

ORIGINAL ARTICLE

The elderly patient's dignity. The core value of healthBENTE HØY¹, LIS WAGNER² & ELISABETH OC HALL¹¹*Institute of Public Health, Department of Nursing Science, University of Aarhus, Aarhus Denmark, and* ²*Research Unit of Nursing, Institute of Clinical Research, Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark***Abstract**

This study shows how care providers in hospital practice perceive the elderly patient's dignity as a core value in health promoting care towards the elderly. Fifteen focus group interviews were conducted with care providers who told about their nursing practice experience. The interviews were analysed using a phenomenological hermeneutical approach. The results disclose that when caring for the elderly patient's health potential, care providers saw dignity as the core value of health. Dignity was found to capture three themes: autonomy, identity, and worthiness. These themes reflect the principles of nursing practice, protecting, enhancing and promoting the elderly patient's health potential. It is suggested that these themes of dignity provide a frame of reference in elder care; they shape the understanding of when health issues become a concern for health-promoting care for the elderly patient and what goals should be defined.

Key words: *Dignity, elderly patient, phenomenological hermeneutical method.***Introduction**

Most human beings become ill, and with age, the probability of illness increases. To promote health, particularly among the elderly patients, it is important to understand what it means to be a patient, both from the perspective of the elders and from the perspective of the care providers. The purpose of this study is to explore the meaning of being an elderly patient as seen from the care providers' perspective. The general understanding of being a patient is linked to a *suffering person* awaiting or undergoing treatment (Merriam, 2004). To some, the term carries connotations of passivity and deference to the care provider, although that is not a constituent part of the definition (Deber, Kraetschmer, Urowitz & Sharpe, 2005). Patient is defined as having or showing patience (Merriam, 2004). Patience in turn is derived from the Latin word *patiens*, the present participle of *pati*, which means to suffer. It is accordingly defined as the capacity to tolerate delay, trouble, or suffering without becoming angry or upset (Pearsall, 2001). These definitions link the term patient to suffering and treatment, not to health and health-promoting care.

In a classic sociological understanding, a person is a patient when he/she is ill and needs help to recover. A patient is assumed to seek help and to get well, but not to have the willpower to act and decide on treatment, and the patient is traditionally exempt from responsibility for self-care (Parsons, 1970, 1975). A more recent interpretation defines a patient as a consumer having the right to choose health care services. According to this view, a person becomes a patient when he/she asks for health service, and care is to deliver the chosen service. Consumerism implies that a patient is the sole arbiter of his needs, and to the care provider, meaning is to satisfy these needs. These theories reflect both different times and perceptions of being a patient. However, regardless of health needs and context, the meaning of being a patient implies either help to a passive "sick role" or an active consumer role.

During the history of nursing care, the meaning of the term patient has continuously been discussed. To Nightingale (Nightingale, 1946/1859), a patient was a person suffering from a disease or a bad condition who needed to be put in the best possible condition for nature to promote the human

potential. According to Henderson (1991) a patient is a person who lacks strength, will, or knowledge to meet fundamental needs. A person becomes a patient, when he/she needs support to overcome a deficit of these human potentials, and assistance to regain his/her independence as quickly as possible. Eriksson (2005), one of today's scholars, conceptualizes a patient as a suffering person in need of care to alleviate suffering and to develop capabilities for self-care. In these views, a person is a patient, when he/she needs care in order to protect or promote his/her human potential. In contrast to the sociological understanding of the concept of patient, nursing theorists link the concept of patient to a concern for promotion of human health potential. However, they leave it to practice to give meaning to such a concept and to decide when health-promoting care becomes an issue for nursing care, and which aspects are significant.

A number of studies have explored the meaning of being a patient to health promotion in hospital nursing practice (Latter, Clark, Wilson-Barnett & Maben 1992; Harder, 1993; McBride, 1994; Davis, 1995; Hartrick, 1998). They have shown that the meaning is related to disease prevention and health education and that health promoting care towards the elderly patient is poorly articulated in nursing practice. Empirical studies of elderly patients have focused largely on the meaning of health in relation to disabilities in old age, and they have contributed little to the understanding of this issue from a health promoting perspective. In a recent study of nurses' understanding of health care towards hospitalised elderly patients, Berg, Hedelin and Sarvimäki (2005) concluded that nurses' discernible understanding of the elderly patient was related to care for diagnosis and treatment; the more complex and comprehensive understanding of what it meant to be a patient was tacit. In conclusion, although theory of nursing care has linked the meaning of being a patient to issues of protecting, enhancing and promoting the human health potential, the articulated meaning of being a patient in nursing care remains linked to disease, symptoms, and treatment. The purpose of the present study is to explore the meaning of being an elderly patient as experienced by care providers working in geriatric and medical hospital units. We assume that an understanding of a patient as a person needing care for promotion of health is an implicit part of nursing care that is more or less tacitly embedded in the care providers' practice experience.

