Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care

Kindness, humanity, and respect—the core values of medical professionalism—are too often being overlooked in the time pressured culture of modern health care, says **Harvey Chochinov**, and the A, B, C, and D of dignity conserving care can reinstate them

The late Anatole Broyard, essayist and former editor of the *New York Times Book Review,* wrote eloquently about the psychological and spiritual challenges of facing metastatic prostate cancer. "To the typical physician," he wrote, "my illness is a routine incident in his rounds while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity… I just wish he would… give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way."[1]

Broyard's words underscore the costs and hazards of becoming a patient. The word "patient" comes from the Latin patiens, meaning to endure, bear, or suffer, and refers to an acquired vulnerability and dependency imposed by changing health circumstances. Relinquishing autonomy is no small matter and can exact considerable costs.[2] These costs are sometimes relatively minor—for example, accepting clinic schedules or hospital routines. At other times, the costs seem incompatible with life itself. When patients experience a radical unsettling of their conventional sense of self[3] and a disintegration of personhood,[4] suffering knows few bounds. To feel sick is one thing, but to feel that who we are is being threatened or undermined—that we are no longer the person we once were—can cause despair affecting body, mind, and soul. How do healthcare providers influence the experience of patienthood, and what happens when this frame of reference dominates how they view people seeking their care?

Dignity and patienthood

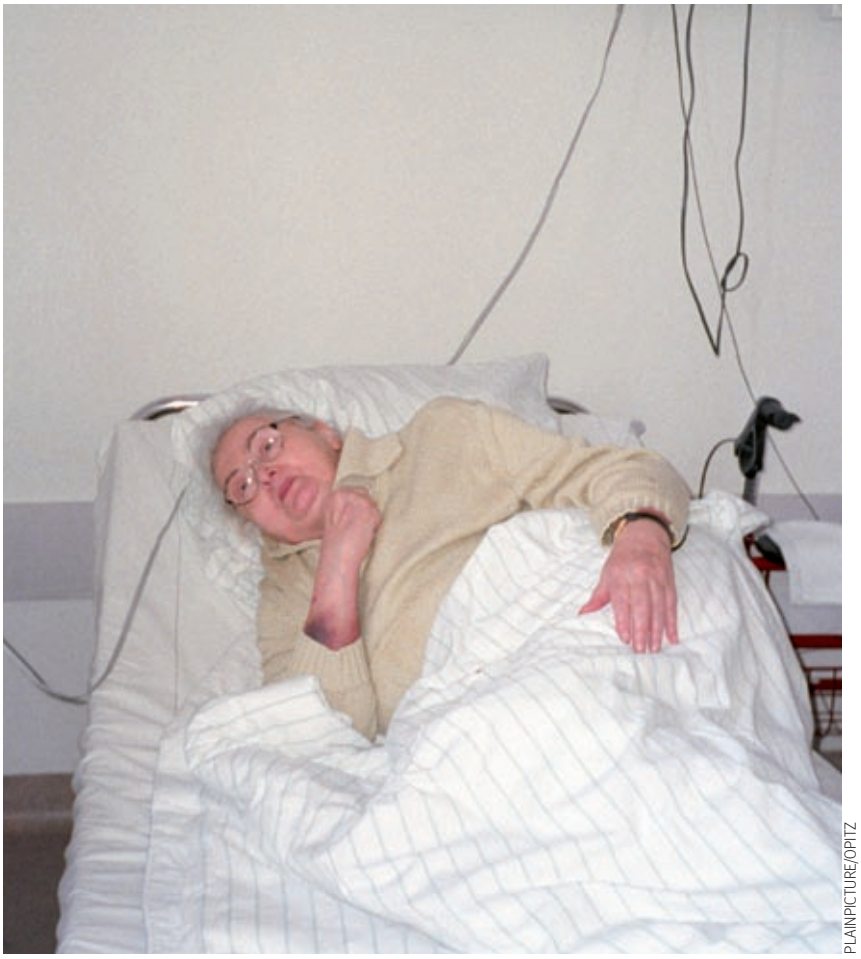
Answering these questions begins with an examination of the relationship between patienthood and notions of dignity. Although the literature on dignity is sparse, it shows that "how patients perceive themselves to be seen" is a powerful mediator of their dignity.[5 6] In a study of patients with end stage cancer, perceptions of dignity were most strongly associated with "feeling a burden to others" and "sense of being treated with respect."[7] As such, the more that healthcare providers are able to affirm the patient's value—that is, seeing the person they are or were, rather than just the illness they have—the more likely that the patient's sense of dignity will be upheld. This finding, and the intimate connection between care provider's affirmation and patient's self perception, underscores the basis of dignity conserving care.[8]

