Palliative and Supportive Care

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A Portuguese trial using dignity therapy for adults who have a life-threatening disease: Qualitative analysis of generativity documents

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Original Article

Cite this article: Julião M, Sobral MA, Johnston B, Lemos AR, Almeida S, Antunes B, Dönmez ÇF, Chochinov HM (2022). A Portuguese trial using dignity therapy for adults who have a life-threatening disease: Qualitative analysis of generativity documents. *Palliative and Supportive Care* **20**, 189–195. https://doi.org/10.1017/S1478951521000754

Received: 9 October 2020
Revised: 9 May 2021
Accepted: 30 May 2021

Key words:
Dignity therapy; End-of-life care; Generativity document; Palliative care; Qualitative analysis; Terminal care

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Abstract

Objectives. Dignity therapy (DT) is a brief, individualized intervention, which provides terminally ill patients with an opportunity to convey memories, essential disclosures, and prepare a final generativity document. DT addresses psychosocial and existential issues, enhancing a sense of meaning and purpose. Several studies have considered the legacy topics most frequently discussed by patients near the end of life. To date, no Portuguese study has done that analysis.
Method. We conducted a qualitative analysis of 17 generativity documents derived from a randomized controlled trial (RCT). Inductive content analysis was used to identify emerging themes.
Results. From the 39 RCT participants receiving DT, 17 gave consent for their generativity document to undergo qualitative analysis. Nine patients were female; mean age of 65 years, with a range from 46 to 79 years. Seven themes emerged: "Significant people and things"; "Remarkable moments"; "Acknowledgments"; "Reflection on the course of life"; "Personal values"; "Messages left to others"; and "Requests and last wishes".
Significance of results. Generativity document analysis provides useful information for patients nearing death, including their remarkable life moments and memories, core values, concerns, and wishes for their loved ones. Being conscious of these dominant themes may allow health providers to support humanized and personalized care to vulnerable patients and their families, enhancing how professionals perceive and respond to personhood within the clinical setting.

Introduction

Dignity can be defined as the quality of being worthy of honor or respect. The concept of dignity is one of the central pillars of holistic medicine and is often described as an integral part of what it means to be human. The undermining of dignity has been associated with depression, desire for death, and a loss of hope among patients with life-threatening and life-limiting conditions. Over the last 20 years, there has been significant scientific investment in clarifying and implementing dignity-conserving care (Chochinov, 2002). The qualitative work by Chochinov et al. (2002) regarding the concept of dignity led to the creation of the Model of Dignity of the terminally ill, which offered essential insights into how patients face terminal illness in terms of illness, social, and personal-related factors. This model was the basis for the creation of dignity therapy (DT), a brief, individualized intervention, which provides terminally ill patients with an opportunity to convey memories, essential disclosures, and prepare a generativity document, addressing psychosocial and existential issues, bolstering a sense of meaning and purpose.

DT has been successfully tested and developed in many countries such as Canada, Australia, Scotland, Portugal, England, Spain, Denmark, and USA (Chochinov et al., 2002, 2005, 2008, 2011; Hall et al., 2012; Julião et al., 2013, 2014, 2017; Houmann et al., 2014; Johnston et al., 2015, 2016; Rudilla et al., 2016). Robust quantitative research demonstrates DT's efficacy on several outcomes such as sense of dignity, quality of life, depression, anxiety, desire for death, and demoralization (Julião et al., 2013, 2014, 2017); and a recent literature review reinforces DT's overwhelming acceptability among patients and loved ones, rare for

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https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

psychosocial-spiritual interventions (Fitchett et al., 2015). DT is also one of the few evidence-based psychotherapies available to people in the last months of life.

