

See page 442 for suggested questions to begin discussion in your journal club.

# Patients' Perceptions of the Importance of Nurses' Knowledge About Cancer and Its Treatment for Quality Nursing Care

Kirsti Kvåle, RN, MSc, and Margareth Bondevik, RN, PhD

**M**any patients with cancer face difficult physical issues from their illness, and treatment modalities can result in serious side effects. Chemotherapy regimens can be very demanding for staff as well as patients (Radwin, 2000; Stiggelbout & de Haes, 2001). Studies that used the Caring Assessment Report Evaluation Method (Larson, 1987; von Essen & Sjöden, 1991; Widmark-Petersson, von Essen, & Sjöden, 2000) revealed that patients with cancer prioritized nurses' technical competence as most important for good care. The patients also valued humanistic aspects of care, but not to the same extent as the nurses (von Essen & Sjöden, 1991; Widmark-Petersson et al., 2000). The use of in-depth interviews can allow researchers to discover what patients consider to be important for effective caring and why. As a result, findings in quantitative studies can be extended and validated.

Other studies have shown that patients often label nurses as professionals; Radwin, Farquhar, Knowles, and Virchick (2005) defined *professional* as "holding the standards expected of a nurse in knowledge, skills, and demeanor" (p. 165). Professional nurses are described as knowledgeable and competent; they know what they are doing and convey their professional knowledge by explaining things. Nurses also know about specialized cancer concerns. Professional knowledge can be demonstrated by showing technical competence in starting IV lines, timing chemotherapy drips, and giving useful answers to patients' questions (Radwin, 2000; Radwin & Alster, 1999). Patients also identified competency in vein puncture, particularly "knowing where to find the vein," as an aspect of effective nursing care (Larrabe & Bolden, 2001). Other aspects included providing pain relief or comfort, watching patients closely, and checking whether patients were comfortable (Larrabe & Bolden, 2001). Roach (2002) stated that "compassion

**Purpose/Objectives:** To gain insight into how and why patients' perceptions of nurses' knowledge about cancer and its treatments relate to quality nursing care.

**Design:** Qualitative study inspired by Giorgi's approach to phenomenology.

**Setting:** An oncology ward in a regional hospital in Norway.

**Sample:** 20 patients (10 women and 10 men). Most received life-prolonging and symptom-relieving treatment, whereas 4 had the possibility of being cured.

**Methods:** In-depth interviews were tape recorded, transcribed, and analyzed. The text was read as a whole, condensed into units of meaning, and clustered into themes of importance. Finally, the consistency between identified themes and the general structure of the interviews was checked.

**Findings:** Patients regarded knowledge about cancer and its treatment as basic in nursing and took for granted that nurses had this competency. Three themes were identified that explained why the knowledge was important: (a) it makes patients feel safe and secure and alleviates suffering by providing useful information, (b) it prevents and alleviates suffering and insecurity during chemotherapy, and (c) it alleviates suffering by relieving side effects caused by the treatment and symptoms caused by the disease.

**Conclusions:** Patients appreciated meeting nurses who had experience and could combine clinical and biologic knowledge and nursing skills with a human touch. In addition, nurses alleviated patients' bodily and existential suffering and made them feel safe and secure.

**Implications for Nursing:** Experienced, effective nurses with knowledge about cancer and its treatments are needed in oncology wards to provide optimal care to patients.

without competence is a meaningless, if not harmful, intrusion into the life of a person needing help" (p. 54). Halldorsdottir and Hamrin (1997) also found that caring without competence was meaningless for patients in most cases.

Professional knowledge is important for earning patients' trust. Trust is identified as a chief value in the nurse-patient relationship and has been described by patients as important for their well-being. When trust is established, patients feel confident, safe, and less vigilant. Trust most often develops over time, and continuity of care gives nurses the time needed to demonstrate professional knowledge and, therefore, earn trust. Benner (1984) identified the administration and monitoring of therapeutic interventions and regimens as one of seven domains in clinical nursing practice. Benner (1984) also described the expert nurse as an experienced nurse with theoretical and experiential knowledge. Bevis (1981) described care as an art but emphasized that, just as a pianist must practice to be a good pianist, caring also requires practice.