Yet, many healthcare providers are reticent to claim this particular aspect of care, which is variously referred to as spiritual care, whole person care, psychosocial care, or dignity conserving care.[9-12] This reluctance is often framed in terms of lack of expertise or concern about how much time this might consume. Yet, when personhood is not affirmed, patients are more likely to feel they are not being treated with dignity and respect.[13] Not being treated with dignity and respect can undermine a sense of value or worth.[5] Patients who feel that life no longer has worth, meaning, or purpose are more likely to feel they have become a burden to others, and patients

EDITORIAL, p 167

Harvey Max Chochinov
professor, department of psychiatry, University of Manitoba. CancerCare Manitoba, Winnipeg, MB, Canada R3E 0V9
harvey.chochinov@cancercare.mb.ca

Accepted: 15 May 2007



PLAINPICTURE/OPITZ

Box 1 | Attitudes

Questions to be asked

- How would I be feeling in this patient's situation?
- What is leading me to draw those conclusions?
- Have I checked whether my assumptions are accurate?
- Am I aware how my attitude towards the patient may be affecting him or her?
- Could my attitude towards the patient be based on something to do with my own experiences, anxieties, or fears?
- Does my attitude towards being a healthcare provider enable or disenable me to establish open and empathic professional relationships with my patients?

Actions to be taken

- Make a conscious effort to make these questions a part of your reflection on the care of each and every patient
- Discuss the issue of healthcare providers' attitudes and assumptions, and how they influence caring for patients, as a regular part of case reviews and clinical teaching
- Include ongoing professional development activities that have you challenge and question your attitudes and assumptions as they might affect patient care
- Create a culture among your colleagues and within your healthcare setting in which acknowledgement and discussion of these issues becomes a standard part of providing care

who feel they are little more than a burden may start to question the point of their continued existence.[14-16] Redressing the "incongruity" that Broyard raises—that is, the separation of humanity and compassion from healthcare delivery—requires that "treatment of disease takes its proper place in the larger problem of the care of the patient."[16]

The A, B, C, and D of dignity conserving care

The notion of dignity conserving care, while emerging primarily from palliative care, applies across the broad spectrum of medicine. Whether patients are young or old, and whatever their health problems, the core values of kindness, respect, and dignity are indispensable. Just as the simple "A, B, C" mnemonic (airway, breathing, and circulation) effectively summarises the fundamentals of critical care, an easily remembered core framework of dignity conserving care—the A, B, C, and D of dignity conserving care—may remind practitioners about the importance of caring for, as well as caring about, their patients.[16]

Attitude

"A"—attitude—underscores the need for healthcare providers first and foremost to examine their attitudes and assumptions towards patients. Attitude can be defined as an enduring, learnt predisposition to behave in a consistent way towards a given class of objects (or people), or a persistent mental or neural state of readiness to react to a certain class of objects (or people), not as they are but as they are conceived to be. The perceptions on which attitudes are based may or may not reflect the patient's reality. For instance, might an assumption of poor quality of life in a patient with longstanding disabilities lead to the withholding of life sustaining choices?[17] Might ageist assumptions mean that conversations about intimacy are rarely initiated?[18] Is a health worker more likely to assume intoxication in a confused, homeless patient, before considering whether they have a metabolic disorder? Do people with chronic mental illness provoke assumptions about malingering or somatoform disorders, even before an appropriate medical examination has been done?

Examining attitudes and assumptions is a deeply personal task, requiring approaches suited to the individual (box 1). At a minimum, healthcare providers must ask some basic questions, meant to help them understand how attitudes and assumptions can influence the way they deal with patients. They are reminded that "what they believe about patients and their potential may affect them profoundly. The attitude of an expert is contagious and can become limiting."[19] As a case in point, inordinately high suicide rates were reported among Scandinavian patients with advanced cancer, who were offered no further treatment or contact with the healthcare system.[20] While the rationale for this may have been based on considerations of resource allocation or medical futility, the psychological and spiritual fallout is clear: people who are treated like they no longer matter will act and feel like they no longer matter. In other words, patients look at healthcare providers as they would a mirror, seeking a positive image of themselves and their continued sense of worth. In turn, healthcare providers need to be aware that their attitudes and assumptions will shape those all-important reflections.

