

Reflections on the Function of Dignity in the Context of Caring for Old People

GEORGE J. AGICH

Bowling Green State University, Bowling Green, Ohio, USA

This article accepts the proposition that old people want to be treated with dignity and that statements about dignity point to ethical duties that, if not independent of rights, at least enhance rights in ethically important ways. In contexts of policy and law, dignity can certainly have a substantive as well as rhetorical function. However, the article questions whether the concept of dignity can provide practical guidance for choosing among alternative approaches to the care of old people. The article explores the paradoxical relationship between the apparent lack of specific content in many conceptions of dignity and the broad utility that dignity appears to have as a concept expressive of shared social understandings about the status of old people.

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The employment of the concept of dignity in policy contexts has undoubtedly broad implications for designing systems of care for old people. Beyond committing society to recognizing a fundamental responsibility to care for dependent old people, the question is, “Can this concept help to prioritize among various competing approaches that each particularizes the way that caregiving is structured?”

In this article, I accept the proposition that old people want to be treated with dignity. I also accept that statements about dignity point to ethical duties that, if not independent of rights, at least enhance rights in ethically important ways. In contexts of policy and law, dignity can certainly have a substantive as well as rhetorical function. The provocative conclusion urged by Ruth Macklin (2003) that dignity is a useless concept that

Address correspondence to George J. Agich Ph.D., Professor of Philosophy, Director of BGeXperience Program, Bowling Green State University, 404 Moseley Hall, Bowling Green, OH 43403, USA. E-mail: agichg@bgsu.edu

should be eliminated from bioethics without any loss of content is premature as Richard Ashcroft (2005) has argued.

I am doubtful, however, that the concept of dignity can provide practical guidance for choosing among alternative approaches to the care of old people. The task of this article is to work out the paradoxical relationship between the apparent lack of specific content in many conceptions of dignity and the broad utility that dignity appears to have as a concept expressive of shared social understandings about the status of old people.

Many people accept that a basic requirement for any action-guiding concept or principle is that it should be able to provide justification for action.¹ Although important theoretically, this is a topic that can be put to the side since my concern is not with justification, but specification — namely with the question, “Does dignity have implications in the domain of practice for ordering the available alternatives, and for guiding the design of acceptable alternatives?” That old people have dignity, and/or that they deserve a type of care that accords them dignity, may be tacitly accepted, but how can this concept guide the difficult choices that policy makers must make when there are multiple alternative approaches, each with potentially significant resource implications.²

Studies of the care of old people in different international settings with regard to dignity present a snapshot of a very complex and diverse picture not only of long-term care, but also of the underlying institutional, personal, political, and social values and beliefs that shape the ways that care is provided to old people. The similarity of demographic trends, resource limits, and health care needs of old people, as well as some of the reported results, should not obscure the fundamentally different background cultural, economic, social, and political conditions of the locations of these studies.

Given the presence of diversity, it is hard to understand how a single concept could provide a primary guide for action across these different cultural, political, and social settings. Of course, if dignity is a socially-dependent concept that expresses shared intuitions about what respectful or ethically appropriate care for old people should involve, then it will be useful so long as it resonates within its intuitively shared base of meanings. Notice, however, that the utility of the concept will reside not only in the fact that the concept *expresses* a set of *shared understandings*, but, perhaps more importantly, in that these shared understandings reflect or incorporate *a set of specific background values and commitments*. Under these conditions, then, what contribution might the concept of dignity make toward addressing the complex ethical issues associated with caring for old people?

Lennart Nordenfelt (2004) has pointed out that the concept of dignity turns up prominently in a number of international policy statements; for example, the Council of Europe’s *Bioethics Convention* (1997) and UNESCO’s *Universal Declaration on the Genome and Human Rights* (1997), or the recent version of the *Swedish Health and Medical Services Act* (1997)

and a Commission on Terminal Care entitled *Death: Everybody's Concern* (2001), where the main question discussed concerns the nature of a dignified death (Nordenfelt, 2004, p.70). Doron Shultziner (2003) has pointed out that, although these documents do not explicitly address the theoretical underpinnings of the concept of human dignity, or even offer a standard definition, they refer to a notion of dignity that seems to have meaning insofar as it relies on a tacit or background set of shared intuitions or beliefs. In recent policy work in the United States, the concept of dignity has enjoyed a resurgent appeal.

