Oncology patients' perceptions of "The Good Nurse": a descriptive study in Flanders, Belgium

Van der Elst, E., Dierckx de Casterlé, B., Biets, R., Rchaidia, L., Gastmans, C.

Abstract

Purpose: The image of "the good nurse" is mainly studied from the perspective of nurses, which often does not match the image held by patients. Therefore, a descriptive study was conducted to examine oncology patients' perceptions of "the good nurse" and the influence of patient- and context-related variables.

Method: A cross-sectional, comparative, descriptive design was used. The sample comprised 557 oncology patients at one of six Flemish hospitals, where they were treated in an oncology day-care unit, oncology hospital ward, or palliative care unit. Data were collected using the Flemish *Care-Q* instrument. Factor analysis summarised the most important characteristics of "the good nurse". We reassessed the reliability and construct validity of the Flemish *Care-Q* and examined the influence of patient- and context-related variables on patient perceptions.

Results: Using factor analysis, we grouped the different items of the Flemish *Care-Q* according to three characteristics: "The good nurse" (I) has a supportive and communicative attitude towards patient and family, (II) is competent and employs a professional attitude, and (III) demonstrates personal involvement towards patient and family. Median factor scores of Factors I, II, and III, respectively, were 8.00, 9.00, and 8.00 (varying from 1, not important, to 10, very important). In order

of importance, Factors II, I, and III were identified as valuable characteristics of "the good nurse". Gender, care setting, and province were influential variables.

Conclusion: As perceived by oncology patients, "the good nurse" has a broad range of qualities, of which competence and professionalism are the most valuable.

Keywords: oncology, patients, perceptions, "the good nurse", nursing, *Care-Q* instrument

Introduction

The image of "the good nurse" has been discussed intensively from a theoretical and empirical perspective. From a theoretical perspective, the picture of "the good nurse" evolved from the traditional mother figure and loyal doctor's assistant to the current image of a professional caregiver who has comprehensive knowledge and technical skills (Ashley, 1976; Winslow, 1984; Bishop and Scudder, 1990; Fealy, 2004). From an ethical perspective, "the good nurse" is someone who does "the right things" (Smith and Godfrey, 2002) and cultivates good qualities (Purtilo and Cassell, 1981; Benjamin and Curtis, 1985; Gastmans, 1999). This refers to a considerate, flexible, and empathetic person who has a professional attitude, clinical skills, and comprehensive knowledge (Sellman, 1997; Smith and Godfrey, 2002; Sartorio and Zoboli, 2010).

The focus of empirical research on "the good nurse" has been mainly on the perceptions of nurses. Nurses often attach great importance to the psychosocial characteristics of "the good nurse", such as active listening, empathy, honesty, professionalism, modesty, and underpinning care with a holistic view of the human being and care (Patistea, 1999; Bassett, 2002; Smith and Godfrey, 2002). Several studies, however, indicate that nurses' views of "the good nurse" often differ greatly from those of patients (von Essen and Sjoden, 1991a; Von Essen and Sjoden, 1991b; Young et al., 1996; Lynn and McMillen, 1999; Patistea and Siamanta, 1999; Patistea, 1999; Attree, 2000; Mulders et al., 2008; Papastavrou et al., 2011). Moreover, in their review, von Essen and Sjoden (1991b) found that the largest discrepancy between perceptions occurs especially in the oncology care setting. Compared to nurses, oncology patients attach more importance to a nurse's technical skills. Moreover, oncology patients especially need nurses who will provide them with correct information about their

health and associated changes and nurses who will ensure that the patients' surroundings are pleasant. Nurses themselves often underestimate these "good nurse" skills (Widmark-Petersson et al., 2000; Liu et al., 2006; Mulders et al., 2008; Rchaidia et al., 2009; Zamanzadeh et al., 2010; Papastavrou et al., 2011).

Background

In light of the above-mentioned discrepancy in patient-nurse perceptions and the current healthcare environment that strives for efficient, qualitative, and patient-oriented care, identifying and understanding patients' perceptions of "the good nurse" is of great importance (Corner, 2008; Mulders et al., 2008). Good agreement between nurses' and patients' perceptions of "the good nurse" clearly has a positive influence on care outcomes in oncology care. The greater the correspondence in perception, the greater is patient satisfaction, recovery, adherence (Zamanzadeh et al., 2010), and pain relief (Chang et al., 2005). Moreover, care given by a nurse with the correct care attitude, evaluated from the perspective of patients, makes patients feel safe and supported, and encourages patients to face their illness more optimistically (Radwin and Alster, 1999; Radwin, 2000; Izumi et al., 2006; Liu et al., 2006; Rchaidia et al., 2009; Zamanzadeh et al., 2010; Papastavrou et al., 2011).

Since oncological illnesses are chronic in nature, patients and nurses experience the nurse-patient relationship as being quite intense (Corner, 2008; Stajduhar et al., 2010; Watts et al., 2010; Zamanzadeh et al., 2010; Papastavrou et al., 2011). Furthermore, the life-threatening character of the disease, as well as the severe physical, psychological, and social consequences of the diagnosis and treatment of the disease, makes oncology patients highly vulnerable (Corner, 2008; Pang et al., 2009; Stajduhar et

5

al., 2010). Although oncology patients' perceptions of "the good nurse" have been examined several times in the USA, Asia, and Scandinavia (Papastavrou et al., 2011), there is a lack of similar research in areas of Western Europe such as Flanders, Belgium (Rchaidia et al., 2009). The current study attempts to fill in this void of knowledge by examining the oncology patients' perceptions of "the good nurse" in Flanders.

