Capabilities Approach, the Dignified Life and Dementia
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Introduction

The claim I make and defend in this paper is that by utilising the capability approach in the care of dementia patients’, caregivers will both recognise, respond to and promote their patients’ dignity as well as demonstrate the virtue of respectful behavior. Regardless of how we define it, dignity demands recognition and response from others. The Capability Approach, particularly the way Martha Nussbaum articulates the approach, would be a practical means to promoting and enhancing the dementia patient’s dignity (or respect-worthiness as a human) and ensuring the patient is flourishing to the degree she is able within the limitations imposed by the disease.

I begin, in section one, by explaining why respect for dignity is important for the dementia patient. In part, my explanation disputes the utility of existing ethical principles invoked in the health care setting, particularly as those principles apply to the dementia patient. The claim I defend in section one is that these existing ethical principles do not adequately capture respect for the dementia patient. In section two I give a brief overview of the ways in which the Capability Approach has been applied to and used in health care. Some of those ways include: as a means of evaluating health related quality of life (Verkerk, Busschbach & Karssing, 2001) and evaluating supportive environments for the elderly (Gilroy, 2006); as an approach to understanding disability (Mitra, 2006); and as an approach to delivering patient-centred care (Entwistle & Watt, 2013). In section three I suggest that while not all ten core capabilities Nussbaum outlines as essential to the life worthy of dignity fall under the purview of health care
provision some do. I argue that promoting and enhancing specific capabilities (namely those that can be addressed in the health context) ensures the dementia patient is living a dignified life. In the fourth, and final, section I argue that by promoting the dementia patient’s capabilities caregivers are, a) respecting patients’ moral worth, b) helping patients be all they can be, and c) actively displaying the virtue of respectful behaviour.

Section 1

Dignity is invoked in a number of different contexts, including law, human rights and bioethics. It is rare to see a thick definition of dignity outside the work of Kant and his commentators. In my own research on the concept of dignity I generally see Kantian approaches at work. The glaring issue I see with Kant’s description of what dignity is, a value beyond mere price\(^1\), is that it is so closely tied to the presumed human capacity for moral autonomy it becomes practically useless for the person who lacks any of the rational capacities for autonomy. As long as dignity is so closely entwined with autonomy the entire notion of dignity, as conceptually distinct, becomes superfluous. Why have a separate concept for absolute moral worth if the human capacity for autonomy will do the job?

In a 2003 *BMJ* article, Ruth Macklin made the scathing claim that dignity is a useless concept in health care ethics and could be dispensed with entirely\(^2\). Macklin claimed that we already have ethical principles in place that adequately address whatever it is dignity is supposed to encompass. She claims that the principles of autonomy, respect for persons and beneficence

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\(^1\) Dignity on Kant’s account is an absolute value; an end in itself rather than of instrumental value.

easily address dignity concerns. Steven Pinker, in a 2008 article in the *New Republican*, was no less dismissive of the concept of dignity, stating the “problem is that ‘dignity’ is a squishy, subjective notion, hardly up to the heavy weight moral demands assigned to it.” I beg to differ. First, just because dignity is under-theorised (which I believe it is; particularly if all we have in terms of ‘respectable’ traditional scholarship on the concept is Kant’s work) does not mean it is a useless concept. A carefully theorised concept of dignity stands to be especially useful for the classes of patients who have limited, or perhaps entirely absent, capacities for autonomy. Consider, for example, the new born infant, the profoundly cognitively impaired or the dementia patient. None of these patients have autonomy in the relevant sense, yet most of us intuitively agree these patients have moral worth that demands our respect. The principle of autonomy, or more precisely respect for autonomy, simply does not tell us what it is about these types of patients that is worthy of our respect. At best, for the patient who will have or once had the capacity for autonomy, we could say the principle of respect for autonomy speaks to the patient’s past or future capacity. This still leaves some patients out in the cold.

