Dignity equals distance?

- Pursuing dignity in user-centred care practices

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# Abstract

Dignity has come to play an increasing role in healthcare discourses, and has also become a healthcare policy-issue (Nordenfelt, 2009). For example, in 2011, both Sweden and Norway included the aim of dignified care services in their social service and health legislation. In Denmark, the 2016 national budget included a ‘dignity billion’ to promote dignity in care services for older people. Furthermore, all municipalities must develop a local ‘dignity policy’, and questions of dignity figure prominently in several national reform initiatives aiming to promote user-centred care practices.

This paper explores how dignity is articulated and pursued in two current initiatives to promote user-centred care in Danish care services for older people, and what implications this has for the work practices of care workers. Based on two ethnographic studies of respectively ‘reablement’ practices, and the use of ‘welfare technologies’, I will show how these attempts to create dignified, user-centred services transform care interactions between care recipients and formal care workers, and especially what has been termed the ‘bodywork’ of care (see Twigg, Wolkowitz, Cohen, & Nettleton, 2011).

In these initiatives dignity is articulated as closely related to older people’s increasing autonomy and independence of formal care – in Dahl’s (2005) words ‘a different form of retrenchment’. Bodily care is seen as a transgression of the care recipient’s bodily autonomy, and as related to the loss of bodily control of ‘the fourth age’ (Gilleard & Higgs, 2011), thus representing a threat to dignity in the form of autonomy. These articulations of (un)dignified care influence care practices in the sense that the bodywork of care becomes more distanced and ‘hands off’, and care workers withdraw from care recipients’ private spheres. These practices rely on increasing care recipients’ abilities to perform self-care (perhaps with guidance or relying on informal care from relatives), and on technological automation of care tasks (e.g. toileting).

However, these articulations of dignity do not stand alone. When care practices are closely examined dignity is also pursued as a question of cooperation and equality between care workers and care recipients, as a question of de-objectification, as promotion of enjoyment and quality of life. In the studied care practices, care is thus ambivalently positioned as both a potential transgression and threat to dignity, and as a prerequisite for achieving it.

# Introduction

Few would probably disagree that dignity is, or at least should be, a central value in care practices for older people. The concept is closely related to notions of human worth and human rights (Meenan *et al.* 2016; Nordenfelt 2003, 2009) and thus has a humanist appeal. Dignity has come to play an increasing role in healthcare discourses, and has also become a healthcare policy-issue (Nordenfelt 2009). For example, the UK has seen a stream of national and local policy initiatives, campaigns and service developments to promote dignified care services (National Dignity Council 2018; Opinion Leader Research 2009; Williams *et al.* 2016). In 2011, Sweden included the aim of dignified services in its Social Service Legislation (Socialdepartementet 2011), and the same year the Norwegian government issued a ‘dignity guarantee’ through a revision of its health services legislation (Helse- og Omsorgsdepartementet 2011). In Denmark, the 2016 national budget included a ‘dignity billion’ to promote dignity in care services for older people, and it has become mandatory for municipalities to develop a local ‘dignity policy’ (Sundheds- og ældreministeriet 2017). Furthermore, an information centre for dignified care for older people has been established, and questions of dignity figure prominently in several national reform programs in the health and social care sector.

The concern with dignity and the eagerness to act demonstrated by central policy actors contains an implicit critique: the current state of affairs in care services for older people does not live up to ideals of dignified care. In most western countries, health care systems and services are under financial strain from decades of continuous retrenchment-efforts (Jordan 2011), combined with an increasing demand for services deriving from an ageing population (Casey *et al.* 2003). It seems more and more difficult to meet the growing care needs of ageing societies with the limited resources available in the health and social care sector. In relation to this, some authors refer to a general ‘crisis of care’ under neoliberal financialised capitalism (Fraser 2016; Wrede *et al.* 2008). This crisis of care is regularly reflected in the surfacing of ‘care scandals’ concerning mistreatment of older care recipients (see e.g. Jönson 2016) and in documentation of experiences of lack of dignity in care services (Dansk Sygeplejeråd *et al.* 2014).