The measuring instrument used in this study was the *Care-Q*, which was originally developed by Larson (1981), and then adapted and translated in Dutch by Rchaidia et al. (2012) for use in Flemish hospitals. Although Rchaidia et al. (2012) considered the Flemish *Care-Q* to be a valid and reliable instrument for measuring oncology patients' perceptions of "the good nurse" in Flemish hospitals, a re-evaluation of its reliability and construct validity is recommended.

The Study

Aims

The present study addressed the following research questions: (1) To what extent is the Flemish adaptation of the *Care-Q* reliable and valid? (2) How do Flemish oncology patients perceive "the good nurse"? (3) Are there any patient-related (gender, age, number of children, cancer diagnosis) and/or context-related (care setting, province) variables that cause differences in these perceptions?

Design

A cross-sectional, comparative, descriptive study design was used.

Sample and participants

The oncology day-care units, oncology hospital wards, and palliative care units of six hospitals in Flanders served as the settings for the present study. Hospitals involved in this study were selected on the basis of (1) their geographical distribution in Flanders; (2) their size; (3) their type; (4) their religious affiliation; (5) the presence of the targeted care units (i.e., oncology day-care unit, oncology hospital ward, and palliative care unit); and (6) their willingness to participate in the study. The nurse directors of selected hospitals received a letter containing information about the research protocol and a request to cooperate with the research. All selected hospitals agreed to participate.

The hospitals included were geographically spread throughout the five Flemish provinces: Flemish Brabant (n=1); Antwerp (n=2); Limburg (n=1); West Flanders (n=1); and East Flanders (n=1). Furthermore, we selected hospitals that varied in size (large, n=4; medium, n=2); type (general, n=5; university, n=1); and religious affiliation (Catholic, n=4; neutral, n=2). All but one of the included hospitals had the targeted care units: oncology day-care unit (n=6); oncology hospital ward (n=6); and palliative care unit (n=5). Oncological palliative patients were located in oncology hospital wards. The nurse director of each hospital commissioned a contact person to act as a facilitator in contacting oncology patients and nursing teams.

Inclusion of oncology patients was based on their presence in one of the selected care units in one of the included hospitals at the time of the study. The following inclusion criteria were used: the oncology patient had to (1) be conscious of his/her cancer diagnosis, (2) remain in the hospital's oncology unit or palliative care unit for five days or longer, (3) be able to understand and speak Dutch, (4) be at least 18 years of age

and mentally competent, and (5) give informed consent. Physically and mentally ill patients that were unable to participate were excluded from the study sample. This decision was based on the judgment of the responsible nurse or contact person, who was aware of the health status of these patients.

Patients eligible to participate were individually approached by a researcher (RB or EVdE), the contact person, or the responsible nurse and were given oral as well as written information about the goal and course of the study and the nature of their participation. Participants were asked to sign the informed consent after we confirmed that they fully understood the information and after they had the chance to express any remaining questions and/or concerns. Actual data collection started at this moment.

The population of oncology patients is considerably large. In 2006, there were 57,702 new cancer diagnoses in Belgium alone (Belgian Cancer Registry, 2008). The required sample size was estimated by using the rule of thumb method of Nunnaly & Bernstein (1987), that is, having at least 10 participants per item of the measuring instrument used in this study (Pett et al., 2003). Thus, we obtained a convenience sample of 557 participants.

Data collection

After obtaining informed consent, we registered some patient- and context-related variables that could influence how patients appraise the characteristics of "the good nurse". Patient-related variables, which consisted of demographic variables such as age, gender, number of children, and diagnosis, were registered using a short closed-ended questionnaire. A researcher registered context-related variables such as care setting

(oncology day-care unit, oncology hospital ward, palliative care unit) and province (Flemish Brabant, Antwerp, Limburg, East Flanders, West Flanders).

The Flemish *Caring Assessment Report Evaluation Q-sort (Care-Q)* was used to record oncology patients' perceptions of "the good nurse" (Rchaidia et al., 2012). The questionnaire was completed independently, or together with the researcher or nurse. At the end, each participant was given the chance to orally or in writing communicate his/her personal remarks on the instrument or his/her feelings about taking part in the study.

Actual data collection lasted from February 2010 through April 2011.

Validity and reliability of the Care-Q

The *Care-Q* is the most used instrument for measuring patients' perceptions of "the good nurse" (Beck, 1999). The original purpose of the *Care-Q* was to identify nurse caring behaviours (acts and attitudes) that patients perceive to be important. The original English version consisted of 50 items, categorised into the following six subscales: "*the good nurse" is accessible* (6 items), *explains and facilitates* (6 items), *comforts* (9 items), *anticipates* (5 items), *builds on a trusting relationship* (16 items), and *monitors and follows through* (8 items) (Beck, 1999). The original version required participants to assign scores to each item by arranging them from the most to least important characteristic (Larson, 1981).

The Flemish adaptation consists of 40 items, which are scored individually, ranging from a score of 1 (not important at all) to 10 (very important). The construct validity was assessed by explorative factor analyses, which resulted in the following five subscales: "the good nurse" is empathic towards the patient and family (6 items), is

professional (6 items), is patient-centred (9 items), is respectful (10 items), and is communicative (9 items) (Rchaidia et al., 2012). The Flemish *Care-Q* can be considered to be a valid and reliable instrument for measuring oncology patients' perceptions of "the good nurse" in Flemish hospitals (Rchaidia et al., 2012), as it has a content validity index of 0.83; a total Cronbach's alpha of 0.92; a subscale Cronbach's alpha ranging from 0.65 to 0.81; fair stability (test-retest: Spearman's r=0.4-0.8); and positively evaluated user-friendliness.

