

Original Article

Cancer patients' perceptions of using a "breast gown": a qualitative study

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Abstract

Recently, radiotherapy breast gowns have been introduced into some Radiotherapy Departments across the country. The idea of using the breast gowns came from issues highlighted regarding privacy and dignity from patient satisfaction surveys. The introduction of the breast gowns was not evidence based, however they have become popular as they were considered a good aid for patients' comfort. This study aimed to investigate patients' perceptions of the breast gowns using a qualitative, phenomenological approach. The methodology was designed to explore patient's feelings about their experiences throughout their cancer journey. The data was collected through semi-structured interviews, which were transcribed and analysed, via content analysis. The key themes that emerged from the study were related to: patients' emotions; dignity and privacy issues; exposure; patient choice and an unexpected result were their views relating to the notion of "possession". The results of this study cannot be generalised due to the methodology chosen, however the findings can aid the development of a multi-centred study to investigate this topic further. In addition, this study has highlighted an important recommendation for radiotherapy practice: the development of a "modesty gown" for most treatment sites.

Keywords

Phenomenology; breast cancer; breast gowns; dignity and privacy

INTRODUCTION

Breast gowns were introduced into Radiotherapy Departments in response to government guidelines, patient satisfaction surveys and the publication of Making Your Radiotherapy Service More Patient Friendly (1999).¹ There is currently very little data available on the use of the Radiotherapy Breast Gown and so the introduction of the garment was not totally evidence based in relation to practice. The use of the gowns in one local Radiotherapy Department was in response to the views of a patient forum where the issue of privacy

and dignity was highlighted. However, the question of why these particular gowns are useful to the patient has never been asked. Therefore, this study aimed to investigate why patients chose to wear or not wear a breast gown in relation to privacy and dignity. This study explored how standards of care are met and maintained in relation to good practice and government policy.

BACKGROUND

Psychological aspects of a diagnosis of breast cancer

A diagnosis of breast cancer can be seen as a personal crisis with a need for mental adjustment to aid the patient through this difficult time.² Patients can

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suffer from a range of emotions when accepting a diagnosis of cancer. Moving through stages such as: shock/denial, anxiety/anger, sadness/despair and then a gradual adjustment/acceptance stage. Not all patients reach a level of acceptance or move equally through the stages. Patients can remain at various stages for weeks and months, and can regress in the adjustment process in difficult situations,³ e.g. undergoing radiotherapy.

Breast cancer patients now have an increased cure rate and longer disease free intervals⁴ and increasingly are being offered choices in treatment. Being offered a choice of treatment may not always be beneficial to the patient. Some patients prefer not to make the decision, thus allowing the doctor to make the "best choice" for them. For other individuals, they may prefer to make that choice so that they have some control over their body (an important aspect of coping and adjusting to the disease). A study by Fallowfield et al.⁵ showed that communication was an important aspect of reducing psychological problems, and one way of achieving this was by ascertaining if the patient wanted to be involved in the choice of treatment. The results showed that the majority of patients wanted the surgeon to make the decision. This shows that not all women want to be involved in treatment decisions, but that could be due to a lack of specific knowledge of cancer treatment and a desire for the "expert" to make the decision. However, choosing to wear a breast gown is a decision many patients may feel they were able to make.

Use of a breast gown could promote privacy and dignity in terms of enhancing body/self image. This image of "the self" is affected by previous social experiences⁶ and for many patients this may determine their body image following surgery. Some patients have avoidance problems, classified as fear avoidance, a situation where patients will not look at their scars or allow others to do so.⁷ This may be concerned with trying to hide the disease fearing social rejection.⁸ It is these effects on body image that can exacerbate the issues of privacy and dignity as well as a patient's emotional health.

It is thought that patients who undergo a lumpectomy experience have fewer psychological problems than patients who have a mastectomy,

but many scientific studies failed to prove this theory.⁹ Maguire¹⁰ investigated the links between surgical techniques and found that 20–30% of mastectomy patients had body image problems from surgery; although lumpectomy patients had a reduced psychological morbidity in relation to body image, they had an increased fear of recurrence. Maguire also discovered that the introduction of chemotherapy and/or radiotherapy did have a negative effect on a patient's emotional well-being. This negative effect could be due to a period of reflection on their diagnosis⁵ and subsequent experiences.

