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ARTICLE

Dignity equals distance? Pursuing dignity in care for older adults

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Abstract

This paper explores how dignity is articulated and pursued by care workers in two currently prominent policy initiatives seeking to reform Danish care services for older people. Based on ethnographic case studies of 'reablement' practices and the use of 'welfare technologies', the paper shows how these attempts to create dignified care services transform interactions between care recipients and care workers. The analysis is inspired by a socio-material perspective on dignity as 'crafted' and 'co-laboured' in daily practices, in an interplay between multiple human and non-human actors. In the cases studied, dignity is articulated as closely related to older people's increasing autonomy and independence of formal care, and is pursued through enhancing care recipients' self-care ability, and through technological automation of care tasks. However, these articulations and pursuits of dignity do not stand alone. When everyday care practices are closely examined, dignity is also pursued by care workers as increased co-operation and equality between care workers and care recipients, as de-objectification, and as promotion of enjoyment and quality of life. In these practices, care is ambivalently positioned as both a potential threat to dignity, and as a prerequisite to achieving it. The paper concludes by discussing the risks of policy agendas pursuing a narrow understanding of dignity as simply independence of care.

Keywords: dignity; autonomy; reablement; welfare technology; independence; care; care work

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 (Nordenfelt, 2003, 2009; Meenan *et al.*, 2016) and thus has a humanist appeal. Dignity has come to play an increasing role in health-care discourses, and has also become a health-care policy issue (Nordenfelt, 2009). For example, the United Kingdom has seen a stream of national and local policy initiatives, campaigns and service developments to promote dignified care services (Opinion Leader Research, 2009; Williams *et al.*, 2016; National Dignity Council, 2018). In 2011, Sweden included the aim of dignified services in its Social Services Act (Ministry of Health and Social Affairs, 2011), and in the same year the Norwegian government issued a 'dignity guarantee' through a revision of its health services legislation (Ministry of Health and Care Services, 2011). In Denmark, where this paper originates, the 2016 national budget included a 'dignity billion' (€13.4 million) to promote dignity in care services for older people, and it has become mandatory for municipalities to develop a local 'dignity policy' (Ministry of Health and Senior Citizens, 2017). Furthermore, an information centre for dignified senior care has been established, and questions of dignity figure prominently in several national reform programmes 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 (Jordan, 2011), combined with an increasing demand for services deriving from an ageing population (Casey *et al.*, 2003). It seems increasingly 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 (Wrede *et al.*, 2008; Fraser, 2016). 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 (*e.g.* Calnan *et al.*, 2013). The problem of undignified care is thus widely discussed – but what does dignified care for older people entail? In this paper, I explore how dignity is currently articulated and pursued by care workers in care practices for older people in Denmark.

Dignity has become a key concept in recent reform programmes in senior care in Denmark. In these initiatives, dignity is articulated in a specific manner that particularly underlines care recipients' autonomy, *i.e.* their access to choice and self-determination in everyday life. However, these notions of increasing autonomy in care for older people have a longer history than the recent initiatives. Danish care services for older people and the professional orientations of care workers in Denmark have, since the 1980s, been influenced by an ideal of providing 'help for self-help' to encourage activity and avoid functional decline among older care recipients (Dahl, 2000). While care workers have found this ideal difficult to realise when 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; Doh *et al.*, 2020). Under the reablement heading, Danish senior care services have for the past 10–12 years been working to reform care practices for older people by focusing on individually adapted programmes aimed at physical exercise, activation and motivation. The programmes seek to support care recipients in maintaining or regaining their self-care capabilities, instead of providing help with physical and practical tasks. The aim is to achieve (partial) independence of formal care services and thus greater self-determination and autonomy for older care recipients (Hansen, 2015, 2016; Bødker *et al.*, 2019). 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 labelled 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, which has emphasised the potentials 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 and various care robots) (Kamp *et al.*, 2019). Many welfare technologies are used with similar aims as reablement efforts, to support increased autonomy of care recipients and at the same time cut expenditure by saving labour in the sector (*see e.g.* Danish Government *et al.*, 2013).

