Acta Biomed for Health Professions 2018; Vol. 89, S. 7: 50-59 DOI: 10.23750/abm.v89i7-S.7931

"I would like to tatoo the illness on my arm". The Integrated Personalized Nursing Diagnosis (IPND)

Giovanna Artioli[1], Chiara Foà[2], Chiara Taffurelli[3], Chiara Cosentino[2]

[1] Azienda USL -IRCCS (Istituto di Ricovero e Cura a Carattere Scientifico), Reggio Emilia, Italy; [2] Department of Medicine and Surgery, University of Parma, Italy; [3] University Teaching Hospital, Parma, Italy

Abstract. *Background and aim*: The nursing diagnosis can based on two different approaches: the standard diagnosis, searching for regularities that can fall within pre-existing categories identified by the nurse, as the expert of the disease; the narrative diagnosis, based on personal meaning attributed to the illness, of which only the patient is the expert. The aim of this work is to underline the usefulness of integration between standard diagnosis and narrative diagnosis, through the Integrated Personalized Nursing Diagnosis (IPND). *Methods*: A 31 years old man, suffering from leukaemia, is welcomed at an Italian Oncological Day Hospital, by a nurse trained in the IPND approach. She used the Gordon functional models on objective data, and collected a narration about patient's experience, which has been analyzed with a Grounded Theory methodology. *Results*: The narrative revealed critical issues and the priorities that patient assigns, which would not have been obtained from a standard diagnosis. From the standard diagnosis, however, emerge several aspects that the patient has neglected to narrate and that does not directly address in his story. The diagnostic integration allowed the nurse to define a conceptual map of problems and resources in a personalized manner. *Conclusion:* The IPND not only gives importance to the priorities of the patient, but also underlines the dynamic path, in which not only the static analysis of needs becomes significant, but also the changes that occur in attributing new meanings to the life experience, as well as the evolution of the person him/herself in this process.

Key words: integrated, personalized, nursing diagnosis, patient, engagement, leukaemia, Oncological Day Hospital

Background

The evolution of the care and assistance system has underlined the need for a global approach to health problems, as highlighted by numerous studies (1-5). The experience of the disease includes, in fact, the bio-physical dimension (disease), the psychological-perceptive (illness) and the socio-relational profile (sickness).

Charon has been analyzing narratives in the clinical setting and she has been using narratives to improve practice, in the light of a new awareness reached thanks to the study of narrative theory (6). Narrative medicine does not represent a different type of medicine, but it is the same practice performed with narrative skills (7). We can identify four situations where narrative skills can be implemented: sympathetic involvement in the physician-patient relationship; a reflexive approach of healthcare professionals with themselves; the relations of healthcare professionals with their co-workers; the physician-society relations, based on mutual trust.

In the perspective of the humanistic narrative approach, the integration model proposed by Silva and Charon (8) aims to integrate the Narrative Medicine with the Evidence-Based Medicine. Also in nursing, the recently proposed Integrated Narrative Nursing Model (INNM) (9) addresses the person as a unit, consisting of a plurality of dimensions (bio-physiological,

psychological, socio-cultural, and spiritual). The model integrates the traditional model based on the disease, with the narrative one based on illness and sickness. It therefore considers health in both the bio-clinical and the psycho-social dimension. Its objectives are to solve problems, but also to understand the person and the family, accompanying them when the problem can no longer be solved. It becomes therefore a shared problem between the sick person expert in his internal life and a professional expert in empathy.

In agreement with Sakalys (10) a restructuring is necessary in patient-nurse relationship during the nursing process, which must pass from a monological meeting to a dialogic approach, encouraging the patient's voice in an interdependent, mutually respectful care process. In this dialogical encounter, shared meanings are developed between professionals and patients.

Starting from these epistemological assumptions, the methodological process that derives from this model has been analytically described, which, rather than breaking up and parceling, integrates the data in order to arrive to an integrated assessment or INNA (11), and at personalized patient education or INNE (12). The model uses both quantitative methodologies and instruments, deriving from the natural sciences (e.g. clinical and instrumental exams, scales, measurement tests), and qualitative ones typical of the human sciences (e.g. interview, narration and patient's agenda).

