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Reflection Article

COMMUNICATION IN PROMOTING DIGNITY IN PALLIATIVE CARE: CHALLENGES FOR NURSING

A COMUNICAÇÃO NA PROMOÇÃO DA DIGNIDADE EM CUIDADOS PALIATIVOS: DESAFIOS PARA A ENFERMAGEM

COMUNICACIÓN EN LA PROMOCIÓN DE LA DIGNIDAD EN LOS CUIDADOS PALIATIVOS: DESAFÍOS PARA LA ENFERMERÍA

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Objective: to understand the influence of communication as a basic nursing instrument in the promotion of dignity in Palliative Care. Method: theoretical reflection through literature review and using Chochinov's Dignity Model. The research of scientific articles was carried out on the online knowledge library, on the Elsevier publications database and on the database-aggregating platform EBSCO Host Web, published during the period 2010-2016. Results: interventions associated with nurses' communication skills that promote the dignity of clients in palliative care were identified. The communication interventions that most promote dignity are those that transmit to the palliative client respect for their individuality and appreciation of their personal history. Conclusion: nurses should adopt a posture of empathic understanding, active listening, availability, attention to emotional needs, nonverbal components (such as physical presence and visual contact), management of expectations and encouragement of self-care.

Descriptors: Nursing. Palliative Care. Communication. Human Dignity.

Objetivo: compreender a influência da comunicação enquanto instrumento básico de Enfermagem na promoção da dignidade em Cuidados Paliativos. Método: reflexão teórica mediante revisão da literatura e com recurso ao Modelo da Dignidade de Chochinov. A pesquisa de artigos científicos foi realizada na biblioteca do conhecimento online, na base de dados das publicações Elsevier e na plataforma agregadora de bases de dados EBSCO Host Web, publicados durante o período 2010-2016. Resultados: identificou-se intervenções associadas às competências comunicacionais dos enfermeiros que promovem a dignidade dos clientes em cuidados paliativos. As intervenções comunicacionais que mais promovem a dignidade são as que transmitem ao cliente paliativo o respeito pela sua individualidade e valorização da sua história pessoal. Conclusão: o enfermeiro deve adotar uma postura de compreensão empática,

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escuta ativa, disponibilidade, atenção às necessidades emocionais, aos componentes não verbais (como a presença física e o contacto visual), à gestão de expectativas e o incentivo do autocuidado.

Descritores: Enfermagem. Cuidados Paliativos. Comunicação. Dignidade Humana.

Objetivo: entender la influencia de la comunicación como instrumento básico de enfermería en la promoción de la dignidad en los Cuidados Paliativos. Método: reflexión teórica a través de la revisión de la literatura y el uso del Modelo de Dignidad de Chochinov. La investigación de artículos científicos se llevó a cabo en la biblioteca de conocimientos en línea, en la base de datos de publicaciones Elsevier y en la plataforma agregadora de bases de datos EBSCO Host Web, publicados durante el período 2010-2016. Resultados: se identificaron intervenciones asociadas a las habilidades de comunicación de las enfermeras que promueven la dignidad de los clientes en los cuidados paliativos. Las intervenciones de comunicación que más promueven la dignidad son las que transmiten al cliente paliativo el respeto por su individualidad y apreciación de su historia personal. Conclusión: las enfermeras deben adoptar una postura empática de comprensión, escucha activa, disponibilidad, atención a las necesidades emocionales, componentes no verbales (como la presencia física y el contacto visual), gestión de expectativas y fomento del autocuidado.

Descriptores: Enfermería. Cuidados Paliativos. Comunicación. Dignidad Humana.

Introduction

Before Nurses' confrontation with others' suffering and contact with their most fragile and vulnerable side in Palliative Care (PC), there arose the need to focus on the present critical and reflective analysis in the promotion of dignity in this context. The relevance of this approach is corroborated by professional codes of ethics and deontology, which state that nursing interventions are performed with the concern of defending the dignity of the human person[1]. The human being is a relationship being. Since the beginnings, the human has been considered a social being of interpersonal relationships. As such, communication becomes a key process for us to be able to live in community.

Transposing this reality into Nursing, communication appears as one of its basic instruments. Therefore, "[...] nurses must ensure the success of the communication they use in the context of care delivery, since effective levels of communication lead to more positive results"[2:32]. Thus, communication is as important as the realization that communicating with the Other is one of our main activities. Based on our empirical experience in the area, it is inferred that communication is a determining factor in promoting dignity in PC, being a preponderant aspect in the promotion of human dignity[3].

The aim of this study is to understand the influence of communication as a basic Nursing instrument in promoting dignity in Palliative Care.

