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Maria Geraldine O'Callaghan McEvoy

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THE RELATIONSHIP OF ONCOLOGY NURSE CARING AND PATIENT SATISFACTION

By

Maria G. McEvoy

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

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1996

ABSTRACT

THE RELATIONSHIP OF ONCOLOGY NURSE CARING AND PATIENT SATISFACTION

By

Maria G. McEvoy

Patient satisfaction is a measurable outcome of care provided. Little is known about the relationship of patient satisfaction and oncology clinical nurse caring. The purpose of this investigation was to examine the relationship of nurse caring and patient satisfaction. Caring is examined in terms of Jean Watson's philosophy of Nursing as human science and human care. Rationale guiding the study is the lack of investigations measuring the effect of nurse caring on patient satisfaction. Secondary analysis of a primary investigation entitled "Rural Partnership Linkage for Cancer Care," by Drs. Barbara and C.W. Given, funded by the National Cancer Institute, Grant # 1R01 CA56338-02, was employed. A convenience sample of cancer patients living in southwestern Michigan counties of Allegan, Barry and Van Buren, experiencing a wide variety of types and stages of cancers participated. A specially designed intervention was employed to bring state of the art cancer care, utilizing OCNS nurse caring. Patient satisfaction with nurse caring was measured 1 year after entry into study. Data collection was through a self-administered, modified, LaMonica-Oberst Patient Satisfaction Survey. Correlation coefficient Pearson's r = .2985 (p=.021), indicated a moderately positive relationship between encounters of nurse caring and patient satisfaction. Implications for further research, education and advanced practice nursing are discussed.

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1996

DEDICATION

To my husband, Jim, for his love, support and patience, and computer expertise -- especially with the word processing, when I would "lose my files". To my children, Jim, Kate, Sean and Kelly for their continued love, despite missed meets and forgotten school treats. To my parents, Hannelore and Jerome, and grandparents Hans and Maria, for being my first teachers of caring.

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I wish to thank my committee, Linda Beth Tiedje, Barbara Given and Celia Wills. Linda Beth, my chair, thank you for helping me stay focused on caring, the heart of my nursing. Barbara, thank you for allowing me to use your data set and be your graduate assistant this past year. In my interviews, I heard over and over again, how much the caring nurses were a part of the healing, for both patient and caregiver. Celia, thank you for your insight into the literature; it allowed me to gain further valuable insights. I wish to thank you all for challenging me to reach for the heights. I also wish to thank Su Hao Tu, for her assistance with data analysis; it was much appreciated.

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INTRODUCTION

There is no question that the current health care system is in a state of flux. Money managers of institutions (such as hospitals) and insurers are evaluating institutional practices to make these practices more cost-efficient (Baer and Gordon, 1994). In order to increase cost-effectiveness, Baer et al. (1994) suggest that institutional managers view nurses as being expendable, that is, there appears to be a belief that, "Other less trained individuals may do the job."

In discussion of machine technologies and caring in nursing, Locsin, (1995) identifies caring as a "central prominence" of nursing, defining caring as a component of machine technologies and patient satisfaction. Since technology is a large part of applied nursing, this is an important reminder of the value of the caring part of nursing.

Measurements of outcome are the major means of demonstrating effectiveness of nursing care provided (Jones, 1993). Rettig (1991) identified outcome measurement as a, "national opportunity to build a stronger research underpinning to nursing." Marek (1989) identifies patient satisfaction as one of fifteen specific outcome measures. Further, the degree to which a patient believes the health care provider cares about them maybe the most important element in determining client satisfaction. (Woolley, Kane, Hughes and Wright, 1978). Ware and Davies (1983) cite three reasons for measurement of satisfaction. 1)Satisfaction is an ultimate outcome of health care delivery; that is,

satisfaction is an evaluation of how well and how acceptable health care providers provide services; 2) Satisfaction ratings provide information about the structure, process and outcome of care; and, 3) Dissatisfied patients may choose not to utilize health care services further. Behavioral consequences of patient dissatisfaction with health care must be considered as a reason to examine patient satisfaction with caring. With the abundance of factors that may lead to dissatisfaction, such as poor communication or lack of availability of one's 'personal' health care provider (Weyrauch, 1996); the importance of describing the factors related to satisfaction become evident. Wiggers, Donovan, Redman and Sanson-Fisher (1990) identify cancer patients as having multidimensional needs. Measurement of satisfaction is an index of the adequacy of care provided. Further, caring received may be one of the factors related to that satisfaction.

Problem Statement

The Advanced Practice Nurse (APN) must be responsive to outcomes based research in health care (McCormick, 1992), including the impact of nurse caring on outcomes. Caring in nursing is a nebulous entity. The purpose of the proposed research is to examine the relationship of nurse caring and patient satisfaction, using a sample of clients from several southwestern Michigan county rural Oncology Clinical Nurse Specialist (OCNS) practices. Specifically, the purpose of this investigation is to examine the relationship of patient satisfaction and number of caring nurse encounters. The hypothesis is that as the numbers of caring encounters increase, patient satisfaction also will increase.

Review Of Literature

Integral to this study are the concepts of patient satisfaction and caring. The definition and literature review of caring will be followed by the definition and literature review of patient satisfaction.

Conceptual Definition of Caring

The conceptual definition of caring for the purposes of this study is nurturance, knowledge provision, mutual respect, empathy and congruence. Caring is a multi-faceted concept, with facets involving a way of being, a thing to do, and something given, as well as received.

Caring is defined in Webster's Collegiate Dictionary (1992) as a regard coming from desire or esteem. Unfortunately, when attempting to define caring as a nursing concept, the literature is much less clear. The American Nurses' Association defines nursing as the diagnosis and treatment of human responses to actual or potential health problems (American Nurses Association, 1980). Swanson (1991) defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 354). Nurses develop care plans for their patients, yet caring remains unclearly specified. Multiple theories of caring abound; among them Boykin and Schoenhofer (1991), Leininger (1993), Swanson (1991) and Watson (1988). Essays on caring as loving (Jacono, 1991) and caring versus empowerment (Malin, 1993) appear in the literature. The parameters of caring are difficult to define. Caring is not a concept with clear physiological delimitation, such as heart rate or blood pressure.

Leininger (1993) defines caring as "the essence of nursing and as a central and major domain of nursing knowledge and practice." Caring involves the whole patient

(Hill, 1991). Burfitt, Greiner, Miers, Kinney and Branyon (1993), when examining professional nurse caring relating to patient perception, conclude caring is a mutual process in which intentions between the nurse and patient are joined to form a shared experience.

Watson (1988) eschews linear definitions of concepts but describes caring as "the moral ideal of nursing, consisting of person to person undertakings to protect, enhance, and preserve humanity by aiding a person to find meaning in illness, suffering, pain and existence; to help a person gain self-knowledge, control and self-healing where a sense of inner harmony is restored regardless of external circumstances" (p.54). Watson (1988) proposes nursing to be a human science and human care process significant to and preserving of humanity. The nurse providing care develops a helping/trusting relationship with the patient. Integral to the helping/trusting relationship are the aspects of congruence and empathy. Congruence involves being genuine, authentic and honest. Empathy involves the ability to experience, understand and communicate understanding of another's perceptions and feelings.

In a comparative analysis of caring literature; Morse, Bottorff, Neander and Solberg (1991), defined 5 major conceptualizations of caring: caring as a human trait; caring as a moral imperative; caring as an affect; caring as an interpersonal interaction; and caring as a therapeutic intervention.

Table 1 depicts the extension of nurturance to be both a human trait and an interpersonal interaction. Respect is a moral imperative and an interpersonal interaction. The helping/ trusting aspects of caring, which are empathy and congruence, are both an

affect and a therapeutic intervention. Finally, knowledge provision is shown as a therapeutic intervention.

Table 1

Relationship: Watson's Concepts (1988) to Morse et al. Traits (1991)

	Nurturance	Respect	Empathy Congruence	Knowledge Provision
Human	X			
Moral		X		
Affect			X	
Interpersonal	X	X		
Therapeutic	X		X	X

Mayer (1987) identified differences in patients' perceptions of nursing care and nurses' perception of caring. Mayer identified that what nurses perceive to be caring and what patients perceive to be caring are different entities. Patients identify knowledge provision, technical care, competence and respect as indicators of caring; while nurses identify non-verbal communications and personal respect as indicators of caring. In this study, it is the patient perception of nurse caring that will be examined.

Conceptual Definition of Patient Satisfaction

Satisfaction, as defined in Webster's Collegiate Dictionary (1992), is the state of feeling that desires, expectations or needs are being met. In measuring nursing care satisfaction, in a primary care perspective, Risser (1975) noted satisfaction is the gratification of needs and the fulfillment of expectations. La Monica, Oberst, Madea and Wolf (1986) defined patient satisfaction as the degree to which there is congruence between care expected and care received. For the purposes of this study, the conceptual definition of patient satisfaction is the written expression of gratification of health care needs.

LaMonica et al. (1986) developed a scale to measure patient satisfaction, which was found to have better reliability, validity, and sensitivity than other available instruments. Satisfaction dimensions included in the scale were from Risser's (1975) conceptualization of three facets of nursing performance: 1)Technical-professional, 2) Trusting relationship; and 3) Education relationship. "Technical-professional" facets include activities that were task oriented and knowledge based. "Trusting relationship" included behaviors and characteristics which permitted productive nurse-patient interactions. "Education relationship" included provision of knowledge and information.