The literature related to psychological aspects of breast cancer show that self-image is an important issue for patients (both at surgery and during subsequent treatment) and indeed government guidelines are beginning to acknowledge this as an aspect of care that must be improved.

Government guidelines on patient care

Recently, benchmarks and improvement agendas have been developed by the Government to ensure good patient care within NHS hospitals. Development of these guidelines occurred due to the risk of impingement of patients' rights (The Human Rights Act of 1998¹¹). The act states in article 3, prohibition of torture:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment".

Although this statement can be viewed as extreme in relation to radiotherapy, some radiotherapy patients have previously stated that the experience of attending for treatment can be degrading.¹²

The Patients Charter was developed by the Government in 1991¹³ with the aim to improve patient's experiences within the NHS. In the charter they stated that patients should be treated with respect in aspects of privacy, dignity and religious and cultural beliefs. In addition, The NHS Cancer Plan¹⁴ encouraged NHS trusts to ask the public about their services. This in turn inspired a local radiotherapy department to form a patient focus forum, to discuss issues around their service provision.

The Essence of Care¹⁵ was a recent government initiative introduced to the NHS by the Modernisation Agency. It involves benchmarking for best practice within patient care with section six focusing on privacy and dignity as a benchmark to encourage trusts to develop this aspect of care. A survey of cancer patients carried out by the National Centre for Social Research¹⁶ shows that 79% of patients always felt that they were treated with respect. This could perhaps be improved, although with recent increased pressure to reach Government health targets some areas of patient care like privacy and dignity are being detrimentally affected due to increased throughput of patients.¹⁷

As a health care professional, it is the responsibility of all to care for patients with humanity and dignity¹⁸ and it is their ethical duty to respect the patient.¹⁹ The publication *Making Your Radiotherapy Service More Patient Friendly* by the Royal College of Radiologists in 1999¹ contains a section on maintaining dignity and privacy throughout the patient radiotherapy journey. This document encourages radiotherapy staff to be aware of how the patient may be feeling.

The introduction of the radiotherapy breast gown

From the results of a patient focus group in one radiotherapy department, the breast gowns were introduced in response to vulnerability and dignity issues. The gowns, which have a zip down the front and Velcro on the shoulders/sides allows the patient to be covered as they walk over to the couch and when they are in the treatment position only the affected breast/chest wall is exposed. The patient is offered the gown at their initial simulator appointment and it is available at any time throughout their treatment if the patient changes their mind or forgets their own gown. The patient can keep the gown throughout their radiotherapy treatment. It is then returned on the final day of treatment to be laundered by the hospital. Patients exposing themselves to members of staff can find the situation distressing,²⁰ consequently, the gowns can help to eliminate this distress, especially if a member of the opposite sex is treating the patient. There are obvious benefits of patient modesty and reduced exposure of the

patient; however there are benefits to the staff also. There is a reduction in the amount of time a patient requires to get changed and means the throughput of patients is quicker. The material also allows easier movement of patients into the correct position on the breast board.

The earliest publication regarding patient gowns was by Healey and Devine.²⁰ Due to the conservative nature of the United Kingdom population, they felt all patients should be provided with an adequate patient gown. They did highlight that nearly every diagnostic department used gowns, but at times the gowns did not fit and were indecently transparent, still therefore exposing the patient and compromising their privacy and dignity. The researchers then looked at the use of a gown for all diagnostic investigations that would allow the radiographer to complete the examination whilst allowing the patient to keep their dignity throughout the procedure. Unfortunately, in this study, there were no responses from patients documented; therefore it is not clear what the patient feelings were about the gown. However, it does highlight the early aims to provide patients with a high standard of care.