This methodology requires a training of the nurse to the flexibility and to the specific assessment of the situation, including the context and the person, as well as the knowledge of effective protocols in the treatment of the disease. Thus, a critical and reflective thinking and a relational awareness help the nurse to organize data efficiently in a dynamic way, establishing the main needs, as well as the welfare priorities and the educational goals, choosing the most suitable methodology based on personal characteristics and situation, inside the particular and unique framework of the assisted person in his/her history of illness.

The aim of this work is to offer further development to the INNM model and the INNA model through the Integrated Personalized Nursing Diagnosis (IPND).

As well as the model from which it originates (INNM), nursing diagnosis is also characterized by the integration of information coming from two different approaches applied to the diagnosis of the same person. Using a terminology typical of the psychological debate on the assessment of the personality and the individual, the first approach is represented by the standardization of nursing language (13, 14) and is characterized by being nomothetic, monosemic and centered on the detection of laws and rules common within the population.

In the individual, the effort is the search for regularities that can fall within pre-existing categories, be they statistical, diagnostic or symptomatological. This type of nursing diagnosis therefore leads to the formulation of a judgment concerning the responses of a person to health problems, real or potential, which is based on hypothetical-deductive thinking. This method adopts a defined set of areas of possible impairment of the patient, ranging from the physiological, to the psychological, social and spiritual one, from time to time selected based on the pathology and risk taking place in the specific case.

The other approach, represented by the narrative diagnosis, is instead an idiographic and polysemic one, which is centered on the detection of the unique and unrepeatable characteristics of the individual, implying a deep analysis of the single narrated story, and on an interpretative, analogical and associative type of knowledge. Referring to the methodology of the Grounded Theory (15, 16), the diagnosis uses the "raw" material provided by that particular patient. According to this perspective, it is not the nurse theoretical model that guides the path, but it is the material shared by the patient himself or herself.

The standard diagnosis, duly known by the professional, comes to be integrated to "give voice" to the patient and his/her experience. The narration is understood and analyzed as a unitary material, as it is aimed at reconstructing the complex and idiosyncratic meaning attributed to the experience of illness and sickness, of which only the patient is the undisputed expert (17).

Narrative uses active listening, empathy and active participation of the person in the diagnosis as well as in the whole process of assistance, through the patient engagement (18).

It is then integrated with the standardized assessment that is expressed by the professional, as the undisputed expert of the disease.

The basic approach is therefore oriented towards the support and co-construction of shared meanings. Person and nurse, according to this approach, provide a joint judgment on real and potential problems, as well as on the resources that can be put in place.

As recently argued in the clinical-care setting (11), the evaluation and understanding of the free patient narratives makes use of a professional who collects the story and develops a strong professional competence in identifying the words and key concepts that emerge from that specific narration. This is combined, in this case, with the competence related to the knowledge and applicability of the standard diagnosis, quantifying the trend of the salient thematic categories.

In summary, the combination of these two diagnoses, one in depth, dynamic and ideographic and the other objective, defined and nomothetic, allow to return a personalized, unique and unrepeatable evaluation framework for every person who experiences illness.

Method

The purpose of this work is to integrate diagnostic information from both a nomothetic and an ideographic evaluation of the same person, in order to be able to make a personalized diagnosis

The case analyzed in this paper is that of Paul, 31 years old, suffering from acute myeloid leukaemia and afferent at the Oncological Day Hospital (DH) in a city in Northern Italy.

Paul is at the first access to the service and he is welcomed by Diletta, a nurse duly trained in the assessment of the person with the IPND approach. The nurse offers a first nursing evaluation based on the Gordon functional models (14) and on objective data related to the patient's health status together with an overview of the main problems reported.

Subsequently, the nurse decides to collect a narration of the person about his own experience of illness, starting from a question: "Would you tell me about your experience of illness?" which is followed only by brief questions of clarification. The narration collected with the written consent of the person, has been recorded and entirely transcribed.

Subsequently, three independent judges analyzed the free narration, with a Grounded Theory methodology. This research approach involves the progressive identification and integration of meaning categories deriving from the information collected. The method places the emphasis on the identification of the categories and the relationships that exist between them, to create an explanatory context concerning the investigated phenomenon. The categories emerge from the grouping of narrative components that share the central characteristics (19).