However, a few methodological limitations should be considered concerning the psychometric assessment of Rchaidia et al. (2012): small sample size with little representativeness (100 patients in one oncology day-care unit), some content/interpretative ambiguities, and relatively low subscale reliability. In light of these limitations and the continuous nature of the validation process, we re-evaluated some psychometric properties (e.g., reliability of the Flemish *Care-Q* and its subscales and its construct validity) using Cronbach's alpha and explorative factor analysis, respectively, based on a larger sample and with more coverage of different care settings.

Ethical considerations

Ethical approval for multi-centred research was obtained from the ethics committee of the university (anonymous). Also, the research protocol was approved by each of the hospitals' local ethics committee. Participation was voluntary and informed consent was obtained. Anonymity and confidentiality were guaranteed. Before and after completing the *Care-Q*, the participants had the opportunity to discuss their feelings or remaining questions with a researcher.

The study population consisted partly of oncology patients in palliative care units; these patients are a very vulnerable patient group. Just like the other patients, they were approached with understanding and respect. Inclusion of these patients always happened in close cooperation with the units' head nurse or contact person, who decided which patients could participate in the study and introduced the researcher to the patients. Each patient could then decide whether to take part in the study. Due to these additional precautions and due to the limited number of beds and the physical and psychological limitations of these patients, including palliative patients in this study was very difficult. For this reason data collection from palliative care units was spread over time. Researching palliative patients is and remains an important but highly sensitive matter (Casarett, 2005; Keeley, 2008; LeBlanc et al., 2010; Stajduhar et al., 2010).

Data analysis

Statistical software (IBM SPSS Statistics version 19) was used to analyse the data, with a predetermined significance level of $p < 0.05$. Patient characteristics were described using descriptive statistical techniques (Median & %).

Construct validity of the Flemish *Care-Q* was re-evaluated by explorative factor analysis based on principal component analysis (Rchaidia et al., 2012), which also provided us with a presumptive image of the main characteristics of "the good nurse". We aimed to compose an acceptable factor solution (Pett et al., 2003) by using multivariate exploratory techniques, together with Varimax rotations and factor extraction based on scree plots (eigenvalues >1.0), percentage of explained variance, and factor clarity. Recalculation of Cronbach's alpha (criterion value >0.70) was used to evaluate the internal consistency of the Flemish *Care-Q* and its composite subscales.

We examined patient- and context-related variables that could influence oncology patients' perceptions of "the good nurse" using non-parametric tests (Mann-Whitney U test and Kruskal-Wallis test).

Findings

Description of the sample

A total of 569 oncology patients took part in the study. Twelve participants were removed from analysis due to missing data; thus, data from a sample of 557 participants were analysed *(Table I).* The sample consisted of 240 males (43.1%) and 317 females (56.9%), with a median age of 62 years, ranging from 18 to 95 years. The majority (36.4%) had two children (Med = 2). In terms of oncologic illness, there was a considerable amount of variety, with cancer of blood, lymph, and bone marrow (28.9%), and breast-cancers (25.9%) comprising the largest proportions.

Data collection occurred in the three predetermined care settings: oncology day-care unit (49.2%), oncology hospital ward (41.8%), and palliative care unit (9%). Due to the above-mentioned limitations for patients in palliative care units, the number of respondents in these units was limited to 50. Data were collected from the five provinces of Flanders: Limburg (22.1%), Antwerp (29.8%), Flemish Brabant (20.6%), East Flanders (14.0%), and West Flanders (13.5%).

[Table I. Description of the sample]

Psychometric properties of the Flemish *Care-Q*

The Flemish *Care-Q* originally consisted of 40 items and five subscales (Rchaidia et al. 2012). In the present study, the exploratory analysis results differed to that of the original because of our larger and more diverse sample. The care setting, geographical spread, and cancer diagnosis were different. Six items were removed due to factor loadings of <.40, loading on multiple factors, and/or the lack of content uniformity (i.e., contained aspects of more than one factor). Based on loading on multiple factors, three items were retained because of their content relevance and/or influence on Cronbach's alpha of the subscale *(Table II).* The removal/retention of the above-mentioned items and the use of multivariate exploratory techniques together with Varimax rotations resulted in a scale of 34 items, divided into three subscales. This three-factor solution, with an explained variance of 44.731%, represents the most internally consistent and conceptually coherent factor solution *(Table III).*

Recalculation of Cronbach's alpha for the full scale (40 items) resulted in an alpha of 0.941, decreasing only to 0.933 after removal of the six above-mentioned items. This represents very good reliability and internal consistency, also with regard to Factors I, II, and III (Cronbach's alpha values of 0.905, 0.838, and 0.803, respectively).

[Table II. Justification for removal / retention of items]

Finally, the use of exploratory factor analysis resulted in a three-factor solution based on 34 items. The first subscale (Factor I)—*"The good nurse" has a supportive and*

communicative attitude towards patient and family—consists of 15 items with moderate to high factor loadings (.412-.762) *(Table III).* The items describe "the good nurse" as a person who communicates clearly and informs the patient about the care given, the disease, the treatment, and other opportunities for health care. "The good nurse" involves the patient and his/her relatives and encourages active participation in care. "The good nurse" facilitates contact between the patient and his/her physician, and educates the patient, thereby adequately supporting the patient and family to cope. Active listening and supporting the patient and relatives after bad news or with other health-related problems are other characteristics of "the good nurse" described in the first subscale.

