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Salient Visionary Publications

Patient Dignity Inventory in Cancer Patients: A Narrative Review

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ABSTRACT

Background: Human dignity must be respected and preserved in all interactions between healthcare professionals and patients. The Patient Dignity Inventory (PDI) is a questionnaire designed to identify problems associated with the loss of dignity at the end of life.

Aim: This narrative review of the literature aims to investigate the use of the PDI tool in the context of the oncology pathway and to understand its implications for managing these patients.

Method: Multiple searches were performed in electronic databases: Medline (via PubMed), Web of Science, and Scopus. Keywords linked to Boolean operators were used to identify studies conducted in adults in oncology and palliative care, published in Italian or English from 01/01/2019.

Result: A total of 96 articles were found. Eight studies were included in the narrative review at the end of the selection process. All the studies in the selection were on the characteristics of the concept of dignity through the use of the PDI. The main factors investigated that influence patients' perceived dignity, are preservation of autonomy and hope, quality of communication, and time left for patients.

Conclusion: In the oncology pathway, the use of the Patient Dignity Inventory in clinical practice has the potential to benefit both patients and the care team, and to improve the quality of care.

Keywords: Oncology service hospital; Dignity Therapy; Terminal care; Patients right; Palliative care

INTRODUCTION

Human dignity is a universal concept that indicates the value of the human person and therefore, implies the recognition and respect for the fundamental rights of every individual such as freedom, equality, autonomy, and personal integrity [1]. In the health care context, an inpatient's personal dignity refers to the respect and value that is

attributed to his or her person at all stages of their health care experience [2]. This complex and multidimensional aspect is referred to by the World Health Organization (WHO) as a fundamental factor in the quality of health care, deeply embedded in the person-centered approach to care, which must be respected and preserved in all interactions between health care providers and patients [3]. In fact, the perceived sense of dignity is conditioned by the context of care relationships and preserved through care staff's affirmation of the patient's value [4]. For a patient, the value placed on their person takes the shape of being treated with respect, kindness, and compassion by health care personnel, respect for privacy and confidentiality of information, consideration of personal preferences and values, autonomy in making decisions about one's own health, and support offered to maintain people physical, emotional, and spiritual integrity [5]. The experience of illness can wound a person's identity by questioning their role in everyday life, or increase their vulnerability, due to loss of autonomy or the prospect of death [6]. People with cancer illnesses are among the most fragile individuals facing these difficulties. In the next twenty years, these patients are expected to increase in striking numbers and in younger and younger age groups [7]. In Italy, for example, in the period 2020-2023, new oncology diagnoses are estimated to increase by 5%, and for the next two decades this trend is expected to worsen [8]. The more health care providers are made aware of the types of distress related to loss of dignity in these patients, the more likely they are to be able to respond to them [9]. The Patient Dignity Inventory (PDI) is an instrument developed by Harvey Max Chochinov, a Canadian physician and researcher, to better understand the psychosocial and spiritual needs of terminally ill patients and to identify possible problems related to loss of dignity. It was constructed based on a model of the meaning of dignity consisting of three main dimensions (illness-related concerns, dignity-preserving repertoire, and social dignity inventory) and their sub-items. The PDI consists of a questionnaire consisting of 25 questions scored on a five-point scale ranging from "Not a problem" equivalent to a score of 1, to "An overwhelming problem" associated with the maximum score of 5 [10,11]. Following the respondent's cues, a brief individualized psychotherapy can be performed: Dignity Therapy (DT). Following a protocol, trained staff facilitate the patient's expression of thoughts, feelings, and memories, which are then put into a narrative document that the patient can share with a friend or person. DT is one of the most popular psychotherapies in palliative care settings. Countries such as Brazil [12], Korea [13], China [14], Mexico [15], Turkey [16] and Greece [17] have recently joined the nations that, like Italy [11], have already performed PDI translation and validation. In recent years, there has been increased interest around the preservation of dignity as a value of care, as well as on the differences in its perception that exist between patient, family member and health care provider [18].