Concern has been expressed in the nursing literature that providing holistic and compassionate care may not be possible in the computerized and mechanized environment of modern nursing; whether and how "high tech" and "high touch" are reconcilable has been debated for many years (McGrath, 2008). However, promoting care need not devalue the significance of technical expertise or rational scientific knowledge (McKenna, 1993). Science and technology only are tools of caring, and they must be used wisely to ensure that the central focus of nursing care is not lost (Manns, 1993). Technology is not going away, and nurses have to learn to work with it, not against it (Loscin, 2001). However, a relationship among knowledge, skills, and judgment must exist in nursing practice. Technology and skills cannot stand alone (Evans & Donnelly, 2006).

Eriksson (2002) viewed patients' suffering as the motive for caring and the alleviation of suffering as the main purpose of care, claiming that suffering is related to the patient's whole experience of life (Eriksson, 1995). Studies have shown that the way in which healthcare professionals attend to symptom relief also affects existential areas of concern such as supporting hope and coping (Carter, MacLeod, Brander, & McPherson, 2004; Clayton, Butow, Arnold, & Tattersall, 2005). The nursing literature shows that effective nursing care results from the combination of knowledge, skills, and attitudes and has an intellectual, psychological, spiritual, and physical dimension; nurses who are prepared with knowledge and clinical expertise will have much to offer in all aspects (Scotto, 2003; Thompson & McClement, 2002). In a study by Calman (2006), patients assumed that technical care was a safeguard that must be in place to protect them, but when nurses' technical competence was assumed, interpersonal attributes become the most important indicator of the quality of nursing care. Patients seem to regard quality of care as comprised of many inter-related dimensions that, taken together, form a whole (Basset, 2002; Wilde, Starrin, Larsson, & Larsson, 1993).

The literature findings, in part, provided the background for this qualitative study. The current study was aimed to gain insight into patients' perceptions of the importance of nurses' knowledge about cancer and its treatment for quality nursing care, as well as the reasons why certain knowledge was perceived as important.

## Methods

### Design

Giorgi's (1985) approach to phenomenology was chosen as the research design. Giorgi (2000) modified Husserl's philosophical phenomenologic method to be used for scientific analysis, arguing that when phenomenology began as a philosophy, the tenets of scientific practice were to be followed when doing research. The aim of scientific phenomenology is to elucidate the essential meanings of a phenomenon as the informants experience it in their life's world. The researcher aims to describe the phenomenon as accurately as possible, refraining from any preconceptions but remaining true to the facts (Groenewald, 2004). However, the formation of units of meaning and themes from the data takes place as the researcher observes them (Kvale, 1996). The goal of phenomenology is to describe phenomena, not to generate theories and models or to develop general explanations (Morse & Field, 1996).

### Participants and Setting

The participants were patients in an oncology ward in a regional hospital in Norway. Staff nurses selected participants according to inclusion criteria and the guidelines of the Data Inspectorate of Norway. Inclusion criteria were patients who were aged 25–80 years, informed by a doctor about their cancer diagnosis, admitted to the ward for palliative or curative treatment, and assessed by the medical and nursing staff to be mentally and physically able to participate in the research project. Sampling was purposive. Ten women and 10 men were interviewed; the gender balance was not deliberate. Three more patients were invited to participate in the study but declined for unknown reasons. Data saturation was reached in the later interviews and, therefore, no more patients were included in the study.

### Procedures

The study was conducted according to the rules of the Helsinki Declaration of 2002 (World Medical Association). The Western Norway Regional Committee of Research Ethics and the director of the oncology department of the hospital granted permission to conduct this research. Data collection also followed the guidelines of the Data Inspectorate of Norway. Patients gave written

consent to participate in the study and to allow tape recording of the interviews. The researcher assured participants by letter that the interviews would be deleted after transcription.

The first author conducted all interviews while the informants were inpatients. Four themes related to the importance of nurses' knowledge about cancer and its treatments emerged. The opening question was "Do you feel that nurses' knowledge about cancer and its treatment is important for care?" The interviewer encouraged patients to talk about the theme as freely as possible and tried to hold dialogues rather than simply asking questions. Patients' statements to the interviewer about their experiences and feelings led to new follow-up questions and were important in shaping how the interviews proceeded. Open-ended questions such as "Do you want to tell me more about it?" and "Can you tell me why?" were used when needed to gain a deeper understanding of the research question and to meet the aim of the study (Kvale, 1996).

