

Revisiting the Patient Dignity Question: Paying Attention to Personhood

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Abstract

The Patient Dignity Question (PDQ)—What do I need to know about you as a person to give you the best care possible—was designed as a simple and practical way to elicit personhood in the clinical setting. For the PDQ to be effective, however, clinicians must think of it as the basis of a conversation to be had rather than simply a question to be asked. This special report provides an overview of the PDQ, including the literature that has emerged since it was published over a decade ago, the importance of placing personhood on one's clinical radar, and guidance on how to optimize its application.

Keywords: dignity; palliative care; Patient Dignity Question; personhood

“What do I need to know about you *as a person* to give you the best care possible”—the Patient Dignity Question (PDQ)—first appeared in the literature a decade ago.¹ Since then, it has been implemented in various context worldwide;^{2–5} translated into about 20 languages and studied in diverse patient populations within and beyond the purview of palliative care.^{5–12} It was originally conceived as a means of eliciting personhood in the most simple, feasible way possible. As described in our first PDQ article, patients are invited into a conversation that begins by acknowledging that although we know a great deal about their medical circumstances, far less is known about who they are as persons. This segues to the PDQ, which forms the basis of a brief discussion about “who they are” rather than whatever ailment brought them to medical attention.¹

PDQ conversations can take as little as five minutes or as much as 10–15 minutes. Their essence resides within personhood: who are you?; how would you like to be seen or known?; what is it anyone walking into this room should be aware of or understand to know who they are really looking after? Responses are summarized into no more than a few paragraphs, reviewed with the patient to ensure they are accurate, and then, with the patient's permission, placed on their chart or at their bedside. Ten years of data and experience affirm that PDQs are highly appreciated by patients and families and can enhance health care providers sense of empathy, connectedness, respect, and even job satisfaction. By combining transactional and relational elements of medicine, PDQs make patient care more interesting and engaging, hence mitigating the risk of professional burnout.^{1–12}

But Does It Work?

Over the years, colleagues have occasionally expressed reservations about the PDQ, indicating it doesn't always work. When I ask them to explain, they tell me some patients “just don't get it.” There are several reasons the PDQ might not elicit the kinds of responses it's intended to. A question about personhood may seem far afield from medicine, leading patients to look for answers shaped by their medical circumstances rather than describing who they are as persons. For some the question feels too broad or vague, leaving them unsure where to begin. Finally, and perhaps most critically, if clinicians think of the PDQ as a question to be asked rather than a conversation to be had, this approach can easily fall flat.

I recall my own early experiences with the PDQ and seeing a gentleman who was hoping to be discharged, at least briefly, from the inpatient palliative care unit. During our meeting, I asked him, “what do I need to know about you *as a person* to give you the best care possible.” What I got back was a blank, confused stare. English was his second language, so I restated the question in a variety of ways I thought might be easier to understand. At one point he told me he was worried about how he'd manage the stairs at home, thinking this was the kind of information I was looking for. I told him that was important, and I'd be sure to let his health care team know. I persisted by saying I wanted to know “how you'd like anyone walking into this room to see you or appreciate who you are as a person.” Up until that moment his wife had sat quietly at his bedside. “Now I understand,” she said, and proceeded to tell me her husband was a member of the community choir

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and was the person their neighbors would come to for advice or assistance with household repairs. I nodded my head approvingly as they gushed with enthusiasm and pride, regaling me with further details about who this man really was.

Making It Work

Making the PDQ work means thinking of it as the beginning of an important conversation. Simply reciting or paraphrasing the PDQ without facilitating disclosures focused on personhood often isn't enough. Prompts are sometimes necessary, such as, "are there special qualities you want us to see?," "are there key roles or relationships you want us to know about?," "are there important beliefs or values you'd like to tell us about?" The things patients share through this process permanently change how we see them: the dying Indigenous woman who told me she was a residential school survivor and frightened by professionals wearing white coats; the woman who said her pending death wasn't a tragedy, but thinking about her dying son and wondering what would become of her daughter-in-law and two grandchildren was unbearable; the gentleman who wanted everyone to know he had been a physician and former head of a department of medicine.

So when might the PDQ not work? Only perhaps if we can conceive of patients who are indifferent to being appreciated and understood as unique individuals. In my experience and consistent with my research, the need to be known, to be affirmed, and to be treated with respect and dignity are universal and woven into our collective humanity. Years ago, I wrote, "the reflection that patients see of themselves in the eye of the care provider must ultimately affirm their sense of dignity."¹³ The PDQ offers patients a way to shape the lens through which they are seen, ensuring patienthood doesn't eclipse personhood.

While using the PDQ isn't mandatory, the goals it aims to accomplish are. These include making space for patients to be acknowledged as persons, finding out what patients want us to know about who they are, and using this approach to optimize patient care. Ignoring personhood increases the risk of discordance in goals of care, heightens the chance that patients and families will be dissatisfied and complain about their care, and renders health care professionals more vulnerable to burnout. To be clear, the practice of medicine requires knowledge, diagnostic acumen, and technical skills. But those alone are insufficient, unless patients know we take an interest in them as unique, whole persons. The PDQ is one way to demonstrate that interest, ensuring the human side of medicine remains fixed on our clinical radar. Remember, patients will not care what you know until they know that you care.

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