In this study, the three independent judges decided not to use descriptive or analytical labels to identify the categories, but to use the salient words of Paul himself. Therefore, from the analysis of the narrative, some thematic areas emerged that have been integrated and defined, starting from the contents themselves. We then proceeded to the structuring of the categories with the addition of the same extracts of the narrative composing them. The main active role of who collects a history of illness is characterized by the use of soft skills, such as empathy and active listening that, in clinical practice, translates into an advanced competence in identifying the central themes that emerge from the story. Since the latter is a free production characterized by logical and temporal jumps, recursion and "generative chaos", the nurse limits herself to ordering and aggregating the data, without interpreting them, increasing the comprehensibility of the words also in the eyes of Paul himself.

The personalized diagnosis, which emerges from this type of analysis, is therefore a joint and dynamic judgment on the current, potential and personal resources of the person, which takes into account the patient's voice, directly collecting the meaning that he attributes to his story.

Results

1. Standard Diagnosis

Paul, 31 years old, is being treated at the oncological Day Hospital, with a diagnosis of acute myeloid leukaemia after allogeneic transplantation from a consanguineous donor.

Currently he is in good general condition.

Paul shows slight loss of appetite with significant weight loss outcomes. He currently weighs 70kg and his BMI index indicates a slightly underweight (BMI=18).

Paul is quite worried about excessive weight loss, even admitting signs of embarrassment and shame. He also shows slight signs of fatigue and intolerance to daily activity.

He finally complains about some adverse effects of cortisone therapy, such as fluid retention and increased blood sugar levels.

The assistance problems emerged are displayed in Table 1.

There is also a potential problem, which is the risk of complications due to the adverse effects of adrenocorticosteroid therapy.

2. Narrative Diagnosis

The following seven topics emerged from the patient's narration.

1. "I was an invincible type as a person"

Before the onset of the illness, Paul describes himself as an active, dynamic and proactive person on a social, work and recreational level, as emerges from the following extracts.

"It was always me who gave a help to others […]"It was the first time I needed someone, although I never acted like I needed" (Extract 36).

"Having a very strong character, to avoid disputes I used to do things. I have done relatively little wrong, but because I have always studied the work choices I have made" (Extract, 52).

"I was doing a job that ... There are 150 phone calls a day, 40,000 km a year, that is ... so you're always there, full all day, completely always at high stress level" (Extract 12).

"I've always been on holiday alone, every year, 10-15 days, to see if I could handle stress, if I managed to handle a lot of things" (Extract 11).

"Until just before the discovery ... [...] being quite young, I have always done many sports activities.. Just before getting sick I did a 3,000 m long trek, four mountain peaks 25 days before. On Monday we had a game of soccer [...] after a few days I had a bit of trouble breathing and [...] basically everything started there" (Extract 2).

2. "Like a bolt from the blue"

In this image of independence, strength and performance, the disease broke out in a sudden and overwhelming way, with repercussions on Paul's identity and on his management of everyday life.

"*They are all very sudden discoveries, so they do not give you much warning" (Extract 1).*

"Everything is completely sudden, you do not have time to prepare at all" (Extract 3).

"In a few hours everything was involved: professional activity, offices, and employees. You get up one morning and you have to close. I had commitments and it was very complex" (Extract 4).

"As long as I was alone in the rooms it was always better [...] because I had my rhythms, my times, my thoughts, and my dynamics with my partner. It was terrible" (Extract 100).

Table 1. Paul's assistance problems according to Gordon's diagnosis

Gordon's functional health patterns	Nursing diagnosis
Self perception/self concept	Fatigue related to increased metabolism, organism-to-nutrient neoplasm competition, anemia, and tumor-related stressors
	Body image disorder related to changes in appearance secondary to disease
Nutritional metabolic	Unbalanced nutrition: lower than the need related to increased caloric needs and difficulty in assuming a sufficient quantity of nutrients secondary to cancer
Role relationship	Impairment of the role due to discontinuance of relationships

"For me it was an abstract stuff, a physical condition in my life that was impossible to happen, of any kind. And as long as one does not live it, he can not understand it. You do not understand how much the legs can be important […]the legs keep you standing, there's nothing to do" (Extract 65).

"One says <the hospital steps?> Yes, the hospital steps were the daily obstacle. [...] when you are destroyed" (Extract 66).

"In the morning I can hardly get up, it hurts a bit, my legs. I feel a little slobbering everywhere. I take some paracetamol and then I pull it forward and the next day I get up" (Extract 80).

"I realize that I have physically deficiencies compared to before, but I also see that I can recover. I know that something will follow me for the rest of my life. I have dysfunctions, but I hope not "(Extract, 60).

