ESTUDOS DE PSICOLOGIA
Psychological Studies

RESEARCH REPORT

Health Psychology

Editor
Raquel Souza Lobo Guzzo

Conflict of interest
The authors declare that there are no conflicts of interest.

Data Availability
The research data are available from the corresponding author upon reasonable request.

Received
September 19, 2023

Final version
October 11, 2024

Approved
March 7, 2025

Healthcare professionals and dignity in the care of terminally ill older adults: a mixed-methods study

Profissionais de saúde e dignidade no cuidado de idosos terminais: um estudo de método misto

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Article based on the dissertation by F. A. C. VALENTIM, entitled "*Profissionais de saúde: percepção sobre a dignidade no cuidado ao paciente idoso terminal*". Universidade Católica de Brasília, 2023.

How to cite this article: Valentim, F. A. C, & Alves, V. P. (2025). Healthcare professionals and dignity in the care of terminally ill older adults: a mixed-methods study. *Estudos de Psicologia* (Campinas), *42*, e230116. https://doi.org/10.1590/1982-0275202542e230116

Abstract

Objective
This research investigated healthcare professionals' perceptions of dignity in the care of terminally ill older adults.

Method
A mixed-method approach was used, with the End-of-Life Patient Dignity Model as the theoretical framework. A total of 101 participants were interviewed, and the data were analyzed using descriptive and inferential statistics, as well as thematic content analysis.

Results
Maintaining dignity involves empathy, communication skills, respect for values and beliefs, and attention to religious/spiritual needs. Technical knowledge, teamwork, patient-centered care, and professional conduct also contribute to preserving dignity.

Conclusion
Dignity in end-of-life care requires integration of relational and technical competencies. Further research is needed to inform care initiatives and health education guidelines that support dignity-conserving practices.

Keywords: Aged; Dignity; Health personnel; Palliative care; Terminal care; Terminally ill.

Resumo

Objetivo
Esta pesquisa investigou percepções de profissionais de saúde sobre dignidade no cuidado ao paciente idoso terminal.

Método
Utilizou-se uma abordagem de método misto e o Modelo da Dignidade do Paciente em Fim de Vida como referencial teórico. 101 participantes foram entrevistados e os dados foram analisados por meio de estatística descritiva e inferencial e análise de conteúdo, abordagem temática.

Resultados
Preservar a dignidade envolve empatia, habilidades de comunicação, respeito por valores e crenças e atenção às necessidades religiosas/espirituais. Conhecimento técnico, trabalho em equipe, cuidado centrado no paciente e conduta profissional também ajudam na preservação da dignidade.

Conclusão
A preservação da dignidade no fim da vida requer a integração de competências relacionais e técnicas. São necessárias mais pesquisas para subsidiar iniciativas assistenciais e e diretrizes para educação em saúde.

Palavras-chave: *Idoso; Dignidade; Profissionais de saúde; Cuidados paliativos; Cuidados de fim de vida; Paciente terminal.*

The preservation of the dignity of terminally ill older-adult patients is one of the objectives of end-of-life care (Choo et al., 2020), serving as a metric of excellence in hospital care for these patients (Tauber-Gilmore et al., 2018). A seminal study in this field, Dignity in the Terminally Ill: A Developing Empirical Model, conducted by Chochinov et al. (2002), highlighted the correlation between patients' sense of dignity at the end of life and psychosocial determinants affecting treatment, particularly in hospital settings. The results of this research served as the basis for the formulation of the End-of-Life Patients Dignity Model (Chochinov et al., 2006), a conceptual framework that synthesizes the physical, psychological, and social elements related to the experience of dignity among terminally ill patients.

The Dignity Model posits three main dimensions that affect patient dignity: patients' concerns regarding the effects of illness on their personal dignity; individual, psychological, or spiritual resources that shape the subjective experience of dignity; and social aspects that encompass interpersonal relationships and the contexts in which the patient is situated (Saracino et al., 2019). These social interactions, particularly those maintained with healthcare professionals, play a fundamental role in preserving patient dignity (Mema et al., 2024).

The competencies needed to establish these relationships are outlined in the article *Dignity and the essence of medicine*: *the A, B, C, and D of dignity conserving care* (Chochinov, 2007), which delineates a clinical application of the concepts developed in the Dignity Model, thus proposing a pragmatic framework for healthcare professionals to preserve the dignity of terminal patients. The acronym ABCD represents the following dimensions: A, attitude, which encompasses the intrinsic beliefs and perspectives from which the professional perceives and evaluates the other; B, behavior, which involves the actions and conduct that manifest these attitudes; C, compassion, which pertains to the recognition of the suffering experienced by the patient; and D, dialogue, which refers to all communication that acknowledges the personhood of the patient (Chochinov, 2023).