Study design and method

The present study evolved from a study that aimed to enhance our understanding of health promotion

as a health-oriented approach to the elderly hospitalized patient. The study has a qualitative explorative design and draws on principles of ethnoscience (Spradley, 1979; 1980). This approach helped to identify constitutional principles of nursing practice and to conceptualize the symbolic meaning of being an elderly patient in a hospital setting.

Sample and data collection

Data collection began with non-participant observations for 30 days, 5 days in all units, followed by interviews (Spradley, 1979; 1980). The purpose was to go beyond the care providers' articulated view of practice and gain knowledge about the more complex and comprehensive situations related to health promotion towards the older patients. The informants were 29 nurses and assistant care providers who worked in geriatric and internal medicine wards at a university hospital in Denmark. The patients were mainly elders (65 years or more) who were hospitalized due to stroke, fractured hip, infection, or chronic diseases such as diabetes or chronic obstructive pulmonary disease (COPD). Fourteen group interviews were conducted inspired by focus group methodology (Morgan, 1996); one interview was undertaken as an individual interview. The interviews created a natural communicative context, where the care providers could share their experience. The interviews lasted from 50 to 90 min and they were undertaken by the first author (BH); they took place at the hospital during working hours and in a quiet room without disturbance. The care providers were encouraged to talk about their practice related to elderly patients' health concerns, about patient and care provider relationships, about the clinical environment, and about how they met these challenges. Only the patient-related data will be reported in this study. The participants were provided with written and verbal informed consent, which was signed prior to each interview.

Analysis

The analysis was inspired by Ricoeur's phenomenological hermeneutics (Lindseth & Norberg, 2004). The method was developed at the Universities of Tromsø and Umeå and has previously been used (Lindseth, Marhaug, Norberg & Uden 1994; Nordam, Sorlie & Forde, 2003; Delmar et al., 2006). It was chosen because it enables the investigator to capture the essential meaning of lived experiences. All interviews were transcribed verbatim and transformed into text. The textual analysis was carried out in a spiral-like hermeneutic process of interpretation through three phases: a naïve reading, a

structural analysis, and a comprehensive understanding including the discussion.

The *naïve* reading consisted of a superficial reading of the text to get an overall impression and to obtain an initial holistic understanding of the meaning of being a patient as well as to obtain clues for the subsequent structural analysis. The impression obtained from this reading was taken down in order to verbalize the first understanding of the care providers' experience of the hospitalized elderly patients.

The *structural analysis* intended to clarify the dialectic between the holistic understanding of the naïve reading and an explanation of "what the text is about". The guiding principle in this process was to trace the thematic structure of the text and to find the threads of meaning weaved into the different text parts (Lindseth & Norberg, 2004). The text was divided into meaning units according to the concerns raised. These meaning units were condensed and discussed among the authors, and themes and sub-themes were identified (Table I). This process included examination of parts of the text in order to validate or refute the initial understanding obtained.

The *comprehensive understanding* produced an in-depth interpretation of what the text was about based on the naïve reading, the structural analysis and the authors' pre-understanding. The text was read in extenso, and the understanding was developed as a reflection on the themes and pertinent literature.

Ethical considerations

All participants gave written and verbal informed consent. The senior nursing officer of the ward and the charge nurse signed a consent form for the participant observation. The participants of the interviews signed a consent form prior to each interview and they were assured that all data would remain confidential and anonymous (Northern Nurses' Federation, 2003).

Findings

Naïve reading

The naïve reading provided a phenomenological understanding of the text, identifying descriptive phrases and metaphors describing the phenomenon of being a patient from the care provider's perspective. Reading the text gave the impression that the most prominent meaning assigned to being a patient was a concern for dignity. Dignity was woven into the care providers' concern which addressed the elder's self-care, the elder's wish to look respectable and to have his/her needs met. Dignity was also involved in a concern for whether the elder was wearing a hospital gown or private clothes, whether the elder was seen as an individual or as a patient, or whether the elder was in or on the bed. Generally, dignity, as the core value of health, consisted of three constituent themes: autonomy, identity, and worthiness.

