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The Health Care Providers' Perspectives on End-of-Life Patients' Sense of Dignity. A Comparison Among Four Different Professionals' Categories

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Abstract

The studies on terminally ill patients' dignity as perceived by health care providers (HCPs) in palliative care are growing. The comparison of different HCPs' perspectives in particular is necessary to explore how HCPs perceive patients' dignity in order to promote reflection on this core issue. This study aimed to investigate the perspectives on end-of-life patients' sense of dignity among four different categories of professionals: nurse assistants, nurses, psychologists, and physicians. A sample of 306 HCPs completed the Patient Dignity Inventory-Italian Version (PDI-IT) adapted for them and an ad hoc semi-structured written interview. Their responses were then analyzed using frequencies of the answers to the PDI-IT, a multivariate analysis of variance, Pearson's correlation index, *t* tests, and content analysis. All HCPs scored the relevance to the dignity-related physical aspects highly, followed by the psychological distress. Nurse assistants and nurses provided higher scores on the psychological and existential and spiritual PDI subscales than the other HCP groups. The social sphere was evaluated as the least salient for the patients' sense of dignity. Physicians who attended a course on dignity considered the psychological and existential dignity dimensions more. Differences in role and expertise could lead to different HCPs' perspectives on dignity, while the multidisciplinary work could favor their aligning. Therefore, it is essential to encourage HCPs' communicative exchange and reflective awareness through training, i.e., courses, seminars, and focus groups. These developments could promote increasingly adequate patient-centered care.

Keywords Dignity · Health care providers · End-of-life patients · Cancer · Palliative care

Introduction

In the past two decades, dignity has become a core theme in palliative care. Dignity can be defined as a multidimensional construct deriving from conceiving own Self through internal representations and the relationship with others [1, 2]. The dignity model, developed by Chochinov and colleagues [2, 3], identifies the main aspects that can affect patients' dignity: *illness-related concerns* (physical and psychological symptoms, directly related to the clinical conditions); *dignity-conserving repertoire* (internal resources, based on patients' prior experiences, psychological states, and spirituality); and *social dignity inventory* (factors related to the social environment affecting patients' sense of dignity). Subsequently, Chochinov and colleagues (2008) created the Patient Dignity Inventory (PDI), an instrument designed to explore the various sources of dignity-related distress [4]. Chochinov et al. (2012) have shown the PDI usefulness in detecting dignity-related concerns and enabling clinicians to provide more targeted therapeutic treatment to patients' needs [5].

As regards patients' care, a recent review by Guo and Jacelon (2014) demonstrated that, specifically in the context of palliative care, patients' sense of dignity is preserved in the following conditions: perceiving minimal physical distress; receiving limited invasive treatments; being treated as a human; maintaining, as long as possible, independence and autonomy; achieving own spiritual and existential goals; having privacy; maintaining meaningful relationships; and receiving dignified care [6]. All these aspects are essential components of a successful care process. Their assessment and

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safeguarding are crucial, since in the terminal phase, the patient's dignity could be threatened and profoundly impaired, affecting the patient's psychological and spiritual well-being and quality of life and death [7].

Relatively to the relationship between patients' dignity and health care providers' (HCPs)' cares, Ferri and colleagues (2015) stated: "[…] whereas the hospital environment should provide the physical and managerial facilities for promoting patients' dignity, each individual staff member must promote patients' dignity through their own behavior and must be aware of their impact on patients' vulnerability." [8]. Therefore, investigating HCPs' perceptions of patients' dignity appears to be necessary to improve interventions aimed at preserving dignity [9–11].

The HCPs' point of view on patients' dignity has been explored in several studies in different care settings with different types of patients, such as in the hospital emergency setting, hospital surgical acute ward, and in nursing homes [12–15], as well as comparing patients' and caregivers' perspectives [6–20]. Since the construct of personal dignity includes the features of unicity and individuality, patients', caregivers', and HCPs' perceptions and conceptions of dignity could be different, as highlighted by some of the abovementioned studies. Researchers found that physicians tend to focus mostly on physical aspects of dignity-related concerns, while patients and family caregivers usually have a broader perspective, including psychosocial and spiritual concerns [16, 19, 21]. Furthermore, holding different roles in the end-of-life care process might influence the perceptions on terminally ill patients' dignity.

