

Journal Watch

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Full Reference: Chochinov HM, Krisjanson LJ, Hack TF, Hassard T, McClement S, Harlos M. Dignity in the Terminally Ill: Revisited. *J Palliat Med* 2006; 9(3): 666-71.

Abstract:

Background: Several studies have been conducted examining the notion of dignity and how it is understood and experienced by people as they approach death.

Objective: The purpose of this study was to use a quantitative approach to validate the Dignity Model, originally based on qualitative data.

Design: Themes and subthemes from the Dignity Model were used to devise 22 items; patients were asked the extent to which they believed these specific issues were or could be related to their sense of dignity.

Results: Of 211 patients receiving palliative care, “not being treated with respect or understanding” (87.1%) and “feeling a burden to others” (87.1%) were the issues most identified as having an influence on their sense of dignity. All but 1 of the 22 items were endorsed by more than half of the patients; 16 items were endorsed by more than 70% of the patients. Demographic variables such as gender, age, education, and religion affiliation had an influence on what items patients ascribed to their sense of dignity. “Feeling life no longer had meaning or purpose” was the only variable to enter a logistic regression model predicting overall sense of dignity.

Conclusions: This study provides further evidence supporting the validity of the Dignity Model. Items contained within this model provide a broad and inclusive range of issues and concerns that may influence a dying patient’s sense of dignity. Sensitivity to these issues will draw care providers closer to being able to provide comprehensive, dignity conserving care.

Comments

Strengths/uniqueness:

In this study, “feeling a burden to others” and “not feeling treated with respect or understanding” were identified as the most highly endorsed dignity related concerns. Different demographic populations were also studied and found to have varying dignity related concerns. Patients identified as having their dignity breached showed a trend towards endorsing more items as being associated with their dignity than those whose dignity was intact. Logistic regression further showed that “feeling life had no longer meaning or purpose” was the only item with predictive value in relation to a sense of dignity.

Weaknesses:

The patient population in this study had cancer. Individuals with terminal illnesses arising from non-malignant disease may have different dignity related concerns. Data in this study was collected mainly from an older population (mean age: 67years). Younger

patients may have different dignity related concerns based on their life experiences. The sample population was also not sufficiently culturally diverse to delineate cultural factors that may affect dignity. The authors also concede that the Dignity model is temporally unstable, that concerns may change as death draws closer.

Relevance to Palliative Care:

Physicians are less adept at recognizing and addressing psychosocial and existential aspects of a dying patient's care. The Dignity Model tries to breach the gap by identifying physical, psychological, social and existential issues which may impact on the patient's perception of self-worth and dignity.

By ascribing meaning to this period of their lives, and helping our patients find a sense of purpose, we can prevent them from feeling that they are burdensome or no longer worthy of respect