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What’s New in the Healthcare Literature

CE Activity: Psychosocial Needs of Cancer Patients Living in the Adirondacks: A Needs Assessment
Revisiting Professional Ethics and the Nursing Care Model in an Era of Healthcare Reform

The mandate for healthcare reform required by the Affordable Care Act has kindled the nursing profession to examine the quality of its services in a probing and introspective manner.

Providing quality healthcare is a professional responsibility and a patient expectation. Nursing services are provided around the clock, across many settings, and throughout the healthcare continuum. They are accountable for the majority of health-related activities observed in hospitals, clinics, and nursing homes as well as in private homes, schools, work settings, and even in the communities. Studies have documented that professional nursing services are known to contribute to specific outcomes that benefit patients and their families.

Notably, there is increasing research evidencing the associations between the amount of professional nursing care and positive health outcomes. Preliminary investigations have also suggested that the features or characteristics of patient-centered nursing interactions lead to improved healthcare outcomes. Recent studies have demonstrated a link between nurse caring and patient satisfaction, and nurse staffing levels and selected patient outcomes have now also been linked in several studies. Evidence-based studies have shown that increased amounts of registered nurse (RN) care were associated with better quality in hospitalized patients. These staffing studies suggest that lower numbers of RNs are related to higher adverse outcomes in the acute care population.

Nevertheless, across the nation and within our state, changes in healthcare reimbursement structures are placing a high value on cost effective, technologically sound, competent healthcare delivery. The demand for cost containment, expeditious care, shortened length of stays, or, in some cases, no-stay—[no admission] creates workplace pressures which may lead to poor care transitions and instances of moral distress.

Today’s healthcare environment poses ethical and caring challenges and raises troubling questions for many nurses. Nurses who are committed to practice excellence must now ask themselves how often they are in a situation where the workplace or healthcare environment compromises their principles as they endeavor to process the colliding pressures of being an employee of an institution that is more focused on profits and budget cuts while balancing the individualized needs of the patient.

Are nurses compromising their values as they advance through an evolving healthcare continuum? Are nurses compromising their ethics as they endeavor to maintain their position in the healthcare marketplace? Is the healthcare environment prohibiting patient-centered, caring models of nursing? At what point in the care-giving process should nurses take the time to reevaluate their roles, practice, ethics, and principles?

As you read this issue of the Journal, you will be offered an opportunity to reevaluate your professional values and to reflect upon how much professional ethics influence your practice.

Similarly, this Journal’s article on the scarcity of oncology nurse specialists and other healthcare professionals in rural areas will provide our readers with a disturbing account on the negative impact on patient outcomes and the ever present challenge of diversity of access to quality patient care. How will healthcare reform address this issue? What is the role of the nurse in the rural healthcare setting? How can nurses be the leaders in mitigating barriers to truly address the healthcare needs of patients in rural, urban, hospital, and home-care settings?

During this time of shifting healthcare priorities, ethics, advocacy, and leadership should remain at the forefront of nursing. Inasmuch as nurses are uniquely positioned to ensure quality patient care, let’s remind ourselves that nurses must maintain their key role of patient advocacy and facilitator.

Anna Cella, MA, MEd., RN
Meredith King-Jensen, MA, MSN, RN
Dana Deravin Carr, DrPH, MS, MPH, RN-BC, CCN
The quality of care that practitioners and hospitals provide to patients has always been important, and only recently has the patient had the opportunity to make an informed choice about which hospital to utilize. Consumers of health care services now have the ability to compare how other patients rate their hospital benchmarked against other hospitals in the geographical area. The Centers for Medicare & Medicaid Services (CMS, 2010a) have taken steps to collect and publicly report information about patient perceptions of their hospital experiences, thus allowing the public to make comparisons of hospitals based upon patient satisfaction scores (Health and Human Services [HHS], 2010). The public reporting of patient satisfaction survey scores is intended to create incentives for hospitals to improve the quality of care (CMS, 2010a). The key factors associated with higher performance and patient satisfaction, therefore, have become a top priority for health care organizations (Stuart, Parker, & Rogers, 2003; Vina, Rhew, Weingarten, & Chang, 2009), particularly in the emergency department (Hall, 2010; Messner, 2005).