3. "I never cried"

In an attempt to maintain an image of strength, autonomy and combativeness, it is not surprising that Paul's attitude is oriented towards "forgetting" pain and suffering, while he was conscious of living a particularly serious and complex clinical situation.

"The doctors said <<look at this guy ... he will have about two or three months of life, not more>>" (Extract 23).

"Even the doctors at the beginning said [...] that I dealt with this thing blandly, that I did not realize what was happening to me, because in the morning I put the music. I have never cried, except for two or three times for painful situations [...] for six months long, I have faced it like this" (Extract 22).

"I have always gone beyond the expression of pain. Always, it was something that I wanted to manage" (Extract 37).

"I felt pretty good, even if everyone was talking about pain. I was dealing with it pretty well, so I did not feel super problematic, even though I was. And anyway I was well aware of the survival rates of the type of illness I have, that was very low" (Extract 28).

"So sharing my pain or things could not help me. I had the strength to handle this and so I always did it. It seemed like a right path, here" (Extract 38).

"There are some aspects that I do not remember, because in my opinion they do not lead me to anything, such as physical pain. That is to remind me how painful it was, it is useless" (Extract 43).

"Hearing my partner saying < you do not tell me the truth, you do not tell me how bad you feel >yes it is true. But that's okay, in the sense that she helps me in another way. It's not like I'm here to tell her <I feel awful. I can not stand up, I can not get the shopping bag, but I do it, I feel as though a truck had passed over me> I would get nothing. I would only get her to focus on a worry that does not lead to any kind of advantage, whereas now peace can help me instead" (Extract 39).

"And then in the post-transplant phase, everyone feels very bad, even I was very sick. And hearing <"you could even die from here to tomorrow> are things that do not have to touch you too much" (Extract 42).

4. "I have faced it completely"

Paul never took a self-pitying attitude, but showed instead a rational and conscious approach to the disease, combined with an active and problem focused coping.

"It is a general thought that a person can go crazy ... that he can not sleep anymore. Actually it was not like that for me, it has never been like that" (Extract 7).

"I'm not an atheist ... but if I felt the need to pray and face the disease from the spiritual point of view in my path, no, no! This was in strong contrast with the rational aspects. It was just the opposite. I was focusing on to deal with it. I had to understand how a protein reacted or why the chromosome had changed like that, or how a medicine had effect on my body" (Extract 98).

"But if you commit to this, in the end you have nothing to do, you can understand certain things. There are many university theses, which explain many paragraphs to you in a usable way, so that you can understand the mechanisms. If one begins to understand, he also understands the directions doctors are taking. Because in the phase of chemotherapy the patient basically does not think he can decide anything. These are really technical things and you can not decide how much medication you can take or not. What chemotherapy to take or not. No. One can only know how he feels" (Extract 13).

"I was able to concentrate completely on this thing, because I made a choice. I chose to focus on this disease. Not to let it slip away, without knowing. And so I also managed to take away many thoughts from my mind, which

I've always had. So it also was a diversion. More than just a diversion, it helped me" (Extract 6).

"The disease ... I tackled it as all other things in my life" (Extract 8).

"To do this you have to know everything, even the bad, be aware of what you study" (Extract 41).

"During my days there were physical obstacles. There were times that I had difficulty pulling the clutch with my foot. But I have always driven, no one has ever accompanied me, despite telling me << I accompany you? >> No, never ever" (Extract 66).

"I was carrying a backpack with me, with useless water inside, but that was a weight to train me. Although I had legs that did not get up" (Extract 67).

"I was always diligent, because caring for me takes effort and steadiness. And it's not simple" (Extract 69).

5. "I was not a patient who does not trust, but who wants to understand"

The desire to know, understand and decide autonomously, has negatively conditioned the establishment of a relationship of trust with the doctors, at least in the initial phase.

In this relationship of incomplete trust Paul confirmed his desire to understand the mechanisms of illness, treatment and to self-determinate his own path.

"In that phase [...] I had not yet found the right balance with the doctors of the department, because there was still a lack of information" (Extract 21).

"They tell you not to look on the internet, not to see situations [...] but then it is right that one chooses alone" (Extract 9).

"They suggested that I avoid going too far into things. But then from there to about 10 days, almost immediately, I decided to investigate very precisely all things and see. Because I am always measured in life [...] appreciating the things you can measure" (Extract 10).