What about the principle of respect for persons that Macklin refers to? On the face of it the principle of respect for persons ought to easily accommodate the non-autonomous patient. But we might want to dig a little deeper by asking, what exactly is a person? Or, the more pertinent question, what is it about persons that is respect-worthy? I am not going to delve into the first question – what exactly is a person – since this is only going to land us in murky waters. There are far too many diverging conceptions of personhood. On some accounts of personhood,

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3 The relevant sense of autonomy in the health care context is the ability to give informed consent for treatment. While the human infant will presumably one day have the capacity for autonomy, and the dementia patient once had this capacity, which might give us reason to offer them respect, what about the cognitively impaired who have never had the capacity for autonomy?
we might find ourselves obliged to show a particular type of respect to dolphins, great apes, and perhaps a few dogs; all of which I have no issue with, but I am concerned here with the world of health care provision to human animals. If we look to the Belmont Report’s account of what the principle of respect for persons means in practical terms we find that the principle effectively collapses into the principle of respect for autonomy or the principle of beneficence:

Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy. (Belmont Report 1978)

It is pretty clear what it means to treat an individual as an autonomous agent but what exactly does it mean to ‘protect’ those with diminished autonomy? I suggest protecting the individual with diminished autonomy falls under the purview of the principle of beneficence. So, for example, in the context of medical research (which is what the Belmont Report is intended to address) we could interpret the requirement to protect the potential research subject as acting in their best interests or perhaps promoting their best interests, which is precisely what the principle of beneficence requires of us. Presumably, then, if the potential research subject is unable to consent to participate then it is in his or her best interests to be excluded from the pool of potential subjects. While it seems that the aim of the principle of respect for persons is to include all potential research subjects, but it remains unclear to me what it is about the subject with diminished autonomy that is worthy of respect. Assuming I am correct in believing protecting those with diminished autonomy amounts to acting in their best interests, which just is the principle of beneficence in action, I am still left asking what it is about the individual that
demands our respect. The answer I have for this is dignity or the moral worth of the individual; and, further, that it is dignity that underlies the principle of beneficence, or for that matter the principle of respect for persons. Presumably what is respect-worthy about persons just is their moral worth. In which case, dignity is implicitly doing some work in the background when we invoke the principle of respect for persons or the principle of beneficence.

While I do not dispute the prominent and important role the principle of beneficence plays in health care – at the very least it is a professional duty of any health practitioner to act on the patient’s best (medical) interests – it is not obvious to me whether the ground of beneficent action has its source in the agent acting or in the subject toward whom the beneficent action is directed. If the ground of beneficence is something in the subject to whom beneficent action is directed, then what is it about the subject that is worthy or deserving? If beneficence finds its source in the agent who acts, then is the agent responding to something in the beneficiary of his or her action or is the agent simply acting on his or her ‘good character’? While I think it is a professional duty for health practitioners to act in ways that are ‘for the good of the patient’ I am not convinced beneficence in the health care context is about responding to something morally worthy in the patient. At least it is not clear that beneficence needs to involve responding to the patient’s moral worth. As I said above, if beneficence is about responding to the worth of the patient then there must be another principle at play. If beneficence is largely about the professional duty to act on the patient’s best medical interests, then we could insist the principle of beneficence is nothing more than a reiteration of professional codes of conduct. And, in practice, acting on the patient’s best medical interests need not involve any real show of respect for the patient as morally worthy. The focus of beneficent action in the health context needs to only be on the medical interests of the patient, and those interests tend to be determined by the
health professional rather than the patient. There is also the problem of genuinely understanding what the best medical interests of the patient are. For example, if we understand best interests of the patient to mean returning the patient to an optimal level of health then providing terminal sedation to the competent patient who is in unremitting pain would be deemed medically harmful action.

