

Editor's key points

- ▶ The Patient Dignity Question (PDQ) is a tool that can be applied in any health care setting. It consists of asking only 1 question: "What do I need to know about you as a person to give you the best care possible?" By asking patients this single question, and from the discussion that follows, one can elucidate the patient's needs and concerns, allowing providers to more effectively tailor their approach to the patient's care.
- ▶ The Algonquin Grace Hospice in Huntsville, Ont, was interested in trialing the PDQ in its small centre. During the PDQ interviews, patients' stories revealed much about their accomplishments, hopes, and fears. Staff had access to the PDQ interview documents, from which they gained deeper knowledge about the patient (eg, family dynamics, behaviour patterns, likes and dislikes); these insights enabled better relationships and helped staff members be more in tune with the whole person.
- ▶ The written document resulting from the PDQ intervention might also serve as a meaningful "last gift" to be left behind for loved ones.

Patient Dignity Question

Feasible, dignity-conserving intervention in a rural hospice

Pamela McDermott MD CCFP FCFP

Abstract

Objective To investigate the feasibility of using the Patient Dignity Question (PDQ) in a small rural hospice setting.

Design Prospective study.

Setting The 5-bed Algonquin Grace Hospice in Huntsville, Ont.

Participants Nineteen patients who met the research criteria and who were admitted to the hospice from September 2015 to December 2016.

Methods Participants completed the Patient Dignity Inventory and modified versions of the Edmonton Symptom Assessment Scale and Integrated Palliative Care Outcome Scale before and after the PDQ interviews.

Main findings While each of the 19 PDQ interviews was unique, there were many consistencies regarding accomplishments (eg, being a good parent), hopes (eg, one's need of being respected), and fears (eg, concerns about pets) that emerged from participants' stories. Hospice staff found the documents from PDQ interviews to be very valuable in their understanding of patients. Staff and patients unanimously wanted the program to continue. An unexpected benefit was the response of the patients' families who were deeply moved by the legacy documents, often sharing them following their family member's death.

Conclusion The PDQ is a dignity-conserving intervention that serves as a meaningful end-of-life legacy document that benefits patients, staff, and families. Using the PDQ at the hospice helped patients feel truly heard, and increased caregivers' compassion and understanding of patients' needs.

Question sur la dignité du patient

Intervention pratique pour préserver la dignité du patient dans un centre de soins palliatifs rural

Pamela McDermott MD CCFP FCFP

Résumé

Objectif Explorer la possibilité d'utiliser la Question sur la dignité du patient (QDP) dans un petit centre de soins palliatifs en milieu rural.

Type d'étude Étude prospective.

Contexte La Maison de soins infirmiers Algonquin Grace à Huntsville (Ontario), qui contient 5 lits.

Participants Dix-neuf patients qui répondaient aux critères de la recherche, admis au centre de soins palliatifs entre septembre 2015 et décembre 2016.

Méthodes Les participants répondaient aux questionnaires du Portrait de la dignité du patient ainsi qu'à celles des versions modifiées de l'Échelle d'évaluation des symptômes d'Edmonton et de l'Échelle des résultats des soins palliatifs intégrés, et ce, avant et après les entrevues réalisées au moyen de la QDP.

Principales observations Même si chacune des 19 entrevues réalisées à l'aide de la QDP était unique, de nombreuses constantes se sont dégagées des histoires des patients à propos des réalisations (p. ex. avoir été un bon parent), des espoirs (p. ex. que ses propres besoins soient respectés) et des craintes (p. ex. inquiétudes pour les animaux de compagnie). Le personnel du centre de soins palliatifs a trouvé très utiles les documents tirés de l'entrevue réalisée avec la QDP pour mieux comprendre les patients. Le personnel et les patients voulaient unanimement que le programme se poursuive. Un bienfait inattendu est apparu : la réaction positive des familles des patients, profondément touchées par les documents laissés en héritage, souvent remis aux membres de la famille après le décès du patient.

Conclusion La PDQ est une intervention pour préserver la dignité du patient qui sert de document à léguer en fin de vie et qui apporte des bienfaits aux patients, au personnel et aux familles. L'utilisation de la PDQ au centre de soins palliatifs a véritablement aidé les patients à se sentir écoutés, et a accru la compassion des aidants et leur compréhension des besoins des patients.

