**The Correlation between Respecting the Dignity of Cancer Patients and the Quality of Nurse-Patient Communication**

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No potential conflicts of interest were disclosed.

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**Main article**

**Introduction**

The diagnosis of cancer may have a lot of negative effects and destroy the patients’ hopes and aspirations and cause many physical signs ([1](#_ENREF_1)). Also, it causes stress and anxiety, personality disorder, fear of death, difficulties in social roles and disruption of communication. All these factors may lead to defects in the dignity of patients (2,3). The dignity of patients admitted to the hospital are more vulnerable to be damaged, due to changes in the environment, hospitalization in an unfamiliar environment, dependence to healthcare personnel and lack of control (4).

Dignity is one of the main components of human rights and is the core in the provision of quality nursing care delivery (5,6) and as an interpersonal concept, it contains those elements that are grounded in personal beliefs and aspects of the body. It seems to be a personal refuge; one cannot be deprived of the core of dignity even under the worst circumstances (7). It should be considered that despite the importance of the concept of dignity, it remains largely unclear and it has been recognized with the following concepts such as respect, privacy, self-confidence, independence, social relationships, and positive self-control (8).

One of the effective factors influencing the respect for the dignity of the patients, is the quality of their communication with healthcare personnel, including nurses (9-11). Effective nurse-patient communication is a worldwide healthcare priority and it is recognized as a main clinical skills (12). However, communicating appropriately with all the patients is an essential requirement, but establishing such communication process that takes place between cancer patients and their care specialists is much more important (13). It is very difficult to communicate with the admitted cancer patients while providing care (14). Personal communication of cancer patients is dramatically impaired because of their uncertainty about the future, high levels of stress, anxiety, depression, fear of death, mental distress, incompatibility and poor self-satisfaction (11,14,15). These issues lead to poor communication between nurses and other healthcare providers with patients (16) and result in some problems for healthcare system, patients and their families in such a way that patients cannot take advantages of the presence of clinicians and they do not receive sufficient support needed to identify and understand their medical options (17).

As the fear of death and dying is inherently stressful; it makes nurses to limit their communication with patients and hinders an open and supportive communication between the patients and their families with the staff. Thus, the rights of cancer patients do not respected very well most of the time (18). These patients should be aware of their diseases’ diagnosis, clinical course and treatment in order to establish an adequate communication and receive social and emotional support (19). Cancer patients who have better social communication are more successful in coping with the nature of their disease (20) and they are more satisfied with the received nursing care services (21).

Patients’ dignity comprises feelings, physical presentation and behavior. The environment, staff behavior and patient factors affect patients’ dignity and lack of environmental privacy threatens dignity. A favorable physical environment, dignity-promoting culture and other patients’ support promotes dignity. Healthcare personnel being curt, authoritarian and breaching privacy threaten dignity. Healthcare personnel promote dignity by providing privacy and interactions which made patients feel comfortable, in control and valued (22). The use of effective interpersonal communication skills along with trust reflects respect for the dignity of the patients and without establishing of a proper communication, healthcare providers will not be able to understand the needs and expectations of patients. in addition, the patients may lose to access their required rights and opportunities (17). There is not carried out any study which indicated the mentioned relationship between these two concepts in Iranian healthcare setting. Therefore, it is obviously necessary to conduct a study to determine the presence, extent, direction and intensity of such relationships.

**Materials & Methods**

This descriptive-correlation study was conducted on the oncology departments of Tabriz Shahid-Ghazi hospital affiliated to Tabriz University of Medical Sciences, Tabriz, Iran from July to December 2014. The study population included all cancer patients admitted to that center to receive healthcare services. The inclusion criteria were: having a definite diagnosis of cancer, being at least 18 years old, awareness of cancer patients of their disease diagnosis, being hospitalized for at least 5 days and the having the ability and willingness to participate in the study. A participant’s decision to leave the study considered as the exclusion criterion. The sample size was determined 235 subjects based on a pilot study. During the study, 270 patients were invited to participate in the study, using convenience sampling method. Finally, 250 subjects were completed and returned the distributed questionnaires (response rate = 92.6%).