The point I am trying to make regarding the principle of beneficence is that it is not always clear a) what beneficent action is (i.e. is it focused on the patient as a whole multifaceted person or just on the patient’s medical well-being); b) whether beneficence is a professional duty, hence the obligation to act in the patient’s best interests (medical or otherwise) is just part of a professional code of practice; c) whether acting beneficently is part of the professional’s ‘good character’⁴, hence finds its source in the actor; or d) whether beneficent action is in response to something about the patient him or herself, in which case it could be argued that beneficent action responds to the moral worth of the patient.

Rather than borrowing from existing principles, and cobbling together the suitable bits and pieces from each principle, why not be clear about what it is about patients that is worthy of our respect? Consider the dementia patient whose autonomy is diminished, at least in the relevant ways (no clear ability to consent to treatment), and whose medical best interests might be, on the face of it, quite clear to the health professional. Taking care of the dementia patient’s medical interests stands to do very little, or not enough, for his or her potential to flourish in all areas of life. After all, good health is important for the good life (however defined) but there is more that can and should be addressed. Humans are social, needy, vulnerable, relational

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⁴ Virtue ethicists might be inclined to argue that beneficent action is a result of the agent’s good character, not so much a response to the morally worthiness of the beneficiary of the action.
creatures; if these elements of a distinctively human life are neglected the human in question is hardly living a life worthy of dignity. Implementing a capability approach to providing care for the dementia patient would be a means to respecting the patient’s dignity. But first we need to stop being wary of giving dignity a prominent role in health care ethics. The principles of respect for autonomy, respect for persons and beneficence do not directly capture respect for patient dignity:

“Concern about dignity is not only about respect for wishes or opportunities for flourishing; it is also about acknowledgement at a general level – giving respect or esteem that is each person’s due. This concern is not derived from other ethical principles but is … the object of a special virtue. Indeed this is particularly so in relation to conditions such as dementia where it is more of a challenge to express respect and self-respect.” (Jones 2015, 96)

Section 2

The Capability Approach is no stranger to the health care context and has been adapted and used, for example, as a tool for measuring health related quality of life (Verkerk, Busschbach & Karssing, 2001), as an approach to understanding disability (Mitra, 2006), as a tool for evaluating supportive environments for the elderly (Gilroy, 2006), and as a way to support ‘patient-centred’ care (Entwistle & Watt, 2013). The Capability Approach’s use as an evaluative tool in health research seems to be a natural extension of Sen’s more open ended and, arguably, flexible approach to the health research world. As a means to understand what it is to be disabled or as a way to conceptualise health the Capability Approach offers a path to better grasp what we mean by the terms disability and health, and, in turn, will have implications for possible policy change. Entwistle and Watt (2013) get fairly close to the way I suggest the Capability Approach could be used in individual patient care. My intention here is highlight a sample of the ways the Capability Approach has been taken to health related issues.
As an evaluative tool the Capability Approach has been suggested as a viable approach to measuring quality of life issues in a manner that avoids relying on a subjective notion of happiness. Verkerk, Busschbach and Karssing’s 2001 paper, “Health-related quality of life research and the capability approach of Amartya Sen”, makes a compelling case that Amartya Sen’s version of the Capability Approach gives researchers the flexibility to adapt to a specific context when designing quality of life questionnaires. They claim many of the standard quality of life questionnaires researchers rely on are too generic, hence lack the sensitivity to grasp what is important in terms of quality of life and will often overlook or be unable to capture the coping mechanisms research participants might use to deal with ill health. The Capability Approach’s differentiation between functionings and capabilities is the key to capturing some of the nuances many quality of life measures miss. By focusing on capabilities rather than functionings the difference between being capable of engaging in an activity, but choosing not to, and simply coping with a real inability to engage in an activity can be captured. For example, being able to move about freely in one’s community is the capability to choose to go out into one’s community, whereas actually opening one’s door and moving about in one’s community is the actual functioning. By adopting the Capability Approach a quality of life instrument can capture this very important difference. Once the lack of a particular capability is identified it can then be addressed. What is important, then, is not so much the functioning part (in my example above, the actual moving about in one’s community) but the capability (being able to move about in one’s community, if one chooses to do so). Perhaps the most significant nuance adopting a Capability Approach for quality of life measurements brings to the table is highlighting where institutional or policy change can improve quality of life and where personal characteristics of individuals make the difference.
Gilroy’s 2006 paper, “Taking a Capabilities Approach to Evaluating Supportive environments for Older People”, adapts the Capability Approach to a very particular case. The aim of the paper is to examine how places can either support or diminish older people’s quality of life as they define it. Drawing on existing research Gilroy’s paper suggests ways the environments, both physical and social, in which older people live could be improved. By focusing on what older people themselves have identified as significant the findings are especially useful for policy makers. For example, all too often policy makers focus on the needs of the frail elderly at the expense of those who do not see themselves as especially frail or vulnerable. What is needed is a broader look at possible environmental changes that could enhance feelings of independence and well-being for all older people, not just those identified as especially frail; many of these changes could be best addressed at a policy level.