Table I. Examples from the structural analysis.

| Unit of meaning | Condensation | Sub-theme | Theme |
|---|--|-----------------------|---------|
| "It is as if the patient leaves his dignity outside the hospital door and says, now you may do with me what you like, I don't care". | Becoming a patient in health, concerns care for self-care to maintain dignity of autonomy. | Dignity as autonomy | Dignity |
| "It has to do with dignity, that you look proper. That you do not walk around in the short white hospital gown; you have just been to the toilet and a corner of the gown is stuck in your underwear". | A patient in health concerns looking respectable to maintain dignity of identity. | Dignity of identity | |
| "Being dressed in private clothes changes the way you look at the patient. You look at the elderly as a person and not just as a diagnosis as stroke, fractured hip or infections. You see the patient as Ms Jensen or Petersen and then you can establish a dignifying dialogue" | Becoming a patient in health concerns seeing the patient as a unique person to maintain dignity of identity. | Dignity of identity | |
| "Dressed in private clothes, it is not easy to have the sick role. The clothes change the role and thereby your sense of worthiness. When you have your own clothes on you can still be ill, but you become more self-confident" | A patient in health may wear private clothes to change the sick role and sense of worthiness. | Dignity as worthiness | |

The structural analysis

Dignity of identity

Dignity of identity was a constituent theme that had to do with looking respectable, having needs met, and maintaining the individual self.

Looking respectable. The care providers found that being a patient raised the issue of looking respectable. The elderly patients were admitted to the hospital due to physical disability or chronic illness, and they expected to return home in a better condition. However, in the care providers' experience the elders' visible signs of vulnerability led to disrespect and reduced dignity. Hence, the elderly patient needed care to look decent and to feel that his/her sense of self-esteem did not decline. Dignity thus conceived was enhanced through body care, clothing, hairdressing and nail cutting, and by keeping the patient clean and tidy. One care provider said: "It has to do with dignity that you look proper. That you do not walk around in the short white hospital gown, e.g. you have just been in the lavatory and a corner of the gown is stuck in your underwear".

Having needs met. A patient was not a priori expected to be able to meet his or her own basic needs in terms of nutrition, bodily hygiene, and support, but had to rely on the care providers' help for this. Non-fulfilment of such needs reduced their physical, social, and existential integrity, whereas dignity was enhanced when the elderly patient was perceived and met as a person with unique needs. A care provider said, "When caring for a sick person this care then becomes health promotion. First the nurse helps the patient to secure dignity and integrity. Then the nurse assists the patient until the patient is able to do it by himself/herself". The text disclosed how the care providers felt responsible for responding to the patient's appeal and how they encountered his/her physical, social, and existential needs. The care providers felt particularly responsible for identifying unexpressed needs. Recognizing, seeing, and meeting the elderly patients' needs was viewed as essential to enhance dignity of identity.

Maintaining the individual self. One of the core meanings of being a patient was experienced as maintaining the individual self through wearing private clothes instead of a hospital gown. The patients should preferably wear private clothes, because that was thought to protect and promote their identity. Although hospital gowns may be loose

and comfortable, they made the patient anonymous; the care providers felt that they "lost sight" of the patient and his/her identity. Private clothes were found to facilitate self-esteem. A care provider said:

When we have two male patients in their beds and you can only identify the top of the head, they look identical. When dressed in different shirts and trousers, they are unique people and you recognize them as Mr Jensen and Mr Petersen. They grow half a meter when walking down the corridor; you can really see the difference. Likewise, their identity disappears when in bed and dressed in hospital clothes.

Another care provider said:

When the patients are more than 80 years of age and wearing hospital clothes, they are dependent because of elimination problems. It is easy to give them a diaper and leave them in bed, because you have put them in a category, where you may not be emotionally touched and moved by their illness.

Therefore, to the care provider it was important to make the elderly patient visible through private clothing; it facilitated the elderly patient's self-esteem and made the care providers emotional touched.

Dignity as autonomy

A second constituent theme was dignity as autonomy, which was seen to encompass self-care ability and mastery of activity.

