Original Article

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

Zoleikha Avestan, Vahid Pakpour[1], Azad Rahmani, Robab Mohammadian[2], Amin Soheili

Department of Medical Surgical Nursing, Nursing and Midwifery, Faculty of Tabriz University of Medical Sciences, [1]Department of Public Health Nursing, Nursing and Midwifery Faculty, Hematology and Oncology Research Center of Tabriz University of Medical Sciences, [2]Department of Nursing, Nursing Faculty, Islamic Azad University, Marageh Branch, Tabriz, Iran

Abstract

Context: Nurse–patient communication is one of the important factors affects the promotion and maintenance of the dignity of cancer patients in the hospital settings. **Aims:** This study aimed to determine the perceptions of cancer patients regarding respecting their dignity and its correlation with nurse–patient communication in the hospital settings. **Subjects and Methods:** 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 the data. **Statistical Analysis Used:** Descriptive and inferential statistics were applied to the data. **Results:** The score of nurse–patient relationship is significantly correlated with patient's dignity score ($R = -0.21$, $P = 0.001$). **Conclusions:** 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 "nurse's communication skills."

Keywords: Cancer patients, dignity, nurse–patient communication, nursing ethics

Introduction

The diagnosis of cancer may have a lot of negative effects and destroy the patient's hopes and aspirations and cause many physical signs.[1] Furthermore, 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 is more vulnerable to be damaged, due to changes in the environment, hospitalization in an unfamiliar environment, dependence on health-care 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 health-care personnel, including nurses.[9-11] The effective nurse–patient communication is a worldwide health-care 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

Address for correspondence: Dr. Azad Rahmani, Department of Medical Sciences Nursing, Nursing and Midwifery Faculty, South Shariati Street, Tabriz, East Azerbaijan Province, Iran.
E-mail: azad.rahmani@yahoo.com

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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 health-care providers with patients[16] and result in some problems for health-care 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 are 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 disease's diagnosis, clinical course, and treatment 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]

Patient's dignity comprises feelings, physical presentation, and behavior. The environment, staff behavior, and patient factors affect patient's dignity, and lack of environmental privacy threatens dignity. A favorable physical environment, dignity-promoting culture, and other patient's support promote dignity. Health-care personnel being curt, authoritarian and breaching privacy threaten dignity. Health-care personnel promotes 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, health-care 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 health-care setting. Therefore, it is obviously necessary to conduct a study to determine the presence, extent, direction, and intensity of such relationships.

Subjects and 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 2014 to December 2014. The study population included all cancer patients admitted to that center to receive health-care services. The inclusion criteria were: having a definite diagnosis of cancer, being at least 18-year-old, awareness of cancer patients of their disease diagnosis, being hospitalized for at least 5 days and then 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 patients based on a pilot study. During the study, 270 patients were invited to participate in the study, using convenience sampling method. Finally, 250 participants 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 *et al*. 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. The permission for use in this study was granted by the developer of the instrument.[23] The third part was the Nurse Quality of Communication with Patient Questionnaire (NQCPQ) which was designed by Vuković *et al*. in 2010. It consists of 24 items that measure verbal communication, nonverbal 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 ten academic member professors in nursing at the Tabriz University of Medical Sciences. The instrument was piloted on 30 cancer patients. Then, its Cronbach's 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 the study, one of the researchers constantly visited the hospital wards and identified the eligible patients. The objectives of the study were explained to the participants 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. Furthermore, 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, USA) at statistical significance level 0.05.

Results

Some demographic characteristics and illness-related characteristics of patients participating in the study are

presented in Table 1. The study participants were men and women with a mean age of 50.5 ± 17.7 years. The majority of the participants were illiterate (42%), homemaker (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 patient's answers to each item of PDI are listed in Table 2. The mean score of dignity was 83.2 out of 125. Furthermore, the patient's complaints in three-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 100), respectively.