The awareness of these different points of view might help implementing a high-quality health care in the palliative setting [16]. The previous research studies on HCPs' perceptions of patients' dignity, to our knowledge, had mainly a qualitative approach (i.e., semi-structured interviews, focus group) [12–15, 18, 22–24]. Such studies focused their attention on the staff members' thoughts on patients' dignity, mainly using the focus group as investigation instrument. Only Oosterveld-Vlug and colleagues compared different HCPs' perceptions, in particular the physicians' and nurses' perspectives, and highlighted how they had a similar consideration of both the physical and psychosocial aspects associated with patients' dignity [14]. Moreover, regarding methodology, only Albers and colleagues used a quantitative method, by comparing physicians' and volunteers' perspectives through the PDI [19].

Due to the lack of specific assessment of the HCPS' point of view on dignity using the PDI, and following the suggestion to implement the research on dignity from the HCPs' perspectives, the aim of this research was to first compare the perceptions of the patients' dignity among nurse assistants, nurses, physicians, and psychologists involved in hospital end-of-life care, in order to examine differences and similarities among their perspectives. The second aim was to evaluate whether HCPs' years of service and trainings on the topic of dignity might be associated to a greater sensitivity towards this core clinical issue.

Methods

Setting and Sample

The sample was recruited from March to October 2017, at "Città della Salute e della Scienza" Hospital of Turin. All participants at the time were HCPs employed at the hospital (i.e., being in regular contact with patients) and provided care to terminally ill patients. The aim of the enrollment was to engage HCPs with different job profiles. Recruitment consisted in the selection of different wards of the hospital, where usually terminally ill patients are treated, such as Dermatology, Oncology, Internal Medicine, Hematology, Geriatrics, General Medicine, Urology, and Psycho-Oncology. The interviewers presented the research to the HCPs of the abovementioned wards explaining that, to participate in the research, they should have provided care to at least one terminally ill patient. The consent form and the tools used for the study (the PDI-IT and an ad hoc interview) were left in the common areas dedicated to the staff members of each ward so that the HCP interested in participating in the research could anonymously complete the forms.

A total of 357 HCPs participated in the study of which 51 had incomplete data. Therefore, the final sample consisted of 306 participants, who were divided into four groups according to their job profiles: 44 (14.4%) nurse assistants, 141 (46.1%) nurses, 89 (29.1%) physicians (oncologists, internists, and palliative care physicians), and 32 (10.5%) psychologists. Each participant had experiences with terminally ill patients. Participants completed the Patient Dignity Inventory-Italian Version (PDI-IT) adapted for the HCPs and an ad hoc written interview. The research was approved by the ethics committee of the "Città della Salute e della Scienza" Hospital of Turin. Informed consent was obtained from all the participants.

Data Analysis

First, the answers to the PDI-IT were analyzed, comparing the PDI-IT mean scores obtained from the four groups of HCPs. The average scores at the PDI-IT subscales, the average scores on each item, and the percentage of "4" and "5" responses for each item were examined. The average scores obtained by the professional groups were compared using an ANOVA. The associations between the PDI-IT scores and the participants' age and years of service were analyzed using Pearson's correlation index. The association between having attended a course on dignity and the PDI-IT scores was analyzed using *t* tests. The need for additional information on the patients' life was explored through content analysis. All assumptions of the statistical procedures were checked, and all the tests were two-sided; *p* values less than 0.05 were considered statistically significant. Statistical analyses were executed using the software SPSS Statistics Version 24.0 (IBM Corp. Armonk, NY, USA).

Measures

Patient Dignity Inventory-Italian Version

The PDI-IT [25] is a 25-item self-report questionnaire, which explores various sources of dignity-related distress. The test is tailored for end-of-life patients; however, in this study, the instrument was administered to HCPs. The instructions of the questionnaire were modified, resulting in: "Thinking about your experience as a HCP, could you please indicate the extent to which each of the following items is relevant with respect to end-of-life patients' sense of dignity?" The items were scores using a 5-point Likert scale, ranging from 1 (not a problem) to 5 (an overwhelming problem), and the HCP rates how much each of the items represents a concern relating to dignity-related distress. The test includes five subscales: "Psychological Distress," "Social Support," "Physical Symptoms and Dependency," "Existential Distress," and "Loss of Meaning and Purpose."