This narrative review of the literature aims to investigate the use of the PDI tool in various oncology settings, and to understand its possible implications in the care pathway of these patients.

The research question of this narrative review of the literature is, "Does the use of the Patient Dignity Inventory bring benefits for the maintenance of dignity in patients and for the quality of care delivered throughout the oncology pathway?

METHOD

This is a review, developed in the following phases: identification of the topic and elaboration of the guiding question, definition of the inclusion and exclusion criteria, critical analysis of the selected studies, and the discussion of the main results and synthesis of the presentation of knowledge. The P.I.C.O. methodology was used for the search strategy, summarized in Table 1. Having identified the keywords these were combined with each other using Boolean operators, constructing search strings for each database (Table 2). The search of bibliographic sources was carried out by browsing Medine databases (*via* PubMed), Web of Science and Scopus in March 2024.

Table 1: P.I.C.O. Strategy.

ELEMENTS	KEY CONCEPTS	SEARCH WORDS
Population (P)	Adult cancer patients	" Cancer patients"; "End of Life"
Intervention (I)	Dignity assessment using PDI	"Patient Dignity Inventory"
Comparison (C)	No structured assessment approach	
Outcome (O)	Maintenance of personal dignity	"Dignity"

Table 2: Search strings.

DATABASE	SEARCH STRING
	"Patient dignity inventory" AND "cancer patients" AND "Dignity"
PUBMED	Limit: PUBYEAR from 2019 to 2024
	"Patient dignity inventory" AND "cancer patients" AND "Dignity"
WEB OF SCIENCE	Limit: "TOPICS", PUBYEAR from 2019 to 2024
	"Patient" AND "Dignity" AND "Inventory" AND "Cancer" AND"End of life"
SCOPUS	Limit: TITLE-ABS-KEY; PUBYEAR from 2019 to 2024

RESULT

From multiple searches, 96 citations published from 01/01/2019 in English and Italian were identified. After removal of duplicates, 59 citations were screened for relevance by title and abstract. Twenty articles were found to be potentially eligible and, after obtaining the full text, were evaluated for inclusion and exclusion criteria (Table 3). The study search and selection process are summarized in Figure 1 [19]. At the end of the process 8 studies were included in this narrative review (Table 4).

Table 3: Inclusion and exclusion criteria of studies in the narrative review.

INCLUSION CRITERIA	EXCLUSION CRITERIA
Oncology patients admitted to the wards of: oncology, oncology day hospital, palliative care 18 years old	Patients with non-oncological conditions, children or adolescents
Studies concerning the application of dignity assessment instruments with Patient Dignity Inventory	Studies that did not apply dignity assessment instruments
Published studies from 2019 to 2024	Studies beyond 2019
Studies in English or Italian	Other languages than Italian and English

Table 4: Characteristic of included studies.