Although there are a large number of papers using quantitative methods to assess DT's efficacy, across several psychosocial outcomes, qualitative descriptions of themes emerging within generativity documents are still lacking (Goddard et al., 2013; Dose and Rhudy, 2018; Testoni et al., 2019). The latter provides opportunities to explore further and better understand the perspectives of people regarding their end-of-life experience (Johnston et al., 2015; Dose and Rhudy, 2018). A study by Hack et al. (2010) reported qualitative analysis of 50 generativity documents, showing that DT serves to provide a safe, therapeutic environment for patients to review the most meaningful aspects of their lives in such a manner that their core values become apparent. Their findings show that dying patients commonly used DT as a mean to affirm significant others and to express wishes and gratitude toward others. The most common values expressed included "family," "pleasure," "caring," "a sense of accomplishment," "true friendship," and "rich experience." As part of a feasibility study of implementing DT for patients receiving hospice care, Montross et al. (2011) performed the qualitative analysis of 27 generativity documents, and 11 themes emerged. Documents showed that all of the patients used the opportunity to discuss their pertinent autobiographical information, loved ones they had experienced in life, and the lessons they had learned along the way. The majority of patients also discussed their defining roles, accomplishments, character traits, unfinished business, hopes and dreams for others, and times that were important.

Another study by Johnston et al. (2015) analyzed generativity documents from people with early-stage dementia using framework analysis. Main themes from the analysis were the "origin of values," "essence and affirmation of self," "forgiveness and resolution," and "existentialism/meaning of life." Each of these categories can contribute to the care and support of people with dementia, providing vital information to enable connections to be established or continued. Even when communication ability diminishes and cognition is compromised, healthcare providers should prioritize, promote, and safeguard human dignity.

Following the quantitative analysis of the Portuguese randomised controlled trial (RCT) on DT's efficacy in palliative care patients (Julião et al., 2013, 2014, 2017), the authors decided to analyze the generativity documents resulting from DT. We aimed to use qualitative methodology to extract the main themes emerging from 17 generativity documents, in order to gain a deeper understanding of the value of using DT for people who have life-limiting disease. The question guiding the qualitative work of the study was: can the thematic features of generativity documents provide a deeper understanding of the value of using DT for people who have a life-threatening disease?

Methods

Study design

Generativity documents from a phase II nonblinded RCT were subjected to qualitative analysis (Julião et al., 2013, 2014), applying inductive content analysis. Inductive content analysis is an ideal research method for approaching largely unknown phenomena (Kyngas, 2020). This approach was deemed suitable, given that few studies have examined this particular issue (Kyngas, 2020). This approach allowed us to discern what is most salient under the rubric of generativity for patients nearing death (Starks and Trinidad, 2007). It also enabled us to understand and explore various dimensions of the shared narrative voiced by this cohort of dying patients. The theoretical underpinning for this study was based on Erikson's (1963) theory of psychosocial development and, in particular, generativity. According to this theory, leaving a legacy is an important part of generativity for individuals nearing death. Our study contributes to individual generativity by way of facilitating the creation of legacy documents.

Our study received ethical approval from the Ethics Committee of the Instituto das Irmãs Hospitaleiras do Sagrado Coração de Jesus – Casa de Saúde da Idanha and from the Ethics Committee of the Faculty of Medicine of the University of Lisbon.

Participants and setting

Purposive sampling was undertaken with adults who had a life-threatening disease. Patients were recruited for the RCT from an inpatient palliative medicine unit in Lisbon, over 36 months. We used the following inclusion criteria for the RCT: 18 or more years of age; having a life-threatening disease with a prognosis of 6 months or less; no evidence of dementia or delirium, determined by chart review or clinical consensus of the palliative care team; Mini-Mental State score 20 or more; ability to read and speak Portuguese; ability to provide written informed consent; and able to take part in four to five research encounters over a period of 1 month.

Data collection

Patients enrolled in the DT group were guided through a conversation by a trained DT therapist, in which aspects of their lives that they would most want their loved ones to know about or remember were audio-recorded. These recorded sessions provided the basis of an edited transcript or generativity document, which was returned to patients for them to share with individuals of their choosing, within two to three days after the therapeutic session occurred. As is usual in DT, the participants were able to add information to the generativity documents they received from the researchers during the feedback phase. Therapeutic sessions, usually running between 30 and 60 min, were guided using the Dignity Therapy Question Framework (DT-QF) comprised of nine questions based on the fundamental tenets of the Dignity Model (Table 1),. The DT-QF is not intended to be rigid or prescriptive. Each question is meant to elicit some aspect of personhood, provide an opportunity for affirmation, or help patients reconnect with elements of self that were, or perhaps remain, meaningful or valued. The DT-QF provides a flexible structure, within which patients are able to share memories, guidance, and wisdom with those they are about to leave behind. Trained therapists have the latitude and responsibility to explore legacy-related issues, as dictated by the needs and goals of each individual patient. Before performing DT, patients were provided with the DT-QF, thus giving them time to reflect and shape their eventual responses. All DT sessions were conducted according to guidelines described and published by Chochinov (2011) and were completed by the principal investigator (M.J.), an experienced DT therapist and researcher. Field notes were not collected.