Undignified care is thus widely problematized – but what does it entail to provide dignified care for older people? In this paper, I explore how dignity is currently pursued in care practices for older people in Denmark. In these practices, the pursuit of dignity is closely related to specific prominent policy-driven ideals of good care and quality of life in old age – that is, ‘user-centered care’ and increased autonomy for care recipients. This entanglement of ideas of dignity and good care is expressed in two major reform programs that have recently been implemented in Danish care services for older people – ‘Reablement’ and ‘Welfare technologies’. Based on empirical examples from two ethnographic studies of respectively reablement practices and care practices involving welfare technologies, I will show how these attempts to create dignified, user-centred, autonomy-promoting care services transform care interactions between care recipients and care workers, and especially what has been termed the ‘bodywork’ of care (see Twigg *et al.* 2011). Furthermore, I will show how these new care practices may lead to contradictory constructions of care as both a threat and a prerequisite to dignity.

# Dignity and care work for older people

The issue of dignity in healthcare-research, -policy and -practice has been widely discussed and analysed. The question of how to define dignity and provide dignified care for older people is not easily answered on an abstract level, and some authors have argued that the concept of dignity is too loosely defined, rendering it useless, as it entails no more than respect for persons or their autonomy (see e.g. Macklin 2003; Pinker 2008). Others, e.g Killminster (2010), argue that dignity is indeed a useful concept and principle, that may guide healthcare-research and -practice, if only it is operationalized and clearly defined. However, there is no consensus on how dignity should be defined and operationalized among those who consider it a useful concept.

Nordenfelt (2009), who has made an important contribution in the specific field of dignity in care for older people, argues that dignity is something that people possess or obtain (and may be deprived of), and provides a typology of four types of dignity: Dignity as Merit, Dignity as Moral Stature, Dignity of Identity and Dignity of Human Worth (Nordenfelt 2004). Furthermore, he relates dignity to questions of quality of life, autonomy and integrity (Nordenfelt 2009). A different conceptualisation can be found with Frank (2004), who argues that the experience of dignity has a very high degree of local and personal specificity, and therefore should not be understood as a quality, but as an event happening between persons facilitated through dialogue. Somewhat in the same vein, Killminster (2010) conceptualises dignity – as a state or a capacity, that is: *”the capacity to live by one’s standards and principles”* (Killmister 2010: 160). Yet another take on dignity, emphasising specificity and variation in the question of dignified care, comes from Pols et al. (2018), who see dignity as *’relational engagement in concrete care situations’* (Pols *et al.* 2018: 89). They emphasize the importance of exploring how dignity emerges in the practices, in which it is pursued, rather than focusing on it as an abstract concept and endeavouring to determine its finite meaning. In this paper, I follow this latter practice-oriented approach to dignity, exploring how dignity emerges in concrete care settings and situations where it is pursued.

# Analytical approach

When exploring dignity in care work for older people, the bodily elements of these practices are important to consider. Researchers increasingly emphasise the need to see care work as not only a form of emotional labour, but also as a form of ‘bodywork’ – work focusing directly on the bodies of others (Twigg 2000; Twigg *et al.* 2011; Wolkowitz 2002). In this perspective, the bodily elements of care work and embodied experiences of giving and receiving care are emphasised. Care work is in many ways transgressive in its dealings with human bodies – as Dahle has put it: *“health personnel need to go beyond all bounds of decency in dealing with human bodies, and they often have to ‘breach’ normal rules of intimate physical contact”* (Dahle 2005: 101). This transgressive element makes experiences of (in)dignity in care a pertinent issue for both care workers and care recipients. Moreover, the need to receive help and care may in itself be experienced as an indignity. In theoretical discussions and more broadly in western culture, it has become common to distinguish between a ‘third’ and a ‘fourth age’ (Gilleard and Higgs 2000; Laslett 1991). In this ‘fragmentation’ of old age the third age is culturally represented as a time of leisure, consumption, activity, self-realisation and adventure. A representation that challenges previous perceptions of life after retirement as secluded and marked by illness and decay. However, Gilleard and Higgs have described how what they term the ‘social imaginary of the fourth age’ (i.e ‘deep old age’) appears as a new ‘residual category’ in conjunction with optimistic representations of third age-ageing. The fourth age, they argue, is instead marked by a state of marginalisation, objectificaton and abjection entailing a *“perceived loss of agency and bodily self control and the failure to achieve any restoration of that loss”* (Gilleard and Higgs 2011: 141). Losing agency and bodily control, and thus being (permanently) dependent on care, may in this perspective be seen as a signifier of one’s loss of subjectivity and entry into this abject and marginalised position – a state one would hardly associate with common notions of dignity. However, Gilleard and Higgs actually point to caring relationships as possibilities to counter risks of marginalization and compensate for the lack of individual agency and control in the fourth age (Gilleard and Higgs 2011). Practices of bodily care for older people who have lost the ability perform this care themselves, thus both contain a potential for experiences of transgression, loss of control, and indignity, but also a potential for countering or reducing such experiences.