In policy discourses, both the reablement and welfare technology agendas are closely related to the question of dignified care for older people, through the notion that the autonomy and self-care promoted through these interventions will lead to a more dignified life. As a Danish local politician phrased it, commenting on a new autonomy-enhancing technology under implementation 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)

Dignity is thus equated with a high degree of autonomy in everyday life, which is thought to be best achieved through the gradual minimisation or elimination of formal care services from older persons' lives (managing on your own) by way of reablement efforts and use of new care technologies.

Based on empirical examples from two ethnographic studies of care workers, involved in reablement and welfare technologies, respectively, this paper will show how specific ways of pursuing dignified care in these practices transform interactions between care recipients and care workers. Furthermore, I will show how these care practices involve contradictory articulations of care as both a threat and a prerequisite to dignity. Before turning to this analysis, I first present the analytical framework and methodology of the paper.

Dignity and care work for older people

Dignity in health and care 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.* Killmister (2010), argue that dignity is indeed a useful concept and principle that may guide health and care research and practice, as long as it is operationalised and clearly defined. However, there is no consensus on how dignity should be defined and translated into practice among those who consider it a useful concept.

Some scholars understand dignity as something people possess or obtain, and point to specific variants of dignity (*e.g.* Nordenfelt, 2004, 2009). Others underline the situatedness and specificity of dignity and define it as an event that occurs between people (*e.g.* Frank, 2004), while others again see dignity as a capacity 'to live by one's standards and principles' (Killmister, 2010: 160). Yet another approach to dignity, also emphasising specificity and variation in the question of dignified care, comes from Pols *et al.* (2018). They see dignity as 'relational engagement in concrete care situations' (Pols *et al.*, 2018: 89), thus emphasising 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.

When exploring pursuits of dignity in senior care, both the emotional/relational and physical/bodily elements of these practices are important to consider. Care work is a form of emotional labour, but also a form of 'bodywork': work focusing directly on the bodies of others (Twigg *et al.*, 2011). In this perspective, embodied experiences of giving and receiving care are emphasised and the relational and bodily elements of care work are seen as interwoven. In many ways, care work violates boundaries in its dealings with human bodies, as Dahle (2005: 101) has expressed 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.' This boundary-crossing element makes experiences of (in)dignity in care a pertinent issue for both care workers and care recipients (*see e.g.* Stacey, 2005; Andersson and Kalman, 2016). Intimate bodywork often involves a sense of intrusion and violation of bodily sovereignty, but this experience can be mediated through skilful enactments of emotional labour by care workers (Korczynski, 2013).

Moreover, from one perspective, the need to receive (bodily) help and care may be experienced as a threat to dignity or an indignity in itself. In theoretical discussions and more broadly in Western culture, it has become common to distinguish between a 'third' and a 'fourth age' (Laslett, 1991; Gilleard and Higgs, 2000). In this 'fragmentation' of old age, the third age is culturally represented as a time of leisure, consumption, activity, self-realisation and adventure. This is thus a narrative that challenges previous perceptions of life after retirement as secluded and characterised 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 the third age. The narrative of the fourth age, they argue, instead represents old age as a state of marginalisation, objectification 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, which is a state one would hardly associate with common notions of dignity.

However, from another perspective, the acts of giving and receiving (bodily) care may also be perceived as prerequisites for a dignified life. Weicht (2011) argues that, while independence and self-sufficiency are constructed as ideals for human existence in public discourses on care, and dependency is seen as an inferior state of life, dependency and care needs can instead be seen as neutral and normal aspects of human existence. Relatedly, caring relationships may in fact be seen as opportunities to maintain identity, counter the risk of marginalisation, and compensate for the lack of individual agency and control related to the fourth age (Gilleard and Higgs, 2011; Lloyd *et al.*, 2014).

As I will show, these contradictory articulations of care as, respectively, a threat and a prerequisite to dignity in old age also permeate day-to-day care practices, where care workers pursue dignity in various manners. To capture the variation and complexity of these quests, I draw on the understanding of dignity of Pols *et al.* (2018) as 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 the dignified death at home of a patient diagnosed with cancer:

> 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 (2015: 268) 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"'. These understandings emphasise the socio-material and collectively accomplished character of care and dignity in care.