Points de repère du rédacteur

► La Question sur la dignité du patient (QDP) est un outil qui peut servir dans tout établissement de santé. Il ne compte qu'une seule question : « Que dois-je savoir à propos de vous en tant que personne pour que je puisse vous donner les meilleurs soins possible? » En posant cette seule question, et à partir de la discussion qui s'ensuit, il est possible de clarifier les besoins et les inquiétudes du patient, ce qui permet aux soignants d'adapter plus efficacement leur approche quant aux soins à prodiguer à ce patient.

► La maison de soins palliatifs Algonquin Grace Hospice à Huntsville (Ontario) souhaitait mettre à l'essai la QDP dans son petit centre de soins palliatifs. Durant les entrevues au moyen de la QDP, les histoires des patients en ont révélé beaucoup à propos de leurs réalisations, de leurs espoirs et de leurs craintes. Le personnel avait accès aux documents sur les entrevues réalisées avec la QDP, ce qui leur permettait de mieux connaître le patient (p. ex. dynamiques familiales, habitudes comportementales, ce qu'il aime et déteste); ces renseignements ont facilité les relations et ont aidé le personnel à être davantage au diapason de la personne toute entière.

► Le document écrit tiré de l'intervention réalisée avec la QDP peut aussi servir de précieux « dernier cadeau » à laisser aux personnes chères.

The belief that one may persist, not in one's individual personhood, but through values and actions that ripple on and on through generations to come can be a powerful consolation to anyone anxious about his or her mortality.

Irvin D. Yalom¹

The importance of retaining dignity in the face of a life-limiting illness and impending death has been a focus of study and research for several decades.²⁻⁴ From their work on the influencers of dignity in palliative patients, Dr Harvey Max Chochinov, Director of the Manitoba Palliative Care Research Unit of CancerCare Manitoba in Winnipeg,^{5,6} and his team developed a dignity-conserving model of care⁷ as a succinct way of thinking about, and addressing, the issue of dignity conservation.

Briefly, the dignity-conserving model identifies 3 main categories of factors that affect an individual's sense of dignity: how the specific illness itself affects the patient's sense of dignity; how the patient's own perspectives and practices influence his or her sense of dignity; and the positive or negative effects of interactions with others on a patient's sense of dignity.

Research stemming from this model led Chochinov and his team to devise a number of practical tools and therapeutic interventions to assist health care providers to better enhance a patient's sense of dignity. One of these tools is the Patient Dignity Inventory (PDI), available at **CFPlus**,* which consists of 24 questions about the most common factors that influence a person's sense of dignity and provides a "moment in time" look at what most affects the patient currently.^{8,9} The PDI questions are scored on a Likert scale from 1 (not a problem) to 5 (an overwhelming problem). The answers can help identify areas of distress related to loss of dignity leading to a deeper exploration of issues specific to each patient. The PDI is a unique measure in that it includes not only the physical realm, but also the psychosocial, spiritual, and existential ones. The tool has been found to have clinician and patient acceptance in a variety of settings, as well as in cancer and noncancer populations.^{8,10}

More recently, Chochinov and his team developed a tool called the *Patient Dignity Question (PDQ)*,¹¹ a brief intervention that can be easily applied in any health care setting.¹² It consists of asking only 1 question: "What do I need to know about you as a person to give you the best care possible?" By asking this single question, and from the discussion that follows, one can elucidate the individual's more hidden and, as of yet, unexpressed desires and fears, allowing the provider to more effectively tailor care to the individual's needs. Equally important is enhancing the patient's sense of personhood—in other words, patients become aware

about what makes them unique and learn to understand that they are not merely defined by their illness. Giving patients an opportunity to express how their illness affects them allows the health care providers a deeper understanding of that individual's unique needs. The written document resulting from this intervention might serve as a legacy to be left behind for loved ones, thereby providing a meaningful "last gift."

The PDQ was first trialed in a large urban centre by Dr Chochinov's team. Because of its inherent simplicity, as well as the capacity to enhance our care including fostering greater dignity, our group was interested in trialing the PDQ in our small centre. The goal was to investigate the feasibility and potential effects of using the PDQ in a small residential hospice in a rural setting with limited resources of time and personnel.

— Methods —

Setting

Algonquin Grace Hospice is a 5-bed residential hospice that supports the rural northern community of Huntsville, Ont, with a population of 19800,¹³ and the surrounding areas. Most of the admissions are local patients who are expected to die within 3 months.

Study design

Patient inclusion protocol. All the patients were inpatients at Algonquin Grace Hospice. The facility uses the Palliative Performance Scale to measure 5 observer-rated parameters: ambulation; activity and evidence of disease; self-care; intake; and level of consciousness. Patients who met the following criteria were invited to participate: scored 30% or higher on the Palliative Performance Scale¹⁴; were able to read and write English; and were not delirious or otherwise cognitively impaired.

