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**The Status Quo of Dignity Care for Residents in
Long-term Care Institutions**

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Abstract

Changes of social environment and family structure have put the elderly and the disabled in need of care. In this study, the Patient Dignity Inventory (PDI) (Chinese version) was used to conduct a questionnaire survey on residents in long-term care institutions. Exploratory factor analysis was conducted on the collected questionnaire data. The questionnaire items were classified into Constructs of “perceived dignity”, “emotion management”, and “living management”. The survey resulted in a number of findings. First, residents received proper and dignified care of their perceived dignity and emotion management and have dignified care during the period of settlement of maintenance institutions. However, on the part of living management, they had poor feelings between “a problem” and “major problem”. Second, the residents hoped to receive support from “living

management” the most. Third, manufacturers should make great efforts to develop living assistive devices to make the residents’ lives more convenient.

Keywords: *Dignity Care, Long-term Care, Living Assistive Devices*

1 Introduction

Changes of social environment and family structure have put the elderly and the disabled in need of care. The ratio of elders living in long-term care institutions has been increasing year by year, which has led to an increase in Taiwan’s long-term care resources, especially 24-hour institutional care. Among all types of long-term care services in Taiwan, the types of institutional care include: (1) chronic beds and nursing homes in the health system; (2) long-term care institutions, maintenance institutions, and elderly support institutions in the social welfare system; and (3) chronic beds, maintenance, and elderly support institutions in the Retired Officers and Soldiers Counseling Committee system. The needs for long-term care are increasing in the long run. With the increase of the elderly population, the demand for long-term care institutions is also increasing. According to statistics of Ministry of the Interior in March 2017, the proportion of the elderly population over the age of 65 reached 14.05%, which was higher than the threshold of 14% for what is considered an “aging society”. In other words, one out of seven citizens is elderly. The responsibility of caring for the elderly will gradually be transferred to professionals. This responsibility includes not only the expectation of family members for long-term care institutions but also the expectation of maintaining the dignity of the elderly. After living in long-term care institutions, elders often have feelings of frustration, abandonment, insecurity, low self-esteem, and depression, which affect their quality of life. How to work efficiently and maintain the dignity of the elderly are the goals and criteria of long-term care institutions.

What is a person’s dignity? In fact, there is nothing special about dignity. The most important thing is that individuals can be treated in a humane way after they are born into the world (Working Group on International Affairs of the National Federation, 2017). Maintaining patient dignity and quality of life has always been emphasized by nursing professionals. However, there are different feelings and opinions about the real connotations of the term “dignity” due to differences between Chinese and Western cultures. Its influencing factors and measurement methods have been clarified in the literature. Therefore, after examining the essence of dignity, this paper found that although dignity is a kind of inherent human need, it is influenced by personal and interpersonal views on individuals’ self-worth, which then generates value judgments and feelings that vary from person to person. Furthermore, this subjective psychological feeling includes not only the affirmation of inner self-worth and an individual’s feeling of others’ respectful attitudes towards him or herself, its origins have deeper social and cultural implications. In other words, dignity is judged by different social and cultural values. Tseng, Chan, and Tai (2011) summarized the attributes of dignity as self-esteem, self-empowerment, autonomy, responsibility for one’s own actions, and interactive influence. Nurses’ understanding of the concept of dignity can help them use the concept of dignity in the nursing process to ensure and improve patients’ perception of dignity.

The purpose of this study was to investigate the residents of selected elderly support institutions in order to find out: (1) whether they were cared for properly and with dignity during their stay in the support institutions; (2) which aspect of dignity the residents most wanted to receive; and (3) a reference basis for providing the research results to manufacturers for the research and development of life assistive devices.

2. Literature Review

In this paper, a literature review was made on the following issues: definition of dignity, dignity care, patient dignity and health outcomes, and a dignity perception scale as well.

2.1 Dignity

The word “dignity” originates from the Latin word *Dignitas*, meaning a valuable or respected state or quality (Webster, 2019). Kant once said that human beings are subjects of rationality, autonomy, and self-determination, and they cannot be materialized or objectified. Dignified behavior must be learned, because individual perceptions of dignity will be affected by the treatment of others. Dignity is mutual and can be manifested through behaviors of self-respect and respect for others. Dignity is also a cultural concept. Individuals’ standards and expectations for dignity will change according to their attitudes, values, and perceptions (Jacelon, Connelly, Brown, Proulx, & Vo, 2004).