From its first report *Human Cloning and Human Dignity*, to its most recent report *Taking Care: Ethical Caregiving in Our Aging Society*. The President's Council on Bioethics has alluded to dignity repeatedly in addressing a wide range of controversial bioethics topics. Like the international uses of the concept, the President's Council usage does not offer a formal definition, though dignity was the subject of two hearings on December 8, 2005, and February 2, 2006, as well as the topic of a background staff working paper prepared for the President's Council by Adam Schulman (2005). In this testimony and working paper, the complexity of the concept was evident, and a serious question was raised regarding its capacity to provide a firm foundation upon which to construct policy on controversial bioethics issues (Childress, 2005).³ It would take us too far afield to assess or fully discuss the function of the concept of dignity in these policy contexts.

Authors like Bayertz (1996), Childress (2005), Fedoryka (1996), Nordenfelt (2004), and Sulmasy (1997, 2006) have helpfully addressed the complex varieties of meaning associated with the term *dignity*. These papers suggest that the concept of dignity has some application in policy settings, but this application is more limited than proponents admit. Dignity does not seem to provide an independent foundation for policy, but has a strong expressive function that reflects intuitively shared beliefs and values. For this reason, it is often conjoined with other concepts, like rights or welfare that help to operationalize it for policy applications.

Nordenfelt (2004, p. 80) has offered a reasonable taxonomy of the concept in which four types of dignity are distinguished: *Menschenwürde*, which pertains to all human beings to the same extent, and cannot be lost as long as the persons exist; *dignity of merit*, which depends on social rank and formal positions in life; *dignity of moral stature*, which is the result of moral deeds of the subject, and so can be reduced or lost through (im)moral action; and *dignity of identity*, which is tied to the integrity of the subject's body and mind, as well as the subject's self-image.⁴

Nordenfelt (2003) has also discussed dignity in the context of caring for old people, and argued that old people possess a distinctive type of dignity that he has characterized as a *dignity of wisdom* and a *dignity of merit*, both resulting from their life-long efforts and achievements. Such a generalized

concept of dignity for old people, however, is fraught with problems since it is obvious that not all old people possess either merit or wisdom. Clearly some—perhaps many—old people acquire wisdom and earn merit, but there is ample reason for skepticism that such variable qualities can provide a sound basis for designing systems of care for old people universally, because there are many old people whose functional capacities and personal histories are deficient simply do not attain merit or wisdom.

For example, it is not at all clear that the concept of dignity as wisdom could determine, in any helpful way, the type of care that might be thought appropriate for demented old people, except perhaps in supporting the conclusion that the demented state makes them ineligible for certain, or even all, types of care. Since people with advanced dementia lack even the most basic cognitive capacities, much less wisdom, they would seem not to deserve care based on wisdom.

Moreover, since old people who have lived lives of abject desperation have not achieved much, does that mean that dignity of merit would require that no care is appropriate to their status? Analogously, how are accomplishments or attainments of old people to be used in assessing the care that they deserve? In general, we might accept that, *as a class*, old people deserve not to be abandoned or treated in ways outside the bounds of human decency, because, as a heterogeneous class, old people possess the dignity of wisdom and/or merit. Accepting this as a general proposition, however, does not advance us very far in defining practical rules to guide choices among alternative systems of care. Thus, even if the concept of dignity, for example, dignity in the sense of *Menschenwürde*, justified an obligation to provide care for dependent old people, the concept does not establish an ethically sound basis for guiding choices among competing alternatives, or for concretely shaping systems of caregiving.⁵

Since dignity relies on broadly shared and, perhaps, tacit understandings, the vagueness of the concept is not only understandable, but may actually be advantageous. Clear articulations of dignity would reflect distinctions, and distinctions tend to divide. The broad beliefs and values implicit in the understanding of dignity are beyond question just because they are tacit and accepted intuitively. They are tacitly accepted, in part, because they do not have analytical rigor.

However, if dignity is appealed to, or used in contexts of policy, in order to shape or guide concrete choices, it is reasonable to ask whether it can offer more than a general support to, or express more than an accepted general intuition about, the broad duty to care for old people. Can dignity, in other words, provide specific practical guidance in concretely defining the ethically defensible care options for old people?

Consider the challenge that this question forces us to face. If the dignity of old people is understood to involve sustaining their independence as much as possible, which seems to be a preference and presumption of

many old people in the United States, then drawing out the implications of this reading of dignity-as-independence would oppose placing old people in communal/institutional living arrangements, such as residential long-term homes or nursing homes, no matter what their level of quality unless of course the old people consented. A communal style of care might thus tend to be regarded as an affront to dignity, because these settings of care involve a loss, or recognition of the loss, of independence that is (assumed to be) essential to their dignity.