The study period was from September 2015 until December 2016. Nineteen individuals participated. The study recruiter, who was not otherwise involved in the care of the patients, approached those who met the inclusion criteria with a prepared script, introducing them to the goals of the study as well as providing written information. Once written and informed consent was acquired, the recruiter administered the PDI and modified versions of the Edmonton Symptom Assessment Scale (ESAS)¹⁵ and the Integrated Palliative Care Outcome Scale (IPOS).¹⁶ These measures were only used in this study to assess changes following the intervention. Within a day or 2, the investigators met with each patient and asked the PDQ, asked other clarifying questions, and answered patient queries. From the written notes, the results were typed up and then read to the patient, allowing for subsequent editing. Then, again with permission, this document was put in the patient file for the staff to read, and copies were given to the patient to distribute as he or she wished. Within another

*The **Patient Dignity Inventory** is available at www.cfp.ca. Go to the full text of the article online and click on the **CFPlus** tab.

few days, the recruiter again administered the same 3 questionnaires with 1 additional question that asked patients how completing the PDQ affected them. The results of the questionnaires were anonymized.

Staff participant protocol. Following the completion of the PDQ interviews, staff members (consisting of registered nurses and personal support workers) were invited to anonymously respond to a health care provider feedback questionnaire, which was a modification of the questionnaire used in a study by Chochinov et al that evaluated the influence of the PDQ on health care providers.¹⁷ At Algonquin Grace Hospice, each 8-hour shift is staffed by a registered nurse and a personal support worker.

The protocol was approved by the Research Ethics Board at Laurentian University.

— Findings —

The care of the sick unfolds in stories.
Columbia Narrative Medicine¹⁸

Over the course of this study, there were 131 admissions to the hospice. Of these patients, 34 met the inclusion criteria and were approached to participate in the study. Six patients declined to participate owing to either lack of interest or feeling too ill. One individual consented, but his son objected, and he was excluded from the study. There were 8 patients who began the study (doing the 3 pre-PDQ questionnaires [PDI, ESAS, and IPOS] and the PDQ) but deteriorated before doing the 3 questionnaires again after the PDQ interview. Nineteen individuals (11 women and 8 men) completed the whole process.

Most of the patients (17 of 19) who completed the study were admitted with terminal cancer (brain, lung, hematologic, bowel, pancreas, prostate, ovarian, liver, laryngeal, melanoma, breast, and renal); 1 was admitted with terminal chronic obstructive lung disease and 1 with frailty.

Themes that emerged from the PDI

From participants' PDI results, any response with a score of 3 or higher was considered an area of concern to be explored further by the investigators and staff. In our study sample, the areas of greatest distress were dependency issues: the inability to carry out tasks associated with daily living (eg, getting dressed, washing) and not being able to attend to bodily functions (eg, needing toilet-related assistance). Fourteen of 19 (74%) participants scored this as *a problem* (score of 3) or *a major problem* (score of 4). Nine patients identified the changes in how they looked to others as a problem, which is in the category of existential distress. In the area of symptom distress, 8 patients indicated feeling uncertain about their health and worrying about the

future as substantial (*major* or *overwhelming*) problems and 7 respondents identified not being able to carry out usual routines as a problem. Less than 25% of participants found factors such as physically distressing symptoms, anxiety, depression, lack of peace of mind, and lack of social supports as *a problem* or *major problem*. These findings closely match other studies on dignity-related distress at end of life.¹⁹⁻²¹

An attempt was made to address each area of concern for each patient (eg, reviewing nursing interventions, medications for symptom control, and psychosocial supports).

Themes that emerged from the PDQ

While each of the 19 PDQ interviews was unique, there were many consistencies regarding accomplishments, hopes, and fears that emerged from participants' stories. **Tables 1** and **2** present various themes and participant revelations that emerged during the PDQ interviews.

Themes that emerged from staff feedback

Although staff members did not administer the PDQ interviews, they had access to the completed documents in the patient files. As patients' primary caregivers during their stay at Hospice, staff members are in a unique position to comment on the effects of the PDQ on patients and their care. One staff member's statement summed this up:

I think they [PDQ interviews] give a voice to the resident. For some the diagnosis has been very sudden—for others, it's death by degrees. Regardless, this opportunity to put pen to paper, so to speak, allows the resident to describe themselves, not in terms of illness, but in terms of life.