Harris and Haas²¹ were involved in the design of what is now commonly known as the Plymouth breast gown. They studied a group of patients who did not wear the gowns on one day and then wore the gowns on another. The results showed that the majority of patients felt more comfortable wearing the gown as opposed to nothing at all and they also felt they were beneficial in preserving their modesty. A potential bias was present in this study as the staff and researchers aided the patients with filling in the questionnaires and due to the small sample size the statistical significance is therefore low for this study. There may be also an ethical issue in terms of patient choice, i.e., other patients not involved in the study may have wished to use a gown.

Comfort is something that is highlighted in previous studies, however, it is unclear if it is linked to emotional comfort or that the gowns are merely comfortable to wear. With regards to emotional comfort, the breast gowns can be viewed as a form of "security blanket" for the patients. In the local Radiotherapy Department, the gowns

are provided for the duration of the treatment, so it is possible that an attachment could be formed with the gown, known as transitional object theory. This theory is often related to children and those with personality disorders. However, in essence, it is the premise of a child having a transitional object, which can give them comfort whilst their mother is not with them.²² The full explanation of transitional object theory is complicated and beyond the realms of this study. However, to summarise, the object that is chosen is one that provides the person comfort, support and reduced anxiety. It provides a substitute, if comfort from a close relationship is not available to them at the time of their distress.²³

In conclusion, it is evident that breast gowns could be useful in providing privacy and dignity, however to date little empirical research has been conducted and after reviewing the literature it is clear that there is a gap in the evidence with regards to patients' opinions. Therefore, the significance of this research is to explore patients' feelings and perceptions about the gowns and to investigate how patients' dignity and privacy is protected.

METHOD

For the study, a qualitative research approach was used to explore the patient experience. Qualitative research is the most suitable approach because it gives a view of participants' subjective consciousness.²⁴ The methodology applied to this study was phenomenology, with the aim of exploring patients' feelings from their own lived experiences. The humanistic approach enables researchers to investigate issues, which are difficult to measure.²⁵ This method is commonly used by health care professionals when investigating this subject type²⁶ and was the most appropriate method for this study. The term phenomenology is influenced by many philosophers,²⁷ and is based on work by Husserl and Heidegger; Alfred Schutz later developed their work further for social science.²⁸

For the purpose of this study, a more descriptive phenomenological approach was used to achieve and understand the experiences of the participants.²⁵ This is namely transcendental phenomenology²⁹ a method that aims to elicit experiences

from the informants without influencing the outcome with preconceived ideas²⁶ and theoretical views, which may be held by the researcher.³⁰ It uses intersubjectivity, to research individuals who have a common experience;²⁶ an approach influenced by Husserl (1859–1938) the author of the essential structure of phenomenology.²⁷

Husserl advocates that the researcher brackets away any information that could influence the outcome of the study, which allows phenomenological reduction to discover the essences of the lived world.³¹ Bracketing also allows the data to be seen in its principle state that in turn promotes scientific rigor.²⁵ It could be argued that Heidegger's philosophical method is more appropriate in this study, as it allows the life experiences of the researcher to contribute to the outcome of the study.³² However, in this study the researcher has no first hand experience of breast cancer, and would only be able to recall previous patients' experiences.

Sampling

Convenience sampling is used when gaining access to potential participants is difficult.²⁶ It was anticipated that there would be potential problems in gaining an adequate sample size because of the sensitive issue to be discussed and the vulnerability of the target population. A convenience sampling method was necessary because of the need to recruit patients who are willing and able to discuss their experiences.

Potential participants must have also experienced the phenomenon of the cancer journey, which can also have a negative effect on the sample size.²⁵ It was decided that a sample size of approximately ten patients would be invited to participate (half would have used the breast gown throughout their radiotherapy treatment; the other half would not). All patients receiving radiotherapy to the breast are offered the use of a breast gown throughout their treatment, and therefore this offer would not be withdrawn from the potential participant, the choice would remain theirs.

A larger sample size would have given more validity to the results, but due to the factor of time for this study this was the largest number feasible.

Table 1. Inclusion criteria

Criteria
Have a diagnosis of female breast cancer
Receiving radiotherapy to the breast or chest wall
Curative treatment intent with a good prognosis
Psychologically well (HAD screening tool)

The lower sample size also supports the method chosen in relation to phenomenology²⁵ and the potential saturation of data.

