FACTORS INFLUENCING COMMUNICATION BETWEEN THE PATIENT DIAGNOSED WITH CANCER OF THE BREAST AND THE PROFESSIONAL NURSE

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Communication in nursing is to establish a nurse-patient relationship. Some nurses are quite effective at this whilst others are not so effective. The female patient diagnosed with cancer of the breast can face many dilemmas ranging from a physical, psychological and psychosocial domain. Nursing, being an interactive skill, requires the nurse to be able to communicate with the patient. The inability to communicate can hamper this very crucial relationship. For the purpose of this study it was decided to provide an in-depth account of the management of the nurse-patient communication in the ward.

The rationale for choosing this setting (ward) were based on the comprehensive functions of a professional nurse and his/her ability to communicate.

The objectives set for the study were to describe the manner in which professional nurses communicated with the patient diagnosed with cancer of the breast and who underwent a mastectomy, barriers that prohibited the communication and the patient's perception of the communicative processes.

A quantitative, exploratory and descriptive approach was applied to investigate and describe factors that influence communication between the patient with breast cancer and the professional nurse within a provincial hospital in the Western Cape.

The total population included only female patients diagnosed with cancer of the breast who underwent a mastectomy and who were referred to the breast outpatient clinic. These female patients had to be diagnosed during a twenty month period as of January 2007 to August 2008 and had to be hospitalised within a ward setting after their diagnosis. The population size consisted of 27% of the total population with a 9% refusal rate. A survey was done using a six point Likert scale ranging from strongly disagree, disagree and mildly disagree to mildly agree, agree and strongly agree. The questionnaire consisting of close-ended questions were used for the collection of data and the researcher personally collected data. Ethical approval was obtained from the Committee of Human Science Research at Stellenbosch University and the Department of Health - Cape Town. Consent to conduct the research was obtained from the institution and informed consent from the participants. A pilot study was conducted to test the questionnaire which did form part of the study. A 10% sample of the population, namely 10 participants, was involved in this study. The validity and reliability was assured through the pilot study and the use of a statistician, experts in oncology nursing, an oncology doctor and the research methodologist.

Data was tabulated and presented in histograms and frequencies. Statistical significant associations were drawn between variables, using the Chi square test. The Spearman rank (rho) order correlation was used to show the strength of the relationship between two continuous variables.

Findings included statistical significance between the level of schooling and the nurse, who took the respondents at face value and communicated what she deemed necessary (rho=0.29, p=0.00). The respondents also showed concern and disagreed that the ward nurses provide their family with relevant information (p=0.00).

Recommendations include:

- Nursing education should include a module in communication on a graduate and post graduate level
- In-service training programmes should focus on the interpersonal relationship between the nurse and the patient and the importance thereof.
- Continuous Quality Improvement should include patient satisfaction surveys.
- Awareness campaigns about the importance of communication between the patient and the health professional should be conducted
- Developing protocols and policy guidelines that can assist the nursing staff with the communication process.

Since communication is an interactive process it requires skillful conduct. Nurses need to realize the importance communication plays in the health sector and the impact it has on patients, irrespective of whether it is from a verbal or non-verbal content. Effective communication or not can have an everlasting impact.

OPSOMMING

Kommunikasie in verpleging behels die vestiging van ’n verpleegster-pasiënt verhouding. Sommige verpleegsters is taamlik effektief hierin, terwyl andere nie so effektief is nie. Die vroulike pasiënt wat met borskanker gediagnoseer is, kan baie dilemmas in die gesig staar wat wissel van ’n fisiese, psigologiese tot ’n psigo-sosiale domein. Verpleging, wat ’n interaktiewe vaardigheid is, vereis dat die verpleegster met die pasiënt moet kan kommunikeer. Die onvermoë om te kan kommunikeer, kan hierdie beslissende verhouding belemmer. Vir die doel van die studie is besluit om ’n indringende verslag van die bestuur van die verpleegster-pasiënt kommunikasie in die saal te doen.

Die rasionaal vir die keuse van die omgewing (saal) is gebaseer op die komprehensiewe funksies van ’n professionele verpleegster en sy/haar vermoë om te kan kommunikeer.

Die doelstellings wat uiteengesit is vir hierdie studie is om die manier te beskryf waarop professionele verpleegsters met die pasiënt wat met borskanker gediagnoseer is, en wat ’n mastektomie ondergaan het, omgaan, asook die hindernisse wat kommunikasie en die pasiënt se persepsie van die kommunikatiewe prosesse belemmer het.

’n Kwantitatiewe, verkennende en beskrywende benadering is toegepas om faktore te ondersoek en te beskryf wat kommunikasie tussen die pasiënt met borskanker en die professionele verpleegster in ’n provinsiale hospitaal in die Wes-Kaap beïnvloed.

Die totale bevolking het slegs vroulike pasiënte wat met kanker gediagnoseer is en ’n mastektomie ondergaan het en na die bors buite-pasiënt kliniek verwys is, ingesluit. Hierdie vroulike pasiënte moes gedurende ’n periode van twintig maande vanaf Januarie 2007 tot Augustus 2008 gediagnoseer en gehospitaliseer gewees het in ’n saalomgewing na hul diagnose. Die bevolking grootte het bestaan uit 27% van die totale bevolking met ’n 9% verwerpingskoers. ’n Opname was gedoen wat die ses punt Likert skaal gebruik wat wissel vanaf sterk verskil van mening, verskil en effense verskil van mening tot effens saamstem, saamstem en sterk saamstem. Die vraelys wat uit geslote vrae bestaan, was gebruik vir die insameling van data en die navorser het die data persoonlik gekollekteer. Etiese goedkeuring was verkry van die Raad vir Geesteswetenskaplike navorsing aan die Universiteit van Stellenbosch en die Departement van Gesondheid – Kaapstad. Toestemming om die navorsing uit te voer is verkry van die inrigting en ingeligte toestemming van die deelnemers. ’n Loodsprojek is uitgevoer om die vraelys te toets wat deel van die navorsing uitgemaak het. ’n 10% Steekproef van die bevolking, naamlik 10 deelnemers, was betrokke by die studie. Die geldigheid en betroubaarheid was verseker deur die loodsprojek en die gebruik van ’n

statistikus, kenners in onkologie verpleging, ’n onkologiese dokter en die navorsingsmetodoloog.

Data is getabulleer en aangebied in histogramme en frekwensies. Statistiese beduidende assosiasies is gemaak tussen veranderlikes, deur gebruik te maak van die Chi-kwadraat toets. Die Spearman rang (rho) orde korrelasie is gebruik om die sterkte van die verhouding tussen die aaneenlopende veranderlikes te wys.

Bevindings het statistiese beduidendheid ingesluit tussen die vlak van geleerdheid en die verpleegster wat die respondente op sigwaarde geneem het en die kommunikasie wat sy noodsaaklik gevind het (rho=0.29, p=0.00). Die respondente het ook besorgdheid getoon en het nie saamgestem dat die saalverpleegsters hul gesinne van die relevante inligting voorsien het nie (p=0.00).

Aanbevelings sluit in:

- Verpleegopleiding behoort ’n module in kommunikasie op graad en nagraadse vlak in te sluit.
- Indiensopleidingsprogramme behoort te fokus op die interpersoonlike verhouding tussen die verpleegster en die pasiënt en die belangrikheid daarvan.
- Deurlopende kwaliteitsverbetering behoort pasiënt tevredenheidsopnames in te sluit.
- Bewusmakingsveldtogte oor die belangrikheid van kommunikasie tussen die pasiënt en die gesondheidsprofesioneel behoort gelood s te word.
- Protokolle en beleidsriglyne wat die verpleegpersoneel kan help met die kommunikasie proses behoort ontwikkel te word.

Sienende dat kommunikasie ’n interaktiewe proses is, word vaardige gedrag geverg. Verpleegsters behoort die belangrikheid wat kommunikasie speel in die gesondheidssektor te besef en die impak wat dit op die pasiënte het, ongeag of dit verbaal of nie-verbaal is. Effektiewe kommunikasie aldan nie, kan ’n ewigdurende impak hê.

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CHAPTER 1:
SCIENTIFIC FOUNDATION OF THE STUDY

1.1 Introduction

Communication is a complex phenomenon that may be studied from multiple perspectives (Roter & Frankel, 1992:1097). In the general healthcare environment, the activity of consultation may be influenced by the interpersonal, organisational, political, legal and cultural context within which the encounter takes place. Much attention has been focused on the provider-patient relationship (Stewart, 1995:1423) to discover and explore ways in which medical consultations are perceived.

Communication is fundamental to all nursing and interpersonal relationships. Communication can be either verbal or non-verbal. Healthy interactions with patients, families, and other staff members are very important in today's fast-paced and information driven society.

According to Richards (1990:1407), statistics in the past has indicated that the majority of public complaints or malpractice allegations about health care professionals do not stem from issues of competency, but rather arise from problems in communication. Globally, the Department of Health's National Health Service Cancer plan, London (2000) stated that complaints by patients focused not on a lack of clinical competence per se, but rather on a perceived failure of communication and an inability to adequately convey a sense of care.

In this proposed study, the researcher aims to explore the factors influencing communication between the patient diagnosed with cancer of the breast and the professional nurse working in the ward environment in the public health sector. Communication will be discussed, with a special focus on a health-related theory and the importance of the ecology of communication between the professional nurse and the patient. For the purpose of this research assignment the researcher will be referring to a registered nurse working in the ward environment as a professional nurse.

The data of breast cancer globally, as well as within a South African perspective, a brief description of the histology most evident in females with this particular cancer (breast) and psychosocial issues affecting females diagnosed with cancer of the breast, will be discussed in chapter one. Chapter two focuses on the interpersonal relationship theory by Hildegard Peplau. The importance of an interpersonal relationship between the patient and the professional nurse will be discussed in this chapter. The chapter will also focus on the work a professional nurse does especially from a South African perspective and how communication takes place in nursing. In chapter three the design and methodology of the study will be

discussed. Chapter four will focus on the results of the study and the interpretation thereof and chapter five will conclude the research with the necessary recommendations by the researcher.

According to the researcher ineffective communication will not only place a significant burden on professional nurses, but has the potential to create unfavourable outcomes. The researcher would therefore investigate the patients' viewpoint regarding nurse-patient interactions (communicative sessions) in the ward, for the purpose of promoting favourable outcomes for both the patient and the ward nurse.

1.2 Rationale of the study

Kumar, Abbas and Fausto (2005: 270) describe cancer as a common term being used for all malignant tumors. They continue to describe it to derive from the Latin for crab because a cancer can adhere to any part that it seizes upon in an obstinate manner like the crab.

Breast cancer is not a homogeneous disease. It differs in histologic, biologic and immunologic characteristics. Breast masses are divided into benign and malignant with 80% - 90% benign and 10 -20% malignant. The malignant lumps are harder and fixed compared to the benign. Malignancies of the breast are broadly divided into two categories namely non-invasive and invasive (Lichter, 2004:1301).

A malignancy confined to the ducts or lobules is known as non-invasive or carcinoma in situ (CIS). This basically indicates that the malignancy is well defined to a specific area of the breast, namely the ducts or the lobules only. If the cancer develops in the ductal system it is referred to as ductal carcinoma in situ. Ductal carcinoma in situ (DCIS) has five histological subtypes called comedo, solid, cribriform, papillary and micropapillary. The comedo type is more aggressive with an increased risk of node metastasis and increased risk of transformation to invasive type of cancer (Lichter, 2004:1302).

If the carcinoma is within the lobule system it will be known as lobular carcinoma in situ (LCIS), the other type of non-invasive breast carcinoma with an abnormal proliferation of epithelial cells in the lobules of the breast. Once the malignant cells penetrate past the tissue outside the ducts or the lobules, the cancer will be known as infiltrating or invasive. The most common form of breast cancer is known as infiltrating ductal carcinoma. It accounts for more than 80% of all cases. This type arises in the ducts from the milk-producing glands. Histologically ductal carcinoma is divided into well-, moderate- and poorly differentiated carcinoma (Lichter, 2004:1302).

Well-differentiated tumour cells are usually slower-growing and are less likely to metastasise and respond well to treatment. Moderate and poorly differentiated tumour cells simply means that the tumour tissue has lost some or all resemblance to the corresponding normal tissue and can grow faster. Well-differentiated tumours are known as low grade tumours and poorly differentiated tumours are known as highly malignant, high grade tumours responding poorly to treatment (Maree, 2007:888).

The other form of invasive breast cancer is "infiltrating lobular carcinoma." This type occurs in breast tissue between either the ducts or elsewhere in the mammary tissue. The lobular carcinoma compared to the ductal carcinoma is more likely to be multifocal and bilateral (can affect both breasts). Infiltrating lobular carcinoma accounts for about 10% of all breast carcinomas compared to infiltrating ductal carcinoma.

Less common are inflammatory carcinoma of the breast. This can be a particularly virulent form of breast cancer. It is characterized by breast enlargement, general breast tenderness and redness with a purple area over the tumour. Areas of indurations caused by subdermal spread of the disease can be present. Usually there is no palpable lump. Symptoms tend to progress rapidly and often the disease is not diagnosed until there is lymph node involvement and even gross distant metastasis (Choa, Perez & Brady, 2002:349).

Although breast cancer is a multicentric disease, almost half of all breast tumours occur in the upper outer quadrant of the breast. These tumours tend to drain to the axillary lymph nodes, therefore sentinel lymph node biopsy or axillary lymph node dissection is a part of the surgical management of breast cancer. The likelihood of axillary node involvement increases with the size of the tumour.

The most commonly used method of defining these disease stages are known as the TNM system. Staging a tumour is determined by the size of the tumour (T), lymph node (N) involvement and the presence of metastases (M) (Maree, 2007:896). Presented below is the new sixth edition of the staging system as presented by the American Joint Committee on Cancer (2002: 255)

Tumour stage

T1 = tumor < 2 cm in greatest dimension

T2 = tumor >2cm but not > 5 cm in greatest dimension

T3 = tumor >5 cm in greatest dimension

T4 = tumor of any size with direct extension to the chest wall, skin or both

Nodal status

N1	=	Metastasis to moveable ipsilateral axillary lymph nodes
N2	=	Metastasis in ipsilateral axillary lymph nodes are fixed or matted or the metastasis are only in clinically apparent (detected by imaging studies) ipsilateral internal mammary nodes without axillary lymph node involvement
N3	=	Metastasis in ipsilateral infraclavicular lymph nodes or metastasis in the ipsilateral internal mammary lymph nodes and the axillary lymph nodes or metastasis that occur in ipsilateral supraclavicular lymph nodes

Distant metastases (M)

Mx	-	presence of distant metastasis cannot be assessed
Mo	-	No distant Metastasis
M1	-	Distant Metastasis present

Breast cancer may metastasize widely and unpredictably either early in the course of the disease or late (sometimes years after a woman appears to be disease-free). Risk factors for distant metastases are: the size of the tumour, the number of positive nodes, and the histologic grade of the tumour.

The risk of distant metastases increase with a higher grade of tumour, the size of the tumour and the number of lymph nodes involved. The grading of the tumour depends on the number of mitotic cells and the type of epithelium involved. A malignant tumour has the ability to proliferate destructively into surrounding tissue and to metastasise to other parts of the body (Maree, 2007:889). With regard to metastases (spreading of the disease) one of the common sites is the pulmonary system, the skeletal system, particularly the ribs, vertebrae, skull, pelvis, and upper femurs. The disease may also spread to the liver, brain and less commonly to the kidneys, adrenal glands, ovaries, pituitary gland, and the thyroid according to G. Georgiev (personal communication, 24 June 2008).

When breast cancer is detected in its early stages, the chances of survival increase dramatically. The goal of screening programs is to make the diagnosis within three months of finding a lump. If this is done then 90% of cancers can be effectively treated. This will not only ensure a better survival rate but a better quality of life too.

Finding out that one has cancer is a shocking and traumatic experience. This is news that nobody foresees. According to Fallowfield, Lipkin and Hall (1998:1961-1968), many patients experience distress, characterised by fear, anger, anxiety, depression or helplessness, after diagnosis. Breast cancer is the most common cancer in women worldwide and accounts for 22% of all cancers in women (Parkin & Ferlay, 2003:7). According to the statistics obtained about cancer of the breast from the National Cancer Registry of South Africa's Annual Statistical Report for 1999, 5901 breast cancer cases were reported. It comprised of 19, 4% of all cancers reported and was the leading cancer in 1999 (South African Institute for Medical Research, 2004). The National Cancer Registry is one of the sources of information on cancer morbidity which collects all information of cancer diagnosed from all of the country's pathology laboratories. However as a result, this is an underestimate of the true incidence of cancer. Globally breast cancer ranks second in incidence and fifth in mortality among all cancers with approximately 1.05 million new cases and 373 000 deaths in the year 2000 (Parkin 2001:534). According to the Statistics South Africa (2006) the female deaths in breast cancer were 296 351 in South Africa for the year 2006.

Statistics from the Tygerberg Tertiary Hospital indicate that the number of female patients to attend the breast cancer clinic over a six year period has escalated. Figure 1.1 shows a significant increase in the number of newly diagnosed patients (n=435) who attend this specialised unit with an attendance of more than 50%. The number of females who had surgical interventions done, such as tumour excisions and sentinel lymph node biopsy, simple mastectomy, modified radical and bilateral mastectomies which were cancer related, amounted to 240 females (n=240) excluding non-cancer related surgical procedures for the year 2007.

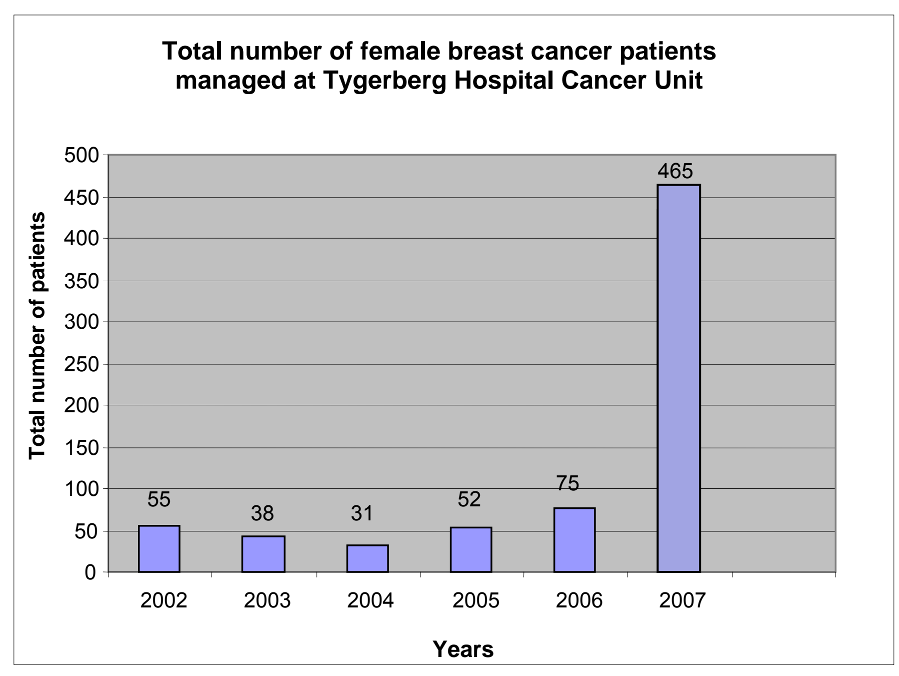

Figure 1.1: The total number of newly diagnosed female breast cancer patients managed at Tygerberg Hospital over a six year period.

For women diagnosed with cancer of the breast this is a life event not anticipated. Bodkin & Arunachallam (2007: 300) states that a diagnosis of breast cancer for most women is devastating. He continues to state that they (patient) may have to cope with the prospect of mutilating surgery to a part of the body that is associated with femininity, sexuality and motherhood, to the prospect of several months of intensive medical treatment and the possibility that they may eventually die of the disease. The treatment can also threaten a woman's appearance, sexual life and ability to work.

In the researcher's opinion, a life threatening illness can test one's ability to give and receive affection for example a woman undergoing a mastectomy may wonder if she is still loved or even loveable. The need for belonging will become more important given a poor prognosis and when the transition from curative to palliative care takes place. Females can have different roles. They can be mothers, friends or partners to their significant others. They too do have a need for love and meaningful relationships.