Box 2 | Behaviours

Disposition

- Treat contact with patients as you would any potent and important clinical intervention
- Professional behaviours towards patients must always include respect and kindness
- Lack of curative options should never rationalise or justify a lack of ongoing patient contact

Clinical examination

- Always ask the patient's permission to perform a physical examination
- Always ask the patient's permission to include students or trainees in the clinical examination
- Although an examination may be part of routine care, it is rarely routine for the patient, so always, as far as possible, take time to set the patient at ease and show that you have some appreciation for what they are about to go through (for example, "I know this might feel a bit uncomfortable"; "I'm sorry that we have to do this to you"; "I know this is an inconvenience"; "This should only hurt for a moment"; "Let me know if you feel we need to stop for any reason"; "This part of the examination is necessary because . . .")
- Limit conversations with patients during an examination (aside from providing them with instruction or encouragement) until they have dressed or been covered appropriately

Facilitating communication

- Act in a manner that shows the patient that he or she has your full and complete attention
- Always invite the patient to have someone from his or her support network present, particularly when you plan to discuss or disclose complex or "difficult" information
- Personal issues should be raised in a setting that attempts to respect the patient's need for privacy
- When speaking with the patient, try to be seated at a comfortable distance for conversation, at the patient's eye level when possible
- Given that illness and changing health status can be overwhelming, offer patients and families repeated explanations as requested
- Present information to the patient using language that he or she will understand; never speak about the patient's condition within their hearing distance in terms that they will not be able to understand
- Always ask if the patient has any further questions and assure them that there will be other opportunities to pose questions as they arise

Box 3 | Compassion

Getting in touch with one's own feelings requires the consideration of human life and experience

- Reading stories and novels and observing films, theatre, art that portray the pathos of the human condition
- Discussions of narratives, paintings, and influential, effective role models
- Considering the personal stories that accompany illness
- Experiencing some degree of identification with those who are ill or suffering

Ways to show compassion

- An understanding look
- A gentle touch on the shoulder, arm, or hand
- Some form of communication, spoken or unspoken, that acknowledges the person beyond their illness.

Behaviour

A change, or at the very least an awareness, of one's attitudes can set the stage for modified behaviour—the "B" of dignity conserving care. Once healthcare providers are aware that they play an important role in mediating patients' dignity, several behaviours should logically follow (box 2). Healthcare providers' behaviour towards patients must always be predicated on kindness and respect. Small acts of kindness can personalise care and often take little time to perform.[21] Getting the patient a glass of water, helping them with their slippers, getting them their glasses or hearing aid, adjusting a pillow or their bed sheets, acknowledging a photograph, greetings card, or flowers—these behaviours convey a powerful message, indicating that the person is worthy of such attention. Such behaviour is particularly important when caring for patients with advanced disease "both because of the physical threats of dying and because of the challenge to our sense of self worth and self coherence."[22]

Box 4 | Dialogue

Acknowledging personhood

- "This must be frightening for you."
- "I can only imagine what you must be going through."
- "It's natural to feel pretty overwhelmed at times like these."

Knowing the patient

- "What should I know about you as a person to help me take the best care of you that I can?"
- "What are the things at this time in your life that are most important to you or that concern you most?"
- "Who else (or what else) will be affected by what's happening with your health?"
- "Who should be here to help support you?" (friends, family, spiritual or religious support network, etc)
- "Who else should we get involved at this point, to help support you through this difficult time?" (psychosocial services; group support; chaplaincy; complementary care specialists, etc)

Psychotherapeutic approaches

- Dignity therapy
- Meaning centred therapy
- Life review/reminiscence

One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient

Certain communication behaviours, as outlined in box 2, enhance the trust and connection between patients and their healthcare providers. Certain intimacies of care require special mention—taking the time to ask patients their permission to perform an examination will make them feel less like a specimen to be poked and prodded and more like a person whose privacy is theirs to relinquish under mutually agreed conditions. This quality of professionalism and connectedness also increases the likelihood that patients will be forthright in disclosing personal information, which so often has a bearing on their ongoing care.