LaMonica et al. (1986) noted that patient satisfaction with nursing care is important to those interested in monitoring quality of care and effectiveness of specific interventions. Munro, Jacobsen and Brooten (1994) state patient satisfaction may be considered to be a better measurement of outcome of nursing care than morbidity and mortality, since nurses seldom make diagnostic decisions affecting morbidity and mortality. This author would disagree with the opinion that nurses seldom make

diagnostic decisions affecting morbidity and mortality. APNs make daily strategic and diagnostic decisions regarding care that does affect the outcomes of morbidity and mortality, length of stay and patient satisfaction. For example, the APN may recommend and develop a regular exercise program for a hypertensive patient to minimize the effects of hypertension on the cardiovascular system. The OCNS in this study may identify and treat oral candidiasis in the immunocompromised cancer patient, clearly affecting morbidity outcomes and increasing his/her quality of life.

Examining the concept of satisfaction from the literature, Pascoe (1983) defined patient satisfaction as the health care receiver's reaction to the context, process and result (outcome) of his or her health care experience. The patient evaluates the structure, process and outcome of the received service. The patient also applies an emotional component to the same structure, process and outcome of services, leading to a dual system of evaluation of the provided services: objective as well as subjective. The result is the structure, process and outcome of received services are judged by the patient in the subjective as well as the objective realms.

Ware and Davies (1983) cited three reasons for measuring satisfaction. First, satisfaction is an ultimate outcome of health care delivery; therefore satisfaction must be evaluated to determine how well and how acceptable health care providers provide services. Second, satisfaction ratings provide information about structure, process and outcomes of care. For example, ratings of satisfaction may examine the physical surroundings (structure); is the office clean, in a new or old building, easy to reach by public transportation? Examination of process may include large clinic or small private office; and how they were treated by office or clinic personnel. Outcome ratings examine

satisfaction with the speed at which the patient may return to work or level of function returned post treatment.

Ware, Snyder, Wright and Davies (1983) examined satisfaction as both a measure of care and a measure of the patient providing the rating defining the care. They further defined patient satisfaction as a multidimensional concept corresponding to characteristics of providers and services. Dimensions of patient satisfaction identified included interpersonal manner, technical quality, accessibility/ convenience, finances, efficacy/outcomes, continuity, physical environment and availability.

Eriksen (1995) identifies three antecedents to satisfaction with nursing care: 1) An interaction between the patient and the nurse; 2) A development of expectations of the service the nurse provides; 3) An interaction between the expectations of the performance and the perceptions of that performance, from which the patient evaluates the result. Eriksen (1995) further proposes there are consequences that result from satisfaction, and delineates three of interest to health care providers. These are: adherence to health care regime, increased participation of the patient and positive influence to continue to use the service again.

Eriksen (1995) further defines patient satisfaction with nurse caring as the "patient's subjective evaluation of the cognitive/emotional response that results from the interaction of the patient's expectations of nursing care and their perception of actual nurse behaviors/characteristics"(p.71).

Dimensions of Patient Satisfaction

Pascoe (1983) delineated eight dimensions of patient satisfaction. These eight dimensions are: service delivery, availability- accessibility- convenience, financial- structural characteristics, provider-patient interaction, technical competence, interpersonal skills, continuity of care, patient-provider fit and clinical outcome.

Service delivery addresses the type of service received. Pascoe (1983) reviewed the types of delivery of care, which range from primary care with a family-centered style to tertiary, acute care such as an emergency department. Pascoe (1983) found that patient satisfaction is consistent with improved organization, but noted that this may be more a reflection of patient idiosyncrasies, than the actual service provided. Patients develop a personal definition of organized care by which they judge the organization of the service delivery.

Availability, accessibility and convenience are a dimension of the eight defined by Pascoe, 1983. Increased satisfaction has been demonstrated with decreased travel time and waiting time in the office. Brief delays in obtaining services also correlate positively with increased patient satisfaction. Kurata, Nogawa, Phillips, Hoffman and Werblun (1992) reported a patient satisfaction rating of 73-87%, in a study of a family practice residency program, identifying waiting time for appointments as being a cause of dissatisfaction. This is an important aspect of this study, since caring is being provided in the rural area in close proximity to the patient's home.

Financial and structural characteristics are a third dimension of patient satisfaction (Pascoe, 1983). Quality of care and socioeconomic status are very much interrelated. Findings indicate that the less costly the care, the more satisfied the patient. Insurance status also affects satisfaction in that patients with insurance generally preferred private practice, while patients without insurance generally preferred or had been assigned to clinics.

Provider-patient interaction forms a fourth dimension of satisfaction, and has been the most commonly investigated source of satisfaction. Woolley, Kane, Hughes and Wright (1978) state the degree to which a patient believes the physician cares about them may be the most important element in determining compliance and satisfaction. DiMatteo et al. (1993) report that even with time limited visits, physician job satisfaction positively affected patient satisfaction. Weisman and Nathanson (1985) found that job satisfaction among family planning and community health nurses positively effected satisfaction among patients in county health department family planning clinics. Duffy (1992) asserted that nurse caring is an important predictor of patient satisfaction. This dimension of satisfaction is intimately involved with the present study as nurse caring requires the establishment of a therapeutic interaction.

Technical competence, Pascoe (1983) continues, is the best predictor of overall satisfaction. Kurata et al. (1992) reported a 97% satisfaction rate with the technical competence of providers in a family practice residency program. Risser (1975) found that patient perceptions of nurse behaviors in the knowledge and technical expertise domains were the greatest predictor of patient satisfaction.

Fosbinder (1994) notes that patients value interpersonal skills in 'bedside nursing' as being important, and relates these skills as important toward technical competence.

The question of whether a patient is an adequate judge of technical expertise then arises. Can a lay person truly judge whether a provider is technically expert? Perhaps the perception by the patient that their provider has technical expertise is the important concept in operation. The issue is not whether the patient is an adequate judge, but if the patient has a global perception of expertise on the part of the provider, and how that global perception effects their satisfaction. Although Risser (1975) identified knowledge and technical expertise as predictors of satisfaction, intra/interpersonal functions and development of a trusting relationship were also identified as being integral to patient satisfaction. Ben-Sira (1982) concluded that satisfaction with a physician's affective behavior greatly influences the evaluation of professional competence. The global perception of expertise Ben Sira (1982) proposes is linked to satisfaction, integral to this process is the trust the patient develops for their provider. Therefore, satisfying interpersonal interactions may positively influence the perception of technical expertise.

Woolley et al. (1978) note that effective communication leads to a perception of 'being cared for.' Interpersonal skills were seen as a fifth dimension of patient satisfaction by Pascoe (1983). He reported that clear communication and interest shown in the patient are part of the process of satisfaction. In a study of APNs in a breast clinic in the United Kingdom; Hammond, Chase and Hogbin

(1993) found that patients were more satisfied with nurse practitioners over house physicians, especially in terms of communication. In a marketing and managerial targeted investigation, Bowers, Swan and Koehler (1994) determined that communication is a significant determinant of patient satisfaction. Interestingly, they also found that caring was a significant predictor of patient satisfaction. This then is another dimension of patient satisfaction intimately involved with this study.

Continuity of care is a sixth dimension of patient satisfaction. Having a regular provider of care is directly associated with increased satisfaction (Starfield, 1992). Weyrauch (1996) noted continuity of care in the HMO clinical setting increases patient satisfaction.

Patient-provider fit are a seventh dimension of patient satisfaction according to Pascoe (1983). Patient-provider fit examines the degree of congruence between the socio-economic status of the physician and the socio-economic status of the patient; the greater the degree of accord between the status of the patient and the status of the provider, the greater the degree of satisfaction. Extending this to the APN in primary practice, nurses may be seen as being more on the level of the 'common individual' than the physician, and hence clients may be inherently more satisfied with nurses, particularly middle and low income clients.

Clinical outcome is the last dimension of patient satisfaction. The better the clinical outcome, the greater the degree of satisfaction. The reverse does not hold true, however, that is poor outcomes do not produce dissatisfied patients.

Woolley et al. (1978) reported that 92 percent of all patients expressed satisfaction with care received, even though a poor outcome was the result. This may be a measure of the fact that the health care provider "tried his/her best" and an acknowledgment of that.

The relationship of nurse caring and patient satisfaction is predicated by these 8 dimensions of care. It is important for APNs providing nurse caring to be cognizant of these dimensions, since failure to address those that the APN has responsibility for may result in inappropriate utilization of services.

To summarize, 8 dimensions of care affect patient satisfaction. Although APNs are not able to affect all 8 dimensions, such as financial-structural characteristics and convenience, they are able to impact interpersonal interaction and skills. APNs also may impact the fit between patient and provider, and most assuredly impact outcome.

Measurement Issues

Some measurement issues related to patient satisfaction are the concepts which may externally effect satisfaction, these being: 1) Macro versus micro levels of satisfaction; 2) Satisfaction with life in general; and 3) Health status in general. Roberts, Pascoe and Atkisson (1983) reported that macro measurement of patient satisfaction of health care in general, and micro measurements of patient satisfaction of a particular episode of health care provided to the particular patient produce dissimilar results. That is, patients report their personal health care (micro) is generally satisfactory, but considering health care globally (macro), health care is not satisfactory. Roberts et al. (1983) related this

phenomenon to the quality of life satisfaction of the respondent. Patients with general feelings of well-being and life satisfaction are satisfied with their health care; patients unsatisfied with life may tend to blame external forces more, resulting in dissatisfaction with health care. Hall, Milburn and Epstein (1993) also observed that health status is a causal determinant of satisfaction in a sample of HMO based older patients. This study will only attempt to investigate the micro level of satisfaction, that is satisfaction with their personal health care.