The inclusion criteria (see Table 1) was developed to ensure that the participants had experienced the phenomenon that the researcher wished to investigate. It was also important that the patient was attending for curative treatment to reduce the potential psychological problems, which would have in turn affected the sample size.

Those who did not meet the criteria were excluded from the study.

ETHICAL ISSUES AND CONSENT

The main concern for the researcher was their moral duty to protect the participant and to respect their dignity and human rights,³⁰ which must take priority over the research project itself.³² To ensure the patient was protected ethical approval was sought from the recognised boards. The proposal passed a three-tier approval system (University ethics, NHS Research & Development and LREC) with only minor modifications necessary. An ethical issue that did need to be considered was the risk that the patients may have felt obliged to participate because of the medical care they were receiving. This could cause problems with the informed consent process; however, all participants were fully informed about the study and only those patients interested were considered.

Prior to gaining informed consent potential participants were asked to complete the hospital anxiety and depression scale (HAD scale). The cut off point to classify a patient as "psychologically well" was 8–10, the value recommended by the authors of the tool. This is a valid and effective tool used often in the hospital setting that involves the psychological assessment of a physically ill patient.³³

Table 2. Interview questions

Open questions/themes for interview
1. How do you feel about the breast gowns?
2. Why did you feel you did/did not need a breast gown?
3. How do you feel your dignity has been protected throughout your cancer journey?

Due to the sensitivity of the study, all participants were offered additional support; they were given contact details for the Macmillan Support Radiographer for counselling. None of the participants required a referral.

Data collection

The use of interviews is the most effective form of communication³¹ and therefore the most productive at gaining an insight into the participant's experience.³⁴

A semi-structured approach was more applicable for a qualitative data collection,³⁵ although this does have an implication on the sample size. The sample was small, but it was considered that the data would be adequate to support further study.³⁰ For the interview, the researcher utilised an interview guide that had three key questions (see Table 2). The questions were used as a framework to allow a reproducible format for interview and in keeping with the phenomenological approach to interviewing were open questions. The ordering of the questions was not important because the interviewer was free to probe as the topics arose.²⁸ It could be argued that this was a focused interview,³¹ although it has to be said that all interviews even unstructured ones have an element of planning and structure to gain the outcome required.

The interview was completed face to face so that the researcher could control the data collected and it also allowed further probing from the immediate responses.³⁵ In addition, the interviewer was able to document non-verbal responses, which can be an indication of the interviewer probing too deeply.³¹ Field notes were taken by the interviewer to support the interview. For the purpose of this study, each interview was allocated half an hour, which was considered adequate time to allow the participant to discuss their experiences and permit the interviewer to elicit their

responses.³⁵ This was confirmed to be sufficient time, as some interviews took less than 30 min and it was apparent that the data was saturated as no new information was being generated.

The interview took place away from the treatment area and any distractions so that the participant was more comfortable and relaxed. The location was safe for both the respondent and the interviewer.³⁵ The actual timing of the interview was the participant's choice so that the study did not impinge on their lives. The interview took place during the participants' last week of radiotherapy; this is commonly the final aspect of the patient's treatment and is an appropriate time for the respondents to reflect on their journey so far. It was noted that some patients do experience psychological morbidity during radiotherapy because they have reached a point of reflection in their experience.³⁶ Emotional disturbances can also occur because it is the end of the patients' treatment and they may feel abandoned when the responsibility of their health care is primarily theirs again.³⁷ Although, it was important that the interview took place at this time so that the patients' feelings were fresh in their minds and enabled them to reflect.