Mitra’s 2006 paper, “The Capability Approach and Disability”, utilises the Capability Approach to help conceptualise disability in a manner that avoids the pitfalls of either the social model of disability or the medical model. The social model of disability tends to ignore the very real problems that come with a physical impairment by insisting disability is really just another social construct; that in fact disability is not an attribute of the individual but is created by the social environment, hence the solution to disability is social change (Mitra 2006, 237). The medical model denies any possible social bases of disability, instead viewing disability as an individual medical problem that requires fixing. Sitting somewhere between the social and medical models of disability is the World Health Organisation’s International Classification of Functioning, Disability and Health (ICF), which manages to capture how both social structures and the impairment itself contribute to disability. Mitra argues that the advantage the Capability Approach has over other models of disability is that it is better able to capture socio-economic
dimensions of disability. Although the ICF does consider economic achievements of individuals in terms of employment earnings and economic self-sufficiency, on the Capability Approach “poverty is seen as a factor that interacts with the individual’s characteristics and environment, leading to disability” (Mitra 2006, 242). The Capability Approach may not necessarily be a better approach to understanding disability than the ICF, but it does manage to encompass a broader range of potentially disabling factors in an individual’s life that the ICF tends to overlook in practice (Mitra 2006, 243).

Entwistle and Watt’s 2013 article, “Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care”, overlaps with my own thoughts on the way the Capability Approach could enhance patient care. Entwistle and Watt argue that incorporating the Capability Approach into person-centred care could offer much needed direction regarding what person-centred care requires in clinical practice. A particularly salient issue the authors point out is that person-centred care is either thought of as a set of processes, focusing only on its instrumental value, on the one hand, or thought of in terms of respecting patient preferences or choice, when those preferences or choices might not be well informed, strong or related to issues of any real significance (Entwistle and Watt 2013, 31). In the first case, thinking of person-centred care as a set of processes misses the point of person-centred care entirely by trying to create a recipe-like procedure for patient care that is then expected to work all the time and for all patients. In my view, this recipe-like procedure ignores the individuality and particularity of patients. In the second case, focusing too much on patient preference or choice places too much emphasis on patient autonomy; and, in my view, respect for patient autonomy is only one aspect of good patient care. Furthermore, for the dementia patient (and others with severely diminished capacities for autonomy) respect for autonomy is probably a
moot point. Even for the patient deemed autonomous being left to make choices about her health care options can be experienced as distressing and the patient may feel unsupported by her health care team. The authors argue that to be person-centred involves seeing the patient as relational rather than as an unfettered independent individual; the capabilities any individual have are at least somewhat constituted by her environment, relationships and social circumstances. What a Capability Approach can bring to the patient care context is a clear acknowledgement that a person’s capabilities are enhanced or diminished by social context, environment and relationships with others (including the health care team).