Watson (1988) specifies qualitative means of measurement for the investigation of caring. In a personal communication, March 10, 1996; Dr. Watson expressed pragmatism about the necessity of measurement of caring, yet felt that measurement of caring "takes away from caring". Yet to document the "hard science" effect of caring, one must attempt to measure it quantitatively. Caring has been measured by the Q-sort technique (Von Essen et al, 1991), as well as by use of several tools developed, e.g., Duffy (1992) with the Caring Assessment Tool, and Wolf, Giardino, Osborne and Ambrose (1994) with the Caring Behaviors Inventory, both of which have limited generalizability related to sampling technique. The sample utilized in Wolf et al. (1994) was a convenience sample of 278 nurses and 263 patients in secondary and tertiary setting. Duffy (1992) also utilized a tertiary care setting, however it was a randomly selected sample of admissions to the hospital, with a new random number generator reset every 24 hours.

Patients are reluctant to report negative feelings (Ventura, Fox, Corley & Mercurio, 1982). Reluctance to report negative feelings causes a problem in the

measurement of satisfaction creating generally high ratings, with little variability. In the Ventura et al. (1982) review of patient satisfaction as a criterion to evaluate primary care, patients were reluctant to express negative feelings, especially if care was needed in the future. Ventura further discussed that scales are frequently distorted by the use of primarily positively worded items, which also skews positively results.

Another reason for problems in measuring patient satisfaction is that of dissatisfied patients may choose not to be patients. Satisfaction, or dissatisfaction, with care results in decisions regarding care seeking, adherence behavior and reactive behavior, according to Ware and Davies (1983). Care seeking includes whether the patient seeks care for illness treatment, well-care appointments, or numbers of visits during a specific time. Adherence includes cooperation with health care recommendations established by a patient-provider collaborative effort; for example, medication regimes or lifestyle changes. Reactive behavior examines actions by consumers expressing satisfaction or dissatisfaction with their health care. Reactive behavior may include patients speaking out publicly about dissatisfaction, the filing of legal suits, or seeking new providers. Thus, satisfied clients are more apt to seek care, adhere to recommendations and engage in less negative reactive behavior.

Ware and Davies (1983) concluded that consumer behaviors, specifically patient recommendations for or against specific providers, changing health plans, filing formal complaints or malpractice suits are substantially related to dissatisfaction with health care services. Ware and Davies (1983) concluded

further that patient dissatisfaction may account for delays in care seeking and doctor shopping.

Fiesta (1991) cited patient dissatisfaction as a primary cause of malpractice suits. Elgin (1990) reported 70 percent of malpractice suits were related to patients' dissatisfaction with communication patterns with their health care provider. Elgin posited the pervasive use of 'Mdeityspeak' as being a prime contributor to dissatisfaction with communication with health care providers. 'Mdeityspeak,' according to Elgin, is the mode of questioning used in the interview that does not allow the patient more than 18 seconds to complete the reply. This finding specifies communication as an area to be examined when measuring patient satisfaction, although this will not be investigated in this study.

A final consideration of the inherent difficulties of measurement of patient satisfaction is the limited potential percentage for improvement. Since the literature indicates a high rate of satisfaction, there is little upon which to improve. It must be considered that not all of the dimensions of satisfaction have as yet been identified.

Therefore, this study examined patient satisfaction in the context not only of satisfaction with Pascoe's delineated dimensions, but also in relationship with other concepts, such as caring. To review, the dimensions of patient satisfaction specifically being examined in this study are: 1) Service delivery, primary care by an OCNS; 2)Availability, accessibility and convenience in a rurally located clinic; 3) Provider-patient interaction between the OCNS and the patient; 4) Technical competence as perceived by the patient; 5) Interpersonal skills, specifically

effective communication between the OCNS and the patient. Examination of the relationship of nurse caring on patient satisfaction, although perhaps somewhat "soft," may provide many opportunities. These being: 1) The opportunity of APNs to document effectiveness; 2) The opportunity to decrease reactive behaviors, such as filing of legal suits, "provider-shopping," improper utilization, such as seeking care at after-hours clinics or emergency departments or failure to seek care at all; 3) Nurse caring may also provide the opportunity for increased satisfaction keeping patients in health plans, making the APN a valued team member.

Relationship of Caring and Patient Satisfaction

What is the relationship between patient satisfaction and caring? Duffy (1992) noted three consistent themes in a review of patient satisfaction studies over the last thirty years. First, in general, patients are satisfied with hospital services. Second, demographics do not seem to be a significant factor in patient satisfaction. Third, satisfaction with nursing care is a consistent factor in overall satisfaction with hospitalization. The third result indicates that nurses and caring are in a prime place to effect patient satisfaction (Duffy, 1992).

Quality assurance is a method of measuring effectiveness of care. The current health care system is in a crisis. Costs continue to rise with no end in sight. Cost benefit and effectiveness are increasingly being examined by payors and consumers (Hegyvary, 1991). Health care professionals must begin to view their services as results and products. Patients are titled "guests" or "customers". Customer satisfaction is being sought to maintain "business."

Quality assurance standards previously had examined delivered care from the perspective of structure (Bauman, 1991). For example, highly organized structures were able to provide quality care. Currently, the standard of quality assessment and assurance has shifted to include goals of improved patient outcome, which includes customer satisfaction. First, evaluation of care from a patient perspective allows the patient to tell nursing if the care provided met their needs. Second, analysis of patient outcomes measures if optimal care was provided at optimal price. Third, a system that provides the highest quality outcome of patient satisfaction due to nursing care, holds the most promise for advancement of professional nursing (Bauman, 1991). A system holding the highest quality patient outcomes would hold the most promise for the APN in primary care practice, proving not only societal but monetary worth to employers, such as managed care. A high quality system utilizing APNs to provide primary care with satisfied clients is cost effective, has cost benefits and meets patient's needs. Patient outcomes present the opportunity to demonstrate effectiveness of provided nursing care (Jones, 1993). Applying the concept of outcome measurement to the practice of the APN would make evident the advantages of care provision by the APN.

Outcome measures, specifically patient satisfaction, may be used to measure practice, demonstrate effectiveness and justify continued expansion of the APN role. Marketing of the practice of the APN may be accomplished by using satisfaction measures. Current users of the APN practice will most likely continue to utilize the practice, if they are satisfied. If these users are women,

they will tend to continue using the same providers over the lifetime of their family (Naylor, Munro, & Brooten 1991). Consequently, the practice of the APN will fuel expansion of the role of Clinical Nurse Specialist/Nurse Practitioner in health care provision. Women proportionately seek health care in greater numbers than men (Naylor et al., 1991). When the APN may provide greater satisfaction with health care to these women, especially considering the perceived congruence of socio-economic status as well as gender, the APN will be a sought-after provider.

The APN whether in primary care, serving a managed care population or in focused care of oncology patients, may use the documentation of his/her advanced caring abilities as a tool to document worth to the employer.

Critical Discussion

In summary, there are several shortcomings in the available literature in relation to the purpose of this study. First, the literature is mainly hospital based and developed for the hospital setting. Measures of patient satisfaction developed for in-patient settings are not necessarily transferable to outpatient, rural oncology clinics. Second, the patient satisfaction literature indicates most patients, 92-97 percent, are satisfied with their care (Woolley et al., 1978; Kurata et al., 1992). In review of satisfaction as a criterion to evaluate primary care, patients are generally reluctant to report negative feelings, especially if they believe they may need care in the future (Ventura, Fox, Corley & Mercurio, 1982).

There are few studies related to patient satisfaction with advanced practice nursing as the focus. Safriet (1992) notes in a treatise on the role of advanced

practice nursing and health care regulation, that APNs have a higher overall rating of patient satisfaction than physicians, related to conveyance of information, reduction of professional mystique and the costs of care.

As previously noted, caring is a construct of nebulous definition. Caring currently has no physical parameters by which it may be measured. Few tools have been developed to measure caring. Despite much literature discussing caring, no one author has given a clear, concise measurable definition of caring. Von Essen and Sjoden (1991) using the CARE-Q method identifying which behaviors were most important. Duffy (1992) developed the Caring Assessment Tool, for use in measurement of nurse caring in the in-patient setting. The encounters in this study have been designed to be of a nurse caring nature, and will for that reason provide the means to measure caring by variation in numbers of their encounters.

The study examined the correlation between the number of encounters of nurse caring from a patient's perspective and their subsequent satisfaction with nursing care. This study clarified the relationship between the caring provided by the Oncology CNS (OCNS) and demonstrated that this caring is an integral part of ultimate health care satisfaction. OCNSs in a rural setting positively impacted the global satisfaction with health care and thereby documented the value of OCNS nursing. Long term benefits obtained from ONCS caring will be cost - effective for the insurers and managed care concerns overriding the short term potential for increased costs by: 1) Increasing adherence behaviors; 2) Decreasing

reactive behaviors; and 3) Decreasing morbidity, and possibly mortality through early identification of risk factors and increased patient participation.

Theoretical Framework

Watson's (1988) Philosophy of Nursing as Human Science and Human Care was developed originally as a textbook for a Baccalaureate nursing program. Watson is heavily influenced by belief in the metaphysical aspects of our existence. She believes the health/illness and human care process is too abstract to be limited to empirical science and the physical-materialistic views. Society needs the caring professions, and nursing in particular, to help restore humanity and nourish the human soul in an age of technology, scientism, and stress. Nursing, according to Watson (1988) is "knowledge, thought, values, philosophy, commitment and action with some degree of passion" (p.53). Each person is the locus of their existence with three spheres of being: mind, body and soul.

The art of caring is expressed when the nurse "having realized or experienced the feelings of another, detects and senses these feelings and creates a condition where the other is able to experience these feelings more freely and release the feelings he/she has been longing to express" (Watson, 1988, p. 68). An actual caring occasion involves action and choice by both the nurse and patient and has the potential to influence both the nurse and patient in the future (See Figure 1).