A three-part questionnaire was used for collecting data. The first part included demographic data and illness-related characteristics in cancer patients. The second part addressed the Patient Dignity Inventory (PDI) that was developed by Chochinov in 2008. It consisted of 25 items in 3 dimensions; illness-related concerns (8 items), dignity conserving repertoire (12 items) and social dignity inventory (5 items). The answers were measured through a 5-point Likert scale provided for each statement (included; not a problem, a slight problem, a problem, a major problem and an overwhelming problem) ranges from 1 to 5. Lower score indicates a greater respect for the dignity of patients. Permission for use in this study was granted by the developer of instrument (23). The third part was the Nurse Quality of Communication with Patient Questionnaire (NQCPQ) which was designed by Vukovic et al. in 2010. It consists of 24 items that measure verbal communication, non-verbal communication and communication in general, using marks from 1 to 6 (24). In this study, the English version of the questionnaire was translated into Farsi by a translator, expert in both English and Farsi, and then, the accuracy of the translation was validated by two other experts. Content and face validity of the instrument were confirmed by a panel of experts consisted of 10 academic member professors in nursing at the Tabriz University of Medical sciences. The instrument was piloted on 30 cancer patients. Then, its Cronbach alpha was calculated as 0.96. Data from the pilot study were not included in this study.

The study was approved by the Institutional review board and the ethics committee of Tabriz University of Medical Sciences. Moreover, permissions were obtained from Tabriz Shahid-Ghazi university hospital officials and hospital wards managers. Then during study, one of the researchers constantly visited the hospital wards and identified eligible patients. The objectives of the study were explained to the subjects and all of them signed an informed consent form before the questionnaires handed out. The questionnaires were anonymous and respondents were assured of the confidentiality of their responses. Also, measures were taken to counsel the participants if required. In addition, data of literate and illiterate patients were collected by private interviewing.

Data analysis was performed using descriptive statistics (including frequency, percent, mean, and standard deviation) and inferential statistics including Pearson correlation coefficient (r) by IBM SPSS software (version 13; SPSS, Chicago, IL).

**Results**

Some demographic characteristics and illness-related characteristics of patients participating in the study are presented in Table 1. The study subjects were men and women with a mean age of 50.5 ± 17.7 years. The majority of participants were illiterate (42%), housewives (37.6%), unemployed (32.4%), married (88%) and had earned less money (98.6%). The blood cancers were the most important category of diagnosis in this study. All patients were also undergoing chemotherapy.

The patients’ answers to each item of PDI are listed in table 2. The mean score of dignity was 83.2 out of 125. Also, the patients’ complaints in 3 dimensions of PDI were related to illness-related concerns (74 out of 100), dignity conserving repertoire (65.4 out of 100) and social dignity (57.6 out of), respectively.

The patients’ answers to each item of NQCPQ are presented in table 3.In total, data analysis of this questionnaire showed that the mean score of nurse-patient communication was 79.1 out of 144 (SD= 12.58). The highest scores in this questionnaire were related to the following statements; accepting the quality of nurse’s communication method (4.4 ± 1.21), understanding the presence and role of nurses in the course of the disease (4.1 ± 1.11), communicating through generally speaking during nursing care (3.7 ± 1.12) and meeting the needs without asking meanwhile the severity of the condition (3.7 ± 1.12). As well, the mean verbal, non-verbal and communication in general were examined. The highest satisfaction scores of cancer patients were related to verbal communication (55%), communication in general (55%) and non-verbal communication (6/54%), respectively.

The relationship between nurse-patient communication scores and respecting the dignity of cancer patients were examined using Pearson correlation test that indicated a weak and inverse correlation between these two variables (r= -.21, p=.001), that means, the higher communication scores result in lower dignity scores and therefore the dignity of cancer patients respected further.

**Discussion**

This study conducted to determine the relationship between respecting the dignity of cancer patients and the quality of nurse-patient communication in the hospital settings. According to the review of the literature, this is the first study conducted on respecting the dignity of cancer patients and its relationship with nurse-patient communication in Iran and other Middle Eastern countries. The results showed that the dignity of cancer patients was not well respected and the quality of nurse-patient communication remained in a moderate level in this study.

The majority of respondents were dissatisfied with loss of their dignity in the oncology departments of Tabriz Shahid-Ghazi university hospital. This finding is consistent with a study conducted by Chochinov et al. that showed 87.1% of patients were not treated with respect and the dignity of patients was not respected completely (25). In an earlier qualitative study, Matiti et al. has also reported that a significant number of patients were dissatisfied with the lack of respect to their dignity in the hospitals (26).