Author	Year	Country	Desing	Methods	Objective of study	Summary of Resuts
Bovero et al. [20]	2023	Italy	Cross-sectional	Study of 207 cancer patients whose variables were assessed through the following rating scales: Patient Dignity Inventory - Demoralization Scale - Functional Assessment of Cancer Therapy Scale -Functional Assessment of Chronic Illness Therapy -Spiritual well-being, Brief Coping Orientation and Herth's Hope Index.	investigate Dignity-Related Loss of Personal Autonomy (DR-LPA) intended as loss of relational independence causing dignity-related distress	The study shows that functional, social, emotional, spiritual well-being, discouragement, as well as age and gender, emerged as significant predictors of dignity-related loss of personal autonomy.
Rantanen et al. [21]	2022	USA	Cross-sectional	Multicenter study of 331 elderly cancer patients undergoing palliative care. Examining demographic, religious, medical factors with the PatientDignity Inventory (PDI).	understanding of existential quality of life at the end of life	The study shows that improving the understanding of existential quality of life in elderly cancer patients receiving palliative care, including important clinical and religious factors, improves quality of life.
Andreis et al. [22]	2023	Italy	Descriptive	Study of 107 cancer patients administered two self-report questionnaires: the PatientDignity Inventory (PDI-IT) for measuring perceived level of dignity, and the Italian version of the Zimbardo Time Perspective Inventory scale (ZTPI)		The study shows the importance of a treatment pathway that integrates the constructs of Dignity and Temporal Perspective. Dignity and temporal perspective play a central role as indicators of quality of care.
Buonaccorso et al. [23]	2021	Italy	Retrospective	Study of 37 patients undergoing dignity therapy sessions. In which responses to two dignity therapy questions were thematically analyzed.		The study shows three significant themes: Meanings concerning present life and illness, including the experience of suffering; Thoughts and actions toward self, including ways in which patients felt alive; Thoughts and actions toward others, mainly about love for self and others.
Nunziante et al. [24]	2021	Italy	Descriptive (Feasibility)	Study of 28 patients submitted to both the PatientDignity Inventory and the Dignity Therapy Patient Feedback Questionnaire.		The study shows and supports the acceptability of PDI and nurse-led Dignity Theraphy in cancer patients in hospital settings.
A	2	I	D	Study of 250 cancer patients. Subjected to		The study shows that the nurse-patient

vestanet et al. [25]	019	ran	escriptive	the PatientDignity Inventory and the Nurse Quality of Communication with PatientQuestionnaire.		relationship score is significantly correlated with the patient dignity score.
Boveroet et al. [26]	2020	Italy	Survey	Study of 306 participants, divided into four groups according to their professional profile: 44 nursing assistants, 141 nurses, 89 physicians (oncologists, internists and palliative specialists). attending physicians) and 32 psychologists. Subjected to assessment with the Patient Dignity Inventory-Italian Version (PDI-IT) adapted for health care professionals and an ad hoc written interview.		The study shows that caregivers and nurses assigned higher scores to the PDI-IT subscales "Psychological distress," "Existential distress" and "Loss of purpose and meaning" than physicians. Psychologists assigned higher scores in the PDI-IT subscale "Existential distress" than physicians and lower scores in the PDI-IT subscale "Psychological distress" than caregivers and nurses. Nurses scored higher in the PDI-IT subscale "Social support" than physicians.
Boveroet et al. [27]	2021	Italy	Cross-sectional	Study of 350 cancer patients subjected to the Patient Dignity Inventory (PDI), Demoralization Scale (DS), Hospital Anxiety and Depression Scale (HADS), Functional Assessment of Chronic Illness Therapy (FACIT-Sp), and Visual Analogue Scale for Pain (VAS) and Herth Hope Index (HHI).		The study shows that hope is a basic need and tool for patients coping with their disease, it is essential to implement realistic and stage-specific interventions that facilitate hope and support patients in their search for meaning.