Watson's philosophy of nursing has its basis in phenomenology and existentialism. The belief is of nursing as a human science and human care process as a significant humanitarian and epistemic act that contributes to the preservation of humanity. Concepts integral to the understanding of this theory are: 1) caring- all factors used by a nurse to deliver healthcare, including knowledge provision, and nurturance; 2)

congruence- an aspect of the helping/trusting relationship that involves being genuine, authentic and honest; 3) empathy- an aspect of the helping/trusting relationship that involves the ability to experience, understand and communicate understanding of another's perceptions and feelings; and 4) carative factors- structural components that describe caring process, including mutual respect and how a client maintains, attains or sustains a peaceful death.

Transpersonal caring is a "special type of human care relationship" (Watson, 1988). This relationship is a union with another person dependent on: a)a moral commitment to protect and enhance human dignity, b) nursing intent to affirm personhood, c) nurses' ability to realize and accurately detect feelings and inner conditions of another, d) nurses' ability to realize and feel a union with another - to be expressed in some manner, e) nurses' own sensitivity gathered through life experiences, personal growth and identifications of personal values (Watson, 1988). Watson's construct of transpersonal caring melds the facets of caring as a human trait, moral imperative, affect, interpersonal interaction and therapeutic intervention.

The concepts of knowledge provision, nurturance, mutual respect and the congruence and empathy aspects of the helping/trusting relationship may be extracted and supported by this theory as the previously noted conceptual definition of caring. The following model of caring as being an essential supporting factor of patient satisfaction is proposed (Figure 2).

Watson's (1988) model depicts the overlap of experiences between the nurse and patient. The dashed line represents the lived experience of the nurse, while the dotted line the patient. The caring occasion takes place when the two come together during the

present, bringing their past experiences along. The proposed model of the study constructs indicates where the caring occurs, and how the constructs of the study are applicable. Patient satisfaction is measured in the future, after the caring occasion has occurred.

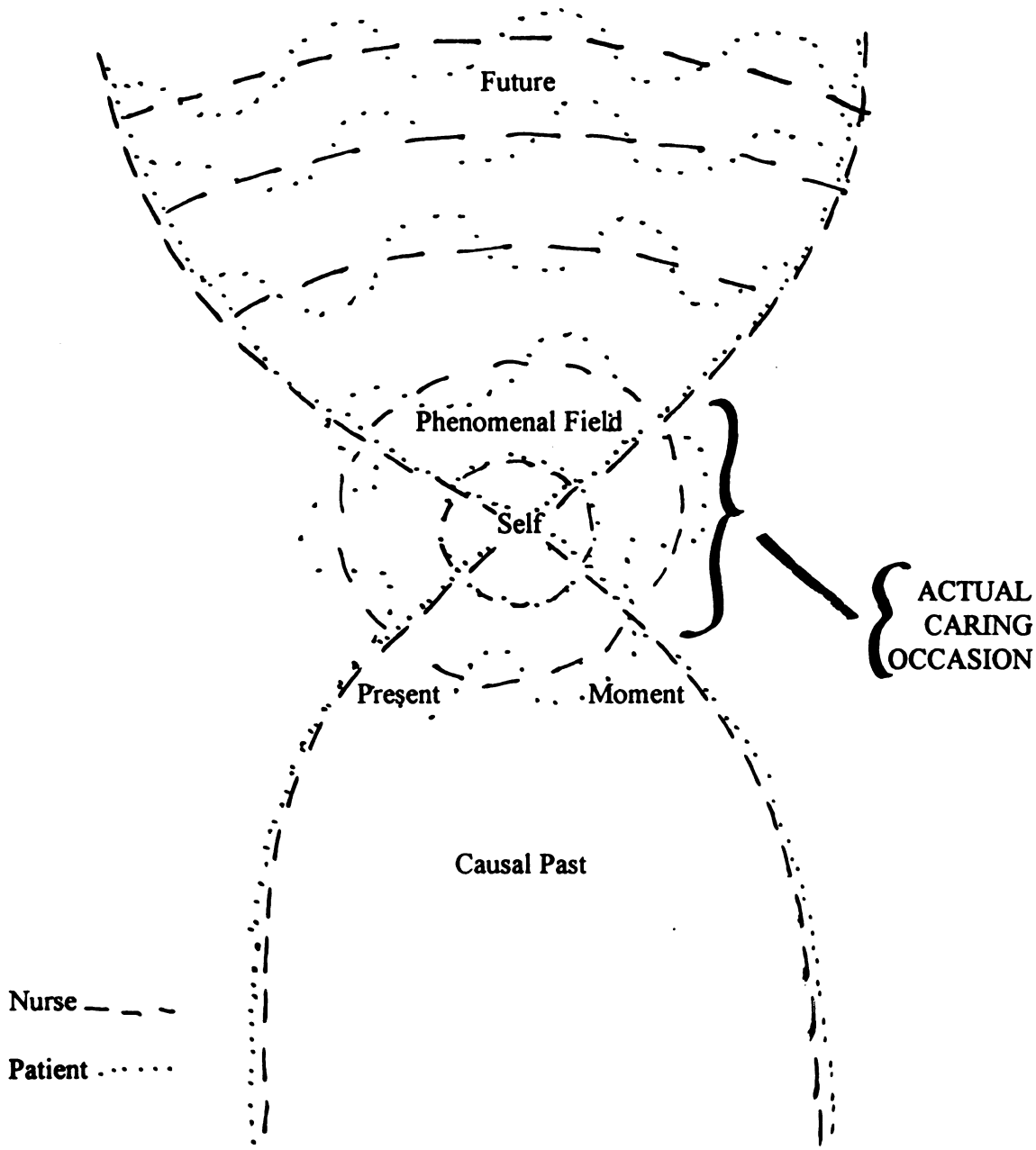

Figure 1. Watson's Model of Nursing (1988, p.59)

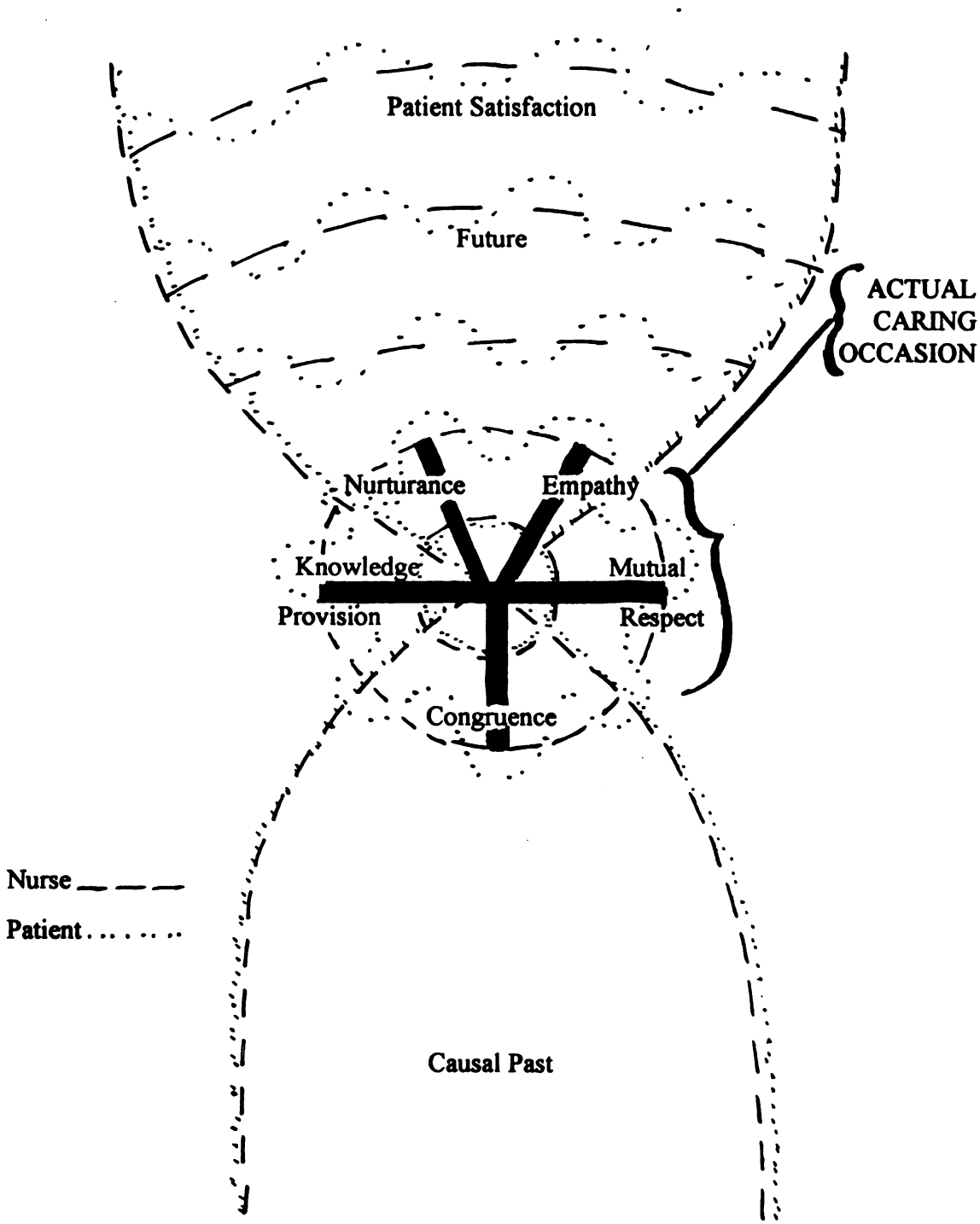

Figure 2: Watson's Model of Nursing with Study Concepts

Rationale

The underlying rationale for this study is the lack of a clearly documented link between nurse caring and patient satisfaction. When examining the rising cost of health care, outcomes of nursing care must be measured and documented. The profession of nursing must increase efforts to document effects of nurse caring on health care outcomes. Outcome-based measures are a means to do so. Patient satisfaction is a frequently measured outcome, and therefore nursing can begin to measure and document it as an outcome. Documentation of the positive effects that caring nurses may have on patient satisfaction, specifically by examining the benefit of care provision by rural CNS's, might encourage greater utilization of the CNS/APN. With caring provided by the CNS/APN; increased satisfaction for the patient may ultimately translate into high quality, accessible care, decreased costs, and better overall outcomes for patients

Methods

A secondary analysis will be done using data from a primary investigation by Charles W. Given, PhD and Barbara A. Given, RN, PhD, FAAN, Principal Investigators. The primary investigation was entitled the "Rural Partnership Linkage for Cancer Care," and was funded by the National Cancer Institute, Grant No. 1R01 CA56338-02. This was an investigation into the treatment and supportive care of multiple types of cancer patients living in three rural counties in southwestern Michigan. The quasi-experimental study was funded for 5 years, and is currently beginning the fourth year. This study has developed and implemented interventions of oncology clinical nurse specialists in rural cancer clinics, and continues to measure the effectiveness of the OCNS/ rural cancer clinics. The rural areas of the country must generally wait for progressive modalities of

treatment. By consciously bringing state of the art cancer care to the rural communities, the intervention hopes to improve outcome of cancer treatment.