## Analysis

The interviews were transcribed in full and analyzed according to Giorgi's (1985) step-by-step approach to phenomenology. The transcribed interviews were read intensively as a whole to gain a general understanding of what the patients expressed about the phenomenon. Interviews then were reread several times and the text was condensed into units of meaning. The identified units of meaning were clustered into themes of importance related to the disciplinary language with the help of the method of free imaginative variation. The units of meaning had to be examined, probed, and redescribed to show the disciplinary value of each unit. Checking consistency between the identified themes and the general structure of the interviews for a second time concluded the analysis.

The quotations (translated from Norwegian) used to elucidate the identified units of meaning were composed from direct statements from single patients as well as composite statements from many patients. The units of meaning are not interpreted; only descriptions of how patients experienced the phenomenon in their own world, formed into themes by the researcher, are provided. Validity is determined by deciding to what degree the researcher has been able to grasp the meaning of the participants' experiences; therefore, the findings were checked and rechecked (Kvale, 1996). Researchers often are advised to re-interview participants (Kvale, 1996) and obtain comments from them about the researcher's analysis as a part of validation; however, Giorgi (1985) recommended against it and argued that the interviewer is the researcher, not the participant. The authors found re-interviewing the current study's participants difficult because of their life situation and the seriousness of their cancer.

## Findings

Most patients were aged 40–70 years, with various cancer diagnoses and prognoses. Sixteen had metastases. Most were given life-prolonging and symptom-relieving treatment, whereas four had possibility of cure.

The essential finding that emerged was that nurses who were perceived as demonstrating knowledge about cancer and its treatment and good technical skills were able to alleviate suffering and made patients feel safe and secure. Patients regarded such knowledge as basic to nursing and took for granted that nurses had this competency. Another finding was that patients seemed to rely more on experienced nurses than on inexperienced ones. Three themes were identified that explained why clinical knowledge was important for quality nursing care: (a) it makes patients feel safe and secure and alleviates suffering by providing useful information, (b) it prevents and alleviates suffering and insecurity during chemotherapy, and (c) it alleviates suffering by relieving side effects of the treatment and symptoms of the disease. The following quote illustrates the essential finding.

The main task for the nurses who take care of me is to administer and organize the chemotherapy in the best possible way. They have to start the chemotherapy at the right time and monitor and follow it through. This is care. They must also have knowledge about what they are doing, and if they do not have good technical skills, it is of no use being kind and smiling. I feel safe in their hands when they have competence, but I also like to talk to them when they are giving the chemotherapy.

Another unit of meaning illustrates patients' appreciation of nurses with experience.

It is very good when one can ask the nurses about things and know that their answers are based on what they have learned in school or experienced in practice. The experienced nurses have been on the ward for a long time and I get very good answers because they are well informed.

## Providing Useful Information

Patients emphasized the importance of meeting a nurse with experience, particularly when they met doctors that patients knew had little experience. However, patients stressed that nurses are not supposed to be doctors and should consult the doctors when they do not know the answers.

One discovers very quickly if the nurses have knowledge about the disease. They know what they are talking about. That makes me feel secure. I do not have confidence in all the nurses. I ask the ones I trust. I often meet a new doctor who is inexperienced,

and I see doctors for a short time and forget to ask all the questions. Then it is good to ask a nurse who has knowledge. It is important to meet a nurse that knows me and my disease. Some of the nurses are afraid to tell me too much, but I want the facts about my disease. If I am denied that, I have no need to talk to a nurse.

Nurses with knowledge about cancer and its treatment also alleviated suffering when patients were at home between chemotherapy sessions.

When I was at home I developed a urinary infection in the middle of the night. I was in severe pain and I called the hospital and talked to a night nurse. She said it could be urinary infection. That was not uncommon because of low immune system. She said that she would talk to a doctor. That was very, very good. It feels very reassuring to know that you can call a nurse who has knowledge at all hours. They are always there. That makes me safe and secure.