For the adult female sexuality is considered important therefore her breasts are the most valued asset and visible expression thereof. Females, diagnosed with cancer of the breast, who have undergone mastectomies might feel that their appeal to their partners has been obliterated and this can result in rejection. She has to accept and integrate this new physiognomy of her body as part of her new image and adjust accordingly. Not only do some females suffer physically but emotionally too as they are put under the scrutiny of the public eye that can contribute to a decreased self esteem. Outward appearance constitutes an

important part of one's sexuality, self-image and how one wishes to be perceived by others (Pervan, Cohen & Jaftha, 1995:683-688).

A positive breast cancer diagnosis usually brings about the fear of dying and, with it, some degree of anticipatory anxiety and grief, a process well described by Kübler-Ross (1973:10).

According to the statistics obtained from Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana, Norman, Pieterse and Schneider (2004:254) breast cancer has become one of the leading cancers in the Western Cape.

It is with reference to the above statistics that it is important for the nurse to create an environment whereby the women diagnosed with cancer of the breast feel involved, cared for, educated, respected and accepted. These women, newly diagnosed with cancer of the breast, can experience treatment ranging from surgery, chemotherapy, radiotherapy to palliative care. Each aspect of care is important not only to rehabilitate the women but to anticipate common concerns in their care. When a woman is discharged not knowing what to do, where to go and what to expect, it impacts on her quality of life as well as that of her family. It is important to realise and regard that nursing cancer patients are more than just understanding the pathology and treatment and dealing with the physical manifestations of the disease, but also to know that it is more than just coping with a chronic disease. To encapsulate the essence thereof, it is to cope with the human consequences, misery and anxiety that cancer brings with it (Maree, 2007:912). She also regards the oncology nurse as a specialist with acquired specialised knowledge and skills to help the patient and care-givers adapt to the reality of living with cancer while maximising quality of life. However for the professional nurse who is not oncology trained, good communication should be the centre of their clinical governance. Determining the way a patient is coping thus demands accurate observation and effective listening on the part of the professional nurse, as well as the ability to communicate effectively. The researcher believes that communication is a social skill which proliferates within the psychological domain. It is also the researcher's belief that the interpersonal relationship and effectiveness are determined by the acquisition of verbal and non-verbal responses. This might not sound significant but it relays how one would like to be spoken to. It thus becomes empirical that the concerns, needs and preferences needs to be elicited and identified in order for the professional nurse to tailor their communicative abilities that will affect the most important consumer in health care, the patient.

1.3 Research problem

Burns and Grove (2001:85) define a research problem as “an area of concern in which there is a gap in the knowledge base needed for nursing practice.”

The researcher observed that when inpatients (women hospitalised after receiving a mastectomy) felt uncomfortable and unhappy with the communication process with professional nurses, they would avoid the professional nurses, discontinue receiving nursing care, or continue to accept care while feeling slightly awkward. It has therefore become essential that a scientific investigation is undertaken to investigate the communication that occurs between women diagnosed with cancer of the breast and professional nurses during the time women are undergoing treatment as inpatients.

1.4 Research purpose

According to LoBiondo-Wood and Haber (2002:60) the purpose of the study indicates the goals the researcher wishes to achieve in the research.

The purpose of this study is to investigate factors influencing communication between the patient diagnosed with cancer of the breast and the professional nurse.

1.5 Research objectives

Polit and Hungler (1999:50) describe research objectives as obtaining answers to the research question. The objectives of this study are to determine:

- the manner in which communication is relayed from the professional nurses
- whether barriers exist to communication
- the participant’s perception of the communicative processes they experience with the professional nurses.

1.6 Research question

The researcher therefore poses the following research question as a guide to this research study: “What are factors influencing communication between the patient diagnosed with cancer of the breast and the professional nurse?”

1.7 Research methodology

1.7.1 Research design

Designs are the blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. A design is also developed to reduce bias in a study (Burns & Grove, 2002:537). The purpose of the research design is to achieve greater control of variables, thus improving the validity of the study in examination of the research problem. This study employed a quantitative design using a descriptive, exploratory survey.

This design will be used to describe and explore the communication between the patient diagnosed with cancer of the breast and the professional nurse, and the factors affecting it.

According to Burns and Grove (2002: 537) is a descriptive design used to identify a phenomenon of interest and the variable within the phenomenon, develop conceptual and operational definitions of variables and to describe these variables.

Quantitative research design is the formal, objective, systematic process used to describe variables, test relationships between them and examine cause and effect interactions among variables (Burns and Grove, 2002: 551).

It is within the researcher's opinion that a quantitative and exploratory survey could be used successfully in this study. Surveys are used to obtain information about people's beliefs, attitudes, opinions and interests and according to Burns and Grove (2002: 556) is a design used to describe a phenomenon by collecting data using questionnaires or personal interviews.

1.7.2 Population and sampling

The target population for this study will be women who are diagnosed with cancer of the breast and have received a mastectomy. A convenience sample that include the first 100 female patients who have been positively diagnosed as having cancer of the breast, who underwent a mastectomy during the month of January 2007 to August 2008, and who has been referred to the oncology centre for further treatment will be drawn (n=100). Where the patient refuse to consent the other patients would be interviewed until the target population has been reached.

1.7.3 Validity and reliability

Validity of a measurement procedure is the degree to which the measurement process measures the variable it claims to measure (Gravetter & Forzano, 2003:87).

Polit and Hungler (1999:227) state that validity and reliability are methods of evaluating control. In this study the sample of respondents chosen will be representative of the population under study. The content of the scale will be examined by a panel of 1 trained nurse in the field of Oncology, as well as a trained Oncology doctor. The panel of experts will examine whether or not the states described in the scales represent states of communication. The scale will also be reviewed by the experts for its level of clarity, user friendliness and speed.

Reliability is the degree of accuracy with which the instrument measures what it is supposed to measure. For the study and its results to be reliable, it means that similar results would be obtained if the study were to be replicated using the same method (Polit & Hungler, 1999: 411). The reliability of the research will be determined by the Biostatistician prior to and after the completion of the pilot study to ascertain the validity and the reliability of the measurement tool including the transferability thereof.

1.7.4 Pilot study

According to Bless and Higson-Smith (2000:155) a pilot study is a small study conducted prior to the main research study to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. A pilot study will be conducted consisting of 10 (10%) participants of the actual sample to examine problems with the research design and to refine those before conducting the research. The instrument will be pretested for ambiguity and inaccuracies. Participants will be included in the actual sample.

1.7.5 Ethical consideration

Ethical issues considered in this study included the rights of the respondents, institution and the scientific honesty on the part of the researcher.

1.7.5.1 Rights of the respondents

The respondents can withdraw at any time from the study without incurring any negative consequences whatsoever. To increase participation and interest, the respondents' confidentiality will be guaranteed. The consent of the participant will be obtained in writing and will be communicated to each patient prior to the commencement of the research.

1.7.5.2 Rights of the institution

Permission to conduct the research will be obtained from the Human Research Committees of Stellenbosch University and the Ethical Committee of Tygerberg Hospital. Permission will also be obtained from the Department of Health.

1.7.5.3 Scientific honesty of the researcher

The researcher is aware that data should not be falsified nor manipulated in order to maintain the quality of the research and of the report (Mouton, 2001: 240).

1.7.6 Data collection approach

Data collection is the gathering of information that is necessary for the research study. Structured questionnaires will be utilized to obtain data relevant to the study (Polit & Hungler, 1999:700).

1.7.7 Data analysis

Data collected need to be analysed to give meaning to the numbers.

Data analysis will be done by using MS Excel. Data will be expressed in frequencies, histograms and tables. A statistician will be consulted to assist with the analysis of the data which will be analysed using the statistical programme. Further analysis will include statistical associations using the chi-square on a 95% of confidence interval.

1.8 Definitions

Cancer: Cancer develops when cells grow and divide uncontrollably outside the normal cell regulatory mechanisms (Maree, 2007:888).

Communication: is the process of transmitting thoughts, feelings, facts, and other information that includes verbal and nonverbal behaviour (Delaune & Ladner, 2002:190).

Rehabilitation: It is the process during which the client is helped to return to the life and social activities which society and the client expect, through reintegration into the community as independent members of society (Smith & Middleton, 1999:2).

Perception: It is a person's sensing and understanding of the world. Perception is influenced by culture, socialization, education and experience and helps the individual to determine the

meaning of the words and the content of the messages being communicated (Delaune & Ladner, 2002:192).

Nursing: means a caring profession practised by a person registered to do so, and who supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives in comfort and with dignity until death (South Africa, 2005).

Professional nurse: means a person registered as such in terms of section 31 of the Nursing Act no. 33 of 2005 underpinning the registration of such a nurse. A professional nurse is also referred to as a registered nurse (South Africa, 2005).

Likert scale: is a psychometric scale commonly used in questionnaires, and is the most widely used scale in survey research (Machin, Campbell and Walters, 2007: 221).

1.9 Conclusion

This chapter introduced the study as well as described the need for effective communication within the health sector.

The rationale for the study, purpose, objectives and significance were briefly discussed. Chapter two will discuss the literature review conducted to describe the importance of communication between the patient diagnosed with cancer of the breast and a professional nurse.

CHAPTER 2:
LITERATURE STUDY

2.1 Introduction

Communication is an essential aspect of practice that a healthcare professional especially professional nurses will have to master. For the following chapter the researcher will describe communication and the negative effects thereof, the interpersonal communication theory, the interpersonal theory of Hildegard Peplau and the role the professional nurse has in this regard, as well as the factors that affect the fluidity of communication in the ward. Emphasis has been placed on the ward for the sole purpose of this research assignment.

Balzer-Riley (1996:94), describes communication as a reciprocal process of sending and receiving messages using a mixture of verbal and non-verbal communication skills. Verbal communication is spoken, while non-verbal communication comprises forms of message sending such as facial expressions and/or gesturing. According to Wilkinson (1991:678) effective communication is one of the most important aspects of nursing care in an oncology setting. Patients with cancer consider healthcare professionals as a primary trusted source of information, in which the nurse plays a big part, however, poor communication has negative consequences for both nurses and patients (Fallowfield, 1998:728).

2.2 Poor communication

Poor communication leads to heightened anxiety and depression (Fogarty, Curbow, Wingard, McDonnell & Somerfield, 1999:371), poor psychological adjustment (Schofield, Butow, Thompson, Tattersall, Beeney & Dunn, 2003: 49), ineffective coping, hopelessness and reduced quality of life (Ong, Visser, Lammes & De Haes, 2000:146). Thorne, Bultz and Baile (2005:876) concur with their assumption that poor communication may have untoward effects on the treatment process, information transmission, decisional processes and the psychosocial experiences with which the patient is confronted. Just as communication can be positive in the health care sector, so too can it be negative - leading to misunderstanding, dissatisfaction, wrong decisions and even law suits (Koehler, Fottler & Swan, 1992: 456).

Bensing (2000:19) states that unsatisfactory interactions will not produce healthier patients. A hospital does not only serve a multicultural generation but Williams and Giles (1996:222) consider communication satisfaction as an essential ingredient of effective intergenerational relations, of which the professional nurse is exposed to. Armstrong and McKechnie (2003:14) not only agree with this statement but can concur that the institutional setting provides a very different communicative environment to that of a person’s own home.

Kruijver, Kerkstra, Francke, Bensing and Van der Wiel (2000:129-145) showed that nurses' communication exhibits more negative or blocking features than positive facilitative ones during interactions with cancer patients.

Lancely (2001:133) also noted that most nurse-patient communication research was done with a positivist-psychological orientation. A study by Hall, Roter and Katz (1987:399) demonstrated two types of communicative behaviours used by nurses, which are instrumental (information giving, providing medical and practical services) and affective (respectful, comforting, imbuing trust) behaviours. Communication is the primary method that the nurses use to try and establish and maintain a nurse-client relationship. It is important to realize that this is an essential activity (communication) in the caring of patients. Nursing has a heavy responsibility in this context because it is carried out from the viewpoint of either a relatively short or long-standing social relationship. It becomes evident to say that the feature most characteristic of nursing is the shared interpersonal experience of the nurse and the patient.

2.3 The Dyadic Interpersonal Communication theory

Berlo (1960: 10) describes the dyadic interpersonal communication as a dynamic interactive process that comprises a source or sender (encoder). The aim of the sender, is to be understood by another person (decoder). The decoder processes, analyses, decodes and comprehends the message. The recipient responds to the message based on her interpretation of the message. Communication occurs within a context influenced by the situation, the message content, attitude, perception and the emotional and physical state of the sender and recipient.

Berlo places great emphasis on dyadic (communication between two people) communication, therefore stressing the role of the ***relationship*** between the source and the receiver as an important variable in the communication process.

2.4 The Nursing Theory

Nursing implies a special kind of meeting of human beings. It occurs in response to a perceived need related to the health-illness quality of the human condition.

For the purpose of this study Hildegard Peplau’s (1952:22) interpersonal theory is applied to conceptualise nursing and displays the important role it has in delivering quality communication. This research assignment will not only focus on the aspect of nursing but also on the important aspect of having the ability to communicate to the patient and the

contribution it has or can have on the patients' general wellbeing. Communication will be focused on in the context of being therapeutic.

As the word denotes, therapeutic communication as described by Bradley and Edinburg (1986:326) implies that it is any communication designed to increase the self-worth of the patient or to alleviate psychological distress. It also implies unconditional positive regard for the patient from the professional nurse and is done in a caring, concerned, and empathic manner.

Peplau believed that the behaviour of the nurse (professional nurse in this context) towards and with a patient does impact on the patient's well-being, quality and outcome of her nursing care. She referred to nursing as an interpersonal process and often a therapeutic one underpinning psychodynamic nursing. Theoretically Peplau describes this as understanding one's own behaviour in order to help others. The nursing theory of Peplau by Belcher and Brittain Fish in George (2002:61) describes the nurse-patient relationship as the foundation of nursing practice which she divides into three phases, namely: the orientation, working and termination phases. In the orientation phase, the nurse and the patient meet as strangers and strive towards identifying the problem, gradually becoming more comfortable with each other. McAllister, Matarasso, Dixon and Shepherd (2004:575) state that communication during this initial phase of the nurse-patient relationship is very important because roles are clarified and standards are established. Henceforth the slogan 'first impressions always last', becomes evident whether communication be within the axiom of verbal or non-verbal communication.

The working phase encourages the nurse to use skills such as clarifying, listening, accepting, teaching and interpreting, in order to offer services that the patient can use to solve the problem. During the termination phase the patient learns to become independent, and thus a stronger person. This phase, however, only occurs if the orientation and working phases were successful. Peplau developed the three phases which include the three modes namely dependent, interdependent and independent of accomplishing the work required for goal achievement by the patient.

Within these phases she describes the six nursing roles that a professional nurse has to perform that includes instrumental and affective behaviours not directly mentioned but typical of clinical nursing. These roles are that of a stranger, resource person, teacher, counsellor, surrogate and as an active leader. Reference is made to these roles as the professional nurses in the ward meet patients and people as strangers before any other roles can be utilised. Many roles are thus demanded of these nurses. These various roles as described by

Peplau emanate given the domain they work and function in. Peplau (1952:43) mentions that society has views on how nurses should function and these conceptions vary in communities and economic groupings, and suggest principles that govern effective performance in the roles indicated.

2.4.1 Roles as described by Peplau

Within these roles as previously described(paragraph 2.4), Peplau describes how the patient and nurse meet as strangers. Within this realm this assertion poses a question whereby one would like to know the expectations this patient might have of how the professional nurse will treat her. Peplau states that the principles of meeting new people are all the same whereby respect and positive interest should be accorded to every stranger (patient) and this includes the same ordinary courtesies that any new guest in any situation should receive.

As a resource person, “not all patients have the time to dig out facts useful to full understanding of a medical problem” (Peplau, 1952:48). This is where the professional nurse acts as a resource person where, out of a background of specialised preparation and knowledge, she/he can answer questions and give appropriate health information.

The teaching role is an important role in nursing and proceeds from what the patient knows and develops with the guidance of the professional nurse around the patients’ interest in wanting and being able to use additional medical information.

Peplau confers that in clinical situations patients often cast professional nurses in the role of a leader. Individual patients identify with professional nurses and expect them to offer direction during the current difficulty they are experiencing (Peplau, 1952:49). Different kinds of leadership do not only create different types of atmosphere but affects participation too. A democratic leadership encourages participation by everyone engaged in an endeavour, whilst an autocratic leadership is dictated by the leader. A laissez-faire leadership lacks active participation and the patient may feel that a lack of human interest is shown. Leadership is a function in all situations and can be verified with the content of what is said, as well as the emotional tones that accompany it.

Patients can view a professional nurse as someone else who can symbolise a mother, sister, child or someone who reminds them of someone else. Within this constellation the surrogate role is determined by psychological needs that give rise to psychological tasks to be met in nursing situations by nurses. Peplau views this role stating that the behaviour of the nurse (professional), her appearance, mode of action, body gesture and manner of speaking often operate in such a manner reminding the patient of someone else. The patient’s relations with

the nurse are more likely to be in terms of her relations to that someone else she has in mind. Here the professional nurse can help the patient learn that there are likenesses and differences between people by being herself.

As a counsellor the professional nurse has to deal with helping the patient to remember and understand fully what is happening to her in the present situation, in order for the patient to integrate her experience rather than dissociate from other experiences in life.

The relationship which develops between the professional nurse and the patient is vital in the nursing process. An effective relationship is a dynamic ability which implies not only the knowledge and ability of the professional nurse but also the confidence of this professional nurse while working with the patient on aspects which may be difficult. A simplified overview of the three phases will indicate the importance and the impact communication has on the nursing sphere.

2.4.2 The three phases

2.4.2.1 The orientation phase

During the orientation phase the nurse must place emphasis on the needs of the patient, including orientation regarding her new situation, strangers, and her state of health. The patient has a “felt need” and seeks professional assistance (Tomey & Alligood, 1998:337).

In all the settings the patient will be anxious and may forget some information which has been provided. In the orientation phase, therefore, it is necessary to interrogate the patient to obtain data from her status prior to this illness situation and provide information related to names, procedures and repetition of actions. It is an interrogation and a search for information by both parties which may aid in clarifying the perceptions of the patient and the expectations of the nurse, giving the patient an idea as to what may be expected from this relationship. Nurses and other professional caregivers must remind the patient who they are, what they do, and explain the objectives of the procedures using language which she can understand and indicate what she must do to recover her health. This phase determines the characteristics and objectives of the relationship.

2.4.2.2 The working phase

The working phase encompasses the activities previously known as the identification and exploitation phases (Belcher & Brittain Fish, 2002:66). Within this phase the identification begins while patients are in the orientation phase during which they make a global evaluation of what is happening and determine which people will be able to do something to help them.

This is when the patients clarify their problems in their minds. This phase implies that the patient identifies with the nurse who has experience and can help her (Tomey & Alligood, 1998:337). She trusts the professional to do things which she says she will do and to fulfill her promise. Patients identify with nurses who are open and honest in their approaches and provide information, thereby augmenting this identification which enables the patient to solve her problems.

In this phase the nurse-patient relationship may take different directions. The patient may become more implicated in her care and widen the relationship along productive lines or the patient may avoid the implication initiated with the nurse on the first contact and the possible associated anxiety or may be passive and allow the nurse to do everything. A patient may begin by being somewhat passive but when she starts to identify with the nurse, she may become more involved in her care. In this phase the nurse should be aware of the change in the behavioural patterns of the patient, which will give clear comprehension as to what the patient is thinking and feeling.

This phase continues whereby an informed patient will develop a clear idea of her situation and begin to identify her needs. This phase is characterized by the patient making full use of the resources available around her, namely the persons and the environment. The nurse-patient relationship is the central point, the main pathway in which the patient uses her situation and the healthcare professional to her benefit. The patient searches for more information regarding her health problem and reviews the resources around her to see whether her immediate and long-term health objectives are fulfilled. She will discuss things with other patients to evaluate whether she is obtaining the necessary information. The most important thing in this phase is the concept of the patient taking partial control of her situation. In this phase the relationship is at a significantly productive level, converting the planning and execution of the care into a cooperative process.