Human dignity exists with life. When people lose their physical functions, their dignity will also be threatened. Therefore, maintaining patient dignity is also a top priority for medical care. Maintaining patient dignity is an attitude that includes respecting the patient’s uniqueness, privacy, and rights to get adequate information. Autonomy is the manifestation of human dignity; that is, patients have the right to make decisions by themselves, participate in the decision-making process of the treatment, and participate in self-care. Failure to properly safeguard patient dignity shows disrespect for patients, which makes patients feel they are being treated as an object rather than a person. Patients will also feel the indifference of their caregivers and the sense of abandonment and alienation from society, which will also result in patients’ lack of self-worth, thus affecting their mental health and recovery. If patients are given medical treatment without getting sufficient medical information, it may cause irreversible harm to patients and their families. Medical staffs’ understanding and support of patient dignity not only improve medical and nursing quality but also improve patients’ quality of life (Chen, 2012).

Human dignity is one of the core concepts of human rights and also the most fundamental concept of human rights. Human dignity is an intrinsic value of human beings that must not be violated. The three elements of human dignity are the integrity of human life, the possibility of survival as a human being, and the ability and opportunity of self-determination (Hung, 2004). In recent years, several photo incidents that infringe on patient privacy and medical disputes have occurred, which not only endangered the patients’ dignity and life but also aroused negative public impressions on medical institutions and health caregivers and condemnations against their professional ethics. Therefore, the principle of maintaining patient dignity will affect the results of health care. Health caregivers’ attention to patient dignity will be internalized and displayed in their actions, and they will take the maintenance of patient dignity as their professional duty and social responsibility.

2.2 Dignity Care

The concept of human dignity is long-standing in medical ethics. In 1948, the World Medical Association advocated that clinicians should include respect for human dignity while providing profound medical services. In the 1990s, it began to advocate that the maintenance of dignity is no longer the responsibility of physicians, and that patients could require health caregivers to respect their dignity (Graff & Delden, 2009). In 1985, the American Nursing Society also emphasized in the Code of Nurses that nurses should provide individualized services with respect for patients’ human dignity regardless of the patients’ social status, economic status, personal traits, or the nature of their health problems (Yin et al., 2008).

Matiti (2007) pointed out that privacy is important for the maintenance of patient dignity. Inpatients will feel shameful and disturbed if they have to expose their bodies to strangers or be separated only by a curtain for

examination or treatment. In addition, Matiti also mentioned that adults generally expect to have control over themselves and situations, which, however, will be quickly destroyed when they are ill. When patients are totally excluded from the treatment plan or nursing activity arrangement for their disease, they will suffer from embarrassment. Therefore, it is of significance for the patient's psychological preparation to provide complete information when planning treatment and care. Patients and nurses have different perceptions of dignity. From the patient's point of view on patient dignity, patients feel that dignified care is not just about appropriate clothing or covers but also appropriate time allocation and an understanding of their views and consideration of their feelings, as patients' do not want their bodies to be seen as objects. Matiti and Trorey (2008) found that inpatients believe that the maintenance of dignity includes maintaining privacy (especially avoiding exposure of the body), keeping secrets, being able to communicate (and get the required information), and the ability to choose to control and participate in the care, as well as being respected (which is the need that requires the most attention and consideration in the views of the patients). Some actions will invisibly violate the patient's privacy and injure the patient's dignity, such as taking off the patient's quilt to expose a wound without informing the patient in advance during nursing, treatment, or ward rounds, publicly discussing the patient's condition in ward areas with two or more beds, or allowing others to wait in the clinic at the same time when the patient is seeing the doctor.

Nurses believe that the key to maintaining patient dignity is respecting patients and their privacy, enhancing their sense of control, and giving them time, etc. Heijkenskjöld, Ekstedt, and Lindwall (2010) pointed out that nurses should treat patients as human beings to maintain patient dignity. In addition, maintaining patient dignity also involves finding the right time for patients to talk about and share their life experiences, allowing patients to participate in self-care, devoting time to patients, and forbidding other nurses to violate patient dignity. Conversely, if nurses do not respect their patients' wishes, give up on patients, are indifferent to patients, or treat patients as objects, it is a serious violation of patient dignity.