Ad hoc Interview

During an interview, we collected socio-demographic information such as sex, age, years of service, and job profile, and participants were asked if they have ever attended any types of training on the topic of end-of-life dignity (i.e., courses, seminars, lessons, congresses, and practices). Moreover, participants were asked (1) to order the physical, psychological, existential, and social dimensions related to the patients' dignity, according to the relevance of each area for a hypothesized clinical intervention (the areas referred to the dignity dimensions evidenced through the PDI-IT) and (2) to answer to the following questions: "Thinking about the development of an appropriate intervention on the patient's dignity, do you need to receive more information on the patient? If yes, which kind of information?"

Results

Socio-demographic Characteristics of the Sample

The sample consisted of 306 HCPs, of which 44 (14.4%) were nurse assistants, 141 (46.1%) nurses, 89 (29.1%) physicians, and 32 (10.5%) psychologists. Most of the participants were female ($n = 231$, 75.5%). The participants' average age was 43.70 years (sd = 10.72; range 22–69), and their average years of service was 16.42 years (sd = 11.28; range 1–42). Eighty-one participants (26.5%) attended at least one course on dignity.

PDI-IT Scores of the Four Professional Groups

By analyzing the intra-group scores, the nurse assistant group scored the "Psychological Distress" and "Physical Symptoms and Dependency" PDI-IT subscales the highest, while the nurse, physician, and psychologist groups scored the "Physical Symptoms and Dependency" PDI-IT subscale the highest. Every group scored the "Social Support" PDI-IT subscale the lowest.

Regarding the between-group comparison, the PDI-IT scores significantly varied according the different professional groups (F (25, 264) = 5.17, $p < .001$). Nurse assistants and nurses assigned higher scores on the "Psychological Distress," "Existential Distress," and "Loss of Purpose and Meaning" PDI-IT subscales with respect to the physicians. Psychologists assigned higher scores on the "Existential Distress" PDI-IT subscale than physicians and lower scores on the "Psychological Distress" PDI-IT subscale than nurse assistants and nurses. Nurses scored the "Social Support" PDI-IT subscale higher than physicians.

Significant inter-group differences emerged with regard to the single PDI-IT items. Nurse assistants and nurses considered the sense of uncertainty, acceptation, and combativeness (Psychological Distress) and the routine activity maintenance (Physical Symptoms and Dependency) as important/overwhelming problems for patients' dignity more frequently than physicians and psychologists did, and the continuity of the Self and the maintenance of values and roles (Existential Distress) and the meaning of life (Loss of Purpose and Meaning)—more frequently than physicians. Psychologists considered patients' dignity and the feeling of being a burden to others as an important/overwhelming problem more frequently than physicians, and the sense of control over one's own life (Existential Distress) with a higher frequency than nurses.

Regarding the similarities, nurses and nurse assistants on one side, and physicians and psychologists on the other, had similar average scores on the "Psychological Distress" subscale, while nurses, nurse assistants, and psychologists had similar average scores at "Existential Distress" and "Loss of Purpose and Meaning" subscales. A consistency in the average scores also became apparent with respect to the items relating to the following concerns: depression, anxiety, worries about the future, the perceived support received by providers, autonomy, and physical distress. Therefore, for more than half of the PDI-IT items, nurses' average scores were similar to nurse assistants' ones, and physicians' average scores were similar to psychologists' ones.

Finally, almost all average scores on the items in the sample were between 3 and 4.5. The results are reported in Table 1.