Overall, the existing literature indicates a connection between the meaning of dignity for healthcare professionals and the quality of hospital care administered at the end of life (Choo et al., 2020). However, despite this evidence, there is a gap in research on the topic within the Brazilian context. Furthermore, it remains uncertain how healthcare professionals understand dignity in end-of-life care and the implications of this understanding for the quality of care provided to terminally ill older adults. Thus, this research aimed to investigate healthcare professionals' perceptions of dignity in the care of terminally ill older adults, utilizing the End-of-Life Patients Dignity Model as the central theoretical framework.

Method

A concurrent embedded mixed-methods study was conducted, with the notation QUAL(+quan) due to the predominance of the qualitative approach. The theoretical framework of the research was defined by its primary orientation, with the second data set serving as a supplement to this approach (Creswell & Plano Clark, 2014). The qualitative findings were organized into thematic categories and discussed in light of the End-of-Life Patient Dignity Model by Chochinov et al. (2002).

Participants

Participants were recruited between April and May 2023 in two settings of the Health Department of Distrito Federal, Brazil: the Hospital Regional de Ceilândia (HRC) and the Hospital de Apoio de Brasília (HAB). The HRC is a general hospital that provides care across various medical specialties, while the HAB specializes in neuromuscular rehabilitation and oncological and geriatric palliative care (Secretaria de Saúde do Distrito Federal, 2022a; 2022b).

Non-probabilistic, purposive sampling was employed, with the inclusion criterion being healthcare professionals who had been working for at least six months in one of the research settings. Professionals on leave for any reason were excluded. Selected participants were approached individually and directly, provided with a detailed explanation of the research, after which they gave their free and informed consent.

Instruments

The data were collected through semi-structured interviews, beginning with socio-professional information. Subsequently, participants were presented with four guiding questions, constructed based on the A, B, C, and D of Dignity Conserving Care (Chochinov, 2007). The interviews were conducted individually and in person. The responses were audio-recorded and later transcribed in full.

Procedures

The quantitative data and responses to the guiding questions were subjected to statistical analysis and thematic analysis, using Bardin's (2011) approach. Descriptive statistical analyses and inferential tests were conducted using the R programming language. The qualitative data were processed using the IRaMuTeQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) software, version 0.7 alpha 2. For this purpose, the audio recordings of the interviews were transcribed using Microsoft Word 2013® software. The resulting material was consolidated into a file, with each interview separated by a command line. Each command line contained six variables considered relevant to the study design: age, sex, marital status, workplace, academic background, and experience in palliative care.

The embedding technique (Creswell & Plano Clark, 2014) was employed to combine the qualitative and quantitative datasets, using contiguous presentation of the results in separate sections to facilitate further analyses and interpretations (Fetters et al., 2013).

The research was approved by the Research Ethics Committee of the Universidade Católica de Brasília (protocol No 5.680.693) and the Research Ethics Committee of the Fundação de Ensino e Pesquisa em Ciências da Saúde do Distrito Federal (protocol No 5.862.376), in accordance with Resolution No 466/2012 of the National Health Council.

Results

Quantitative data

A total of 111 healthcare professionals were approached, of which 101 met the eligibility criteria. The majority were female (78.22%), married, and aged between 30 and 50 years. The average age of the group was 39 years, ranging from 21 to 67 years (Table 1).

Table 1

Distribution of participants according to sociodemographic data

Variables	%
Sex	
Female	78.22
Male	21.78
Age	
20 |– 30	22.77
30 |– 40	26.73
40 |– 50	38.61
50 |– 60	10.89
60 |– 70	1.98
Marital status	
Married/Cohabiting/Common-Law Marriage	65.35
Single	27.72
Separated/Divorced	6.93
Hospital	
HAB	39.60
HRC	60.40
Affiliation	
Staff member	81.19
Resident	18.81

Note: HAB: *Hospital de Apoio de Brasíli*a, HRC: *Hospital Regional de Ceilândia*.

Most participants were nurses, nursing technicians, physicians, and psychologists (70.29%). While nearly half of the healthcare professionals had specializations, only one (32.67%) had additional training in geriatrics or palliative care. More than half reported having experience in palliative care (Table 2).

