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Variations in patient satisfaction with care for breast, lung, head and neck and prostate cancers in different cancer care settings

Andreas Charalambous*

Research Centre for Oncology and Palliative Care, Nursing Department, School of Health Sciences, Cyprus University of Technology, 15th Vragadinou Streer, 3041 Limassol, Cyprus

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A B S T R A C T

Purpose of the research: To assess cancer patients' satisfaction and the extent to which it varies between cancer care centres.
Methods and sample: This is a multi-site descriptive study reporting on the satisfaction of patients with breast, prostate, head and neck and lung cancers in Cyprus. The sample consisted of 272 patients randomly selected. Data were retrieved with the Patient satisfaction Scale additionally to 7 single questions reflecting 7-care dimensions namely "access to care", "explanation at first visit", "understanding of diagnosis and treatment", "first treatment: respect communication and involvement", "first treatment: pain and discomfort", "first treatment: hospital management" and "discharged co-ordination".
Results: Participants were overall satisfied by the nursing care (mean 3.5) however, dissatisfaction was expressed in relation to the 7-care dimensions ($p < 0.001$). Variations in satisfaction were found across the oncology settings as well as across cancer types. The variables gender, age, marital status, level of education, length of stay in the department, previous hospitalization, tumour type and treatment type had an influence on patients' perceived satisfaction ($p < 0.001$).
Conclusions: Seemingly identical nursing care can be measurably different between cancer care centres. Based on the findings the satisfaction variations can be attributed to factors personally experienced by the patients as well as to systemic hospital-level factors. The notion of patient satisfaction is important to clinical practice as a tool to assess and plan the nursing care and managers should bear in mind that patient satisfaction is sensitive to person specific variables as well as to many extraneous variables.

Introduction

Since the first use of the term "satisfaction" by Thorndike (1911) to reference a unique state of existence for a living organism, the term has received numerous conceptualizations as well as applications in health care. Patient satisfaction with nursing care has been defined as the patient's opinion on the received care from the nurses (Wagner and Bear, 2009) and often the patient's expectations form the structure against which satisfaction is evaluated (Kane et al., 1997; Risser, 1975). In recent years, the assessment of patient satisfaction has somewhat become an important means for evaluating the quality of nursing care because it gives information on the provider's success at meeting those values and expectations which are matters on which the patient is the ultimate authority.

Drawing on the principles of the Donabedian theory of quality (Donabedian, 1980) patient satisfaction can be classified as an outcome quality indicator (Johansson et al., 2002) whilst others view it as a separate dimension (Kane et al., 1997). The proposed structure, process and outcome quality indicators by Donabedian (1966) has generated an international debate of which indicators are better in the assessment of quality of health care, and arguments have been proposed in favour of one or another quality indicator (Gross, 2012). Donabedian (1966) himself triggered this debate by stating that "Outcomes remain the ultimate validators of the effectiveness and quality of medical care" and at the same time acknowledging that process criteria "may, however, be more relevant to the question at hand: whether medicine is properly practiced" (p168). Mant (2001) asserts that it is simplistic to view process and outcome measures as being in competition with each other, however at the same time he acknowledged that there are circumstances when one type of measure is more useful than the other (p475). There are no "magic portions" answers to this debate and as Gross (2012) asserts this debate is likely to continue whilst the solution lays perhaps in the consideration of aspects such as the type of the disease, the information being requested, the effective implementation of the measurement effort, and the evidence base

* Tel.: +357 25002011; fax: +357 25002822.
E-mail address: andreas.charalambous@cut.ac.cy.

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for associating a process with an outcome before deciding on which quality measure to apply. Further to this debate, an aspect that needs to be considered is that there are evidence in the literature that patients' clinical outcomes (i.e. survival) variations can be attributed to organizational characteristics (De Roos et al., 2005; Tourangeau et al., 2006) whilst there is less evidence for organisational factors relating to satisfaction (Sherlaw-Johnson et al., 2008). In the same way, the connection of patient satisfaction to patient outcomes is less clear and needs further exploration (Gross, 2012).

In order to frame this paper it is noted that nursing care has been identified as a large component of health care delivery that impacts on overall patient satisfaction (Al-Mailam, 2005). The rise of patient satisfaction as a quality indicator of the healthcare has urged health care systems to work towards achieving high levels of patient satisfaction and to an extend quality care. Dissatisfaction with the care may further lead to lower utilization of the health care services by the patients (Yunus et al., 2004). This comes as no surprise as many researchers have acknowledged that patients' satisfaction should not be dealt with merely as a measure of quality, but rather as the ultimate goal of health care delivery. The purpose of such quality measures is to provide data on the "basis of which practical conclusions could be drawn by administrators, practitioners and consumer groups in a variety of health care settings" (Linder-Pelz, 1982, p.1).