With this point of departure I will examine care workers' varied and situated articulations and pursuits of dignity in day-to-day care practices, which take place in the specific policy setting described in the Introduction, emphasising autonomy and 'managing on your own' as signifiers of dignity.

Methodology

The paper draws on two studies of care workers' day-to-day work practices and professionalism influenced by the reablement and welfare technology reform programmes in Danish public-sector care organisations. These studies had a broader framework than the present paper, but pursuits of dignity were included as a focus in both. The study of reablement was conducted from 2011 to 2015 by the author, and the study of welfare technologies took place from 2015 to 2019, involving the author and three colleagues. The two reform programmes 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 care organisations.

The study of reablement took place in two municipal home care units and consisted of 30 semi-structured interviews with care staff, managers and administrators, shadow observations (Czarniawska, 2007) of the workdays of 20 home care workers, and participant observation in a number of meetings where reablement was discussed among care workers and managers. The study of welfare technologies was larger, encompassing a number of case studies of local practices with specific welfare technologies. In this paper, I will draw on one of these, a study of the use of automatic toilets. The empirical data in this case study come from three sites (two care centres and a home care unit) in two municipalities. We conducted nine semi-structured group interviews and 11 semi-structured individual interviews with care staff, managers and administrators (35 individuals in total), and carried out shadow observations of the workdays of 17 care workers on day, evening and night shifts.

The interviews were recorded and transcribed, and observations were documented through notes and quotes jotted down during shifts, and shortly afterwards elaborated into fuller narrative descriptions of events and impressions by the observing researcher. In addition to interviews and observations, case-specific and general policy documents on reablement and welfare technologies were collected to contextualise the studies.

The care staff involved in the studies were primarily social and health-care aides and assistants,[1] but registered nurses, occupational therapists and physiotherapists were also included. In the following, the focus will mainly be on social and health-care aides and assistants as they are the primary staff groups performing practical senior care in Denmark. I refer to them collectively as 'care workers' for simplicity.

Informal conversations and interactions with care recipients during observations played a part in both studies, but representation of the voices and views of care recipients was not formally included in the design and methodology of either study. This choice was based on the studies' overall focus on work practices and professionalism among care workers. However, in the context of this paper and its focus on how dignity is co-laboured in practice, the non-inclusion of care recipients' voices is a clear limitation. The analysis presented thus provides only a partial perspective on the pursuit of dignity in care practices, and further empirical work on the co-labouring of dignity that includes care recipients' voices is needed in the future.

The selection of the specific cases was based on the criterion that reablement and the use of automatic toilets would be well-established practices in the day-to-day work of the care organisations. The organisations studied had thus moved beyond the inevitable 'teething troubles' related to the implementation of new approaches and technologies. This enabled a focus on how the latter reconstituted practices of bodywork and related pursuits of dignity in everyday care, instead of focusing on implementation challenges. On a more general level, reablement and automatic toilets were chosen as foci because they represent initiatives that aim to transform care work and care relationships fundamentally, and thus also potentially transform how dignity may be pursued and realised in care practices, as mentioned above. In line with this and following Shore and Wright (2011: 12), the chosen cases may be seen as 'small sites that open windows onto larger processes of political transformation'. In my observations of these small sites, I was a partly participating observer (Fangen, 2010), interacting with both care workers and care recipients, but not participating directly in care tasks. The observations focused on the social and bodily interactions of care: the oral communication that took place, the physical positioning of the bodies of the care worker and recipient in relation to each other, and to the material surroundings and technologies, as well as the forms of touch and divisions of labour that were developed. In interviews and more informal conversations during observations, my focus was on the meanings and understandings attached to the new care practices involving reablement and automatic toilets, including how specific understandings of dignified care were articulated. This approach was based on an understanding of care practices as 'bodily and discursive choreographies' (Nicolini, 2013: 223), emphasising the situated and material interactions of bodies as well as their relations to broader discursive frameworks.

