Perceptions of Iranian Cancer Patients Regarding Respecting their Dignity in Hospital Settings

Zoleikha Avestan1*, Azad Rahmani2, Fatemeh Heshmati-Nabavi3, Sima Mogadasian1, Safieh Faghami4, Arman Azadi5, Ali Esfahani2

Abstract

**Background:** There are several factors that threaten the dignity of cancer patients in hospital settings. However, there is limited literature regarding the degree to which dignity of cancer patients is actually respected in daily clinical practice. The aims of this study were therefore to explore cancer patient perceptions of respecting their dignity and related variables in an Iranian cancer specific center. Materials and Methods: This descriptive-correlational study was carried out among 250 cancer patients admitted to a cancer specific center in East Azerbaijan Province, Iran. These patients were selected using a convenience sampling method. The Patient Dignity Inventory (PDI) was used for data collection. Descriptive and inferential statistics were used for data analysis. Results: The patients' scores in 18 out of 25 items of PDI were 3 or greater which indicate the importance of considering these items in clinical settings. Also, the score of patients in three sub-scales of PDI including illness-related concerns, personal dignity, and social dignity were 74, 65 and 57, respectively (based on a total 100). The overall score of PDI was statistically associated with age, history of disease recurrence, education, employment and economic status of participants. Conclusions: According to the study findings the dignity of Iranian cancer patients is not completely respected in clinical settings which require special considerations. As nurses spend more time at patients’ bedsides, they have an important role in maintaining and promoting dignified care.

Keywords: Dignity - cancer patients - ethical treatment - Iran

Introduction

In addition to death, cancer diagnosis is accompanied by lots of complications for patients. The most negative consequences of cancer include but not limited to anxiety and fear, doubt about belief and religious values, impaired identity and body image, sleep disorders and role function problems (Esmaeili et al., 2012; De Sousa et al., 2012; Afrooz et al., 2014). All of these problems as well as, financial distress, marital issues and ambiguity regarding the future can lead to patients’ perception of lack of respected dignity (Chochinov et al., 2007; Fahollahzade et al., 2014; Ghasempour et al., 2014).

Dignity is a main part of human rights (Parmar et al., 2014) and preserving and enhancing patients’ dignity is one the essential part of nursing care (Jacobson, 2007; Nasrabadi et al., 2011). The importance of patient dignity is also reflected in various nursing codes of ethics worldwide (International Council of Nurses, 2001; Sanjari et al., 2011). Providing dignified care also has undeniable effects on health indicators including life expectancy and quality of life (Chochinov et al., 2005). On the other hand, violation of patients’ dignity may influence their psychological and spiritual status and also adversely affect their cooperation with medical staff (Walsh and Kowanko., 2002).

Cancer patients are constantly at risk for loss of sense of dignity. However, factors such as change in living environment, unfamiliar setting and dependence on health care workers significantly affect patients’ dignity during hospitalization (Walsh and Kowanko., 2002). The three most significant factors that affect patients’ dignity include illness-related concerns, personal and social factors. Pain, anxiety, fear of death, and feeling uncertain regarding illness and treatment are categorized as illness-related concerns. Personal factors include psychological integrity, hopefulness, and maintaining independence and self-esteem. Also, providing a private environment, social support and interactions with others, especially family and healthcare workers are social factors that affect patients’ perception of dignity (Chochinov et al., 2008). Recognizing and focusing on these factors will help healthcare workers to preserve and promote patients’ dignity (Thompson and Chochinov., 2008; Li et al., 2014).