Table 2

Distribution of participants according to socio-professional data

1 of 2

Variables	%
Academic Background	
Nursing	29.70
Medicine	17.82
Nursing technician	13.86
Psychology	8.91
Physical therapy	8.91
Nutrition	5.94
Pharmacy	3.96
Social services	3.96

Table 2

Distribution of participants according to socio-professional data

2 of 2

Variables	%
Dentistry	3.96
Speech-Language pathology	1.98
Occupational therapy	0.99
Supplementary academic training	
Specialization	45.54
Master's Degree	9.90
Doctorate	0.99
Others	7.92
None	35.64
Academic training in palliative care	
Yes	32.67
No	67.33
Experience in palliative care	
Yes	53.47
No	46.53

The examination of temporal variables revealed that the average length of employment for participants was 6.92 years, while the average length of employment in the specific sector within the hospital was 5.83 years. The study found that participants obtained their academic degree, on average, 14.15 years ago and had 13.72 years of experience in their field of study. The majority reported having experience in palliative care (53.47%), with a range from 6 months to 17 years ($\overline{x}$ = 6.01) (Table 3).

Table 3

Statistics of time variables

Variable	*N*	Mean (years)	Standard Deviation	Median (years)	Minimum (years)	Maximum (years)
Years working in the hospital	101	6.92	5.98	5	0.50	31
Years working in the sector	101	5.83	5.54	5	0.08	31
Years of academic training	101	14.15	9.26	13	0.00	48
Years of experience in the field of training	101	13.72	9.20	12	0.00	48
Years of experience in palliative care	54	6.01	4.01	5	0.50	17.25

Chi-square and Fisher's tests were conducted to examine associations between the terms used to define dignity and the socio-professional variables. A statistically significant association was found at the 10% significance level between the variable "hospital" and the word "comfort" (χ^2 = 3.6548; *p*-value = 0.05591), as evidenced by the post-hoc analysis of the standardized residuals table.

Similarly, for the variable "experience in palliative care", a statistically significant association was observed at a significance level of 5% with the term "nurturing" (χ^2 = 3.9973; *p*-value = 0.04557), based on the post-hoc analysis of the standardized residuals table.

Binary logistic regression analyses were conducted to determine predictive variables for a selected binary dependent variable. The odds ratio (OR) was used to compare the probability of occurrence of this variable in two groups. The term "comfort" was examined as the dependent variable, while "hospital" and "sex" were independent variables. The results showed that affiliation with HRC led to the definition of dignity as "comfort" at a significance level of 5% (p-value = 0.0275).

Another dependent variable, "experience in palliative care", was also examined, with "hospital" and "age group" as independent variables. The results indicated that being part of the HRC reduced the likelihood ($OR = 0.1144$; $p < 0.01$) of gaining experience in palliative care compared to affiliation with the HAB, at a significance level of 5%.

Regarding age, participants aged 40 to 50 years had a significantly higher probability of having experience in palliative care compared to other age groups ($OR = 14.001$; $p < 0.01$).

Qualitative Data

When categorizing the data, IRaMuTeQ allowed for the application of three analysis techniques: Descending Hierarchical Classification (DHC), Specificity Analysis, and Word Cloud.

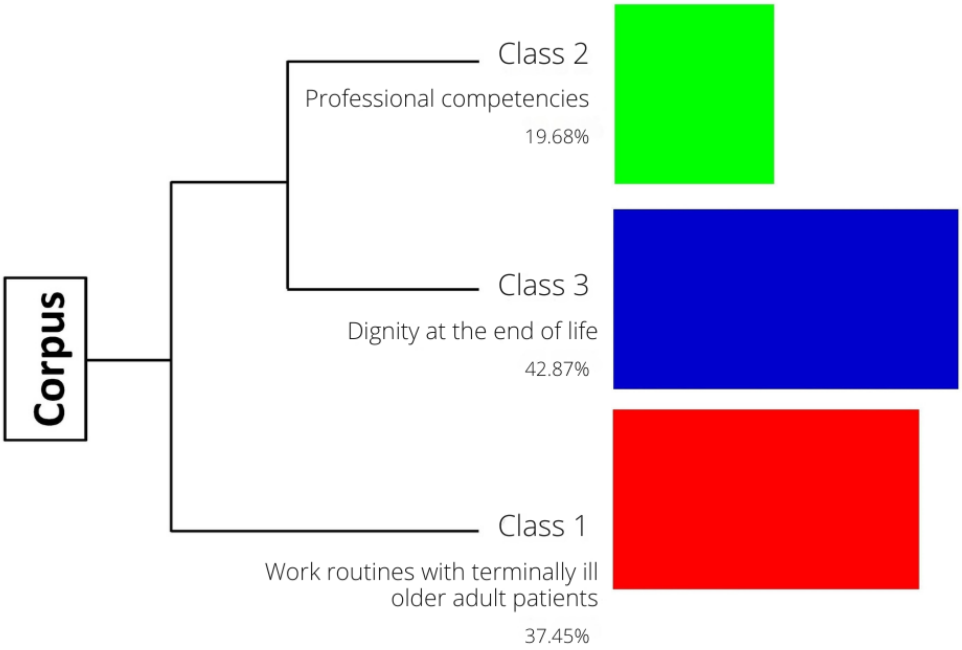
The initial processing revealed that the corpus consisted of 101 texts, from which 56,718 words emerged. Of these, 2,546 were distinct words, and 1,032 occurred only once. The average number of words per text was 561.56.