Respect and patient dignity are priorities of nursing ethics and basic elements of interaction between people. Respect for others should follow the principle of being empathetic about others and not regarding others as a tool or method to achieve certain goals. On the contrary, the exploitation of others is a manifestation of disrespect (Jameton, 1984). From the perspective of nursing activities, respectful behavior can be in the forms of language and non-language, such as appropriate titles (avoiding using inappropriate words), being candid and honest, being willing to take time to listen to patients, allowing patients to express their feelings, and supporting patients' spirit of independency in making attempts. In contrast, it is disrespectful to label patients, talk about patients' conditions, treat patients benevolently, or listen selectively.

Autonomy is a basic ethical principle for medical staff in caring for patients. Before providing any medical care for patients, medical staff should provide all the information related to medical care to the patients and let them make their own decisions. In the medical system, the definition of patient autonomy is that under the conditions that patients are conscious, not attempting to harm themselves, and that non-retrievable obstacles are removed, everyone has the right to choose the treatment for their own physical conditions, ask for an explanation of the disease and relevant medical information, and participate in the whole medical process according to their own wishes (Yin et al., 2008). Chochinov (2010) also proposed that the best strategy to maintain patient dignity is to support patients' sense of autonomy and control in order to enhance their self-confidence and spiritual comfort.

2.3 Patient Dignity and Health Outcomes

Matiti and Trorey (2008) proposed that maintaining the dignity of inpatients is conducive to their emotional comfort and rehabilitation. Dignity is the basis of health for every individual in society. Chochinov et al. (2002) conducted a study on the dignity of terminal cancer patients, through which they came to the finding that 7.5% of

patients feel deprived of dignity, and that the more they feel deprived of dignity, the more psychological stress and symptoms they suffer. On the contrary, the more dignified the patients are, the less they are involved in depressive, hopeless, and anxious emotional reactions, the stronger their will to live, and the higher their satisfaction with their quality of life. Khatib and Armenian (2010) studied the relationship between dignity and health, and the results showed that physical and psychological health are positively correlated with degree of dignity, and that the more dignity the respondent felt, the more energetic they were, and the less sense of fatigue and emotional problems they had.

Through the above review of the literature on patient dignity, this paper argued that in order to maintain patient dignity, medical staff must be able to provide humanized medical treatment and nursing, have professional knowledge and an understanding of dignity, have insight and sense responsibility, and make self-reflections from time to time. Reflection is necessary for the development of personal knowledge and self-awareness, which are important elements of maintaining patient dignity. Moreover, no matter in medical basic education or in clinical continuing education, it is important to continuously cultivate trainees' humanistic literacy and sentiment of caring for life so as to have a deeper understanding and practice of maintaining patient dignity. Maintaining patient dignity is an important aspect of medical practice. Every health caregiver has the responsibility to support and consider patient dignity when serving patients. The Federal Constitutional Court of Germany has declared that where human life exists, human dignity lies (Tsai, 1992). Dignity is an inherent trait of human beings and a basic human right. Maintaining patient dignity is the most important ethic in the process of care. Therefore, every health caregiver has the responsibility to prudently evaluate and protect patient dignity while practicing medical and nursing activities to help their patients recover as soon as possible. Everyone has his or her own goals and meanings of life. After understanding that everyone's life has equal dignity and value, we should urge ourselves to affirm the equality between others and ourselves. Everyone's life is noble and should also live a dignified life.

2.4 Dignity Perception Inventory

Chochinov et al. collected information on how terminal cancer patients understand and define dignity by semi-structured interviews in 2002. Afterward, the Patient Dignity Inventory (PDI) was developed on the basis of this dignity model (Chochinov, Hassard, and McClement et al., 2008). Soon after its publication in 2008, the PDI was adopted by Oechsle, Wais, and Vehling et al. (2014), who revised and applied it in a variety of language environments. Ripamonti, Buonaccorso, and Maruelli (2012) validated the PDI by focusing on Italian patients in oncology treatment centers. The results showed that the Italian version of the PDI was a reliable and valid tool for evaluating issues related to patient perceptions of dignity. The PDI was also translated by Sautier, Vehling, and Mehnert (2014) into a German version, and the results also showed good reliability and validity. Oosterveld-Vlug, Onwuteaka-Philipsen, and Pasman (2015) proposed including the views of family members, nurses, and doctors to measure reports of patient dignity. Chiang and Cheng et al. (2013) also focused on the study of dignity of terminal cancer patients using the PDI as a tool. Ge et al. (2016) translated the PDI into a Chinese version, and the results also showed good reliability and validity. The results of the above studies showed that in different linguistic and cultural contexts, the PDI scales were supported positively with reliability and validity.