The care practices I discuss in this paper seek to accomplish the latter – they pursue dignity in care. In analysing these pursuits, I draw on Pols et al.’s (2018) understanding of dignity something ‘co-laboured’ and ‘crafted’ in specific situations in relationships between multiple human and non-human actors. As they describe in their discussion of a case involving a cancer-patient’s dignified death at home:

”Although ‘home’ is where most people prefer to die, it can only provide for a good death when it is firmly supported by relations with specific other places (health-care institutions, electricity companies), technologies (bed, medication, electricity), regulations and people.” (Pols et al. 2018: 95)

In a similar vein, Gherardi and Rodeschini, define care as ‘an ongoing socio-material accomplishment’ that is “realized by a heterogeneous collective of more or less able-bodied humans, tools, technologies, rules and other ‘non-humans’ or ‘more than humans’” (Gherardi and Rodeschini 2015: 268). With these understandings emphasizing the socio-material and collectively accomplished character of care and dignity in care, the realisation of dignity in care practices is analysed as relying on much more than individual care workers’ attitudes, behaviours and ethical decision-making.

In relation to this perspective, emphasis should also be given to the governmental and managerial setting of the care practices in question. As Hillman et al. (2013) argue, policy priorities, management strategy and the organisational cultures of healthcare institutions shape how staff care for their patients, and thus their possibilities for providing dignified care for older people. In a study exploring dignified care of older people in acute hospital wards in England and Wales, Hillman et al. (2013) illustrate how specific governmental rationalities concerning risk shape how staff care for their patients and challenge their possibilities for providing dignified care. In the Danish setting, the policy ideals concerning increased autonomy and user-centeredness in care practices are influential governmental rationalities, and I will show how these rationalities may shape the crafting of dignified care in practice.

# Methodology

The paper draws on two ethnographic studies of professional care practices influenced by two major reform programs that have recently been implemented in Danish care services for older people – ‘Reablement’ and ‘Welfare technologies’. The study of reablement was conducted from 2011-2015 by the author, and the study of welfare technologies took place from 2015-2019 with participation of the author and three colleagues. The two reform programs have involved major public investments, involve all Danish Municipalities to some extent, and may be said to epitomise the currently dominant discourses on good care for older people in Denmark. Both studies are based on ethnographic case studies in eldercare organisations.

The study of reablement took place in two municipal homecare units and consists of all together 30 interviews with care workers, shadow observations of the workdays of 20 homecare workers, and participant observation in a number of meetings where reablement was discussed. The study of welfare technologies was larger, encompassing four case studies of local practices with specific welfare technologies (intelligent floors, virtual homecare visits, telemedical ulcer-care, and automatic toilets). In this paper, I will draw on the study of automatic toilets. The empirical material in this case study comes from three sites – two care centres and a homecare unit in two municipalities. We conducted 9 group interviews and 11 individual interviews (in total 35 individuals), and carried out shadow observations of the workdays of 17 care workers in day, evening and night shifts.