In terms of illness-related concerns, results of other studies also showed that cancer patients experiencing large amount of anxiety and depression due to their mental and physical pain and suffering during their diseases that it could lead to the loss of their dignity (27,28).In a previous study carried out by Vehling and Mehnert on symptom burden, loss of dignity, and demoralization in German cancer patients, patients expressed thier concerns about future (12%) and uncertainty in the their diseases treatment (13%) (29). In terms of dignity conserving, a prior study, conducted by Chochinov et al. on distress in the terminally ill, cancer patients’ concerns were largely related to not being able to continue usual routines (51.4%), not being able to carry out important roles (37.5%) and no longer feeling like who I once was (36.4%), that profoundly influences patients’ sense of dignity (23). And regarding social dignity, Chochinov et al. that 40% of the patients feeling themselves to be a burden to others and the majority (60%) indicated varying degrees of burden-related distress (4). In an Iranian study, Torabizadeh et al. noted that the physical privacy of patients was not respected in clinical settings (30). That all these issues and problems faced by cancer patients in the hospital setting, threatening the dignity of patients.

To assess the quality of nurse-patient interaction, the average score of all three types of verbal communication, non-verbal communication and communication in general were measured. The average score of all three types was approximately identical and patients had moderate satisfaction with the communication quality of oncology nurses. In line with the results of this study, Uitterhoeve et al. revealed that effective communication was more satisfactory for Dutch cancer patients than merely the quality of treatment and most patients were satisfied with the ways, nurses communicated them (31). Findings from a recent descriptive study conducted in Tabriz by Moghaddasian et al. showed that cancer patients were more dissatisﬁed with verbal communication than non-verbal communication and they expressed relatively high satisfaction of nurses’ communication (21). Akhtari-Zavare et al. revealed that 81.5% of patients were satisfied with communication and information given by nurses in hospital settings (32). In another Iranian study, Akbary et al. found that 79.5% of patients were satisfied with the healthcare providers’ communication (33).

As far as cultural issues are concerned, ﬁnding a high satisfaction rate is not surprising because people in Iran usually are not very critical when appraising a service. Proper communication and politeness are the most important concerns of people in Iran. Patients’ expression clearly shows that patients are gradually realizing the right to ask question, yet this is an area that requires improvement. It is argued that in order to tackle the sense of powerlessness and culture of passivity among patients towards the medical knowledge and the healthcare system, they should be assisted and educated to gain some basic understanding so as to make demands and choices effectively (34). Akhtari-Zavare et al. were also noticed that higher level of patience and use of appropriate communication skills may increase patients’ level of satisfaction towards nursing care, and these also help the nurses to be more satisfied in their work (35). Findings of the study conducted by Caris-Verhallen et al. indicated that the nurses more often display non-verbal behaviors and they reported that on average, in 41% of the observation time the nurses looked in the direction of the face of the patients and in nearly all encounters nurses smiled and made head nods. Also, in 58% of the nursing encounters, nurses displayed forward leaning, expressing immediacy and interest behaviors (36). These non-verbal behaviors are important in establishing a good relationship with the patient.

The other ﬁnding of this study was a statistically significant relationship between the quality of nurse-patient communication and respecting the dignity of cancer patients. This result confirms the findings of many other studies indicate that the cancer patients’ satisfaction with the quality of nurses’ communication and nursing care reduces their stress, anxiety, mental and spiritual distress and it also promotes and upholds their dignity (37-39). In an study conducted on 24 patients in an acute hospital in England, Baillie noted that Staff can promote the dignity of patients by providing privacy and interactions, giving a sense of comfort, convenience and confidence, giving information and awareness to patients and adequate explanation on the implementation of the procedure, which made patients feel comfortable, in control and valued (22). In another study conducted on 560 nurses who cared for dying patients in hospitals and clinics in Ethiopia, India, Kenya, and the United States, Coenen et al. also declared that nurses can obviously promote the dignity of patients by establishing appropriate communication, providing confidence and reassurance about maintaining comfort, talking about death, listening and acknowledging patient perceptions, staying at the bedside of patients and etc (40). In a PhD dissertation carried out on patients admitted to the medical-surgical ward of Iranian healthcare systems, Torabizadeh implies that nurses do not have the necessary verbal and non-verbal communication skills and it leads to ineffective interaction, emotional disconnected between patients and nurses and feeling of humiliation and ignorance in patients. Negligence in establishing an effective communication with patients induces this feeling in patients that the clinicians do not value them and it results to the loss of their dignity (41).