3. Research Method

The Patient Dignity Inventory (PDI), developed by Chochinov, Hassard, and McClement (2008), is mainly applied to critically ill patients at the end of life. Although residents in long-term care institutions are not critically ill patients at the end of life, most of them still rely on caregivers to take care of their daily lives. Therefore, the Chinese version was used as a tool to measure the dignity perception of residents in long-term care institutions. The participants were residents randomly selected from 11 long-term care institutions in Yunlin and Chiayi

districts. The questionnaire was administered on residents of the institutions by means of general surveys. If the residents were unable to answer the questionnaire by themselves, their caregivers were asked to read the questionnaire items to the residents, and then the caregivers were asked to fill out the questionnaires. After the questionnaires were collected, exploratory factor analysis was carried out on the PDI items in order to understand the composition of the Constructs of the PDI factors and verify their reliability, and then the characteristics of the factors of each item were analyzed and explained. Following the Likert's scale analysis model, this PDI questionnaire adopted a five-interval design. The respondents were asked to select the degree of their feelings about the problems or phenomena they had recently experienced, with scores divided into: 1=not a problem; 2=minor problem; 3=common problem; 4=major problem; and 5=significant problem.

4. Data Organization and Analysis

The PDI survey was carried out on residents of 11 long-term care institutions in Yunlin and Chiayi districts. A total of 367 valid questionnaires were collected. The questionnaire administration period lasted from April 9 to April 30, 2019. The questionnaire was administered to residents of the institutions by means of general surveys. If the residents could not answer the questionnaire by themselves, their caregivers were asked to read the questions to the residents and then answer the questionnaire truthfully. The basic data and PDI data of the collected questionnaires were analyzed as below.

4.1 Basic Information Analysis

The number of samples filled out by the residents in the 11 long-term care institutions is summarized in Table 1, which shows that the quantity of samples collected from each institution was between 20 and 40, for a total of 367 responded samples.

Table 1: Distribution of Samples Filled out by Residents in Long-term Care Institutions

Institution no.	Number of samples	Percentage
1	30	8.2
2	30	8.2
3	35	9.5
4	36	9.8
5	20	5.4
6	25	6.8
7	49	13.4
8	31	8.4
9	31	8.4
10	40	10.9
11	40	10.9
Total	367	100.0

As shown in Table 2, among the 367 collected copies, the majority of the residents had relatively high ages of 70-79 years old, and 80 years old and above, accounting for 36.8% and 39.5%, respectively (for a total of 76.3%), which was supported by the fact that 68.1% of the questionnaires were filled out by the caregivers of long-term care institutions.

Table 2: Age Distribution of the Responding Residents in Long-term Care Institutions

Age	Number of samples	Percentage
Below 40 years old	6	1.6
40-49 years old	11	3.0
50-59 years old	22	6.0
60-69 years old	48	13.1
70-79 years old	135	36.8
80 years old and above	145	39.5
Total	367	100.0

It could be known from Table 3 that female respondents accounted for a higher ratio of the answering residents in long-term care institutions.

Table 3: Gender Distribution of the Responding Residents in Long-term Care Institutions

Gender	Number of samples	Percentage
Male	155	42.2
Female	212	57.8
Quantity	367	100.0

As shown in Table 4, the educational level of the responding residents of long-term care institutions was low (see Table 2), which could be reasonably inferred from their high ages.

Table 4: Distribution of Educational Level of the Residents in Long-term Care Institutions

Educational Level	Number of samples	Percentage
Elementary school and below	304	82.8
Senior high school or vocational school	39	10.6
Junior college or university	18	4.9
Graduate school and above	6	1.6
Total	367	100.0

As can be seen from Table 5, the most popular religious belief of the responding residents of long-term care institutions was Taoism, which accounted for 56.1%.