Method

This work consists of a critical and reflective analysis of an extensive literature review on a specific and delimited theme.

A bibliographical research was carried out on databases considering the credibility and timeliness of the research produced, especially for the Nursing area. In this investigation, the search included scientific articles in Portuguese and English, on the online knowledge library (b-on), on the database of Elsevier publications, and on the database-aggregating platform EBSCO Host Web (mainly using MEDLINE with full text, CINAHL with full text and Cochrane Database of Systematic Reviews), published during the period 2010-2016. After analyzing the texts, the final course report was prepared "The result mirrors an alliance between the critical analysis of the current panorama and the analysis of the texts". The critical analysis starts from the empirical experience that the group elements have in the area, as well as the basic training in PC. The present study took place between March and June 2016.

Results and Discussion

Palliative care

The adjective palliative is currently attributed to what "has the quality of calming down, temporarily slowing down an evil (medicine

or treatment)", which "serves to mitigate an evil or delay a crisis (means, initiative, etc.)"[4]. As a result of this idea, PC can be defined as total care for patients with life-threatening diseases, as well as for their families, provided by a multidisciplinary team, in the time period in which the disease no longer responds effectively to curative treatments[5]. This definition can also be enriched with that of the World Health Organization (WHO): "[...] an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness"[6:2]. They also state that the approach focuses on "[...] prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"[6:2].

Thus, PC represents the holistic care of clients with progressive and advanced diseases that no longer respond to curative treatment. The PC includes four fundamental pillars: symptomatic control – mobilization of pharmacological and non-pharmacological strategies; appropriate communication – use effective relational and communication skills for clients and families; family support – include the family in the care process and assess their needs; teamwork – integrate the contributions of professionals from various areas, with the common purpose of comfort and well-being of clients and families[6]. These four aspects are equally important, and the practice of quality PC would not be feasible if any of them were overlooked[6].

Palliative Care Nursing - Current Conceptualization

In the postmodern era, the first Nursing theories emerged, which considered the adequacy of holistic principles to care practices[7]. In this new current of thought, the paradigm of transformation emerges, representing a change in mentality whose dynamics emanates from the continuous interaction between complex and global phenomena with the world[7]. For Nursing, the focus of attention became the individualization of human care and the specificity of each person as a unique being. This school of thought in Nursing comprises Jean Watson's Theory of Care Humanization, in which the person is seen as a harmony between all his/her aspects: body, soul, spirit and health. Nursing care is not only manifested in an attitude or emotion; it corresponds to an intersubjective process, a moral ideal, which aims to protect, improve and preserve the dignity of the person cared for[8].

In PC, this concept of caring for is reflected when nurses interact with clients, to understand their experiences and enable the expression of feelings and thoughts. Thus, the objective is to reduce the suffering of clients and families, in order to facilitate their adaptation process to the experience they live[6]. Two of the most important dimensions of this care, centered on the help relationship, are empathy and respect for the dignity of each client and family. Thus, upon using different communicative strategies, nurses promote the principle of autonomy and help clients and families to reflect on the most appropriate decision-making, taking into account their values, their needs and their emotional status[7].

Dignity

Dignity is a complex concept that is difficult to define, since its contours change according to the contexts in which it is addressed[9]. In Ancient Rome, in the middle of the XIII century, the term *Dignitas* meant "merit", "reputation", being associated with the notion of hierarchy[9]. A crucial point in the transition to modern concepts of dignity arises in the Renaissance, when, in 1480, the Italian philosopher Pico della Mirandola (1463-1494) associates the concept of human dignity with freedom[10].

Years later, inserted in the context of the ideological builders of liberalism, the German philosopher Immanuel Kant[11] (1724-1804) makes one of the most decisive contributions to the definition of this concept, stating that "In the realm of ends, everything has a price or a dignity. When a thing has a price, one can put, instead of

it, something else as equivalent; but when one thing is above all price, and [...] does not allow equivalent, then it has dignity"[11:77]. Humans have no price, no equivalent, but have dignity.

Then comes the premise "Act in such a way that you treat humanity, both in your person and in the other's, always and at the same time, as an end and never simply as a means"[12:8].

With the end of the Holocaust, it became imperative to build a world under new ideological foundations. To this end, the Universal Declaration of Human Rights was drafted in 1948[13]. The document contains 30 articles, which name basic human rights, based on the premise that human dignity results from the recognition of a value, translating as the moral principle based on the human purpose and not on its use as a means. It is the manifestations of rationality, freedom and purpose in themselves that make the human a constantly developing being, in an incessant search for personal accomplishment.