### Preventing and Alleviating Suffering and Insecurity During Chemotherapy

Patients described how nurses without good technical skills increased their suffering and insecurity during treatment.

There is a great difference between the experienced nurses and those with less experience when they are doing vein puncture. Some nurses are very insecure and then I become insecure myself. One can of course not expect too much from the newly qualified nurses. Then there are those students, they are supposed to learn how to handle the technical equipment. Of course they have to get the chance to try, but I don't like it.

Patients also described the dilemma they experienced when nurses did not ask for help when they were unsuccessful with the vein puncture and how this influenced their well-being.

It is better that the nurses ask somebody more experienced to try when they do not succeed in doing the vein puncture. I have told them that they are not allowed to try again and again. Sometimes it seems as if they want to be better than the others and, therefore, continue trying.

Patients felt secure when they received information about quality assurance procedures in the ward, particularly during their first treatment.

I had no reason to doubt that they gave me the right dose. There are good quality assurance procedures in the ward. It is important that the experienced nurses also follow them. Nurses do things differ-

ently sometimes, and it is important for me to be sure that they know what they are doing. I ask them why and they inform me. Then I feel safe.

### Relieving Cancer Symptoms and Treatment Side Effects

When I had chemotherapy, I got all the side effects possible. The people who informed me so I could understand what was happening with my body were the nurses. When I was in isolation, I got *Candida* in the mouth, and they helped me. They did not treat it as a minor issue.

One patient described a bad experience with nurses who lacked knowledge.

They told me that the doctors did not allow them to give me more pain medication. That was very hard. I told them that I had needed more. So at last I got it. When the nurse told me that I could have no more and I had to suffer, I [crying] . . . was it because of lack of knowledge do you think, or was it because she had too much respect for the doctor?

The following quotes illustrate how knowledgeable nurses provided care to patients with pain and nausea.

They will not let me be in pain. That is very good to know. Now I get medication regularly so I don't have to ask. If the nurses tell me that I cannot have more, they also explain why, for instance that it can hurt other organs.

The knowledgeable nurses can discuss what types of drugs are best for me. When I get nausea for instance, they give me two choices. When I am in pain, they tell me I can have something else if my pain medication is not good enough. They tell me that different drugs have effect on different sorts of pain. That is very good to know. The nurses who have knowledge are good at explaining what is happening.

### Discussion

Nurses who were perceived to demonstrate knowledge about cancer and its treatment and effective nursing skills alleviated patients' suffering and made them feel safe and secure. Many studies have shown that knowledge and skills are valued highly by patients, often more highly than by nurses themselves (Basset, 2002; Lynn & McMillen, 1999; Widmark-Petersson et al., 2000). Starting IV lines and timing chemotherapy drips correctly also were identified by the patients in the current study as an important aspect of quality professional care; the finding also was reported by Larrabe and Bolden (2001), Radwin and Alster (1999), and Radwin et

al. (2005). Nurses alleviated patients' suffering by surrendering their pride and finding someone else to do the vein puncture when they did not succeed. Patients did not like having student nurses and part-time nurses practice on them but knew that the inexperienced nurses had to learn. Patients in the current study were seriously ill and should be spared this dilemma. Novices (Benner, 1984) should practice on patients who are not having chemotherapy, which most often is the case. Patients emphasized that nurses had to know what they were doing and that being kind and smiling was useless without competence. The finding agrees with other studies (Basset, 2002; Halldorsdottir & Hamrin, 1997; Radwin et al., 2005; Roach, 2002).

The current findings may elucidate why patients with cancer rated technical competence as the most important aspect of effective caring in the quantitative studies that formed part of the background for the current study (Larson, 1987; von Essen & Sjöden, 1991; Widmark-Petersson et al., 2000). The findings also confirm that patients view quality nursing skills as a safeguard (Calman, 2006).

As mentioned, patients in the current study claimed that they felt safe and secure when nurses demonstrated knowledge and effective skills; likewise, patients felt insecure when nurses lacked this competency. According to Maslow's (1968) Hierarchy of Needs, feeling safe and secure is the most basic need of a human being. Patients in the current study also made clear that they often felt more secure with nurses who they knew had years of experience than with the less experienced ones. The finding can be related to Benner's (1984) work. Patients mentioned that the notion was particularly important when they met doctors who had been on the ward only for a short time. The finding underlines the importance of having experienced nurses in oncology wards.

