

Dignity Conserving Care and Dignity Therapy

Peter Huggard

Correspondence to: p.huggard@auckland.ac.nz

ABSTRACT

Dignity Conserving Care is a process whereby we examine our attitudes and behaviours towards our patients, and the ways in which we display compassion and conduct our conversations. Dignity Therapy is a therapeutic interview between a clinician and their patient near the end of the patient's life. This process is used to guide a clinician – patient interview that is structured so as to enable the patient to experience increased dignity in their final days alive.

Keywords

Dignity Conserving Care, Dignity Therapy

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*'I know a little bit
About a lot of things
But I don't know enough about you'*
Peggy Lee, 1946

Dr Tony Townsend opened his editorial on Generalism¹ in the December issue of *NZFP* with these words sung by Peggy Lee. The last verse of the song, written by Peggy Lee and her husband, guitarist Dave Barbour, is: *'I know a bit about biology,
A little more about psychology,
I'm a little gem in geology
But I don't know enough about you'*.

Not 'knowing enough' may mean that important information, and not that just relating to a patient's illness, but relating to the patient as a human being, may be missing. This gap in understanding may lead to a missed opportunity for clinician and

Peter Huggard is a senior lecturer in the Department of General Practice, School of Population Health, University of Auckland, and is the Deputy Director of the Goodfellow Unit. He teaches a postgraduate course in therapeutic communication and is in the final phase of a doctoral degree exploring compassion fatigue in doctors.



patient to maximise the therapeutic nature of their relationship. Dignity Conserving Care is an approach to 'learning more about you', and while the process has more recently focused on the therapeutic interaction between clinician and patient at the end of the patient's life – the Dignity Therapy model^{2,3} – the principles have application across both the life span of a patient and the professional life span of the clinician.

A recent visitor to New Zealand, Professor Harvey Chochinov, described Dignity Conserving Care as 'Old wine in a new bottle'. Professor Chochinov was in Auckland at the beginning of February to present a seminar on Dignity Conserving Care and conduct training on Dignity Therapy. He came as the first 2008 International Speaker in a joint venture programme between the University of Auckland's Goodfellow Unit, the School of Nursing, and Mercy Hospice Auckland.

This programme aims to attract world leaders in the area of palliative care to New Zealand. Professor Chochinov is internationally recognised as a leader in end of life re-

search. He is a Professor of Psychiatry, Community Health Sciences, and Family Medicine (Division of Palliative Care), University of Manitoba, and Director of the Manitoba Palliative Care Research Unit, CancerCare Manitoba, Canada. He holds the first Chair in Palliative Care Research in Canada.

Throughout the two days, Professor Chochinov linked clinical practice with empirical research when demonstrating the Dignity Therapy intervention as a means of ultimately improving the quality of care provided to patients and their families. Over 100 health professionals – nurses, general practitioners, medical specialists, counsellors, social workers, health researchers, hospice volunteers – attended a two-day training workshop. A central theme in the training was that all professionals have the opportunity to promote dignity with their patients, particularly with those whose lives are ending.

Dignity Conserving Care is a way of relating with patients which incorporates elements of the clinician's attitudes, behaviours, degree of compassion, and the structure of the dialogue between clinician and patient.

It is a way of being with the patient and can form the basis for all communication between clinicians and their patients. The framework for Dignity Conserving Care focuses on kindness, humanity, and respect. In Professor Chochinov's model, these key elements of empathic relationship are represented as an A, B, C, D model. This A, B, C, D model provides a structure to guide our interactions with patients.²

Using the A, B, C, D framework, certain questions and reflections of the clinician are suggested.

A (Attitude) leads us to consider our attitude and judgement towards patients, and the assumptions we might make. Suggested questions include:

- 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?

Actions include:

- Making a conscious effort to have these questions a part of your reflection on the care of each and every patient
- Create a culture among your colleagues and within your health care setting in which acknowledgement and discussion of these issues becomes a standard part of providing care.

B (Behaviour) talks to the nature of our interaction with our patients and the degree of professionalism we need to bring to that interaction. Important themes for consideration are:

- Treating 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
- 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

- Always ask if the patient has any further questions and assure them that there will be other opportunities to pose questions as they arise.

C (Compassion) focuses on the degree to which we connect with our own feelings and our consideration of human life and experience, and includes:

- Reading stories and novels and observing films, theatre, and art that portray the pathos of the human condition
- Considering the personal stories that accompany illness
- Experiencing some degree of identification with those who are ill or suffering
- Some form of communication, spoken or unspoken, that acknowledges the person beyond their illness.