The hapax coefficient – words or terms that occur only once in the corpus – was used to demonstrate data saturation (Lima et al., 2021). The examined corpus had a low number of these occurrences (3.51%), indicating sufficient sample size and consistency in responses to the guiding questions.

The DHC divided the corpus into 1,614 Text Segments (TS), of which 1,311 (81.23%) were utilized. These relevant TS were partitioned into three classes: (1) Work routines with terminally ill older adult patients, comprising 491 TS (37.45%); (2) Professional competencies, comprising 258 TS (19.68%); (3) Dignity at the end of life, comprising 562 TS (42.87%). In the end, a dendrogram was generated with these classes (Figure 1).

Figure 1

Dendrogram generated from the Descending Hierarchical Classification (DHC) analysis



Source: Elaborated by the authors based on the results of IRaMuTeQ (Ratinaud, 2013).

This material was examined using Bardin's (2011), content analysis method to identify the meaning of the formed classes. These classes were then named and analyzed according to the distribution and association of the words included in them.

Class 1 – "*Work routines with terminally ill older adult patients*"

This class comprised 37.45% (*f* = 491 ST) of the analyzed corpus and consisted of words and roots within the range of χ^2 = 3.85 (case) and χ^2 = 24.77 (stay). It included terms such as "talk" (χ^2 = 48.16); "time" (χ^2 = 32.87); "explain" (χ^2 = 29.99); "converse" (χ^2 = 24.49); "alone" (χ^2 = 22.77), and "companion" (χ^2 = 21.93).

This class presented content related to the challenges faced by healthcare professionals in hospital care for terminally ill older adult patients. Participants expressed their concerns about family support and providing ideal care to patients. They also highlighted the emotional challenges at work, communication with families, and respecting patients' privacy.

> I always try to explain as much as possible to the companion about what is happening, to describe all the symptoms, not to hide anything. If the companion, for instance, asks how many days he [the patient] has left to live, we talk about days to weeks. (Participant 15)
>
> When the family members are present, I see that it's calmer, more peaceful (...). (Participant 23)
>
> (...) but, at the same time, it's painful to see the elderly person in this moment, because they didn't build relationships, and sometimes they end up dying without having anyone by their side. (Participant 30)
>
> There are many who remain alone and do not receive any affection from their family. Sometimes people have children, have siblings, and no one comes to see them. (Participant 61)

Class 2 – "*Professional competencies*"

This class involved 19.68% (*f* = 258 ST) of the analyzed corpus, composed of words and roots within the range of χ^2 = 3.86 (listen) and χ^2 = 120.08 (team). It included terms and expressions such as "palliative care" (χ^2 = 73.05); "communication" (χ^2 = 63.74); "humanize" (χ^2 = 66.67); "knowledge" (χ^2 = 11.87); "interdisciplinary" (χ^2 = 4.2).

The content of this class highlighted the importance of training in palliative care and communication between teams, emphasizing the gap in understanding principles of palliative care between specialized and routine teams, often lacking effective communication between them.

> (...) I think that all healthcare professionals involved in any kind of primary-level care, doctors, and those in high-complexity areas, especially in hospitals, should at least have a theoretical course on what palliative care means. (Participant 57)
>
> (...) we can provide team education, which would really bring this knowledge to the team caring for the patient. I think this facilitates treating him [the patient] with more dignity (...). (Participant 16)
>
> (...) this is not just the psychologist's or the doctor's job, but the whole team can contribute positively to this process. (Participant 27)

Class 3 – "*Dignity at the end of life*"

This class encompassed 42.87% (*f* = 562 ST) of the analyzed corpus, composed of words and roots within the range of χ^2 = 4.01 (biography) and χ^2 = 105.18 (dignity). It included terms such as "care" (χ^2 = 52.72); "treat" (χ^2 = 38.94); "comfort" (χ^2 = 37.1); "empathy" (χ^2 = 25.17); "nurturing" (χ^2 = 24.05); and "respect" (χ^2 = 23.94).