Both studies are reported more extensively elsewhere (Hansen 2015; Hansen *et al.* 2018; Hansen and Grosen 2019; e.g. Hansen and Kamp 2018; Kamp and Hansen 2019; Meldgaard Hansen 2016). In this paper, I will thus not endeavour to give a full account of the insights this large and multifaceted empirical material may lend. Instead I will ‘read across’ the two studies and draw on central insights and examples that relate to the question of the pursuit of dignified care and its transformation of care interactions between care recipients and care workers. Before I turn to this analysis, I will give a brief account of current policy initiatives and discourses on dignified care for older people in Denmark – the governmental rationalities, which frame care workers’ day-to-day practices and pursuits of dignified care (cf. Hillman *et al.* 2013).

# Danish care policies – dignity, autonomy and user-centred care

As described in the introduction, dignity has become a key concept in recent policy initiatives in the field of care for older persons in Denmark. In these initiatives, dignity is articulated in a specific manner, underlining user-centred care and autonomy. An example of this particular articulation of dignified care can be found in a recent publication from the Danish Ministry of Health – ‘Dignity in care for older persons – a matter very much at heart’:

“In some cases when older persons move into a care centre, this may be experienced as an institutionalisation and standardisation of their life. The government and the Danish People’s Party [supporting party] has with a number of initiatives, among other things dignity policies and vouchers for care centre residents, strengthened older persons’ self-determination.” (Ministry of Health 2018: 5)

In this quote, the need to receive care is connoted with a risk of institutionalisation and standardisation of older persons’ lives, much in line with Gilleard & Higgs’ observations on the social imaginary of the fourth age and its embedded risks of loss of control and agency. In a related passage in the same document, the need to receive care is in itself articulated as a risk: “*We have an increasing number of older people, who are so dependent on care that this risks threatening their experience of self-determination and experience of being part of the community”* (Ministry of Health 2018: 5). The risks to self-determination embedded in receiving care are to be countered through local policies focusing on dignity in care and through increased possibilities for choice of care services through a voucher system. These articulations of dignity and threats to dignity revolve around the previously mentioned prominent care ideals of ‘user-centred care’ and autonomy. Through initiatives furthering choice and self-determination, care is to be personalised and individually adapted rather than institutional and standardised, with dignity as the result.

However, these notions of increasing autonomy and user-centeredness in care for older people have a longer history than the recent initiatives described above and in the introduction. Danish care services for older people and the professional orientations of care workers working here, have since the 1980’s been influenced by an ideal of providing ‘help for self-help’ to stimulate activity and avoid functional decline among older care recipients (Dahl 2000). While this ideal has been found difficult to realise by care workers, working under the influence of New Public Management-inspired rationalisation efforts and standardisation of care services (Swane 2003), it has in later years been reinvented and re-prioritised under the heading ‘Reablement’. Many high-income countries currently invest in and experiment with reablement to different degrees and in different forms (Aspinal *et al.* 2016). Under the reablement-heading, Danish municipalities have for the last approximately 10-12 years been working to reform care practices for older people, to focus them on individually adapted programs for physical training, activation and motivation of older care recipients. The programs seek to support care recipients in maintaining or regaining their abilities for self-care, instead of providing help with bodily and practical tasks. The aim is to achieve (partial) independence of formal care services and with this increased self-determination and autonomy for older care recipients (Bødker *et al.* 2019; Hansen 2015, 2016). However, the reablement agenda also has an economic dimension, as reablement efforts are expected to reduce the overall need for care services and thus expenditure in the sector. Dahl (2005) has coined this development ‘a different form of retrenchment’, contrasting it to other retrenchment strategies, e.g. regular downsizing of public services.

During the last 8-10 years, the reablement agenda has been supplemented by another prominent policy agenda, emphasizing the potentials of furthering the use of ‘welfare technologies’ in care for older people. Welfare technology is a broad term, used mostly in the Nordic countries and covering a variety of technologies that may aid in the delivery of care services (e.g. telecare-systems, GPS-trackers, automatic toilets, sensor-systems, various care robots and many more) (Kamp *et al.* 2019). Many welfare technologies are used with similar aims as reablement efforts, to support increased self-sufficiency of care recipients and at the same time cut expenditure by saving labor power in the sector (see e.g. The Government *et al.* 2013).