Table 5: Distribution of Religious Beliefs of the Residents in Long-term Care Institutions

Religious Belief	Number of samples	Percentage
Buddhism	94	25.6
Taoism	206	56.1
Christianity	7	1.9
Catholicism	3	0.8
Others	42	11.4
No Belief	15	4.1
Total	367	100.0

As can be seen from Table 6, among the financial sources of the responding residents in long-term care institutions, the highest proportion of financial support was provided by their children, accounting for 78.5%, while the proportion of support from social welfare institutions and government support was not high.

Table 6: Distribution of Financial Support of the Residents in Long-term Care Institutions

Financial sources	Number of samples	Percentage
Themselves	54	14.7
Their children	288	78.5
Social welfare institutions	22	6.0
Government	3	0.8
Total	367	100.0

As can be seen from Table 7, the highest percentage of questionnaires was filled out by caregivers in long-term care institutions, accounting for 68.1%, which was due to the residents' higher age and lower education level.

Table 7: Distribution of Questionnaires Filled out by Caregivers in Long-term Care Institutions

Whether filled out by caregivers	Number of samples	Percentage
Yes	250	68.1
No	117	31.9
Total	367	100.0

4.2 PDI Data Analysis

In this study, exploratory factor analysis was used to reduce the inventory items of the questionnaire. The larger the KMO statistics of the exploratory factor analysis, the more common factors among variables would be, and the more suitable it would be for factor analysis to consolidate the questionnaire items. According to Kaiser's point of view, factor analysis can be performed if the KMO value is greater than 0.5. In this study, the KMO value for factor analysis was 0.956. Bartlett's spherical test was used to test whether the correlation coefficients between

items were different and greater than 0. The significant spherical test indicated that the correlation coefficients were sufficient for factor analysis to extract elements. The Bartlett spherical test score for this factor analysis was 7717.585, its degree of freedom was 300, and its p value of significance was 0.000. These test statistics showed that the PDI could be used for exploratory factor analysis. The 25 items in the PDI were then reduced to three constructs for data interpretation. However, in the analysis, it was found that the factor loading values of items A03, A08, A09, A11, A12, A13, and A14 after rotation were all less than 0.6 in all constructs, therefore they were excluded from the analysis. The items represented by the title numbers are shown in the appendix.

The extraction method of principal component analysis was used for the exploratory factor analysis in this paper, and Kaiser's Normalized Varimax Method was used for rotation. Using the Eigenvalue greater than 1 as the screening standard, there were three factor dimensions, and the accumulative loading variance of the squared sum of the rotating axis was 66.926%. After examining the items of each dimension, the component matrix after rotation was renamed as three constructs: "Perceived Dignity", "Emotion Management", and "Living Management". The items for each construct are listed in Table 8 and the content of the items are described in the Appendix. In this study, Cronbach's α coefficient was used as the basis for reliability test of all constructs. The higher the coefficient value, the higher the reliability would be. The statistics of the construct were collated into Table 8. As seen, the lowest Cronbach's α value of the three constructs was 0.88, which indicated that the items in each construct had high internal consistency. The average value of Perceived Dignity and Emotion Management was lower than the median value of 3, and the maximum value was also lower than the median value of 3, which showed that the Perceived Dignity and the Emotion Management of residents in long-term care institutions were between "A SLIGHT PROBLEM" and "A Problem". However, the average value of Living Management was slightly higher than the median value of 3, which indicated that the Living Management of the residents of long-term care institutions was between "A Problem" and "A MAJOR PROBLEM"; i.e., there were obviously many problems to overcome or improve upon in their Living Management.

In the construct of Perceived Dignity, the average score of A22 (Not feeling supported by my health care providers) was 2.34, which was the lowest in the construct, indicating that the residents felt that the Perceived Dignity was between "A SLIGHT PROBLEM" and "A Problem", which was satisfactory. The score of A15 (Feeling that I am not making a meaningful and/or lasting contribution in my life) in the construct of Perceived Dignity was 2.93, a figure close to the median value of 3, which indicated a nearly balanced feeling.