Drew Christiansen has critically characterized this reaction to accepting the limitations associated with the dependencies involved with being old as *counter-dependence*, an attitude that he claims is endemic to liberal Western society (1971). Because of the unrealistically high expectations implicit in the liberal ideal of independence, the need for care and supportive services is denied, since to acknowledge or accept this need involves a denial of the worth of the old person in question. Dignity understood primarily in terms of independence, thus, would tend to rule out or undervalue institutional care arrangements without necessarily identifying how institutional care might be made acceptable or improved.⁶ Such an understanding of dignity would also seem to be singularly unhelpful to policy-makers having to decide whether in-home care services provided by paid caregivers are preferable over arrangements in which family members are enabled to provide the needed services, or whether other arrangements for care provided outside the home are acceptable. This concept of dignity does not help us to choose among the alternatives, because independence, as the primary defining value of dignity, is simply analytically ineffective in deciding whether it is the care provider or the setting of care that should be the key component of a dignified old age.

It might be pointed out that the idea of dignity-as-independence involves an individualistic, liberal view of the autonomy that fundamentally supports a market approach or, at least, one that gives individual old people significant degrees of choice. Therefore, one implication of the value framework underlying dignity-as-independence might be the creation of multiple and competing systems of care open to individual choice, since the view of dignity focused on independence would insist that people should choose the alternative that best suits their personal values or preferences.

In this view, the very question of who should design systems of care for old people is expanded beyond health care professionals or policy makers to include private developers and others in the context of a market mechanism that is deemed the best able to identify the preferences of old people. Whether the design of systems of care for old people should occur as a matter of centralized public social policy and planning, or strictly within the marketplace, is a further issue that is raised by the underlying commitments associated with the interpretation of dignity-as-independence.

On the other hand, the difficult fact that many old people lack the financial resources to realize the choices that they would like to make cannot be ignored. This and other questions suggest that any single concept of dignity—not just dignity-as-independence—might not be able to provide the guidance needed unless the concept is, at every turn, supplemented by other concepts and considerations.

Further, an individualistic vision of the dignity of old people defined in terms of their capacity for autonomous action, decision making, and independence would conflict with a more communitarian view of dignity that is centered on the membership of individuals in the family. The important point is that implicit in all concepts of dignity are fundamentally different understandings of, and commitments related to, the nature of human flourishing that are so complex that no single concept of dignity can reasonably be expected to articulate fully. Thus, unless dignity is enriched or specified by additional concepts, or appealed to within well-defined and cultural, religious, or social settings where particular visions of human flourishing are shared, it might not provide the kind of guidance that policy-makers or legislators require. As a result, it is hard to see how dignity alone, or without a great amount of analysis and significant differentiation, can help to decide such matters.

These challenges follow from considerations about what dignity practically involves, or what respect for dignity entails, with regard to the care of old people. These challenges are not to be taken as an objection to the relevance of dignity for the ethics of long-term care, but as an unavoidable feature of the language game of care. Within its intuitive framework of usage, dignity is meaningful and points to shared views and attitudes about the needs of old people, as well as to broad approaches to their satisfaction.

Outside these particular systems of belief or frameworks, however, one should expect conflict. Even within the communities of shared intuitions about dignity, conflict is still possible regarding the implications of such intuitions in concretely structuring the care of old people. However, since specificity does not seem to be characteristic of the main concepts of dignity that function in the international and national policy statements that were discussed earlier, such concepts can cement general agreement, but will have only a weak role to play in choosing among competing policy options.

In the international policy statements, a foundational, but non-specific concept seems to be at work. Adam Schulman (2005) has pointed out that theoretical precision—or, as I would prefer to express it, specification—was less important in international contexts after World War II than was a practical consensus that atrocities like concentration camps, mass murder, and slave labor should not be repeated. Although practical, this consensus did not contain a detailed understanding that could answer the forward looking

question, "Is this particular practice acceptable, or which of several available alternatives is preferable?"

However, this consensus was practical in the sense that it expressed a deeply held conviction about or commitment to outlawing certain ethically egregious practices that post-war governments sought to eliminate. The concept was thus used to give expression to what was widely accepted as ethically problematic about a complex set of practices and policies that occurred under the Nazi regime, and which European governments hoped would not be repeated. Rather than positively defining a moral or legal standard, this promissory or aspirational character of dignity expresses a hope or commitment to avoid objectionable practices that need not be specifically enumerated.

