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PERSPECTIVE 3

Medical professionalism through the lens of dignity in older adult care

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Abstract

Medical professionalism represents the ethical and moral foundation of clinical practice. Within geriatric care, professionalism finds its most profound meaning through the preservation of dignity – a quality that safeguards the identity, autonomy, and humanity of older adults. This review explores how the concept of dignity integrates with the values and domains of medical professionalism, particularly in the care of frail, dependent, or cognitively impaired older persons. Dignity is multifaceted – comprising intrinsic, relational, and personal dimensions. In geriatrics, each of these becomes vulnerable to erosion through functional dependency, institutionalisation, or ageist attitudes. Professionalism thus extends beyond competence to encompass moral imagination and relational ethics. The clinician's duty is not merely to diagnose or cure but to affirm personhood through respect, truthful communication, empathy, and advocacy. Professional virtues such as altruism, integrity, and accountability gain tangible meaning when operationalised through dignity-preserving practices, such as inclusive decision-making, safeguarding privacy, and compassionate presence.

In resource-constrained contexts such as Sri Lanka, where systemic and cultural pressures often threaten humane care, reaffirming dignity is both a professional and a moral imperative. Professionalism in geriatrics is best understood as the daily discipline of dignity—an ethical commitment to recognise, respect, and uphold the humanity of older adults amidst vulnerability and decline. Such practice restores the moral heart of medicine and reinforces trust in the physician–patient relationship.

Keywords: dignity, medical professionalism, older adults, geriatric ethics, compassionate care, humaneness

Introduction

Medical professionalism is the foundation of the healing process, extending beyond the prowess and mastery of knowledge and skill. As a contract made with society, it is founded on trust, candour, responsibility, and duty, and is conducted with integrity. At its heart, it makes physicians obligated not to be mere instruments of clinical service but to be custodians and advocates of human dignity, especially when caring for the vulnerable.[1] This requires a reciprocation of unique moral urgency in geriatrics. Older adults, especially those who are frail, functionally dependent, or cognitively challenged, more frequently experience disturbance in autonomy, voice, and visibility. **Dignity** in such circumstances is not just an abstract thought or ethical principle, but a tangible experience affirmed or denied by interactions. Upholding the dignity of older adults is the clinician's primary task, whether through respectful communication, the protection of privacy, or inclusive decision-making.

There is a deep intertwining of dignity with identity and self-worth. Preservation of dignity is a key aspect of quality of life. However, in low and middle-income countries such as Sri Lanka, where existing health services are often exhausted and stretched by time constraints, workforce shortages, and protocol-driven care, dignity is at risk of being eclipsed by efficiency and expediency [2]. Both implicit and institutional ageism further compound this

problem. Seniors are frequently stereotyped as a burden, being deprived of intensive care or meaningful participation in their own treatment decisions. Additional challenges include **functional dependency** (undermining self-esteem), **cognitive decline** (complicating communication and consent) and **institutionalisation** (leading to depersonalised care).

The clinician stands at a significant moral crossroads in such adversity. While clinical knowledge guides management, the **moral compass of professionalism** ensures care is delivered in a way that affirms patients' humanity. Caring is not simply management of disease but preservation of identity, fostering dignity, and accompaniment of respect and compassion.

Domains of dignity

Dignity is a foundational concept in both ethics and professionalism, although it can be elusive in clinical practice. Dignity becomes increasingly fragile yet vital in geriatric practice, where patients often experience cumulative losses of health, independence, cognition, and social status. Healthcare professionals must first comprehend its multidimensional nature and how older individuals experience it. It can be conceptualised in three overlapping domains [3].

Intrinsic dignity: This is the inherent worth that every human being possesses simply by being 'human'. This is universal and inviolable, and it is not dependent on age, ability, or social contribution. Recognition of intrinsic dignity requires treating every older adult as a person of equal value, irrespective of conditions.

Relational dignity: Contrastingly, this is moulded on how a person is treated by others. It is upheld or violated through interactions, language, tone, and behaviour. A patient ignored, spoken over, or treated as an object rather than a participant may experience a deep assault even if clinical needs are technically met.

Personal dignity: This reflects a sense of self-worth, identity, and autonomy. It is deeply personal with the axe at functional dependency, public exposure of vulnerabilities or loss of roles/relationships that once gave meaning to life. Personal dignity is expressed through various preferences (e.g., modes of address, routines, rituals, decision-making processes).

Protecting dignity extends beyond good intentions, demanding deliberate, thoughtful action rooted in empathy and ethical awareness [4].

Dignity experienced by older adults

The experience of dignity can vary depending on the care environment and the attitudes of caregivers. As an example, a hospital admission can be both physically disorienting and emotionally dehumanising due to many factors. Privacy may be compromised by disregarding personal routines, while clinical decisions are made without adequate consultation. The erosion and deviation of social identity by retirement, bereavement, and reduced engagement can further compound the loss of dignity. Where productivity and independence are overly emphasised, older persons may feel invisible or burdensome, intensifying their vulnerability to undignified treatment.