Both the reablement and welfare technology agenda are in public and political discourse closely related to the question of dignified care for older people. Both types of interventions may support dignity in the sense described above of increasing care recipients’ autonomy and possibilities for individually adapted care. However, increased autonomy and individual adaptation are in both cases closely connected to economic considerations and the idea of increasing self-care and independence of care services. This coupling of dignity and ‘managing on your own’ often surfaces in public debates on the matter. A recent example comes from a local politician commenting on a new independence-enhancing technology being implemented in his municipality:

“We have a positive view of human nature, and we think that it’s dignified to manage on your own. We will do our utmost to support our citizens in this.” (Hedensted Municipality 2016)

In short, the governmental rationalities informing the pursuit of dignity through various reforms of care services frames receiving care as a potential risk and threat to a dignified life. Furthermore, dignity is connoted with increased autonomy and personalisation/user-centered care, but in a manner that idealises the notion of ‘managing on your own’, which also serves economic/retrenchment agendas.

# Pursuing dignity in care practices

In this section, I will draw on the two studies of care practices focusing respectively on reablement and welfare technology, and use these to examine how dignity is pursued and crafted in local practices and care interactions, with and despite of the above-described governmental framework. Both reablement practices and the use of welfare technologies involve a move towards more distance in the bodywork of care for older people. Care workers are encouraged to and in various ways draw back from physical care interactions to encourage care recipients to ‘manage on their own’ – what I and others have elsewhere framed as ‘caring at a distance’ (Hansen 2016; Hansen *et al.* 2018; Pols 2012). This increasing use of distance in the provision of care is in line with the notions of bodily care as potentially transgressive (cf. Dahle 2005) and as a threat to dignity as descried above. However, the pursuit of dignity in the studied care practices involves more than these distancing practices. It involves what Korczynski (2013), parallel to the idea of ‘crafting dignity’, has described as a ‘skillful search for dignity within bodywork interactions’.

## Reablement – dignity through distance, demands, equality and de-objectification

In my study of reablement, a widespread interpretation of what it meant to do care work in a reabling manner was ‘to keep your hands behind your back’ and actively refrain from carrying out care tasks. Instead, care workers would guide care recipients in carrying out care tasks themselves (e.g. bathing, cleaning, dressing), training them to become more independent of care. These practices were seen as dignity-enhancing, as a referrals officer told me:

“**Vibeke**: It’s very exciting, I think. You know, when the care recipient has cognitive problems, and you can go in and find a way, so they can manage more themselves. Then it becomes more dignified!

**Interviewer**: And that’s the goal?

**Vibeke**: Instead of us just doing everything, right?”

(Interview, Vibeke, Referrals officer)

This understanding that managing (more) on your own contributed to enhancing dignity was widely accepted among the care workers, and conforms with the above described governmental rationalities. A care worker, Line, told me that this pursuit of dignity was linked to supporting care recipients’ self-esteem: *“you give them something by giving them a pat on the back – that they can actually do some things themselves, even though they’re old.*” (Interview, Line, care worker).

However, succeeding in crafting this type of dignity was not always straight-forward, as not all care recipients shared this view or conformed to it right away. This is where the so-called motivational work of care workers became central – they spent a lot of time discussing and convincing care recipients that doing more themselves would be beneficial and more dignified (see also Hansen 2016). In some cases this motivational work involved being quite direct with care recipients, as Laura, a care worker told me during one of my shadow observations:

“Laura tells me about a care recipient with an alcohol addiction, who she felt she had to be quite direct with in order for him to maintain his dignity. She had told him very frankly that he had to pull himself together and take some responsibility for his life. (…) She finds that, especially with care recipients who potentially have many years left to live, you have to put in a lot of effort. Because if you just let them be dependent, they will need help for many years in the future.” (Observation-notes, Laura, care worker)

In cases such as this, dignity is pursued by demanding self-care and responsibility of care recipients. Another care worker, Sofie, similarly told me of a care recipient she had to have a ‘serious talk with’ about responsibility, and how “*you are responsible for your own life; that you cannot just lie down and expect the municipality to come and take care of it all – then you become a burden*” (Observation-notes, Sofie, care worker). A position as dependent on care and a potential burden on municipal budgets in the future is seen as fundamentally undignified.