"One thing that I did not appreciate was [...] that they explained to me the things about the transplant, the risks of the transplant, in a phase in which I could not decide. I did not like this thing. Nobody liked it. So this kind of meeting must be done abundantly before" (Extract 70).

"I would have liked a more open discussion on these aspects. I had to create this discussion with a bit of violence, studying, trying to have talks with the doctors up to what they represented, of the profession they had, in my limits of course, because I graduated, I understand things, to give me the opportunity to set some situations under my responsibility" (Extract 72).

"How does the doctor evaluate the benefit? Who is it? How can you afford? Based on what? Does he know how bad I feel? No!" (Extract 77).

"I've been a very troublemaker patient! Very, very, very! But in the end, it is my life and I respect it. Therefore where I can decide, I decide for myself. Where I can do it, I entrust myself. But I still rely on a minimum of knowledge. Not completely by chance" (Extract 84).

The relationship with the doctors has however evolved over time, given the widening of his knowledge and having received clearer and more direct information from the doctors*: "When they started to explain things, in all the terms it started to be more balanced, then more trustful" (Extract 26).*

"But with the studies, deepening things, I realized that probably, the chosen strategy created virtuosity in my immune system, which was favorable to fight the disease. So, in the end, I think the strategy was right. At the beginning I did not understand this thing well" (Extract 34).

6. "Today my time has a different value"

Paul's illness had great impact especially on his time management: "*If today I had to say << but what did you understand, what's important? >> The time is important! [...] a condition that people do not value. Even I did not valued it so much. The freedom!" (Extract 46).*

"Today I use my time. If I want to stay a little longer with my partner and a little less to work, I do it" (Extract 47).

Paul claims to have reached a more harmonious relationship with work.

"Fortunately, this has happened in a trend of my personal decisions, to free myself from many things, including just work commitments" (Extract 4).

"I'm trying to do a job, but differently" (Extract 12).

"I'm re-starting a little bit to work, but with a totally different stress management" (Extract 59).

Paul also describes a change in his social and family relations, in terms of a greater awareness of past investments and their current downsizing.

"I have made a life very dedicated to others. [...] Helping often takes up your time. You can also learn many new things by contacting people. I've always been a kind

person like that… So it was important for me, but it was a job, among many jobs. It was a social aspect that I took care of, over many years, that has repaid me. Under the hospital window, every day someone came. For my birthday, they made a banner and they came in 50. So I've always had a lot of people doing a lot of things. It was important. At the same time, however, I understood who was really there, in these moments" (Extract 49).

"Above all, those left behind in my family made me understand this. I've always been a child who has supported and been close to my family for many years. So, I realized that in reality their presence was due more to exculpation to them, or to an action that had to be done. And so in the hospital you had to come on that date, at that time" (Extract 51).

"But in reality they were not really there to help me" (Extract 53).

The romantic relationship with the partner takes on even greater importance in Paul's path.

"On the other hand, my partner, who unfortunately slipped into this situation, after a very short time that we had met, has learned what kind of commitment meant this thing. But now we are together, we live, soon we will get married. She is a rather tough woman, a person I have never had by my side in my life. Thanks to her I understood things in my life did not go well. I worked too much; I wasted too much energy for things that were not essential or important" (Extract 54).

"Before the illness [...] I did not realize that I was unhappy. I devoted time to an unattainable family ideal" (Extract 88).

7. "I would like to tatoo the illness on my arm"

Finally, personal considerations regarding the overall sense that the disease has taken in Paul's life are represented. The disease is symbolically associated with an indelible mark, which at the same time takes on the positive connotation of a life teaching.

"Understanding the energies I put into dealing with things, remembering certain things, in my opinion is positive. So [...] tomorrow I would like to tatoo the illness on my arm [...]. I have another tattoo for me very important on the right, which is my father who committed suicide ... I would not be afraid to write it down. It's not that if I see it every day I remember the pain and the suffering ... I remember the ability to face the thing, the enthusiasm, the smile of every day, the fact that today I am here"(Extract 45).

"I do not want to forget anything at all. I want it to stay in my mind so clear" (Extract 94).

"I know that something will follow me in the course of my life" (Extract 61).

"I could almost say that a path of illness made of sacrifices can somehow be a fortune for a lifetime. Because [...] I think that these things put you in front of situations to see life in technicolour. Before I saw life more or less in black and white, only sometimes I saw it in technicolour. I used to see the technicolour when I bought something, or because I was on vacation […] things like that. So only in flashes it became technicolour. While this type of path gives you the opportunity to see it in full technicolour" (Extract 56).