The second subscale (Factor II)—*"The good nurse" is competent and employs a professional attitude*—consists of 10 items with moderate to high factor loadings (.435-.764) *(Table III).* "The good nurse" has sufficient knowledge; he/she knows how and when to perform nursing care and if necessary asks for help. "The good nurse" conveys a professional attitude; he/she is respectful, honest, punctual, and makes the patient feel comfortable.

The third subscale (Factor III)—*"The good nurse" demonstrates personal involvement towards patient and family*—consists of nine items with moderate to high factor loadings (.418-.636) *(Table III).* "The good nurse" is personally involved with the patient and relatives and pursues a nurse-patient relationship, wherein interest in the patient as a person is made possible. "The good nurse" understands and empathises with the patient; he/she takes responsibility for following up and for responding timely and appropriately to the patient's care needs. "The good nurse" emphasises his/her presence by spending a sufficient amount of time alongside the patient so as to get to know each other better.

[Table III. Three-factor solution with factor loadings.]

Description of the perceptions of Flemish oncology patients

We calculated general factor scores based on the scores that the patients individually assigned to the different items of the Flemish *Care-Q*. The median factor scores for Factors I, II, and III were 8.00, 9.00, and 8.00, respectively. These high scores emphasise the importance of all the characteristics of "the good nurse": "The good nurse" is a person with a broad range of qualities. Further investigation revealed a certain hierarchy: Factor II had the highest mean factor score at 8.6550 (95% CI=8.5815-8.7285). Flemish oncology patients attached the greatest importance to the professional attitude and competence of "the good nurse". Factor I had the second highest mean factor score at 7.9062 (95% CI=7.8092-8.0031). Also, the supportive and communicative attitude of "the good nurse" towards patient and family was found to be of great importance. Last but not least, Factor III had a mean factor score of 7.1930 (95% CI=7.0844-7.3016), from which we concluded that personal involvement towards the patient and family, evaluated from the perspective of Flemish oncology patients, was also an important characteristic of "the good nurse".

Influence of patient- and context-related variables

Compared to female respondents, male respondents assigned significantly lower scores to Factor I (7.7213 for males vs. 8.0462 for females) and Factor II (8.5313 for males vs.

8.7487 for females). Female oncology patients seemed to give more importance to the competence and the professional, communicative, and supportive attitude of "the good nurse". There were no significant differences found in terms of age, number of children, or cancer diagnosis *(Table IV).*

We found a difference across care settings (context-related variable). Oncology patients in palliative care units assigned a significantly higher score to Factor III than patients in the other care settings (7.8489 in palliative care units vs. 7.1159 and 7.1431 in oncology daycare units and oncology hospital wards respectively). Oncology patients in palliative care units considered the personal involvement of "the good nurse" to be more important than oncology patients in oncology day-care units or in oncology hospital wards. Another difference was found with respondents from West Flanders, who assigned a significantly higher score (7.7348) to Factor III than respondents elsewhere in Flanders. Oncology patients from West Flanders seemed to consider the personal involvement of "the good nurse" to be the most important *(Table IV).*

[Table IV. Factor scores associated with patient- and context-related variables.]

Discussion

Methodological strengths and limitations

16

In the current study, we used a cross-sectional, comparative, descriptive design, a study design that has some strengths and weaknesses. This study design is suitable for research that aims to depict reality, and thus is appropriate for describing perceptions. One potential weakness of this study design, however, is its limited control over confounding variables (Polit and Beck, 2008). To address this issue, we made every attempt to approximate, as closely as possible, the Flemish oncology care setting by including in our study six hospitals located in different geographical regions of Flanders and including hospitals that varied in size, type, and religious affiliation. However, we included a limited number of palliative patients, as strict ethical standards needed to be applied prior to including them in our study. Unfortunately, for practical reasons it was not possible to describe other eventually relevant variables as patients' socio-economic status, educational background, and how long in treatment. According to Nunnaly's rule of thumb (Nunnaly and Bernstein, 1987), our sample size (n=557) was suitable, with at least 10 respondents per included item (Pett et al., 2003). However, as this sample is a convenience sample, its representativeness can never be guaranteed.

Hospital contact persons played a key role in recruiting oncology patients for our study and in collecting data. Only patients recruited by the contact persons were included in our study, thus possibly resulting in selection bias. To mitigate this type of bias, we clearly defined the rules for including patients and refined the inclusion criteria. Another possible form of bias is social desirability in cases in which patients completed the questionnaire with a unit nurse, and to a lesser extent in cases in which patients completed it with a researcher, which was mostly the case. Respondents were provided with clearly defined instructions for completing the questionnaire, so as to avoid additional bias.

According to a pilot study, the Flemish *Care-Q* can be considered to be a valid and reliable instrument for measuring oncology patients' perceptions of "the good nurse" in Flemish hospitals (Rchaidia et al., 2012). Nonetheless, some methodological problems remained, prompting us to refine some of its psychometric properties. Some psychometric properties (reliability and construct validity) of the adjusted *Care-Q* and its subscales were re-evaluated and positively assessed through the course of the current study. We carefully deliberated the removal and/or retention of selected items. Statistical techniques used in this study—i.e., factor analysis with principal component analysis and Varimax rotations—are especially useful for summarising the relationships between a large number of variables with a smaller number of components, thereby creating a simple structure factor solution (Pett et al., 2003). Hence, one of the significance of our study lies within having a refined Flemish Care-Q instrument.