All of the interviews were audio taped, which provided a permanent record³⁴ and aided in the elimination of bias, memory recall and human error.³⁰ Some participants were wary of the audio-tape and sat defensively, demonstrating that it did affect them from fully "opening up" to the interviewer.³⁸

Data analysis

Content analysis was the method of choice because it identifies key themes from a small study.³⁰ It provides objective data related to meanings and context, which is valid and reliable in terms of a phenomenological approach.³⁹ To aid validity, the participants read the transcriptions first, to ensure that the information truly reflected how they felt. An iterative mode, which uses a three-stage analysis process, was used for this study. Firstly, the researcher critically analysed the data to identify key themes. The second stage occurred a few weeks later when the data was re-read and gaps identified, this also eliminates any risk of

fatigue on the analyst's part.³⁹ For this study, a second colleague was involved for the third stage of analysis to provide independent researcher analysis to ensure reliability of the data analysis and to reduce researcher manipulation of the data.⁴⁰ This colleague was not involved in the study until this point to ensure there were no other contributions to bias.⁴¹ Finally, the data was coded into key themes, which generated discussion points. Computer based analysis may have been of benefit for this study, however, the disadvantages of this technique such as decrease in researcher intuition, data overload and focusing on only superficial data³⁰ made this type of analysis impractical.

Limitations

In hindsight, due to the lack of research on breast gowns, the use of grounded theory may have been a methodology to consider for this study. However, this approach was rejected by the researcher as the purpose of the study was to elicit the patients' experiences of wearing or not wearing the gown thus it could be argued that the phenomenological approach was appropriate.

The main limitation of this study was that the results could not be generalised to the wider population. This approach, by its very method, does not allow the researcher to present a consensus of opinion. Therefore, the researcher urges the reader to interpret the results as individuals' lived experiences and perhaps relate this to their own clinical practice.

The researcher aimed to reduce bias by bracketing their experiences in association with the methodology chosen. However, bracketing can be difficult to attain due to background knowledge and the feelings the researcher may have if they found themselves in that situation. Thus, one must acknowledge the role of "reflexivity," in that the researcher's background knowledge and role within the study itself would make bracketing difficult to achieve.

DEMOGRAPHIC RESULTS

Prior to interview, brief demographic information was collected to ascertain if there would be any potential link between age, surgery type, referral pattern and the decision on whether to wear the

Table 3. Identified themes

Identified themes	Number of patients (%)
Dignity and privacy	50
Exposure	70
Choice	70
Patients emotions	40
Possession and attachment	50

gown. As this was a small scale study other demographic data was not collected, but should be considered for a larger scale study. From the total of ten participants, five of the participants used the breast gowns throughout their radiotherapy journey and five chose not to use the breast gowns. In relation to surgery, there was no link between those who received a mastectomy and those who had a lumpectomy in connection with the choice of wearing a breast gown, i.e., mastectomy patients were no more likely to wear the gown than the lumpectomy patients. Although in terms of adequate sampling only three of the ten participants were mastectomy patients, this is obviously linked to the reduced number of patients requiring radiotherapy after this surgical intervention or is a negative effect of the small sample size. From the sample, the mean age was 52.2 years, with the youngest patient being 40 years of age and the oldest being 61 years. The main identified themes from the data can be seen in Table 3, which also highlights its importance to the patient.

DISCUSSION

As previously stated the gowns were introduced as a consequence of patient focus groups and recent Government initiatives. The results showed that patients' views on the gowns were complex and "privacy" was perhaps not their main concern. The following discussion explores the themes in more depth and highlights some other issues that should be considered.

Dignity and privacy

Although dignity and privacy was considered one of the most important factors at the outset of the study, the general view of participants was that it was not the most important consideration. Many of the government policies focus on the issue of privacy and dignity, ensuring that health care professionals offer gowns to patients. The

guidelines stipulate that the choice is offered to enable the patient to be as comfortable as possible throughout their time in the department. For the participants their privacy and dignity was more about how they were treated by the professionals not the breast gowns themselves. The fact that someone had thought so much about the introduction of the breast gowns was very important to them. The feeling of being respected by the health care professionals was also significant:

"Being made to feel special because the health care staff ensured I was comfortable".

As well as making them feel special, they also felt normal, something that made them feel less stigmatised. The majority of patients commented on the caring attitude and professionalism from those staff they had come into contact with throughout their cancer journey. It is those emotional feelings in relation to privacy and dignity more than the physical issue that was important to the patients. That is, respect for the person as an individual rather than respect for the body, which could perhaps be viewed as the most important aspect of privacy and dignity. In fact, patients did not use the terms privacy and dignity, but alluded to it with the use of other words, which will be discussed further.