"The possibility that today I have been given the opportunity to face life in technicolour is not a trivial matter; it is not to be underestimated [...].Currently I do things in this way" (Extract 58).

"In reality, my mood, already during the hospital, but even more so today, has definitely improved and it is all connected to the fact that I currently see life in technicolour" (Extract 89).

"So it's like that. I'm better now. I'm worse physically, but mentally I'm better. I do not give more value to the money I gave before; it does not mean that I think I'm going to die tomorrow, but I think the future is uncertain, it's right to realize it" (Extract 90).

Discussion

As emerged from the diagnosis, we are facing a person who has developed a serious condition such as leukaemia, which involved transplantation. From the narrative diagnosis emerged several critical issues in the history of Paul's illness and especially the priorities that he assigns to these problems. In fact, the results reveal personal critical issues, which Paul has chosen to share with the nurse, which would not otherwise have been obtained from a standard diagnosis.

From the standard diagnosis, however, emerge several aspects that Paul has neglected to narrate and that does not directly address in his story. For example, the fatigue and the body image, although greatly modified by the disease, as well as an unbalanced nutrition,

do not seem to take on particular importance for Paul.

Thus, the personalized diagnosis (IPND) was a process of integration between the standard diagnosis and the narrative diagnosis which led the nurse to the following considerations.

The set of diagnostic data converges towards a coherent configuration, which describes a task oriented person, who tries to stay in control over his life, and to face difficulties with commitment. This is highlighted in the social-relational life, in which in the past the person has assumed the role of caregiver, in the work experience, in which he has always strenuously committed, as well as in the context of his challenging sporting activities.

The self-image is therefore highlighted as a strong, independent, active, proactive and dynamic person, whom the disease has partially affected. In this configuration it is not surprising that he avoids everything associated with weakness, pain and suffering, as they affect the image of the performance strength of his social role. Facing the challenges that the disease has placed before him, he declares, his choice to tackle them completely, as he has always done in his life. This is also confirmed by the rationalizing style with which he approached the illness path, being perfectly informed about mechanisms, progress, treatment and complications of the disease. Wanting to know every detail, to be able to decide in a completely autonomous way seemed to be the motivational drive that also affected his relationship. This self-determination of the treatment process has therefore slowed down, at least initially, the establishment of a relationship of complete trust in the professionals.

In general emerges a person unwilling to rely on faith, and who, far from showing a victimized attitude, underlines the positive aspects of the experience, even though aware of the seriousness of his clinical condition. In this challenge that life has placed before him, considering the sense of the experience of illness in his life, Paul suggests that it is not the disease that has won: if the disease has taken away the physical forces, internally it made him even stronger and this is what he seems to want to remember about his experience.

Considering the dynamic process that takes into account the two different ways of making a diagnosis, the following six aspects emerge.

1. An impetuous event

At first, the disease has been experienced as unexpected, and obstructive. It has been experienced with physical dysfunctions that Paul partially denies or holds in low consideration.

2. Hide the pain

After this he showed the tendency to hide pain and suffering, even though he is aware of his complex clinical situation.

3. Personal resources

Paul showed a defensive attitude during clinical treatments, but thanks to his resources he faced the disease, trying to understand it. He also acted effectively on his condition, thanks above all to his high resilience.

4. Change priorities

There is an important evolution in the disease, linked to the new meaning that Paul attributes to interpersonal relationships, work and in general to the management of his time.

5. An indelible mark

At the current time the disease is experienced as an indelible mark that no longer goes away. It is not useful to remind him of pain and suffering, but his strong ability to deal with leukaemia, just as he has faced other events in his life.

6. Give other meanings

Paul does not talk about spirituality, rather he denies it. However the disease offered Paul the chance to give a better meaning to life.

This diagnostic integration is illustrated by the conceptual map represented in Figure 1.