The data have been analysed in various processes since the first reablement case study was initiated in 2012. The insights in the present analysis have thus developed over the following nine-year period of the two studies, in an iterative interpretative process moving between field and desk, and in dialogues with study participants and academic colleagues through the years. In both studies, an initial open and inductive thematic analysis of the material was conducted, followed by several more focused readings, zooming in on specific aspects of the practices developed by care workers under the two reform programmes. Both studies are reported more extensively elsewhere (*e.g.* Hansen, 2015, 2016; Hansen and Kamp, 2018; Hansen *et al.*, 2018; Hansen and Grosen, 2019), and in this paper, I will therefore not give a full account of the various insights that may arise from this large amount of multifaceted data. For the production of this paper, I conducted a systematic reading of the data, focusing on the question of care workers' pursuit of dignified care and the related transformations of care worker–recipient interactions.

Ethical considerations

The two studies were registered, conducted, and data securely processed and stored, in accordance with the regulations of the Danish Data Protection Agency, and subsequently the European Union General Data Protection Regulation (European Union, 2016) and the Danish Code of Conduct for Research Integrity (Ministry of Higher Education and Science, 2014). According to Danish research guidelines, qualitative studies require no further approval process. All interviewed and shadowed care workers, and the care recipients visited with them, gave informed consent to participate in the research, and were informed of their right to withdraw at any point. All individuals, workplaces and municipalities were anonymised to prevent identification. Care recipients, and if relevant their relatives, were informed in advance that researchers would accompany their care workers on visits, and given the opportunity to refuse this. Care recipients considered unable to give consent to researcher participation due to, for example, severe dementia or other cognitive challenges, were not included in the research. Securing ongoing consent from recipients to the researchers' presence as observers in very intimate care situations was a concern in both studies. Consent to participation in research of this kind is a delicate matter that should be continually negotiated during the research process, beyond the initial and formal consent procedures. This involves careful attentiveness during observations by the researcher to both verbal and non-verbal 'signals and silences' from study participants (Attuyer *et al.*, 2020), who may find themselves in vulnerable situations. In practice, this implied close attention by the researchers to care recipients' reactions to their presence, and taking cues from care workers familiar with the recipients, in order to withdraw from situations where recipients, verbally or non-verbally, expressed discomfort with our presence, *e.g.* to another room or completely from their home.

Pursuing dignity in care practices

In this section, I will examine how dignity is articulated and crafted in local care practices, and how care interactions are transformed. Both reablement practices and the use of welfare technologies involve a move towards more physical distance in the bodywork of care for older people. Care workers are encouraged to withdraw in various ways from physical care interactions to encourage care recipients to 'manage on their own'; this has been termed 'caring at a distance' (Pols, 2012; Hansen, 2016; Hansen and Kamp, 2018). This increasing use of distance in the provision of care is in line with notions of bodily care as potential violation (*cf.* Dahle, 2005) and a possible threat to dignity. However, the pursuit of dignity in the care practices studied also involved close bodily contact and practices more in line with the notion of care as a prerequisite to dignity.

Reablement: dignity through distance, demands, equality and de-objectification

In the 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', 'not take over for the care recipient' and actively refrain from carrying out care tasks. Instead, care workers would instruct recipients in how to carry out care tasks themselves (*e.g.* bathing, cleaning, dressing), encouraging them to become more independent of care. These practices were seen as dignity-enhancing, as Vibeke, a referrals officer, told me in an interview:

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, you see?

This understanding that managing (more) on one's own enhanced dignity was widely accepted among the care workers. One of them, 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 – they can actually do some things themselves, even though they're old' (interview, Line, care worker). With this approach, needing care is seen as damaging to a person's self-esteem, and reablement is seen as the attractive alternative that may help care recipients overcome the potential challenges and limitations of ageing. Care workers seek to craft dignity by assuming an identity as optimistic and supportive coaches for care recipients (*see also* Hansen and Kamp, 2018).