This phase may be seen as a work phase in which the patient begins to assume a more active role, the previous forms of patient behaviour are analysed and an alternative conduct is introduced, if necessary. Peplau states that this is a dynamic process which implies changes in the nurse-patient relationship, from a situation of dependence to another where both the nurse and the patient begin to work as adults, identifying and exploiting areas of independence and interdependence. This behavior may occur in all the phases, but particularly in the working and the last phase, that of termination. The professional nurses who see the changes in behaviour are able to adapt to the effort of independence. The nurse must also feel capable of taking care of the problems which inevitably appear in the process of dependence to independence.

2.4.2.3 The termination phase

Peplau sees the termination phase as a process of gaining freedom, in which the patient begins the steps for preparing to leave the hospital or living a healthy life at home. In contrast with social relationships, the nurse-patient relationship is an oriented and temporary service which finishes when the objectives are achieved and the work with the patient has been completed or the professional nurse has moved on to another patient. The termination of the care must be planned; the patient needs to be prepared for this next situation and it should not be terminated abruptly.

When the objectives have not been reached, the termination may be more difficult, which is why it is important to establish some realistic and potentially achievable objectives.

The roles that the professional nurse assumes as mentioned previously (paragraph 2.4.1) is designed to aid the patient in achieving specific therapeutic objectives and in communicating those objectives.

Peplau by (Belcher and Brittain Fish in George, 2002:62) continues to describe nursing as an interpersonal process that involves interaction between two or more individuals with a common goal, whereby both respect each other, learn and grow as a result of the interaction. Although Peplau provided this theory which is very oriented to working with patients presenting some alteration in mental health and on which the basis of the intervention is mainly related to communication, it generally can be applied to any setting (ward, clinic) where nurse-patient interaction takes place.

She continues to state that each individual can be viewed as a unique biological-psychological-spiritual-sociological structure that will not react the same as any other individual. Each person will come with preconceived ideas that somehow influence their perceptions stemming from their home base discourse (mores, customs and beliefs) and from their culture. These perceptions can vary given the experience the individual undergoes with the healthcare professional.

It can be deduced from Peplau's theory that patients identify themselves with professional nurses based on useful services rendered and on the basis of earlier experiences. Patients evaluate the behaviour of the professional nurse in terms of their past experience(s). No professional nurse can assume or "*possibly know what is in the mind of a patient until there is some communication between them*" (Peplau, 1952:37). Patients who have had negative interpersonal experiences in the past with professional nurses in relation to emotional and physical health care outcomes, can have difficulty in developing trust, or the ability or

willingness to communicate (Bradley & Edinburg, 1986:85). Searle (2002:256) agrees with this statement and says that the nurse practitioner should eliminate all the indirect aspects of communication that can undermine the patient's trust.

Patients that are especially confined to a ward setting where cancer patients are nursed may request services from basic nursing care to more complex education or even counselling. Here, it becomes evident the role communication has to play in nursing as the patient can have many facets with which the professional nurse has to deal with.

When a member of the public enters a hospital setting it virtually becomes impossible to not communicate with them. Certain expectations are expected on the clients' behalf and as the Batho Pele principles states: "Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Patients should be aware (through communication) of the level of nursing care that can be expected" (South Africa, 1997:15). According to the Code of Conduct for the public service (South Africa, 2002), an employee (nurse) promotes the unity and well-being of the South African nation in performing his or her official duties. The patients can thus exploit services on the basis of self-interest and need. During the initial phase the patient is more dependent on the nurse to perform different roles in their quest for health. As time progresses this patient can become interdependent and learn how to do things for herself, eventually progressing to the independent mode whereby she relinquishes their relationship in preparation to go home. Here success will be determined by the various roles the professional nurse played or whether the patient can integrate what has been taught as an inpatient. Termination of this relationship can only take place if success has been achieved in the preceding phases (orientation and identification) and most importantly the interpersonal relationship they have one with the other.

2.5 Nursing

Nursing is regarded as a noble profession, mainly on the basis of the actions of nurses. From a South African perspective, Searle (2002:128) stated that the scope of practice of registered persons has to ensure *"The facilitation of communication by and with a patient, as well as their family. Interpersonal relationships such as assisting a patient to communicate his needs to others and communication with his relatives and friends are part of this function. All other forms of communication, both verbal and non-verbal, are of importance".*

To nurse does not mean only to nurture. In its total concept it means to protect, cherish, watch over and guard (Searle, 2002:73). The nursing profession and society have a special relationship. Under its terms, society grants the profession authority over functions vital to

itself and permits them considerable autonomy in the conduct of their own affairs. In return, the profession is expected to act responsibly, always mindful of the public trust. Self regulation to assure quality in performance is at the heart of this relationship.

Nursing practice takes place in a variety of settings. It can be primary, secondary or tertiary levels of care. Nurses also need to keep abreast with continuing change and development to ensure patient safety. A nurse according to the Nursing Act No 33 of 2005 (South Africa, 2005) is a licensed person who is registered with the Nursing Council based on completion of a recognized education and training programme to nurture, assist and treat the client who can be an individual, family or group, sick or well, in the performance of those activities that contribute to the attainment or maintenance of health, to optimum recovery and rehabilitation or to peaceful, dignified death.

The professional nurse's primary responsibility is towards those people who require nursing care. The professional nurse, in providing this care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected. According to Searle (2002:141) the manner in which each nurse practises her profession will articulate the nursing profession's unique contribution to society. Searle (2002:116) continues by saying that defining the scope of practice of professions for each category of nursing, is essential so that only persons registered in that profession may perform the acts pertaining to the profession. The intention of this distinction is to assist the public in identifying what they can expect from each category of nursing. Here the various categories of nurses will meet the patient during the orientation phase but the onus is on the professional nurse to ensure safe, competent nursing care through good verbal and non-verbal behavior.

According to the Wiedenbach's prescriptive theory as described by Bennett and Foster in George (2002:217), nursing is a helping service that is rendered with compassion, skill and understanding to those in need of care, Wiedenbach states that the art of nursing is a goal-directed activity requiring the application of knowledge and skill toward meeting a need for help experienced by a patient. It is the professional nurse's duty to prescribe, implement and evaluate nursing care plans according to the patient's illness and needs. If this is not done on a regular basis the patient might not receive appropriate care.

The Nursing Act No 33 of 2005 (South Africa, 2005) ensures that the nurses registered according to this act respect the publics' constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action will be taken where failure to do so exists. The professional nurse will be held liable for negligence if they fail to practise as a reasonable and prudent nurse in their practice and specialty areas. Nursing is ultimately a

very demanding and challenging career that entails working with human life. This demands that professional nurses have the utmost respect for their patients whether young or old. Nursing the patient is what encapsulates the nurse's work and is their centre point and principle objective for practising. Communication however, plays a part of that practise whereby patients need to be informed verbally of the care they will receive and it remains important in the manner in which they will receive it from their primary caregiver. Lack of information regarding their health status is contributory to blocking the relationship and creates negative undertones.

2.6 Communication in Nursing

Peplau as described by Belcher and Brittain Fish (2002:63), believed that the behaviour of the nurse (professional) interacting with the patient does have a significant impact on the patient's well-being, quality and outcome of her nursing care. Peplau confirms that behavioural conduct is elementary in the field of nursing, be it from providing information to delivering physical care. It basically becomes the assumption of the researcher that without the skill of communication, nursing can become tyrannized.

It is also the contention of the researcher that effective communication contributes to the patient's well-being and that the inability thereof can have a detrimental effect on the patient and her well-being.

Purtilo and Haddad (2007:162) states that professional nurses rely heavily on verbal, non-verbal and written communication to share information, plan care and collaborate with other members of the healthcare team. They continue to state that verbal communication is required in order to: establish rapport, obtain information concerning the patient's progress, confirm understanding by the patient regarding their illness and treatment, relay information to other health professionals and instruct the patient and her family. Verbal communication becomes aligned with instrumental (information giving) communication in lieu of its information process. This needs to be done verbally and cannot constitute assumptions. Non-verbal communication goes far beyond words. It can be expressed consciously or unconsciously. Non-verbal communication expresses emotions and attitudes, and is a means by which one can establish, develop and maintain social relationships.

As females diagnosed with cancer of the breast are consumers in the healthcare industry, they need to believe that the professional nurse cares about them and is committed to their well-being. No patient would like to be ignored whilst being hospitalised. The professional nurse caring for the mastectomy patient can convey interest by being attentive, making good

eye contact, listening and questioning the patient thoughtfully. Non-verbal behaviour such as one's tone, attitude, gestures, attention and facial expressions can all have an impact on the patient.

By appearing busy, always in a hurry, distracted, or by being brusque one can make the patient feel insecure and unwilling to develop any interpersonal relationship with the nurse. The nature of the professional nurse's work not only leaves her with the responsibility to acquire and facilitate the acquisition of social skills but to improve the quality of nursing care. The ability of communicating effectively is not an end in itself, it is the need of the patient which becomes paramount as well as the need for the patient and the nurse to be humane towards one another in doing so. Suffice to say it is not merely what is being said but the way (manner) in which it is said.

To be able to communicate effectively the professional nurse should be able to continually supply the patient with information relevant to her disease, plan her care and/or rehabilitation and be approachable towards the patient especially in the manner things are being said or done. Imparting information forms part of the verbal process whilst the non verbal communication is indicative of how it is being done. Peplau also described in her work that "*understanding of the meaning of the experience to the patient is required in order for nursing to function as an educative, therapeutic and maturing force"* (Peplau, 1952:41).

With reference to the rehabilitation process and the importance thereof Dorothea Orem as described by Bennett and Foster in George (2002:131) developed the nursing concept of Self-care and stated that when able, individuals can care for themselves, but when unable to do so the nurse provides the assistance needed. She describes her theory of nursing systems which is based on the assessment of an individual's self-care needs and on the assessment of the patient's ability to perform these self-care activities. She describes three systems namely the wholly compensatory, partly compensatory and the supportive-educative systems. The wholly compensatory system is patients who are socially dependent on others for their continued existence and well-being. The partly compensatory nursing system is whereby the nurse and patient perform care measures or other actions that involves manipulation tasks or ambulation. Here, the compensatory nursing system moves towards a complementary relationship in which the nurse is superior to the patient and there are five methods of helping. These methods are: doing or acting for another, guiding or directing, providing physical support, and providing an environment that supports development. The third system namely the supportive-educative system is whereby the patient learns to perform the required measures of externally or internally oriented therapeutic self-care with assistance. Here the patient does all of the self care. The patient's need for help or

assistance would be confined to decision making, behaviour control, and acquiring knowledge and skills. Thus patient-centred care incorporates the overt physical, psychological, emotional and social needs of the patient. It is a model of caring for the whole person as an individual, not as an example of disease, medical diagnosis or medical condition (Mosby's Medical, Nursing and Allied Dictionary, 1998, s.v. 'patient-centred'). The patient being the core and centre most point of the health care system, it is important that the professional nurse develops good services that revolves around them (patients) and are responsive to their needs and preferences and to assist the patient to helping themselves wherever possible. No patient should leave the hospital not knowing what to do.

2.7 Factors influencing verbal communication

2.7.1 Information

Information is one of the principal needs that has been identified in studies with cancer patients and their families (Wilkes, White & O'Riordan, 2000:41).

Wilkes *et al*. (2000: 41-46) continues to suggest that the most important aspect is the provision of information to the patient and her family on all aspects of the particular cancer from which they are suffering. Wilkes et al. continues to state that this information should include details regarding the disease, symptoms, prognosis, treatment, side-effects and community resources. It is important to realize that the patient is usually part of a family whose members are concerned about her health and are likely to suffer repercussions from her ill health or disability. The family, therefore, should be involved in any decision making and treatment strategy as they constitute an important element in the patient's cooperation. This is also especially important in the process of rehabilitation, in coping with a chronic disease, and in coming to terms with long-term or permanent disability. Fallowfield and Jenkins (1999:1593) state that patients are often dissatisfied with the amount and nature of information they receive and that many cancer patients are dissatisfied with much of the communication that takes place within hospitals. Thorne (1999:371) concurs with this statement and says that failure to provide proper information can cause serious psychological harm to the patient, even if they do recover from the disease.

According to Petersen and Waddel (1998:273) studies have demonstrated that when patients participate in their care they experience positive outcomes. These outcomes include greater satisfaction with care, a sense of control, decreased vulnerability and stress of hospitalization and in being effectively prepared to be discharged. It therefore becomes

extremely important for the patient to participate in her care if the professional nurse is to assist the patient in caring for herself effectively once discharged.

Thorne (1999:372) also states that information has an effect on a cancer patient's quality of life. Previous research suggests that cancer patients do not receive enough information (Mills & Sullivan, 2000:236-246), and that the task of providing information is complex. Previous research has also shown that the patient's personality, demographic characteristics and level of knowledge all influence the extent to which professionals decide to give information to their patients (Veronesi, Von Kleist, Redmond, Costa, Delvaux, Freilich, Glaus, Hudson, McVie, Macnamara, Meunier, Pecorelli & Serin, 1999:1667-1675).

Feldman-Stewart, Brundage and Hayter (2000:8) recognized that information needs are highly individualized, and that this individualization of information is rarely achieved. This can further be characterized according to their level of participation as described by Petersen and Waddel (1998:275) who observed different styles of participation, the degree to which patients participated and the extent to which the professional nurses encouraged participation. These styles were described as inclusive participation whereby both parties are aware that this participation involves the patient in all areas of care. The patient considers the nursing care as a cooperative process and believes in the equal input from both parties. This kind of participation encourages partnership whereby the mutual information sharing maximizes patient participation in all aspects of care.

Petersen and Waddel (1998:279) also describes partial participation as the patients' perception of nurses and doctors as experts and knowledgeable sources of information. The patients at this level will take advice as given and not question what they are being told. The patients at this level of participation believe that the professional nurse will provide them with the necessary information if and when they as nurses perceive them as the patients to be in need thereof. Petersen and Waddel (1998:280) also found that patients at this level of participation expressed their concerns in stating that there were times whereby they did not fully understand what to expect or do about their care once discharged.

The last style represents exclusive participation. Here the professional nurses are clearly in charge and the patients are there only to follow orders. Initiation of participation is generally poor as patients do not want to disturb the professional nurse, whilst the professional nurse is concerned with completing her tasks before the shift ends. The patient at this level is only concerned about complying with the professional nurse's instructions and can regard her as an authoritative figure. It becomes disconcerting to say the least if this aspect of verbal communication can impact on the patients' health.

Health is a fundamental right of all human beings. The basis for nursing also entails the planning of this individualized care of each patient being hospitalized and respecting the patients' individuality as the foundation of humane medical care. The professional nurse's actions are thus characterized by involvement realizing the human finiteness and individuality of each person ascribing their own personal experience differently. This approachable nursing action can be reflected in everything the professional nurse does or says.

2.8 Factors influencing non-verbal behaviour

Patients want information that is combined with the physical care they receive regarding their illness. These kinds of patients' needs can be met by instrumental communicative behaviours that are task-oriented and address the physical problem at hand. Patients however have emotional needs too in which they seek reassurance and understanding about their illnesses. Affective communicative behaviours such as showing respect and building trust are needed to meet these patient needs as described by Bakker, Fitch, Gray, Reed and Bennet (2001:69).

On dealing with the component of non-verbal communication (all behaviours that convey messages without the use of verbal language) Caris-Verhallen, Kerkstra and Bensing (1999: 808-818) found in their study that estimates of the nonverbal component comprised of 55% to 97%. Despite the variations in these values they believe that the nonverbal aspects of communication are consistently thought of as being more influential than verbal behaviours. Although there are many dimensions within the verbal and non verbal communication, for the purpose of this study the focus will be on those aspects most noticeable to the patient.

Wilson-Barnett (1988: 216) mentioned that the manner in which the professional nurse initiates contact with the patient is known to be important in helping to alleviate the high anxiety that often is associated with hospital admissions. Searle (2002: 253) states that the professional nurse's actions that are being communicated to the patient and her/his family will determine the degree of trust that the patient has in the professional nurse.

Due to the fact that human-beings learn to communicate at an early stage of their lives, it may appear that communication is quite simple. However, communication is a complex process and attention needs to be paid to how one approaches a patient faced with so many dilemmas.

Communication where healthcare professionals, especially professional nurses are concerned, should be used to encourage patients to interact in a manner that promotes their well-being and moves them toward their treatment goals. All communication that takes place

should be aimed at preserving the self respect of both the carer (professional nurse) and the cared for (patient), as well as assist them (patient) in their goal attainment.

As was described in chapter one, the female diagnosed with cancer of the breast can have an emotional reaction to her illness. Thus with this specific illness there will be a human being suffering. Peplau (1952:12) might have written her theory from a psychiatric perspective but good social skills somehow seem to be interrelated to the aspect of developing that interpersonal relationship.

As a human, being hospitalised the patient will find herself immersed in a strange and unfamiliar world whereby the doctor and nurses can dictate to her on what to do and what not to do. The patient may also feel scared and lonely. In this situation it seems important to realize that however brief or long the relationship the patient might have with the professional nurse, she (professional nurse) has to realise that the patient has been taken away from her familiar surroundings and now has to relate to strangers and an unfamiliar setting. It is essential to realise that the patient moving from the orientation phase through to the termination phase of her care can become affected by how she is being spoken to or approached. (Peplau, 1952:14).

Non-verbal communication can be considered a powerful part of the communication process as described by Burgoon and Guerrero (1994:165) and because this nonverbal behaviour takes place outside of the conscious awareness, it can easily be misinterpreted. Nonverbal communication is classified according to the different codes or modes of expression used. This study concentrates primarily on nonverbal behaviours such as chronemics, kinesics and vocalics and how it interrelates with the way the professional nurse speaks to the patient in a clinical setting (Burgoon & Guerrero, 1994:131). Burgoon and Guerrero continue to state that these codes have unique properties that somehow influence the communication roles it performs.

2.8.1 Chronemics

Chronemics involves how human beings use time and include elements such as urgency, duration, waiting time and punctuality. Chronemics describe human beings' notion of time, how it is used and the emotional response to it. Time is revealed through the reliance on clocks. Procedures and tasks can be planned according to when it should take place, what time of the day it should take place, how long it should take and in many aspects it is viewed as a commodity. The use of time can affect lifestyles, daily agendas, speed of speech, movements and how long people are willing to listen. In a ward setting where most of the mastectomy patients are nursed, time management is of importance. There are many tasks

to complete within a given period of time, and what places more strain on the time factor are the absence of personnel. Formal time depicts days, months and years, while informal time is considered the "loosely defined and out of consciousness time system" (Burgoon & Guerrero, 1994:134). Informal time will consist of phrases such as "in a moment", "be back shortly" or "will come back later" that do not stipulate specification and if not complied with will cause great disturbance to the patient. If the professional nurse does not fulfil her promise on the time period, which can mean anything from 5 minutes to 5 hours, the patient can develop a negative impression of the professional nurse and the trust she has to maintain with the patient (Burgoon & Guerrero, 1994: 135).

2.8.2 Kinesics

Kinesics depicts the visual aspects of behaviour and has been classified as emblems, illustrators, affect displays, adaptors and regulators. The emotional state of the professional nurse can easily be revealed through the kinesic behaviour such as the body, face, eye contact and gestures are exemplary of. Kinesics gives meaning to an interaction by visually observing the other party's behaviour when relating. Although not much research has been done on the nonverbal behaviour of the professional nurse, this form of communication conveys emotions in terms of how the nurse will express herself through her body movements and facial expressions. According to an old proverb "your eyes are the window to your soul" can relinquish what the nurse might think of the request from a patient, command or person they are interacting with, by merely looking at their expression. According to Tanner (2006:198) there are various facial expressions. These facial expressions are also carriers of emotion which are happiness, sadness, surprise, fear, anger, disgust and interest (Williams, Moss & Bradshaw, 2004:155-172). These features are shown by various movements of the cheeks, mouth and brow. They continue to state that the role that the facial expression plays in the interpersonal relationship signals the persons' attitude and emotion and it is a significant factor in the formation of relationships. Facial expressions can also show whether what has been said was understood and in terms of the nursing profession can indicate to the patient whether the nurse shows an interest in what has to be done, or in communicating with her. Looking is a form of communication and a channel for collecting information (Tanner, 2006:198-199). According to Williams *et al.* (2004:155-172) research has found that the amount of times people look at each other during a conversation varies and depends on whether they are speaking or listening. Listeners spend a lot of time looking, which is linked to its function as a social reinforcer. They also concur that looking is a form of showing the other individual that you are paying attention. On the other hand if the nurse looks away, it might indicate avoidance or lack of interest but cognisance has to be

given to cultural sensitivity as described by Williams *et al.* (2004). They also regard smiling as a signal of positive feelings and is an affectionate way of communicating. Smiling acts as a reinforcer and is a way of encouraging the speaker to continue with a topic. Suffice to say that this reinforcer encourages patients to want to interact with the caregiver and share their goals at hand.