Conclusion

As we tried to highlight, through the presentation of a clinical case, the purpose of this work was to underline the richness of integration between standard diagnosis and narrative diagnosis, through the Inte-

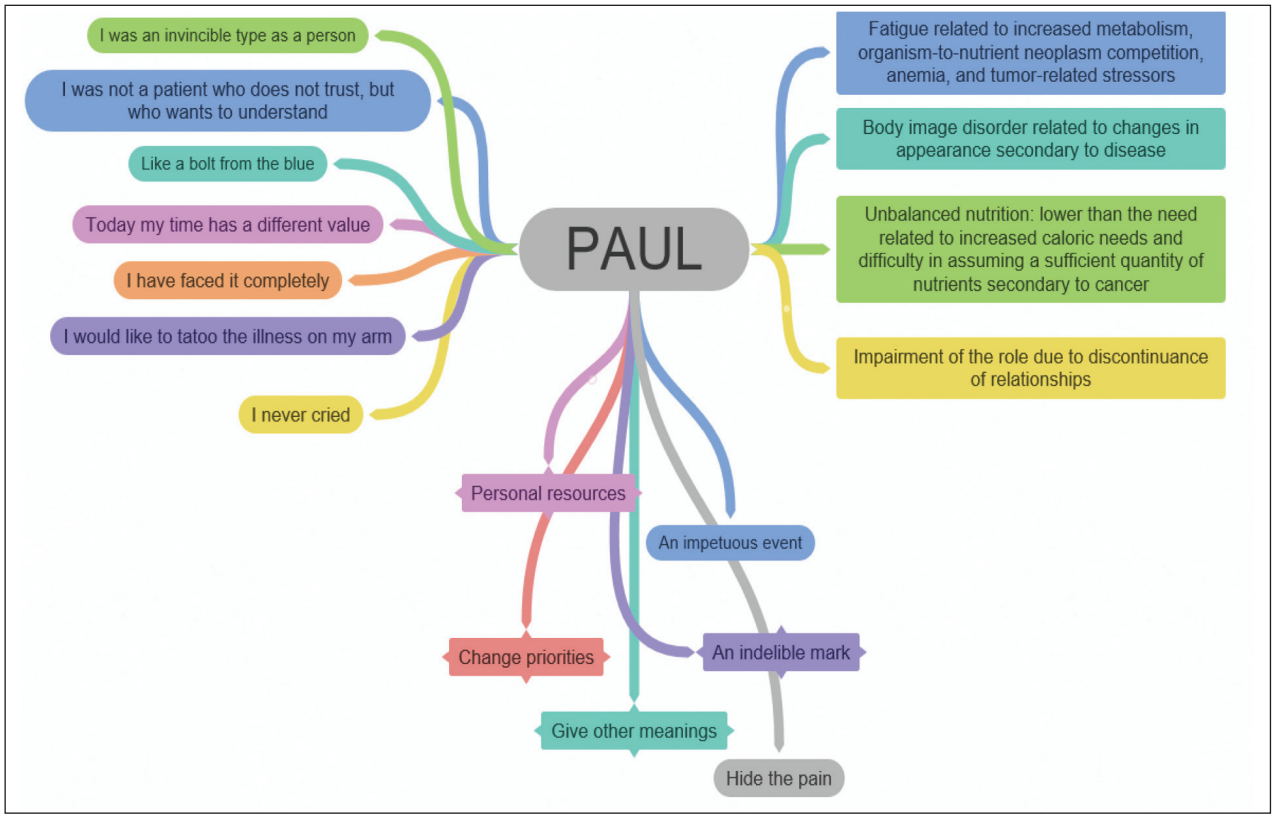

Figure 1. Integrated Personalized Nursing Diagnosis of Paul (conceptual map)

grated Personalized Nursing Diagnosis (IPND). The diagnosis made by the professional (traditional diagnosis), which is of an interpretative nature, is complementary to the introspective one derived from the person (narrative diagnosis), which highlights the priorities of the person.

As we have argued, the active participation of the person in the treatment process is based on the patient's engagement, which allows highlighting current and potential problems and individual resources, which are of great importance and which must be analyzed and used by the professional for schedule a personalized assistance plan.

The two approaches, one of a top-down type (in the case of the standard diagnosis) and the other of a bottom-up type or data driven (in the case of narrative diagnosis) certainly have both limitations and advantages. In the first approach, the advantages lie in the possibility of sharing the diagnostic categories in the scientific community and in the transversal scientific language used to describe the person's criticality and resources. The disadvantages lie instead in the simplification process, which uses the categories already possessed by the professional to describe the person.