D (Dialogue) is when we acknowledge personhood, and particularly the degree of distress our patients may be feeling. We need to learn what we can of our patients that can help us gain a greater understanding of them as a person. 'Dialogue' includes such statements as:

- *'This must be frightening for you.'*
- *'It's natural to feel pretty overwhelmed at times like these.'*
- *'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 sup-

port; chaplaincy; complementary care specialists, etc.)

These principles and actions come together to form the basis of a Dignity Therapy interview towards the end of the patient's life.⁴ Research with palliative cancer patients by Professor Chochinov's team found three major themes relating to how individuals experienced dignity as they approach death. They were: illness-related concerns, dignity conserving repertoire, and a social dignity inventory.⁵ These themes are further described in Table 1.

Using a Dignity Therapy framework, the clinician interviews the patient using a series of questions that aim to obtain information from the patient that is of importance to them – information that often tells the story of the significant events in their lives. The interview is audio-taped and a transcript given to the patient. Any editing of the transcript is only for the purpose of attending to pauses, silences, and improving the logical flow of themes. The patient can then choose, if they wish, to pass this on to their surviving family members. Questions guiding the interview process include:⁵

- Can you tell me a little about your life history – particularly those parts that you either remember most or think are the most important?
 - Are there specific things that you would want your family to know about you, and are there particular things you would want them to remember?
 - What are the most important roles (e.g. family, vocational, community service) you have played in life?
 - Why are they so important to you, and what do you think you accomplished in those roles?
 - What are your hopes and dreams for your loved ones?
 - Are there words or perhaps even instructions you would like to offer your family, in order to provide them with comfort or solace?
- While these questions are asked during an interview towards the end of

Table 1. Dignity conserving psychotherapy (Chochinov, 2008)

Major Dignity Categories Themes and Sub-Themes		
Illness-related concerns	Dignity conserving repertoire	Social dignity inventory
<ul style="list-style-type: none"> • Level of independence <ul style="list-style-type: none"> – Cognitive acuity – Functional capacity • Symptom distress <ul style="list-style-type: none"> – Physical distress – Psychological distress 	<ul style="list-style-type: none"> • Dignity conserving perspectives <ul style="list-style-type: none"> – Continuity of self – Role preservation – Generativity/legacy – Maintenance of pride – Hopefulness – Autonomy/control – Acceptance – Resilience/fighting spirit • Dignity conserving practices <ul style="list-style-type: none"> – Living 'in the moment' – Maintaining normality – Seeking spiritual comfort 	<ul style="list-style-type: none"> • Private boundaries • Social support • Care tenor • Burden to others • Aftermath concerns

a patient's life, the process of Dignity Conserving Care and the structure of the Dignity Therapy interview are as applicable at any stage of an interaction between clinician and patient – from the first time that they meet through to the closing stages of the patient's life. It is a process that we intuitively know, and is, as Professor Chochinov described, '*Old wine in a new bottle*'.

How does this work translate to use in New Zealand? What are the implications for clinical practice? There are several broad possibilities. Firstly, adoption of the general framework described above as Dignity Conserving care – the A B C D Model. Using this approach, and thinking in this way about our interactions with patients, offers us the opportunity to learn more about our patients and about ourselves – and it doesn't stop with patients. The application of these principles in all areas of communica-

tion – with our patients, their families, our colleagues, and in our private lives, offers us the opportunity to connect with others at a deeper and more meaningful level.

Secondly, taking the time to use the questioning approaches of Dignity Therapy enables a much closer connection with our patients towards the end of their life and offers them the opportunity to 'have a conversation' that may never have been had before for the lack of an interested, engaging and facilitative listener. Even if the full Dignity Therapy interview and feedback does not take place, questions suggested above may be interwoven into other communication and become a regular part of the interaction with patients at what may be a very vulnerable time in their life.

Thirdly, one might integrate the Dignity Therapy process with the biography services currently offered by many hospices. Biographers, usu-

ally volunteers, meet with patients who are terminally ill and record their life history. These histories are then produced in the form of a small book, and may include photographs from the patient or their family. Trained health professionals could facilitate a Dignity Therapy interview that may be given separately to the patient or could become part of the patient biography.

Lastly, the privilege of this much deeper intimacy and connection with patients may provide an opportunity for us to connect with our own mortality and raise thoughts that we may not have consciously considered, or perhaps consciously suppressed, in the past. This is a gift, and one to be used when reflecting on our personal and professional life – with family, colleagues, or within peer groups.

Competing interests

None declared.

References

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