Discussion of content

Firstly, oncology patients need a nurse who is professional and competent. This is true in Flanders as well. "The good nurse" is respectful, honest, and punctual; he/she is knowledgeable and knows how and when to perform nursing care. Secondly, "the good nurse" supports the patient and family, and promotes a good doctor-patient relationship. "The good nurse" communicates clearly and informs the patient and family about care, and about the patient's illness and treatments. He/she involves them in planning and organising nursing care. Thirdly, from the perspective of Flemish oncology patients, "the good nurse" puts the patient's interests first; he/she empathises with the patient and does not mind spending additional time providing care. The "good nurse" is a person

with a broad range of qualities, of which competence and professionalism are most valuable. Overall, "the good nurse' is an empathic, communicative, and personally involved healthcare worker.

These findings are similar to those of other recent research studies performed in oncology settings. Some studies found an emphasis on the clinical competence of "the good nurse" (Radwin et al., 1999; Radwin, 2000; Chang et al., 2005; Liu et al., 2005; Izumi et al., 2006; Rchaidia et al., 2009; Zamanzadeh et al., 2010; Papastavrou et al., 2011). Other relevant studies confirmed the value of the communicative and supportive attitude of "the good nurse" (von Essen and Sjoden, 1991a; Widmark-Petersson et al., 2000; Izumi et al., 2006; Rchaidia et al., 2009) and his/her personal involvement (Radwin et al., 1999; Radwin, 2000; Chang et al., 2005; Liu et al., 2005; Izumi et al., 2006; Rchaidia et al., 2009). The current study, however, was the first of its kind in Western Europe.

During the current study, we identified patient- and context-related variables that influenced the perceptions of Flemish oncology patients about "the good nurse". One of the most notable influences was gender: Female oncology patients gave more importance to the competence and professional, communicative and supportive attitude of "the good nurse" than did male oncology patients. However, there is little evidence to support this finding. One study in acutely ill elderly patients found that women valued physical and psychosocial care more than men (Chang et al., 2003). Another study confirmed the influence of gender on patients' perceptions but did not provide an explanation (Bond and Thomas, 1992).

Another important difference was found with care setting as a context-related variable: Oncology patients in palliative care units assigned significantly higher scores to the personal involvement of "the good nurse" compared to their peers in other care

units. This observation may be associated with the fact that palliative patients are part of an extremely vulnerable patient group (Casarett, 2005; LeBlanc et al., 2010), which is due to their confrontation with the life-threatening aspects of their disease. This vulnerability might explain why oncology patients value the personal involvement of "the good nurse", who knows and appreciates them as they are (Pang et al., 2009; LeBlanc et al., 2010; Stajduhar et al., 2010). "The good nurse" sees and recognises the patient in his/her vulnerability; he/she is able to personally and adequately fulfil their needs (Fealy, 2004; Pang et al., 2009; Stajduhar et al., 2010).

The results of the current study have generated an image of "the good nurse" as a person with a broad range of different qualities: professionalism, competence, communicative skills, and personal involvement. The question remains: Is this a realistic image? Should this image be considered as an ideal, one that should be strived for? In this regard, respondents often noticed that some of the responsibilities mentioned in the questionnaire also applied to other healthcare workers or those of other disciplines. Some respondents acknowledged that nurses could have a hard time fulfilling these care expectations, considering the heavy weight they carry due to time pressure and continuing economisation of care (Milisen et al., 2005). The image of "the good nurse" provided in this study might better be conceived as a dynamic target. Thus, each nurse should aim for this target, taking into account the personal and contextual limitations of the current healthcare system.

In order to develop and to cultivate "good nurse" characteristics that are described in this study, nurses need to be supported by the organizational context wherein they are functioning. Poor collaboration and leadership, insufficient resources and staff, and a negative ethical climate have a negative effect on moral agency of nurses (Lützen et al., 2010; Pauly et al., 2012) and on their motivating spirit to become a good

nurse. Although the character of nurses is an important factor, healthcare organizations play a significant role in supporting patient-centered behaviour in nurses. If healthcare organizations want "good nurses", then they must critically assess their organizational cultures, policies, and practices. Hence, further research on policies and organizational environments that nurture supportive practices, professionalism, and patient-centeredness is required.

Conclusion: implications for research, practice, and education

The above-mentioned strengths and weaknesses of the current study imply the necessity of future research. Additional research should focus on the influence of patient- and context-related variables, especially in the context of palliative oncology patients' perceptions of "the good nurse". As the needs and expectations of palliative patients may differ from those of other oncology patients, in palliative care "the good nurse" could take on a different profile. Quantitative studies are limited in terms of researching patients' perceptions of "the good nurse". In this study, respondents often expressed their desire to elaborate upon their answers. Qualitative research could provide a more detailed, in-depth image of "the good nurse", and create new insights into patients' perceptions.

Considering the chronic nature of their disease and considering the severe physical, psychological, and social consequences of their cancer diagnosis and treatment, the oncology patient is a vulnerable patient who in many cases depends on nursing care (Corner, 2008; Pang et al., 2009; Rchaidia et al., 2009; Stajduhar et al., 2010). Therefore, it is extremely important for nurses to know and understand their expectations and

needs, so that nurses can provide them with the care they need. In this way nurses are able to precisely intervene, fulfil these expectations, and provide oncology patients with high-quality patient-centred care. The proven positive influence of "the good nurse" on patient outcomes in oncology care supports these assumptions (Wolf et al., 1998; Lynn et al., 1999; Chang et al., 2005; Pang et al., 2009; Oflaz et al., 2010; Zamanzadeh et al., 2010; Papastravou et al., 2011).