In the second approach, the advantages lie instead in the accuracy and personalization of the diagnosis in which the expert is the assisted person. The individual highlights certain aspects of the experience of illness, neglecting others. The disadvantage, instead, is being a more expensive process, which requires specific training in empathy, active listening and recursive and critical thinking. The methodological process is therefore based on the attention paid to the person's own words, without interpretations and without pre-established categorizations. Integration and comparison between different reading lenses, perspectives and languages is therefore fundamental.

The patient's engagement can enrich data already detected in the standard diagnosis, can detect aspects not obtainable from the latter or even integrate aspects

that only the professional can highlight. The use of both approaches therefore justifies the complexity of the assisted person: from their successful integration it is possible to reach a richer, more articulated and completely tailored diagnosis based on the uniqueness of the person.

The Integrated Personalized Nursing Diagnosis (IPND) not only gives primary importance to the priorities expressed by the patient, but also underlines the dynamic path, in which not only the static analysis of needs becomes significant, but also the changes that occur in attributing new meanings to the life experience, as well as the evolution of the person him/herself in this process.

Acknowledgment

Thanks especially to Dr. Diletta Artioli for her precious collaboration in the collection of information used in this work.

References

1. Artioli, G, Amaducci G. Narrare la malattia. Nuovi strumenti per la professione infermieristica [Narrate the desease. New tools for the nursing profession]. Roma: Carocci, 2007.
2. Giarelli G, Good BJ, Del Vecchio Good MJ, Martini M, Ruozi C. Storie di cura. Medicina narrativa e medicina delle evidenze: l'integrazione possibile [Stories of care. Narrative medicine and medicine of evidence: the possible integration]. Milano: FrancoAngeli, 2005.
3. Marcadelli S, Artioli G. Nursing Narrativo [Narrative Nursing]. Rimini: Maggioli, 2010.
4. Marinelli N. Le competenze infermieristiche [The nursing skills]. Risorse, analisi e sviluppo 2009; 10 (2): 20-25.
5. Maturo A. Sociologia della malattia. Un'introduzione [Sociology of the disease. An introduction]. Milano: FrancoAngeli, 2007.
6. Charon R, Wyer P. Narrative Evidence Based Medicine. Lancet 2008; 371 (9609): 296-7.
7. Charon R. Narrative Medicine: Form, Function, and Ethics. Ann Intern Med. 2001; 134: 83-87.
8. Silva SA, Charon R, Wyer PC. The marriage of evidence and narrative: scientific nurturance within clinical practice. J Eval Clin Pract 2011; 17 (4): 585-93.
9. Artioli G, Foà C, Taffurelli C. An integrated narrative nursing model: towards a new healthcare paradigm. Acta Bio Medica For Health Professions 2016; 87 (4): 13-22.
10. Sakalys JA. The political role of illness narratives. J Advan Nurs 2000; 31 (6): 1469-75.
11. Artioli G, Foà C Cosentino, C, Taffurelli, C. Integrated narrative nursing: a new perspective for an advanced assessment. Acta Bio Medica For Health Professions 2017; 88 (1) 7-17.
12. Artioli G, Foà C, Cosentino C, Sulla, F, Sollami A. Taffurelli C. "Could I return to my life?" Integrated Narrative Nursing Model in Education (INNE). Acta Bio Medica For Health Professions 2018; 89 (4) 5-17.
13. Carpenito-Moyet, L J. Diagnosi infermieristiche. Applicazione alla pratica infermieristica [Nursing diagnosis. Application to nursing practice]. Milan: Casa Editrice Ambrosiana, 2015
14. Gordon, M. Diagnosi Infermieristiche. Processo e applicazione. [Nursing diagnosis. process and application]. Milan: Casa Editrice Ambrosiana, 2009.
15. Lo Biondo- Wood G, Haber J. Metodologia della ricerca infermieristica [Nursing research methodology]. New York: McGraw-Hill, 2004.
16. Mortari L, Zannini L (editor). La ricerca qualitativa in ambito sanitario [Qualitative research in the health sector]. Rome: Carocci, 2017.
17. Kleimann A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books, 1988.
18. Graffigna G, Barello S. Engagement - Un nuovo modello di partecipazione in sanita'. [A new model of participation in health care]. Rome: Il Pensiero Scientifico, 2018
19. Willig C. Introducing Qualitative Research in Psychology. Maidenhead, Berkshire, UK: McGraw Hill Education, 2013.

Correspondence:
Giovanna Artioli
Azienda USL -IRCCS
E-mail: giovanna.artioli@ausl.re.it