The patient's 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 (standard deviation = 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, nonverbal, and communication, in general, were examined. The highest satisfaction scores of cancer patients were related to verbal communication (55%), communication in general (55%), and nonverbal 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 ($R = -0.21$, $P = 0.001$), 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

Table 1: Participant characteristics (*n*=250)

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

SD: Standard deviation

Table 2: The responses of participants to the patients dignity inventory

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

SD: Standard deviation

not respected completely.[25] In an earlier qualitative study, Matiti and Trorey have 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, the patients expressed their concerns about future (12%) and uncertainty in 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 patient's 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 patient's sense of dignity.[23] Moreover 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, nonverbal 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 nonverbal communication and they expressed relatively high satisfaction of nurse's communication.[21] Akhtari-Zavare *et al*. revealed that 81.5% of patients were satisfied with the 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 health-care provider's 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

Table 3: The nurse quality of communication with the 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
Nonverbal communication	54.6±8.5
Communication in general	55±12.25

SD: Standard deviation

critical when appraising a service. Proper communication and politeness are the most important concerns of people in Iran. Patient's 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 to tackle the sense of powerlessness and culture of passivity among patients toward the medical knowledge and the health-care 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 patient's level of satisfaction toward 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 nonverbal 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. Furthermore, in 58% of the nursing encounters, nurses displayed forward leaning, expressing immediacy and interest behaviors.[36] These nonverbal 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 patient's satisfaction with the quality of nurse's 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, and staying at the bedside of patients.[40] In a PhD dissertation carried out on patients admitted to the medical-surgical ward of Iranian

health-care systems, Torabizadeh implies that nurses do not have the necessary verbal and nonverbal communication skills and it leads to ineffective interaction, emotionally 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]

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 patients.

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

Conclusion

Finally, 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 "nurse's communication skills."

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Conflicts of interest

There are no conflicts of interest.

References

1. Sellman D. Trusting patients, trusting nurses. Nurs Philos 2007;8:28-36.
2. Esmaeili R, Ahmadi F, Mohammadi E, Tirgari Seraj A. Life threatening: The most important concern of patients confronting cancer diagnosis. Hayat 2012;18:12-22.
3. Weaver CN. Trust in people among hispanic Americans. J Applied Soc Psychol 2006;36:1160-72.
4. Chochinov HM, Kristjanson LJ, Hack TF, Hassard T, McClement S, Harlos M, *et al.* Burden to others and the terminally ill. J Pain Symptom Manage 2007;34:463-71.
5. Sanjari M, Zahedi F, Aalaa M, Peimani M, Parsapoor A, Cheraghi MA, *et al*. Code of ethics for Iranian nurses. Iran J Med Ethics History Med 2011;5:17-28.
6. ICoN I. The ICN Code of Ethics for Nurses; 2006.
7. Pleschberger S. Dignity and the challenge of dying in nursing homes: The residents' view. Age Ageing 2007;36:197-202.
8. Haddock J. Towards further clarification of the concept 'dignity'. J Adv Nurs 1996;24:924-31.
9. Jacobson N. Dignity and health: A review. Soc Sci Med 2007;64:292-302.
10. Villagomeza LR. Spiritual distress in adult cancer patients: Toward conceptual clarity. Holist Nurs Pract 2005;19:285-94.
11. Fellowes D, Wilkinson S, Moore P. Communication skills training for health professionals working with cancer patients, their families and/or carers (Cochrane Review). In: Oxford: Update Software: The Cochrane Library; 2003.
12. Jones A. Nurses talking to patients: Exploring conversation analysis as a means of researching nurse-patient communication. Int J Nurs Stud 2003;40:609-18.
13. Bakker DA, Fitch MI, Gray R, Reed E, Bennett J. Patient-health care provider communication during chemotherapy treatment: The perspectives of women with breast cancer. Patient Educ Couns 2001;43:61-71.
14. Fallowfield LJ, Hall A, Maguire GP, Baum M. Psychological outcomes of different treatment policies in women with early breast cancer outside a clinical trial. BMJ 1990;301:575-80.
15. Highfield MF. Spiritual health of oncology patients. Nurse and patient perspectives. Cancer Nurs 1992;15:1-8.
16. Stead ML, Brown JM, Fallowfield L, Selby P. Lack of communication between healthcare professionals and women with ovarian cancer about sexual issues. Br J Cancer 2003;88:666-71.
17. Rutter DR, Iconomou G, Quine L. Doctor-patient communication and outcome in cancer patients: An intervention. Psychol Health 1996;12:57-71.
18. Mehnert A, Lehmann C, Graefen M, Huland H, Koch U. Depression, anxiety, post-traumatic stress disorder and health-related quality of life and its association with social support in ambulatory prostate cancer patients. Eur J Cancer Care (Engl) 2010;19:736-45.
19. Hack TF, Degner LF, Parker PA; SCRN Communication Team. The communication goals and needs of cancer patients: A review. Psychooncology 2005;14:831-45.
20. Parsapoor A, Mohammad k, Malekafzali H, Alaeddini F, Larijani B. The necessity of observing patients' right: Surveying patients', physicians' and nurses' attitudes around it. Journal of Medical Ethics and History of Medicine 2009;2:79-90.
21. Moghaddasian S, Abdollah-Zadeh F, Rahmani A, Salehain M, Firouzian A. Nurse -patient communication and its relation to satisfaction with nursing services in view point of cancer patients hospitalized in Shahid Ghazi hospital, Tabriz. J North Khorasan Univ Med Sci 2013;5:459-66.
22. Baillie L. Patient dignity in an acute hospital setting: A case study. Int J Nurs Stud 2009;46:23-36.
23. Chochinov HM, Hassard T, McClement S, Hack T, Kristjanson LJ, Harlos M, *et al.* The landscape of distress in the terminally ill. J Pain Symptom Manage 2009;38:641-9.
24. Vuković M, Gvozdenović BS, Stamatović-Gajić B, Ilić M, Gajić T. Development and evaluation of the nurse quality of communication with patient questionnaire. Srp Arh Celok Lek 2010;138:79-84.
25. Chochinov HM, Krisjanson LJ, Hack TF, Hassard T, McClement S, Harlos M, *et al.* Dignity in the terminally ill: Revisited. J Palliat Med 2006;9:666-72.
26. Matiti MR, Trorey GM. Patients' expectations of the maintenance of their dignity. J Clin Nurs 2008;17:2709-17.
27. Wilson KG, Curran D, McPherson CJ. A burden to others:

A common source of distress for the terminally ill. Cogn Behav Ther 2005;34:115-23.
28. Coyle N, Sculco L. Expressed desire for hastened death in seven patients living with advanced cancer: A phenomenologic inquiry. Oncol Nurs Forum 2004;31:699-709.
29. Vehling S, Mehnert A. Symptom burden, loss of dignity, and demoralization in patients with cancer: A mediation model. Psychooncology 2014;23:283-90.
30. Torabizadeh C, Ebrahimi H, Mohammadi E, Valizadeh S. Incongruent perceptions among nurses and patients: A qualitative study of patient's dignity in Iran. Ethics Behav 2013;23:489-500.
31. Uitterhoeve R, Bensing J, Dilven E, Donders R, deMulder P, van Achterberg T, *et al.* Nurse-patient communication in cancer care: Does responding to patient's cues predict patient satisfaction with communication. Psychooncology 2009;18:1060-8.
32. Akhtari-Zavare M, Yunus Abdullah M, Syed Hassan ST, Binti Said S, Kamali M. Cancer patients' satisfaction with communication and information given by nurses at teaching hospitals of Tehran, Iran. Med J Islam Repub Iran 2011;24:212-20.
33. Akbary F, Hosseini M, Arab M, Chozokly N. Study of effective factors on inpatient satisfaction in hospitals of Tehran university of medical sciences. J Sch Public Health Inst Public Health Res 2006;4:25-35.
34. Sadjadian A, Kaviani A, Yunesian M, Montazeri A. Patient satisfaction: A descriptive study of a breast care clinic in Iran. Eur J Cancer Care (Engl) 2004;13:163-8.
35. Akhtari-Zavare M, Abdullah MY, Hassan ST, Said SB, Kamali M. Patient satisfaction: Evaluating nursing care for patients hospitalized with cancer in Tehran teaching hospitals, Iran. Global J Health Sci 2010;2:117.
36. Caris-Verhallen WM, Kerkstra A, Bensing JM. Non-verbal behaviour in nurse-elderly patient communication. J Adv Nurs 1999;29:808-18.
37. Maguire P. Improving communication with cancer patients. Eur J Cancer 1999;35:1415-22.
38. McQuellon RP, Wells M, Hoffman S, Craven B, Russell G, Cruz J, *et al.* Reducing distress in cancer patients with an orientation program. Psychooncology 1998;7:207-17.
39. Delvaux N, Razavi D, Farvacques C. Cancer care – A stress for health professionals. Soc Sci Med 1988;27:159-66.
40. Coenen A, Doorenbos AZ, Wilson SA. Nursing interventions to promote dignified dying in four countries. Oncol Nurs Forum 2007;34:1151-6.
41. Torabizadeh C. The Maintenance of the Hospitalized Patients' Dignity and Development of a Promotional Model [PhD Dissertation]. Tabriz University of Medical Sciences; 2011.