Patients did not have confidence in all nurses, and they were able to tell very quickly whether the nurses were knowledgeable when they asked questions. From the nurses' answers, patients determined whom they could trust. Patients also stressed the importance of continuity among nurses so they could meet and talk to the same nurses who knew them and knew their disease when they were inpatients. The finding agrees with other studies (Radwin & Alster, 1999; Radwin et al., 2005). However, patients stressed that nurses were not supposed to answer all of their questions and should consult doctors when they do not know the answer. Patients appreciated that nurses were present night and day and gave examples of the importance of having knowledgeable nurses whom they could call from home at all times. Nurses' availability alleviated patients' suffering and made them feel safe and secure between chemotherapy sessions.

Although patients in the current study regarded technical skills as very important, they also wanted

to talk to nurses while receiving chemotherapy. The finding confirms the importance of the combination of knowledge, skills, and attitudes (Scotto, 2003; Thompson & Clement, 2002); once technical skills are in place, interpersonal attributes become important (Calman, 2006; Loscin, 2001). Technology and human touch have to be combined (Loscin, 2001; Manns, 1993; McKenna, 1993; Scotto, 2003); the combination is a criteria for being an expert in nursing (Benner, 1984). Nurses should not worry about modern technologic developments (McGrath, 2008) but should learn how to master them (Halldorsdottir & Hamrin, 1997; Loscin, 2001) and view good technique as a challenge, not an issue (Basset, 2002; Manns, 1993; Wilde et al., 1993).

Patients described how nurses who were perceived to have sufficient knowledge alleviated their suffering from the symptoms of cancer and from side effects of the treatment. Patients also emphasized the importance of being explained what happened to their bodies during chemotherapy, stating again that the information made them feel safe and secure. Patients gave examples of how nurses who lacked knowledge attended to their pain and how knowledgeable nurses met their needs. A patient who was denied pain medication because the nurse told him that the doctor did not allow her to give more asked whether the issue occurred because the nurse lacked knowledge or because she had too much respect for the doctor. However, other studies show that patients want nurses to be competent enough to know when to call the doctor (von Essen & Sjöden, 1991; Widmark-Petersson et al., 2000). Patients perceived that knowledgeable nurses listened to them, informed them, and did not let them have pain. Patients' dignity is violated when they are not believed or taken seriously (Eriksson, 1995). Bodily suffering leads to existential suffering, and the findings confirm that alleviation of all dimensions of suffering must be the aim of nursing care (Eriksson, 2002). Symptom relief can have an important effect on other aspects of patients' existential being, such as hope and coping (Carter et al., 2004; Clayton et al., 2005).

## Strengths and Limitations

The first author has much experience in cancer nursing and knowledge of the topic as a lecturer. Therefore, she had to be careful not to change roles from interviewer to therapist when she met with the patients (Kvale, 1996). She also had to be aware of her own preconceptions of the phenomenon and not ask leading questions (Nyström & Dahlberg, 2001). Attention was given to the validity of the analysis throughout the entire research process (Kvale, 1996), which is important for the trustworthiness of the study. The researcher's competence and experience (competence validity), dialogue with others about the findings (communicative validity), and the extent to which the findings can lead to changes in practice (pragmatic validity) also are

important for trustworthiness (Kvale, 1996). Readers must judge the transferability of the findings to other contexts; to make this judgment possible, the first author has provided a detailed description of the current study's research context and method. The qualitative method used revealed that patients valued nurses' knowledge and technical competence and described the reasons why they were important. Quantitative and qualitative methods have complementary strengths and limitations, and using both methods to answer a research question can extend and validate the findings (Polit & Hungler, 1999).