In recent years, the US health care system’s reimbursement model has undergone a paradigm shift. A hospital-based pay for performance (P4P) and public quality reporting program is currently underway to align providers behind the objectives of delivering higher quality patient care (Ryan, 2010). The emerging concept of rewarding hospitals for meeting performance measures that are based upon patient satisfaction surveys and quality performance, rather than on the volume of services provided, has resulted in the identification of high-performing and low-performing providers and concomitant reductions in reimbursement rates for low-performing hospitals (CMS, 2010b; Vina et al., 2009). Additionally, hospitals that do not participate in patient satisfaction surveys altogether will receive less Medicare reimbursement than those that do (CMS, 2010a; Lutz & Root, 2007).

The Affordable Care Act (ACA § 3001) authorizes the establishment of the P4P quality initiative payment program for hospitals effective with the fiscal year 2013 for Medicare discharges occurring on or after October 1, 2012. The P4P initiative is designed to “transform CMS from a passive payer of claims to an active purchaser of care” (CMS, 2010b). Under the P4P system, financial

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### Abstract

This study examines the relationship between four variables and patient satisfaction in an emergency department setting in a small community hospital in Suffolk County, New York. Patients were assessed utilizing four variables: communications with doctors, communications with nurses, communications with ancillary staff, and environment of ED care. The study adds to the literature on which factors have the greatest influence on patient satisfaction in an emergency department setting. The purpose of the present study was to explore how ED patient satisfaction was influenced by their communications with physicians, nurses, and ancillary staff. Pearson correlation coefficients resulted in a statistically significant correlation between all variables and patient satisfaction. Path analysis showed the interrelationship between the four variables and patient satisfaction. Regression analysis predicted the extent to which each variable influenced patient satisfaction. The strongest predictor of patient satisfaction was communications with ancillary staff.

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**Key Words:** (Patient Satisfaction, Medicare Reimbursement, Pay-for-Performance, Emergency Room Department, Communications with Doctors, Communications with Nurses, Communications with Ancillary Staff, Environment of ED care).
incentives are used to drive improvements in patient centeredness outcomes (CMS, 2010b).

According to Stuart et al. (2003), “Understanding and acting on [sic] patient expectations are preconditions for improving patient satisfaction in the emergency department” [sic] (p. 370). Ultimately, when patient expectations are met, patients are more satisfied and have better outcomes. In an era in which health care practitioners will be increasingly measured by the outcomes of their treatments, it is critical for them to understand the issue of patient satisfaction. Understanding how to improve patient satisfaction outcomes, therefore, becomes an integral component in reimbursement payment calculations and incentives and an important initiative for health care organizations (Press, 2012).

Current literature suggests that several factors are associated with higher patient satisfaction scores. Some of these factors include: patients’ communications with physicians and nurses (Byrne, Richardson, Brunsdon, & Patel, 2000; Griffith, Wilson, Langer, & Haist, 2003; Jennings, Lee, Chao, & Keating, 2009; Redsell, Stokes, Jackson, Hastings, & Baker, 2007; Seale, Anderson, & Kinnerley, 2006); patients’ communications with ancillary staff (Stuart et al., 2003); and provisions in the environment of care conducive to privacy, comfort, and safety (Stuart et al., 2003; Vina et al., 2009). While some of the studies report higher patient satisfaction following nurse consultations when compared to physician consultations (e.g., Seale et al., 2006), others report higher patient satisfaction in facilities with strong physician leadership (e.g., Vina et al., 2009). Additional research is needed in this area to expound on these findings.