Dignity in Palliative Care

As already mentioned, in palliative care, given the vulnerability of its patients, health professionals' approach needs to have as one of its focuses the preservation of the dignity of the sick. The principle of dignity in medical ethics is expressed in the development of palliative care[14]. It intends to provide adequate conditions for the status of human beings, both in life and during the process of death[14].

According to this last idea, the "Person" should be seen as a multidimensional being that transcends corporeal limits. In an attempt to outline the different domains of dignity in PC, one of the most recognized studies developed in scientific evidence is the Model of Dignity in End-of-Life Patients[15]. The objective of this theoretical model focuses on the identification of clinical-demographic variables that influence dignity (Chart 1).

Chart 1 – Categories, themes, subthemes and item of the Model of Dignity in End-of-Life Patients

Disease-Related Concerns	Dignity Personal Resources	Dignity Social Resources
Level of independence: Cognitive acuity Functional autonomy Symptomatic decompensation: Physical distress Psychological distress: Clinical uncertainty Anxiety/fear of the death	Dignity-protecting perspectives: Self-continuity Preservation of roles Legacy/inheritance Keeping proud Hope Autonomy/control Acceptance Resilience	Privacy (and its limits) Social support Caring Tone Caregiver's burden Concerns about the future
	Dignity-protecting actions: Live the moment Keep normality Seek spiritual comfort	

Source: Chochinov HM, Hack T, McClement S, Kristjanson L, Harlos M[15].

Thus, a relational aspect of dignity appears in the discourse of patients, which is constructed in interaction with the Other[6]. Consequently, communication becomes an essential aspect in promoting the dignity of sick people.

Communication in palliative care

Over time, many authors have written about communication, its concept and its characteristics as a basic nursing instrument. In this case, it is important to define the concept applied to the nursing area. Thus, communication can be defined as "a process of creation and re-creation of information, exchange, sharing and common feelings and emotions among people"[16:23].

A study[16] states that "Communication is transmitted consciously or unconsciously by verbal and nonverbal behavior, and more globally, by the interveners' way of acting"[16:23].

Thus, communication allows us to " [...] learn and [...] understand the intentions, opinions, feelings and emotions felt by the other person and, as the case may be, create meaningful bonds with him/her"[16:23].

The components of communication are not restricted to the verbal exchange of information, of cognitive content, because there is also an affective counterpart manifested in the non-verbal behavior and the person's way of being. Similarly, it is possible to observe that approximately 75% of communication in nursing actions are non-verbal, which are more authentic and genuine and less subject to the disapproval of the conscious[6]. Although these manifestations may be less evident, they are less important than verbal communication, since they are the emotions implied in the words expressed by the person that make the other react[16].

The literature reveals that the mobilization of communication skills is an effective therapeutic intervention, allowing the person to "[...] share fears, doubts and suffering, contributing to reducing psychological stress and ensuring his/her autonomy, providing more quality and gaining more personal satisfaction"[17:11].

For this reason, communicating effectively is a basic need in the intervention to the client/family in PC. Communicating effectively, in this context, constitutes a challenge, since it requires the mobilization and development of basic expertise for communication among the nurse-client-family triad, thus emerging the need for adequate training[6,18].

The influence of Communication in the promotion of Human Dignity

Many professionals have carried out investigations in order to explore the meaning of dying with dignity and its influencing aspects in PC. One of the essential aspects with a strong impact on the preservation of dignity is the communication established between health professionals and sick people[3]. Then arises the need to understand that nurses can put in place communication interventions to safeguard the dignity of the people they care for. In an attempt to bring about such communication interventions, the Model of Dignity in End-of-Life Patient[15] was converged with the communication skills of a general care nurse. We present, by sequence, Charts 2, 3 and 4 resulting from the reflections made by the authors and acquaintances.

Chart 2 – Nursing Interventions in the disease-related concerns dimension

Disease-Related Concerns		**Nursing Interventions**
Level of independence	Cognitive acuity Functional autonomy	Educate clients about what is normative. Orient clients to reality, when appropriate.
Symptomatic decompensation	Physical distress Psychological distress	Combine pharmacological strategies with communication strategies (keep eye contact, be present, use therapeutic touch).
		Dialogue about the death and fears of clients, using active listening to their perceptions. Share experiences when asked. In the transmission of bad news, the nurse must emphasize the therapeutic potential of clients, informing them of what can be done.

Source: Created by the authors.