In response to the question about what they learned that was new information or what affected them emotionally, staff members identified areas concerning patients' family backgrounds, past experiences, deaths, spouses, and families. They believed this information enhanced their ability to create a deeper therapeutic relationship with the client and increased their compassion and understanding. Staff members were also able to have a more in-depth understanding of certain behaviour patterns and traits. They could identify patients who "didn't want a fuss to be made," as they gained insight on how these patients approached their life and impending death.

In addition, staff not only learned the patients' likes and dislikes (eg, food choices, opinions on being touched, sociability qualities, philosophic ideas), but also the reason behind certain behaviour patterns and mannerisms (eg, experience of childhood abuse). These insights enabled better relationships and a deeper perspective on the individual, and, in short, helped them be more in tune with the whole person. Staff knew which

Table 1. Themes that were most commonly discussed by participants who completed the PDQ interview: *N* = 19.

THEME	NO. OF PARTICIPANTS
Marriage	13
Love of their spouse	4
Children*	16
One's childhood	1
Working history [†]	19
Religion	
• Very religious [‡]	1
• Not very religious [‡]	5
• Moderately religious [‡]	7
• Non-traditional form of religion	1
• "Have lost my faith and am finding my way back"	1
• No religious belief	4
Accomplishments	
• Having a good personality	3
• Being a good parent	5
• Raising good children	4
• Doing good for others	5
• Making a good family life	7
• Giving back to the community and friends	5
Messages to others	
• Work hard	3
• Express your love for those around you	6
• Do not take others for granted; people can change	5
• Set an example; do what is right	5
• Give thanks for life	4

PDQ—Patient Dignity Question.

*Three participants were overwhelmed with the happiness and pride their children brought them.

[†]All but 2 participants mentioned positions they had held with a sense of pride.

[‡]In the traditional form of religion.

patients wanted more space and those who wanted more contact. Through this window, insight was also gleaned into family dynamics, which helped in maneuvering through the sometimes difficult family relationships, thereby being a source of nonintrusive support.

Reading the PDQ interviews was also found to improve compassion among staff: the knowledge of what others have faced in their lives generated an empathic response that increased levels of compassion among several staff members. Levels of respect were not changed: all staff were committed to giving all

patients respect regardless of any other factor, because of their commitment to hospice palliative care and inherent human duty to others. Compassion and empathy were also seen as "a given," although these were easier to achieve knowing the patients' stories and having that connection with them.

Being a witness to the PDQ stories gave staff a great deal of personal satisfaction. It was often their first opportunity to know their patients as the people they were before their illness, to see them outside the clinical frame. The PDQ became an unexpected tool allowing provision of more individualized end-of-life care. The perception among staff members of the PDQ being important for themselves and for the patients is reflected in these 2 comments.

I would like to see the PDQs continued. The brief look inside one's life can have a profound effect on one's end of life.

I feel they are important, not only for staff to establish, maintain, [and] expand the caregiver relationship, but also give the person a chance to reflect on their life in a constructive way.

Although this study did not aim to formally seek out the opinions of family members, we did receive much informal feedback. Several families told us they read the PDQ document out at the funeral or framed it to be on display at the visitation.

— Discussion —

A whole is that which has beginning, middle and end.
Aristotle

Over the past decades, medical care has evolved from disease-oriented care (where the disease is central), to patient-oriented care (which puts the patient at the centre), to person-centred care (which considers the needs of the person within the patient role), and now to whole-person care.²¹⁻²⁴ This latter approach means seeing the patient as a person in the context of his or her culture, family, and community system.⁵ Listening to the patient's story is an important place to begin to adequately achieve this goal.

The PDQ is a dignity-conserving intervention that serves as a meaningful end-of-life legacy document that benefits the patients, staff, family, and loved ones. It can highlight patients' concerns, as well as their hopes, fears, and dreams, allowing caregivers a deeper understanding of the individual and enhancing end-of-life care. It gives patients a voice and opportunity to speak about topics that are deeply important to them and that they might have not have spoken about before. Staff who share in this knowledge gain a framework within which they can individualize the care to that patient.