For the proposed study, secondary analysis of the data from wave 4, one year after entry into the study, was done. A OCNS, with a minimum of a Baccalaureate degree in Nursing and advanced certification in oncology nursing performed the intervention and was instructed in provision of care consistent with empathy, nurturance, knowledge provision, mutual respect and congruence. Wave 4 included a measure of patient satisfaction. From these data the relationship of number of encounters of nurse caring on patient satisfaction was examined. The study was a correlational, cross-sectional design. Justification of the design of this investigation was guided by several factors. Selection was limited to patients who have already developed cancer. Under study was the relationship of the effect of nurse caring as provided in frequency of encounters and rural cancer patient satisfaction, making this a correlational study. Cross-sectional studies collect data only at one point in time and therefore are meant to obtain measurements of the moment. These types of studies describe what exists today, and make no effort at prediction or causation. Measurement of patient satisfaction with perceived nurse caring may help guide future practice, but satisfaction is only at one point in time. The limitations of this method will be further discussed in the discussion section. Convenience sampling was employed since random sampling of cancer patients in the three specified counties did not provide a large enough sample size, and was too expensive to do so.

Sample

The study sample was a convenience sample, composed of patients living in the rural Southwestern Michigan counties of Allegan, Van Buren and Barry. Eligibility criteria included referral by oncologist, community agencies, self-referral, family or primary care physicians. There were 190 patients enrolled in the intervention at the time of the study onset, of which 131 have reached Wave 4, 48 percent attrition. The patients' ages range between 32 and 92. Sample size for this study was 47. (See Table 2).

Of 190 patients enrolled, 131 have reached Wave 4. The failures to complete may be accounted for as follows: 45 have died, 7 were too ill to complete Wave 4; and 11 refused to complete. Sixty-eight patients remain of the original 131, of whom 49 have returned the questionnaire, however, 2 were returned blank. The attrition rate is 21 or 38 percent related to refusal to complete.

The intervention in this study was designed to bring state of the art cancer care to rural communities. Oncology Clinical Nurse Specialists providing this nurse caring interaction are Baccalaureate, Masters candidates or Masters prepared nurses with certification in Oncology Nursing, specially trained in state of the art caring. The special training procedure will be further outlined in the next section.

Table 2:

Socioeconomic Distribution

Socio-Demographic Variable	Value	Percent	Number
Gender	Male	34	16
	Female	66	31

Socio-Demographic Variable	Value	Percent	Number
Marital Status	Single	2.1	1
	Married	59.6	28
	Divorced	12.8	6
	Widowed	25.5	12
Race	Caucasian	63.8	30
	African American	4.3	2
	Native American	2.1	1
	Refused	29.8	14
Educational Level	Grade School	8.5	4
	Some High School	8.5	4
	High School Graduate	34.0	16
	Some College	29.8	14
	College Graduate	12.8	6
	Graduate Degree	4.3	2
	Refused	2.1	1
Household Income in U.S. Dollars	0-4,999	2.1	1
	5,000-9,999	12.8	6
	10,000-14,999	6.4	3
	15,000-19,999	12.8	6
	20,000-24,999	8.5	4
	25,000-29,999	8.5	4
	30,000-34,999	6.4	3
	35,000-39,999	6.4	3
	40,000-44,999	6.4	3
	45,000-49,999	6.4	3
	50,000-59,999	6.4	3
	70,000-79,999	2.1	1
	Refused	14.9	7
Diagnosis	Breast	46.8	22
	Colon	10.6	5
	Ovary	8.5	4
	Lung/Respiratory	8.5	4
	Prostate	6.4	3
	Lymphoma	4.3	2
	Cervical /Uterine	4.3	2
	Larynx	2.1	1
	Leukemia	2.1	1
	Melanoma	2.1	1
	Thymus/Heart	2.1	1
	Esophagus	2.1	1

Training Nurses to Provide "Caring" Interventions

The multiple goals of the intervention are to assist patients and their families with acquiring the necessary knowledge, skills and support, to obtain the services and resources necessary to live with cancer, manage their disease and treatment. Managing their cancer was done with the least impact on their physical and psychosocial functioning (Given, 1995). Care provided by nurses in an advanced practice role complemented the medical care patients and their families receive from primary care physicians and cancer specialists.

The contacts for the structured caring intervention included, but were not limited to (Given, 1995):

1) Receipt of ongoing education, strategies, information and psychosocial support about cancer as a disease. Information also included facts about cancer treatments and problems they may or do experience. Knowledge provision is a crucial component of this portion of the intervention.

2) Patients were aided in development of adaptational strategies to live with the cancer, gain control of side effects of treatment or enhance rehabilitation during the first months of adjuvant therapy. Anticipatory guidance was offered by the nurse, and patients were encouraged to express needs based on their experiences. Empathy, nurturance and congruence were keys to this section of the intervention.

3) Problem-solving approaches were used to help the patient make the necessary life-style changes resulting from the disease and its treatment. This was an on-going intervention with the patient and his/her family due to the ever-changing needs of the

illness. Knowledge provision, empathy and mutual respect are especially important in problem solving approaches.

4) Networking skills were developed in response to patient needs. Mobilization of formal and informal community resources was assisted through the development of these skills. Patients and families were assisted to follow their prescribed therapeutic plan of cancer care. Mutual respect of the competency of the patient to make decisions, and utilize resources was critical.

5) Ongoing emotional support and counseling was provided to deal with problems, issues and concerns related to the cancer diagnosis and treatment; to anticipate the follow-up care that was needed and to complete the prescribed therapeutic regimen. Referrals were used when other care providers were needed. Empathy and nurturance were characteristics of a caring encounter that are very important for this portion of the intervention.

6) The oncology clinical nurse specialist (OCNS) assumed a case manager role of advocacy, counseling and support, service coordination and collaboration and consultation with the primary and specialty care health professionals (physicians, nurses, etc.) to ensure that the therapeutic plan and follow-up care was followed and received. Mutual respect was important, especially respect of the nurse for the inherent abilities and capabilities of the patient.

7) Health and symptom status, and the psychosocial, physical and functional level of the patients were assessed at each encounter. An initial intake assessment was completed and each subsequent visit included a follow-up assessment. A plan of care was completed at each visit based on problems identified. The ability to empathize with and

nurture the patient through this difficult time was an important component in this intervention.

8) Referrals were made to the appropriate home care and hospice agencies as needed. Knowledge of available resources and provision of this knowledge to the patients and their families was an aspect of caring.

The intervention described above is directed toward patients to provide continuing and supportive care in the immediate period following cancer diagnosis. This period included a minimum of ten to twelve contacts: there were two visits months one and two following diagnosis; one visit months three through six following diagnosis, and two telephone contacts per month. Additional contacts were available as needed.

The interventions operationalize the identified components of caring in several ways. Ongoing guidance of the patient and family, being supportive, counseling, providing anticipatory guidance all involve the components of empathy, congruence, mutual respect and nurturance. Knowledge provision involves the teaching aspects of the role; and outright knowledge provision, anticipatory guidance, and networking skills were all items of learning. Congruence again is the ability to be genuine and honest, making it a critical component of the entire intervention.

The oncology clinic nurse provided nursing care that was accountable, responsible, comprehensive, continuous and coordinated. The oncology clinic nurse was in a collaborative relationship with the specialty physician as well as the primary care physician. The patient and family were at the center of the plan of care and were members of this collaboration. The aspects of caring: knowledge provision, empathy,

congruence, mutual respect and nurturance, are integral to the collaborative effort of oncology patient care, as well as to the provision of nurse caring.

Data Collection

This secondary analysis used data collected from Wave 4: evaluation of effectiveness of the intervention and the extent to which the clinic services meet the continuing needs of patients and their families. Wave 4 measurement was done of patients who completed 15 visits with the oncology clinical nurse specialists, approximately 1 year after intake into the study. Wave 4 consisted of (among other things) a modified LaMonica-Oberst Patient Satisfaction Scale (LOPSS), Appendix A.

The measure of caring is the number of caring encounters with the OCNS. Since this intervention is designed to be of a caring nature, so all encounters are presumed to caring encounters and therefore, adequate measures of caring as provided by OCNSs.