Self-care ability. The care providers found that when the elders were hospitalized, they gave up their autonomy and left the responsibility for self-care to the care providers. One nurse said; "It is as if the patient leaves his or her dignity outside the hospital door and says, 'now you may do with me what you like, I don't care'". From a health care perspective, this attitude may precede frailty and loss of dignity, and it makes it difficult for the patient to participate in self-care. Such patient attitudes, therefore, compel the care provider to promote the patient's dignity by caring for his or her ability to take control of self-care. The text disclosed, e.g. how the care provider supported the patient in making choices in supporting self-care activities, for example by respecting the patient's right to say "no" to certain activities and choosing between activities such as having a bath or a shower.

Mastery of activity. In the care providers' experiences, being a patient included that the elderly was urged to walk as soon as possible, and that the elderly rested on the bed instead of spending the day between the sheets in the bed. In the care providers' view, the elderly patient traditionally had a perception of the hospital as a place of being sick in bed, expecting the care provider to know best and being the expert. The care provider realized that being tucked in the bed was sometimes important for health and well-being; however, in the long run it could precede vulnerability and make it difficult for the elderly patient to participate in self-care. The patients may not see participation as part of their role; some believed that it was their right to be cared for. The care provider regarded it as important not to see the patients as either active or passive, but as persons in need of guidance and help in order to master to become active and self-determined. A care provider said, "When the patients prefer the traditional sick-role and stay in bed, you have to be firm. Sometimes you have to persuade them. You say, 'Try to get up and see what happens; if you don't manage, I will help you back in bed'". Being a patient was experienced as a stepwise process from wanting not to participate in self-care to becoming an active party to the process. However, the patients were not expected to walk alone. When persuaded to get out of the bed, the meaning of being a patient in the care provider's experience would shift both physically and symbolically, and the patient's role would change from being passive towards participation and enhanced dignity.

Dignity as worthiness

A third constituent was dignity as worthiness. Being a patient also involved being perceived as a person of value in relation to others and being treated as such. This was interpreted as dignity of worthiness. The care providers found it important that the elderly patients were not "seen as diagnoses", but were valued as individuals with unique beliefs, values, and capabilities. A care provider expressed this constituent of dignity in this way:

If the patient is wearing private clothes, it changes the way you look at the patient. You look at the elderly as a person and not just as a diagnosis of stroke, fractured hip, or infection. You see the patient as Mr Jensen or Mr Petersen, and then you can establish a dignifying dialogue.

One of the ways of making the elderly patient feel valued was to involve him/her in some kind of social life outside the sickroom. From the care providers'

point of view, this would change the sense of sick-role and make the elder more visible as the person he/she was before being hospitalized. The care providers emphasised that the elderly patient had lived a long life and acquired much wisdom. When being in the living room of the ward, both the care provider and the patient himself discovered the embedded resources and roles. The care providers told examples of women acting as housewives, caring for their fellow patients, or of how a retired director regained his role as the boss when stepping out of the passive sick-role. Being in situations where the patients could use their capabilities, both patients and care providers discovered health resources among the patients that were not evident in the sick-role. These roles enhanced the patients' dignity and feeling of worthiness. However, dressed in hospital clothes, the patients lost their dignity and responsibility for self-care; they became pathetic and asked for more help than needed. One care provider said:

Dressed in private clothes, it is not possible to stay in the sick role. The clothes change the role and thereby your sense of worthiness. When you wear your own clothes, you can still be ill, but you become more confident.

Discussion

The above account makes it possible to interpret the meaning of being an elderly patient from a health-promoting care perspective. The findings illuminate that dignity is a core health issue that should be protected, enhanced, and promoted. Dignity was expressed, in particular, as a value related to identity, autonomy, and worthiness. An elderly patient was experienced as a person possessing dignity that could be enhanced or violated by the care provider's acts, the patient's own acts, or by events in the environment. From the care provider's perspective, these issues were seen as essential for health-promotion.

The findings disclosed that being a patient, *dignity of identity* was the most prevalent constituent. Dignity of identity captured the majority of the sub-themes and the meaning of this element was rooted in issues of looking respectable, having needs met and maintaining the individual self. Nordenfelt (2004) defines this type of dignity as the value that is attached to the self as an integrated autonomous person; a value based on a person's history, vision for the future, and relationships to other human beings. He also emphasizes that dignity of identity is particularly important in the context of health,