2.8.3 Vocalics

Vocalics concentrates on the vocal aspects of speech. It is not merely the content of what is said but how it is being said. Vocalics maintain its relevancy in terms of the impression that people would like to create, it regulates the interaction and is also known as the learning and persuasion process. Burgoon and Guerrero (1994:144) state that the voice is also a key carrier of emotional messages because it reflects our attitude towards others and our relationship with them, whilst Williams *et al.* (2004) concurs that different emotions characterise the changes in the volume of the speech. According to Williams *et al.* (2004) poor voice quality such as a harsh, tense or hoarse voice is unpleasant for the listener. Speaking too fast might indicate impatience whilst speaking patiently shows respect. The production and processing should allow the listener to assimilate and process information depending on the rate of speech. Problems can arise due to the patients' age or their level of understanding. Patients may not want the natural rhythm to be distorted and want to be spoken to at their level of understanding.

From the orientation phase through to the termination phase the professional nurse has a duty in providing the patient with information and care sufficient for them to be able to move on to the termination phase. These processes can only be done if there was success in the preceding phases (orientation and working) and cannot occur effectively if there are communicative difficulties within the nurse-patient relationship.

2.9 Conclusion

The professional nurse, who seems to be one of the healthcare practitioners who spends a considerable amount of time with the patient whilst being hospitalized, should not loose sight of the patient as a human being who is experiencing the illness. Suffice to say no other profession really gets to know the patient at such an in depth level that involves her health, illness, hopes, fears, expectations and innate thoughts. As human beings we can move from the equation of being healthy to becoming ill and visa versa. Confronted with being ill, the patient would not only want to know about her medical condition but to be treated as an individual with respect, be it from the way she is being approached to the manner in which

she is spoken to, informed and supported through to the termination of their relationship. All aspects of communication are considered vital to the patient and the role the nurse plays in delivering it.

This chapter discussed the literature review undertaken on communicative aspects that can be experienced between a patient diagnosed with cancer of the breast and the nurse whilst they are being hospitalised. The literature review covered both intrinsic and extrinsic factors that affect the communication process and which could contribute to the nurses' decision as to whether or not to improve on these areas of communication.

Chapter three will describe the research methodology adopted to study communication between the breast cancer patient and the nurse.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 Introduction

Promoting effective communication with the patient will improve the quality of care including adherence, co-operation and her rehabilitation, as well as form a trusting relationship with her caregiver, the nurse.

Ineffective communication will not only place a significant burden on both parties, but has the potential to create unfavourable outcomes. It is in view of these factors that the researcher explored the patient's viewpoint regarding nurse-patient communication, for the purpose of finding out whether the communication between these two parties are effective or not. In this chapter the purpose, objectives, research question, the research design, population and sampling, criteria for the study, the questionnaire utilized to collect the data, validity, reliability, pilot study, limitations to the study and ethical considerations of the study are described.

3.2 The purpose

The purpose is to investigate factors influencing communication between the patient diagnosed with cancer of the breast and the professional nurse.

3.3 Objectives of the study

The objectives for the study are to determine

- the manner in which communication is relayed from the professional nurses
- whether barriers exist within communication
- the participant’s perception of the communicative processes they experience with the professional nurses.

3.4 The research question

The research question that was posed for the purpose of this study was “What are the factors influencing communication between the patient diagnosed with cancer of the breast and the professional nurse?”

3.5 Research design

Designs are developed to reduce bias in a study (Burns & Grove, 2002:537) and is the overall plan for conducting the study in order to answer the research question.

A quantitative research design using a descriptive, explorative survey was conducted at Tygerberg Academic Hospital in the Cape Metropolitan area to explore and describe the factors that influenced the communication between the patient diagnosed with cancer of the breast and the professional nurse.

According to Burns and Grove (2002:537) descriptive research is conducted to discover new meaning, describe what exists, determine the frequency with which something occurs and to categorize information. According to Polit and Hungler (1999:712) quantitative research is the study conducted using a controlled design to obtain quantified data. This study also attempted to quantify factors influencing the communication between the patient diagnosed with cancer of the breast and the professional nurse in a public institution. Quantitative research has the following characteristics as described by Burns and Grove (2001:39):

- it uses a deductive form of reasoning
- the meaning is given by the researcher who interprets the quantitative research results and thus uses etic perspectives
- quantitative research answers the research question that has been stated at the beginning of the research process
- the phenomenon under study is controlled in order for the research findings to be an accurate reflection of reality, thus reducing errors and enhancing the reliability and validity of the research results
- data is presented in figures which are easy to quantify
- data analysis follows a standardized procedure
- the sample is usually representative of the population.

The researcher used a quantitative research design because the data was presented in frequency counts and percentages, and the responses were analysed numerically.

Descriptive/explorative survey studies are also used to determine differences between variables (Lobiondo-Wood & Haber, 1998: 198). In descriptive/explorative surveys, the investigator attempts only to relate one variable to another and do not attempt to determine causation.

3.6 Population and sampling

According to Burns and Grove (2002: 324) sampling is the process of making a selection of the study sample with which to conduct a study.

A convenience sample that included the first 100 female patients who have attended Tygerberg hospital and were referred to the breast outpatient clinic during the months of January 2007 to August 2008 was drawn (n=100) for this study. These patients had to experience a mastectomy whether unilateral or bilateral. During the year 2007, 240 patients had mastectomies and during the year 2008, 131 patients had mastectomies till August 2008. 27% of the 371 patients was used as the sample size amounting to 100 patients (n=100). According to Machin, Campbell and Walters (2007:223) convenience sampling are known as grab or “make-do” sampling in that only subjects who are available to the interviewer can be questioned. The advantage of using this minimum number of 100 patients who prior to the ethical approval and in consultation with the biostatistician was decided upon, was to build in reliability, and furthermore these patients confirmed findings and broadened understandings.

The researcher obtained the patients’ information after consent was given by the institution to access their files. The information was collected at the clinic designated for females with cancer of the breast. Due to the large number of breast cancer patients attending the clinic and with different diagnosis, the researcher could verify the patients who underwent mastectomies by being in consultation with the department of surgery at the institution. Electronic data supplied the researcher with dates that the females attended and their demographic details. In the event where these details were not up to date, the researcher accessed their files personally. The individual patients were then contacted by the researcher in order to verify whether or not they would agree to complete the questionnaire.

3.7 Criteria

The inclusion criteria included patients who

- were positively diagnosed as having cancer of the breast
- underwent a mastectomy
- who has been hospitalised after their mastectomies
- were currently still receiving treatment for their breast cancer (chemotherapy, radiotherapy or follow-up treatment).
- have been diagnosed with cancer of the breast within a 20 month period
- were able to complete a questionnaire

- had no serious mental problems such as retardation
- could partake in a structured interview (to complete the questionnaire) for those who were unable to read and write.

The exclusion criteria included patients with

- neurological problems and patients lacking mental clarity
- biophysical conditions such as being unable to hear, visual inabilities, motor dysfunction and biochemical imbalances.

3.8 Instrumentation

A data collection instrument is the device used to collect data in an objective and systematic manner for the purpose of the research. Data collection instruments can be questionnaires, interview schedules, tests and available records (LoBiondo-Wood & Haber, 2002: 294-296).

The research was conducted using a self reported questionnaire. A 6 point Likert scale was used ranging from strongly disagree, disagree and mildly disagree to mildly agree, agree and strongly agree. The questionnaire developed consisted of 6 pages (See appendix I). All the questions posed were closed-ended questions. According to Machin, Campbell and Walters (2007: 221) when a closed question has an odd number of responses, it is often called a Likert scale. Dempsey and Dempsey (2000:195) regard a questionnaire as a paper and pencil data collection instrument that is filled in by the respondents for the purpose of the research study. The duration of an interview was determined by the patient's ability to understand the questions asked and the average time required to complete a questionnaire. The duration of the structured interview that was conducted was 30 minutes. For this study the researcher used a questionnaire to collect data about factors that can influence the communication between a patient diagnosed with cancer of the breast and the professional nurse.

According to Gillman (2000:8) the following are characteristics of a questionnaire:

- they are less expensive and many respondents can be reached within a short period of time
- they provide an easy way to get a lot of information within a limited period of time
- respondents can complete the questionnaire in their own time without the pressure of immediate response
- anonymity can be guaranteed, no one will know any specific respondent's answer
- questions are standardised, every respondent gets the same questions.

3.8.1 Content of the questionnaire

All of the questions in the questionnaire were closed-ended questions.

Section A referred to personal data and consisted of questions 1 to 6. Section A required the respondent to make a choice with regard to personal data which was given in the format of intervals. Questions 2 to 6 contained multiple questions that ended Section A with 33 questions.

Section B referred to barriers to communication with regard to a ward setting in a tertiary hospital. Respondents were required to answer the questions by marking with a cross ”X” to what they deemed as the most appropriate answer ranging from strongly disagree, disagree to mildly disagree and mildly agree, agree to strongly agree. Section B consisted of questions 34 to 84. These questions covered both affective and instrumental communication.

The questionnaire was based on the literature review (see chapter 2). The questionnaire was compiled and discussed with the researcher’s supervisor, statistician and another professional nurse specializing within the field of oncology nursing. Changes suggested by these persons were implemented. Most of these suggested changes pertained to rephrasing specific items and to the visual design of the questionnaire. The instrument was first used in a pilot study before the commencement of the actual study.

3.9 Validity and reliability

Validity of a measurement procedure is the degree to which the measurement process measures the variable it claims to measure (Gravetter & Forzano, 2003:87).

The content of the scale was examined by a specialised professional nurse in the field of Oncology, as well as an Oncology trained doctor. The experts examined whether or not the states (conditions) described in the scales represent states of communication. The scale was also reviewed by the experts for its level of clarity, user friendliness and speed.

Reliability refers to a measuring instrument’s ability to yield consistent numerical results each time it is applied (Gravetter & Forzano, 2003:91).The reliability of the research was determined by a biostatistician to ascertain the reliability of the measurement tool including the transferability thereof.

The validity and reliability of the study was further enhanced by conducting a pilot study during which the feasibility of the study was determined and the instrument was pre-tested for ambiguity and inaccuracies.

3.10 Pilot study

A pilot study comprising of a sample of 10% (n10) of the actual size (n=100) of the sample of the study was conducted under similar circumstances as the actual study. The pilot study formed part of the actual study as this was discussed and approved by the biostatistician. The rationale for including the pilot study was that it was difficult for the researcher to obtain the population size with the specific criteria. The purpose of the pilot study was to test the research design and, questions for ambiguity and inaccuracies. According to Bless and Higson-Smith (1995:155) a pilot study is a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The researcher, on completion of the pilot study, brought about changes in the visual design as well as statements in the questionnaire.

3.11 Data collection

The data collection was planned over a period of about 5 weeks. The researcher visited each respective participant at their homes. Consenting patients met the researcher for approximately 30 minutes. It was conducted at their homes to ensure privacy and to exclude bias. This minimized any interference with the functioning of the cancer clinic or to cause undue discomfort or inconvenience to both the patient and the staff. The researcher explained the study and the subjects completed the questionnaire in the presence of the researcher. The researcher approached 110 patients of which 10 declined and 100 (n=100) patients were interviewed.

3.12 Data analysis

Data analysis has been done with the help of a biostatistician. A Statistical Programme was used to analyse the data, expressing data in frequencies, histograms and tables. Descriptive statistics were done as well as various associations between variables were determined using the chi square test on a 95% confidence interval.

3.13 Limitations

The study focused on investigating the factors that could have an influence on the communication between the patient diagnosed with cancer of the breast and the nurse, and although the consented procedure and the confidentiality had been explained to the patients, many felt that this was the hospital where they have to receive their long term treatment and did not want to impart any negativity towards what they thought could jeopardize their treatment.

The majority of the patients who attended the public hospital were of a low socio-economic level, had low educational levels and were of the coloured ethnic background.

According to the ethnicity 83% were coloured, 2% black and 15% white. This sample was cross sectional as it examined data at one point in time with the same subjects. According to Brink (2000:12) cross-sectional samples describe designs conducted in the present time to examine what currently exists. The sample was not cross cultured as it could have represented all socio-economic levels and ethnic backgrounds.

3.14 Ethical Considerations

Ethical issues considered in this study included the rights of the respondents and the institution, as well as the scientific honesty of the researcher.

3.14.1 Rights of the respondents

It was indicated to the respondents that they could withdraw at any time without incurring any negative consequences whatsoever. To increase participation and interest, the respondents' confidentiality was guaranteed. The consent of the participant was obtained in writing and was communicated to each patient prior to the commencement of the research.

The research report only portrays statistics about the data obtained and no reference is made to any specific person. Only the researcher had access to the data which was kept secure in a locked cupboard. All data will be destroyed after a period of five years.

3.14.2 Rights of the institution

Permission to conduct the research was obtained from the Human Research Committees of Stellenbosch University and the Ethical Committee of Tygerberg Hospital. Permission was also obtained from the Department of Health. The investigator did not impose on any of the nursing staff or any other human resources when she visited participants in their homes, in her personal capacity. Access to the relevant patients' files was required in order to obtain their information. Confidentiality, including privacy, was maintained throughout the research period. The participating institution will also receive copies of the research report compiled at the completion of the study.

3.14.3 The principles of research ethics

The principles of beneficence and respect were observed during the data collection.

The principle of beneficence encompasses freedom from harm and exploitation that the researcher has to consider throughout the research study (Polit & Hungler, 1999:134). In this study there was no harm intended resulting from the completion of the questionnaire. The researcher's telephone number was provided should any respondent have wished to discuss any aspect further or had experienced any psychological discomfort.

The principle of respect for human dignity includes the right to self-determination and to full disclosure whereby participants should have the right to decide voluntarily to participate in a study and to terminate the participation at any time. The researcher has to fully disclose the nature of the study, risks and benefits (Polit & Hungler, 1999:136). These rights were respected and the respondents were informed of the nature of the study, benefits and voluntary participation. This was attached to the questionnaire in the form of a covering letter (see annexure A).

Informed consent was obtained. Confidentiality was maintained as there were no names on the questionnaire, only numbers in the right side corner of the questionnaire for statistical purposes. The researcher's name and address were also supplied in the cover letter.

3.14.4 Scientific honesty of the researcher

The researcher's goal in conducting the research was to generate knowledge through honest conduct, reporting and publication of a research report. The researcher is aware that data should not be falsified or manipulated in order to maintain the quality of the research and of the report (Mouton, 2001:240).

3.15 Conclusion

This chapter discussed the research methodology of the study that was followed and describes the research design, population and sampling, validity and reliability, pilot study, data-collection, instrumentation, limitations experienced in the study and ethical considerations that were adhered to.

Chapter four will present the analysis and discussion of the research results.

CHAPTER 4: ANALYSIS OF DATA AND INTERPRETATION OF RESEARCH FINDINGS

4.1 Introduction

In this chapter the results of the research study will be presented and interpreted. The data is predominantly quantitative.

4.2 Description of statistical analysis

The data was analysed and were presented in the form of frequency distribution tables (one- and two-way). Bar charts were created from the frequency distribution tables. A follow up confirmatory analysis to test for equality of proportions across the levels of the variables were carried out using the Chi-square test (one-way tables).

The analysis includes the calculation of the mean, median and standard deviation.

The mean value is the average value for the variable while the median refers to the middle value when the values are arranged from the smallest to the largest. If the median is larger than the mean value then most of the values will lie above the mean value. The standard deviation is an indication of how closely values are clustered around the mean (Burns & Grove, 2002:418).

The Spearmen test for independence was also used to test for associations between demographic variables and the responses to the questions on communication between the breast cancer patient and the nurse (two-way tables). Due to sparseness of the contingency tables for the two-way cross classifications between demographic data and responses to the questions under study, the responses were collapsed to represent the options agree and disagree only. The Spearman rank order (rho) calculation shows the strength of the relationship between two continuous variables, that is the strength of the correlation. This calculation is used when it cannot be assumed that the variables are normally distributed. If the rho is -1, then it is a negative correlation, for example: increased smoking will decrease longevity. If the rho is +1, then it is a positive correlation for example: increased smoking increases lung destruction (Blanche & Durrheim, 2002).

In the cases in which statistically significant associations were detected, the strength and direction of the respective associations were assessed using odds ratios. The odds ratio (OR) is defined as the measure of association that best describes the analysed data in case

control studies (Lobiondo-Wood & Haber, 2006:497). Odds ratios were generated through logistic regression of the binary responses resulting from the collapsing of the responses into agree and disagree.

The chi-squared tests for goodness of fit show that the responses were not equally distributed across the categories of the variables for all the variables (one-way frequency distributions). Only some selected variables had statistically significant associations with the demographic variables.

The chi square test, a test for significance is used to quantify the degree to which chance variability may account for the results observed in any individual study.The p-value is the measure reported from all tests of statistical significance. It is defined as the probability that an effect at least as extreme as that observed in a particular study could have occurred by chance alone. If the p-value is greater than 0.05 by convention, the chance cannot be excluded as a likely explanation and the findings are stated as not statistically significant at that level (Machin, Campbell & Walters, 2007:100-116). If the p-value is less than 0.05 it is considered significant. Therefore the 95% confidence interval will be applied to determine whether there is an association between variables. This is further illustrated by Blanche and Durrheim (2002) that a 95% confidence interval (CL) could be explained as "…a 95% probability that the actual mean of the larger population from which the sample was drawn lies within the range indicated by this value- either above or below the sample mean".

4.3 Section A: Biographical information

This section refers to personal data of the participant and it consists of seven questions with seven variables.

4.3.1 Question 1: Age

Table 4.1 shows the age range of the participants. The minimum of n=2 (2%) of respondents is between the ages 30-35 while the maximum n=19 (19 %) are between the ages 50–55 years. This finding is supported by the literature as Lichter cites Leibell and Phillips (Lichter, 2004:1299) in that breast cancer is a disease that is associated with increasing age and that a large portion of the risk occurs later in life. Lichter states that nearly 70% of cases diagnosed in women are aged 55 and older.

Table 4.1: Age range of participants (n=100)

Age range	n	%
30–35	2	2
36–40	11	11
41–45	9	9
46–50	7	7
51–60	11	11
61–65	17	17
66–70	14	14
71–75	8	8
76–80	1	1
81–85	1	1
TOTAL N	**100**	**100**

4.3.2 Question 2: Race

Table 4.2 shows the ethnicity profile of the respondents indicating that the majority n=83 (83%) were of the Coloured group, and only n=2 (2%) of the respondents were black. The current ethnicity of the Western Cape Province shows that the Coloured group is in the majority namely 53.9% which explains the rationale for the high number of respondents being Coloured (Western Cape Demographics, 2008).

Table 4.2: Race

Race	n	%
African	2	2
Coloured	83	83
White	15	15
TOTAL N	**100**	**100**

4.3.3 Question 3: Level of education

Table 4.3 shows the education level of the respondents indicating that the majority n=53 (53%) of the respondents were illiterate by definition. Literacy as defined by the Central Statistical Department (2000) indicates that any person 15 years and older with less than seven (7) years of formal schooling up to and including Grade VI are considered illiterate.

Table 4.3: Level education

Level of education	n	%
No schooling	9	9
Grade I-VI	44	44
Grade VII-XII	45	45
Tertiary education	2	2
Total N	**100**	**100**

4.3.4 Question 4: Home language

Table 4.4 shows the language profile of the respondents indicating that the majority 90 (90%) have their first language as Afrikaans. The demographics of the Western Cape Province show that Afrikaans is the dominant language spoken (Western Cape Demographics, 2008).