## Conclusion

The aim of the current study was to determine whether patients with cancer regard technical skills and knowledge about cancer and its treatment as important for quality nursing care. Nurses who were perceived to demonstrate knowledge about cancer and its treatment and quality nursing skills alleviated patients' suffering and made them feel safe and secure by giving useful information, administering chemotherapy in a professional way, and relieving symptoms of cancer and side effects of the treatment. The current study also revealed that bodily suffering can lead to existential suffering, and nursing care should be aimed to alleviate all dimensions of suffering. Symptom relief can have an important effect on patients' existential areas such as hope and coping. The current study also showed that patients

regarded knowledge about cancer and its treatment as the foundation of nursing care and took for granted that nurses had this competency. Patients appreciated experienced nurses more than recently qualified nurses because perceived knowledge was based on experience, as well as theory. The findings also may elucidate why patients rated technical skills as most important in the quantitative studies that partly provided the background for the current research.

## Implications for Nursing

The current study shows that patients want to receive care from experienced nurses who know how to combine clinical expertise, biologic knowledge, and nursing skills with a human touch in oncology wards. When such knowledge is demonstrated, patients' suffering is alleviated both bodily and existentially, and they feel safe and secure.

Kirsti Kvåle, RN, MSc, is a senior lecturer in the Institute of Postgraduate Studies at Betanien Diaconal University College in Fyllingsdalen, Norway; and Margareth Bondevik, RN, PhD, is an associate professor in the Faculty of Medicine, Department of Public Health and Primary Health Care, Section of Nursing Sciences, at the University of Bergen in Norway. No financial relationships to disclose. Kvåle can be reached at [kirsti.kvaale@betanien.no](mailto:kirsti.kvaale@betanien.no), with copy to editor at [ONFEditor@ons.org](mailto:ONFEditor@ons.org). (Submitted February 2009. Accepted for publication August 19, 2009.)

Digital Object Identifier: 10.1188/10.ONF.436-442

## References

- Basset, C. (2002). Nurses' perceptions of care and caring. *International Journal of Nursing Practice*, 8, 8–15.
- Benner, P. (1984). *From novice to expert. Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Bevis, E.O. (1981). Caring: A life force. In M.M. Leininger (Ed.), *Caring: An essential human need. Proceedings of three national Caring Conferences* (pp 49–60). Thorofare, NJ: Slack.
- Calman, L. (2006). Patients' views of nurses' competence. *Nurse Education Today*, 26, 719–725. doi: 10.1016/j.nedt.2006.07.016
- Carter, C., MacLeod, R., Brander, P., & McPherson, K. (2004). Issues and innovations in nursing practice. Living with a terminal illness: Patients' priorities. *Journal of Advanced Nursing*, 45, 611–624. doi: 10.1046/j.1365-2648.2003.02953.x
- Clayton, J.M., Butow, P.N., Arnold, R.M., & Tattersall, M.H. (2005). Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer*, 103, 1965–1975. doi: 10.1002/cncr.21011
- Eriksson, K. (1995). *Det lidende mennesket* [The suffering human being]. Oslo, Norway: TANO.
- Eriksson, K. (2002). Caring science in a new key. *Nursing Science Quarterly*, 15, 61–65.
- Evans, R.J., & Donnelly, G.W. (2006). A model to describe the relationship between knowledge, skill, and judgment in nursing practice. *Nursing Forum*, 41, 150–157. doi: 10.1111/j.1744-6198.2006.00053.x
- Giorgi, A. (1985). *Phenomenology and psychological research*. Menlo Park, CA: Duquesne University Press.
- Giorgi, A. (2000). Concerning the application of phenomenology to caring research. *Scandinavian Journal of Caring Sciences*, 14, 11–15.
- Groenewald, T.A. (2004). Phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3, 1–25.
- Halldorsdottir, S., & Hamrin, E. (1997). Caring and uncaring encounters within nursing and health care from the cancer patient's perspective. *Cancer Nursing*, 20, 120–128. doi: 10.1097/00002820-199704000-00007
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. London, England: Sage.
- Larrabe, J.H., & Bolden, L.V. (2001). Defining patient perceived quality of nursing care. *Journal of Nursing Care Quality*, 16, 34–60.
- Larson, P.J. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviours. *Heart and Lung*, 16, 187–193.
- Loscin, R.C. (2001). Practicing nursing: Technological competency as an expression of caring. In R.C. Loscin (Ed.), *Advancing technology, caring, and nursing* (pp. 88–95). Westport, CT: Auburn House.
- Lynn, M., & McMillen, B.J. (1999). Do nurses know what patients think is important in nursing care? *Journal of Nursing Care Quality*, 13, 65–74.
- Manns, V.C. (1993). Care versus cure: A nursing perspective. *Aspen's Advisor for Nurse Executives*, 8, 4–5.
- Maslow, A.H. (1968). *Toward a psychology of being* (2nd ed.). New York, NY: Van Nostrand.
- McGrath, M. (2008). The challenges of caring in a technological environment: Critical care nurses' experiences. *Journal of Clinical Nursing*, 17, 1096–1104. doi: 10.1111/j.1365-2702.2007.02050.x
- McKenna, G. (1993). Caring is the essence of nursing practice. *British Journal of Nursing*, 2, 72–76.
- Morse, J.M., & Field, P.A. (1996). *Nursing research. The application of*