illness, and ageing; it is a kind of dignity that can be taken from us by external events, by the acts of other people, as well as by illness and old age (Nordenfelt, 2003). In this study, one notion of dignity of identity was the concern for looking respectable. Lack of attention to the patient's appearance by letting the patient walk around in a short, white hospital gown reduced dignity, whereas looking proper enhanced the patient's dignity. This view was also expressed in a study of elderly peoples' experience of dignity in old age (Woolhead, Calnan, Dieppe & Tadd, 2004). This study found that looking "respectable" was important to the patient's ability to maintain dignity, regardless of age and illness. A similar view was emphasised by Edlund (2002), who found that for elderly patients, dignity took a new meaning if they depended on others. When it was no longer possible to manage oneself, qualities of dignity such as "being clean and fresh", "having well-kept clothes", and "having a well-cleaned home" became important signs of dignity. Another view on dignity of identity in this study was reflected in a concern for meeting the elderly patient's physical, social, and existential health needs. Being a patient included an enhancement of dignity, which took the form of recognizing, seeing, and meeting the elderly patient's needs, especially the unexpressed needs. This understanding is supported by Eriksson (2005), who stated that confirming the patients in their suffering, e.g. by inviting them to open up, listening to them, and following up on their needs, is a way of supporting the patients' dignity and of providing them with pathways toward better health. Seedhouse and Gallagher (2002) supported a similar view. They stated that a commonly overlooked aspect of seeking to promote dignity in health care practice is to spend time getting to know the individual and the patient's circumstances. They gave an example of the opposite of dignifying and health-promoting care, e.g. "For one patient, a drink of tea without saucer may not be an issue, while for others it may be a serious and undermining insult" (p. 369). A third significant view on dignity of identity in this study was explained as efforts targeted at maintaining the individual self. Clothes had an important symbolic and practical meaning in the health-promoting process. According to the care providers, the elderly patient was invisible when wearing a hospital gown. This, in turn, made it difficult for the care providers to respond emotionally to the elderly patient's needs and to avoid intruding on the patient's private sphere. In contrast, if the patient wore private clothes, it was less difficult to attach to the elderly patient, to his or her history, visions for the future, and his or her relationships in daily life and thereby

to enhance the patient's dignity. These findings confirm the observations of Woolhead and colleagues (2004), who found that reduced dignity resulted from lack of attention from the care provider, e.g. dishevelled dressing such as a wrongly buttoned shirt. The importance of care aimed at maintaining the individual's self was supported by Randers and Mattiasson (2000), who found that that the individual's self was the part most exposed according to elderly patients in geriatric care. In another study, they found that care for integrity together with care for autonomy upheld the elderly patient's dignity (Randers & Mattiasson, 2004). In a study of male patients' conception of integrity, dignity was explained as an issue of being seen as a person, being respected, and being considered trustworthy (Widäng & Fridlund, 2003).

The texts in this study did not illuminate the importance to dignity of identity of personal and territorial space represented in the bed itself. The hospital bed is a physical facility available to all patients to provide comfort and recovery (Petzell, Berglund & Lundberg, 2001). The bed, as a territory or place, may mean much more to the patient than was described in the text of the present study. A quote from the early theorists (Patterson & Zderad, 1988, p. 35) demonstrates the importance of this place for the patient:

The patient may feel 'out of place' in the health care setting, while it may be commonplace to the care provider. There may be areas in the setting that the patient experiences as his territory, for example, his bed, his room, his ward; while other areas are 'theirs' or 'restricted to authorized personnel'. So, a care provider and a patient may be in a place together, yet one feels at home and the other does not. For the care provider to be really with the patient involves her knowing him in his lived space, in his here and now.

The bed, then, may be the place where the patient tries to feel at home; where the patient belongs during the hospital stay; it is his place to dwell, to find rest and well-being, and to regain health. The bed may be the place where the patient is thinking while being at the hospital, or the place that makes him/her experience a feeling of home in the hospital room (Zingmark, Norberg & Sandman, 1995).

The findings disclosed that *dignity as autonomy* was a significant constituent of being an elderly patient. Dignity as autonomy took the form of care for the self-care ability and care for mastery of the elderly patient's activity. The experience with the patients "leaving their dignity outside the hospital

door" and leaving their self-care to the care provider may refer to the fact that when being a patient you ask for help and at the same time indulge the dependency. However, the meaning of being a patient did not take the form of a concern for technical help as in the classic understanding of the sick role (Parsons, 1970; 1975). Nor did it concern care as a buying of services like in the consumer perspective (Merriam, 2004). The concern was for maintaining dignity related to the patient's capacity for self-determination. Being a patient implied that the individual got out of the bed and walked as soon as possible and rested *on* the bed instead of spending the day between the sheets *in* the bed. Being a patient, of course, involved both, but the care providers were concerned to facilitate dignifying conditions that helped the patient get out of the bed as soon as possible. As Routasalo, Wagner, Bayer and Virtanen (2003) showed that the concern for mastery of activity was rooted in a concern for risks of immobilisation and the patient's ability to perform daily living activities. This understanding of health care is supported by Delmar and colleagues (2006) in a study of chronically ill persons, where they found that self-responsibility and self-control were essential to health, and that dignity was closely related to the ability of being independent of others' help.