Table 4.4: Home language

Home language	n	%
Afrikaans	90	90
English	8	8
Xhosa	2	2
Total N	**100**	**100**

4.3.5 Question 5: Illnesses

Table 4.5 shows that n=57 (57%) of the respondents have diabetes mellitus which may influence the overall healing process of the patient with cancer of the breast.

Yancik, Wesley, Ries, Havlik, Edwards and Yates (2001:888) found that breast cancer patients with diabetes were more likely to die prematurely from breast cancer than were patients without diabetes which suggests that, besides affecting the incidence rate, diabetes also promotes breast cancer mortality, possibly by accelerating cancer growth through altering growth hormones.

Table 4.5: Illnesses

Illnesses	n	%
Diabetes Mellitus	57	57
Heart disease	14	14
Eye problems	7	7
Other	22	22
TOTAL N	**100**	**100**

4.3.6 Question 6: Hospitalisation

Table 4.6 shows the maximum period of hospitalization as 1-2 weeks n=40 (40%)

The minimum hospitalization period is 1 week n=33 (33%).

Table 4.6: Hospitalisation

Hospitalisation	n	%
1 week	33	33
1–2 weeks	40	40
2–3 weeks	14	14
3–4 weeks	9	9
> 4 weeks	4	4
TOTAL N	**100**	**100**

4.4 Section B: Barriers to communication

In this section of the study the emphasis is on the barriers that prevented effective communication between the nurse and the patient as described.

4.4.1 Question 34-36 (n=100)

4.4.1.1 Question 34: As a patient you did not feel free to ask something

Table 4.7 shows that n=44 (44%) of the respondents disagreed that they did not feel free to ask something. A Spearman correlation shows that there is moderate association with no significance between the level of education and speaking freely to the nurse (rho= -.03; p=0.76). Registered nurses are responsible for the nature and quality of all nursing care patients receive. It is important for patients to feel free to communicate with the nurse to ensure that communication between the nurse and patient is promoted. The implication of failing to communicate may result in the loss of valuable information. Ross and Deverell (2004:121) suggest that the patient should be encouraged to talk in order to discuss what is on their minds.

4.4.1.2 Question 35: The registered nurses were to busy to speak to you

Table 4.7 shows that n=64 (64%) of the respondents disagreed that nurses were too busy, however n=36 (36%) indicated that nurses were too busy. Although nurses are compelled to complete various tasks and objectives by the end of their shift, this does not prevent them from being transparent and delivering a service whereby they anticipate the client’s needs (South Africa, 1997).

4.4.1.3 Question 36: There were adequate nursing staff to deliver quality nursing care in the ward

Table 4.7 shows that n=87 (87%) of the respondents agreed that there were adequate nursing staff. A Spearmen correlation shows that there is no statistical significance between any of the variables. Developing and expanding knowledge in the area of nurse–patient communication may contribute to the improvement of nurses' communication skills and thus to better quality of care provided by oncology nurses, providing that there are adequate staff to deliver this service.

4.4.1.4 Discussion

The majority of patients n=87 (87%) indicated that there were enough staff yet patients n=44 (44%) did not feel free to talk to the nurses. If the nurse is the person ostensibly responsible for the patient's care, she should be able to establish rapport especially if there are adequate nursing staff in the ward.

Table 4.7: Question 34-36 (n=100)

Question	Type	Disagree	Agree
34	Feel free to ask	56	44
35	Nurses were to busy	64	36
36	Adequate nursing staff	13	87

4.4.2 Questions 37-41 (n=100)

4.4.2.1 Question 37: The nurse showed an authoritative attitude

Table 4.8 shows that n=82 (82%) of the respondents agreed that nurses had an authoritative attitude. A Spearmen correlation shows that there is a moderate association but with no significance between any of the variables. As stated in the literature by Petersen and Wadell (1998:294), the respondent at this level is only concerned in complying with the nurse's instructions and regards the nurse as someone who knows more, and that they should only comply with the instructions.

Individual patients identify with nurses and expect them to offer direction during the current difficulty they are experiencing (Peplau, 1952:49). In doing so the respondent wants the nurse to relate to them and not in dictating to them all of the time.

4.4.2.2 Question 38: The registered nurse had a positive interpersonal relationship with you

Table 4.8 shows that n=81 (81%) of the respondents agreed that nurses had a positive interpersonal relationship with them. Morrison (1997:6) found that some ways of thinking about the patients were depersonalising and made patients feel like objects. It is therefore important that the nurse maintains a positive interpersonal approach when interacting with the respondent.

4.4.2.3 Question 39: The registered nurse understands the uniqueness of every patient

Table 4.8 shows that n=59 (59%) of the respondents disagreed that nurses understand the uniqueness of every patient. The nurse's primary responsibility is to those people who require nursing care. The nurse, in providing this care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected. Each and every patient is different from the other with their own special needs. Values are another important attribute to the ability of communicating effectively and in realising the uniqueness of the individual. Burkhardt and Nathaniel (2002:73) regard values as abstract ideals that function as important guiding principles. Values can be expressed overtly or can be manifested in an indirect way through verbal and nonverbal behaviour. Institutions generate values that embrace the profession. These are relayed to society and somehow will contradict the institution's value system if they cannot act on what they claim to have professed (e.g. caring behaviour in nursing). Personal values are the individual person's own value system and within nursing are more likely to be manifested in affective situations. Values can be acquired in both conscious and unconscious ways and being aware of one's own values in life, can teach us to discern which choices are rational, preconditioned or disruptive and will come to the fore in interacting with the patient.

4.4.2.4 Question 40: You developed a personal bond with the registered nurse

Table 4.8 shows that n=91 (91%) of the respondents disagreed that they developed a personal bond with the nurse. Ramos (1992:496) describes the nurse-patient relationship as a mutual, professional bonding or attachment between the nurse and the patient. Patients are not obligated to develop this kind of relationship, but the nurse however is expected to deliver and maintain a caring relationship.

4.4.2.5 Question 41: There was an open two way communication between you and the nurse

Table 4.8 shows that n=86 (86%) of the respondents agreed that there was an open two way communication between the nurse and the patient. A Spearmen correlation shows that there is no statistical significance between any of the variables. Wilkinson (1992: 36) states that “nurses not only need good skills, they also have to have an environment conducive to open communication”. Inability thereof, can deter the relationship and cause the communication to be one-way only.

4.4.2.6 Discussion

According to the results obtained to question 37, patients stated that the nurse does have an authoritative attitude, and question 38, the patients agreed that the relationship between them and the nurse was positive. Question 39, the patients disagreed that the nurse understands the uniqueness of every patient. Question 40 n=91 (91%) disagreed that they had a personal bond with the nurse and question 41 patients agreed that when they spoke to the nurse she responded complying with an open two way communication. According to Harris (1998:42) for effective patient education to occur there must be open communication between the professional nurse and the patient. In order for the professional nurse to promote this openness, she needs to be aware of the patients’ needs. Provisioning of health care in a hospital is focused on rendering quality patient care. In order for this to happen care needs to be patient -centred as the emergence of patient-centred care can be seen as mirroring the respect for the individual who will be valued (Binnie & Tichen, 1999:6-7).

Table 4.8: Questions 37-41 (N=100)

		Disagree		**Agree**	
Question	**Type**	**n**	**%**	**N**	**%**
37	Authoritative attitude	18	18	82	82
38	Positive interpersonal relationship	19	19	81	81
39	Nurses understand uniqueness of every patient	59	59	41	41
40	Developing a personal bond with the nurse	91	91	9	9
41	Open two way communication	14	14	86	86

4.4.3 Questions 42-47 (n=100)

4.4.3.1 Question 42: The nurse always smiled

Table 4.9 shows that n=82 (82%) of the respondents agreed that nurses always smiled. According to the Batho Pele principles as stated in the White Paper on the Transformation of

the Public Service (South Africa, 1997:15) it is important to be courteous and deliver service with a smile.

4.4.3.2 Question 43: The nurses tend to look at their watches when communicating with you

Table 4.9 shows that n=53 (53%) of the respondents agreed that nurses tend to look at their watches when they communicated with the patient. A Spearmen correlation shows that there is statistical significance between the level of education of patients and the nurses that tend to look at their watches when communicating to the patient (rho= - 0.29, p=0.00) and also between hospitalisation and the nurses that tend to look at their watches when communicating to the patient (rho= 0.28, p=0.01). Although the rho value remains low, this result can be considered as a moderate correlation. The p=0.00 indicates a strong significance. This indicates that in this modern day and age time is of vital importance. Baile (1995:30) found that nurses are unwilling or reluctant to understand how patients feel because they “would not understand”, or it “interferes with care and is time consuming and they have important tasks to do”. This ultimately can destroy the trusting relationship when nurses look at their watches and make clients/patients feel unimportant.

4.4.3.3 Question 44: The nurse was reliable and trustworthy

Table 4.9 shows that n=90 (90%) of the respondents agreed that nurses were reliable and trustworthy. n=10 (10%) of the respondents disagree. The worst thing in communication in the nursing of a patient, is when the nurse does not listen. This is considered negative and harmful behaviour. Not listening to a patient can mean the difference between life and death in a patient’s treatment.

The nurse needs to be reliable and trustworthy. She/he must listen to the patient and to what she is saying. It may be crucial no matter how insignificant the nurse thinks it may be.

4.4.3.4 Question 45: The nurse had an informal approach towards you as a patient

Table 4.9 shows that n=91 (91%) of the respondents agreed that nurses had an informal approach towards them as patients. With relation to the results it is evident that the patients are more comfortable with a less serious than a serious approach and prefer to converse with a nurse who has an informal approach.

4.4.3.5 Question 46: The registered nurse's body language was professionally acceptable in her approach towards you

Table 4.9 shows that n=95 (95%) of the respondents agreed that the nurse's body language was acceptable to them. According to Harris (1998:43) cancer patients are sensitive to health professionals' tone of voice and body language in determining whether the professionals care about them or whether they are being honest.

4.4.3.6 Question 47: The registered nurse availed herself when you were in need of care

Table 4.9 shows that n=82 (82%) of the respondents agreed that the registered nurse availed herself whenever they were in need of care. One of the nurse's duties is to "take care" (Searle, 2002:212) and in doing so needs to avail herself in order to assist the respondent in whatever quest she may have, depending on the relevancy of the request. Availability involves being there for the patients, not just being present in the wards, but having relationships, providing care, listening, assisting, encouraging and supporting the patient, as well as families and friends who seek clarity on the patients' progress. Being available includes communicating, caring and providing the necessary support that the patient needs.

4.4.3.7 Discussion

According to results obtained from questions 42, 44, 46 and 47, it is evident that the nurse's behaviour is not always 100% acceptable to the patient. In particular Berry (2004:69) states that warmth, caring, positive regard, lack of tension and non-verbal expressiveness appear to be the most important elements in establishing and maintaining a good working relationship. It is also evident that time plays a significant factor in the field of nursing and that the nurse whether consciously or unconsciously makes this known to the patient whilst interacting with the patient.

According to Purtilo and Haddad (2007:231), a patient's confidence will remain high for the health professional whom they realize is being guided and committed by their situation rather than slavishly following the clock. They continue to state that it helps to remind the patient at onset, the amount of time you have and what you need to accomplish in that time.

Question 45 however shows that patients prefer an informal approach. This is indicative of wanting a closer and more comfortable relationship than a formal, more distant relationship.

Table 4.9: Questions 42-47 (n=100)

		Disagree		Agree	
Question	**Type**	**n**	**%**	**n**	**%**
42	The nurse always smiled	18	18	82	82
43	The nurse tends to look at her watch while talking	47	47	53	53
44	The nurse was trustworthy and reliable	10	10	90	90
45	The nurse has an informal approach to you as patient	9	9	91	91
46	The nurse's body language is professional	5	5	95	95
47	The nurse availed herself when you were in need of care	18	18	82	82

4.4.4 Questions 48-56

4.4.4.1 Question 48: You were addressed accordingly e.g. Ms, Mrs

Table 4.10 shows that n=98 (98%) of the respondents agreed that nurses addressed them accordingly. This pertains to the Batho Pele principles (South Africa, 1997) of courtesy and when consulting the patient, respect has to be shown.

4.4.4.2 Question 49: The nurse seemed confident and made you feel comfortable

Table 4.10 shows that n=96 (96%) of the respondents agreed that the portrayal of an aura of confidence in the nurses seemed confident and made them feel comfortable. It is important that the nurse knows what she is doing in order not to harm the patient. The South African Nursing Council states in their Nursing Act (South Africa, 2005:37) that only registered persons may practice and anyone under this act who misrepresents him/herself to be competent to practise nursing in a capacity he/she is not registered for will be guilty of an offence. Nurses therefore have to be competent in whatever they do for the patient in order for them not to harm the patient.

4.4.4.3 Question 50: You received the registered nurse's full attention only when you approached her

Table 4.10 shows that n=85 (85%) of the respondents agreed that they received the professional nurses full attention only when they approached them. A Spearmen correlation shows that there is statistical significance between hospitalisation and receiving the professional nurse's full attention only when approached (rho= -0.26, p=0.01). This seems indicative of a strong downhill linear relationship, depicting that the nurse will pay attention when the patient is willing to communicate.

4.4.4.4 Question 51: The registered nurse had a more formal more rigid approach towards you

Table 4.10 shows that n=85 (85%) of the respondents disagreed that the professional nurses had a more formal rigid approach towards them. Patients want to be able to relay information to the nurses and converse with them and as the Batho Pele (South Africa, 1997) principles state the patient should be shown courteousness and a formal more rigid approach will not be conducive to building this relationship between the nurse and the patient.

4.4.4.5 Question 52: You were addressed in a rather unfavourable manner by the registered nurse

Table 4.10 shows that n=91 (91%) of the respondents disagreed that nurses had an unfavourable manner towards them when they were addressed. No ill person would want to be addressed in a rude or unfavourable manner, thus nurses need to convey respect and establish rapport with the respondent in order to enhance their relationship. Searle focuses her nurse-patient relationship on rapport (Searle, 2002:258) and contends that the nurse practitioners have to ensure in their nursing practice that both direct and indirect communications are conducive to sound practice (Searle, 2002:256).

4.4.4.6 Question 53: The nurse's facial expression was professional and congruent with what she/he had to say

Table 4.10 shows that n=92 (92%) of the respondents agreed that the nurse's facial expression was professional and congruent. When there is a mismatch between a nurse's experience of her thoughts and feelings and her awareness, this incongruence is called denial of awareness or defensiveness and is usually thought of as falseness or deceit (Smith, 1992:76). n=8(8%) of patients perceived the facial expressions of the professional nurses in the wards as not professional or congruent with what she/he had to say, although this percentage is not alarming, it still occurs.

4.4.4.7 Question 54: The nurse seemed genuinely caring when she approached you

Table 4.10 shows that n=93 (93%) the respondents agreed that nurses seemed genuinely caring whenever they were approached. A Spearmen correlation shows a statistical association between hospitalisation and the nurse who seemed genuinely caring when she approached the patient ($p=0.00$, $rho= -0.28$). It is important to realise that nursing a cancer patient has many psychosocial issues that the respondent has to deal with throughout their disease projectory. In being genuine the nurse is likely to deal with and help the client

resolve real problems. Genuineness also refers to the ability to be able to be real and honest with yourself and others and is based on a solid trusting relationship. Searle (2002:258) considers conditions such as rapport, (as described in question 4.4.22) including trust, respect, genuineness and empathy as essential towards the nurse-patient relationship that enhances communication.

4.4.4.8 Question 55: The registered nurse always seemed to be in a hurry

Table 4.10 shows that n=82 (82%) of the respondents agreed that the registered nurse always seemed to be in a hurry. Patients see interaction with the personnel as the basis of their treatment. According to Haggman-Laitila and Astedt-Kurki (1994:353-61) the important aspects of an interactive relationship for patients are cooperation, reciprocal discussion and an interest shown by the personnel. If the registered nurse always seems to be in a hurry, not much interest is shown on behalf of the patient.

4.4.4.9 Question 56: The registered nurse maintained good eye contact when she approached you

Table 4.10 shows that n=91 (91%) of the respondents agreed that the registered nurse maintained good eye contact whenever she approached them. According to Harris (1998:43) nonverbal feedback such as eye contact and having a goal in mind when conversing with patients are crucial.

4.4.4.10 Discussion

Results obtained to question 48, indicate that n=98 (98%) of the respondents agreed that they were addressed according to their title. Despite the fact that only n=2 (2%) disagreed, all consumers of healthcare should be treated with respect.

Results obtained to question 49 state that the respondents agreed that the nurse was competent and made them feel comfortable, while only n=4 (4%) disagreed. The Nursing Act ensures safe nursing care for the public. Furthermore, the White Paper for the Transformation of the Health System in South Africa (South Africa, 1997) emphasises the following critical areas for the nursing profession:

- to ensure that National Health priorities are addressed in all nursing education programmes in order to produce competent and skilled nurses who are lifelong learners and critical thinkers,
- to promote the ability of every nurse to evaluate and assure quality in her practice.

Results obtained to question 50 indicate that the respondents agreed that they only received the nurse's full attention when they approached her. Hospitalisation and the nurse who will give you her fullest attention when approached is statistically significantly correlated at the 1% level (p=0.01). Nurses should not wait on patients to approach them in order to know of any problem, but communicate to the patient in order to evaluate their condition on a daily basis and give appropriate feedback.

Results obtained to question 55 show an alarming high percentage of patients agreeing that the registered nurse always seems to be in a hurry. Being in a hurry restricts accessibility and limits the patient on interacting with the nurse.

Results obtained to question 56 states that respondents agree that nurses maintained good eye contact with them. Although only n=9 (9%) disagreed to this question, Duck (1993:11) quotes that "It is inappropriate, rude and extremely difficult to open up a conversation without looking at the person and having them look back". He continues to state that a person can decline to engage in a conversation merely by refusing to establish eye contact.

Table 4.10: Questions 48-56

		Disagree		**Agree**	
Question	**Type**	**n**	**%**	**n**	**%**
48	You were addressed according to your title	2	2	98	98
49	The nurse was confident and made you feel comfortable	4	4	96	96
50	Received the nurse's full attention only when you approached her.	15	15	85	85
51	The nurse had a formal and rigid approach towards you.	85	85	15	15
52	Addressed in an unfavourable manner	91	91	9	9
53	The nurse's facial expression was professional and congruent	8	8	92	92
54	Genuinely caring when approached	7	7	93	93
55	The nurse was always in a hurry	18	18	82	82
56	Maintained good eye contact	9	9	91	91

4.4.5 Question 57-65

4.4.5.1 Question 57: The registered nurse was often silent and only spoke when it was necessary

Table 4.11 shows that n=82 (82%) of the respondents agreed that nurses were often silent and only spoke when it was necessary. According to Mikanowicz and Shank (2008:20) silence can be of great value when it gives the respondent time to collect her thoughts or

allows the respondent time to consider alternatives. The professional who uses silence because of a lack of knowledge and skills to communicate effectively, must work through this problem before actively getting involved with the patient.

4.4.5.2 Question 58: Light-hearted social chatter made you feel at ease with the registered nurse

Table 4.11 shows that n=93 (93%) of the respondents agreed that light-hearted social chatter made them feel at ease with the registered nurse. A Spearmen correlation shows that there is a statistical significance between hospitalisation and the nurse who chatted light-heartedly (rho= -0.29, p=0.00). It is evident that the patients prefer the nurses to engage in light-hearted social chatter with them. Whether it to establish rapport or to gain their confidence n=93 (93%) stated that it made them feel at ease. Ross and Deverell (2004:121) state that it is also quite possible that respondents may want to talk about quite ordinary little things such as television programmes, sports, events or everyday subjects. Nurses should not be troubled if patients do not want to have a serious conversation at a particular time. Maree (2007:897) mentions that even though a patient may suspect their diagnosis, that they (patients) often cling to hope. Patients therefore might prefer light-hearted social chatter.

4.4.5.3 Question 59: The registered nurse avoided you at times

Table 4.11 shows that n=79 (79%) of the respondents disagreed that the registered nurse avoided them at times. n=21 (21%) agreed that nurses do avoid them at times.