Nursing has strived to capture patients' satisfaction through generic and specific satisfaction questionnaires in a "quest to find the perfect one" (Lis et al., 2009). The application of generic tools in oncology however, does not allow a standardized way of assessing cancer patients' satisfaction or quality of care. This results in a difficulty to make appropriate comparisons and synthesis in collaborative research and finally leads to the minimal application of findings to clinical practice contrary to specific questionnaires that elicit data important to cancer patients and relevant to cancer care. In the literature there are several cancer specific questionnaires such as the Oncology Patients' Perceptions of the Quality of Nursing Care Scale developed by Radwin (2003) which was developed in the Northeastern United States. The La Monica–Oberst Patient Satisfaction Scale (LaMonica et al., 1986) was developed in three sequential studies to assess cancer patients' satisfaction with the nursing care. The Comprehensive Assessment of Satisfaction with Care-CASC (Brédart et al., 2001) is designed to assess cancer patients' perception on the quality of medical and nursing care and their opinion on the quality of selected aspects of the hospital structure and organization. The researchers concluded that socio-demographic characteristics such as age, education and a good state of health are associated with satisfaction. One prominent generic instrument used to assess cancer patients' satisfaction with the nursing care is the Newcastle Satisfaction with Nursing Scale-NSNS (McColl et al., 1996) that has been used in various cancer care settings (Muayyad et al., 2010; Alhusban and Abualrub, 2009).

Preceding studies revealed cancer patient's satisfaction sensitivity to factors such as the provision of information, the relationships between nurses and patients, the support provided to patients, technical abilities of the nurse, the education provided to patients in relation to their health problem, continuity between the hospital setting and home care and communication (Liu and Wang, 2007; Dorigan and Guirardello, 2010). Risser's (1975) scale allows for the exploration of these factors through three distinct dimensions: (a) technical–professional behaviours which includes technical activities and the knowledge base required to competently complete the nursing care tasks; (b) trusting relationship including the nursing characteristics that allow for constructive and comfortable patient–nurse interaction and communication aspects of the interaction; and (c) educational relationship which reflects the nurses' ability to provide information to patients, including answering questions, explaining care, and demonstrating techniques.

A body of literature asserts that further to these factors, specific patient socio-demographic and clinical characteristics can influence patient satisfaction (Sahin et al., 2007). This study aimed to assess the influence of variables such as age, gender, marital status, level of education, tumour type, length of stay, place of residence, previous hospitalization experience and treatment type (curative/palliative) on patients' satisfaction.

In recent years, cancer has become a major health problem in Cyprus and a priority for the healthcare providers. Nowadays, it is the fourth most frequent cause of death among the population being responsible for 2213 new cases and 1137 deaths in 2008 (Ferlay et al., 2010). The focus on cancer care has also brought attention to cancer patients' satisfaction as a means to monitor and improve the quality of the provided care.

The study reports the first attempt to assess patient satisfaction with the care provided in oncology departments in Cyprus and it is guided by the following research questions:

a. Are patients satisfied by the nursing care provided?
b. Are there any hospital-level differences in the expressed levels of satisfaction?

Methods

Settings and target population

This was a multisite study including patients that received care at the three specialized oncology centres in Cyprus in an effort to acquire a comprehensive view of patient satisfaction. These centres provide similar services to patients; however they have specific discrepancies related to delivery, specialisation of care and the links to community services. Therefore, by comparing the findings it would be possible to explore any potential influences on patient satisfaction that can be attributed to hospital-level factors.

The sample size was indicated by power analysis (calculated by PASS) and consisted of 310 patients (maximum sample size). The sample size calculation process considered the power, the size of the type I (alpha) error, and the actual size of the effect. Patients that received in-care and a week passed since their hospitalization were considered eligible given that they met the pre-determined criteria. The participants' selection was done with the use of a table of randomized numbers where a number was assigned to each of the potential participants that met the inclusion criteria and did not have any of the excluding factors.

The inclusion criteria were: (1) first time patients with breast, prostate, head and neck and lung cancers that required hospitalization (2) patients discharged within 7 days, (3) patients who were willing to participate and (4) patients who could speak and write Greek fluently. The decision to focus on the specific cancer types was drawn on the fact that these are the most common types in Cyprus in both sexes. The exclusion criteria included patients with limited cognitive function, extremely ill patients as well as those who said they were preoccupied to participate.

Participants and data collection

The data collection process commenced in February 2010 and was completed in January 2011. Out of the 310 questionnaires send to patients, questionnaires were completed by 272 cancer patients (response rate 87.7%) with each one assigned a code number known only to the researcher. The socio-demographic and clinical