Top 10 Items for the Four Professional Groups

From the answers given to the PDI-IT items, a top 10-item list, representing the ten items with the highest frequency of "4"

Table 1 PDI-IT scores in the four professional groups

	Nurse assistants $n = 44$ 14.4% %[1]	Nurses $n = 141$ 46.1% %[1]	Physicians $n = 89$ 29.1% %[1]	Psychologists $n = 32$ 10.5% %[1]
Psychological Distress[2]	70.5	58.9	34.8	37.5
7. Feeling uncertain about illness and treatment.[3]	81.8	77.3	56.2	65.6
5. Feeling depressed.	72.7	74.5	62.9	62.5
6. Feeling anxious.	61.4	70.9	57.3	53.1
8. Worrying about my future.	79.5	81.6	65.2	65.6
23. Feeling like I am no longer able to mentally 'fight' the challenges of my illness.[2]	75.0	68.1	39.3	40.6
24. Not being able to accept the way things are.[2]	81.8	71.6	47.2	53.1
Social Support[4]	34.1	43.3	28.1	31.3
21. Not feeling supported by my community of friends and family.	56.8	56.0	39.3	50.0
22. Not feeling supported by my health care providers.	43.2	45.4	36.0	40.6
25. Not being treated with respect or understanding by others.	50.0	60.3	42.7	50.0
Physical Symptoms and Dependency	77.3	78.7	79.8	75.0
1. Not being able to carry out tasks associated with daily living.	75.0	85.1	88.8	81.3
2. Not being able to attend to my bodily functions independently.	84.1	87.2	92.1	93.8
3. Experiencing physically distressing symptoms.	86.4	83.0	89.9	84.4
10. Not being able to continue with my usual routines.[5]	75.0	85.8	71.9	65.6
Existential Distress[6]	45.5	50.4	30.3	40.6
4. Feeling that how I look to others has changed significantly.	59.1	75.9	53.9	62.5
9. Not being able to think clearly.[2]	68.2	73.0	41.6	43.8
11. Feeling like I am no longer who I was.[3]	72.7	80.9	55.1	68.8
12. Not feeling worthwhile or valued.[3]	50.0	60.3	38.2	56.3
13. Not being able to carry out important roles.[3]	75.0	73.0	62.9	84.4
18. Feeling that I am a burden to others.[7]	59.1	74.5	66.3	87.5
19. Feeling that I do not have control over my life.[8]	70.5	80.1	56.2	84.4
20. Feeling that my illness and care needs have reduced my privacy.	56.8	59.6	48.3	43.8
Loss of Purpose and Meaning[3]	52.3	42.6	25.8	40.6
14. Feeling that life no longer has meaning or purpose.[3]	75.0	73.8	53.9	68.8
15. Feeling that I am not making a meaningful (and) or lasting contribution in my life.	63.6	64.5	47.2	56.3
16. Feeling that I have 'unfinished business'.	70.5	74.5	53.9	68.8
17. Concern that my spiritual life is not meaningful.[3]	29.5	33.3	19.1	18.8

The table reports information on the answers given by the participants to the PDI-IT and the results of the means comparison between the four professional groups; the table does not show means but only percent frequencies; [1] Percent frequencies of the participants who obtained scores at the subscales corresponding to answers "4" and "5" and percent frequencies of the answers "4" and "5" given to the items by each group; p values ≤ 0.05 were considered significant; [2] Nurse assistants' and nurses' scores are significantly higher than physicians' and psychologists' ones; [3] Nurse assistants' and nurses' scores are significantly higher than physicians' ones; [4] Nurses' scores are significantly higher than physicians' ones; [5] Nurses' scores are significantly higher than physicians' and psychologists' ones; [6] Physicians' score is significantly lower than the others' ones; [7] Psychologists' score is significantly higher than physicians' one; [8] Physicians' score is significantly lower than nurses' and psychologists' ones and "5" answers, was created for each professional group. For the nurse assistants, the most frequent items regarded Physical Symptoms and Dependency and Psychological Distress. Most of the items on the nurses' and physicians' top 10 lists regarded the physical dimension, followed by items on the existential and psychological domains. For the psychologists, the items referred mainly to the Existential Distress, followed by items on the physical, spiritual, and psychological dimensions. Four items were found in all four top 10 lists: physically distressing symptoms, loss of physically independency, worry about future, and incapacity of carrying out routine tasks. None of the items representing the Social Support appeared in the top 10 lists. The results are reported in Table 2.