- qualitative approaches* (2nd ed.). London, England: Chapman and Hall.
- Nyström, M., & Dahlberg, K. (2001). Pre-understanding and openness—A relationship without hope? *Scandinavian Journal of Caring Sciences*, *15*, 339–346. doi: 10.1046/j.1471-6712.2001.00043.x
- Polit, D.F., & Hungler, B.P. (1999). *Nursing research: Principles and methods*. Philadelphia, PA: Lippincott Williams and Wilkins.
- Radwin, L. (2000). Oncology patients' perceptions of quality nursing care. *Research in Nursing and Health*, *23*, 179–190.
- Radwin, L., & Alster, K. (1999). Outcomes of perceived quality nursing care reported by oncology patients. *Scholarly Inquiry for Nursing Practice*, *13*, 327–342.
- Radwin, L.E., Farquhar, S.L., Knowles, M.N., & Virchick, B.G. (2005). Cancer patients' descriptions of their nursing care. *Journal of Advanced Nursing*, *50*, 162–169. doi: 10.1111/j.1365-2648.2005.03375.x
- Roach, S. (2002). *Caring: The human mode of being* (2nd ed.). Ottawa, Canada: Canadian Hospital Association Press.
- Scotto, C.J. (2003). A new view of caring. *Journal of Nursing Education*, *42*, 289–291.
- Stiggelbout, A.M., & de Haes, J.C. (2001). Patient preference for cancer therapy: An overview of measurements approaches. Review. *Journal of Clinical Oncology*, *19*, 220–230.
- Thompson, G., & McClement, S. (2002). Defining and determining quality in end-of-life care. *International Journal of Palliative Nursing*, *8*, 288–293.
- von Essen, L., & Sjöden, P.O. (1991). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies*, *28*, 267–281. doi: 10.1016/0020-7489(91)90020-4
- Widmark-Petersson, V., von Essen, L., & Sjöden, P.O. (2000). Perceptions of caring among patients with cancer and their staff. Differences and disagreements. *Cancer Nursing*, *23*, 32–39. doi: 10.1097/00002820-200002000-00005
- Wilde, B., Starrin, B., Larsson, G., & Larsson, M. (1993). Quality of care from a patient perspective. *Scandinavian Journal of Caring Science*, *7*, 113–120.
- World Medical Association. (2002). *Declaration of Helsinki ethical principles for medical research involving human subjects*. Retrieved from <http://www.wma.net/en/30publications/10policies/b3/17c.pdf>

## For Further Exploration

### Use This Article in Your Next Journal Club Meeting



Journal club programs can help to increase your ability to evaluate the literature and translate those research findings to clinical practice, education, administration, and research. Use the following questions to start the discussion at your next journal club meeting. At the end of the meeting, take time to recap the discussion and make plans to follow through with suggested strategies.

1. How do we measure satisfaction with nursing care in our facility?
2. How are the results used?
3. What strategies do we use to formally influence perceptions of the care we provide?
4. If we have a plan, what evidence do we have that it is working?
5. If no plan exists, what might we consider and how would those strategies fit into the big picture that is satisfaction with care at our facility?
6. Given that this study was conducted in a country outside of the United States, what considerations might be having an effect on the results presented?

Visit [www.ons.org/Publications/VJC](http://www.ons.org/Publications/VJC) for details on creating and participating in a journal club. Photocopying of this article for discussion purposes is permitted.