1Medical Surgical Department, Nursing and Midwifery Faculty, Tabriz University of Medical Sciences, Tabriz; 2Hematology and Oncology Research Center, Tabriz University of Medical Sciences, Tabriz; 3Faculty of Nursing & Midwifery, Mashhad University of Medical Sciences, Mashhad; 4Babol University of Medical Sciences, Ramsar; 5Department of Nursing, Ilam University of Medical Sciences, Ilam, Iran *For correspondence: azad. rahmani@yahoo.com
Despite the importance of dignity, this concept is not well-investigated among cancer patients. Generally, other concepts such as respect, privacy, self-esteem and independence were related to dignity (Haddock, 1996). This complexity has led to many conflicting strategies for maintaining and improving patients’ dignity (Walsh and Kowanko, 2002, Woogara, 2005). Identifying patients’ perception of respectful and dignified care is one the most strategies for further clarification of this concept (Franklin et al., 2006). The findings of a qualitative survey, which explored the meaning of dignity among Iranian patients, highlighted the lack of dignified care (Torabizadeh et al., 2013). In an extensive literature review there was no study which examined the Iranian cancer patients’ perception of dignity using quantitative approach. Accordingly, the aims of this study were to explore cancer patients’ perception of respecting their dignity and related variables in an Iranian cancer specific center.

Materials and Methods

This descriptive-correlational study was conducted in Ghazi Tabatabay hospital affiliated to Tabriz University of Medical Sciences, Iran. This center is the only comprehensive cancer specific center in north eastern of Iran. The study population included all patients who were referred to the centers during the study period and met the following criteria: (a) having confirmed cancer diagnosis; (b) be at least 18 years old; (c) willing to participate in the study; (d) at least 5 days passed since they admitted to the hospital; and (d) were aware of exact diagnosis. The sample size (n=235) was calculated based on a pilot study. Considering a 10% attrition rate, 265 eligible patients were invited to participate in the study using convenience sampling method. Finally, 250 cancer patients accepted to be enrolled in the study (response rate = 94%).

The instrument for data collection composed of two main parts. The first part was to collect some demographic and disease - related characteristics of participants which gathered according to patients self-report or using their medical records. The second part included Patient Dignity Inventory (PDI) developed by Chochinov in 2008 (Chochinov et al., 2008). This 25 items scale has three major sub-scales including illness related concerns (8 items), personal dignity (12 items) and social dignity (5 items). These items classified according to a 5-point Likert scale ranging from 1 (not a problem) to 5 (an overwhelming problem). The total score of PDI is 25 to 125 points (the higher scores indicating higher perceived dignity-related distress). Items with a score of 3 or greater, indicating the importance of considering these items in clinical settings (Chochinov et al., 2009).

For using the scale, PDI was translated into Persian and then, its accuracy and fluency confirmed by a translator expert in both Persian and English languages. The scales face and content validity were assessed and verified by the expert panel constituted ten academic members. The final version of the questionnaires was tested for reliability in a pilot study involving 30 cancer patients. Cronbach-Alpha coefficient value for PDI was 0.92.

Before data collection, the study proposal was approved by the Regional Ethics Committee at Tabriz University of Medical Sciences. Next, researchers were referred to the center to identify eligible cases and patients who met criteria for the study were identified and invited to participate. After being presenting basic information, willing patients were asked to participate in a private interview for data collection. All patients who participated in the study gave informed consent. Data collection lasted from July to December 2014.

Data were analyzed using SPSS version 13. Descriptive statistics such as the frequency, percent, mean and standard deviation were used to describe demographic data and dignity scores. Relationships between patients’ characteristics with dignity scores were assessed by