Significantly, dignity is culturally mediated. In Asian contexts, such as Sri Lanka, notions of dignity are closely tied to interdependence, familial respect, religious beliefs, and the ability to maintain honour and modesty. This necessitates culturally competent care that respects these values rather than imposing Western ideals of autonomy in isolation.

The therapeutic relationship between a clinician and an older adult is inherently asymmetrical (expertise vendor vs. dependent, anxious, and vulnerable). The power imbalance casts an ethical burden on the clinician to create a space to hear the patient's voice while affirming personhood. Simple acts of introducing in consultation, seeking consent before touching, addressing by name and acknowledging life stories can be profound acts of dignity preservation. Conversely, failure in recognising the patient as a person with a past, a context, and a perspective risks reducing them to a diagnosis or a task.

Therefore, professionalism is not only clinical conduct but also a matter of moral imagination: the perspective not only of a body in decline but also of a human being deserving of presence, reverence, and relational respect. Understanding dignity as a living, relational, and contextual experience is the first step in reshaping the culture of geriatrics.

Professionalism through the lens of dignity

Medical professionalism is reflected in the core values of altruism, integrity, accountability, excellence, and respect [5]. These are operational principles that fashion every clinical encounter. Their significance is highlighted when dealing with older adults who are vulnerable, dependent, and at risk of being marginalised. The preservation of dignity is not ancillary to professionalism but rather its most profound expression.

Respect is perhaps the most immediately relevant dimension of professionalism in geriatrics. Extending beyond politeness, it acknowledges the patient as a moral agent, regardless of age, function, or cognitive ability. For those with cognitive challenges, it signifies addressing them directly, explaining procedures, and avoiding the common pitfall of speaking only to next of kin. Respect also requires safeguarding privacy, particularly in intimate care settings. It aims to preserve modesty, ensure appropriate draping during examinations, and minimise unnecessary exposure in shared hospital wards. These gestures restore a sense of control and personhood in depersonalised settings [6].

Altruism entails placing the needs and comfort of the older person above convenience or institutional pressures. Geriatric care often demands time, patience, and emotional presence. These elements are not easily measured but are critical to dignity-preserving practice. Compassion, when authentically practised, enables clinicians to see the suffering beneath the symptoms, the fear beneath the confusion, and the humanity within dependency [7].

Professionalism guided by compassion recognises that a hurried discharge or a mechanistic ward round may overlook essential human needs. A professional response might include sitting down, holding the patient's hand, or asking about their fears, values, and preferences. These simple acts often resonate more deeply with patients than complex interventions.

Older adults are frequently subjected to collusion under the pretence of protection. However, withholding information, even with benevolent intent, undermines dignity by denying the individual their right to truth and autonomy [8]. Professional integrity involves truth-telling with empathy. This means communicating honestly, while adapting the message to the patient's cognitive capacity, emotional state, and cultural context. Professionalism requires clinicians to avoid both brutal honesty and protective paternalism. It demands a balanced ethical sensitivity: to speak truthfully while affirming the patient's ability to engage meaningfully with their care to the greatest extent possible.

Patients with cognitive impairment, poor family support, or institutionalisation are at increased risk of neglect, mistreatment, and dehumanisation. In such cases, the clinician's professional responsibility expands beyond individual care to encompass advocacy. This includes lobbying for adequate staffing, agefriendly environments, and the removal of system-level barriers to dignified care [9]. Accountability also means recognising one's own implicit biases (including ageist attitudes) and actively working against them. Professionalism involves self-reflection, ethical vigilance, and institutional courage to challenge practices that compromise dignity, even when they are normalised within the healthcare culture.

Professional excellence is not measured solely by diagnostic acumen or procedural skill. Instead, it entails integrating biomedical knowledge with psychological insight, social awareness, and ethical reasoning. A clinician who excels treats not only the disease but the person in context, considering functional status, family dynamics, cultural beliefs, and existential concerns. Such holistic care demands clinical humility. It involves recognising that cure may not always be possible, but dignity can always be preserved [10].

Whether through pain relief, careful listening, or sensitive conversations about goals of care, the geriatrician's excellence lies in promoting well-being, even in the face of incurable illness.

Conclusions

Professionalism in geriatrics is inherently relational, emerging not only in algorithms or documentation but also in tone, presence, and the moral attention given to each patient. This relational nature makes it both deeply human and ethically demanding. In this way, professionalism becomes the daily discipline of dignity: an ongoing commitment to uphold the personhood of those who are often overlooked. Caring for older adults is not merely the management of disease but also the cultivation of respect, empathy, and ethical vigilance. Preserving dignity is not supplementary but a defining obligation of the clinician.

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