However, success in crafting this type of dignity was not always straightforward, as not all care recipients shared this view or conformed to it immediately. This is where the so-called motivational work of care workers came to play a key role; they spent considerable time 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 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 to get 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, saying: 'You're responsible for your own life; you can't just lie down and expect the care services to come and take care of it all – then you become a burden' (observation notes, Sofie, care worker). Some of the care workers also talked about being proud of working in reablement, as this work saved taxpayers' money by reducing care expenses. In this approach, a position as dependent on care and a potential burden on municipal budgets now and in the future is seen as fundamentally undignified, and the care workers' pursuit of dignity for care recipients paradoxically seems to be marked by responsibilisation, and even disciplinary practices (*see also* Dahl, 2005; Marhánková, 2011; Mendes, 2013).

However, managing on one's own and becoming independent of care was not the only interpretation of dignity involved. Some care workers viewed reablement more as a question of sharing the work with their care recipients, a number of whom did not become fully independent of care despite reablement efforts. This notion of care as a form of co-operation was perceived by some care workers as a way to create more equal care relationships with the recipients. The striving for equality also had a bodily dimension and was related to the question of dignity. As Inger told me, she found that with reablement 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, you know? Or something like that. I think you can more easily 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 the bodily dimension of care workers' simultaneous disassociation from a position as subordinate to care recipients (reduced to a helping hand, there to serve the recipient) and a position as superior (the professional standing bent over the recipient, working on her or him).

It may seem obvious to presume that care interactions will be marked by the subordination of the care recipient, as he or she is dependent on the care worker's help. Furthermore, bodily care for older people often contains elements of a disciplining and controlling of bodies (*see e.g.* Lee-Treweek, 1997; Twigg, 2006). However, care practices in the Danish context also typically involve strong discourses positioning older care recipients as 'empowered', 'in control', as receiving a 'service' and as exercising power through choice. These discourses have especially flourished with New Public Management initiatives such as the construction of a consumer approach to care and 'free choice' of care providers (Rostgaard, 2006, 2011). Furthermore, bodywork interactions are saturated with complex power relations and status differences related to *e.g.* class, gender and racial inequalities (Wolkowitz, 2002, 2006). Power and status inequalities in care relationships are thus not clear-cut and given in advance, and, as Twigg has phrased it, depend on 'the particular dynamics of the exchange' (Twigg, 2006: 135) between care worker and recipient. In the quote above, Inger seems to perceive the co-operation involved in reablement as helping to level out the potential status inequalities and power relations of bodily care, and enabling the parties to act as autonomous equals by crafting dignity for both of them.

Yet another example of the understanding of reablement as a dignity-enhancing practice emerged when I was shadowing another care worker, Jane. I listened to her helping a care recipient, Lis, wash herself:

> I am standing in the corridor 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 advising Lis on how to wash herself – Lis does not say much:
>
> Jane: Can you wash a bit now, Lis?
> Jane: Have you got an itch? Shall I scratch it for you?
> Jane: You should put some water in the washbasin.
> Jane: We can take this [Lis' singlet, I presume] down a bit, so you can wash under your arms.
> Jane: Here's the flannel.
> Lis: What did you say I should do?
> Jane: You need to wash a bit. You can start, and then I can help you a little if you want.
> Jane: Would you like some soap on the flannel?
> Jane: Wasn't that nice to get some water on your face?
> Lis: Yes, it wakes you up, doesn't it?
>
> They continue like this for a while until Lis has finished washing and dressing. A little later in the day, Jane and I talk about this situation and about her detailed advice to Lis. Jane thinks of this as a 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 bodywork seems to be mostly done by Lis herself in this situation. With this division of labour, where Lis washes according to Jane's instructions, 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 (2000) has described, washing and bathing in care situations may be particularly coercive and disciplinary. Thus, Jane's attempt to make Lis feel included and let her wash herself (with instructions) aims to avoid potential 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 at de-objectification of a care recipient who seems very far from the ideal of being able to manage on her own.