| Table 1. Participant Characteristics (n=250) |
|-------------------------------------------|
| Variable                  | n (%)         |
|----------------------------|---------------|
| Gender                     |               |
| Female                     | 125 (50)      |
| Male                       | 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)       |
| Hand -worker               | 40 (16)       |
| Unemployed                 | 81 (32.4)     |
| Marital status*            |               |
| Single                     | 30 (12)       |
| Married                    | 210 (84)      |
| Divorced \ Widow           | 1 (4)         |
| Economic status            |               |
| Earn equal with expense    | 19 (7.6)      |
| Earn more than expense     | 7 (2.8)       |
| Earn less than expense     | 224 (89.6)    |
| History of recurrence*     |               |
| Yes                        | 113 (45.4)    |
| No                         | 136 (54.6)    |
| Disease                    |               |
| Blood                      | 97 (38.8)     |
| Lung                       | 11 (4.4)      |
| Digestive                  | 72 (28.8)     |
| Breast                     | 34 (13.6)     |
| Head and Neck              | 10 (4)        |
| Prostate                   | 7 (2.8)       |
| Genital                    | 9 (3.6)       |
| Other                      | 10 (4)        |
| Relationship with family   |               |
| Excellent                  | 191 (76.4)    |
| Good                       | 37 (14.8)     |
| Bad                        | 22 (8.8)      |
| Treatment models**         |               |
| Chemotherapy               | 250 (100)     |
| Radiotherapy               | 137 (45.5)    |
| Surgery                    | 139 (55.6)    |
| Other                      | 47 (18.8)     |
| Age in years, mean (SD)    | 50.5 (17.7)   |
| Since awareness of the diagnosis in month, mean (SD) | 22.8 (29.5) |

*some participants did not respond; ** participants be able to select more than one choice; SD = standard deviation
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Table 1 shows some demographic and cancer-related characteristics of participants. As shown in this table, most of participants were married, illiterate, housewife and had a financial condition of income less than expense. The mean of participants’ age (in years) and awareness of cancer diagnosis (in months) were 50 and 23, respectively.

Table 2 shows the mean of participants' scores in each of PDI items. It also shows patients scores in three main sub-scales of PDI including illness-related concerns, personal dignity and social dignity. The patients' scores in 18 out of 25 items were 3 or greater which indicate the importance of considering these items in clinical settings. As shown in this table the highest score (higher perceived dignity-related distress) was related to illness-related concerns and the lowest score (lower perceived dignity-related distress) was associated with social dignity category.

The associations of patients’ perception of dignity with some demographic and disease-related characteristics are displayed in Table 3. As shown in this table, patients with history of disease recurrence had higher PDI score. The study finding also revealed that some of demographic and disease-related characteristics including education (p=0.007), employment (p=0.07), economic status (p=0.001), and history of disease recurrence (p=0.03) were significantly associated with the patients’ perception of dignity. In this regard, Tukey’s post-hoc test showed that patients who were illiterate (p=0.01), unemployed

Table 3. Relationship of Participants’ Perception about Respecting their Dignity with Some Demographic and Disease Related Factors

| Variable                      | Mean (SD) | Statistical analysis |
|-------------------------------|-----------|----------------------|
| Gender                        |           |                      |
| Female                        | 80.84 (20.68) | P=0.39               |
| Male                          | 83.10 (21.45) | t =0.84               |
| Level of education            |           |                      |
| Illiterate                    | 85.60 (17.70) |                    |
| Under diploma                 | 80.28 (22.10) | P=0.007              |
| Diploma                       | 74.89 (25.47) | F=4.15               |
| University degree             | 74.95 (25.54) |                |
| Employment status             |           |                      |
| Housewife                     | 79.68 (20.74) |                    |
| Employee                      | 76.31 (22.31) | P=0.07               |
| Worker                        | 85.10 (20.26) | F=2.31               |
| Unemployed                    | 85.53 (20.75) |                |
| Marital status                |           |                      |
| Single                        | 77.80 (27.12) | P=0.35               |
| Married                       | 82.79 (20.15) | F=1.00               |
| Divorced \ Widow              | 77.20 (19.14) |                |
| Economic status               |           |                      |
| Earn equal with expense       | 59.78 (26.49) | P=0.001              |
| Earn more than expense        | 77.77 (16.26) | F=12.81              |
| Earn less than expense        | 83.98 (19.62) |                |
| History of recurrence         |           |                      |
| Yes                           | 85.00 (21.70) | P=0.03               |
| No                            | 79.37 (20.29) | t =2.11              |
| Disease                       |           |                      |
| Blood                         | 81.65 (21.89) |                    |
| Lung                          | 84.36 (24.38) |                    |
| Digestive                     | 84.23 (18.23) | P=0.57               |
| Breast                        | 78.23 (22.97) | F=0.81               |
| Head and Neck                 | 91.00 (15.63) |                    |
| Prostate                      | 82.28 (22.53) |                |
| Genital                       | 75.00 (18.69) |                |
| Other                         | 75.80 (27.69) |                |
| Relationship with family      |           |                      |
| Excellent                     | 81.62 (22.18) | P=0.89               |
| Good                          | 83.27 (18.91) | F=0.11               |
| Bad                           | 82.77 (13.82) |                |