The present study provides a general image of "the good nurse", evaluated from the perspective of Flemish oncology patients. Nevertheless, most things depend on the individual nurse and the nurse-patient relationship. Each nurse is unique but should incorporate these findings into their nursing tasks. Doing so will help them to reconcile their care activities and care attitudes with the perceptions of oncology patients. Patients' perceptions of "the good nurse" are also important in nursing education, wherein educators need to emphasise to student nurses that a discrepancy exists between the perceptions of nurses and patients. This is important to emphasise to experienced nurses also. Indeed, knowledge of the needs and expectations of patients contributes invaluably to educating nurses in terms of skills, knowledge, and attitudes, and in the long-term, to training "good nurses". Understanding oncology patients' perspectives on "the good nurse" could also motivate nurses to critically reflect on their own perspectives on "the good nurse". Such a dialogue between patients' and nurses' perspectives might increase mutual understanding of what are considered to be essential characteristics of "the good nurse". However, in order to know if Flemish nurses' views on the good nurse differ greatly from those of Flemish patients, more research is recommended, especially on Flemish nurses' perspectives.

References

Ashley, J., 1976. *Hospitals, paternalism and the role of the nurse.* New York: Teachers College Press.

Attree, M., 2000. Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *Journal of Advanced Nursing* 33: 456-466.

Bassett, C., 2002. Nurses' perceptions of care and caring. *International Journal of Nursing Practice* 8: 8-15.

Beck, C.T., 1999. Quantitative measurement of caring. *Journal of Advanced Nursing* 30: 24-32.

Belgian Cancer Registry, 2008. *Belangrijke cijfers.* Viewed September 19th 2011: http://www.kankerregistre.org./

Benjamin, M., Curtis, J., 1985. 'Virtue and the practice of nursing.' In: Shelp EE, editor. *Virtue and medicine.* Dordrecht: D. Reidel Publishing Company; p. 257-274.

Bishop, A.H., Scudder, J.R., 1990. *The practical, moral and personal sense of nursing. A phenomenological philosophy of practice.* New York: State University of New York Press.

Bond, S., Thomas, L.H., 1992. Measuring patients' satisfaction with nursing care. *Journal of Advanced Nursing* 17: 52-63.

Casarett, D., 2005. Ethical considerations in end-of-life care and research. *Journal of Palliative Medicine* 8(1): S148-160.

Chang, E., Hancock, K., Chenoweth, L., Jeon, Y.H., Glasson, J., Gradidge, K., Graham, E., 2003. The influence of demographic variables and ward type on elderly patients' perceptions of needs and satisfaction during acute hospitalization. *International Journal of Nursing Practice* 9: 191-201.

Chang, Y., Lin, Y.P., Chang, H.J., Lin CC. 2005. Cancer patient and staff ratings of caring behaviors: relationship to level of pain intensity. *Cancer Nursing* 28: 331-339.

Corner, J., 2008. The changing picture of cancer. *European Journal of Oncology Nursing* 12: 281-282.

Fealy, G.M., 2004. 'The good nurse': visions and values in images of the nurse. *Journal of Advanced Nursing* 46: 649-656.

Gastmans, C., 1999. Care as a moral attitude in nursing. *Nursing Ethics* 6: 214-223.

Izumi, S., Konishi, E., Yahiro, M., Kodama, M., 2006. Japanese patients' descriptions of 'The good nurse'. Personal involvement and professionalism. *Advances in Nursing Science* 29: 14-26.

Keeley, P.W., 2008. Improving the evidence base in palliative medicine: a moral imperative. *Journal of Medical Ethics* 34: 575-560.

Larson, P., 1981. Oncology patients' and professional nurses' perceptions of important nurse caring behaviours. *Dissertation Abstracts International*;42, 0528B, University Microfilms, N16511.

LeBlanc, T.W., Wheeler, J.L., Abernethy, A.P., 2010. Research in end-of-life settings: an ethical inquiry. *Journal of Pain & Palliative Care Pharmacotherapy* 24: 244-50.

Liu, J.E., Mok, E., Wong, T., 2006. Caring in nursing: investigating the meaning of caring from the perspective of cancer patients in Beijing, China. *Journal of Clinical Nursing* 15: 188-96.

Lützén, K., Blom, T., Ewalds-Kvist, B., Winch, S., 2010. Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nursing Ethics* 17: 213-224.

Lynn, M.R., McMillen, B.J., 1999. Do nurses know what patients think is important in nursing care? *Journal of Nursing Care Quality* 13(5): 65-74.

Milissen, K., Abraham, I., Siebens, K., Darras, E., Dierckx de Casterlé, B., The Belimage group, 2005. Work environment and workforce problems: A cross-sectional questionnaire survey of hospital nurses in Belgium. *International Journal of Nursing Studies* 43: 745-754.

Mulders, M., Vingerhoets, A., Breed, W., 2008. The impact of cancer and chemotherapy: perceptual similarities and differences between cancer patients, nurses and physicians. *European Journal of Oncology Nursing* 12: 97-102.

Nunnaly, J.C., Bernstein, R.L., 1987. *Psychometric theory*. New York: McCraw-Hill.

Oflaz, F., Vural, H., 2010. The evaluation of nurses and nursing activities through the perceptions of inpatients. *International Nursing Review* 57: 232-239.

Pang, S.M., Yahiro, M., Chan, H.Y.L., 2009. 'Knowing the patient and being a good nurse.' In: Loscin RC, Purnell MJ, editors. *A contemporary nursing process: the (un)bearable weight of knowing in nursing.* New York: Springer Publication Company; p. 445-61.

Papastavrou, E., Efstathiou, G., Charalambous, A., 2011. Nurses' and patients' perceptions of caring behaviors: quantitative systematic review of comparative studies. *Journal of Advanced Nursing* 19: 141-149.