Automatic toilets: dignity through automation and co-labouring

There are many parallels between reablement work and efforts to adopt new welfare technologies in care practices. In the case of automatic toilets (toilets which wash and dry the user after 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 autonomy is coupled with dignity: 'Where the wash-and-dry toilet is relevant for the care recipient, it contains great potential, both in terms of the care recipient's autonomy and dignity' (Rambøll, 2012: 6). In another policy document, care recipients' answers to a questionnaire on the topic are reported, including the following question: 'Do you have a positive attitude towards using the following welfare technology, if you had the need and opportunity: an automatic toilet that can wash and dry without the help of human hands?' (The Danish Agency for Digitisation, 2013). The automatic toilets are represented as avoiding 'help of human hands' in care. These understandings of the potentials of automatic toilets seem to draw on notions of dignity as managing on one's own, but add to this a dimension concerned specifically with avoiding physical boundary crossing in a very intimate care task.

In a similar vein, in one of the care centres studied, a connection was made between automatic toilets and ethical care practices: 'The staff find they can meet the residents' needs in an even more ethical manner, and can participate in a more supportive role' (PowerPoint presentation on the use of automatic toilets, care centre). According to this quote, using the toilets in care practices casts staff in a more supportive role (implicitly less likely to violate bodily boundaries), which is equated with more ethical care practices, *i.e.* those that conform to professional standards of good care. Along the same lines, we were presented with several 'success stories' from the care units, which described how automatic toilets had enabled care recipients to become independent of help with toileting, while some became independent of help altogether. For example, Susanne, a care co-ordinator, 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 experience improved 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 home care unit] plan, we have 'toilet visits' scheduled at specific times. That's obvious; we drive around according to a rota. So care recipients become more independent. They can go to the toilet when they want to and when they need to.

Susanne focuses on the potentials of 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 enhancing quality of life, in line with the ideals of achieving dignity through increased autonomy; with the automatic toilet you can go when you please, while with a care worker you have to wait until the scheduled 'toilet visit'. The automatic toilets are thus seen as meeting care recipient needs in a more timely and tailored manner. They may counter mismatches between standard institutional schedules (the toilet visits and rota mentioned above) and care recipients' immediate bodily needs and rhythms (*see also* Tufte, 2013). Such mismatches may lead to undignified situations (*e.g.* wetting oneself) and exacerbate the problem of indignity in public care services and the 'care crisis' (Wrede *et al.*, 2008; Calnan *et al.*, 2013; Fraser, 2016).

However, we were also presented with many examples where the automatic toilets did not enhance dignity in this manner, or where their use required a certain amount of support from care workers to do so. In one of our interviews, Heidi, a home care manager, told us about the difficulties often involved in using the automatic toilets:

> …it has its limits [the automatic toilet]. Even though it's good in theory and in principle, it's still 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, so you can 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 so 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 their physical build. And it would be nice to have systems like 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 bit more than just an automatic toilet.

As Heidi describes, the use of automatic toilets does not guarantee dignified care in the sense of increased independence of care. Rather, the toilets may involve considerable work to function properly for care recipients with differently shaped and sized bodies and various functional impairments, such as weak hands. Other care workers told us about lean care recipients who, if not helped to sit sufficiently far back on the toilet seat, would find the water from the toilet squirting up their back, creating a messy and undignified situation. Moreover, many care recipients, especially those living in care centres, had some degree of dementia or cognitive impairment. In many cases this made it difficult to establish a regular procedure for 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 toileting itself more independent. For the automatic toilets to work, a lot of 'articulation work' (Star and Strauss, 1999) is therefore necessary. Care staff are needed to support the use of the toilets to different degrees, if they are to be used at all, and if their use is to provide more dignified care. With Pols *et al.* (2018), one may say that dignity is co-laboured between the care recipients with their individual bodies and impairments, the automatic toilets and the care workers – and in these situations dignity is pursued in forms other than 'managing on your own'. Crafting dignity in this manner can be quite labour-intensive, thus counteracting the political agenda of saving labour.

An example of what I interpret as a pursuit of dignified care through co-operation involving a care recipient, 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:

> Jeanette and I go to Maren's flat 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 finished 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, on the back of the toilet seat, so the water will hit the right parts 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 has finished 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. Much work thus goes into making the technology function. Throughout the 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 urinating. But she also makes a point of using the wash function, even though it does not seem strictly necessary in the situation and certainly does not save 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, judging by 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 withdraw from the care situation, but works with the technology meant for this purpose to do something else: to add to the resident's enjoyment and quality of life by 'creating a bit of luxury', as she put it.