Salience of the Dignity-Related Areas of Intervention

Considering their importance for the HCPs, the psychological area was ranked first and the physical area second for all the HCP groups, except for the psychologists for which it was the opposite. All groups evaluated the social and existential areas as less important for a hypothesized clinical intervention on the patient's dignity than the psychological and physical areas. The results are reported in Table 3.

Needs for Information on Patients' Life

One hundred and ninety-nine participants (65.03%) expressed a need to receive more information on the patients' life. Of those who indicated what kind of information, 66.67% ($n = 80$) referred to socio-familiar, 60% ($n = 72$) to physical well-being, 20.83% ($n = 25$) to psychological, and 23.33% ($n = 28$) to existential and spiritual areas. With respect to the professional groups, nurses and physicians were the ones who needed most additional information and especially socio-familiar and physical well-being information. Nurse assistants were the group which required the least additional information.

Associations Between the PDI-IT Scores and the Other Considered Variables

Females obtained higher scores on the "Psychological Distress," "Existential Distress," and "Loss of Purpose and Meaning" PDI-IT subscales than males ($t = -2.36$; $t = -3.684$; $t = -2.192$; $p \leq 0.05$). Age and years of service were significantly and positively associated with the participants PDI-IT scores (for all the correlations r ranged from 0.120 to 0.224, $p \leq 0.05$). Having attended at least one training on dignity was not associated with nurse assistants', nurses', and psychologists' scores but was associated among physicians. Among the physicians, the ones who attended at least one course obtained higher scores at the "Psychological Distress," "Existential Distress," and "Loss of Purpose and Meaning" PDI-IT subscales than physicians who never attended a course on dignity.

Discussion

As highlighted by previous studies, from a clinical point of view, it is important to examine the different perspectives of HCPs on dignity [14, 17, 19]. Doing so may promote reflection on this topic, enhance the HCPs' awareness on the complexity of dignity, improve daily clinical practice, and encourage a team-based approach and tailored care, focused on the patients' personal dignity-related needs. In this study, we evaluated the perceptions on end-of-life patients' dignity in a sample of 306 HCPs who belonged to four different professional categories. In line with previous studies [3, 26], the physical suffering—pain and other disabling symptoms—was indicated by most of the sample as the aspect with the greatest influence on patients' dignity. The "Physical Symptoms and Dependency" PDI-IT subscale was the only one to be scored highly and at the same time to not differ significantly among the groups. This result was expected because the physical domain is generally severely affected in the terminal phase of illness, which threatens strongly the patients' dignity preservation. This sensitivity oriented towards the physical domain could be due to the specific approach taken in the care of these patients, i.e., end-of-life care, in which pain and disabling symptom management is considered one of the most important clinical goals to achieve in order to preserve, in as much as possible, the patients' quality of life [27–29]. This could explain why also the psychologists considered the physical sphere highly: all psychologists interviewed for this research had an extensive clinical experience in palliative care, which could have favored the sensitivity towards the most disabling clinical conditions of these patients. Furthermore, feeling burdensome to others and losing autonomy are frequent concerns linked to the physical domain, which can cause distress in these patients [30]. Therefore, HCPs' scores agreed about the physical domain distress being the most important for patients' dignity preservation.

All four groups considered social support to be a less relevant dimension of patients' dignity. This data is in accordance with Oosterveld-Vlug et al.' and Baillie's results, which showed that the social aspects (i.e., receiving social support by relatives and society and not feeling stigmatized) were considered by the HCPs as less salient for the patients' sense of dignity [12, 14]. Nevertheless, the sample's average scores on the items of "Social Support" PDI-IT subscale were high, indicating that attention to patients' social dimension was still substantial. Furthermore, the results emerging from the analysis of the answers given to the open question highlighted a general agreement between the HCPs about collecting more socio-familiar information about the patients, for an

Table 2 Top 10 items according to the salience attributed to them by each professional group