The third constituent of being a patient was *dignity as worthiness*. The meaning of this reflected a concern for treating the elderly patient as an individual human being and not as an object, and in showing concern for the patient's values and wishes. Hospital clothes and the labelling of a diagnosis were seen as examples of significant threats, whereas being able to participate in daily life activities was highlighted as enhancements of the elderly patients' dignity and health. Through participation in activities, it was possible to stress the capabilities and merits that the elderly carried with him/her. Thereby, the patient was seen and valued, and dignity would be maintained and enhanced. This kind of dignity is relative, and it is a value that varies in extent from one patient to another. It can be destroyed as well as re-established (Edlund, 2002). Alternatively, human dignity can also be viewed as an absolute dignity that refers to a kind of *Menschenwürde* that all human beings possess or are assumed to possess, simply because they are human beings (Nordenfelt, 2004). It is a kind of dignity that calls for respect for the individual, freedom from imposition, and responsibility; it cannot be taken from the elderly as long as he/she is alive, but it can be violated. The significance of dignity as *worthiness* in health care is supported by Woolhead and colleagues (2006), who found that

being valued as a person both creates self-respect and makes others respect you. An important threat to such care was the fact that the hospital system gave more priority to measurable activities than to less quantifiable care. Worthiness as a core value of health is further supported by psychological research (Ranzijn, Keeves, Luszcz & Feather, 1998). This research shows that an individual treated as a person of value has a higher sense of self-esteem, copes better with health challenges, and is more independent than a patient who feels worthless. Not being responsive to the patient's worthiness or exposing him/her to uncontrollable circumstances, however, may potentially develop into learned helplessness and induced dependence (Faulkner, 2001).

Methodological considerations

The aim of this study was to explore the meaning of being an elderly patient as expressed by care providers. The text disclosed a rich description of experiences of being a patient and it demonstrated that care providers' experience span a continuum, where the elderly patient's dignity occupied a prominent position. The strength of the study was that dignity as the core meaning of being a patient in health promoting care was discovered through ethnographically inspired methods such as field observations and interviews. Most of the informants spontaneously gave examples of dignity and being a patient. The limitation of the study lies in the issue of semantic validity. The understanding of being a patient was based on themes that emerged in a dialogue between the text and the authors' pre-understanding of nursing care as a health-oriented and value-based approach. This interpretation did not offer an exhaustive frame for the study patients in health promoting care, but it uncovered significant aspects of the phenomenon. However, it is important to emphasize that one single study cannot explore this phenomenon in its full extent. Additional studies describing the phenomenon are needed to enlarge and validate this body of knowledge.

Conclusion and implication

The meaning of being an elderly patient in health promoting care was interpreted as a concern for the patient's dignity, encompassing dignity of identity, autonomy, and worthiness. This framing of nursing practice goes beyond the biomedical and sociological orientation and shows that enhancing dignity and preventing an undignified situation should be an essential concern in health-promoting care for

elderly patients' health potential. The presented results may provide a frame of reference in the care and may help shape the understanding of when health-promoting care practices should be a genuine care issue and what goals should be defined. Such knowledge may guide the care providers' interaction with the elderly patient, and its explicit articulation is vital for the quality of nursing practice. To improve the quality of care, focus should not only be on codes and guidelines for the care providers, but on the entire health care system, and how dignity can be protected and enhanced through policies and organizational structures. In order to ensure the elderly patient's dignity, tasks need to be organised with a focus on the patient's health needs. The current strength of the conception of the patient as a "consumer" provides an obvious basis for giving greater emphasis to dignified care, which will clearly serve to promote the elderly patient's health. Further research is needed to understand dignity as a basic health resource of elderly patients and to understand how care can protect and enhance this resource in hospital practice. We also need research of which issues act as barriers in this process of enhancing the elderly patient's dignity.

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