Concluding discussion

In the analysis above, I have shown how dignity in care for older people is pursued by care workers within a specific policy framework. In both reablement and practices with automatic toilets, dignity is framed as equal to increased autonomy, *i.e.* managing (more) on your own, or at least without the help of human hands. However, the care practices studied here show a more nuanced, but also contradictory, picture of how dignity is crafted in everyday care interactions, where care work is articulated as both a threat and prerequisite to dignity.

In many cases, the call for increased autonomy for care recipients resulted in care practices emphasising more distanced forms of bodywork. Dignity was crafted through the strategy of ‘keeping your hands behind your back’, through ‘motivational work’ and demands on care recipients, and through attempts at automation of intimate care tasks with the use of automatic toilets. In such cases, receiving care is viewed as involving violation of physical boundaries and dependency, and is thus implicitly seen as a threat to autonomy and dignity. Following this line of thought, care workers should ideally try to withdraw from care relationships to increase autonomy and dignity for older care recipients. Returning to Gilleard and Higgs’ observations on the fragmentation of old age, these approaches may be said to seek to overcome or postpone the loss of agency, control and independence related to the narrative of the fourth age. Instead, they link on to the more optimistic narrative of the third age, positing quality of life and dignified ageing as equal to an active life, independent of care (*see also* Hansen, 2016).

However, in other cases the studied care practices drew on different conceptions of dignified care. Dignity in care was also pursued through attempts to create more equal care interactions, and through guidance and supportive approaches, framing and creating care interactions, and the bodywork of care as co-operation between various human and non-human actors. In these cases, the policy imperative of increasing autonomy and independence of care is incorporated in care practices in a less radical manner. The ideal of autonomy is not dismissed, but achieving complete independence of ‘the help of human hands’ is not considered realistic. Age-related loss of bodily control and self-care ability is accepted, rather than looked upon as something to be overcome. Care workers’ crafting of dignity was thus aimed towards creating what Bødker *et al.* (2019) have termed ‘enabling arrangements’, an approach that considers independence as a negotiated, continuous and unstable accomplishment, relying heavily on relations with other humans (*e.g.* care workers) and non-humans (*e.g.* physical surroundings and technologies). This is illustrated in the case of Jeannette and Maren’s use of the automatic toilet and when Jane guides Lis in washing herself, where care workers carefully orchestrate a situation promoting a degree of independence and self-care in care recipients. In these situations care work becomes a prerequisite rather than a threat to dignity in old age, and care workers exhibit what Korczynski (2013: 28) has described as a ‘skillful search for dignity within body work interactions’.

The analysis presented here thus shows considerable variation between articulations and pursuits of dignity in care for older people. However, policy priorities, management strategy and the organisational cultures of health-care institutions shape how staff care for their patients, and thus their possibilities for providing dignified care for older people (Hillman *et al.*, 2013). While the policy agenda that frames dignity as equal to autonomy and independence of formal care (and implicitly dignity as distance and care as a threat to dignity) is not the only reference point for care worker pursuits of dignity, and does not entirely determine care practices, it has manifested itself as influential and transformative of many of the care interactions studied.

As mentioned earlier, the studies presented in this paper have a clear limitation in the non-inclusion of care recipients' voices on the crafting of dignity in practice. A review of Danish studies of reablement efforts (Petersen *et al.*, 2017) gives some indications of care recipients' experiences of the pursuit of dignity through increased autonomy and independence of care. The review points out that the care recipients interviewed were often quite motivated to become independent of care services for intimate bodily tasks (more so than for practical tasks such as vacuuming), thus lending support to the overall strategy of increasing their abilities to 'manage on their own' in these tasks. However, the review also shows how some care recipients reported a perceived loss of dignity when subjected to observations and assessments of their self-care ability during reablement processes. They found that the legitimacy of their expressing care needs and their self-assessment of such needs were questioned, and they were afraid of losing care services they found essential. The research on care recipients' experiences available so far thus paints a complex picture of both dignity-enhancing and dignity-reducing effects of programmes to promote independence of care, underlining the need for further studies that include care recipients' perspectives on the varied and situated articulations and pursuits of dignity in day-to-day care practices.