Exposure

Feelings relating to exposure were discussed the most throughout the interviews. References to scars on the affected breast were made, but were not linked to the decision to wear the breast gowns. One participant found the gown very important because she had received previous surgery on her unaffected breast. She wanted to cover that breast because she felt it looked:

"Like a battlefield, because of all the scars".

This highlights concerns by some participants with regards to body image. The issue of body image was important for some, but not for everyone; in fact one patient claimed:

"They are just a pair of boobs".

As previously stated this attitude depends upon the person's body image⁶ and the above statements support the theoretical perspectives on body

image and integrity. Thus it is evident that this is an individual perception, therefore supporting the notion of individualised patient care.

Length of exposure was another topic discussed by patients that also highlighted differences between the respondents. Some participants commented that it was not a long period of time, especially in relation to the simulator appointment. Participants also mentioned time in association with saving time for the staff. Many patients do just want to have the treatment and leave and can achieve this by using the gowns. It cannot be denied that those patients who are already dressed in their breast gown are quicker to treat because staff do not have to wait for them to get undressed and dressed and this would enable a higher throughput of patients. With regards to patient care this should not be the sole reason for supplying the gowns and the main reason should always be the patients' well-being.

Exposure to non-medical personnel was another aspect of this discussion by patients. To increase the throughput of patients many are asked to change into a gown and then take a seat in the waiting room. One participant stated that:

"You could guess what stage other patients were at by what they were wearing".

She found this difficult and felt she was on a conveyor belt, however, another patient said:

"I found it supportive realising that I was not alone and other women were also going through the same experience".

Along with exposure to other patients, there is also the exposure to other patients' families and friends. Some participants found this upsetting because they thought it was obvious they were the patient not the carer.

Overexposure to staff may be dependent on the sex of the staff. Some participants mentioned that they had a female General Practitioner, which is obviously significant to them. In the local Radiotherapy Department, there were no male members of staff working at that time. Again, this is significant to some participants because they mention the fact that they were:

"All girls together".

Devine and Healey²⁰ also highlighted the issue of gender, stating that even exposing the body to members of the same sex could also be distressing. It is also highlighted in *The Essence of Care*¹⁵ benchmarks to ensure patients are not over exposed in relation to body and people.

One participant also recounted an important issue for her; she was given a gown for surgery, which only allowed the affected breast to be exposed. The fact that staff protected her dignity and privacy whilst under anaesthetic was something that she felt very positive about. Whether patients are offered gowns, or not, could be considered an ethical issue and one must question the right of the patient to choose.

Choice

In relation to the choice of wearing a breast gown, the participants know how they will feel exposing themselves to a group of strangers, which makes it easier for them to make the decision. The consequences of making the wrong choice are also not life threatening because they can always change their minds and ask for a gown at the next appointment or decide not to wear one. It is evident that this was an individual choice, giving back an element of control. However, some patients may still prefer someone else to make the decision for them. All patients in the study were in favour of being offered a gown and said they would be happy to make the choice of whether to wear it or not and the fact that they were given a choice was important to them.

Patients' emotions

As expected, the participants talked about the emotional aspect of having cancer. The results showed that all the participants felt differently at this stage in their journey, as previously stated people's ability to cope is dependent on the way the person views their illness. Moreover, the coping/adjustment process changes constantly to allow the patient to maintain stability in terms of their mental health.⁴² One participant stated that at the beginning of treatment they had felt very "vulnerable" and "frightened", but now felt more positive saying,

"I feel that I have beaten the cancer and the treatment was an insurance measure".

This illustrates that the stage of the coping process that the patient is at and their emotional state could dictate how they react when they attend for radiotherapy. An emotional aspect of the patients' experience was the subsequent "attachment" to the breast gown.