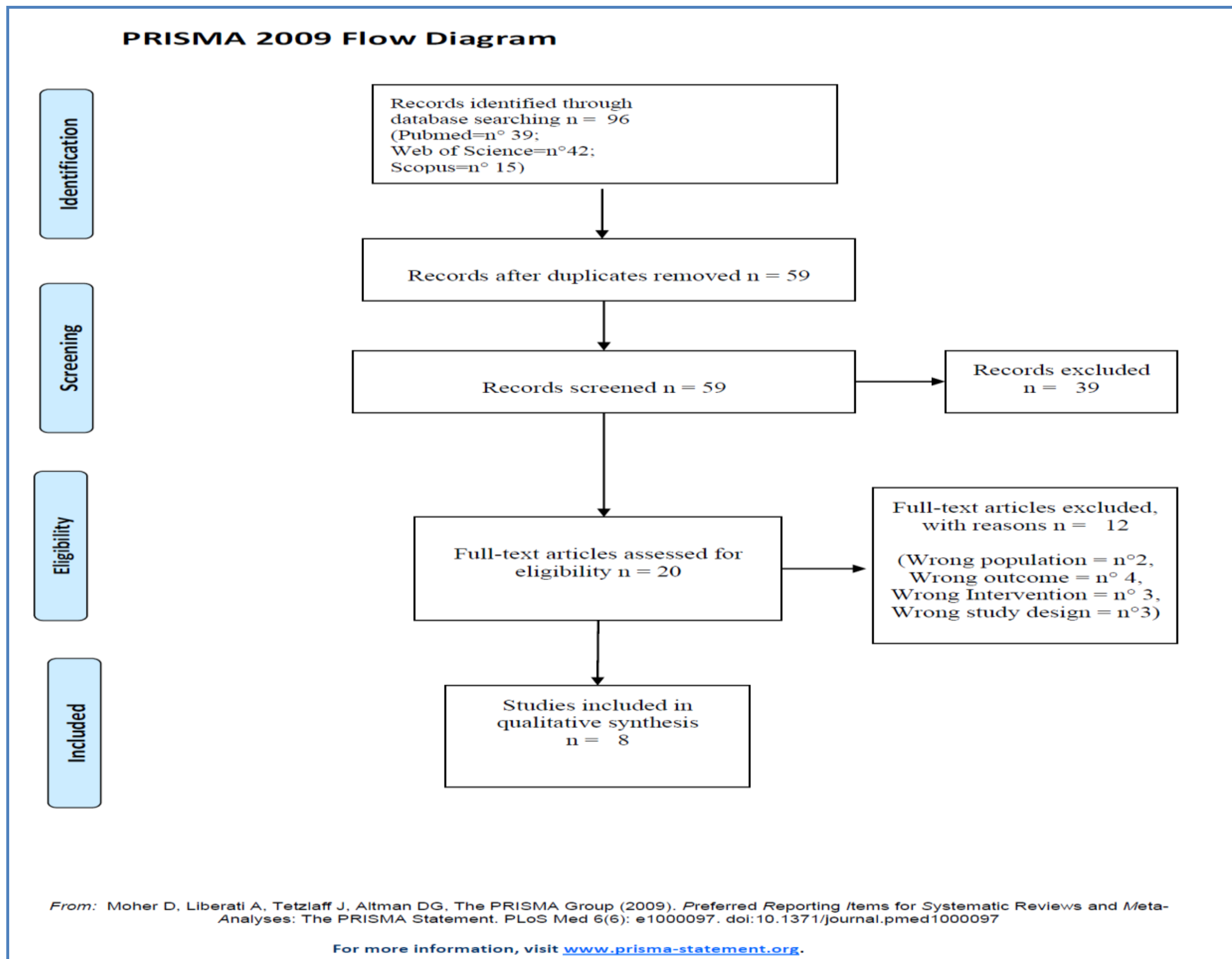

Figure 1: Research and selection process included studies.

DISCUSSION

Although its importance is well known, it can prove very challenging to establish an effective communication process for all parties involved. Indeed, communication with cancer patients, and their family members, is seriously affected by uncertainty about the future, high levels of stress, anxiety, depression, fear of death or physical or mental disability. These obstacles can limit open communication and, consequently, the understanding of patients' needs and expectations by their caregivers [25]. In the study by Bovero et al. [20], it is highlighted how the Patient Dignity Inventory offers patients the opportunity to express their concerns, wishes and preferences regarding care and quality of life. By completing the questionnaire, patients are encouraged to be actively involved in the planning and management of their care, enabling them to maintain autonomy in making choices during their illness and enhancing their sense of autonomy and self-determination. The specific areas of concern or discomfort that emerge allow health care professionals to tailor care in a way that respects the patient's preferences [20]. In agreement with work that identifies autonomy as a determinant of perceived dignity [6], Rantanen et al. [21] considering it a central