Table 2. Revelations from participants during the PDQ discussions

PATIENT*	REVELATIONS: WHAT PARTICIPANTS SHARED DURING PDQ DISCUSSIONS
Patient A	She is a southpaw and wants us to know this so that things are placed properly by her bed. She has always worked hard from when she was a teenager on, eventually working in elder care, which gives her insight into what she wants for herself now. Her biggest accomplishment is being left with the feeling that she is a “nice person.” Because she cared for an elderly parent with cancer at her home, she is grateful to be at Algonquin Grace Hospice where she will receive the same loving care
Patient B	For her dignity, she is doing more for herself. Because just 4 weeks before, she was still caring for herself and driving; the sudden change to dependency has been a hard adjustment. It is hard for her to ask for help, and she wants at least to try. She wants her room to be quiet, and for things to be done quietly and slowly. She wants to be allowed to sit and let memories rise into her mind. She used to be fastidious about her grooming and spent time each day on that task; however, now a good start to the day would be sitting quietly with a good cup of coffee. She is not afraid of dying as long as the pain is controlled. She was always happy and contented, and wants to live her life out that way
Patient C	It has been “beautiful” coming to Hospice, not having to worry about anything. Sometimes she thinks she gets too much care because she wants to still do things for herself. Because she immigrated to Canada as a young person, she has worked hard to build a good life for her family. She misses her husband who died some time ago, but feels there was a reason for his death, as there is for her; however, it is not for her to figure it out. Because she was always forthright with her children, she will die knowing they are clear about what is right and what is not
Patient D	In spite of all the visitors she has, she is actually a private person who likes alone time. Now that she is faced with her own mortality, she is able to be the “bad guy” and ask people to leave, and generally be more vocal and opinionated. The worst thing that could happen to a mother happened when her young son died without a clear diagnosis—after that, it made parenting all the more precious. And seeing how her children do as parents makes her so proud she could shout it from the rooftops. She lost her faith after her child died, but it is gradually returning. And although she is not afraid to die she feels like there is more for her to do. Doing the “end-of-life thing” at home is overrated and, in fact, she now no longer wants to die. But when that happens, she wants it to be peaceful in the way her dad had died
Patient E	She appreciates that the staff check on her and show no impatience no matter how often she rings. Because her husband died at Hospice, she knows what to expect. After the initial diagnosis, she had decided not to pursue further investigations or treatments because of her advanced age. She wants to leave a message for young people to work hard and persevere in their relationships. She once had a disturbing dream about dying, but a minister reassured her and now she knows she is in God’s hands
Patient F	He jokes that the staff is right on top of things, having picked him up off the floor several times already. He admits that he is hard to get along with and “crusty,” so giving up his independence has been tough. He has been married for 60 years and considers this, as well as raising good children, as his biggest accomplishment. He says he has no idea of what happens after death but will rest assured that his wife will be okay without him. He especially wants his family to know how much he loves them
Patient G	He feels like he has been on a merry-go-round following the diagnosis, with everything changing in his health, his interests, and his abilities. He worries about his lack of interest in things and that he will end up with nothing to do. He sees that as the end of life. As a result, he finds himself lashing out at those closest to him; even his voice is so different that he does not recognize himself
Patient H	She has found that the best way to cope is just to cooperate; that going from healthy to dying so rapidly leaves no other options. It is hard for her to give up control, having been a working single mother and needing to be in charge. She needs explanations of what is happening so that she “freaks out” less. She does not feel like she is done with life
Patient I	She values communication, so that she knows what is happening and so that she can prepare for what is ahead. Her faith has underlined the significance and richness of life, to not take life for granted. She wants us to know she has a fear of the dark and likes a light left on. She looks back on her life and work and is grateful that it allowed her love of people to shine through. She expects to see her mother and husband in heaven after she dies and therefore is currently at peace
Patient J	He misses his independence—the little things like getting to the bathroom or having a shower. He appreciates the staff allowing him to do what he can. As there has been some improvement since coming to Hospice, he hopes he can even go home for a time until he deteriorates further
Patient K	He enjoys company and having people to talk with even though he lives alone. He considers his beloved dog his child, and what will happen to the dog when he dies is his biggest worry. He believes that after you die, that is it. He is proud of having been a good advice-giver to others, and wants people to know that if you do not like what you are doing to quit: life is more than just about money