It also explains why, in many policy contexts, the term *dignity* often appears along with other foundational concepts like rights and freedom, which are needed to collectively provide the basis for framing sound policy decisions. These concepts are useful for fleshing out the positive intent that dignity broadly alludes to without precisely defining its implications. The vagueness of dignity is thus an asset since it can garner a broad and intuitively-based endorsement while leaving open the complex and controversial task of defining its practical meaning and implications. These features suggest that, unless the concept of dignity is grounded within a specific cultural, political, religious, or social context that gives it specificity, and which is intuitively relied on when the term is endorsed, it will give only an amorphous intuitive basis for framing the care of old people.

However, for purposes of criticism—for example, criticism of the practices of long-term care institutions in the United States—it is easy to accept that appealing to even a vague concept of dignity can serve legitimate rhetorical, and even, substantive ethical purposes. If old people in nursing homes are treated in ways that violate their fundamental rights, such as, their basic rights of association, visitation, property, or access to friends and activities outside the institution, then it might be perceived as more persuasive or expressive of a stronger outrage to condemn these restrictions as an affront their dignity rather than just as violations of the rights of the individuals who have been harmed. In this instance, a dignity-framed condemnation expresses not only a judgment about the wrongness of the practices, but a *shared* awareness and solidarity with the old people. This sense appears to be an important component of dignity regarded as a universal human quality.

Therefore, saying that some practice or behavior compromises or violates the *dignity* of old people places the rest of society *on their side* in solidarity with them. Dignity can have this function to the extent that it expresses a broadly shared intuition about the fundamental worth of old people, and the problematic character of certain practices that violate this

worth. Criticisms of certain nursing home practices (like the ones mentioned above) underscore that what is most offensive about these practices is that they affront the common status that old people share with the rest of society.

Thus, an appeal to an affronted dignity provides a clarion call to action to refuse to tolerate such practices, and this call seems stronger than simply claiming the wrong to be a violation of someone's individual right. This, of course, does not imply that rights are less significant or weaker ethically or practically than dignity, but rather is a claim that a violation of dignity—as opposed to a right—provides a broader, even if more conceptually diffuse, foundation for motivating redress. Dignity may thus be more practically useful when it provides this persuasive function of ethically condemning a particular action or policy.

This persuasive and condemnatory use of dignity underscores the fact that the problems so noted are accepted as *ours*, and represent a shared or community problem rather than just a private dispute. Such an appeal may work as much (perhaps, more) effectively than a finely reasoned argument, precisely because it relies on deeply felt emotions that rest on a broadly shared, albeit diffuse, set of intuitions (Badcott, 2003). This fact is implicitly recognized by the President's Council of Bioethics' publication of a diverse range of texts in *Being Human: Readings from the President's Council on Bioethics* (Kass, 2004).

These texts are offered as a "foundation" for the approach of the Council to complex bioethics issues. The texts included represent a diverse range of literary, philosophical, religious, and other sources on a range of topics including dignity that express the intuitive and emotional basis on which that body has sought to erect bioethical policy. These texts are not analytically defended, nor are their core commitments precisely identified.

No effort was made to reconcile differences or divergences among the included texts. Rather, the reader is expected to find this diverse range of texts resonating in a felt way with the commitment to the worth of human dignity that animates the approach of the President's Council. Their purpose is to teach by appeal to attitude and feeling rather than argument and analysis, and thereby to shape intuitions in the direction of a consensus around what amounts to a conservative view towards new biomedical technologies and their corrosive implications for human nature.⁷ This example is important for present purposes because it illustrates how dignity can find endorsement in virtue of its reliance on a broad and uncritically examined set of intuitions that involve emotion and attitude rather than conceptual rigor or clarity.

In opposition to this intuitive reliance on dignity, it is natural to assume that the primary question about dignity in the context of practices like the care of dependent old people is: "What are the particular characteristics or

features of the person that are abridged or violated when dignity is said to be violated?" On this view, one of the mistakes that proponents of dignity in public discussions often make—the President's Council on Bioethics at various places is guilty of this error—is that they let this sense of linkage or solidarity between the observer or policy maker on the one hand, and the individuals whose dignity is affronted on the other, do the ethical work essentially on the basis of affect, rather than by offering some argument or explanation for the precise ethical affront or violation committed when so-called dignity is assaulted.