element in palliative care and its loss, correlates with physical, psychological or existential distress. Existential distress describes a form of psychological suffering related to existence itself. It is characterized by feelings of distress, upset or deep concern that arise when a person is confronted with questions regarding the meaning of life, death, freedom or about the sense of worthlessness. This type of distress becomes particularly relevant in crisis situations, such as in receiving a diagnosis of a cancer disease, or while coping with role losses and emotional challenges during the course of illness [21]. Andreis et al. [22] point out that existential crisis includes confrontation with time, death, uncertainty, loss of control, and loss of meaning when given profound changes in personal goals and roles. The avenue of communication offered by PDI supports health professionals in helping patients explore and cope with their distress, and in offering personalized interventions for support and better symptom management. In the psychological sphere of cancer patients, the temporal and dignity perspectives are strongly intertwined. Delineating the temporal profile in cancer patients provides an important indicator to guide supportive therapeutic work. Primarily to attempt to diminish the sense of distress and increase the sense of hope where there is an imbalance toward general pessimism [22]. Perceived hope wanes where fear of one's future, demoralization, anxiety and depression, fatigue and disabling symptoms prevail. But it increases when associated with spiritual well-being, thinking about life spent and recalling happy memories, and setting goals. Feeling that one has resources within oneself, that one is able to care for others and be cared for by them is directly proportional to the increase in hope [27]. For this reason, it is relevant to investigate what variables promote or hinder hope during the phases of a patient's illness and, with Dignity Therapy, offer the person a pathway for the maintenance of hope, as its understood to be the ability to perceive the continuity of meaning and purpose in one's life. Indeed, among the goals of Dignity Therapy is the promotion of generativity: a process through which patients invest in those they will leave behind. The generative document represents something that survives beyond their lifetime and leaves a memory for those left behind. This aspect, greatly felt by patients, becomes essential when facing an inauspicious prognosis or a prognosis of shortening their lives or reducing their activities. Indeed, knowing that their thoughts and words can be considered valuable by someone helps them realize that they are still perceived as people with values [23]. Over time, the Dignity Therapy protocol has been conducted by psychiatrists, psychologists, psychotherapists, social workers and nursing staff, after proper training and preparation. Nunziante et al. [24] investigated nurse-led intervention in hospital settings in Italy. This has been widely accepted and appreciated by patients, and it has also enriched professionals in terms of both personal and professional growth [24]. PDI also allows us to highlight perspectives on the dignity that doctors, nurses, and care support workers have. In agreement with the results of previous work [28,29], Bovero et al. [26] found that physical suffering, related to pain and other disabling symptoms, was indicated by all professional groups as the aspect with the greatest influence on patients' dignity, in the end-of-life phase. In addition, this work performed in various departments of a hospital setting showed that all health care professionals perceived a lack of information about patients' lives, but that this need could decrease for professions that, it is thought, establish relationships with patients characterized by closeness, intimacy and spending time together [26]. The use of PDI in clinical practice could also have a constructive impact in improving

communication among the practitioners involved, stimulating them to exchange knowledge and perspectives on patients, and increasing awareness of the complexity of dignity in the care team.

Dignity is a complex and multidimensional concept, and one of the elements that influences it is the quality of communication between patients and health care personnel.

CONCLUSION

From the included articles, it is clear that the use of PDI in clinical practice can positively influence cancer patients' maintenance of dignity, enabling them to maintain meaningful control over their illness experience. PDI is shown to be useful in enhancing the quality of time by allowing patients to focus on priority areas, and on promoting generativity, which has a significant impact on maintaining dignity. For the quality of care provided, it orients healthcare professionals toward the patient's "perspective," thus helping to create an environment that respects and supports individual needs. In summary, the integration of evaluative tools such as PDI and the consideration of time profiles can improve the overall care and well-being of cancer patients, respecting their dignity and supporting their hope during the disease journey.

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Ethical consideration

The literature review was guided by ethical conduct respecting authorship and referencing sources.

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