Expanding on the research of DeGoias (2006), the focus of this research was to further examine three types of patient communications: those with ED doctors, ED nurses (RNs), and ED ancillary staff. In DeGoias (2006), an ED doctor was operationally defined as one “who takes the professional responsibility of the comprehensive care of unselected patients who enter the emergency department” and who is “committed to care for the patient regardless of age, gender, race, or illness according to the medical school oath” (DeGoias, 2006, p. 8, citing Phillips & Haynes, 2001). An ED nurse (RN) was defined as one “who performs basic duties that include treating patients, educating patients and the public about various medical conditions, and providing advice and emotional support to patients and their family members. RNs record patients’ medical histories and symptoms, help to perform diagnostic tests and analyze results, operate medical machinery, administer treatment and medications, and help with patient follow up and rehabilitation” (DeGoias, 2006, p. 8, citing U.S. Department of Labor, Bureau of Labor Statistics). ED Ancillary Staff was defined as “the licensed and non-licensed ED personnel such as nurse’s aides, transporters, wards [sic] clerks, security personnel, housekeepers, and radiology technicians” (DeGoias, 2006, p. 9). Emergency Department was defined as “any department or facility of the hospital, whether situated on or off the main hospital campus, that: (1) is licensed by the state as an emergency department; (2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or (3) during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis” (DeGoias, 2006, p. 8, citing Department of Health Press Release, 2003). Patient satisfaction in the DeGoias (2006) study was defined as “an aspect of quality health care, which is described as the subjective experience the patient has during receipt of that care” (DeGoias, 2006, p. 10, quoting Messner, 2005, p. 1).

In the current study, we explored the extent to which each type of communication (with ED doctors, ED RNs, and ED ancillary staff) impacted the patient experience and how these interactions worked together to influence patient satisfaction scores. We also explored the relationship between patient satisfaction and ED environment, which included cleanliness, wait time, courtesy, respect, and availability of the services of an interpreter. By analyzing the patient satisfaction surveys that were obtained in the DeGoias (2006) study, we further examined patient satisfaction as a driver of patient outcomes and an important component of pay-for-performance metrics, and we explored the interrelationships between patient-provider communications and patient satisfaction.

Research Questions

This study was conducted to extend the literature regarding nurses’ understandings of patient expectations as it relates to patient satisfaction. First, we examined how communications between patients and doctors, patients and nurses, and patients and ancillary staff related to patient satisfaction. Second, we examined how the environment of emergency department care related to patient satisfaction. Finally, we examined which of these variables best predicted patient satisfaction.

Methods

This research is rooted in Normative Decision Theory (NDT). Through the application of NDT models, Brennan (1995) found that patient preferences can adequately be reflected in measures of patient satisfaction. NDT also provides computational strategies to assign numeric scores to subjective judgments of such abstractions as patient preferences and patient satisfaction.

The study analyzed the relationship between four variables and patient satisfaction in an emergency department setting in a small 341 bed community hospital in Suffolk County, New York. The facility has Joint Commission accreditation and provides over 55,000 emergency service visits per annum. The researchers hypothesized that, between and among the variables analyzed, communications with nurses would be the best predictor of patient satisfaction, followed in successive order by communications with physicians, communications with ancillary staff, and environment of ED care. A quantitative methodological approach and correlational research design was selected for this study.
Data

After Internal Review Board (Appendix A) approval was obtained in the original DeGoias (2006) study, data were collected from patients between October and December of 2005. Patient satisfaction surveys were completed by 104 patients whose ethnic demographics constituted 28.4% white, 18.6% Black/African American, 48.0% Hispanic/Latino, and 4.9% other. Languages spoken among these patients were: English (51%), Spanish (43.8%), Italian (3.1%), and Creole (2.1%). Eighty-two hospital healthcare employees volunteered to participate in the DeGoias (2006) study and were the subjects of the patient satisfaction evaluation tool. The demographics of the 82 ED staff participants comprised 38 ancillary staff, 32 nurses, 12 doctors, 30 men, and 50 women. Of the staff participants, 62.2% were white, 33.8% non-white, 46.9% ancillary staff, 38.3% nurses, 14.8% doctors, 85% born in the United States, and 15% born in the Caribbean, Central America, Asia, or Africa. Two respondents did not complete the gender category.