Asking for a definition of the constituent features of dignity that are at issue or at stake, which is asking for much less than a justification, does not seem to be an excessive demand, though it is one that might be resisted by proponents of dignity. This is more likely wherever the concept is primarily employed in a negative and condemnatory sense. In this usage, dignity serves primarily to thwart analysis and debate by appealing to shared intuitions about a subject. The subject is identified not as a problem open for analysis, but as a danger about which a warning, with emphasis, is needed. Like in a public building, an alarm is sounded. We do not know the nature of the threat, but the alarm triggers the socially conditioned behavior to vacate the space. Like a warning sign outside an abandoned mine that reads "DANGER," we are not informed whether there is a risk of cave-ins or poisonous gas; rather we are simply warned that entering the mine is prohibited. The problem with this cautionary use of the concept of dignity arises whenever the underlying attitudes, emotions, or intuitions are not shared or, more compellingly, when there are strong reasons to enter the forbidden area.⁸

From this discussion we can conclude that the appeal to dignity in the context of the challenging, long-term care of frail and dependent old people is thus problematic in two ways: The first emerges when the issues at hand—like those of stem cell research that can alter the range of human capacities and responsibilities—involve demographically and economically complex challenges that are unique and unavoidable. Thus, stem cell research has been criticized based on intuitions about the degree to which this research violates human dignity; yet, such criticisms fail to advance our moral understanding very far into the burden of responsibility created by prospects of stem cell research. Likewise, the call not to ignore the care needs of the frail and dependent old, and to avoid allowing them to suffer an undignified form of treatment or worse, does not do much to chart the positive course that should be followed.

The second context where reliance on the concept of dignity fails is when an underlying vagueness and generality leads away from specific implications for judging how ethically sound practices or policies might be developed. Even when there is an unassailable and shared intuition about

what compromises dignity, we still need to ask, "What are we required to do if we are to rectify the problematic practices?" Because demographics are forcing societies to enter the area of danger, we need concepts that can illuminate the path or paths ahead. Studies of different localities, even when small scale, can be helpful to broaden our view of the alternatives that are reasonably open.

To answer the difficult policy and practical questions that the long-term care of old people poses for society, specific content is needed. Although the concept of dignity may seem contentful and effective whenever the tacit understandings of dignity are truly shared, we must remember that oftentimes people who share unexamined beliefs and values are also prone to differ about the implications of their beliefs whenever these are subject to open critical discussion and reflection. This is a fact to which the history of deep divisions and disputes in political, religious, and other groups attests.

NOTES

1. Although it is noteworthy that dignity does not figure prominently in the major principlist theories, this absence cannot be taken, without further argument, to imply that it lacks practical relevance in the context of caring for old people. It might be that bioethics theory is deficient in omitting dignity as a core principle or concept. See the testimony by James Childress (2005) and Daniel Sulmasy (2006). There is, of course, significant debate about whether *any* bioethical principle or theory provides a sufficient connection with the concrete cases, problems, or issues in health care to ground policy making or decision making and action in particular circumstances.

2. A corollary way of expressing this question is "How does the concept of dignity *practically* help to shape caregiving for dependent old people who suffer from disabilities and incapacities associated with old age that significantly diminish their functional status?" Since the practical question is bounded by local conditions, resources, interests, etc., the answer supported by the concept of dignity will inevitably reflect the underlying tacitly accepted values and commitments.

3. The reports of the President's Council on Bioethics, background papers, and testimony can be found at the Council's website: www.bioethics.gov (Accessed September 1, 2007).

4. The relationship between *Menschenwürde* and dignity of identity is especially important, and indeed relevant, to the topic of care of old people, but in this short article I will be able to make only one point about dignity. I will argue that in practical terms the concept needs specification in terms of a frame of values that is inevitably local and sectarian. Whether this is a specification of what Nordenfelt terms dignity of identity or something else, I will not consider directly.

5. In previous work, I have argued that the concept of *actual autonomy* can provide a practically useful framework within which to address day-to-day ethical concerns arising in the care of dependent old people. Although this work does not specifically address the duties associated with dignity, the framework built on respecting the actual autonomy of old people can accommodate appeals to dignity. This is so because the concrete commitments and values involved in dignified care are those of the individuals receiving the care and form the content of these individuals' actual autonomy (See, Agich, 1990, 1993, 1998, 2003). I do not argue, however, that this framework provides a firm foundation for deciding the policy of care for old people, except to the degree that systems of care that fundamentally ignore or violate the actual autonomy of old people are ethically problematic even though they may be unavoidable for economic or other empirical reasons.

6. See Agich (2003) for an ethical framework developed to improve the care of dependent old people, especially in institutional long-term care, based on an articulation of the features of actual autonomy that are concretely relevant for ethical caregiving.

7. This is most evident in Leon Kass's *Life, Liberty and the Defense of Dignity* (2002), which relies on what Richard Ashcroft (2005) calls "a metaphysical" interpretation of dignity that is obscure just because it is taken to be a primitive term.

8. Dignity thus can serve *rhetorical purposes* to create artificial consensus, perhaps for political ends.

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