However, managing on your own and becoming independent of care was not the only interpretation of dignity in care at play. Some care workers viewed reablement efforts more as a question of sharing the work with care recipients, and quite a lot of the older persons they cared for did not become fully independent of care despite reablement efforts. This notion of care as a form of cooperation was perceived as a way to create more equal care relationships with care recipients. This striving for equality also had a bodily dimension and was related to the question of dignity. As the care worker, Inger, told me, she found that with rehabilitative care she would no longer ‘be a helping hand’ nor ‘stand bent over’ care recipients:

“Well, I actually think that they [the care recipients] see us more as equals, than they’ve done before. Previously, you were kind of a helping hand, right? Or something like that. I think you’re better able to talk as equals, instead of me standing bent over them or... I prefer it as it is now. I really do.” (Interview, Inger, care worker)

This quote illustrates a bodily dimension of care workers’ simultaneous dissociation from a position as subordinate to care recipients (reduced to a helping hand, there to serve the care recipient) and a position as superior (the professional standing bent over the care recipient, working *on* her/him) (see also Twigg 2006; Wolkowitz 2002). Inger seems to perceive the cooperation involved in rehabilitative care as contributing to a levelling out of the potential status inequalities and power relations of care – thus preserving both her own and the care recipient’s dignity.

Another example of the understanding of rehabilitative care as a dignity-enhancing practice came up when I was shadowing another care worker, Jane. I listened to her helping Lis, a woman with dementia, wash herself:

“I am standing in the hallway outside Lis’ bathroom, where Jane and Lis have gone in. Jane has closed the door to the small bathroom to make the situation more private for Lis. I can hear Jane guiding Lis to wash herself – Lis does not say much:

**Jane**: If you wash yourself a little, Lis.

**Jane**: Do you have an itch? Should I scratch it for you?

**Jane**: You should get some water in the washbasin.

**Jane**: We can take this one [Lis’ singlet, I presume] down a bit, so you can wash under your arms.

**Jane**: Here you have the washcloth.

**Lis**: What did you say I should do?

**Jane**: You need to wash a little. You can start, and then I can help a little if you want.

**Jane**: Would you like a little soap on the cloth?

**Jane**: Wasn’t that nice with a little water on your face?

**Lis**: Yes, it wakes you up, doesn’t it.

They continue like this for a while until Lis is washed and dressed. A little later in the day, Jane and I talk about this situation and about her detailed guiding of Lis. Jane thinks of this as way to maintain some dignity for Lis and avoid disempowering her. Lis can’t cope with a lot on her own, but in this way she’s included a little, Jane tells me.” (Observations, Jane, care worker)

The physical body work seems to be mostly done by Lis herself in this situation. With this division of labour, where Lis on Jane’s instruction washes herself, Jane seeks to maintain Lis’ dignity in a care situation that might otherwise have been far more objectifying, e.g. with Lis’ partly undressed and passive body being washed by an active and clothed professional. As Twigg has described it, washing and bathing in care situations may take on a coercive, disciplinary streak:

“Baths are part of coercive cultures, and something of this is nearly always present where someone is bathed. Power is exercised over their bodies, which are required to be exposed and immersed in circumstances where they are naked and the administrator is not.” (Twigg 2000: 25).

Thus, Jane’s attempt to make Lis feel included and let her wash herself under guidance aims to avoid this potentiality of coercion and subordination – she does not work *on* Lis’ body as a superior professional, but still works with it to ensure its cleanliness. Dignity is in this case pursued through attempts of de-objectification of a relatively passive care recipient who is very far from the policy-ideal of being able to manage on her own.