The data used in the study was derived from a 30 item, 5 point Likert scale survey used by DeGoias (2006, p. 105; Appendix B) and adapted from a survey in the public domain by Garcia, Roy, Okada, Perkins, and Wiebe (2004). The data derived from the DeGoias (2006) study assessed patient satisfaction for the purposes of the present study. The DeGoias (2006) questionnaire reported over 90% reliability. In that study, items 27 and 28 were reversed for factor analysis. The researchers decided to obverse items number 27 and 28 before creating the variables. In addition, the researchers decided to exclude the variable of "interpreter services" from the original study due to the limited number of people who answered this question (N=13).

Statistical Analysis

We explored the relationship between each of the independent variables (communications with ED doctors, ED nurses, and ancillary staff; and environment of ED care) and how they were related to patient satisfaction by using several correlational methods. First, we used a Pearson r correlation coefficient. This statistical test measures the dependence between each variable and patient satisfaction. If two variables are positively related, the Pearson r coefficient will have a value between “0” and “1” (Leedy & Ormrod, 2010).

We also used multiple regression analysis to explore which of the variables was the best predictor of patient satisfaction. This method enabled the researchers to study how these factors, both independently and in combination, affect the outcome variable. This analysis is designed to maximize the correlation between various combinations of variables (Leedy & Ormrod, 2010). Lastly, to determine the strengths of the relationships between the variables and patient satisfaction, and, more importantly, to test the validity of the theory about causal relationships between three or more variables that have been studied using a correlational research design, we used a structural equation model (Path Analysis). This analysis showed the interrelationship and the effects of the four variables on patient satisfaction (Figure 1). Path Analysis differs from multiple regression analysis in that its purpose is to test theories about hypothesized causal links between variables (Leedy & Ormrod, 2010). Statistical analyses were performed using SPSS (version 19) and AMOS software.

Results

The Pearson correlation coefficients resulted in a statistically significant correlation between all variables and were greater than or equal to \( r = .53 \) (\( r = .53 \) to \( r = .78 \); see Figure 1). This correlation measures the degree of association between each variable and patient satisfaction. The results of this statistical test indicate that there was a significant positive association, correlation, and causal influence between each of the variables and patient satisfaction. That is, there was a significant association between the variable “communications between ED doctors” and patient satisfaction. Likewise, there was a significant association between all of the other variables and patient satisfaction (Table 1).

Figure 1: Structural Equation Model (Path Analysis): Interrelationship of Variables on Patient Satisfaction

Multiple linear regressions were evaluated as to how well the independent variables (communications with ED doctor, ED nurse, and ancillary staff; and emergency room care) predicted the dependent variable (patient satisfaction). The result of the bivariate linear regression indicated that the four independent variables were strongly related to patient satisfaction (thus supporting Brennan’s [1995] model in NDT). The strongest predictor of patient satisfaction was communications with ancillary staff.

The Path Analysis resulted in a graphic representation of the interrelationships among the variables (Figure 1). The value of .81 \( (R^2 = .81) \) means that 81% of patient satisfaction can be explained by the three variables (communication between patient and ED doctor, patient and ED nurse, and patient and ancillary staff), the patient variable experience, and the environment of ED care.

