Dignity and the Essence of Medicine: the A, B, C, and D of Dignity Conserving Care

1 a Look at the title of the text above and think about the meaning of 'Dignity Conserving Care'. How do you think this is best achieved?

b Brainstorm possible meanings for each letter of the mnemonic ABCD.

c Scan the text and check.

2 a Read Part I of the text and answer the questions.

1 What does the author mean by suggesting that healthcare workers could act as a mirror for the patient?

2 Small acts of kindness can have a bearing on the rest of a patient's care. How might this be the case?

Part I

Introduction

Perceptions of dignity are most strongly associated with "feeling a burden to others" and a "sense of being treated with respect." As such, the more that healthcare providers are able to affirm the patient's value – that is, seeing the person as they are or were, rather than just the illness they have – the more likely that the patient's sense of dignity will be upheld. The intimate connection between care provider's affirmation and patient's self perception, underscores the basis 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. The simple mnemonic 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.

A

Healthcare providers first and foremost need to examine "A" their attitudes and assumptions towards patients. However the perceptions on which attitudes are based may or may not reflect the patient's reality. For instance, is a health worker more likely to assume intoxication in a confused, homeless patient, before considering whether they have a metabolic disorder? Patients look at healthcare providers as they would a mirror, seeking a positive image of themselves and their continued sense of worth. A case in point: inordinately high suicide rates among Scandinavian patients with advanced cancer, who were offered no further treatment or contact with the healthcare system. 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 turn, healthcare providers need to be aware that their attitudes and assumptions will shape those all-important reflections.

B

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. 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. Getting the patient a glass of water, acknowledging flowers on a bedside table –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." 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 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.

b With a partner, devise a set of questions for self reflection to ensure that when meeting a new patient your attitudes and subsequent behaviour doesn't influence the care you give.

Example: *How would I be feeling in this patient's situation?*

c Compare your ideas with the rest of the group.

3 Take a minute to reflect on an instance in your professional or personal life where your behaviour made a difference. What was the situation and what was the eventual outcome?

4 Read Part II of the text and answer the questions.

1 To what extent is compassion intuitive?

2 According to the author, how can you go about improving your level of compassion?

3 What kind of information might you miss if you didn't communicate adequately enough with your patient? Give your own (or a possible) example of this.

Part II

C

Like empathy (identification with and understanding of another's situation, feelings, and motives), compassion is something that is felt, beyond simply intellectual appreciation. It refers to a deep awareness of the suffering of another coupled with the wish to relieve it. For some healthcare providers, 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 fields of humanities, social sciences, and the arts: reading stories and novels and observing films, theatre and art that portray the pathos of the human condition, or discussions of narratives, paintings, and influential, effective role models. 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.

D

The "D" of dignity conserving care, may be the most—and the least—important component of this framework. At its most basic, dialogue must acknowledge personhood beyond the illness itself and recognise the emotional impact that accompanies illness. 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; 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

Easy to remember and empirically based, the A, B, C, D framework may be readily applied to teaching, clinical practice within the healthcare profession; relocating humanity and kindness to their proper place in the culture of patient care. 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.

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5 The author talks about acknowledging the person and knowing the patient. Brainstorm the following:

1 Statements that indicate you acknowledge the person.

Example: *I can only imagine what you must be going through.*

2 Questions that show you want to know the patient.

Example: *What should I know about you [as a person] to help me take the best care of you [that I can]?*