Data analysis

Generativity documents were iteratively analyzed by applying inductive content analysis. Inductive content analysis is an ideal research method for approaching largely unknown phenomena (Kyngas, 2020). In this study, inductive content analysis was

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

Table 1. DT question protocol

Tell me a little about your life history; particularly the parts that you either remember most or think are the most important? When did you feel most alive?
Are there particular things that you would want your family to know about you, and are there particular things you would want them to remember?
What are the most important roles you have played in your life (family roles, vocational roles, community service roles, etc.? Why were they so important to you, and what do you think you accomplished within those roles?
What are your most important accomplishments, and what do you feel most proud of?
Are there particular things that you feel still need to be said to your loved ones, or things that you would want to take the time to say once again?
What are your hopes and dreams for your loved ones?
What have you learned about life that you would want to pass along to others? What advice or words of guidance would you wish to pass along to your [son, daughter, husband, wife, parents, other(s)]?
Are there words or perhaps even instructions you would like to offer your family, in order to provide them with comfort or solace?
In creating this permanent record, are there other things that you would like included?

used, given that few studies have examined this particular issue (Kyngas, 2020). Data saturation was reached after coding 15 transcripts, with two additional transcripts were analyzed to confirm identified themes and codes.

To ensure the trustworthiness of data analysis, we used a team of two independent coders (A.R.L., S.A.). None had a relationship with the principal investigator or with the patients during the trial period. A.R.L. and S.A. had expertise in qualitative methods and began their initial approach by reading the literature on the Model of Dignity of the terminally ill, DT, and the DT-QF that supports DT sessions, and also research reporting qualitative analysis of generativity documents derived from DT. After doing so, they developed a preliminary coding scheme based on the content and fundamental aspects of DT, including codes that captured key themes such as pride, core values and roles, hopes, dreams, and messages for others.

An independent iterative coding was created, based on a subset of five randomly selected generativity documents. If necessary, new codes were added to reflect new emergent categories as well as looking for redundancies or overlaps. After finishing the initial coding, A.R.L. and S.A. completed coding independently.

Code labels were continuously compared and discussed in successive research meetings to determine the extent of coder agreement and coding framework update. Emerging disagreements were first discussed between the two coders until final consensus was reached. The percent agreement among the codes ranged from 50 to 100%, with an average agreement of 78.6%. If needed, a third researcher (M.J.) was available to resolve any discrepancies. No qualitative data analysis software was used in this study. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) framework was used to report the design, analysis, and findings of our study (Tong et al., 2007).

Results

Participants' characteristics

In total, 39 terminally ill patients received DT, 17 of whom gave written consent for their generativity document to be qualitatively

Table 2. Summary characteristics of participants (*N* = 17)

Female, *n* (%)	9 (52.9)
Caucasian, *n* (%)	17 (100)
Age, years; mean (SD), *n* (%)	64.8 (8.2), range = 46–79
Marital status, *n* (%)	
Married/common-law	9 (52.9)
Widowed	3 (17.6)
Divorced/separated	3 (17.6)
Single	2 (11.7)
Religious affiliation, *n* (%)	
Catholic	15 (88.2)
Other	2 (11.7)
Cancer diagnosis[a], *n* (%)	17 (100)
Time since diagnosis, years; mean (SD), *n* (%)	4.4 (4.0), range = 1–16
Palliative Performance Scale[b], mean (SD)	55.9 (16.2), range = 30–80

SD, standard deviation.
[a]Ovarian, *n* = 4; lung, *n* = 3; breast, *n* = 1; colon, *n* = 1; esophagus, *n* = 1; glioblastoma, *n* = 1; multiple myeloma, *n* = 1; prostate, *n* = 1; skin, *n* = 1; stomach, *n* = 1; tongue, *n* = 1. Metastatic tumors *n* = 10.
[b]Palliative Performance Scale scores: 100% = healthy, 0% = dead.

analyzed. There were nine female and eight male participants, aged ranging from 49 to 79 years. The majority of participants were married and Catholic. All patients had cancer diagnosis, and the average time since diagnosis was 4.4 years. Participants' characteristics are further presented in Table 2.