Nurse assistants	*1. Experiencing physically distressing symptoms.*	PhSD
	2. Not being able to attend to my bodily functions independently.	PhSD
	3. Not being able to accept the way things are.	PsyD
	4. Feeling uncertain about illness and treatment.	PsyD
	5. Worrying about my future.	PsyD
	6. Not being able to carry out important roles.	ExD
	7. Not being able to continue with my usual routines.	PhSD
	8. Feeling that life no longer has meaning or purpose.	LPM
	9. Feeling like I am no longer able to mentally ‘fight’ the challenges of my illness.	PsyD
	10. Not being able to carry out tasks associated with daily living.	PhSD
Nurses	*1. Not being able to attend to my bodily functions independently.*	PhSD
	2. Not being able to continue with my usual routines.	PhSD
	3. Not being able to carry out tasks associated with daily living.	PhSD
	4. Experiencing physically distressing symptoms.	PhSD
	5. Worrying about my future.	PsyD
	6. Feeling like I am no longer who I was.	ExD
	7. Feeling that I do not have control over my life.	ExD
	8. Feeling uncertain about illness and treatment.	PsyD
	9. Feeling that how I look to others has changed significantly.	ExD
	10. Feeling that I am a burden to others.	ExD
Physicians	*1. Not being able to attend to my bodily functions independently.*	PhSD
	2. Experiencing physically distressing symptoms.	PhSD
	3. Not being able to carry out tasks associated with daily living.	PhSD
	4. Not being able to continue with my usual routines.	PhSD
	5. Feeling that I am a burden to others.	ExD
	6. Worrying about my future.	PsyD
	7. Feeling depressed.	PsyD
	8. Not being able to carry out important roles.	ExD
	9. Feeling anxious.	PsyD
	10. Feeling that I do not have control over my life.	ExD
Psychologists	*1. Not being able to attend to my bodily functions independently.*	PhSD
	2. Feeling that I am a burden to others.	ExD
	3. Experiencing physically distressing symptoms.	PhSD
	4. Not being able to carry out important roles.	ExD
	5. Feeling that I do not have control over my life.	ExD
	6. Not being able to carry out tasks associated with daily living.	PhSD
	7. Feeling that life no longer has meaning or purpose.	LPM
	8. Feeling like I am no longer who I was.	ExD
	9. Feeling that I have ‘unfinished business’.	LPM
	10. Worrying about my future.	PsyD

The top 10 lists were created according to the frequencies of answers “4” and “5” given to each item. After selecting the ten items with the highest frequencies for each professional group, they were ordered, starting from the highest frequencies. Items that were present in all the four top 10 lists are in italics. For each item, the corresponding subscale is indicated: “PsyD,” Psychological Distress; “PhSD,” Physical Symptoms and Dependency; “ExD,” Existential Distress; “LPM,” Loss of Purpose and Meaning

appropriate intervention regarding dignity. This result suggests that the HCPs perceive a lack of information about patients’ life, probably due to the specific setting in which medical and clinical aspects are prioritized. The top 10-item list confirmed the general relevance assigned to physical aspects and the relatively minor consideration for social aspects. This could be also due to a lack of time to spend with patients and due to the hospital setting, which is not ideal for all-encompassing palliative care. In this regard, nurse assistants were the group who needed the least additional information on

Table 3 Order of the dignity areas of intervention according to the salience attributed to them by each professional group

	1°	2°	3°	4°
Nurse assistants	Psychological area 21 (51%)	Physical area 14 (34%)	Existential area 13 (32%)	Social area 24 (59%)
Nurses	Psychological area 52 (39%)	Physical area 41 (30%)	Social area 49 (36%)	Existential area 40 (30%)
Physicians	Psychological area 30 (35%)	Physical area 26 (30%)	Social area 25 (29%)	Existential area 29 (34%)
Psychologists	Physical area 15 (46.9%)	Psychological area 17 (53.1%)	Social area 12 (37.5%)	Existential area 7 (2.9%)