The Path Analysis was also used to statistically test and estimate the causal relationship between each of the multiple variables and how they relate to one another. That is, this analysis computes...
statistics that show the strength of the relationship between each pair of variables that are causally linked to hypotheses. In our model (Figure 1), the value of \( r = .57 \) shows the correlation, or relationship, between ancillary staff and ED care. This value indicates that 32% of emergency department care was attributable to ancillary staff. The value \( r = .78 \) shows the correlation, or relationship, between ancillary staff and nurses. This value indicates that there was a 61% interrelationship between ancillary staff and nurses. The value of \( r = .74 \) shows the correlation, or relationship, between ancillary staff and ED doctors. This value indicates that there was a 55% interrelationship between ancillary staff and ED doctors. The value of \( r = .61 \) shows the correlation, or relationship, between ED doctors and ED nurses. This value indicates a 37% interrelationship between ED doctors and ED nurses. The value of \( r = .53 \) shows the correlation, or relationship, between ED doctors and ED care. This value indicates 28% of emergency department care was attributable to ED doctors. The value of \( r = .54 \) shows the correlation, or relationship, between the ED nurse and the ED care. This value indicates that 29% of ED care was attributable to the ED nurses (Figure 1; Table 2).

Additionally, the Path Analysis was used to statistically test and estimate the causal relationship between the independent variables and the dependent variable. These interrelationships are shown in Figure 1, utilizing the standardized beta (\( \beta \)) weights. \( \beta = .39 \) means that 39% of patient satisfaction was due to the contribution of communications with ancillary staff. \( \beta = .31 \) means that 31% of patient satisfaction was due to the contribution of communications with the ED doctors. \( \beta = .20 \) means that 20% of patient satisfaction was due to the contribution of communications with ED nurses. \( \beta = .13 \) means that 13% of patient satisfaction was due to the effect of environment of ED care (Table 3).

Table 1: Correlations

<table>
<thead>
<tr>
<th>Patient Satisfaction General</th>
<th>Patient Satisfaction</th>
<th>ED MD</th>
<th>ED RN</th>
<th>ANCILLARY STAFF</th>
<th>ED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction General</td>
<td>( r )</td>
<td>1</td>
<td>.645*</td>
<td>.698**</td>
<td>.639*</td>
</tr>
<tr>
<td></td>
<td>( p )</td>
<td>.032</td>
<td>.008</td>
<td>.025</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>( N )</td>
<td>11</td>
<td>182</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>ED MD</td>
<td>( r )</td>
<td>.645*</td>
<td>1</td>
<td>.629**</td>
<td>.767**</td>
</tr>
<tr>
<td></td>
<td>( p )</td>
<td>.032</td>
<td>.000</td>
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<td>.000</td>
</tr>
<tr>
<td></td>
<td>( N )</td>
<td>11</td>
<td>82</td>
<td>98</td>
<td>91</td>
</tr>
<tr>
<td>ED RN</td>
<td>( r )</td>
<td>.698**</td>
<td>.629**</td>
<td>1</td>
<td>.782**</td>
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<td>( p )</td>
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<tr>
<td></td>
<td>( N )</td>
<td>13</td>
<td>82</td>
<td>98</td>
<td>91</td>
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<tr>
<td>ANCILLARY STAFF</td>
<td>( r )</td>
<td>.639*</td>
<td>.767**</td>
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<td></td>
<td>( p )</td>
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<td>( N )</td>
<td>12</td>
<td>78</td>
<td>91</td>
<td>96</td>
</tr>
<tr>
<td>ED CARE</td>
<td>( r )</td>
<td>.743**</td>
<td>.549**</td>
<td>.544**</td>
<td>.565**</td>
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<tr>
<td></td>
<td>( p )</td>
<td>.004</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>( N )</td>
<td>13</td>
<td>79</td>
<td>93</td>
<td>97</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

The correlation between medical doctor and patient satisfaction was significant at the 0.05 level (\( p = .032 \)).
The correlation between nurse and patient satisfaction was significant at the 0.01 level (\( p = .008 \)).
The correlation between ancillary staff and patient satisfaction was significant at the 0.05 level (\( p = .025 \)).
The correlation between emergency room care and patient satisfaction was significant at the 0.01 level (\( p = .004 \)).