My aim in this section has been to showcase some of the ways the Capability Approach has been taken to the health care context. Its application as a measurement tool for quality of life shows its utility outside of the global social and political justice sphere; although, arguably, quality of life issues are social justice issues, particularly when quality of life can be improved at an institutional or policy level. My own interest in taking the Capability Approach to the health context overlaps well with Entwistle and Watt’s (2013) proposal that the Capability Approach be used to support person-centred care. I want to push a little further by looking at which of Martha Nussbaum’s core capabilities could effectively be promoted for dementia patients, and which capabilities fall outside of the purview of dementia care.

Section 3

Where Entwistle and Watt’s 2013 paper concentrates more on Sen’s broad conception of the Capability Approach I want to focus on Nussbaum’s version. I do this for two reasons: first, because Nussbaum is particularly clear that the Capability Approach, as she articulates it, needs to encompass the concept of dignity, and what a life worthy of dignity requires; second, because,
on her view, there are core capabilities that must be met for an individual to be living a life worthy of human dignity (See Nussbaum 2011, 31-33). In the health care context respect for the patient is often regarded as synonymous with respect for patient autonomy, which risks leaving patients with diminished capacities for autonomy in a questionable spot. Respect for the dementia patient needs to focus on something other than autonomy, that something I claim is dignity.

    Living a life worthy of human dignity requires, on Nussbaum’s account, that the ten Central Capabilities she outlines are adequately secured. These are: 1. Life. 2. Bodily health. 3. Bodily integrity. 4. Senses, imagination, and thought. 5. Emotions. 6. Practical reason. 7. Affiliation; being able to engage with others in various forms of interaction, and being free from humiliation and discrimination. 8 Other species; being able to live with and have concern for the natural world, including other animals, plants and nature. 9. Play. 10. Control over one’s environment; both politically and materially (Nussbaum 2011, 33-34). All of these apply to all people and are all the responsibility, but not necessarily exclusively, of government institutions. Nussbaum insists these core capabilities are not open to trade-offs; a nation cannot grant a greater amount of one capability at the expense of another (2011, 35). But since I want to take the approach to a very specific context – dementia care – I suspect not all of the core capabilities can or will fall under the purview of health care provision. Still, I think that since health care organisations are structured in an institutional fashion, with rules, policies and procedures guiding the actions of all those employed, incorporating the capabilities approach into individual patient care would be feasible and stands to enhance the patient’s experience. In the health care literature that looks at patient dignity, the recurring findings are that promoting patient dignity requires rather small behavioural changes on the part of health care professionals and that
patients themselves are quick to point out that respecting dignity is not the same as respecting autonomy (See Gallagher 2004; Badcott 2003; Holmberg, Valmari and Lundgren 2012; Wadensten and Ahlström 2009). Autonomy is a moot point for the dementia patient considering those who are in the moderate to advanced stages of the disease are in no position to make choices regarding their own health care (although they may be able to make some less risky health choices in at least some circumstances). Even though the dementia patient cannot be regarded as an autonomous rational decision maker (in most instances), she does still have the capacity to enjoy life and to flourish within the limits posed by the disease. Integrating the Capability Approach into patient care has the potential to ensure dementia patients are being and doing all they can be. I also see the capability approach as giving caregivers concrete direction on how to best help their patients live life to the fullest, and in doing so ensure their patients are living a life worthy of human dignity.

But which of the core capabilities can effectively be promoted in the health care context and which cannot? To varying degrees and in different ways all of the core capabilities can be promoted. The questionable capabilities are, in my view, the capability for practical reason; some aspects of affiliation; and some aspects of having control over one’s environment. I will begin by explaining why I believe these particular capabilities might not be ones that can be promoted in the health context; although, I do want to point out that these capabilities still can be and ought to be promoted at a governmental level.