*SD = standard deviation
The results of present study showed that disease symptoms and uncertainty regarding the ability to work and keeping job were the main factors that led to patients’ sense of loss of dignity in personal dignity dimension. Chochinov et al. (2009) showed that main concerns of cancer patients focused on fears regarding keeping job and not being able to carry out important roles (Chochinov et al., 2009). According to Vehling et al. (2014) the main cause of cancer patients’ perception of lack of dignified care was due to physical related symptoms (Vehling et al., 2014). Faghani et al. (2014) showed that Iranian cancer patients experience many physical symptoms such as pain during the survival period (Abdollahzadeh et al., 2014).

In this study patients’ perception of dignity was more desirable in social dignity than other dimensions. However, patients perceived that their dignity was not properly preserved in some items such as sense of burden to others and reduced privacy. Similar to our findings, in Chochinov et al. (2007) study 40% of cancer patients reported “sense of burden to others” which adversely affects their sense of dignity (Chochinov et al., 2007).

The finding of other studies also showed that the respect for patients’ privacy and dignity are interconnected. The lack of privacy in medical centers threatened patients’ dignity (Matiti et al., 2007; Ebrahimi et al., 2012; Torabizadeh et al., 2013). The findings of some studies in Iran also revealed that patients’ privacy is not protected appropriately (Nayeri et al., 2010; Bagheri et al., 2012).

The study findings also showed significant associations between patients’ perception of dignity with some demographic and disease-related characteristics. In congruent with the findings of other studies, in current study patients’ perception of dignity improved with increasing in patients’ age. The findings of other studies showed that dignity violation is more prevalent among older people (Hall et al., 2009; Oosterveld-Vlug et al., 2013). However, it also has been reported that sense of dignity violation is more common among younger people due to importance of physical appearance, lack of job performance and control over life, early death, and a lesser time to achieve life goals (Calnan et al., 2004; Chochinov et al., 2009).

In the current study the history of disease recurrence have a negative influence on patients’ perception of dignity. Although advances in current treatments dramatically increase the number of cancer survivors in recent years, fear of recurrence is still a main concern for cancer patients (Kim et al., 2012). The findings of some studies conducted in Iran also indicated fear of recurrence as one of the major concerns among Iranian cancer patients (Taleghani et al., 2006; Abdollahzadeh et al., 2014). It seems fear of recurrence negatively influence patients’ perception of dignity. The study findings also revealed that perceived dignity was significantly associated with patients’ education, employment and economic status. However, it seems financial status has greater influence on patients’ psychological condition than other demographic variables. Other studies have already shown similar findings (Rustøen and Wiklund., 2000; Kyngäs et al., 2001).

The study findings will help professionals to design
supportive programs for maintaining and promoting cancer patients’ dignity and providing more dignified care. According to the study findings the dignity of Iranian cancer patients is not completely respected in clinical settings which require special considerations. Dignity is an important part of care and should be considered as other important clinical goals. As nurses are more in touch with such patients, then they have an important role in maintaining and promoting their dignity.

Despite the strength of this study, it also has some limitations. First, a sample of patients admitted to one medical center in East Azerbaijan Province in northwest of Iran cannot represent the overall state of perceived dignity among Iranian cancer patients. Next, the sense of dignity was only explored from the patients’ perspective. In relation to future research, replicating such studies in other Iranian regions is required. Exploring family and healthcare workers’ perception of dignity is also recommended.

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