The professional life of the nurse places demands on her as a qualified practitioner to be accountable as well as clinically effective, therefore she should not avoid the patient in delivering care. Once the professional nurse avoids the patient, she can be held accountable for anything that might happen to the patient, as such behaviour constitutes negligence which is punishable under the Nursing Regulation R387 (South African Nursing Council, 1985) as promulgated by the Nursing Act No 50 (South Africa, 1978), governing the acts and omissions in respect of which the Council may take disciplinary steps. In avoiding the patient, the professional nurse is also violating the patient’s trust in her as she does not have the patient’s interest at heart, irrespective of what the patient might need to discuss.

4.4.5.4 Question 60: There were times where the registered nurse could not speak to you for most of the day

Table 4.11 shows that the respondents agreed that the registered nurse could not speak to them for most of the day.

According to Kagan and Evans (1995) nursing practice consists of a series of rules and regulations governing role behaviour, both at a formal, explicit level and an informal, implicit level. Yam and Rossiter (2000:298) agree with this stating that task orientation virtually means that communicating with patients is a luxury.

4.4.5.5 Question 61: The nurse approached you in a boisterous manner in the ward

Table 4.11 shows that the respondents disagreed that the nurse approached them in a boisterous manner but n=4 (4%) indicated that nurses approached the patient in a boisterous manner in the ward. This is negative behaviour and should not occur at all. When patients are addressed in a loud manner whether it is privately or in front of other patients it indicates disrespect towards them. According to the Constitution of the Republic of South Africa (South Africa, 1996:6) it is their constitutional right to be treated with respect and dignity.

4.4.5.6 Question 62: You felt respected as an individual

Table 4.11 shows that the respondents agreed that they felt respected as an individual. It is unacceptable to have nurses no matter how small the percentage, in this case n= 4(4%) not to have respect for the patient. This is supported by the National White Paper on the Transformation of the Public Service (South Africa, 1997).

4.4.5.7 Question 63: You felt emotionally stirred up in the nurse’s presence

Table 4.11 shows that the respondents disagreed that they felt emotionally stirred up in the nurse’s presence, however n=17 (17%) agreed that they felt emotionally stirred up in the nurse’s presence. Patients are normally under much pressure due to their diseased bodies and should not be placed under more pressure, as this may be a deterrent to good patient care. Cancer patients are faced with many emotional and psychological dilemmas and nurses should not contribute to this dilemma by their behaviour. According to Pervan *et al.* (1995:644), nonverbal communication should be noted and the need for closeness must be observed or heard.

4.4.5.8 Question 64: The registered nurses made you feel uneasy

Table 4.11 shows that the respondents disagreed that the registered nurse made them feel uneasy, however n=21 (21%) of the respondents were made to feel uneasy by the registered nurses. Patients should never be made to feel uneasy as this may cause a breakdown in communication between the nurse and the patient, which may negatively influence the healing process. According to Pervan *et al.* (1995:644), listening to a patient and offering him/her empathy, and also identifying with the patient and understanding their feelings may

offer relief and reduce stress. This however, is only possible if the patient is comfortable in the nurse's presence.

4.4.5.9 Question 65: The nurse took you at face value and communicated what she deemed necessary

Table 4.11 shows that the respondent agreed that the nurse took them at face value and communicated what she deemed necessary. A Spearmen correlation shows that there is a statistical significance between the level of education and the nurse who took the respondent at face value and communicated what she deemed necessary (rho=0.29, p=0.00). Communication which is influenced by the level of education may result in a loss of valuable information if it is hampered. According to Veronessi *et al*. (1999:1667-1675) research has shown that patients' personality, demographic characteristics and level of knowledge all influence the extent to which professionals decide to give information to their patients.

4.4.5.10 Discussion

A nurse according to the Nursing Act No 33 (South Africa, 2005) is a licensed person who is registered with the Nursing Council based on completion of a recognized education and training programme. The training includes information on how to nurture, assist and treat the client who can be an individual, family or group, sick or well, in the performance of those activities that contribute to the attainment or maintenance of health, to optima recovery and rehabilitation or to peaceful, dignified death. In doing so the nurse should be able to converse with the patient, not avoid the patient, be silent and only speak when necessary, make the patient feel disrespected, uneasy or emotionally stirred up in their presence. The nurse should emanate care and the respondent should feel comfortable in their care at all times. Respectful behaviour should not be ephemeral in the field of nursing.

The White Paper on the Transformation of the Public Service (Batho Pele) introduced in 1997, is aimed at improving the delivery of public services, including health care. "Batho Pele" means "people first" and these principles (South Africa, 1997:15) cover the following areas of public service (health care) delivery that is applicable to the study namely:

- Consultation: clients/patients should be consulted about the level of service they receive and be given choices of service offered.
- Service Standards: people should be told what level and quality of service they will receive so that they can know what to expect.
- Courtesy: Patients deserve dignity, courtesy, consideration and respect.

- Information: Give full information to clients or patients regarding the service they are entitled to receive.
- Openness and Transparency: All information and reports should be available for patients or clients.

It is therefore important that patients or clients are treated as the consumers of the health care service requiring the nurse to approach, address, respect and treat the client accordingly.

Table 4.11: Question 57-65

		Disagree		Agree	
Question	**Type**	**n**	**%**	**n**	**%**
57	The nurse was often silent when working with you and only spoke when necessary	18	18	82	82
58	Light-hearted social chatter made you feel at ease	7	7	93	93
59	The nurse avoided you	79	79	21	21
60	There were times when the nurse could not speak to you for a big part of the day	16	16	84	84
61	Approached you in a boisterous manner (loudly)	96	96	4	4
62	Felt respected as an individual	4	4	96	96
63	Felt emotionally stirred up in the nurse’s presence	83	83	17	17
64	The nurse made you feel uneasy	90	90	10	10
65	Took you at face value and communicated what she deemed necessary	55	55	45	45

4.4.6 Questions 66-75

4.4.6.1 Question 66: The nurse assessed your condition and progress daily

Table 4.12 shows that n=74 (74%) of the respondents disagreed that the registered nurse assessed their condition and progress daily. However, 26 (26%) indicated that the nurse did not assess their condition and progress on a daily basis. The Nursing regulation R2598 (South African Nursing Council, 1984) as promulgated by the Nursing Act No 50 (South Africa, 1978), states that the registered nurse shall entail “the treatment and care of and the administration of medicine to a patient, including the monitoring of the patient’s vital signs and of his reaction to disease conditions, trauma, stress, anxiety, medication and treatment”. If the nurse does not assess the patient’s condition and progress daily, she is not performing the above procedure applicable to health care practice. The Wiedenbach's prescriptive theory (1977), as translated by Bennett and Foster in George (2002:217), described in paragraph 2.4, states that the art of nursing is a goal-directed activity requiring the application of knowledge and skill toward meeting a need for help experienced by a patient. It is the registered nurse's duty to prescribe, implement and evaluate nursing care plans

according to the patient's illness and needs. If this is not done on a regular basis the patient might lack receiving appropriate care, delivered by the nurses.

It is important that the registered nurse assesses the patient on a daily basis in order to address her/his goals and to allow the patient to verbalize any stressors or concerns they might be presented with. In daily assessing their coping abilities or questions, the patient will not only feel empowered but value the attention and knowledge they gain within the rather difficult circumstances they are presented with.

4.4.6.2 Question 67: You were timeously informed by the registered nurse of any decision or changes in your treatment

Table 4.12 shows that n=78 (78%) of the respondents disagreed that the registered nurse timeously informed them of any decision and changes in their treatment. The odds ratio (3.02) would indicate that the respondents are more likely to disagree than agree on this issue. According to Berry (2004:71), decision-making entails the patient’s active involvement in medical decision-making. Patients need to participate in order to find common ground regarding their management. With 78% of respondents disagreeing, it is evident that professional nurses are not on par with involving the patients or informing them of any decision or changes in their treatment. The National Department of Health introduced the Patient’s Right Charter, which lists the rights of patients such as the right to participation and decision-making. Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one’s health (South Africa, 1999).

4.4.6.3 Question 68: The registered nurse made you feel involved and informed at all times

Table 4.12 shows that n=66 (66%) of the respondents disagreed that the registered nurse made them feel involved and informed at all times. Sharing information is an important component of the interpersonal relationship. Information is important for the respondents because it helps to reduce their sense of uncertainty and it supplies them with a framework for understanding events around them. Although these results are not statistically significant, a higher percentage of respondents are disagreeing that they are involved and informed. To make the patient feel involved constitutes active participation and more than half of the patients disagreed to this fact. To make the patient feel involved, is a prerequisite for optimal nursing care and with the evidence from the collapsed data this is a fundamental aspect that needs attention. (Harris, 1998:40).

4.4.6.4 Question 69: The clinical registered nurse can be seen as a role model with regard to patient care

Table 4.12 shows that n=56 (56%) of the respondents disagreed that the registered nurse can be seen as a role model with regard to patient care. The role the registered nurse plays in this regard is of profound importance. By being a role model even through the complexities of cancer, nursing not only will enhance the quality and quantity of care the patient with breast cancer receives, but also the impact it might have on both the patient and that of the junior staff. The patients' perception of the nurse can encapsulate that of the different roles she has to play in order to ensure the patients' safety and quality of care they receive. The respondent will disagree that the registered nurse is a role model with regard to patient care if she cannot display the following features of being a role model by:

- teaching those she works with to prevent unskilled or unauthorised persons from performing functions that may harm the patient
- being accountable
- establishing and maintaining professional standards
- upholding the efforts of her profession
- providing nursing care in accordance with the human need and with respect for the dignity of the human being irrespective of their race, creed, nationality, or social standing
- developing her professional competence and assisting other nurses in doing so (Searle, 2002:159).

4.4.6.5 Question 70: The registered nurse encouraged you to voice your ideas, listen to them and reflect for collaboration

Table 4.12 shows that n=68 (68%) of the respondents disagreed that the registered nurse encouraged them to voice their ideas, listen to them and reflect for collaboration. A Spearmen correlation shows that there is a statistical significance between hospitalisation period and the nurse who encourages the respondent to voice her ideas, listens to them and reflect for collaboration ($p=0.00$), which shows a 99% probability. According to Mikanowicz and Shank (2008: 23) collaboration consists of sharing in planning, making decisions, solving problems, setting goals, assuming responsibilities, working together cooperatively and communicating openly. With collaboration the results are positive, communication is satisfying and the relationship is strengthened. With the data obtained, it shows a 99% probability that the period of hospitalisation and for the registered nurse to encourage the patient to voice ideas, listen to them and reflect for collaboration, is significant ($p=0.000$).

4.4.6.6 Question 71: The registered nurse was patient when she explained the procedures and health information to you

Table 4.12 shows that n=69 (69%) of the respondents agreed that the registered nurse was patient when she explained the procedures and health information to the respondent, but 31 (31%) disagreed which is a concern for patient care. Each respondent has own form and level of adaptability and in processing information, thus the nurse in providing information and explaining procedures should do it in a manner whereby the respondent can absorb, understand and clarify what the nurse has said. Timonen and Sihvonen (2000: 543) found that poor nurse-patient communication led to non-participation by patients, which also increased patient's anxiety and insecurity.

4.4.6.7 Question 72: You could approach the registered nurse with questions

Table 4.12 shows that n=42 (42%) of the respondents disagreed that they could approach the registered nurse with questions without feeling hesitant. According to Berry (2004:87), the main objective of self-empowerment is to empower individuals to make healthy choices so that they can increase control over their physical, social and internal environments. Unapproachable behaviour demonstrated by registered nurses obstructs open communication between the nurse and the patient which may prevent the patient from posing valuable questions about her ill condition, which may have promoted the healing process.

4.4.6.8 Question 73: The communication between you and the registered nurse contributed to your general wellbeing

Table 4.12 shows that n=77 (77%) of the respondents disagreed that the communication between the registered nurse and them contributed to their general wellbeing. Effective communication between health professionals and respondents is essential if patients are to receive the information and support they need to cope with a cancer diagnosis (Gysels, Richardson & Higginson, 2004:692-700).

4.4.6.9 Question 74: You felt safe in the nurse's care

Table 4.12 shows that n=94 (94%) of the respondents agreed that they felt safe in the registered nurse's care. As discussed in the literature review (paragraph 2.5), Flook (2003:160) mentions that the regulation of nursing is there to protect the nursing profession and the public. Today the primary purpose is still the protection of the public through defining nursing practice by approving nursing education, and overseeing the competence of nurses

through registration and disciplinary rules and regulations. Ultimately the safety of the patients must remain at the centre of the regulatory debate.

4.4.6.10 Question 75: The registered nurse took their personal baggage out on you

Table 4.12 shows that n=92 (92%) of the respondents disagreed that the registered nurse took their personal baggage out on them. Because cancer provokes fear and uncertainty of the future, Bodkin and Arunachallam in Stellenberg & Bruce (2007:282) states that no respondent should have to experience the personal inadequacies of professional staff especially nurses who are more with the patient than any other profession within the health sector.

4.4.6.11 Discussion

Results obtained to question 66, indicate that the respondents disagree that the professional nurse assessed their condition and progress daily, with only n=26 (26%) agreeing. Nurses should be trained and educated in order to be able to work with human life. It becomes part of the nurse's independent functions (Searle, 2002:162).

Results obtained to question 67, show that the majority of respondents are disagreeing about being timeously informed about any decision or changes in their treatment. According to Pervan *et al.* (1995:738), health education should be a continuous component of all health-care activities. In order for the patient to be part of their treatment, they need to be informed as they are active participants in their quest for health.

Results obtained to question 68 indicate that respondents disagree that they felt involved and informed at all times, while n=34 (34%) agreed. According to Pervan *et al.* (1995:741), it is vital to give the patient information, to explain what is to be expected and what is being done to enable her to cope effectively.

Results obtained to question 69 indicate that the respondents do not regard the nurse as a role model whereas n=44 (44%) agreed that they do regard the nurse as a role model. Searle (2002:144) states that the nurse as a role model should be competent, concerned and compassionate and be able to provide comprehensive nursing within a legal and ethical parameter.

Results obtained in question 70 relay that a large percentage of respondents stated that they are not encouraged to voice their ideas, that they are not being listened to and that they cannot reflect for collaboration. Patient teaching is an integral part of patient-care and should help the respondent to find meaning in illness. Mutual understanding and collaboration are

essential features of the nurse-patient relationship, which bring together the nurse's compassion and knowledge and the patient's experience of her situation. The respondents however, as stated according to results obtained to questions 66, 67 and 68 said that they were not involved, informed or assessed.

Results obtained to question 71 of whom n=69 (69%) agreed, stated that the nurse was patient in explaining procedures or giving health information, and although only n=31 (31%) disagreed, the growing interest shown by respondents in the area of information should make the nurse aware that this interest to acquire new knowledge, attitudes and behaviours will improve the patient's ability to adapt to living with a chronic disease. According to Davis, Williams, Marin, Parker and Glass (2002:134-149), patients with poor health literacy may have difficulty in comprehending information especially if it contains unfamiliar vocabulary or concepts. The nurse therefore has to be patient in explaining procedures or in giving health information to the patient.

Results obtained to question 72 show that almost half of the respondents disagree that they could approach the nurse with questions at any time without feeling hesitant. Wright (1995:599) emphasises that the patient "should be encouraged to make independent decisions, nurses should acknowledge their autonomy and act as nondirective facilitators, supporting the patient's choices. The latter is an example of patient empowerment and the respondent should not feel that they are unable to approach or ask questions of the nurse. This carries direct relation to the Batho Pele principles (South Africa, 1997:15) pertaining to information.

Results obtained to question 73 state that the respondents disagree that the communication between them and the nurse contributed to their wellbeing. According to Henderson (1977) as quoted in Stellenberg (1995:65) states that teaching is inherent in everything that the nurse does. The nurse's constant purpose should be kept in mind in order to restore the patient's independence whereby guidance, training or education are part of the basic care of all who present themselves for treatment. In caring for the patient holistically and using effective communication, can the nurse contribute to the patients' wellbeing.

Results obtained to question 74 indicate that the respondents felt safe in the nurse's care. Searle (2002:74) states that in order for knowledgeable, competent, legally and ethically safe nursing care to be provided, it requires commitment from the nurse in providing empathetic nursing care. Nurses break their trust with the patient and society when they practice in an incompetent, negligent or unethical manner, withholding their services from patients and

exposing the patient to potential harm. It is therefore important that patients be and feel safe in the nurse's care.

Table 4.12: Questions 66-75

		Disagree		Agree	
Question	**Type**	**n**	**%**	**n**	**%**
66	Assessed your condition and progress daily	74	74	26	26
67	Timeously informed of any decision or changes in your treatment	78	78	22	22
68	Felt involved and informed at all times	66	66	34	34
69	The nurse seen as a role model in patient care	56	56	44	44
70	Encourage to voice ideas, listen to them and reflect for collaboration	68	68	32	32
71	The nurse was patient in explaining procedures or giving any health information	31	31	69	69
72	You could approach the nurse with questions at any time without feeling hesitant	42	42	58	58
73	Communication between you and the nurse contributed to your well-being	77	77	23	23
74	Felt safe in the nurse's care	6	6	94	94
75	The registered nurse took their personal baggage out on you	92	92	8	8

4.4.7 Questions 76-84

4.4.7.1 Question 76: The nurse provided you with information relevant to your illness

Table 4.13 shows that n=65 (65%) of the respondents disagreed that the registered nurse provided them with information relevant to their illness. A Spearmen test correlation shows that there is a statistical significance between the period of hospitalisation and the nurse providing the patient with information relevant to her illness (p=0.03). Jensen, Madsen and Andersen and Rose (1993:2236) state that detailed information about the treatment reduced the patients' anxiety and improved their understanding.

4.4.7.2 Question 77: The registered nurse provided your family with relevant information to assist you.

Table 4.13 shows that n=91 (91%) of the respondents disagreed that the registered nurse provided their family with relevant information. A Spearmen correlation test shows that there is a statistical significance between hospitalisation and the registered nurse who provided the patient's family with relevant information to assist the patient (p=0.00) and between education and the registered nurse who provided the patient's family with relevant information to assist the patient (p=0.02). The results clearly indicate that irrespective of the

level of education or the hospitalisation period, the registered nurse does not provide the family with relevant information. Family members can have misconceptions about the illness therefore information is vital for the family in order to build an accurate representation of cancer. Illnesses such as cancer can have major disruptions and may alter family relationships, expectations and responsibilities. By not providing the family with information (educating them), the total comfort of the patient may be disturbed and therefore their quality of life. Total health can be referred to as the holistic health of the patient encompassing the psychological, spiritual, physical and social dimensions. When there is a deficit or problem in one dimension, it will affect all other dimensions. From a family systems perspective, what happens to one family member always affects other family members. How the family confronts and manages a stressor such as breast cancer would determine the survival and the well-being of the entire family. Family support during the difficult times of their ailment is of vital importance to patients (Stewart, Brown, Weston, McWhinney, McWilliam & Freeman, 2003:64). There are lasting effects on quality of life, which include: changes in appearance causing physical and emotional discomfort, ongoing concern about health years after treatment has ended, psychological distress and ongoing challenges for the entire family in coping with these effects (Mellon & Northouse, 2001:446-459).

Therefore, providing the family with the relevant information in order to assist the respondent is important. According to Walsh (2002:130-137) crises and stresses can, however, derail family functioning and affect relationships between family members. The Nursing Regulation R2598 (South African Nursing Council, 1984) as promulgated by the Nursing Act No 50 (South Africa, 1978) state that the registered nurse should ensure the facilitation of the attainment of optimal health for the individual, the family, groups and the community in the execution of the nursing regimen. In doing so, the registered nurse should ensure the communication between her and the family irrespective of whether it is to inform or to educate.

4.4.7.3 Question 78: The nurse was aware of your health status and your ability to speak

Table 4.13 shows that n=98 (98%) of the respondents agreed that the registered nurse was aware of their health status and their ability to speak. According to the Western Cape Language Policy (2005) professionals have to ensure that the Western Cape is a caring home for all by promoting multilingualism, support the Batho Pele initiative of impartial service delivery by promoting equal access to public services and programmes by removing communication or language barriers; and give increasing effect to the equal constitutional status of the three official languages of the Western Cape.