Generativity documents' analysis

The final code-book contained 43 codes and seven main themes: "Significant people and things"; "Remarkable moments"; "Acknowledgments"; "Reflection on the course of life"; "Personal values"; "Messages left to others"; and "Requests and last wishes".

Table 3 presents the seven themes and codes (with the respective percentage of patients describing each code). After 15 transcripts had been coded, no new codes emerged, i.e., thematic saturation was reached.

Theme 1: Significant people and things

Six participants highlighted the role of their wives or husbands as life partners, identifying the moment they met marking the beginning of happiness, as two participants revealed:

> "My wife gave me the guidance I needed. I became happy, very happy." (#TD13)
>
> "I became happier after meeting my wife." (#TD28)

Participants identified that if they had to choose a picture that represented their lives, it would include their family. Two participants narrated the following:

> "If a photo album represented my life,
> I would choose a photo with my daughters."(#TD23)
>
> "It would begin [the photo album] with a beautiful and serene picture in which my husband and my children would represent the people I keep forever with me." (#TD20)

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

Table 3. Themes and codes developed from dignity therapy generativity documents ($n = 17$)

Theme	Codes (%)[a]	Description
Significant people and things	• Husband/wife (35)	• A person or group of persons, identified as having important emotional, relational, or supporting roles in patients' lives. • Objects and/or places with specific meaning and value for patients' lives and during their illnesses trajectories. • The absence of significant ones or things during life and/or illness trajectory.
	• Sons (35)	
	• Family (35)	
	• Brothers (18)	
	• Home (18)	
	• Parents (18)	
	• Books (12)	
	• Friends (12)	
	• Without significant people (12)	
Remarkable moments	• Sons' birth (47)	• Life's moments, periods, or person(s) that are unusual, peaceful, intense, or special in a way that makes patients notice them and be surprised or impressed, keeping an everlasting memories and feelings.
	• Marriage (29)	
	• Childhood (24)	
	• Professional activity (18)	
	• All moments lived with health (12)	
Acknowledgments	• To family (41)	• Appreciation messages to important family members.
Reflection on the course of life	• Proud of professional role (41)	• Critical reflection on personal, professional, and civic roles. • Critical reflection on attitudes toward life, its course, purpose, limited time, and term. • Critical reflection on losing significant ones during life. • Desire for forgiveness. • Learning through suffering and loneliness.
	• Proud of parental role (41)	
	• Proud of man/woman they were (35)	
	• Proud of having positive attitude (24)	
	• Proud of wife/husband role (18)	
	• Happiness in roles played (18)	
	• Wish to have had lived longer/not being sick (12)	
	• Unhappiness for having lost loved ones (6)	
	• Wish to have had more opportunities to be happy (6)	
	• Wish to have had apologized (6)	
	• Learning with illness to think more about others (6)	
	• Learning with loneliness (6)	
Personal values	• Of love/care (65)	• Core values or general expressions of what is most important for patients during their lives in their intricate relationship with others, themselves, and God/The Divine. • An individual's characteristics related to values and spirituality.
	• Honesty (35)	
	• Altruism (24)	
	• Religious devotion (12)	
Messages left to others	• Peace and tranquillity (35)	• Words or phrases conveying pleasant and happy wishes for significant persons. • Words or phrases conveying acknowledgements and gratefulness for care during life and illness. • Words or phrases expressing sorrow for the absence of persons' presence and care. • Patients expression that nothing was left to say, as all-important messages were already said to those they love and care for.
	• Of happiness (29)	
	• Missing (18)	
	• Of gratitude (18)	
	• No messages, everything was already said (18)	
Requests and last wishes	• Happiness (29)	• Messages directed to specific persons, wishing a wide range of special and positive states (happiness, health, love, and honesty) • Messages directed to specific persons asking for forgiveness after patients' absence and particular hurting acts. • Worldwide messages to humankind wishing common goals of piece, respect, and prosperity.
	• Health for others (24)	
	• Apologies for absence (18)	
	• Honesty (18)	
	• Love (18)	
	• Apologies for the way they acted (12)	
	• That the world was in peace/better world (12)	

[a]Percentage of patients endorsing code.