In the construct of Emotion Management, the average score of A05 (Feeling depressed) was 2.63, which was the lowest in the construct, indicating that the residents felt their Emotion Management was between "A SLIGHT PROBLEM" and "A Problem". The score of A07 (Feeling uncertain about illness and treatment) in the construct of Emotion Management was 2.82, which was close to the median value of 3 and indicated a nearly balanced feeling.

In the construct of Living Management, the average score of A10 (Not being able to continue with my usual routines) was 2.97, which was the lowest in the construct, indicating the residents felt that Living Management was close to "A Problem", which was satisfactory. The average score for A02 (Not being able to attend to my bodily functions independently (e.g., needing assistance with toileting-related activities)), referring to situations such as needing others' assistance in toilet use and other related activities, in the construct of Living Management was 3.28, which was much higher than the median value of 3, and which indicated a rather negative feeling between "A Problem" and "A MAJOR PROBLEM".

After analyzing the scores of the three constructs, the PDI questionnaire found that the residents of long-term care institutions needed more support for Living Management. This result indicated that manufacturers should strive to develop living assistive devices to make the residents' lives more convenient.

Table 8: Summary table of the statistical data of each Construct and its items

Item	Quantity	Min.	Max.	mean	S.D.	Construct	Alpha	Mean	Min.	Max.	Variance
A15	367	1	5	2.93	1.20	Perceived Dignity	0.94	2.65	2.34	2.93	0.04
A16	367	1	5	2.85	1.31						
A17	367	1	5	2.70	1.21						
A18	367	1	5	2.83	1.27						
A20	367	1	5	2.61	1.21						
A21	367	1	5	2.37	1.20						
A22	367	1	5	2.34	1.13						
A23	367	1	5	2.71	1.18						
A24	367	1	5	2.69	1.18						
A25	367	1	5	2.47	1.16						
A04	367	1	5	2.77	1.13	Emotion Management	0.88	2.73	2.63	2.82	0.01
A05	367	1	5	2.63	1.22						
A06	367	1	5	2.69	1.20						
A07	367	1	5	2.82	1.19						
A01	367	1	5	3.27	1.35	Living Management	0.89	3.14	2.97	3.28	0.02
A02	367	1	5	3.28	1.44						
A10	367	1	5	2.97	1.29						
A19	367	1	5	3.05	1.24						

5. Conclusions

This research conducted a general survey of the residents of selected elderly support institutions. Through a PDI questionnaire survey of the residents in long-term care institutions, it was found that while living in elderly support institutions, the residents expressed they had received proper and dignified care regarding their Perceived Dignity and Emotional Management, but they had quite a poor feeling about their Living Management, with answers ranging from "A Problem" to "A MAJOR PROBLEM". Next, the residents wanted most to get greater support for living management. Finally, manufacturers should strive to develop living assistive devices in order to improve the convenience of the residents' lives.

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Appendix Items of PDI

#	Items of PDI
A01	Not being able to carry out tasks associated with daily living (e.g., washing myself, getting dressed)
A02	Not being able to attend to my bodily functions independently (e.g., needing assistance with toileting-related activities)
A03	Experiencing physically distressing symptoms (e.g., pain, shortness of breath, nausea)
A04	Feeling that how I look to others has changed significantly
A05	Feeling depressed
A06	Feeling anxious
A07	Feeling uncertain about illness and treatment
A08	Worrying about my future
A09	Not being able to think clearly
A10	Not being able to continue with my usual routines
A11	Feeling like I am no longer who I was
A12	Not feeling worthwhile or valued
A13	Note being able to carry out important roles (e.g., spouse, parent)
A14	Feeling that life no longer has meaning or purpose
A15	Feeling that I am not making a meaningful and/or lasting contribution in my life
A16	Feeling that I have “unfinished business”(e.g., things that I have yet to say or do, or that feel incomplete)
A17	Concern that my spiritual life is not meaningful
A18	Feeling that I am a burden to others
A19	Feeling that I don’t have control over my life
A20	Feeling that my illness and care needs have reduced my privacy
A21	Not feeling supported by my community of friends and family
A22	Not feeling supported by my health care providers
A23	Feeling like I am no longer able to mentally “fight” the challenges of my illness
A24	Not being able to accept the way things are
A25	Not being treated with respect or understanding by others

Source: Chochinov, Hassard, McClement, et al (2008)