For most dementia patients the capability for practical reason was a capability they once exercised regularly\(^5\) and, depending on the stage of the disease, they may still be practical

\(^5\) This might not be the case for some Down Syndrome dementia patients; although even in this case it would be presumptuous to assume an individual with Down Syndrome has no capacity for practical reason.
reasoners in many aspects of their day-to-day lives. Other than the patient in advanced stages of dementia, the ability to reason, to form a conception of the good, to make some choices (even if they are morally trivial) and to have some sense of agency are capabilities/capacities that are very much present, and ought to be promoted, protected and respected. However, there will be circumstances where the patient’s reasoning abilities or her capacity to form a conception of the good is clearly compromised, in which case it will be incumbent upon the health professional to either seek a surrogate to help, ideally someone who knows the patient well enough to know what her preferences are, or the health professional herself may need to take on the role of surrogate. In either case, we ought to resist the substituted judgement approach to choosing or reasoning on behalf of the patient. Substituted judgement claims that when faced with a serious care dilemma (often related to end of life care, but not exclusively) health professionals should seek to find out from the patient’s family what the patient would have wanted. The aim of substituted judgement is to respect patient autonomy even when the patient is clearly in no position to make health care decisions herself. However, there is good evidence that relying on substituted judgement often does not line up with what the patient herself would have wanted (See Torke, Alexander and Lantos 2008). Rather than relying on substituted judgement I suggest health professionals and family members “make decisions that consider the individual’s interests and values in the context of their current situation” (Torke, Alexander and Lantos 2008, 1516). In other words, the surrogate needs to see the patient’s life in all its richness by neither stubbornly holding onto the patient’s past interests, preferences, commitments and values nor by focusing solely on the moment at hand.

Affiliation and control over one’s environment are capabilities that might pose challenges in the health care setting, particularly considering the institutional style of living many dementia
patients will find themselves in (living in a long term care facility, for example). To the degree that the capability for affiliation involves being able to interact on a social level with others affiliation as a capability can be easily supported and promoted. What health professionals need to be mindful of is how they respond to dementia patients. Ensuring the patient is respected and treated as a dignified being whose worth is equal to that of others (Nussbaum 2011, 34) needs to be foremost in health professionals’ minds when interacting with individuals with dementia. In the institutional setting the patient may have very little control over with whom she interacts, and I think it is important that this aspect of institutional living is not overlooked and, when possible, the patient’s social preferences are respected. The capability for political participation is not a capability the health care professional would be able to effectively promote nor should he or she be expected to; promoting the capability for political participation sits well outside the responsibility of the role of health professional.

The remaining core capabilities can all be actively promoted and enhanced in the health context, and in the process of promoting and supporting these capabilities caregivers would be respecting the patient as a person worthy of a life of dignity as well as ensuring the patient is being all she can be within the limitations posed by the disease. The first three capabilities on Nussbaum’s list – Life, Bodily Health and Bodily Integrity – are all a natural fit with the health care setting considering that the health professional is predominantly concerned with the physical well-being of patients. For the dementia patient I think the more salient capabilities are those that address the patient’s ability to relate to others (both human and non-human), to express herself emotionally, to exercise her imagination, to engage her senses, and to play. Rather than standing back and leaving the dementia patient to simply exercise these capabilities to the best of her ability, the caregiver needs to actively promote and support the patient as she attempts to
exercise these particular capabilities. By actively supporting the patient the caregiver shows the patient she is respected, valuable and included.

**Section 4**

For the patient with dementia respect for dignity is part of ‘holding onto’ the person. By holding on I mean doing our bit to hold onto the person’s identity. Our identities are not created in isolation nor do they evolve in isolation. The constant creation and recreation of ourselves is always done with the help of others. We speak of dementia as a loss of self or more accurately, I think, a loss of identity. But I think the more accurate rendering is to say that dementia brings about the loss of some bits, the devolving of bits (only remembering distant memories), the unpredictable re-creation of bits, and, often, the unabashed revealing of bits of identity. Not so much that the person really loses themselves but that the person’s identity becomes unbounded in particular, and often surprising (sometimes good, but more often alarming) ways. As if the person’s identity container has sprung multiple small leaks. The duty of caregivers, family and friends is to respond to this leakiness with empathy and compassion; to do our best to refrain from shock, ridicule, pity and humiliation. Respecting dignity is part of holding onto the dementia patient’s identity.