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

Theme 2: Remarkable moments

Regarding the most remarkable moments in their lives, participants identified their childrens' birth ($n = 8$) and their marriage ($n = 5$). Participants seemed to agree that these two moments fulfilled their lives and represented the starting or turning point for building happy families.

> "One of the most important moments of my life was my marriage." (#TD01)
>
> "I became a happy, accomplished and complete man when I got married. […]
>
> The birth of my sons completed me." (#TD47)

Theme 3: Acknowledgement

Seven participants acknowledged the support and presence of their family, mostly their children and spouses within their generativity document. Their acknowledgment went beyond their current presence during their illnesses and extended across their lifetime.

> "I owe him the constant presence, the permanent support.
>
> Always here, always with me, always with us." (#TD01)
>
> "I miss my husband, and I thank him with all my heart for the true man he has always been to me since the first day we met." (#TD01)
>
> "I thank my sons for being with me, always with me" (#TD24)

Theme 4: Reflection on the course of life

Through the DT question framework, patients were asked to reflect on their personal biography. Seven participants identified they were proud of their professional roles, mentioning that they worked hard and honestly during their life. The parental role was also highlighted by seven interviewees, in which participants noted that they were proud of their children.

> "I am proud that I have always worked without asking anything from anyone." (#TD23)
>
> "I am proud of my professional role because I have always performed it honestly." (#TD02)
>
> "I am proud of my daughters." (#TD23)
>
> "I feel proud of my role as a father." (#TD30)

Six participants revealed that they were proud of their life, what they did, and what they achieved:

> "I am proud of who I am." (#TD26)
>
> "Looking at what I am and what I have been,
>
> I can say this about myself: I am a 'great woman'." (#TD01)

Theme 5: Personal values

Throughout the generativity documents, participants mentioned some personal values that accompanied them throughout their lives; six mentioned honesty (mostly associated with their profession); four, altruism and two, religious devotion.

> "I worked honestly and I got two jobs." (#TD01)
>
> "I am proud to have been promoted professionally with great honesty." (#TD24)
>
> "I think helping others was always a very important part of my life." (#TD47)
>
> "Through suffering I feel more alive. I grow when I suffer, I approach God and draw a lesson from suffering: there is always a meaning […] on our journey towards the Light." (#TD01)
>
> "I want to tell you that I love you all very much […]
>
> And if I left you anything of my inheritance, I would say the following words: Simplicity, leaving things behind, being at peace and tranquillity with God and Humanity." (#TD05)

Theme 6: Messages left to others

Participants also expressed the need to leave a message to others, especially to loved ones. Most patients ($n = 11$) wished to leave a final message expressing love and affection to their family, mostly their sons and spouses. Some participants ($n = 6$) also left a broader message wishing peace and tranquillity to the whole world.

> "I want you to know that I will always be with you and that I love you!
>
> That I simply love you!" (#TD01)
>
> "I have nothing else to say except I love her." (#TD13)
>
> "Honestly, I want, from the bottom of my heart, Peace and Happiness for all of us!" (#TD50)

Theme 7: Requests and last wishes

The main requests or wishes expressed by the participants were related to happiness ($n = 5$) and health ($n = 4$). In other words, what participants wanted most for their loved ones, especially their families, was happiness and good health.

> "I wish you health and happiness. In fact… I wish it to everyone." (#TD16)
>
> "I wish happiness to my sons and family. I wish happiness to all my friends.
>
> I wish happiness to the whole world." (#TD20)

Discussion

The purpose of this paper was to explore the thematic features of generativity documents, providing a deeper understanding of the value of using DT for people who have a life-threatening disease. Seven main themes were identified from the inductive content analysis, including "significant people and things," "remarkable moments," "acknowledgments," "reflection on the course of life," "personal values," "messages left to others," and "requests and last wishes". Our findings suggest that exploring thematic features of the generativity document can help us recognize and understand patients' values, wishes, preferences, and needs, facilitating the delivery of dignity-conserving care and higher quality healthcare for patients nearing the end of life.