The Wave 4 data was collected by telephone interview. Interviewers were graduate assistants employed by Michigan State University, Department of Family Practice, College of Human Medicine, and were specially trained by detailed interviewer training, including a procedure manual for protocols, mock interviews and regular follow-up by monthly taped interviews.

The subjects were interviewed at entry into study (Wave 1), 3 months from initial contact (Wave 2), 6 months (Wave 3), 9 months and 1 year (Wave 4) from initial entry into the study. The medical intervention may be surgery, radio- or chemotherapy, or palliative care. Nursing interventions were based on patient needs. After each interview the subjects were sent a Self-Administered Booklet with questions to complete. Wave 4 was at 1 year from initial entry into the study and was not related to phase in the

treatment, but from phase in the nursing intervention. The satisfaction survey proposed for use in this secondary analysis is from the mailed self-administered questionnaires, consisting of 32 items. It was administered during Wave 4, i.e., 12 months after entry into the study. The basic statement of the survey is, "The nurse in the rural clinic...", to which the patient responded on a 5 point Likert Scale from Strongly Agree to Strongly Disagree.

Protection of Human Rights

Human subjects protection was sought from UCRIHS and obtained for the primary study, # 91-277. Subjects were informed that their participation was optional and would not affect the quality of their care from other settings and providers. Subjects were assigned a case number and all contacts for data collection are by telephone, thus ensuring privacy. Since this is a secondary analysis, an exempt from full review human subjects approval was sought for this investigation. UCRIHS approval # 96-066 was granted for this study. (See Appendix B).

Operational definitions

The operational definition of caring will be the number of caring encounters with the OCNS to include office visits as well as telephone contacts. Since these encounters all have caring as the basis of the intervention, every encounter will be considered to a be a caring encounter.

The operational definition of patient satisfaction will be the score on the LaMonica-Oberst Patient Satisfaction Scale (LOPSS). A mean score of at least 4.00 or better was considered to be a satisfied patient, since they are at minimum agreeing on average with most items.

Instrumentation

For the purposes of this study, a modified LOPSS was used (Appendix A). Patient satisfaction is notoriously difficult to measure. Typically, patients respond with positive reports of satisfaction. This scale used negatively worded items to avoid this pitfall. In previous uses, the LOPSS reported positively skewed findings. In development of the LOPSS, La Monica et al. (1986) attempted to develop a tool free of positive skewing. Coefficient alpha for the entire scale was reported to be .95 (La Monica et al., 1986). Three subscales were identified by LaMonica et al., dissatisfaction, interpersonal support and good impression. The subscale factors reported high internal consistency, (coefficient alpha = .91, .92 & .89). Subscale to subscale intercorrelations support dissatisfaction as separate from other factors. Correlations are: dissatisfaction with interpersonal support r = .59; dissatisfaction with good impression r = .58; and interpersonal support with good impression r = .74. Psychometric testing of the LOPSS by Munro et al. (1994) demonstrated construct validity. Construct validity is the degree of actuality with which the instrument actually measures what it is supposed to measure (Brink & Wood, 1994), and may be asserted by several approaches: contrasted groups, experimental manipulation, and multitrait-multivariate method. Munro et al. (1994), in using three contrasted groups, tested the LOPSS with Cesarean section patients, women with gestational diabetes, and nononcologic hysterectomy. The findings reported this scale to be useful in measurement of patient satisfaction across these groups. Cronbach's alpha was recomputed for the proposed study, since this was a different sample and using revised scale.

Scoring

Values are assigned to each response: 1= Strongly Agree, 2= Agree, 3= No Opinion, 4= Disagree, 5= Strongly Disagree. Positively worded items were reversed scored, and then a mean score for the entire scale was obtained. A score of 4.00 was considered to be indicative of satisfaction since that indicated agreement with positively worded items and disagreement with negatively worded items.

Statistical Analysis

Patient satisfaction was measured and compared to the number of caring encounters made. The null hypothesis is that patients having fewer caring encounters will be equally satisfied as the patients having a greater number of caring encounters. The alternative hypothesis is that patients receiving the greatest number of caring encounters will show the greatest satisfaction with their care. Correlation coefficient (Pearson's r) were employed to determine if there was a relationship between the number of caring encounters and patient satisfaction.

Data

Of the 68 patients eligible for this analysis, 19 did not return their survey. Of the remaining 49, the satisfaction data was not available for 2, leaving an n= 47 (Attrition rate of 38 percent). Cronbach's alpha for the modified LOPSS was 0.9627 for this sample, indicating high internal reliability.

Respondents were asked to rate their satisfaction on a 1 through 5 scale. Since some of the items were positively worded and some negatively worded, positive items were reversed scored. For the positively worded items, items # 1-13 and 28- 32, the response of the patient was recoded to be a consistent value. 1= 5, 2=4, 4=2 and 5=1.

From this recoding a mean patient satisfaction score was obtained for each patient. The total possible mean to indicate complete satisfaction would be 5.00. Satisfaction was assumed when mean scores were at least 4.00 or better, since that indicated disagreement with negatively worded items and agreement with positively worded items (See Table 3).

Table 3

Central Tendencies

Variables	Mean	Median	Mode
Mean Satisfaction	4.592	4.813	5.00
Caring Encounters	10.511	11.000	7.00/13.00

The mean number of encounters of caring was 10.511, with an SD of 4.413 and a range of 19 encounters (1-20), n=47. The median number of visits was 10, and the sample was bimodal at 7 and 13 visits. There was good variation in number of encounters.

The mean satisfaction score was 4.592, SD = .486, range of mean individual scores of 3.25 to 5.00, with 12 perfect 5.00 scores (n =47). There was no data available for 2 cases of the 49 surveys obtained for mean satisfaction, and little variation in scores of satisfaction. The surveys for the 2 cases for which no data was available were returned blank, these patients saw the OCNSs only 1 and 4 times. It is possible these patients experienced no satisfaction or they did not feel qualified to evaluate the caring intervention.

A correlation coefficient (r) was then computed for mean satisfaction and the number of encounters of caring ($r = .2985$, $df = 46$, $p < .05$, $p = .021$). This was statistically significant. This signifies a moderate correlation between the number of caring encounters and the patient satisfaction. Data indicates that as the number of caring encounters increased, patient satisfaction was moderately positively effected.

Upon examination of raw scores of satisfaction of 10 patients scoring less than a mean of 4.00, several items showed a higher incidence of less than complete satisfaction. Items number 31 and 32, communication with family members and collaboration with other health care services and providers, had the highest incidence of no opinion/ no response, or no information. The number of no opinion responses for 31 and 32 were 9 and 7 respectively, each item was left blank two times. The OCNSs may not have communicated with the family well enough. Perhaps this is related to lack of family involvement, no family to involve, or other health care services were not needed. It must also be remembered that some individuals may not be satisfied by any intervention. For caring to be effective there must be communication. Perhaps these patients who indicated less than perfect satisfaction did not communicate their needs to the nurse providing the caring intervention.

Items 14, 15 and 16 also had a higher incidence of less than complete satisfaction. These items were negatively worded, sanctioning a negative response. Item 14 examines whether there was a perception of individuality; 2 no opinion and 3 agree. Apparently, patients felt more often like a case, than an individual. Again, any rationale behind this would be speculation, since we have no qualitative data regarding this response. Items 15 and 16 examine the perception of speed of follow-up and thoroughness. There were 3

responses of agreement, 1 response of strong agreement for each. Item 16 also had 2 no opinion responses, where item 15 did not. Patients responded that they felt things should have been handled more thoroughly, and speedily. Perhaps the patients had too many needs for everything to be handled.

Items 20, 21 and 24 are a third group of items that show less than perfect satisfaction. Again, these items are negatively worded, sanctioning negative response. Item 20, "is impatient with me", was the one item that received the most negative scoring, with 3 patients expressing no opinion, 1 patient agreeing, and 4 patients strongly agreeing. Items 21 and 24 are "acts like I cannot understand the medical explanation of my illness", and "fails to consider my opinions and preferences ..." . Item 21 had 4 no opinion responses; item 24 had 5 no opinion responses. These may be areas of communication nonsuccess.

No significant demographic trend could be identified from the 10 patients whose mean satisfaction was less than 4.00. Patients with a mean score of less than 4.00 tended to be primarily women, 80 percent; married (6/10), widowed (3/10) and divorced (1/10); cancer sites were breast (5/10), colon (3/10), ovarian (1/10) and prostate (1/10).

A point of consideration; the patients received the caring intervention in 3 different clinics, by 4 different providers. The scores were not categorized or analyzed by the clinic in which caring took place. Nor were the clinic personnel, and accessibility of that clinic equal throughout the intervention. It could also be possible that the clients indicating less than 4.00 as a mean satisfaction were provided with caring that encouraged them to comment on areas needing improvement. This may be a strong indicator of effectiveness of communication and support by the OCNSs. "Differing levels

of satisfaction may, therefore, indicate different perspectives on nursing care quality rather than different amounts of satisfaction with the same thing" (Bond and Thomas, 1992). It is possible that the differing levels of satisfaction then may indicate a trend in the willingness of the patients to indicate not so much satisfaction or dissatisfaction, but areas needing improvement and areas meeting expectations.

It must be emphasized that by far, patients agreed or strongly agreed with the positively worded items and strongly disagreed or disagreed with the negatively worded items. The vast majority of responses were therefore indicative of patient satisfaction. The hypothesis of this study is supported; that nurse caring would have a positive relationship with patient satisfaction.

Discussion

The hypothesis proposed by this investigation was supported. OCNS caring moderately related to ($r = 0.2985$, $p=.042$) patient satisfaction. Considering the results, it is apparent that specially designed caring interventions provided by OCNSs are moderately positively related to patient satisfaction. The act of caring through knowledge provision, mutual respect, congruence, empathy and nurturance provided a moderate positive relationship towards gratification of health care needs.