4.4.7.4 Question 79: The registered nurse communicated with you at your personal level of functioning

Table 4.13 shows that n=97 (97%) of the respondents agreed that the registered nurse communicated with them at their personal level of functioning. According to the Batho Pele principle of consultation (listening to the clients' problems) the nurse should be able to speak to the respondent at a level understandable to them (South Africa, 1997). The Constitution of the Republic of South Africa (South Africa, 1996:15) makes it clear that everyone has the right to use the language and to participate in the cultural life of his/her choice. The Constitution also states that each person has the right to instruction in the language of his/her choice where this is reasonably practicable.

4.4.7.5 Question 80: As a patient you understood what the nurse was saying or trying to say

Table 4.13 shows that n=96 (96%) of the respondents agreed that they understood what the nurse was saying or trying to say. According to Harris, 1998:41), "whenever information is not presented in an appropriate manner, (that) patients may not comprehend or retain it". They continue to state that information that distresses the patient often registers poorly and is forgotten. The nurse needs to consider not only the respondent's language but educational level and psychological adjustment to her illness when they are trying to educate or pass on information to the respondent.

4.4.7.6 Question 81: Whatever you did not understand was clarified by the nurse

Table 4.13 shows that n=85 (85%) of the respondents agreed that whatever they did not understand was clarified by the nurse. Patients need to thoroughly understand their illnesses before making decisions. Patients should be well informed about their illnesses so that they can co-operate during treatment and all interventions (Verwey & Crystal, 1998:34). Communication is a way of understanding others and wherein the receiver feels confident to ask questions and clarify doubts (Mendes, Trevizan, Nogueira & Sawada, 1999:640).

4.4.7.7 Question 82: Appropriate health education was given to you by the registered nurse on discharge

Table 4.13 shows that n=67 (67%) of the respondents agreed that the registered nurse gave them health education when they were discharged. With regard to the scope of the profession (Paragraph 2.5), it is clearly outlined in the Charter of Nursing Practice (South African Nursing Council, 2004:47). Each category is outlined and describes the nursing care they should render to any individual or member of the public that can make use of their

services. This is important as nursing is a regulated profession which forms an integral part of a comprehensive health care system practiced by persons registered under the nursing act. According to Searle (2002:141), the manner in which each nurse practices her profession will articulate the nursing profession's unique contribution to society. Searle (2002:116) continues by saying that defining the scope of practice of professions for each category of nursing, it is essential that only persons registered in that profession may perform the acts pertaining to the profession. As a professional nurse that works in the ward it becomes the duty of the registered nurse to act as a teacher and provide the respondent with appropriate health information in order to equip them for their discharge or rehabilitation.

4.4.7.8 Question 83: You understood what you had to do to take care of yourself at home

Table 4.13 shows that n=77 (77%) of the respondents agreed that they understood what to do to take care of themselves at home, however 23% disagreed. This is a large percentage of patients who after such complex therapy is not well informed to take care of themselves at home. It is clear that a deficit exists in patient education. It is imperative that the respondents understand what to do in order to take care of themselves, otherwise all aspects of teaching and providing information will be lost. According to Mossman, Boudioni and Slevin (1999:1588), the provision of information is considered to be a therapeutic intervention and is part of standard care. This will not only help the patient to cope better with her disease but attend to her immediate needs as well.

4.4.7.9 Question 84: You were assisted from a state of dependency towards one of independence

Table 4.13 shows that n=74 (74%) of the respondents disagreed that they were assisted from a state of dependency to one of independence. Cancer nursing focuses on the needs of patients and in caring for them from all dimensions. Mills and Sullivan (1999:632) consider information on treatment and side-effects, extent of the disease, prognosis, and self-care to be the most relevant for cancer patients. Self-care is synonymous with rehabilitation. Nursing may be needed when patients need to incorporate newly prescribed, complex self-care measures into their self-care system, when the individual needs help in recovering from disease or injury or in coping with their effects (Foster and Bennett in George, 2002:129). Breast cancer patients are not only facing a complex but unpredictable disease that requires long term treatment. Post mastectomy patients can for example experience complications such as a stiff arm, lymphedema (collection of fluid in arm) or infection at the wound site if no proper wound care has been done. To discharge a patient without incorporating the

necessary skills of how to look after themselves, that is post treatment, constitutes negligence on behalf of the nurse.

4.4.7.10 Discussion

Question 76 states that the respondents disagreed that they were provided with information relevant to their illness. The Nursing Regulation R2598 (South African Nursing Council, 1984), as promulgated by the Nursing Act No 50 (South Africa, 1978) stipulates that the scope of practise of a registered nurse shall entail the prevention of disease and promotion of health and family planning by teaching to and counselling with individuals and groups of persons. The individual will be the patient concerned and therefore it becomes fundamental that the nurse practises her four-fold function of which teaching is imperative in providing optimal care.

Results obtained to question 77 relay information given to the respondent's family and indicate that the respondents disagree that their families were provided with information and helpful measures to assist them. According to Harris (1998:40) patients with cancer and their families consider healthcare professionals a primary, trusted source of information, therefore nurses must make optimal use of their roles as educators. Harris further contends that patient education is about fostering autonomy and the family can gain information through this process by becoming familiar with situations with which they were not previously familiar.

Results obtained to question 78 states that the nurses were aware of the patient's ability to speak. Nurses need to be aware of whether the patient can speak or not, as it becomes an important factor within the axiom of verbal communication. It also becomes important in her ability to teach the patient and the skills necessary to do so. According to Brown, Butow, Henman, Dunn, Boyle and Tattersall (2002:236-245) there is a need to develop interventions that can meet the individual patient's communication style and strengths in order for their communication goals to be met.

Results obtained to question 79 state that n=97 (97%) of respondents agreed that nurses communicated to them at their personal level of functioning. This excludes using complicated medical language but rather using simple understandable language which the patient can understand. The patient needs to understand in order to comprehend what is happening and what they need to do.

Results obtained to question 80, depict whether the patient understood what the nurse was saying and n=96 (96%) agreed. Searle (2002:149) conveys that the ultimate goal of education is not accumulated knowledge, or merely technical expertise, but in the

development of wisdom, which she continues to state that it is knowledge transmuted into understanding.

Results obtained to question 81 state that the respondents agreed that clarification took place whenever they did not understand. It is important that the patients know what is happening to their own bodies in order to be able to participate in their own healthcare. n=15 (15%) indicated that nurses do not clarify information with them, leaving them without understanding of what is happening to themselves.

Results obtained to question 82, respondents stated that they received health education. Maree in Stellenberg and Bruce (2007:912) states that proper coordination and integration of services are needed in order for the cancer patient's journey through the healthcare system, thus effective communication and discharge planning is essential to optimal care.

Results obtained to question 83 indicated that the respondents said that they understood what they had to do once being discharged, but n=23 (23%) disagreed that they were not informed appropriately. Inadequate information provided on discharge can impact on the healing process of the patient especially if the patient does not know what to do, ultimately affecting their compliance.

Results obtained to question 84 however state that of the respondents disagreed with being assisted from a state of dependence to one of independence. This is a large number of patients to disagree, indicating that the issue of rehabilitation which flows from this question has not been attended to. Normalisation according to Bauer (1989:24), is a challenge to the service providers and communities to find ways of meeting the needs of people appropriately and assisting them to be able to function optimally once discharged.

Table 4.13: Questions 76-84

		Disagree		Agree	
Question	**Type**	**n**	**%**	**n**	**%**
76	You were provided with information relevant to your illness	65	65	35	35
77	Family was provided with information and helpful measures to assist you	91	91	9	9
78	The nurse was aware of your health status and the ability to speak or not	2	2	98	98
79	The nurse communicated at your personal level of functioning	3	3	97	97
80	You always understood what the nurse was saying	4	4	96	96
81	Whatever was not understood was clarified	15	15	85	85
82	Health education was given to you	33	33	67	67
83	You understood what you had to do once discharged	23	23	77	77
84	You were assisted from a state of dependency to one of independence	74	74	26	26

4.5 Conclusion

In this chapter the data was analysed and interpreted. Data is presented in tables, histograms and frequencies.

The aim of the study was to investigate factors influencing communication between the patient with breast cancer and the nurse. In this chapter the research question concerning, the factors that influence the communication between the patient with breast cancer and the nurse, is addressed. The following objectives have been met - the manner in which communication was relayed from the ward nurse, whether barriers exist to communication and the participant's perception of the communicative processes they experience with the nurse. Communication is an inevitable phenomenon that has to feature in the work of a health professional. With the advancement of health care, so the need to communicate with patients about their clinical and non-clinical aspects of their care has grown. Working with patients every day encompasses verbal and nonverbal elements which the patients observe.

Chapter five concludes the study and makes recommendations for practice and further research.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of this study was to identify factors influencing communication between the patient with breast cancer and the nurse. This chapter discusses the conclusions with reference to the objectives and findings of the study and provides recommendations for practice and for further research, based on the scientific evidence obtained through this study.

5.2 Discussion

The discussion will be presented according to the objectives guiding the study and in relation to the Interpersonal theory of Peplau (1952:n.p.).

5.2.1 Objective 1: To determine the manner in which communication is relayed from the ward nurses

For many people, the diagnosis of cancer equates to a death sentence. Existential concerns, considering life and death, can predominate at this time. Communication cannot be regarded as a separate entity and is entwined in all the work the nurse does. Nursing is an interpersonal and interrelated activity that is constructed based on the patient's goals and needs. Careful attention should not only be given to spoken words, but to the speaker's body language. It is also evident that verbal and nonverbal messages can be exchanged at the same time; therefore they are interrelated and cannot be separated.

To determine the manner in which communication is relayed within this realm, the communication is not restricted to facts, diagnosis, treatments and likelihoods of recovery, but include the nonverbal forms of communication such as listening, gesturing, facial expression and tone that express the human condition of health and illness.

Deduced from the study communication between the health-care professional nurse and the patient with cancer of the breast should grow in both importance and sophistication. The first objective focuses on issues mainly governing respect and rapport building and how the nurse physically, verbally and non-verbally address the patient to identify areas in which the communication is still hopeful yet unsatisfactory.

Although relatively little has been written about the impact of communication between the nurse and the patient, or the factors influencing it, this study has been directed towards the more acutely to chronically ill patient in the ward.

The component under scrutiny which is iterative and occurs within a ward setting includes not only what has been said, but also the manner in which it was said including the body language accompanying the content of which was said by the nurse.

The results are obtained in questions 34-41 pertaining to the kind of relationship the respondent had with the nurse, questions 42-65 pertaining to the manner in which the respondent was approached and spoken to by the ward nurse. Questions 34-65 pertained to both components of verbal and non-verbal communication and how the client was approached show that the respondents were generally satisfied with the manner in which they were approached.

From the results as obtained and stated in question 45, respondents prefer to be approached informally. Question 46 also states that the respondents considered the nurse's body language as acceptable. There are numerous aspects to take into consideration when working with human beings. If the nurse's work encapsulates working with the client and looking after the client from a holistic perspective, there should not be any disconcerted aspects within the field of communication. The South African Government set the stage for practising patient-centred care within the health care delivery system by introducing the "White Paper on the Transformation of the Public Service" (South Africa, 1997) otherwise known as Batho Pele. Batho Pele indicates that people should be put first and one of the principles deals with being courteous to all citizens using health care facilities within the public domain.

Nurses should be exemplary to the public with regard to caring ability and professional conduct. Suffice to say the one complements the other and by involving the client as an active participant in their health-illness continuum, there would be a significant contribution to a ward environment where the patient's voice and input are of immense value. The patient looks at the nonverbal messages as one configuration of messages and not as a separate entity. To be able to communicate effectively requires the acquisition of new kinds of skills. The professional nurse should develop skills in realizing that patients regard the nurse's presence as important. In this way she will be able to value each patient as a unique human being experiencing situations unique to her own human circumstances.

5.2.2 Objective 2: To determine whether barriers exist to communication

For individuals to be empowered, they need to acquire the necessary information and decision making skills to participate in their healthcare. A key task for health professionals (professional nurses) assessing cancer patients is to ensure that they elicit their main concerns whether they are physical, social, psychological or spiritual, and attempt to resolve them.

Although it is within the institutions commitment to develop nursing and nurses, nurses are not exempted from the responsibility to become or try to become experts by their own efforts where communication is concerned.

One such barrier that the professional nurses are experiencing is on imparting information and teaching the patient. This is an attribute that not only enriches the patient's life but empowers them with knowledge for the future. Learning is a process through which patients can change as a result of their experiences; however, this view of learning and being taught negates a change in the patient's perception and insight towards learning.

The nurse-patient relationship should be purposeful and mature as the professional nurse works towards achieving the goals set for patient care. Through this process communication becomes an all important aspect in caring for the patient. During the process of looking after the health interest and safety of society, failure to communicate leads to the development of negative behaviour in the interpersonal relationship such as frustration, anxiety, tension, anger and dissatisfaction.

Barriers depicted from the study were based on questions 34 - 65 that focuses on the kind of relationship that the respondent had with the nurse including the manner in which the respondent was approached and spoken to by the nurse. A number of barriers to communication between the nurses and breast cancer patients include questions 34, 35, 37, 39, 43, 55, 57, 60 and 65.

All of the above questions portray negative behaviour that hampers the building of a trusting relationship between the nurse and the patient. The results indicate that patients do not feel free to speak to the nurse and that the nurse only speaks when she deems it necessary. If the nurse is too busy to speak to the patient, then she will not have time to develop any sort of relationship or build rapport with the patient. The nurse who looks at her watch whilst working with the patient might leave the impression that there are constraints such as time limits restricting her from spending valuable time with the patient in which building a trusting relationship could have occurred. The nurse with the authoritative attitude makes the patient

feel vulnerable and doubtful of wanting to communicate and to some extent may fear the nurse. Negative behaviours as shown by the results obtained directly influence and contribute to the poor understanding by nurses of the uniqueness of patients. All of the barriers above not only stipulate poor communicative behaviour on the part of the nurse but also indicate that the nursing care is not patient centred. Clearly the focus is not on "people first" as the Batho-Pele principles state. In summary, the patients should be the priority and the central construct on which nursing care should focus.

Wilkinson (1999:19) sees the key component for good communication with patients having cancer to be not whether to tell the patient the diagnosis or prognosis, but in being able to assess the patient's communication needs and to tailor the communication accordingly, thus preventing barriers.

5.2.3 Objective 3: To determine the participant's perception of the communicative processes they experience with the nurses

The communication that occurs is described within the context of a one to one encounter between the professional nurse and the patient and the key component is that communication should serve to address the particular goals of each respondent within the context of the interaction.

Both the professional nurse and the patient are influenced by external factors encompassing education, expectations, socio-economic background, personal experiences and family and friends. The study revealed that patients consider the professional nurses as poor educators. Education is a very important component of the learning process and assists the patients and their families with coping mechanisms from both a physical and psychological aspect.

Cancer, as discussed in chapter one, is not only anxiety provoking to some patients but can be viewed as repugnant and dreadful. The female diagnosed with cancer of the breast often is informed about the abnormal cells that have invaded a delicate and sensual part of the body. This malignant disease can be considered as a chronic illness, as it is usually permanent and is caused by a non-reversible pathological dysfunction of the cells requiring long term treatment and care. These females are now faced with a new life situation that not only they but also their families will have to deal with. Furthermore, patients diagnosed with cancer of the breast will be subjected to complex therapy which includes possible radium and chemotherapy. Becoming a breast cancer inpatient can arouse many physical and psychological questions for which the patient needs acknowledgement.

Interpersonal communication is the primary tool used for exchanging information between the nurse and patients and their families, as well as for negotiating care. Nurses are a significant source of information and support through this transitional period and the communication between the nurse and patient is highly valued. If the professional nurse cannot educate the patient it will impact directly on the patient's quality of health. Nursing without educating contains no substance and will leave the nurse only to perform physical tasks in the ward.

Based on the data obtained, questions 66-84 focus on the information and education process that entails more specifically the verbal component of communication. In order to provide the patient with information, aspects such as assessment, collaboration and decision-making are important. As stated in questions 66, 67 and 68 that includes being involved and informed by the nurse. The results show that there is a lack of such activities. Nurses tend to underestimate the extent to which patients desire to know about health problems affecting them, discuss medical procedures and their risks and benefits.

Question 69, 70, 71 and 72 show respondents disagree about nurses being role models, or about being able to voice their ideas and reflect with the nurse for collaboration, or about the nurse being patient in explaining procedures or giving health information and about approaching the nurse with questions without feeling hesitant.

Within a ward setting clinical nursing tasks such as assessing the specific needs of patients, providing socio-emotional support, information and delivering physical care all deal with communication and are subject to the rules of interaction. The nurse has to be a role model in the clinical environment because it is through her conduct she is able to teach her subordinates how to deliver patient care that ensures a service of high quality. The process of voicing ideas and reflecting collaboration should be implemented at the orientation phase. This phase emphasises the needs of the patient, including orientation regarding her new situation, strangers, and her state of health. The working phase, is the phase where the patients clarify their problems in their minds and identify with the nurse who has the experience and is able to help them. These two phases determine the outcome of the termination phase, namely, when the patient begins to prepare to leave the hospital. Preparation will include the knowledge gained whilst being hospitalised. This also contributes to the independent state of the patient if success has been achieved at these preceding stages. As Belcher and Fish in George (2002:64) state it is very important for the nurse to work collaboratively with the patient and family in analysing the situation, in order for them both to recognize, clarify and define the existing problem.

When a patient is being managed by a nurse who is rather brusque in explaining procedures or giving health information, it can result in feelings of anxiety, dissatisfaction or uncertainty about issues relating to their health.

Question 72 poses a question on the inability of being able to ask questions, where some information is initiated and acted upon in response to a question. What is imperative to understand is that patients need information and they also need to know and understand how to incorporate this information into their lives. Involving the family in these processes can prove advantageous, as they are most times the primary caregivers to the patient once discharged and may require guidance. If a patient cannot approach the nurse with questions it makes the nurse seem rather unapproachable, thus appearing to take no interest in the health of the patient. According to the regulation R2598 (South African Nursing Council, 1984) as promulgated by the Nursing Act No 50 of 1978 regarding the scope of practice of registered nurses, the nurse should practice the facilitation of communication by and with a patient in the execution of the nursing regimen.

By supplying the patient with information the professional nurse not only addresses the needs, but the goals of the patient too. This individual plan and the effectiveness thereof must be assessed continuously. This should not only be based on the holistic care of the patient but also on what patients want to learn and how it impacts on their lives. This can lead to communication that can contribute to the patient's wellbeing, but as results obtained in question 73 indicate respondents disagree that the communication between them and the nurse contributed to their wellbeing. Developing and expanding knowledge in the area of patient teaching and patient participation can contribute to the improvement of the nurse's communication skills that directly and indirectly can contribute to the patient's wellbeing. The need for information of the patient may vary according to her individual experience. Sawyer (2000: 244-247) indicates that the provision of information can help the patient in terms of physiological and psychological outcomes, enabling them to regain control over their lives and participate fully in treatment. Peplau (1994:5) believes that every professional contact with a patient is an opportunity for educative input by nurses.

Questions 76-77 focus on education, quality of life, rehabilitation as well as understanding the nurse in communicating with the patient.

The results of question 76 show a higher percentage of patients disagreeing about not being provided with information relevant to their illness, or as stated in question 77 about their family receiving information which can assist them in helping the client. A study done by Luker, Beaver, Samuel, Leinster and Owens (1996:488), indicated that most of the women

diagnosed with early breast cancer are not getting sufficient information or education. Based on the data obtained from the study it is evident that patients are more dissatisfied about the information they receive from the nurses in view of their communicative abilities. Information undoubtedly has an important role in the successful treatment and rehabilitation of cancer patients. Patients with a chronic condition require long term educational interactions that focus on living with the illness and learning new health related behaviours. Consequently active patient participation should be encouraged as part of the learning process. Patients can be hospitalised for short term periods as well, thus it becomes crucial for the nurse to be able to lay the foundation of teaching and educating the patients in those aspects that concern their health.

Patient education begins with an assessment of what the patient needs to know, as mentioned previously, in order to achieve recovery and be able to function. Nurses should be able to educate and impart this information prior to discharge and not on discharge. Patients and their families should be given clear information and assistance in the form that they can understand concerning the treatment options and outcomes available to them at all stages of treatment from diagnosis onwards. Rehabilitation starts from the initial diagnosis in order to help pave the future outcome for the individual patient. Patient education can therefore improve the rehabilitation of the patient, enhance and encourage family participation and improve the quality of life of the patient. Suffice to say that without nursing involvement in information-giving, many patients will not truly understand their illness, prognosis or treatment options which could in return affect their recovery (Mills & Sullivan, 1999:633). They continue to argue that the nurse’s involvement in providing and co-ordinating patient education is essential to the patients’ well-being.