This class revealed content related to the operationalization of care aimed at preserving the dignity of terminally ill older adult patients, including participants' beliefs, behaviors, and feelings in delivering this care.

> I believe the first point about dignity at the end of life for elderly patients is respecting what the patient wants (...). (Participant 1)
>
> Dignity is allowing the person to be cared for during such a sensitive time; if they are at the end of life, they may, for example, be receiving analgesia (...) because it is distressing to imagine that the person will feel pain and is unable to speak. (Participant 26)
>
> (...) for us, healthcare professionals, dignity means being able to provide the best possible care to alleviate suffering, giving the patient our full attention, and understanding both their physical and mental health contexts. (Participant 101)

The Specificity Analysis (SA) categorized the corpus based on the categorical variable academic background – which is related to the profession practiced – in order to compare the evocations of different professional categories. In SA, IRaMuTeQ assigns a score to each selected TS, with higher scores indicating greater relevance within the variable under study (Sousa, 2021).

Nurses emphasized the implications of each clinical scenario and highlighted the value of professionalism and empathetic communication, prioritizing patient and family preferences (e.g., "here", "care", "provide", "care for", and "value").

Pharmacists highlighted the importance of recognizing patients' spiritual beliefs but acknowledged the lack of training in this area. Healthcare professionals use religion and spirituality as coping strategies when dealing with individuals near death (e.g., "religion", "sacred", "autonomy", "respect", and "value").

Physical therapists emphasized providing care that prioritizes comfort and alleviation of suffering in terminally ill older patients, recognizing the challenges of effective communication in this context. Considering patient preferences, along with empathy, compassion, and teamwork, is fundamental (e.g., "symptom", "suffering", "team", and "compassion").

Speech therapists emphasized the role of specialized knowledge, active listening, and respectful care. The focus is on ensuring a peaceful and pain-free end of life for terminally ill older patients, while maintaining clear communication with their families. Dignity at the end of life is promoted by providing empathetic and personalized care (e.g., "rights", "intervention", "choose", "conversation", and "respect").

Physicians emphasized the importance of preparing for the loss of loved ones. They also highlighted the need for emotional support. When caring for older patients in their final stages of life, they stressed the importance of effective interaction, simple language, and non-intrusive approaches. Empathy, communication, and compassion were seen as essential in end-of-life care (e.g., "father", "medicine", "avoid", "invasive", and "explain").

Nutritionists recognized the significance of religion as a coping tool and the importance of respecting patients' spiritual beliefs. For them, dignity-conserving end-of-life care demands compassion, attention, and addressing the concerns of both the patient and family. This includes ensuring adequate nutrition and honoring the patient's wishes and values (e.g., "religion", "Catholic", "empathy", and "family").

Dentists emphasized providing individualized care, taking into account the beliefs, values, and aspirations of terminally ill older patients. Listening, understanding, respect, and family involvement are essential. Multidisciplinary teams and palliative care committees facilitate this care (e.g., "happy", "respect", "value", "will", and "attend to").

Psychologists emphasized the importance of understanding patients' wishes and needs, especially in pain management. Person-centered care is a priority, and validating patients' beliefs and values is crucial. They are also concerned with communication among healthcare professionals (e.g., "perspective", "meaning", "understand", "belief", and "communication").

Social workers emphasized the role of communication in palliative care and the need to ensure patient autonomy. Empathy in dealing with patients and the development of communication skills through training on the subject are crucial (e.g., "communicate", "person", "team", "understand").