In this study, we found that "significant people and things" included family members and friends, or books, respectively; and, "remarkable moments" consisting of precious moments with loved ones, childhood memories, or recollections of living in a state of good health. Patients highlighted that the most precious memories in their life were their children's birth or their marriage. Knowing these pivotal moments provides healthcare providers a sense of who their patient is as a person, rather than being understood solely based on their life-limiting condition (Dönmez and Johnston, 2020). Previous research shows that people who have a life-threatening disease usually change their priorities and perspectives on life (Andersson et al., 2008; O'Gara et al., 2018; Dönmez and Johnston, 2020). When people are facing death, basic things such as spending time with family or friends often become more essential than extrinsic aspirations such as acquiring wealth or vocational pursuits. Therefore, inquiring about and exploring "remarkable moments" and "significant people and things" at the end of life allow patients to assert personhood, hence bolstering a sense of well-being (Cottingham

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

et al., 2017). DT is one approach whereby health professionals can support people who have a life-threatening disease, helping them explore the most important things in their life. Furthermore, this approach may help them to live in the moment "in order to help facilitate a dignified quality of life and help people cope with the uncertainty of life by providing person-centred care for people nearing the end of life" (Dönmez and Johnston, 2020).

DT and the qualitative analysis of the generativity document also saw the emergence of additional themes, including "personal values" and "reflection on the course of life". These are important in that they help patients express *who they are*; rather than being defined on the basis of whatever ailment has brought them to the brink of death. Being appreciated as such is the philosophical underpinning of "person-centered care" and a central concept in palliative care (Kitwood, 1997). An individual's characteristics, including their past, roles, self-worth, values, and spirituality, are vital elements of personhood (Buron, 2008).

In this study, despite advanced cancer, participants expressed a sense of pride in the parenteral roles, professional roles, other achievements; as well as their personal values included honesty, altruism, and religious devotion. Cumulatively, these results help increase healthcare providers' insight into patient perspectives, values, and personal make-up, enabling the delivery of dignity-conserving palliative care. Furthermore, recognizing and understanding that all individuals have a unique and distinct personality, personal history, values, and needs are important to help them maintain their personhood when facing death (Dönmez and Johnston, 2020).

Another theme in this study was "requests and last wishes" and "messages left to others". These are consistent with the theme of "aftermath concerns" contained within the Model of Dignity in the terminally ill (Chochinov et al., 2002), and speaks to the lingering burden that one's death will have on those left behind. Exploring these themes can be key in helping patients safeguard the well-being of their soon to be bereft loved ones and to resolve any unfinished business (Johnston, 2010; Johnston et al., 2012). Previous research shows that "resolving unfinished business" is an essential core component of a good death (Yun et al., 2018). Moreover, supporting people nearing the end of life to achieve their wishes and leave messages to loved ones, by listening with compassion and helping them set realistic goals, may contribute to well-being at the end of their life (Johnston, 2010; Johnston et al., 2012).

Findings in this study are consistent with other qualitative studies, which have similar objectives with our study (Goddard et al., 2013; Johnston et al., 2015; Dose and Rhudy, 2018; Testoni et al., 2019). In these studies, the researchers highlighted that the generativity documents are an important tool to recognize and understand individuals' preferences, needs, and values and to deliver dignified high-quality care at the end of life. Each participant's narrative is essential in understanding their identity, values, and purpose. Eliciting this narrative can facilitate patients' search for meaning, particularly when faced with a life-threatening disease (Vuksanovic et al., 2017). Some participants in this study highlighted that they acquired meaning by way of suffering and loneliness. Others approach the end of life and pursuit of meaning as part of attaining positive individual growth (Vuksanovic et al., 2017; O'Gara et al., 2018; Dönmez and Johnston, 2020). Therefore, healthcare providers have an essential role in facilitating and supporting patients' pursuit of meaning at the end of life (Breitbart et al., 2015; O'Gara et al., 2018). Knowing and understanding patients' narratives, their values, experiences, and pivotal moments opens a door for healthcare professionals, and for medicine itself which focuses on holistic and person-centered care researches and practices within the health sciences, to better understanding patients as whole persons and not simply the embodiment of their life-limiting condition. In addition, DT can be easily led and applied by palliative care providers including physicians or nurses who are appropriately trained. Through listening and recording narratives, palliative medicine and palliative care providers can seize a profound opportunity, wherein personhood is not overshadowed by suffering, disease, and vulnerability that is so often encountered by patients facing imminent death.