**Limitations**

This study has several limitations: First, the study was conducted in one of the northwest provinces of Iran and cannot cover the cultural and religious diversity in Iran. Second, all the hospitalized patients, with any cancer diagnosis and without specifying the stage of cancer, were participated in this study. Hence, other similar studies are needed to investigate the outpatient, home care and end stage stages patients.

**Conclusion**

Cancer patients admitted to Tabriz Shahid-Ghazi university hospital expressed a lack of dignity and moderate satisfaction of nurses’ communication. Also, a significant relationship was found between quality of nurses-patient communication and cancer patients’ dignity. Therefore, it’s highly recommended to the nursing clinicians to establish effective communication methods and adopt measures that results in patients’ better understanding of nurses’ benevolent presence and role in clinical environments. Also, the study findings highlighted the importance of the communication quality in order to enhance the dignity of cancer patients. Evidently, the healthcare systems’ officials would benefit more by taking proper actions particularly by educating communication skills to nurses and nursing students.

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Abstract:

Nurse-patient communication is one of the important factors affects the promotion and maintenance of the dignity of cancer patients in the hospital settings. This study aimed to determine the perceptions of cancer patients regarding respecting their dignity and its correlation with nurse-patient communication in hospital settings. This correlational study was conducted on 250 cancer patients admitted to the oncology departments of Tabriz Shahid-Ghazi university hospital, Iran. These patients were selected using a convenience sampling method. The Patient Dignity Inventory and Nurse Quality of Communication with Patient Questionnaire were used for collecting data. Descriptive and inferential statistics were applied to the data. The score of nurse-patient relationship is significantly correlated with patients’ dignity score (r=-0.21, p=0.001). Due to the importance of nurse-patient communication on maintenance of the dignity of cancer patients, it is a necessary requirement to take proper actions in this area, particularly by promoting “nurses' communication skills”.

Keywords: Dignity, Cancer patients, Nurse-ptient communication, Nursing ethics

**Tables:**

|  |  |
| --- | --- |
| **Table 1. Participant characteristics (n=250)** | |
| **Variable** | **N (%)** |
| **Gender** |  |
| Female | 125 (50) |
| Mail | 125 (50) |
| **Level of education** |  |
| Illiterate | 146 (58.4) |
| Under diploma | 38 (15.2) |
| Diploma | 46 (18.4) |
| University degree | 20 (8) |
| **Employment status** |  |
| Housewife | 94 (37.6) |
| Employee | 35 (14) |
| Worker | 40 (16) |
| Unemployed | 81 (32.4) |
| **Marital status\*** |  |
| Single | 30 (12%) |
| Married | 220 (88%) |
| **Economic status** |  |
| Earn equal pay | 19 (57.6) |
| Earn more money | 7 (2.8) |
| Earn less money | 224 (89.6) |
| **History of recurrence** |  |
| Yes | 113 (45.2) |
| No | 136 (54.4) |
| **House hold composition** |  |
| Alone | 4 (4.0) |
| Living with someone | 240 (96) |
| **Disease** |  |
| Blood | 97 (38.8) |
| Lung | 11 (4.4) |
| Digestive | 72 (28.8) |
| Breast | 34 (13.6) |
| Head and Neck | 8 (20) |
| Prostate | 7 (2.8) |
| Genital | 9 (3.6) |
| **Relationship with your family** |  |
| Excellent | 191 (76.4) |
| Good | 37 (14.8) |
| Bad | 22 (8.8) |
| **Treatment models** |  |
| Chemotherapy | 250 (100.0) |
| Radiotherapy | 137 (45.5) |
| Surgery | 139 (55.6) |
| Other | 47 (18.8) |
| **Age (years)** |  |
| Mean (SD) | 50.5 (17.7) |
| **Since awareness of the disease in month** |  |
| Mean (SD) | 22.8 (29.5) |