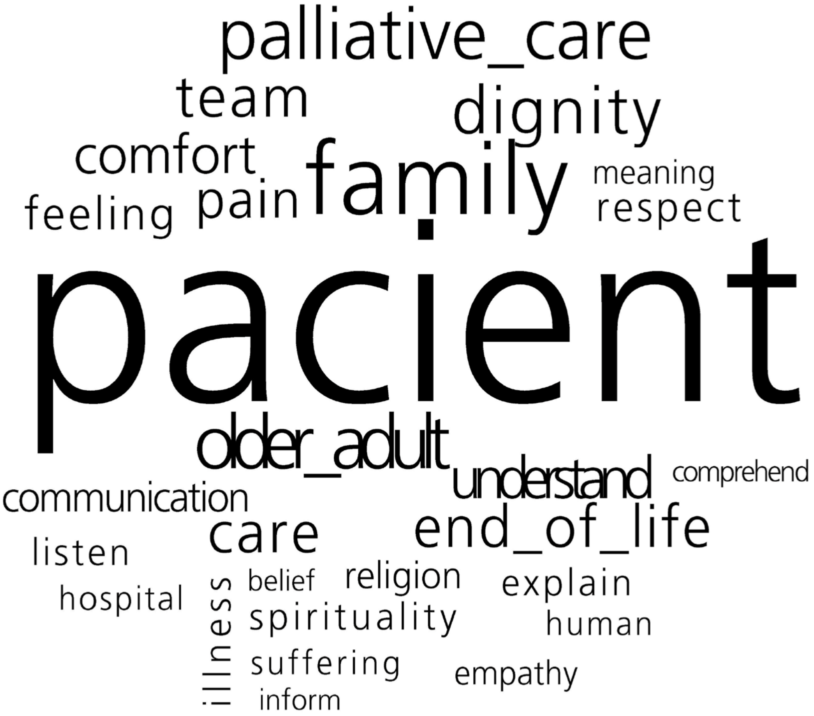
Nursing technicians acknowledged the complex needs of older patients and the necessity of providing empathetic care, taking their religious beliefs into account. The emotional impact of their work was highlighted, as well as the need to maintain a balance between personal and professional responsibilities (e.g., "affection", "sad", "assistance", "feel", "faith", "comfort", and "alone").

Occupational therapists highlighted the importance of protecting patient dignity, respecting their values, and offering support to the caregiver. The need for early palliative care and attention to the spiritual dimension of care were also mentioned (e.g., "life", "care", "spiritual", "diagnosis", and "palliative care").

The Word Cloud (WC) analysis identified that the terms "patient" (*f* = 880) and "family" (*f* = 357) were the most frequently mentioned. The WC visually represents the key elements of the corpus, with the size and centrality of the words being directly proportional to their frequency (Sousa, 2021). Figure 2 represents the WC corresponding to the examined corpus.

Figure 2

Word Cloud related to healthcare professionals' perceptions of dignity in care for terminally ill older adults



Source: IRaMuTeQ (Ratinaud, 2013).

Discussion

When investigating healthcare professionals' perceptions of the concept of dignity in providing care to terminally ill older adults, the sample was predominantly female, consisting mainly of nurses, nursing technicians, physicians, and psychologists, with a smaller percentage having received training on this topic, aligning with previous studies of a similar scope (Bovero et al., 2020; 2022). However, this study stands out for incorporating a broader range of professional categories not covered in other evaluations. This allowed for the expansion of knowledge on this subject to other professions, such as social workers, pharmacists, physiotherapists, speech therapists, and occupational therapists.

Most participants reported having experience in palliative care. This information is relevant, suggesting that some participants possess more knowledge or training in palliative care than others, which may influence their perceptions of dignity in the care of terminally ill older adults (Bovero et al., 2022).

These participants identified the term "nurturing" as an indicator of preserving the dignity of terminally ill older adults. They recognized that being welcomed and treated in the hospital environment with respect and empathy can impact the patients' sense of dignity. Additionally, logistic regressions were conducted to examine the correlation between experience in palliative care and other variables, such as hospital affiliation, age range, and "comfort." The results revealed that participants affiliated with general hospitals were more likely to consider "comfort" an indicator of dignity but were less likely to have experience in palliative care. Conversely, participants aged between 40 and 50 years in both clinical settings were more likely to have experience in palliative care. However, further research is necessary to validate these findings.

Regarding the meanings attributed to dignity at the end of life, the Descending Hierarchical Classification (DHC) identified the main aspects evoked by participants in providing care to terminally ill older adults. The class "Work Routines" refers to the attitude and behavior of healthcare professionals, encompassing their concerns, stances, and daily practices aimed at preserving patient dignity. The class "Professional Competencies" can be associated with the aspects of compassion and dialogue, as it highlights the importance of combining technical knowledge, teamwork, and empathy in patient care. The class "Dignity at the End of Life" is closely linked to the notion of dignity, which entails honoring the patient's values, safeguarding their autonomy, and treating them with respect. These findings align with the Dignity Model for End-of-Life Patients (Chochinov et al., 2002) and the A, B, C, and D of Dignity Conserving Care (Chochinov, 2007; 2023), which affirm that protecting dignity in end-of-life settings is an essential component of providing quality healthcare.

The perspectives of each profession involved in the study on preserving the dignity of terminally ill older adults indicated a predominant and converging belief in the importance of empathy. This perception can be interpreted as a shared reference point regarding the role of empathy in ensuring adequate and compassionate care for these patients (Bovero et al., 2022; Choo et al., 2020; Moudatsou et al., 2020) .