However, based on the studies presented here and others (*see* below), it does seem clear that if a narrow focus on dignity as independence of formal care is allowed to dominate the policy agenda and related priorities in the care field, a number of problematic effects for care recipients, and also care workers, may arise.

Firstly, as indicated by the studies reported here and others (Rabiee and Glendinning, 2011; Dahler, 2018; Bødker *et al.*, 2019), obtaining complete independence of formal care, through either reablement or technological automation, is unrealistic for some older care recipients. Framing dignity as equal to independence of care may have marginalising effects for this group, labelling their situation as undignified by definition and tying them to representations of dependency as an inferior state of life (Weicht, 2011), and to the narrative of the fourth age as a state of abjection and loss of control (Gilleard and Higgs, 2011). Secondly, some of the described attempts to craft dignity in line with this conception permeated care relationships with discipline and responsibilisation, where care workers *demanded* dignity in the form of independence of care from care recipients, and framed their expression of care needs as a lack of self-responsibility and as a burden to society. With this approach, ageing independently is framed as a duty, and care recipients failing to live up to this ideal as neglecting this duty (*see also* Mendes, 2013).

Thirdly, in close relation to the notion of care needs as burdensome to society, there is a risk that the quest for crafting a state of dignified independence for older care recipients may result in unmet care needs. A central tenet of the policy agenda is that increased independence of care will reduce public expenditure on care. In line with this, a recent report shows a significant reduction in the number of frail older persons receiving home care for practical tasks in Denmark (from 43% in 2007 to 25% in 2017) (Rostgaard and Matthiessen, 2019). One interpretation of this decline could be that independence-enhancing efforts such as those described in this paper, which have gained momentum in the report's timespan, have successfully reduced care needs. However, the report finds that the decline in the proportion of frail older persons receiving help cannot be explained by higher levels of autonomy/self-care; on the contrary, a large and increasing share of frail older people report experiences of unmet care needs. The drive towards increased independence and reduction of services thus certainly seems to have affected home care allocation practices, but the desired results in terms of more autonomous older people living more dignified lives through independence of care seem more difficult to achieve. The potentially increased experience of dignity through independence of care may very well be challenged by the likely indignities of living with unmet care needs.

Fourthly, the studied care workers' 'skilful search for dignity' in creating 'enabling arrangements' specifically suited to care recipients' individual situations and capabilities was quite labour-intensive and time-consuming. In a policy environment oriented towards expenditure cuts, such labour-intensive practices are unlikely to have high priority in time and resource allocation for care services. Lack of time to create enabling arrangements may result in care workers either refraining from engaging in their creation, or in 'invisible work' (Star and Strauss, 1999) carried out in addition to formally allocated services. Performance of such 'extra services' is a well-known and long-standing phenomenon in the care sector, related to care worker engagement in the wellbeing of care recipients, but often resulting in work intensification for themselves (*see e.g.* Wærness, 1984; Rasmussen, 2004; Kirchhoff and Karlsson, 2013).

To counter these problematic effects and potentials of the narrow pursuit of dignity as 'managing on your own' in current policy discourses, a more prominent focus could be given to approaches accepting vulnerability and dependency as a common human condition (Weicht, 2011). This entails valuing care, physical closeness and touch as a prerequisite rather than a threat to dignity for many care recipients. The studies presented in this paper show that initiatives to increase care recipients' autonomy may certainly contribute to crafting dignity in care, but cannot stand alone as a one-size-fits-all solution. They need to be supplemented by more person-centred approaches to care (*see e.g.* Leplege *et al.*, 2007; Wilberforce *et al.*, 2017). Much can be learned in this respect from close examination of care workers' day-to-day interactions with care recipients and their varied pursuits of dignity through creation of continuously adapted, person-specific and often quite labour-intensive enabling arrangements.

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Note

1 Training in gerontology and elementary nursing takes 14 months for social and health-care aides and 26 months for social and health-care assistants.

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