Compassion

Attitude and behaviour can be examined within the realm of the intellectual, but compassion, the "C" of dignity conserving care, requires a discourse about the healthcare provider's feelings. Compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it. Compassion speaks to feelings that are evoked by contact with the patient and how those feelings shape our approach to care. Like empathy (identification with and understanding of another's situation, feelings, and motives),[23] compassion is something that is felt, beyond simply intellectual appreciation. Healthcare providers arrive at compassion through various channels (see box 3). For some, compassion may be part of a natural disposition that intuitively informs patient care. For others, compassion slowly emerges with life experience, clinical practice, and the realisation that, like patients, each of us is vulnerable in the face of ageing and life's many uncertainties. Compassion may develop over time, and it may also be cultivated by exposure to the medical humanities (http://medhum.med.nyu.edu/), including the interdisciplinary field of humanities (literature, philosophy, ethics, history, and religion), social sciences (anthropology, cultural studies, psychology, sociology), and the arts (literature, theatre, film, and visual arts). Each of these will not speak to every healthcare provider, but they can offer insight into the human condition and the pathos and ambiguity that accompany illness.

Although the process of arriving at compassion can be difficult or complex, showing compassion often flows naturally and can be as quick and as easy as a gentle look or a reassuring touch. In fact, compassion can be conveyed by any form of communication—spoken or unspoken—that shows some recognition of the human stories that accompany illness. As Broyard stated in his wonderful way, "I'd like my doctor to scan me, to grope for my spirit as well as my prostate. Without some such recognition, I am nothing but my illness."[1]

Dialogue

Dialogue, the "D" of dignity conserving care, may be the most—and the least—important component of this framework. Through a genuine examination of attitudes that shape patient care, a change in behaviour

that draws from these insights, and the awakening of compassion, many fundamental aims of dignity conserving care will already have been achieved. The practice of medicine requires the exchange of extensive information, within a partnership whose tempo is set by gathering, interpreting, and planning according to new and emerging details. As such, dialogue is a critical element of dignity conserving care. At its most basic, such dialogue must acknowledge personhood beyond the illness itself and recognise the emotional impact that accompanies illness (box 4).

Several psychotherapeutic approaches (dignity therapy,[24] meaning centred therapy,[25] life review or reminiscence[26]) engage patients in more extensive, formatted dialogue, with the intent of bolstering their sense of meaning, purpose, and dignity (see further reading in box).[27] Dialogue should routinely be used to acquaint the healthcare provider with aspects of the patient's life that must be known to provide the best care possible. Treating a patient's severe arthritis and not knowing their core identity as a musician; providing care to a woman with metastatic breast cancer and not knowing she is the sole carer for two young children; attempting to support a dying patient and not knowing he or she is devoutly religious—each of these scenarios is equivalent to attempting to operate in the dark. Obtaining this essential context should be a standard and indispensable element of dignity conserving care. It will also foster a sense of trust, honesty, and openness, wherein personal information and medical facts are woven into a continuous and rich dialogue informing care.

Conclusions

In his 1927 landmark paper "The care of the patient" Francis Peabody wrote: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."[16] The A, B, C, and D of dignity conserving care may provide clinicians with a framework to operationalise Peabody's sage insight and relocate humanity and kindness to their proper place in the culture of patient care. Easy to remember and empirically based, this framework may be readily applied to teaching, clinical practice, and standards at undergraduate and postgraduate levels and across all medical subspecialties, multidisciplinary teams, and allied health professions. For anyone privileged to look after patients, at whatever stage of the human life cycle, the duty to uphold, protect, and restore the dignity of those who seek our care embraces the very essence of medicine.

Funding: HMC is supported by funding from the Canadian Institutes of Health Research and the Canada Research Chairs programme; his work is also supported by CancerCare Manitoba Foundation.

Competing interests: None declared.

SUMMARY POINTS

Healthcare providers have a profound influence on how patients experience illness and on their sense of dignity

Dignity conserving care has an important effect on the experience of patienthood

The A, B, C, and D of dignity conserving care—attitude, behaviour, compassion, and dialogue—provide a framework to guide healthcare practitioners towards maintaining patients' dignity

This framework can be applied to teaching, clinical practice, and standards at undergraduate and postgraduate levels and across all medical subspecialties, multidisciplinary teams, and allied health professions