|  |  |
| --- | --- |
| **Table2. The responses of participants to the Patients Dignity Inventory (PDI)** | |
| **Mean (SD)** | **Variable** |
| 1.5(0.49) | Not being able to carry out tasks associated with daily living |
| 2.9(1.36) | Not being able to attend to my bodily functions independently |
| 3.7(1.3) | Experiencing physically distressing symptoms |
| 3.3(1.28) | Feeling that how I look to others has changed significantly |
| 4.1(1.20) | Feeling depressed |
| 4.1(1.20) | Feeling anxious |
| 4.1(1.22) | Feeling uncertain about my illness and treatment. |
| 4.2(1.11) | Worrying about my future. |
| 3.6(1.24) | Not being able to think clearly. |
| 3.9(1.09) | Not being able to continue with my usual routines. |
| 3.5(1.15) | Feeling like I am no longer who I was |
| 3.1(1.31) | Not feeling worthwhile or valued |
| 3.4(1.21) | Not being able to carry out important roles |
| 3.3(1.19) | Feeling that life no longer has meaning or purpose |
| 3.3(1.35) | Feeling that I have not made a meaningful and lasting contribution during my lifetime. |
| 3.9(1.21) | Feeling I have 'unfinished business' |
| 1.2(1.00) | Concern that my spiritual life is not meaningful |
| 3.7(1.35) | Feeling that I am a burden to others |
| 3.3(1.27) | Feeling that I don't have control over my life. |
| 3.2(1.38) | Feeling that my illness and care needs have reduced my privacy |
| 2.1(1.26) | Not feeling supported by my community of friends and family. |
| 2.8 (1.63) | Not feeling supported by my health care providers |
| 3.1(1.28) | Feeling like I am no longer able to mentally 'fight' the challenges of my illness. |
| 2.9(1.34) | Not being able to accept the way things are. |
| 2.5(1.42) | Not being treated with respect or understanding by others |
| **74(19.12)** | **Illness-related concerns (based on 100)** |
| **65.4(17.68)** | **Dignity conserving repertoire (based on 100)** |
| **57.6(22.12)** | **Social dignity inventory (based on 100)** |
|  | **\*SD = standard deviation** |

|  |  |
| --- | --- |
| **Table 3. the Nurse Quality of Communication with Patient** | |
| **Variable** | **Mean (SD)** |
| Based on the quality of communication with the patient, I evaluate his/her current condition as | 3.6 (1.28) |
| During conversation with me, the patient is showing interest in hospital regimen and the lifestyle he/she should lead in hospital environment, according to his/her illness | 3 (1.23) |
| From the conversation I conclude that the patient accepts his/her pharmacotherapy | 3 (1.12) |
| The information I receive through talking to patient shows that this pharmacotherapy would be acceptable for application at home settings: | 3.2 (1.17) |
| The patient shows me that he/she understands hospital regimen, by respecting it: | 4.4 (1.21) |
| Generally speaking, the level of my communication with the patient, keeping in mind severity of his/her condition, I can describe as: | 3.2 (1.11) |
| The patient talks to me about various themes, but avoids or is not able to answer my questions about her/his illness | 3.2 (0.98) |
| The patient talks to me about details related to his/her personal hygiene while I assist her/him in changing bedclothes or underwear | 2.9 (1.09) |
| The patient accepts conversation with me about her/his medication | 3.3 (1.01) |
| Based on the patient reactions, I can say that his/her treatment is resulting in: | 3.1 (1.07) |
| I fully understand the severity of the patient’s illness, and I talk with him/her about it: | 3.1 (0.95) |
| I believe that, due to the severity of the illness, the patient talks to me in such a way that I can understand him/her: | 3.5 (1.12) |
| Based on the observation of the patient, I believe that her/his current condition is: | 3.3 (0.99) |
| The patient talks to me about details related to his/her nutrition while I help him/her with feeding or supervise food intake during meals | 2.9 (0.96) |
| The patient actively participates in maintaining her/his personal hygiene | 3.1 (1.00) |
| The patient looks like he/she listens to what I am saying about his/her condition, but avoids or is not able to adequately cooperate with me while talking to him/her: | 3 (0.95) |
| The patient is active during meals and asks for appropriate assistance from me: | 2.2 (0.67) |
| The patient accepts and understands my presence related to her/his illness: | 4.1 (1.11) |
| Generally speaking, the level of my communication with the patient while I carry out or monitor his/her pharmacotherapy, I can describe as | 3.2 (1.07) |
| I fully understand the severity of the patient’s illness, therefore only by observing the patient’s gestures I conclude that my communication with him/her is | 3.2 (0.99) |
| The patient accepts conversation about his/her illness in the following way: | 3.5 (1.11) |
| Generally speaking, the level of my communication with the patient during care procedures, I can describe as: | 3.7 (1.12) |
| I believe the patient has difficulties in communication due to the severity of her/his condition, therefore I understand her/his needs in the following manner | 3.7 (1.12) |
| The conversation with the patient shows that prescribed pharmacotherapy works as: | 3.5 (1.59) |
| verbal communication | 55 (10.31) |
| non-verbal communication | 54.6 (8.5) |
| communication in general | 55 (12.25) |