Patistea, E., Siamanta, H., 1999. A literature review of patients' compared with nurses' perceptions of caring: implications for practice and research. *Journal of Professional Nursing* 15: 302-312.

Patistea, E., 1999. Nurses' perceptions of caring as documented in theory and research. *Journal of Clinical Nursing* 8: 487-495.

Pauly, B.M., Varcoe, C., Storch, J., 2012. Framing the issues. Moral distress in health care. *HEC Forum* 24: 1-11.

Pett, M.A., Lackey, N.R., Sullivan, J.J., 2003. *Making sense of factor analysis. The use of factor analysis for instrument development in health care research*, 1st ed. California: Sage Publications.

Polit, D.F., Beck, C.T., 2008. *Nursing research: generating and assessing evidence for nursing practice,* 8th ed. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Purtilo, R.B., Cassell, C.K., 1981. *Ethical dimensions in the health professions.* Philadelphia: WB Saunders.

Radwin, L., Alster, K., 1999. Outcomes of perceived quality nursing care reported by oncology patients. *Scholarly Inquiry for Nursing Practice* 13: 327-343.

Radwin, L., 2000. Oncology patients' perceptions of quality nursing care. *Research in Nursing & Health* 23: 179-190.

Rchaidia, L., Dierckx de Casterlé, B., De Blaeser, L., Gastmans, C., 2009. Cancer patients' perceptions of the good nurse: a literature review. *Nursing Ethics* 16: 528-542.

Rchaidia L, Dierckx de Casterlé B, Verbeke G, De Blaeser L, Gastmans C. 2012. Cancer patients' perceptions of the good nurse. Psychometric evaluation of the Flemish adaption of the Care-Q instrument. *Journal of Clinical Nursing* 21: 1387-1400.

Sartorio, N.dA., Zoboli, E.L.C.P., 2010. Images of a 'good nurse' presented by teaching staff. *Nursing Ethics* 17: 687-694.

Sellman, D., 1997. The virtues in the moral education of nurses: Florence Nightingale revisited. *Nursing Ethics* 4: 3-11.

Smith, K.V., Godfrey, N.S., 2002. Being a good nurse and doing the right thing: a qualitative study. *Nursing Ethics* 9: 301-312.

Stajduhar, K.I., Thorne, S.E., McGuiness, L., Kim-Sing, C., 2010. Patient perceptions of helpful communication in the context of advanced cancer. *Journal of Clinical Nursing* 19: 2039-2047.

von Essen, L., Sjoden, P.O., 1991a. The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies* 40: 487-497.

von Essen, L., Sjoden, P.O., 1991b. Patient and staff perceptions of caring: review and replication. *Journal of Advanced Nursing* 16: 1363-1374.

Watts, R., Botti, M., Hunter, M., 2010. Nurses' perceptions on the care provided to cancer patients. *Cancer Nursing* 33(2): E1-8.

Widmark-Petersson, V., von Essen, L., Sjoden, P., 2000. Perceptions of caring among patients with cancer and their staff. Differences and disagreements. *Cancer Nursing* 23: 32-39.

Winslow, G.R., 1984. From loyalty to advocacy. A new metaphor for nursing. *The Hastings Center Report* 14: 32-40.

Wolf, Z.R., Colahan M, Costello A. 1998. Relationship between nurse caring and patient satisfaction [Abstract]. *MEDSURG Nursing: The Journal of Adult Health* 7(2): 99-105.

Young, W.B., Minnick, A.F., Marcantonio, R., 1996. How wide is the gap in defining quality care?: Comparison of patient and nurse perceptions of important aspects of patient care. *Journal of Nursing Administration* 26(5): 15-20.

Zamanzadeh, V., Azimzadeh, R., Rahmani, A., Valizadeh, L., 2010. Oncology patients' and professional nurses' perceptions of important nurse caring behaviors. *BMC Nursing* 9(10): 1-9.

Tables

Table I Description of the sample

Variable	Frequency (n=557)	Proportion (%)	Median
Gender			
Male	240	43.1	
Female	317	56.9	
Age			62
Number of children			2
none	103	18.5	
1	127	22.8	
2	203	36.4	
3	74	13.3	
≥4	50	9.0	
Cancer			

Gastrointestinal	85	15.3
Urogenital	81	14.5
Blood, lymph, bone marrow	161	28.9
Breast	144	25.9
Skin	7	1.3
Bone	1	0.2
Brain	11	2.0
Lung	41	7.4
Head/neck	23	4.1
Unknown	3	0.5

Care setting

Oncology day-care unit	274	49.2
Oncology hospital ward	233	41.8
Palliative care unit	50	9.0

Province

Limburg	123	22.1
Antwerp	166	29.8
Flemish Brabant	115	20.6
East Flanders	78	14.0
West Flanders	75	13.5

Table II Justification for removal/retention of items

Items removed

Item	Factor load			Content	Cronbach's alpha
	I	**II**	**III**		
… is pleasant and friendly with my family and significant others	.326	.139	.270	ambiguous	TOT: - .000 I: - .000
… doesn't stray off during my care but is sincerely interested in me	**.489**	**.465**	.227	ambiguous	TOT: - .002 I: - .005
… listens to me	.354	.393	**.405**	broad and unclear	TOT: - .002 III: - .014
… communicates important things about my illness to the other members of the healthcare team, such as nurses and physicians, if necessary	**.582**	**.422**	.017	ambiguous	TOT: - .001 I: - .005
… is honest with me about my medical condition	**.411**	**.414**	- .062	ambiguous	TOT: - .000 I: - .003

... introduces himself/herself and tells me what he/she does	.315	.276	**.401**	ambiguous	TOT: - .001 II: - .012

Items retained

... is calm	.059	**.501**	**.403**	most relevant for Factor II	II: - .012 III: + .011
... checks on me frequently	**.403**	.206	**.468**	ambiguous	III: - .029 I: + .004
... is interested in me as an individual and not only as a patient	**.463**	.003	**.459**	most relevant for Factor III	I: - .003 III: + .024

TOT= decrease in Cronbach's alpha of the entire instrument after removing the concerning item.