Quality of life is a term that is not easily quantifiable. It is a term that is dependent on many personal value judgments, cultural orientations and social considerations. According to Stellenberg (1995:56), they identify four components which make up quality of life which are: life-satisfaction, self-esteem, health and functioning, and socio-economic status.

Mastectomy patients can suffer from post-mastectomy pain syndrome, lymphedema, limited shoulder motion, decreased muscle strength or sensory changes, changes in body image and emotional discomforts (Voogd, Ververs, Vingerhoets, Roumen, Coebergh & Crommelin, 2003:76-81). King, Kenny, Shiell, Hall and Boyages (2000:791), state that although these physical symptoms might decrease during treatment, it still can be significant factors that can result in discomforts in daily living and threatening the quality of life. Deprivation of information regarding these symptoms will not only affect the patient psychologically but

physically as well. Patients should be made aware of the impact of the disease and measures that need to be taken in order to help them on their road to recovery.

Rehabilitational nursing as quoted in Hoeman (1996:40) states that it is whereby individuals with functional disabilities should make informed decisions about their future and support interventions to help themselves re-establish and maintain control over all aspects of their lives. As previously mentioned in chapter 2 (paragraph 2.3.2.3), Peplau states that each individual can be viewed as a unique biological-psychological-spiritual-sociological structure that will not react the same as any other individual. This does not only refer to the hospitalisation period but also includes the rehabilitation and the quality of life of each individual.

Results obtained in questions 78, 79, and 80, show that respondents agreed on aspects that focus on the verbal aspect and the ability of the patient to communicate, as well as the importance of the respondent in understanding the nurse and on the content of what the nurse communicated.

Question 81, 82, 83 and 84 focused on the communication between the nurse and the patient with specific reference to information received at discharge, planning and assisting the patient to be able to help themselves. According to Drew and Fawcett (2000:443-446) patients are now more involved in their own care and therefore information-giving has become a priority for nurses. Although the respondents agreed to receiving the abovementioned, results obtained in question 84 revealed that respondents disagreed about being assisted to a state of independence.

Information seems vital for the adherence process, longevity and ultimate satisfaction of the patients and their families. Strategies to enhance patient information should include patient participation, providing family skills training and facilitating continuity of care that include educating the patient on a regular basis and in preparation for her discharge.

Based on the scientific evidence as discussed, the following recommendations are made to address the factors that contribute to the communication between the patient with breast cancer and the nurse.

5.3 Recommendations

5.3.1 Nursing education

Nursing is a profession whereby interaction becomes fundamental to its existence. The development of professional skills in communication has become imperative. The higher

demand for professional conduct and skills therefore warrants an improvement in the effective preparation of the professional nurse training which include aspects of communication and the impact it has on enhancing patient satisfaction.

5.3.1.1 Curriculum Development

Curricula designed for basic graduate and post-graduate training programmes should include communication as a core module for all programmes. The powerful dynamics of patient communication are most times being underestimated.

5.3.1.2 In-Service Nurse Training Programmes

Improving in-service training programmes for nurses should include topics on the interpersonal relationship between the nurse and patient and the importance of effective communication between them.

Barriers that hinder effective communication between the nurse and the patient should be addressed, such as nurses having authoritative attitudes, nurses looking at their watches, nurses being too busy to speak, as well as patients not feeling free to speak.

5.3.2 Continuous Quality improvement

Continuous quality improvement programmes should include programmes with the emphasis on programmes which will enhance communication between the nurse and the patient which will ultimately improve the level of quality in patient care.

5.3.2.1 Patient surveys

Patient satisfaction surveys should be conducted regularly, at least once every 3-months to identify whether patients are satisfied with the communication skills of the nurses and whether their needs are met. In addition all patients should always complete a patient satisfaction questionnaire. A teaching profile and a follow up questionnaire could be formulated in the ward in order for the patient to verbalise their understanding and indicate areas that need attention. Evaluation of patient feedback should be completed and be acted upon.

5.3.2.2 Awareness Campaigns

Awareness campaigns about the Batho Pele principles should be conducted to not only inform patients of their rights to a quality service but also to show the importance of

communication between the health professional and the patient. The use of the media could assist with such campaigns.

5.3.2.3 Developing Protocols and Policy Guidelines

To ensure quality assurance and continuous quality improvement, protocols and policy guidelines should be developed to enhance the quality of patient care, which will include patient communication.

Guidelines should be developed to assist nursing staff with the communication process.

5.3.2.4 Patient Education Programmes

Patient education programmes should be designed which include the comprehensive approach to the management of the patient with cancer of the breast. Patients need to be trained pre and post operatively needing surgical interventions, and pre-treatment for those patients requiring non-surgical interventions.

Nurses as part of their teaching role need to reinforce teaching sessions that include the patient on a regular basis and encourage active participation.

These programmes should also include frequently asked questions and answers. Patient communication will further be enhanced through not only verbal communication but also through handouts that address their needs.

5.3.2.5 Assessment of Patients

Patients should be assessed fully. Staff should be guided with a protocol in how to conduct an interview that can elicit the patients' perception and understanding about their illness and their expectations of the treatment. The patients' individual information needs need to be elicited and that of their families. Based on the findings a score can be formulated which will guide the daily assessments and provide the required information.

5.3.2.6 Patient Information Centre

The institution should provide members of the public with an information centre based at the hospital that can see to the informational needs of the public, and which contains all the necessary materials to help the patients in their recovery and rehabilitation or quality of life.

5.3.3 Building a Trusting relationship

Peplau's theory is a middle range theory that analyzes key principles that concerns learning, language and the relationship between patient and the nurse. Although Peplau's theory concentrated on the psychiatric nurses, the application of communication and the interpersonal relationship describe clinical exemplars and testable interventional strategies for direct clinical practice.

The professional role of the nurse requires a direct relationship with the client on an ongoing basis. Cancer nursing in particular moves beyond disease management and requires that the nurse and patient collaborate towards health. Collaboration with the intent of achieving holistic health that mandates a focus on the whole person is required. An interpersonal relationship refers to connectedness but when there are impediments in this relationship it can hamper the growth and development thereof.

The patient's opinion of a nurse is formulated through observation whether it be from the axiom of a verbal or non-verbal content. These entail aspects of how the nurse speaks to the patient, to aspects of how she behaves in the presence of the patient. Good effective communication is therapeutic, whilst bad communication leads to avoidance and a poor interpersonal relationship.

However one might look at the interpersonal relationship the nurse-patient has within the health sector, no other component encapsulating communication is more important within the nursing sector. The patient becomes the epitome of nursing and depends on services that ensure quality and good effective communication that can contribute to her ultimate wellbeing, rehabilitation or dignified death.

5.3.4 Further Research

The researcher suggests that further research be conducted that covers a cross sectional diverse population group in order to obtain data from a wider spectrum, with an increase in the number of participants.

5.4 Conclusion

This chapter discussed the findings and conclusions of the study and made recommendations for practice, improved communication and for further research. The findings emphasise the eminent need for professionals to communicate effectively with their clients.

Skillful regulation of interpersonal communication is essential to the conduct of human relationships. Most researchers claim that between 65 percent and 93 percent of social meaning is carried by non-verbal behaviour (Singelis, 1994:275). A major portion of this non-verbal meaning is communicated through vocal tones and facial expressions. Non-verbal communication is a powerful medium for meaning that is conveyed through the communication process. Singelis continues to state that the meaning of non-verbal behaviour is, most of the time, determined by the receiver, who seldom confirms it with the sender. The patients can form their own opinion of what they see about the nurse's behaviour. One can ask a speaker to repeat a verbal statement but seldom asks them to repeat a gaze or an eye movement. The nurse in working with the patient everyday conveys messages to the patient in both her verbal and non-verbal conduct.

Apart from how the nurse interacts, aspects such as information giving and educating the patient are superseding the communication process. Where the family is concerned, lack of information or misunderstanding of cancer can cause heightened anxiety. Education is an all important source of intervention to both the patient and their families. Because families differ in their needs while dealing with cancer, interventions should be based on what is worrying the family most at the time and in involving them. Education is an ongoing process between the nurse and the patient including the family. The patient and family are helped to attain and maintain control when given information about the treatment's purpose, adverse reactions and how to minimize them, as well as signs and symptoms to report to the nurse.

In avoiding these tasks the communicative capabilities that the nurse needs to have with the patient will not only diminish, but mutilate the nurse-patient relationship as well.

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ANNEXURES

Annexure A: Questionnaire

Communication between the patient with breast cancer and the nurse
Survey Questionnaire

Study Aim

The purpose of this study is to determine the communication between the patient and the nurse.

There is no right or wrong answers to this questionnaire and your information is of importance for the success of this study.

All information will be treated as confidential and the researcher undertakes not to reveal any individual information that appears in this questionnaire.

To complete this 6 paged questionnaire will take no more than 30 minutes. All you need to do is to mark off with a cross (x) your most appropriate response. An example follows:

For each of the statements below, indicate the extent of your agreement or disagreement by placing a tick in the appropriate box.

The response scale is as follows:

1. **Strongly disagree**
2. **Disagree**
3. **Mildly disagree**
4. **Mildly agree**
5. **Agree**
6. **Strongly agree**

Example

STATEMENTS Category: Patient Care	Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree
The clinical registered nurses are only supposed to look after children and not adults.	X					
Nurses always encourage patients to voice their ideas and listens to them.					X	

Thank you for agreeing to partake in this survey.

Lesley Paterson

Researcher

Tel: 0730442127

Section A

Indicate your answer with a tick (x) in the appropriate column

1. **Age** ____________________

2. **Race group**

7	African	
8	Coloured	
9	Indian	
10	White	
11	Other Specify	

3. **Level of education**

12	No schooling	
13	Scholastic level grade I - grade VI	
14	Grade VII – XII	
15	Tertiary education	
16	Other (specify):	

4. **Home Language**

17	Afrikaans	
18	English	
19	Isi-Xhosa	
20	Isi-Zulu	
21	Other (specify):	

5. **Do you suffer from any disease such as**

22	Diabetes	
23	Heart disease	
24	Eye problems	
25	Ear problems	
26	Head trauma	
27	Epilepsy	
28	Other (specify):	

6. **Duration of Hospitalization for your breast problem**

29	≤1 week	
30	>1≤2 weeks	
31	>2 ≤3 weeks	
32	>3≤4 weeks	
33	> 4 weeks	

Section B.

For each of the statements below, indicate the extent of your agreement or disagreement by placing a tick in the appropriate box.

The response scale is as follows:

Strongly disagree	Mildly agree
Disagree	Agree
Mildly disagree	Strongly agree

STATEMENTS: BARRIERS TO COMMUNICATION	Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree
34 As a patient you did not feel free to ask something.						
35 The nurses were to busy to talk to you.						
36 There were adequate nursing staff to deliver quality nursing care in the ward.						
37 The nurse showed an authoritative attitude.						
38 The nurse had a positive interpersonal relationship with you.						
39 The nurses understand the uniqueness of every patient.						
40 You developed a personal bond with the Nurse.						
41 As a patient there were open two-way communication between you and the nurse.						
42 The nurse always smiled.						
43 The nurses tend to look at their watch when talking/communicating with you.						
44 The nurse was trustworthy and reliable.						
45 The nurse had an informal approach towards you as a patient.						
46 The nurse's body language was professionally acceptable in her approach towards you.						
47 The nurse availed herself to you whenever you were in need of care.						

STATEMENTS: BARRIERS TO COMMUNICATION	Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree
48 You were addressed according to your societal status e.g. Mrs, Mr, Ms.						
49 The nurse relayed an aura of confidence and made you feel comfortable.						
50 You received the nurse's full attention only when you approached her.						
51 The nurse had a formal, more rigid approach towards you as a patient.						
52 You were addressed in a rather unfavorable manner by the nurse.						
53 The nurse's facial expression was professional and congruent with what he/she had to say.						
54 The nurse seemed genuinely caring when he/she approached you.						
55 The registered nurse always seemed to be in a hurry.						
56 The registered nurse maintained good eye contact when she approached you.						
57 The registered nurse was often silent with you and only spoke when necessary.						
58 Light-hearted social chatter made you feel at ease with the nurse.						
59 The registered nurse avoided you at times.						
60 There were times where the registered nurse could not speak to you for most of the day.						
61 The nurse approached you in a boisterous manner (loudly) in the ward.						
62 You felt respected as an individual						
63 You felt emotionally stirred up in the nurse's presence						

STATEMENTS: BARRIERS TO COMMUNICATION	Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree
64 The registered nurse made you feel uneasy						
65 The nurse took you at face value and communicated what she deemed necessary.						
66 The nurse daily assessed your condition and progress						
67 You were timeously informed by the registered nurse of any decision or changes in your treatment						
68 The registered nurse made you feel involved and informed at all times.						
69 The clinical registered nurse is seen as a role model with regard to patient care.						
70 Registered nurses encourage patients to voice ideas, listen to them and reflect for collaboration.						
71 The registered nurse was patient in explaining the procedures and health information to you.						
72 You could approach the registered nurse with questions at any time without feeling reluctant or two-minded.						
73 The communication between you and the registered nurse contributed to your general wellbeing.						
74 You felt safe in the nurses' care						
75 Registered nurses take their personal baggage out on the patients.						
76 The nurse provided you with information relevant to your illness.						
77 The registered nurse provided your family with relevant information to assist you.						
78 The nurse was aware of your health status and your ability to speak or not.						

STATEMENTS: BARRIERS TO COMMUNICATION	Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree
79 The registered nurse communicated with you (patient) at your personal level of functioning						
80 As a patient you understood what the nurse was saying or trying to say.						
81 Whatever you did not understand was clarified to you by the nurse.						
82 Appropriate health education was given to you by the registered nurse on discharge.						
83 You understood what you had to do to take care of yourself at home.						
84 You were assisted from a state of dependency towards one of independence.						

Annexure B: Participant information leaflet and consent form

TITLE OF THE RESEARCH PROJECT:

Communication between the patient with breast cancer and the nurse

REFERENCE NUMBER: N08/05/130

PRINCIPAL INVESTIGATOR: Lesley Paterson

ADDRESS: T24 Plantation Road, Ottery, 7800

CONTACT NUMBER: 0730442127

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please feel free to ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Committee for Human Research** at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The study will be conducted at each participant's house. This is to ensure privacy and for the participant to be in an environment comfortable to them. A total number of 100 participants, that attends the Outpatient cancer department at Tygerberg Hospital, will be recruited by the researcher that lives in the Cape Metropolitan area. The participants will be adult female patients diagnosed with cancer of the breast and that receives active treatment at this hospital. This process will be done by obtaining patient data from the clinical area only after permission has been granted by the Ethical committee for Human Research at Stellenbosch University, the Department of Health, Cape Town and from the Directors at Tygerberg Hospital.

This study is to gain an understanding of the communication that occurs between women with breast cancer and ward nurses during the time women are undergoing treatment as inpatients.

The study will assess the following:

- Investigate the perception of the patients newly diagnosed with cancer regarding the information they receive and the manner in which it was relayed from the ward nurses.
- Establish whether barriers exist to good quality communication.
- Investigate the participant's perception of the communicative processes they experience with the nurses in the public sector.

If you volunteer to participate in this study, we would ask you to do the following things: To complete a self report questionnaire that will take approximately 30-45 minutes in duration.

The completion of the questionnaire will be done at the [subject/participants] house.

Why have you been invited to participate?

You have been invited to partake as you are a patient diagnosed with cancer of the breast receiving treatment at this Institution (Tygerberg Hospital). You have also been invited to participate as you have had contact with nurses as an inpatient or whilst receiving treatment.

Will you benefit from taking part in this research?

During the investigation period the [subject/participant] will not benefit from the study.

Are there in risks involved in your taking part in this research?

There are no foreseeable risks involved in this study. The investigator will, in order to eliminate any inconveniences contact the [subject/participant] 24 hours prior commencement and make appropriate arrangements with the participant.

If you do not agree to take part, what alternatives do you have?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Psychologically and emotionally traumatised subjects/participants will be terminated if deemed necessary by the investigator.

Who will have access to your medical records?

Any information that is obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law. This study will be conducted according to the ethical guidelines and principals of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research. The investigator and her supervisor will be the only parties to access this information.

Will you be paid to take part in this study and are there any costs involved?

The [subject/participant] will not receive any payment for participating in this study.

Is there any thing else that you should know or do?

You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in a research study entitled *(insert title of study)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........…………….. on (*date*) …………....……….. 2008.

……………………………………………………… ……………………………………………………

Signature of investigator **Signature of witness**

Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....…........…………….. on (*date*) ……....………..............2008.

……………………………………………………… ……………………………………………………

Signature of investigator **Signature of witness**

Verwysing
Reference 19/18/RP58/2008
Isalathiso

Navrae
Enquiries
Imibuzo Dr T. Naledi

Telefoon
Telephone 021 483 9901
Ifowuni

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

Ms L. A. Patterson
PO Box 125
Ottery
7800

FAX: 021 9317516

Dear Ms Patterson

Communication between the patient with Breast Cancer and the nurse

Thank you for submitting your research proposal. We are pleased to inform you that your study has been approved based on the following conditions:

1) Kindly specify whether or not you intend on recruiting Xhosa-speaking patients, as your questionnaire and consent are in Afrikaans and English only.
2) Please send a final report to the department about your results and findings, on completion of your study.

You may contact the following members of staff to assist you with access to the facilities:

1) Dr T. Carter at tcarter@pgwc.gov.za Tel: 021 9384136 (Tygerberg Hospital)

We look forward to hearing from you.

Yours sincerely

DR JRS CUPIDO
DEPUTY-DIRECTOR OF HEALTH
DISTRICT HEALTH SERVICES AND PROGRAMMES
DATE: 12/8/2008

Dorpstraat 4
Posbus 2060
KAAPSTAD
8000

4 Dorp Street
PO Box 2060
CAPE TOWN
8000

RESEARCH PROJECTS

Communication between the patient with breast cancer and the nurse.

ETHICS REF: ***N08/05/130***

Research conducted by: **Ms L Paterson**

NAME	APPROVED	SIGNATURE	COMMENT	DATE FORWARDED
Dr M Mukosi **Clinical Executive**	✓	[signature]		08/08/2008
Dr R Thomson **Clinical Executive**				
Ms J Jooste **Asst Director**	✓	[signature]	Pts written consent to provide info is required.	05-08-2008
Mr P J Wolfaardt **Deputy Director**	✓	[signature]	SUBJECT TO PATIENT APPROVAL	6/8/2008
Ms R Basson **Dep Dir: Nursing**	✓	R M Basson		7/8/08
Ms C Ford **Dep Dir: Pharmacy**	✓	C Ford		7. 8. 08
Dr T Carter **Chief Director**	✓	[signature]		8. 8. 08

Contact Details : Ms L Paterson x 4439 (073 044 2127)

Collected by : Paterson

Date : 8/08/08

/Research Projects voorblad desktop

TERUG NA MEV L BINDEMAN , ADMIN
NADAT ALMAL GETEKEN HET.

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

16 July 2008

Ms L Paterson
Division of Nursing
Dept of Interdisciplinary Health Sciences

Dear Ms Paterson

RESEARCH PROJECT : "COMMUNICATION BETWEEN THE PATIENT WITH BREST CANCER AND THE NURSE"
PROJECT NUMBER : N08/05/130

It is my pleasure to inform you that the abovementioned project has been provisionally approved on 14 July 2008 **for a period of one year from this date**. You may start with the project, but this approval will however be submitted at the next meeting of the Committee for Human Research for ratification, after which we will contact you again.

Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please quote the abovementioned project number in all future correspondence.

Please note that a progress report (obtainable on the website of our Division) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Committee for Human Research complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Kind regards

MERTRUDE DAVIDS
RESEARCH DEVELOPMENT AND SUPPORT (TYGERBERG)
Tel: +27 21 938 9207 / E-mail: mertrude@sun.ac.za
Copy to Supervisor : Dr E Stellenberg

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