The findings of this study would accentuate APN practice to be an asset to health care. Since patient satisfaction has been linked to greater adherence, increased patient participation and increased likelihood of continued use of the provider, the advantage of using an OCNS's to provide care to rural cancer patients becomes clear. Decisions regarding care seeking, reactive behavior, proper utilization of health care resources may

be made with more information and less emotion with patients satisfied with the caring provided by nurses.

Health care, and nurse caring, is not provided in a vacuum. It is a business, a major part of the country's Gross National Product in fact. In order to remain viable, this business must encourage "repeat customers". Providing caring, the OCNS's have demonstrated that they are a valuable asset to the "company," since their caring is related to increased satisfaction and return visits.

Again, as in previous patient satisfaction studies, little variation in satisfaction scores is noted. With satisfaction rates in the literature ranging from 92-97 percent (Kurata et al., 1992; Woolley et al., 1978), there is little room to improve. Patients are infinitely diverse individuals, with infinite factors that affect perception of satisfaction. It is foolhardy to expect to develop an intervention that will satisfy completely everyone. This is not to say satisfaction is not a significant outcome to measure, since it does have a significant effect on patient behaviors, such as adherence, utilization and participation.

Communication is again an area where satisfaction is less than optimal. This area did not meet the patients' expectations. Communications must be clear, and APNs are traditionally strong in this facet of practice. Again, the infinite diversity of the patients may account for the lack of complete satisfaction with the communications skills of the APNs. Conversely, it may also be that the APNs in this intervention communicated information to the patients that was not desired. For example, some patients in this investigation may have just wanted to know the bare minimum, in the patriarchal mode of treatment. It is possible that these patients were dissatisfied by the amount of communication, that is to say, they may have wanted the professional mystique to

continue. Being kept informed by the APN may have required the patient to take a responsibility for themselves that they did not wish.

The components of caring in this investigation were not exhaustive, nor can they be carefully measured or controlled between providers. Additionally, the question arises, is caring an irreducible concept; unable to be measured in parts, because the whole of caring is greater than the sum of parts. Again, caring's indistinct definition makes it difficult to measure.

Since health status is a causal determinant of satisfaction with medical care (Hall, Milburn & Epstein, 1993), it can be extrapolated that health status may also affect the patient satisfaction with OCNS caring. With the findings of this investigation, that OCNS caring was positively related to satisfaction in light of a life-threatening illness, the value of OCNS caring is documented. That is to say, since most persons would not consider themselves healthy when they are diagnosed with cancer, it is a negative health status. These patients, although experiencing negative health, continued to rate their satisfaction with OCNS caring highly, in spite of the negative health status.

The lack of significant effect of income and education level may be due to several factors. Data is lacking regarding the number of respondents who indicated their income ($n = 39$), and education ($n = 46$). This may have been too small a sample to adequately measure any differences. There was little variability; therefore for an effect to be significant, the numbers would have had to be much greater.

Adequacy of Theoretical Model

The model of Watson's (1988) theory with satisfaction was an adequate representation of the proposed relationship. However, it was difficult to accurately depict

the relationship of caring with satisfaction, as it appears in the model as a sequela of caring. Through this investigation a moderate, not causal, relationship occurred. The model (Figure 2) does depict the caring occasion occurring with knowledge provision, mutual respect, empathy, congruence and nurturance during the encounter, with satisfaction measured after the encounter. This demonstrates patient satisfaction as a phenomenon that is measurable following a caring encounter. The model was effective in it's application to advanced practice nursing.

Limitations

There are several limitations to the design of this study. A major limitation is the difficulty associated with measurement of patient satisfaction. The lack of a tool that is not positively skewed in measurement of the satisfaction limits this investigation. This, however is a global problem in measurement of patient satisfaction. Sources of error in measurement of patient satisfaction lie in social desirability and acquiescent response set (Brink & Wood, 1992; Pascoe, 1983; Ventura et al., 1982). Social desirability is defined as the subject response is what they believe is the positive social response (Brink et al., 1992). Acquiescent response set is defined as consistent agreement or disagreement with the questions (Brink et al., 1992). Munro et al. (1994) recommends development of more sensitive items to avoid acquiescence response set. To date, no more sensitive instrument has been developed. The modified LOPSS distributed by this investigation attempts to reduce the bias of social desirability, as well as acquiescence response by balancing the positively worded items with negatively worded items. Negatively worded items acknowledge the possibility of dissatisfaction and therefore sanction negative responses. Patients being surveyed then feel it is acceptable to respond negatively. Munro et al.

(1994) recommend input from patients for the development of a more sensitive pool of items. This investigation did not attempt this, however.

The use of non-probability sampling to obtain participants also allows for bias. The sample used may not be truly representative of all rural cancer patients and this limits generalizability. The participants in this investigation have the opportunity to self select themselves into the study. This allows for participants who are open and possibly eager to experience the care of a OCNS that may bias their perceptions. Lack of a control group is also a limitation, however it is not ethical to withhold treatment from cancer patients, so an experimentally pure control group is not ethically possible. It would be possible to provide "regular care" in the community, as a control group, but this investigation did not attempt this. This study does not include a limited caring control group. Extraneous variables of race, social support, previous health status, previous negative health care encounters and general life satisfaction were not included in this investigation. Minorities are not excluded; however the demographics of the area residents do not include a high minority population. This will limit generalizability to rural minority groups.

Since cancer is a disease that sometimes causes death, attrition is somewhat of a limitation. Some participants did not survive a year to participate in Wave 4, and hence, were unable to evaluate the caring of the nurse and how it affected their satisfaction. Conversely, some of the subjects were diagnosed and completed treatment early in the disease process. These patients are discharged from the intervention early, and do not require 15 visits; so have fewer encounters of caring by which to evaluate their satisfaction. These clients were included in the study.

Requiring participants to mail the surveys back accounted for some attrition in data collection. Participants may have chosen not to complete the survey, forgotten, been too ill, or too close to death. Efforts were made to collect this data through reminder letters and telephone calls, but some data were still lost.

Secondary analysis of data limits investigation due to the inability to collect the exact information desired. The researcher must use what is available and measures used by the primary researcher. The attempt is made to fit the question to the available data, as opposed to designing the data collection to fit the question.

A final limitation of this investigation is the aforementioned indistinct concept of caring. Although this investigation defines caring, each practitioner will interpret and perform the caring intervention in a personal manner. It may be a limitation by assuming each encounter was a caring encounter, since each encounter was not observed

Implications

Practice Implications

Implications for practice of the APN abound. Satisfaction is a useful and valid tool to measure the concurrence between the patient's expectation of nurse caring and their perception of the actual nurse behaviors/characteristics. The consequences resulting from satisfaction; adherence to health care regimen, increased participation of the patient and positive influence to continued use of health care again may be extrapolated from this study. These characteristics may make the population utilizing APNs proactive in their health care, increasing the overall health of the population. Additionally, there may be a greater demand for caring as provided by APNs.

Adherence to health care regime may result in more appropriate use of the health care system. For example, the patient who because the APN was able to communicate the importance of continued regular use of anti-emetics may not need to seek care in an emergency department related to dehydration from chemotherapy. In lack of understanding and adherence, this patient will over utilize, the system leading to increased costs. Another example, a patient educated about the side effects of the medication may be aware of what to expect and choose to continue therapy, knowing this is expected. This patient would then not under utilize services, which may lead to potential for increased failure to cure rate. This ultimately would cost the system more in time spent on cure at a later stage of the disease process, and work force in attempt to effect that cure.

Increased patient participation in the cure process may result from the APN caring intervention which provides psychological support. The post-mastectomy woman, experiencing limitations in arm movement, who due to the APN caring, does her arm exercises outside of the physical therapy session will most likely return to full range of motion sooner than the patient who faithfully goes to physical therapy, but only does her range of motion at physical therapy.

Managed care relies on the ability to continue to keep patients in the system. Although they may ultimately cost the system more than they have contributed by the payment of premiums, there are intangibles involved. The intangible factor of goodwill developed by the patient whose participating APN who aids them through the crisis of acute cancer treatment. Not all cancer patients die, and as in this study, some are quite young and may remain vital and part of

the system for some time. These patients may, after acute treatment, become once again become less costly to the system. Another area of goodwill may develop from the family members who are not and may not be consumers of the health care system at the moment the patient is. The patient who is provided with caring by the HMO participating APN probably has family. These family members are going to remember the caring from the APN and the HMO who allowed them to utilize her services. If those services eased the death of the loved one, and consequently satisfied the family, there will be the intangible goodwill of desire to stay with that HMO because "they really took care of Nana well", with the unspoken thought that "I want them to take care of me that well".

Areas identified as having less than optimal satisfaction in this study, reiterate areas where satisfaction traditionally is less than optimal. These areas being: communication and; thorough and speedy follow-up (Kurata et al., 1992; Bowers et al., 1994; Elgin, 1990; Pascoe, 1983; Wooley et al., 1978). For the APN in practice, this means attention must be paid to communication style and practical items, such as, waiting time. Recognition of the individuality of each patient's situation is a critical strength of the APN. The site and staging of the cancer is important, as well as family situation, presence of caregiver, social resources and age. This is where APNs are most suited to the primary care of the patient. The holistic focus of caring allows the APN to evaluate for the effect of the myriad of factors influencing the response to the actual or potential health problems. Although in this investigation, the APNs did not score complete satisfaction with all patients, their caring was moderately related to satisfaction

experienced by the majority of the patients. APNs must be cognizant of and continually honing the holistic focus of their caring. APNs may use the documentation of increased satisfaction with care as a marketing tool, documenting the value of the APN to any health care practice, or corporation.