Limitations

This study was limited to 17 adult patients who had a cancer diagnosis recruited at a single inpatient palliative medicine institution. Although this study offers insights into the perspective of a limited range of patients nearing the end of life, the volume of data was sufficient to achieve data saturation.

Conclusion

DT allows patients to express their deepest hopes and wishes for those closest to them. Although some generativity documents may convey expressions of sorrow and guilt, the majority of themes emerging from the analyses conveys messages that are affirming, including messages of love, appreciation, and forgiveness. It appears that such life review and the construction of legacy supported by DT help dying patients make peace with themselves and those they care about most. In addition to the benefits to patients and families, DT appears to offer healthcare providers a new perspective on how to understand and bear witness to patients who are suffering. It also ensures that personhood is never overshadowed by patienthood, which, in the final analysis, is the essence of dignity-conserving care (Chochinov, 2002).

Acknowledgments. We thank each terminally ill patient who participated in this study.

Author contributions.
M.J., M.A.S., B.A., B.J., and C.F.D. were responsible for the conception, design, and writing the initial draft. M.J., A.R.L., and S.A. were responsible for the database managing and data analysis. All co-authors made the revision of the final report and had full access to all the data.

Funding. B.A. is funded by the National Institute for Health Research (NIHR) Applied Research Collaboration East of England (ARC EoE) programme. The views expressed are those of the author and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

Conflict of interest. None declared.

References

Andersson M, Hallberg IR and Edberg AK (2008) Old people receiving municipal care, their experiences of what constitutes a good life in the last phase of life: A qualitative study. *International Journal of Nursing Studies* **45**(6), 818–828.

Breitbart W, Rosenfeld B, Pessin H, *et al.* (2015) Meaning-centered group psychotherapy: An effective intervention for improving psychological well-being in patients with advanced cancer. *Journal of Clinical Oncology* **33**(7), 749–754.

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press

Buron B (2008) Levels of personhood: A model for dementia care. *Geriatric Nursing* **29**(5), 324–332.

Chochinov HM (2002) Dignity-conserving care—a new model for palliative care: Helping the patient feel valued. *JAMA* **287**(17), 2253–2260.

Chochinov HM (2011) *Dignity Therapy: Final Words for Final Days*. New York: Oxford University Press.

Chochinov HM, Hack T, McClement S, *et al.* (2002) Dignity in the terminally ill: A developing empirical model. *Social Science & Medicine* **54**(3), 433–443.

Chochinov HM, Hack T, Hassard T, *et al.* (2005) Dignity therapy: A novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology* **23**(24), 5520–5525.

Chochinov HM, Hassard T, McClement S, *et al.* (2008) The patient dignity inventory: A novel way of measuring dignity-related distress in palliative care. *Journal of Pain and Symptom Management* **36**(6), 559–371.

Chochinov HM, Kristjanson LJ, Breitbart W, *et al.* (2011) The effect of dignity therapy on distress and end-of-life experience in terminally ill patients: A randomised controlled trial. *The Lancet Oncology* **12**(8), 753–762.

Cottingham AH, Cripe LD, Rand KL, *et al.* (2018) "My future is now": A qualitative study of persons living with advanced cancer. *The American Journal of Hospice and Palliative Care* **35**(4), 640–646.

Dönmez ÇF and Johnston B (2020) Living in the moment for people appoaching the end of life: A concept analysis. *International Journal of Nursing Studies* **108**, 103584.

Dose AM and Rhudy LM (2018) Perspectives of newly diagnosed advanced cancer patients receiving dignity therapy during cancer treatment. *Supportive Care in Cancer* **26**, 187–195.

Erikson EH (1963) *Childhood and Society*. New York, NY: Norton.

Fitchett G, Emanuel L, Handzo G, *et al.* (2015) Care of the human spirit and the role of dignity therapy: A systematic review of dignity therapy research. *BMC Palliative Care* **14**, 8.