Similarly, maintaining the dignity of older adults at the end of life had communication as an essential component, emphasizing clear language and the gradual and repetitive delivery of prognostic information. Effective communication fosters greater prognostic awareness among terminally ill older adults and their families (Gabbard et al., 2020), empowering them to make informed decisions about their future care while simultaneously promoting a stronger sense of emotional support (Im et al., 2019).

Our findings also indicate that, in the hospital context, the definition of dignity in the care of terminally ill older adults involves demonstrating respect for the patient. This includes providing care that acknowledges not only their medical needs but also their life history, beliefs, values, and personal preferences. In essence, this understanding requires a shift from a disease-centered approach and reliance on the traditional biomedical model to a person-centered care model (Bovero et al., 2020).

Additionally, the study participants emphasized the importance of understanding the religion and spiritual beliefs of terminally ill older adults. By doing so, they use their own spiritual beliefs as a reference to demonstrate compassionate behavior. Typically, older individuals rely on their faith to cope with challenges and chronic illnesses (Moreira et al., 2021), and by addressing this dimension in their practices, healthcare professionals contribute to preserving the dignity of older adults nearing the end of life (Balducci, 2019; O'Brien et al., 2019; Pentaris & Tripathi, 2022).

In general, for healthcare professionals, preserving the dignity of terminally ill older adults involves care based on empathy, effective communication, respect for their values and beliefs, as well as attending to their religious and spiritual needs. Technical knowledge, teamwork, patient-centered care, and professional conduct are necessary to enhance these aspects. These findings align with the concept of dignity-conserving care, which encompasses attitudes, behaviors, compassion, and dialogue (Chochinov, 2023).

Conclusion

This research highlights an important yet under-investigated topic in palliative care: the care of older adults at the end of life. It achieved its objective by investigating healthcare professionals' perceptions of dignity in the care of terminally ill older adults. Furthermore, it produced relevant information regarding the participants' perspectives on the subject. The sample size, the heterogeneity of professional categories, the methodological approach, and Chochinov's theoretical framework represent its main strengths.

However, it is not without limitations. Conducted in Distrito Federal, Brazil, the study was carried out in two hospital settings with distinct clinical characteristics. Additionally, the sample of participants was determined by convenience, which may introduce sampling bias. It is noteworthy that the literature review did not identify any studies applied to the Brazilian context regarding the subject of this research. Furthermore, it is necessary to expand the investigation into the correlation between the Hapax coefficient and data saturation in qualitative research.

More research is needed to understand the perceptions of professionals working in other clinical settings and to further examine the concept of dignity in care for other specialties. Findings in this regard may contribute to the development of care initiatives and guidelines for health education.

References

Balducci, L. (2019). Geriatric oncology, spirituality, and palliative care. *Journal of Pain and Symptom Management, 57*(1), 171-175. https://doi.org/10.1016/j.jpainsymman.2018.05.009

Bardin, L. (2011). *Análise de conteúdo*. Edições 70.

Bovero, A., Tosi, C., Botto, R., Cito, A., Malerba, V., Molfetta, V., Ieraci, V., & Torta, R. (2020). The Health Care Providers' Perspectives on End-of-Life Patients' Sense of Dignity. A Comparison Among Four Different Professionals' Categories. *Journal of Cancer Education, 35*(6), 1184-1192. https://doi.org/10.1007/s13187-019-01577-4

Bovero, A., Tosi, C., Botto, R., Pidinchedda, A., Gottardo, F., Asta, G., & Torta, R. (2022). A Qualitative study to explore healthcare providers' perspectives on end-of-life patients' dignity. How can dignity be defined, and which strategies exist to maintain dignity? *Journal of Cancer Education*: *The Official Journal of the American Association for Cancer Education, 37*(2), 280-287. https://doi.org/10.1007/s13187-020-01808-z

Chochinov, H. M. (2007). Dignity and the essence of medicine: The A, B, C, and D of dignity conserving care. *BMJ, 335*(7612), 184-187. https://doi.org/10.1136/bmj.39244.650926.47

Chochinov, H. M. (2023). *Dignity in care*: *the human side of medicine*. Oxford University Press.