I, II, and III= decrease (-) or increase (+) in Cronbach's alpha of the subscale by removing (-) or adding (+), respectively, the concerning item.

Table III Three-factor solution with factor loadings

"The Good Nurse"…	Factor		
	I	II	III

Factor I: … has a supportive and communicative attitude towards patient and family (α= .905)

… helps me with asking my doctor questions	**.762**	.067	.200
… anticipates my family's feelings concerning my diagnosis and offers support	**.714**	.045	.173
… involves my family or significant others in my care	**.698**	.005	.185
… tells me, in understandable language, what is important to know about my diseases and treatment	**.658**	.331	.025
… includes me in the planning and management of my care whenever possible	**.619**	.303	.123
… takes my wishes and feelings into account when professional appointments are made	**.593**	.228	.303
… takes care of me after having heard or having been confronted with bad news	**.553**	.328	.215
… teaches me how to care for myself whenever it's possible for me to do so	**.546**	.360	.113
… allows me to express my feelings about my disease and treatment	**.532**	.292	.379

… helps me clarify my thinking in regard to my disease and treatment	**.532**	.252	.283
… tells me about available support systems, such as self-help groups or patients with a similar disease	**.502**	.168	.291
… encourages me to call if I need something or if I have a problem	**.480**	.295	.307
… does not rigidly impose rules or does not just follow instructions when it's really necessary to help me	**.468**	.286	.141
… asks me if he/she can discuss my problems or questions with the nursing team or doctor	**.460**	.140	.261
… encourages me to ask any questions I might have	**.412**	.385	.216

Factor II: … is competent and employs a professional attitude (α= .838)

… knows how to perform nursing care	.089	**.764**	-.030
… knows when to call the doctor	.345	**.673**	.070
… doesn't express any negative attitudes such as impatience and disgust, even when performing dirty work	.109	**.664**	.071
… keeps his/her promise with me	.119	**.645**	.030
… gives my treatments and medications on time	.328	**.608**	.059
… recognises that the 'first times' are the hardest and pays special attention to me during these times	.375	**.531**	.228
… is calm	.059	**.501**	**.403**

… provides a comfortable environment	.127	**.496**	.390
… apologises when he/she makes a mistake	.224	**.451**	.370
… respects my privacy	.123	**.435**	.387

Factor III: … demonstrates personal involvement towards patient and family (α= .803)

… puts me first no matter what else happens	.114	.241	**.636**
… asks me what names I prefer to be called	.108	-.017	**.618**
… doesn't mind spending some extra time beyond duty hours in taking care of me	.338	-.081	**.618**
… is professional in appearance—wears appropriate, identifiable clothing and identification	.204	.175	**.565**
… sits down with me when we talk	.339	.059	**.537**
… checks on me frequently	**.403**	.206	**.468**
… is interested in me as an individual and not only as a patient	**.463**	.003	**.459**
… knows when I have 'had enough' and ensures I get enough rest	.327	.329	**.428**
… responds quickly to my calls	.227	.399	**.418**

Table IV Factor scores associated with patient- and context-related variables

Variable	Factor scores		
	Factor I	**Factor II**	**Factor III**
General factor score	7.9062	8.6550	7.1930
Gender	**p=.001**	**p=.046**	p=.888
Male	7.7213**	8.5313**	7.1266
Female	8.0462**	8.7487**	7.2433
Age	p=.072	p=.070	p=.150
18-45 years	7.6170	8.7245	6.7374
46-70 years	7.9460	8.6379	7.2034
71-95 years	7.9181	8.6704	7.3382
Number of Children	p=.600	p=.607	p=.957
0	7.7968	8.6519	7.0583
1	8.0034	8.6823	7.1601
2	7.9046	8.6143	7.2471
3	7.9847	8.7014	7.2935
≥4	7.7747	8.6890	7.1856
Cancer	p=.462	p=.142	p=.402
Gastrointestinal	7.8808	8.5700	7.2170

Urogenital	8.0926	8.7370	7.4060
Blood, lymph, bone marrow	7.8878	8.6416	7.1487
Breast	7.9687	8.7885	7.1427
Skin	7.3524	8.3143	6.3492
Bone	6.0000	7.4000	5.5556
Brain	8.1212	8.3591	7.3535
Lung	7.8374	8.5195	7.3306
head/neck	7.3246	8.5217	6.8889
Unknown	8.1111	8.3333	7.9259
Care setting	p=.208	p=.213	**p=.000**
Oncology day-care unit	7.9796	8.6953	7.1159
Oncology hospital ward	7.8094	8.6174	7.1431
Palliative care unit	7.9547	8.6100	7.8489**
Province	p=.139	p=.194	**p=.001**
Limburg	7.8759	8.6321	7.2638
Antwerp	7.8452	8.7331	7.0110
Flemish Brabant	7.7617	8.5122	7.1459
East Flanders	7.9940	8.5295	7.0171
West Flanders	8.2209	8.8693	7.7348**

**Significantly different.

Mann-Whitney U test for two independent groups.

Kruskal-Wallis test for more than two independent groups.