1 Broyard A. *Intoxicated by my illness: and other writings on life and death*. New York: Ballantine, 1992.
2 Murata H. Spiritual pain and its care in patients with terminal cancer: construction of a conceptual framework by philosophical approach. *Palliat Support Care* 2003;1:15-21.
3 Burt R. *Death is that man taking names: intersections of American medicine, law, and culture*. Berkeley: University of California Press, 2002.
4 Cassel EJ. The nature of suffering and the goals of medicine. *N Engl J Med* 1982;306:639-45.
5 Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M. Dignity in the terminally ill: a cross-sectional, cohort study. *Lancet* 2002;360:2026-30.
6 Chochinov HM. Dignity and the eye of the beholder. *J Clin Oncol* 2004;22:1336-40.
7 Chochinov HM, Krisjanson LJ, Hack TF, Hassard T, McClement S, Harlos M. Dignity in the terminally ill: revisited. *J Palliat Med* 2006;9:666-72.
8 Chochinov HM. Dignity-conserving care—a new model for palliative care: helping the patient feel valued. *JAMA* 2002;287:2253-60.
9 Mount B. Whole person care: beyond psychosocial and physical needs. *Am J Hosp Palliat Care* 1993;10:28-37.
10 Safran DJ. Defining the future of primary care: what can we learn from patients? *Ann Intern Med* 2003;138:248-55.
11 Murillo M, Holland JC. Clinical practice guidelines for the management of psychosocial distress at the end of life. *Palliat Support Care* 2004;2:65-77.
12 Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol* 2005;23:5520-5.
13 Wilson KG, Curran D, McPherson CJ. A burden to others: a common source of distress for the terminally ill. *Cogn Behav Ther* 2005;34:115-23.
14 Chochinov HM. Burden to others in the terminally ill. *J Pain Symptom Manage* (in press).
15 McPherson CJ, Wilson KG, Murray MA. Feeling like a burden: exploring the perspectives of patients at the end of life. *Soc Sci Med* 2007;64:417-27.
16 Peabody FW. The care of the patient. *JAMA* 1927;88:876-82.
17 Stienstra D, Chochinov HM. Vulnerability, disability, and palliative end-of-life care. *J Palliat Care* 2006;22:166-74.
18 Lovell M. Caring for the elderly: changing perceptions and attitudes. *J Vasc Nurs* 2006;24:22-6.
19 Remen RN. The power of words: how the labels we give patients can limit their lives. *West J Med* 2001;175:353-4.
20 Louhivuori KA, Hakama J. Risk of suicide among cancer patients. *Am J Epidemiol* 1982;109:59-65.
21 Bollinger JL. Five dynamics in patienthood. *Bull Am Protestant Hosp Assoc* 1978;42:90-4.
22 Callahan D. Pursuing a peaceful death. *Hastings Center Report* 1993;23:33-8.
23 Spiro H. What is empathy and can it be taught? *Ann Int Med* 1992;116:843-6.
24 Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol* 2005;23(24):5520-5.
25 Breitbart W. Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. *Support Care Cancer* 2002;10:272-80.
26 Bulter RN. The life review: an interpretation of reminiscence in the aged. *Psychiatry* 1963;26:65-76.
27 Chochinov HM, Cann B. Interventions to enhance the spiritual aspects of dying. *J Palliat Med* 2005;8:S103-15.

FURTHER READING

Block SD. Perspectives on care at the close of life. Psychological considerations, growth, and transcendence at the end of life: the art of the possible. *JAMA* 2001;285:2898-905.

Breitbart W, Gibson C, Poppito SR, Berg A. Psychotherapeutic interventions at the end of life: a focus on meaning and spirituality. *Can J Psychiatry* 2004;49:366-72.

Bauby J. *The diving bell and the butterfly: a memoir of life in death*. New York: Knopf, 1997.

Charon R. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA* 2007;286:1897-1902.

Chochinov HM. Dying, dignity, and new horizons in palliative end-of-life care. *CA Cancer J Clin* 2006;56:84-103.

Lo B, Ruston D, Kates LW, Arnold RM, Cohen CB, Faber-Langendoen K, et al. Discussing religious and spiritual issues at the end of life: a practical guide for physicians. *JAMA* 2002;287:749-54.

Maguire P, Pitceathly C. Key communication skills and how to acquire them. *BMJ* 2002;325:697-700.

Sulmasy D. Spiritual issues in the care of dying patients: ". . . it's okay between me and God". *JAMA* 2006;296:1385-92.

Tulsky JA. Interventions to enhance communication among patients, providers, and families. *J Palliat Med* 2005;8(suppl 1):S95-102.