of money always to the forefront. In terms of services for older people, it was felt that these were less developed than services for younger people and were less well funded. Community services in particular, which would allow older people to remain independent for longer, were inadequate. Without adequate resources it is very difficult to deliver individualised care either in a hospital or in the community, so people do not always get the care they need. Carrying out assessment of needs in such circumstances can lead to frustration for both patients and staff when expectations are not met due to lack of funding. And where choices are limited, dignity is often compromised.

In terms of policy-making, older people and their carers often felt excluded. In some instances older people or their carers were not aware of their entitlements. It has to be recognised, however, that the statutory provision of services does not always meet with approval. Some older people resent strangers coming into their home, while for others their pride prevents them from seeking the services they are entitled to.

Regarding best practice, the training of professionals was an issue that needed to be addressed. Skill in communication was singled out for special attention while training for health care attendants and carers was also mentioned. There was also the issue of proper screening of health care assistants who take up posts in nursing homes.

It is still an open question whether dignity for older people is more respected or less respected today than in the past. What is clear is that ageist attitudes still exist in society. Legislation may be part of the solution but it is not the entire solution. Much more attention needs to be given to preserving the dignity of older people and promoting their dignity in every way possible. For those who care for older people, their dignity too needs to be recognised, not just in terms of the important role they play in healthcare but because they too as individuals have their own dignity to preserve. However, until ageism in all its forms is addressed at a societal level, the indignities sometimes experienced by older people in care settings will simply continue to reflect what is happening to older people in the wider society.

Appendix

The 'DOE' Project

'Dignity and Older Europeans' (DOE) is a research project that was funded under the European Commission Fifth Framework (Quality of Life) Programme and involved health care professionals, social scientists and philosophers from six European countries including the UK, Spain, Slovakia, Ireland, Sweden and France.

The main aims of the project were to:

1. Raise awareness of the importance of human dignity in the context of health and social care delivery for older people.
2. Provide health and social care professionals with improved understanding to enable them to enhance service delivery within a climate of mutual respect.
3. Positively influence societal images of older people.
4. Enhance intergenerational solidarity.

The focus group discussions that provided the material for this report took place between 2002-2003. Eleven focus groups were held with older people in a variety of settings including nursing homes, day care centres and social clubs. Thirteen focus groups were held with professionals in hospitals, day care centres and community units. Altogether 59 older people (38 women and 21 men) took part in the discussions, ranging in ages from 63 – 94, the average age being 76. There were 67 professionals involved in the study, 59 women and 8 men. Their ages ranged between 21 and 64, the average age being 38. Among the professional group were 4 doctors, including one consultant geriatrician; 7 nurses, including 1 director of nursing and 2 assistant directors; 20 staff nurses; 17 health care attendants; 8 social workers; 4 physiotherapists; 2 occupational therapists; 1 speech therapist; 1 dietician; 1 coordinator of services at a social center; 1 assistant manager at a day care center and 1 kitchen supervisor. Most were qualified for more than 5 years and almost all had contact with older people during their childhood or adolescence. Focus groups were also conducted among young and middle-aged adults in the community but the results are not included in this report. More details on the project can be obtained on <http://www.cardiff.ac.uk/dignity/>

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