Goddard C, Speck P, Martin P, *et al.* (2013) Dignity therapy for older people in care homes: A qualitative study of the views of residents and recipients of 'generativity' documents. *Journal of Advanced Nursing* **69**(1), 122–132.

Hack TF, McClement SE, Chochinov HM, *et al.* (2010) Learning from dying patients during their final days: Life reflections gleaned from dignity therapy. *Palliative Medicine* **24**(7), 715–723.

Hall S, Goddard C, Opio D, *et al.* (2012) Feasibility, acceptability and potential effectiveness of dignity therapy for older people in care homes: A phase II randomized controlled trial of a brief palliative care psychotherapy. *Palliative Medicine* **26**, 703–712.

Houmann LJ, Chochinov HM, Kristjanson LJ, *et al.* (2014) A prospective evaluation of dignity therapy in advanced cancer patients admitted to palliative care. *Palliative Medicine* **28**, 448–458.

Johnston B (2010) Can self-care become an integrated part of end-of-life care? Implications for palliative nursing. *International Journal of Palliative Nursing* **16**(5), 212–214.

Johnston B, Östlund U and Brown H (2012) Evaluation of the Dignity Care Pathway for community nurses caring for people at the end of life. *International Journal of Palliative Nursing* **18**(10), 483–489.

Johnston B, Lawton S and Pringle C (2015) 'This is my story, how I remember it': In-depth analysis of dignity therapy documents from a study of dignity therapy for people with early stage dementia. *Dementia* **16**(5), 543–555.

Johnston B, Lawton S, McCaw C, *et al.* (2016) Living well with dementia: Enhancing dignity and quality of life, using a novel intervention, dignity therapy. *International Journal of Older People Nursing* **11**(2), 107–120.

Julião M, Barbosa A, Oliveira F, *et al.* (2013) Efficacy of dignity therapy for depression and anxiety in terminally ill patients: Early results of a randomized controlled trial. *Palliative Support Care* **11**(6), 481–489.

Julião M, Oliveira F, Nunes B, *et al.* (2014) Efficacy of dignity therapy on depression and anxiety in Portuguese terminally ill patients: A phase II randomized controlled trial. *Journal of Palliative Medicine* **17**(6), 688–695.

Julião M, Oliveira F, Nunes B, *et al.* (2017) Effect of dignity therapy on end-of-life psychological distress in terminally ill Portuguese patients: A randomized controlled trial. *Palliative Support Care* **15**(6), 628–637.

Kitwood T (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham, UK: Open University Press.

Kyngas H (2020) Inductive content analysis. In Kyngas H, Mikkonen K & Kaariainen M (eds.), *The Application of Content Analysis in Nursing Science Research*. Oulu: Springer Press, pp. 13–21.

Montross L, Winters KD and Irwin SA (2011) Dignity therapy implementation in a community-based hospice setting. *Journal of Palliative Medicine* **14**, 729–734.

O'Gara G, Tuddenham S and Pattison N (2018) Haemato-oncology patients' perceptions of health-related quality of life after critical illness: A qualitative phenomenological study. *Intensive & Critical Care Nursing* **44**, 76–84.

Rudilla D, Galiana L, Oliver A, *et al.* (2016) Comparing counseling and dignity therapies in home care patients: A pilot study. *Palliative and Supportive Care* **14**, 321–329.

Starks H and Trinidad SB (2007) Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research* **17**(10), 1372–1380.

Testoni I, Bingaman KA, Dlapico G, *et al.* (2019) Dignity as wisdom at the end of life: Sacrifice as value emerging from a qualitative analysis of generativity documents. *Pastoral Psychology* **68**, 479–489.

Tong A, Sainsbury P and Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal of Quality Health Care* **19**(6), 349–357.

Vuksanovic D, Green H, Morrissey S, *et al.* (2017) Dignity therapy and life review for palliative care patients: A qualitative study. *Journal of Pain and Symptom Management* **54**(4), 530–537.

Yun YH, Kim KN, Sim JA, *et al.* (2018) Priorities of a 'good death' according to cancer patients, their family caregivers, physicians, and the general population: A nationwide survey. *Supportive Care in Cancer* **26**, 3479–3488.

https://doi.org/10.1017/S1478951521000754 Published online by Cambridge University Press