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Dignity in End of Life

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The concept of dignity is transversal to the different historical epochs, having evolved and assuming different dimensions over time. At present, various normative documents assume human dignity as a bioethical principle, as it is present in UNESCO's Universal Declaration of Bioethics and Human Rights, which establishes that one of the main objectives is to promote respect for human dignity and human rights respect for life and its fundamental freedoms, taking into account international human rights law [1]. It is important to emphasize that, in the 1990s, the right to treatment and to death with dignity proclaimed in the Declaration of the Rights of the Patients of the World Health Organization [1,2].

The concept of dignity at the end of life is often associated with Palliative Care. Dignity is a complex and subjective concept that defines something unique to every patient and family. It is up to health professionals to consider this concept when they provide health care to end-of-life patients [3]. Palliative Care are based on their multidisciplinary clinical activity, the dignity of the sick person and his family. They are an approach that promotes the quality of life of patients and family members who are dealing with a life-threatening illness through the prevention and relief of suffering by identifying and treating early pain and other physical, psychosocial, and spiritual [4].

In the last decades, Palliative Care have been producing specialized knowledge in symptom management, biopsychosocial attention, improving communication of bad news and making complex decisions on the part of the patient, their relatives and the hospital team. The main objectives of Palliative Care are: to recognize and relieve pain and other associated symptoms; recognize and treat psychosocial symptoms (anxiety, depression, loss of autonomy, loneliness, fear of death); adequately support family members and promote the quality of life of the patient and the family [4].

Palliative Care neither accelerate nor postpone death, only affirm life, and regard death as a natural process, and provide support for the patient to live as actively as possible. They should be started as early as possible, along with life-prolonging measures. For this form of care to happen properly, good communication between health professionals, patients and their families is essential [4]. For Chochinov, the concept of preserving dignity in the care of the end of life should become part of the vocabulary of the Palliative Care and the way of acting in relation to all the patients who are approaching the end of life. By presenting some references to interviews with patients, family members and health professionals about what it means to die with dignity, Chochinov sets out for different concepts of dignity, based on the life experience of each actor, his / her culture, psychosocial aspects, spirituality and of existential meaning 5.

He began his study from the bibliographical research of other research works and emphasizes the preservation of dignity, as one of the fundamental objectives of the CPs. Dignity should be defined as the "quality" or state of "having value," being honored or esteemed. In this study, individuals include what for themselves is "dying with dignity" practical matters such as basic comfort, type or quality of care and spirituality [5].

Chochinov identified the different perceptions that end-of-life cancer patients had regarding dignity. This model was entirely created from the analytical study of patient reports and is divided into three main categories:

i. Sickness Concerns - physical and / or psychological factors that derive from the direct experience between the individual and his illness, interfering with or threatening the sense of dignity;

ii. Personal Resources of Dignity - psychological and / or spiritual factors that influence the sense of dignity. They are related to the inner heritage of each individual, their personal history, their life experiences and the way they shape the capacity to see and react to the world;

iii. Social Resources of Dignity - externally mediated

through the social context, its positive contributions and the challenges of adversity and suffering [1].

The perception of how patients are cared for, through compassion, frankness, and relational truth, influences their sense of dignity [6]. At each clinical meeting, each patient looks at health professionals, seeking to recognize a comforting and healthy image. Dignity can provide a central framework that can serve as a guide for the health professional, the patient and his family in defining underlying end-of-life therapeutic goals and considerations. Hence the importance of carrying out an evaluation of the degree of satisfaction, psychological comfort, the capacity for self-control and support, positive self-concept and its meaning for the patient. Naturally, the concept of dignity involves an individual reflection, holistic and influenced by the sociocultural characteristics of each individual. In this process, communication becomes a central element during care, since the patient has the ability to perceive both the verbal and non-verbal communication of the professional, and this interferes with the effectiveness of the therapeutic process. It is important for the user to feel that the practitioner is effectively with him and that he / she has an active role in the care process.

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