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PATIENT*	REVELATIONS: WHAT PARTICIPANTS SHARED DURING PDQ DISCUSSIONS
Patient L	She can be “crusty” and wants to be treated fairly. She is not afraid to speak up when she wants something. While she knows it was the right decision to come to Hospice, things have happened so fast and it has been a tough adjustment. Because she had a broken home, it was important to her to make her marriage work. She is proud of her connection with her children, grandchildren, and great-grandchildren. She has sorrow around a son she does not see. She is saddest during the night when she is alone. She believes that when you die, you die; so because she’s made all the arrangements for after death, she is sad but accepting
Patient M	He wants to be treated as a man and not a child. And does not want to be treated in a “sugary” manner. He has been independent, living in the bush and not needing a lot of people except his wife. He feels trapped by having to ask for things even though the staff is very responsive. He recalls his rural life growing up with his grandparents when his dad went off to war, so he felt closer to his grandfather as a result. He fell in love with his wife when she was just 12, so had to wait until she was 18, and they have been married for 54 years. There are things about his work in emergency services that still haunt him. His biggest accomplishment is raising his sons and trying to teach them something each day, like his grandfather did. He thinks that there is some sort of god, and although there’s a soul that goes somewhere, mainly when you’re dead, you’re dead. He would like to be remembered for doing the very best that he could
Patient N	He has various likes and dislikes: how he likes his food, his position in bed, what kind of bath. He loves company and is proud of his sense of humour. He wants the facts and to see the medical reports for himself. Some of his best years have been recently, having begun to live with his new love. It helped him recover from the loss of his wife of 30 years. He loved being a dad and loved helping people, especially displaced people after the war, helping them get settled and get work. He thinks it is important to set an example to others about love and not taking relationships for granted. Having his XX stay the night here with him means the world. He sees God as creating the world we live in and then He checks out and leaves it for us to work it out. He has resigned himself to dying and feels at peace with God and hopes God is at peace with him
Patient O	She wonders if she should have pushed more to find out about her symptoms, but on the other hand never wanted to get old and disabled, so she asked to avoid any “heroics.” She is not one to get into a “fuss or dither” and does not worry about the future. Her parents both died young, so she relied on herself. She is proud that she never got up in the morning with any regrets. She feels ready to go when the time is right and what happens after that is not her concern. Her only advice for others is to be nice. She says she is not here to judge others; she has lived her life, chosen her route, and it is up to others to do theirs
Patient P	He likes to have company to talk with even though he has not always been someone who likes company. He has been a bachelor all his life and considers his dog his family; that is who he worries about when he is gone. He says he is not religious and believes that when you die, that is it. His advice to others is to find what you are good at and enjoy it: it’s the only way to have a satisfactory life

PDQ—Patient Dignity Question.
 *Owing to the sensitive nature of the material, only nonidentifying excerpts from the summaries have been included.

And the patient’s family and loved ones have a document to remember the patient’s poignant last days.

Administering the PDQ took approximately 1 hour: 30 minutes for interviewing, 15 minutes for transcribing, and 15 minutes for sharing with patients and making any alterations. Although useful information was gleaned from the PDI and the ESAS and IPOS scores, very ill patients found them tiring, and these measures will not be included in the future.

Being able to administer the PDQ on admission would increase the yield of patients well enough to participate.


Although our study required the investigators to administer the PDQ, it can be administered by general staff members from a variety of disciplines (nursing, medicine, social work, pastoral care) or volunteers who are trained in interviewing techniques.²⁴ This would enable a wider use of this tool, especially in settings with limited staffing resources. The nursing staff at the hospice expressed interest in using this tool. Volunteers are already integrated at the hospice and readily accepted by families and patients.

Limitations

This study involved a small sample size over a short period of time, and the patients knew the purpose of the intervention before participation. The participants were all very ill and close to death, which might have influenced their responses. Almost all of the participants had previously been under the care of the local palliative care team before admission, and it is possible many of their concerns had already been addressed.

Conclusion and future directions

This study found that the use of the PDQ in a small hospice centre provided residents with an opportunity for their voice to be heard and staff members with invaluable knowledge about patients that helped them in their care approach. Hospice staff and patients unanimously wanted the program to continue. Training interested staff and selected volunteers to administer the PDQ would improve general accessibility to this meaningful intervention.²⁴ Also, including family members during PDQ interviews would enable patients who are unable to answer for themselves to participate, and add a deeper dimension to the final

product. A future study will be designed to survey families, asking them about how the PDQ affected them following their loved one's stay at the Algonquin Grace Hospice. In addition, both the PDI and the PDQ would be useful adjuncts to palliative patients from the entry point into our palliative care services. Repeating these from time to time throughout the course of a patient's illness could serve to highlight shifting areas of concern. 

At the time of the study, Dr McDermott was Assistant Professor with the Northern Ontario School of Medicine, and was Psychosocial Team Lead for the Hope Huntsville Palliative Care Team, a division of the Algonquin Family Health Team, in Ontario.

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Competing interests

None declared

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