Chochinov, H. M., Hack, T., McClement, S., Kristjanson, L., & Harlos, M. (2002). Dignity in the terminally ill: a developing empirical model. *Social Science & Medicine, 54*(3), 433-443. https://doi.org/10.1016/S0277-9536(01)00084-3

Chochinov, H. M., Krisjanson, L. J., Hack, T. F., Hassard, T., McClement, S., & Harlos, M. (2006). Dignity in the Terminally Ill: Revisited. *Journal of Palliative Medicine, 9*(3), 666-672. https://doi.org/10.1089/jpm.2006.9.666

Choo, P. Y., Tan-Ho, G., Dutta, O., Patinadan, P. V., & Ho, A. H. Y. (2020). Reciprocal dynamics of dignity in end-of-life care: a multiperspective systematic review of qualitative and mixed methods research. *American Journal of Hospice and Palliative Medicine®, 37*(5), 385-398. https://doi.org/10.1177/1049909119878860

Creswell, J. W., & Plano Clark, V. L. (2014). *Pesquisa de métodos mistos* (2nd ed.). Penso.

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs-principles and practices. *Health Services Research, 48*(6pt2), 2134-2156. https://doi.org/10.1111/1475-6773.12117

Gabbard, J., Johnson, D., Russell, G., Spencer, S., Williamson, J. D., McLouth, L. E., Ferris, K. G., Sink, K., Brenes, G., & Yang, M. (2020). Prognostic awareness, disease and palliative understanding among caregivers of patients with dementia. *American Journal of Hospice and Palliative Medicine®, 37*(9), 683-691. https://doi.org/10.1177/1049909119895497

Im, J., Mak, S., Upshur, R., Steinberg, L., & Kuluski, K. (2019). "Whatever happens, happens" challenges of end-of-life communication from the perspective of older adults and family caregivers: a qualitative study. *BMC Palliative Care, 18*(1), 113. https://doi.org/10.1186/s12904-019-0493-7

Lima, V. M. D. R., Amaral-Rosa, M. P., & Ramos, M. G. (2021). Análise Textual Discursiva apoiado por software: IRaMuTeQ e a análise de subcorpus. *New Trends in Qualitative Research, 7*, 1-9. https://doi.org/10.36367/ntqr.7.2021.1-9

Mema, A., Bressan, V., Stevanin, S., & Cadorin, L. (2024). The perception of dignity in the hospitalized patient: findings from a meta-synthesis. *Nursing Ethics, 32*(1), 19-41. https://doi.org/10.1177/09697330241238339

Moreira, D. A., Portella, M. R., & Alves, V. P. (2021). Espiritualidade e a velhice: perspectivas na produção científica. *Interações, 16*(1). https://www.redalyc.org/journal/3130/313066091005/movil/

Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The role of empathy in health and social care professionals. *Healthcare, 8*(1), 26. https://doi.org/10.3390/healthcare8010026

O'Brien, M. R., Kinloch, K., Groves, K. E., & Jack, B. A. (2019). Meeting patients' spiritual needs during end-of-life care: a qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training. *Journal of Clinical Nursing, 28*(1-2), 182-189. https://doi.org/10.1111/jocn.14648

Pentaris, P., & Tripathi, K. (2022). Palliative professionals' views on the importance of religion, belief, and spiritual identities toward the end of life. *International Journal of Environmental Research and Public Health, 19*(10), Artigo 10. https://doi.org/10.3390/ijerph19106031

Ratinaud, P. (2013). *Iramuteq*: *interface de R pour les Analysis Multidimensionnelles de Textes et de Questionnaires* (Versão 0.7 alpha 2) [Phyton; Software para análise textual]. Université de Toulouse - Laboratoire d'Études et de Recherches Appliquées en Sciences Sociales. http://www.iramuteq.org/

Saracino, R. M., Rosenfeld, B., Breitbart, W., & Chochinov, H. M. (2019). Psychotherapy at the end of life. *The American Journal of Bioethics, 19*(12), 19-28. https://doi.org/10.1080/15265161.2019.1674552

Secretaria de Saúde do Distrito Federal. (2022a). *Força de trabalho*. *Portal Infosaúde*. Governo do Distrito Federal. https://info.saude.df.gov.br/forcadetrabalho/

Secretaria de Saúde do Distrito Federal. (2022b). *Hospitais. Portal Infosaúde*. Governo do Distrito Federal. https://info.saude.df.gov.br/hospitaisses/

Sousa, Y. S. O. (2021). O Uso do Software Iramuteq: fundamentos de lexicometria para pesquisas qualitativas. *Estudos e Pesquisas em Psicologia, 21*(4), Artigo 4. https://doi.org/10.12957/epp.2021.64034

Tauber-Gilmore, M., Addis, G., Zahran, Z., Black, S., Baillie, L., Procter, S., & Norton, C. (2018). The views of older people and health professionals about dignity in acute hospital care. *Journal of Clinical Nursing, 27*(1-2), 223-234. https://doi.org/10.1111/jocn.13877

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