Regarding physical distress, upon combining communication strategies with pharmacological strategies when symptomatic decompensation occurs, nurses enhance clients' comfort, helping them to deal with this moment[18]. By applying the interventions in Chart 2, the nurse will be enhancing the mental preparation of clients and families for the evolution of the disease, anticipating possible functional and cognitive losses. Furthermore, it allows clients to begin a preparatory mourning process, that is, the process of accepting their finitude, without losing faith and hope[18]. A study[19] shows that most clients want someone who has cared for end-of-life people – a palliative doctor or nurse – to share experiences that help them clarify the evolution of the disease, attributing a meaning to them.

Chart 3 – Nursing Interventions in the dignity personal resources dimension

Dignity Personal Resources		**Nursing Interventions**
Dignity-protecting perspectives	Self-continuity Preservation of roles Legacy/inheritance Keeping proud Hope Autonomy/control Acceptance Resilience	Encourage the establishment of realistic goals. Promote the sharing of emotions and feelings, responding to possible spiritual needs. Convey true information. Encourage the preservation of personal habits and routines. Encourage clients to act in the way they most identify with. Encourage clients to focus on the present. Negotiate with clients the possibility of solving old problems.
Dignity-protecting actions	Live the moment Keep normality Seek spiritual comfort	

Source: Created by the authors.

A study[6,20] says that in the constant attempt to defend the dignity of their clients, nurses should: pay attention to their emotional needs, as well as those of families; negotiate and set realistic goals, clarifying that there will be "good days and bad days"; discuss the experience of one day at a time, focusing on the present – establishing this belief in the *carpe diem* premise –; and balance the transmission of true information with the promotion of hope[6,20]. Following this line of thinking, these strategies that facilitate the experience of the disease process in the palliative phase also include: encourage clients to take advantage of the days when they feel good and help them overcome the days when they feel worse; not frequently anticipate negative scenarios that may not occur; encourage them to maintain habits and routines that meet their tastes and preferences (such as respecting the clients' schedules) in an attempt to preserve a sense of normality for cared for patients; encourage clients not to be focused on death uninterruptedly, because "[...] life does not stop when one is dying"[6:361].

Chart 4 – Nursing Interventions in the dignity social resources dimension (continued)

Dignity Social Resources	**Nursing Interventions**
Social support	Promote the preservation of meaningful relationships.

Chart 4 – Nursing Interventions in the dignity social resources dimension (conclusion)

Dignity Social Resources	Nursing Interventions
Caring Tone	Adopt a supportive behavior, based on affection, respect and empathetic understanding. Establish genuine and authentic interactions. Use humor when appropriate (avoiding crises such as symptomatic decompensation, for example).

Source: Created by the authors.

Several studies reveal that the establishment of meaningful relationships with the people around us is a primary aspect in promoting dignity in PC[3]. For this to be possible, it is essential that nurses listen to clients actively, giving them confidence and a genuine empathic understanding. Moreover, it is not possible to build meaningful relationships if affection and love are not present in them, in a positive feedback process[3]. Thus, it is basal for nurses to acquire and improve communication and relational competencies that allow the construction of dignity-promoting relationships.

Dignity is a concept with tenuous limits and difficult to define. It is expected that this work has contributed to a better understanding of what dignity is, helping with its perspective in Nursing care. Thus, it is intended to sensitize the nursing community to adopt a clinical practice that safeguards the dignity of clients, enhancing it in this phase of vulnerability.

Conclusion

Experiencing the cognitive and functional decline of the other, culminating in his/her death, forces nurses to think and confront their own death, which inevitably brings an associated emotional component. Here, the investment in the nurse's self-knowledge and the development of communication and relational skills become indispensable. Being aware of their skills and limitations is an important tool for building an effective therapeutic help relationship, since nurses can see how far their intervention produces the desired effect, promoting the physical, psychological and emotional well-being of those who are caring. As such, the importance of self-knowledge lies in the way we begin to face each other and face the world around us.

From the work done, we can affirm that dignity is an intrinsic value of the human being, resulting from his/her recognition as a Person. Based on the premise that the Human is a being of relationship, in constant communication with those around him/her.

In order to operationalize the promotion of dignity in PC, nurses should adopt an empathic understanding behavior, established with respect for the person cared for. In addition, nurses have a range of communication interventions at their disposal, including: the response to emotional needs, through the transmission of true information; the management of expectations, which allows keeping hope by setting realistic goals; and the incentive to self-care, which promotes the autonomy of the client through the valorization of his/her personal project.

Collaborations:

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2 – Writing of the article and relevant critical review of the intellectual content: Bruno Miguel Freire Monho and Maria Deolinda Antunes da Luz Lopes Dias Maurício;

3 – Final approval of the version to be published: Maria Deolinda Antunes da Luz Lopes Dias Maurício.

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