By focusing on promoting the patient’s capabilities – especially the capabilities to relate to others, to engage the senses and imagination, and to play – caregivers have the opportunity to help patients be all they can be given the limitations imposed by dementia. Dementia patients in the more advanced stages of the disease will be unable to direct the course of their lives in any significant manner, but the capacities for engaging with their world through their senses, through imagination, through social interactions with others, and through play are still significant and
should be promoted. There is more to being human and living a life of worthy of dignity than our supposed ability to reason and our capacity for autonomy. This is especially so for the dementia patient (and any other patient whose cognitive impairment renders her unable to take significant control over her life), yet the dementia patient is still worthy of our respect and needs to be treated as a being of equal dignity. One of the advantages adopting a capability approach in the care of dementia patients is that it offers caregivers clear direction regarding how to treat patients with respect. While it may be the case that the dementia patient is no longer autonomous in the relevant way\(^6\) it is not the case that she is no longer able to live a life worthy of human dignity or that lacking the capacity for autonomy makes her less morally worthy. By emphasising the capabilities that are more to do with experiencing life (engaging the senses, imagination, relating to others etc.) rather than making rational choices about how to live life, caregivers will be helping their patients be all that they can be and acknowledging their patients’ moral worth. By promoting the dementia patient’s capabilities, caregivers can be assured they have treated the patient with respect, and in doing so have also explicitly, through their behaviours toward the patient, demonstrated the virtue of respect.

**Conclusion**

I began the paper by arguing the principles of beneficence and respect for patient autonomy cannot adequately capture respect for the patient whose capacity for autonomy is either entirely absent or significantly diminished. I concluded the first section by arguing that it is the patient’s dignity which demands respect, and that neither the principle of beneficence nor

\(^6\) In the medical context to be autonomous in the ‘relevant way’ is to be able to provide informed consent for treatment, which most cognitively impaired patients are unable to do.
the principle of autonomy can adequately capture respect for dignity. Adopting a capability approach to caring for dementia patients would give health professionals (and other caregivers) a practical guide for how best to treat dementia patients with respect. By focusing so heavily on the capabilities that are oriented toward every day experience – senses, imagination, thought; emotion; and play – it could be objected that by neglecting or glossing over the capabilities of practical reason, affiliation and control over one’s environment I am simply choosing the capabilities that suit my purposes. Further, that if a person lacks these capabilities she is not living a life worthy of human dignity. I have two responses. First, ensuring patients have the capabilities necessary for political engagement and choice (i.e. affiliation and control over one’s environment) is too much to ask from health care and/or health care professionals. The capabilities that address political engagement, choice, free speech etc. are well outside the responsibility of health care. Second, the capability for practical reason might not be entirely lost for the patient with dementia but it might only manifest itself in morally trivial ways, such as being able to make choices regarding the scheduling of a day’s activities or deciding what to eat. If practical reason includes having some agency over one’s life, then there is no good reason to assume all dementia patients are lacking in this regard. So, it may well be that the patient is deficient in these capabilities but only to the extent that these capabilities cannot always and consistently be transformed into actual functionings. Through the use of surrogates there may well be ways of transforming these capabilities into functionings, but health care and health professionals need not be the ones responsible. My choice to use Nussbaum’s ten central capabilities list is a practical choice. The capabilities Nussbaum outlines are clear, distinct and practical, which means they can provide real guidance for health professionals. Regardless of
how we conceptualise dignity, adopting the capability approach offers health professionals a guide for how to respect the patient’s dignity.
References