## Automatic toilets – dignity through automation and co-labouring

There are many parallels between reablement efforts and efforts to bring new welfare technologies into use in care practices. In the case of automatic toilets (toilets which wash and dry the user after toilet-use), the pursuit of dignity through care worker withdrawal from care tasks is also present. However, in this case the ambition is not to transfer the task to the care recipient, but to a technology.

In policy documents this type of technologically mediated self-sufficiency is coupled with dignity: *“Where the wash-and-dry toilet is relevant for the care recipient, the wash-and-dry toilet contains great potential, both in terms of the care recipient’s self-sufficiency and dignity…”* (Rambøll 2012: 6). In another policy document, care recipients’ answers to a questionnaire on the topic are reported, among these the following question: “*Do you have a positive attitude towards using the following welfare technology, if you had the need and opportunity to: an automatic toilet that can wash and dry without the help of human hands?”* (The Digitalisation Administration 2013). The automatic toilets are represented as facilitating avoidance of ‘help of human hands’ in the meeting of care needs. These understandings of the potentials of automatic toilets seem to draw on the same notions of dignity as described above (managing on your own), but adding to this a dimension concerned specifically with avoiding the transgression of bodily boundaries in a very intimate care task.

In a similar vein, in one of the studied care centers, a connection was made between the automatic toilets and ethical care practices: *“The staff experience being able to meet the resident’s need in an even more ethical manner, and can participate in a more supportive role.”* (PPT-Presentation on use of automatic toilets, care center). According to this quote, using the toilets in care practices casts staff in a more supportive role (implicitly less transgressive of bodily boundaries) and this is equated with more ethical care practices, that is care practices conforming to professional standards of good care. Along the same lines, we were presented with several ‘success stories’ in our case studies, which described care recipients who with the help of the automatic toilets had managed to become independent of help for toileting, and some independent of help altogether. For example, a care coordinator told us in one of our interviews:

Interviewer: Has there been a clear effect [of the automatic toilets] for you?

Susanne: With some care recipients, yes. With some there has been. And the care recipients actually gain a higher quality of life. At least those I have been in contact with. Because you don’t need another person to stand there and help you, when you have to go to the toilet. (…) And also, you don’t have to be dependent. Because when we [the homecare unit] plan, then we have ‘toilet-visits’ scheduled at specific times. That’s evident, we drive around according to a rota. So the care recipient becomes more independent. They can go to the toilet when they want to and when they need to. (Interview, Susanne, care coordinator).

Susanne focuses on the potentials embedded in the toilets, emphasising being independent of care services and free to go to the toilet when you need and want to. This automation of the care task is seen as promoting a higher quality of life – in line with the ideals of achieving dignity through increased autonomy and through this individual adaptation/user-centredness of care – with the automatic toilet you can go when you please, with a care worker you have to wait your turn.

However, we were also presented with many examples where the automatic toilets did not work to promote dignity in this manner, or where they required quite a bit of support from care workers to do this. In one of our interviews, Heidi, a homecare manager told us about the difficulties often involved in using the automatic toilets:

“ … because it has its limits [the automatic toilet]. Even though it’s good in theory and in principle, it’s nevertheless not so good in practice. Because if we look at a couple [of care recipients] which I have in mind right now, who weigh a certain amount – then you still need help to sit so that your buttocks are open, in order to be washed. Because if you sit as you usually do, then it’s closed off. So even if you push wash and dry, it doesn’t go to work in the places where it should. So there are quite a few [automatic toilets] that after all can’t be used sensibly. Because the care recipients we have, don’t have a lot of strength in their hands, and therefore they can’t just say: ‘ok then I’ll separate my buttocks so I can be washed and dried’. And that’s where it falls short. (…) you have factors relating to the bodily build. And it would be nice with systems such as these, but then you have to think a little differently about their function. If they are to give care recipients more independence and restore more self-respect, so they can go to the toilet independently, then you need a little more than just an automatic toilet”. (Interview, Heidi, homecare manager)