Each participant ordered the four areas giving them the numbers "1," "2," "3," and "4". For each group, the area with the highest frequency (reported in the table as both absolute and percent) of number "1" resulted in the 1° position, and the same criterion was used for the 2°, 3°, and 4° positions

patients, possibly because of the specific relationship they maintain with patients, characterized by proximity, intimacy, and consistently spending time together. Furthermore, it is relevant to stress how four of the PDI-IT items ("physically distressing symptoms," "loss of physically independency," "worry about future," and "incapacity of carrying out routine tasks") were found in the top 10 lists across all four professional groups, highlighting a common ground among HCPs' perceptions. Results also highlighted other similarities between the HCP groups. Nurses and nurse assistants seemed to have similar perspectives on all dignity-related aspects, while physicians and psychologists agreed more on the psychological aspects. Additionally, nurses, nurse assistants, and psychologists had similar scores on items representing existential and loss of purpose and meaning concerns. Thus, despite distinct roles and clinical activities, HCPs can achieve a cohesive and comprehensive perspective on patients' dignity, which could promote a more personalized and accurate intervention designed to preserve patients' dignity. Furthermore, HCPs considered the following dignity-related topics as very important: depression, anxiety, and perceived support received by providers. In this regard, there is also consensus between the HCPs regarding the psychological domain.

The multidisciplinary nature of health care could play a role with respect to the alignment of the providers' points of view, because it stimulates the exchange of knowledge and perspectives on patients. On the other hand, results also indicate significant differences in the HCPs' sensitivities regarding dignity. Nurse assistants and nurses considered the psychological, existential, spiritual, and social issues as more important than the other HCPs, and psychologists appeared more sensitive to the existential concerns compared with physicians. This variability might be related to the specific role and relationship between the patient and various HCPs: nurses and nurse assistants are generally closer to patients; they spend more time with him/her than a physician does and can focus their communications on the aforementioned aspects. Moreover, nurses and nurse assistants deal with the ongoing clinical management of the patients, while physicians spend less time with patients and focus their visits more on the physical and medical aspects. For their part, the psychologists mainly deal with the patients' psychological, spiritual, and existential concerns. In that sense, it is possible that different clinical activities might lead to different sensitivities among HCPs. These results support those of Albers et al., highlighting how the PDI items representing the physical domain were more highly ranked by the physicians [19]. Nevertheless, physicians who have attended at least one training session on dignity evaluated the dignity-related psychological, existential, and spiritual distress as more salient than physicians that did not attend such training. This result suggests that adequate training on dignity might stimulate physicians' reflection on other dignity aspects, aside from the physical. Moreover, considering the different HCPs' expertise, the differences observed among the HCPs' perspectives, and the fact that HCPs' perceptions might be driven by the role and work responsibilities during clinical practice, it would be useful to develop and to improve training activities on dignity for HCPs, such as courses, seminars, and focus groups. The latter represent an effective instrument to promote HCPs' awareness on the topic and encourage communication among the HCPs. Furthermore, encouraging the debate on end-of-life patients' dignity and enhancing HCPs' awareness of their different and similar perspectives are crucial in providing an adequate patient-centered care, in which the patient's physical, psychological, social, spiritual, and existential needs are detected and met [16].

Conclusion

This study contributes further to the investigation of HCPs' perspectives on dignity in EOL care and aims to open up a conversation about the crucial issue of patient dignity, a matter that is of utmost importance to be handled effectively in near-death patients. The differences which emerged in the perspectives and sensitivities towards the patients' dignity among HCPs emphasize the importance of encouraging HCPs' exchange and debate about dignity in daily clinical practice. This could promote the integration of different reflections leading to more in-depth reasoning of a patient-centered "dignified therapeutic choice" which aptly values the specific personal needs of each patient.

The relevance of this research is the investigation among four different HCP groups' perspectives on dignity using the PDI to identify differences and similarities according to their professional profiles. Regarding the limitations, a higher uniformity in the groups relative to the number of enrolled participants would be recommended. Moreover, there is a lack of enquiry on the impact of the HCPs' personal characteristics such as empathy and other psychological variables on their perspectives on dignity.

Adequate research implementations could involve comparing HCPs' perspectives with the perspectives of patients' and family caregivers' ones. Furthermore, it is also important to foster research on the topic using a qualitative approach. It is our intention to implement this study in future research using focus groups on dignity with HCPs in hospital wards. Finally, focusing on dignity treatments, further studies should improve the assessment of HCPs' perceptions on factors influencing specific dignity care interventions.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional ethics committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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