Attachment

This was a surprising finding from the study in that some participants related to the breast gown as something constant, something they did not want to give back (a form of security blanket), which could be explained by the transitional object theory. It seemed at this time of transition in their lives they reverted to child like comforts to support them through their radiotherapy.²³ Some patients seemed to receive comfort from the gown particularly whilst they were alone in the treatment room. Patients may travel to their radiotherapy appointments alone, which could have a significant effect on their well-being. The gown then takes the place of the supportive person, to reduce the psychological anxiety the patient may potentially suffer from. At times of distress it could be said that people revert back to their childhood, potentially this could explain patients' attachment to the gown; clinging to an object to replace the comfort of a mother figure.²² The idea of the gown being a comfort was investigated by Harris and Haas²¹ and this study certainly supports the idea that comfort is brought to the patient from the gown.

Participants also had issues with the number of gowns given to them throughout their hospital experience. They preferred the idea of having the gown constantly throughout their radiotherapy; they could then clean it and prepare themselves for treatment.

Additional findings from the study

Some patients did not see the gown as a comfort; they talked about it being a label. They viewed it as a garment that labelled them a "patient" and someone who is classified as "sick". Patients attending for breast radiotherapy rarely feel ill, therefore wearing the gown could make them feel like a "victim" as one participant stated.

The study also highlighted educational issues as some participants could not visualise what the gown looked like when they were first offered it. One participant said that they thought they wore a gown with a whole cut out to expose the breast.

The environment the patients found themselves in during their medical appointments was as important to them as wearing or not wearing the gowns themselves. This is a potential problem in many departments because space is often limited. Many of those participants who did not wear the gowns focused on the environment around them and the fact that they did not feel exposed or threatened when they undressed. The fact they were in an enclosed room or curtained environment made them feel comfortable and unexposed. If that environment had not made the patient feel safe, then perhaps they would have decided to wear a gown. The breast gowns, to some extent, did aid the patient undergoing radiotherapy; however, used in conjunction with a more practical environment the problems of privacy and dignity could be significantly reduced.

CONCLUSION AND RECOMMENDATIONS FOR PRACTICE

In conclusion, through interviewing ten participants with a diagnosis of breast cancer and who were receiving radiotherapy, five key themes have been identified relating to why breast cancer patients choose to wear or not wear a breast gown. The themes identified were different to those expected when the study was initially being developed showing that the issue of patients' emotions is still an important matter for health care professionals to recognise. The surprise elements of the study were patients' views on possession of the gown which were linked to "comfort" and "consistency" throughout the treatment. In addition, the amount of focus on "exposure" demonstrates the impact on patients' dignity and privacy.

In terms of recommendations for practice; patients could be given a photograph of someone wearing the gown with a brief explanation about its function before they attend for simulation. This would eliminate the educational issues highlighted within the discussion and allow the patient time to

consider if they would prefer to wear a gown. Currently, many departments give a welcome pack explaining the radiotherapy process; this would be an ideal place to introduce this information.

Suggestions for improving the facilities and environment could involve the use of changing cubicles and small private waiting rooms away from the hustle and bustle of the larger waiting rooms where the patients are at risk of over exposure with regards to other patients and carers. With changes to the environment, the reasons for wearing the gowns could alter, although individual choice is still important.

The study has highlighted that patients receiving treatment to other areas of the body are not currently catered for, e.g., pelvis treatments. This can also be a very distressing area of the body to uncover, but due to the way that radiotherapy is administered this reduces the options available for modesty gowns. The breast gown itself has also been offered to other patients in the department, those receiving radiotherapy to the chest and those having Hickman lines removed in the hope of improving their dignity. Perhaps a change in terms in relation to the name of the breast gowns should be considered. The term breast gown gives the impression that the gowns can only be used for those breast cancer patients. A name change to a "modesty gown" would be more appropriate. A change in name would also reduce the labelling of patients wearing them as "breast cancer patients".

However, in congruence with the methodological approach chosen for this study and in relation to the sample size, the results should not be generalised. Nevertheless, the results prove that the ideal of treating patients as individuals is still as important as ever. Due to the Husserlian phenomenological approach, a true conclusion cannot be made; yet, the results of this study should support further multi-centre research into this issue of privacy and dignity. By including other centres, the range of participants can be improved to allow further exploration of the influence of demographic factors on patient choice in issues of privacy and dignity.

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