The documentation of caring as a valuable, indeed integral part of patient satisfaction, an outcome measurement, articulates the need for a paradigm shift in the education of nurses. Bevis and Watson (1989) suggest a shift towards a caring curriculum. Bevis (1989) believes the current nursing curriculum operates in a masculine, behaviorist paradigm. She states this is appropriate for memorization and skills learning, however, nursing is much more than memorization and skills. Bevis (1989) declares "nursing and education are feminine fields" (pg. 4) and as nontraditional, human sciences the fields of nursing and education require open, flexible, whole theories which allow for multiple realities, and encourage intuitive learning.

Watson (1989) advocates that the development of a human caring curricula "requires a personal, social, moral, scientific and spiritual engagement of the nurse educator and a commitment to self and other" (p. 42). She promotes the development of a framework accommodating of "an evolving personal consciousness" allowing for "methods that attend to moral ideals and values that are relational, subjective inner experiences while honoring intuition, personal, spiritual, cognitive and physical senses alike" (p. 53). Watson (1989) further describes a human caring-human science perspective to curriculum development,

combining and integrating cognitive with beauty, art, esthetics, intuition and spiritual awareness of the human caring process.

To teach caring Watson (1989) makes the following recommendations: 1) Modeling- educators who encourage self-affirmation and self-discovery model caring. Teaching moments become caring occasions; 2) Dialog- genuine dialog opportunities between faculty and students must be created; 3) Practice- caring theory can first be applied in the educational setting and then moved to the clinical setting; 4) Confirmation- in the educational caring occasions, nursing lays the foundation for human caring in health care.

Bevis (1989) proposes the following goals of a paradigm shift and projects the anticipated impact should this shift occur:

1) Nursing graduates would be more responsive to societal needs. "Nursing has a unique societal mission: to care for the vulnerable and to provide caring services in prevention, cure and maintenance" (p. 350). To meet this goal, nurses must become politically effective in shaping health care policy. The finding of this study of patient satisfaction being moderately positively related to nurse caring would be an area where APNs may demonstrate and seek a voice in health care policy. Obtaining third party reimbursement for the "caring" service would be a first step.

2) Critical thinking skills form the second goal of the paradigm shift (Bevis, 1989). Using a scholarly approach to client and societal problems and issues is another part of caring. Too often nurses are 'trained' on what to do, but not educated how to think. Educating nurses how to provide caring will again

provide the reinforcement of the relationship of caring and satisfaction, potentiating the adherence to health care recommendations, increasing the likelihood of return visits, and increasing patient participation, thus paving the way for increased health on the part of the population served by caring nurses.

3) Humanization of the complex and technological health care milieu is the third shift to take place. Bevis (1989) proposes increasing the exposure to arts and humanities as a means to do so. The caring received by patients in this study took place in a 'human' manner.

4) The fourth goal of the paradigm shift is to increase the nurses insight into ethical and moral issues, so that they may become better patient advocates for these issues. Caring "cannot be a means, but must be an end in itself" declares Bevis (1989). This study does not specifically increase the insight into these issues, but does suggest caring as a valued process in nursing.

Implications for Educating Caring

The study accentuates how nurses must be educated in caring. That nursing currently operates in a behaviorist mode, with outcome criteria in each course, which must be met and demonstrated before one is able to progress in the curriculum is evidence of this. In fact, outcome measures, one of which is patient satisfaction are also masculine and behaviorist. The development of a paradigm shift in health care which examines the wholeness of theories accommodating a personal consciousness may negate the need for such measurements. Caring would become the standard by which all nursing is applied.

All of nursing must shift to that of a caring paradigm, for by doing so, it will not only relate to patient satisfaction, but also to the valuation of caring in society. For this, nursing must be educated, to practice and model caring. Nursing must also educate and create an awareness in society of the absolute value of caring, creating the necessary policy shifts.

Research Implications

Further research for Clinical Nurse Specialists/Nurse Practitioners lies in several areas. First, although measurement of caring "takes away" from the caring encounter (Watson, personal communication, March 10, 1996), we continue to work in a behaviorist milieu, therefore a means to define and measure the concept must be developed. Caring is that entity which is central to nursing. To define ourselves and that "commodity" which we nurses are bringing to society, we must document its existence and the outcome it has on patients. By definition of this "commodity," APN practice may be brought to the forefront of the health care system; which at this time emphasizes cure over care (Watson, 1988).

Williams (1994) proposes patient satisfaction is artificially constructed by forcing service users into evaluating service with unfamiliar terms. He further suggests that providers need to identify the perception of patient satisfaction from the patient perspective, and develop tools from this direction. Munro, et al. (1994) make a similar recommendation to involve the patient. Areas of examination might include qualitative and quantitative work to include the patient in development of a tool to measure caring and subsequent satisfaction with caring provided by APNs. Investigating satisfaction and the effectiveness of other APN practices (Jones, 1993) would further document

effectiveness, and build a greater research underpinning to nursing practice (Rettig, 1991).

Hence, a second recommendation is development of a tool, free of skewing, by which to adequately measure patient satisfaction with nurse caring. Although this seems to contradict earlier statements by this author, we again must recall that nursing currently practices in a behaviorist milieu, which requires documentation of phenomena. To develop this tool, APNs must involve the patient and develop qualitatively a set of themes which are truly evaluative of advanced practice nursing. From these themes, a tool maybe developed that will accurately measure patient satisfaction with advanced practice caring.

A third recommendation for further research in patient satisfaction with OCNS caring might relate overall health and life satisfaction. Since not all health care is received by healthy people identifying the factors that lead to satisfaction and dissatisfaction that are within the realm of nurse caring would be worth investigating. Considering the findings of Roberts et al (1983) and Hall et al (1993), that patients with generalized feelings of well-being and life satisfaction and had greater overall feelings of satisfaction with health care, it would be interesting to examine the relationship between prior health status, general life satisfaction and patient satisfaction with nurse caring. A much larger sample size would also be needed to develop relationships between the extraneous variables of income, education level, site and staging of cancer. Insurance, social support, previous negative health care encounters are also variables which could also be examined in light of satisfaction with OCNS caring. A replication of this investigation, controlling for the additional variables mentioned.

Fourth, Ben Sira's (1982) finding that satisfaction with a physician's affective behavior greatly influences the evaluation of professional competence must be examined in light of Fosbinder's (1994) finding that patients value nurses' interpersonal skills highly and relate these skills toward technical competence. Does the conclusion of Ben Sira extrapolate to nursing, and will patients evaluate APN's as being more, or less competent as a result of the evaluation of their affective (caring) behavior? Does this mean that since nurses are experts in caring, which is often perceived affectively, they will be accorded higher competence ratings? Will this matter to the patient utilizing an APN? Will it make the patient seek out the services of an APN over a physician perhaps, given all other variables being equal? It would be very interesting to determine what effect the Clinical Nurse Specialist/ Nurse Practitioner would have on patient satisfaction.

Advance practice nurses, be they Oncology Clinical Nurse Specialists; Pediatric, Adult or Family Nurse Practitioners, Nurse Midwives, or Clinical Nurse Specialists, by virtue of their advanced education should be experts in caring. They must document and market this facet of their practice. They must also share this caring expertise with other nurses.

APPENDIX A

SATISFACTION WITH CARE FROM RURAL CLINIC

(Check one response for each of the following:)

THE NURSE IN THE RURAL CLINIC:	Strongly Agree	Agree	Neither Agree nor, Disagree	Disagree	Strongly Disagree
Is gentle in caring for me					
Helps me to understand my illness and treatment					
Understands me when I share my problems					
Is available when I need support					
Gives the impression my care is top priority					
Makes me feel secure					
Gives complete explanations and information					
Gives instructions and information					
Appears to enjoy caring for me					
Makes me feel like I can share my feelings					
Does things to make me more comfortable					
Makes me feel better by just talking					
Service provided by nurse was helpful					
Makes me feel like a "case," not an individual					
Does not follow through quickly enough					
Should be more thorough					
Is not as friendly as she could be					
Seems more interested in completing tasks than listening to my concerns					
Neglects to be sure I understand the importance of my treatments					

THE NURSE IN THE RURAL CLINIC:	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Is impatient with me					
Acts like I cannot understand the "medical" explanation of my illness					
Is not as attentive as she should be					
Does nothing with information I give					
Fails to consider my opinions and preferences regarding plans for my care					
Does not keep promises to do things for me					
Talks "down" to me					
Does not answer my phone calls promptly					

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Seeing a nurse closer to my home as opposed to a more distant location was helpful					
The booklets and educational materials information given to me were helpful					
The assistance I received from the nurses helped me deal with my problems or treatment					
Family members who assisted me with care found the nurses visits and contacts helpful					
The nurse assisted with my care by locating services and talking to other health care providers					

APPENDIX B

MICHIGAN STATE
UNIVERSITY

April 25, 1996

TO: Maria McEvoy
2250 Karen Dr.
Howell, MI 48843

RE: IRB#: 96-066
TITLE: THE RELATIONSHIP OF OCNS NURSE CARING ENCOUNTERS AND PATIENT SATISFACTION
REVISION REQUESTED: N/A
CATEGORY: 1-E
APPROVAL DATE: 02/15/96

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

PROBLEMS/ CHANGES: Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely.

David E. Wright

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Charles Given
Barbara A. Given
Linda Beth Tiedje

MICHIGAN STATE
UNIVERSITY

March 6, 1996

TO: Charles Given
B100 Clinical Center

RE: IRB#: 9[illegible]-277
TITLE: RURAL PARTNERSHIP LINKAGE FOR CANCER CARE

REVISION REQUESTED: N/A
CATEGORY: FULL REVIEW
APPROVAL DATE: 03/04/96

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

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If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517) 432-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Barbara A. Given

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