As Heidi describes, the use of automatic toilets does not guarantee dignified care in the sense of increased independence of care. Rather, they can require quite a lot of work to function properly in their meetings with differently shaped and sized bodies with functional impairments of various kinds (e.g. weak hands). Other care workers told us about care recipients who were quite skinny, who, if not helped to sit sufficiently to the back of the toilet seat, would have the water from the toilet squirted up their back, creating a quite messy and undignified situation. Moreover, many care recipients, especially in the care centres, had some degree of dementia or cognitive impairment. In many cases, the staff told us, this made it difficult to establish a lasting routine around using the toilets independently. Furthermore, many care recipients were not sufficiently mobile to get to and from the toilet independently, ruling out total independence of assistance, but perhaps making the toileting act itself more independent. For the automatic toilets to work, a lot of what Star & Strauss (Star and Strauss 1999) have termed ‘articulation work’ is thus necessary. Care staff is needed to support the use of the toilets to different degrees, if this use is to be realized at all and if some potential for more dignified care is to be derived from their use. With Pols et al (2018), one may say that dignity is co-laboured between the care recipients, their individual bodies and impairments, the automatic toilets and care workers – and in these situations dignity may be pursued in other forms than ‘managing on your own’.

An example of what I interpret as a pursuit of dignified care through the cooperative efforts of a care recipents, an automatic toilet and a care worker, comes from my observations at one of the care centres, where a care worker, Jeannette, was helping a resident, Maren, who suffered from dementia:

Jeanette and I go to Maren’s apartment to help her out of bed. Jeanette walks to the bathroom with her, supporting her as they go. After Maren is safely seated on the automatic toilet, Jeanette exits and closes the door behind her. Then it’s more private for Maren, she tells me. Shortly after, Maren says that she’s done using the toilet. Jeanette enters the bathroom again. Maren has started wiping herself with toilet paper, but Jeanette convinces her to use the toilet’s washing function. “Let’s just let this smart thing wash you”, she says. Jeanette instructs Maren in how to sit correctly on the toilet – that is, to the back of the toilet seat, so the water will hit the right spots and clean her properly. When she is positioned correctly, Jeanette pushes the on-button for Maren. The toilet starts washing. Maren seems to be enjoying it and is smiling broadly. “This is fun!” she exclaims. When the toilet is done washing, Maren wipes herself with toilet paper, guided by Jeanette. They do not use the drying function, as it does not do the job properly, Jeanette later tells me. (Observations, Jeannette, Care worker)

It is evident in this situation that Maren could not use the automatic toilet without the help of human hands. She needs support and guidance to reach the toilet and to position her body correctly on it. Furthermore, she needs to be reminded to actually use the wash-function. A lot of work thus goes into making the technology work. Through the whole situation, Jeannette seems oriented towards making the situation dignified for Maren, but in more ways than one. She is obviously concerned with the issue of bodily boundaries and privacy related to toileting, as she makes sure to give Maren a private space while she is actually urinating. But she also makes a point of actually using the wash-function, even though it does not seem strictly necessary in the situation and certainly does not save her time or effort. Curious about this part of the situation, I asked Jeannette about it later on, and she explained that some of the residents at the centre really enjoyed using the automatic toilets and found them luxurious. When Jeannette insisted on using the wash function, she was thus aiming to create an enjoyable situation for Maren, and obviously succeeded in this cf. Maren’s excited exclamation. I interpret this as a different pursuit of dignity than simply avoiding the help of human hands or supporting increased independence. Jeannette is not aiming to draw back from the care situation, but works with the technology meant for this purpose to do something else: add to the resident’s enjoyment and quality of life – creating a bit of luxury, as she put it.

# Concluding discussion (very preliminary/unfinished)

In the analysis above, I have tried to show how dignity in care for older people is pursued in concrete care practices, taking place within a specific policy framework. Both in the case of reablement and automatic toilets (welfare technology), dignity is politically framed as equal to managing (more) on your own, without the help of human hands. The analyses show that care workers pursue and craft dignity in this manner, but also in quite different manners in their meetings with care recipients, who to different degrees conform to the ideal of being motivated for and able to manage on their own. In these practices care is ambivalently positioned as both a potential threat to dignity, and a prerequisite for achieving it.

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