Table 2: Strength of Relationship between Each Variable in Percentages

<table>
<thead>
<tr>
<th>Patient Satisfaction</th>
<th>ED MD</th>
<th>ED RN</th>
<th>Environment of ED Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary Staff</td>
<td>55%</td>
<td>61%</td>
<td>32%</td>
</tr>
<tr>
<td>ED MD</td>
<td>37%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>ED RN</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Percentage of Contribution of Independent Variable to Patient Satisfaction

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Patient Satisfaction (Dependent Variable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications with Ancillary Staff</td>
<td>39%</td>
</tr>
<tr>
<td>Communications with ED MD</td>
<td>31%</td>
</tr>
<tr>
<td>Communications with ED RN</td>
<td>20%</td>
</tr>
<tr>
<td>Environment of ED Care</td>
<td>13%</td>
</tr>
</tbody>
</table>

Discussion

This study indicated that the strongest predictor of patient satisfaction in the Emergency Department was communications with ancillary staff. Therefore, the researchers’ hypothesis that between and
among the variables analyzed, communications with nurses would be the best predictor of patient satisfaction, followed in successive order by communications with physicians, communications with ancillary staff, and environment of ED care was partially supported by the data.

Although the data supported the researcher’s hypothesis regarding the strengths of the relationships between patient satisfaction and communications with emergency physicians and environment of ED care, thus supporting the validity of the theory about the causal relationships between these variables, the data did not support the researchers’ hypothesis regarding the strengths of the relationships between patient satisfaction and communications with emergency nurses and emergency ancillary staff. Sources of uncertainty influencing the results of this study include the then existing nurse-to-patient ratios while data was collected and the concomitant challenges of low nurse staffing levels in maintaining direct and continuous communications between patients and nurses in the ED.

Nevertheless, this study provides a visual model of some of the factors which significantly influence patient satisfaction in hospital emergency departments. The results of this study are in accord with many of the common themes emerging from healthcare policy with regard to healthcare reimbursement and patient satisfaction scores. Health care law now requires a new reimbursement for method for patient services. Patient satisfaction scores are now regarded as reflecting the quality of care provided in Emergency Departments and will be used to adjust reimbursement payments to hospitals accordingly (CMS, 2010b; Ryan, 2010; Vina et al., 2009).

The importance of communications between healthcare providers and emergency room patients and their relationship to patient satisfaction has been reported in the literature (Byrne et al., 2000; Griffith et al., 2003; Hall, 2010; Jennings et al., 2009; Kalisch, Gosselin, & Choi, 2012; Seale et al., 2006). Our research resulted in similar findings, showing that there are clear, positive interrelationships among and between ED staff and patient satisfaction. Improved communications between ED staff and patients can therefore result in higher patient satisfaction scores. Thus, if the interrelationships between and among ED staff and patients can be improved upon, then overall patient satisfaction scores can be improved, and increases in provider reimbursements from the CMS can be achieved.

The importance of provisions in the environment of care to ED patients and its relationship to patient satisfaction has also been reported in the literature (Stuart et al., 2003; Vina et al., 2009). The current research resulted in similar findings. Viewing care through the eyes of the patient becomes a necessary factor in evaluating the environment of ED care. Reimbursement outcomes will turn on whether the patient satisfaction scores meet desirable, expected, and set goals as determined by the Centers for Medicare & Medicaid Services.

The study further identified that while multiple organizational factors remain important in optimizing patient satisfaction scores, patients’ communications with ancillary staff in this small community hospital were statistically and significantly the greatest factor in influencing patient satisfaction. It is important for ED nurses to understand that their relationships with ancillary staff will greatly influence patient satisfaction scores and the ultimate reimbursement rates received by the hospital. Likewise, it is important for ED nurses to understand that factors associated with improving their direct communications with patients, such as adequate nurse staffing levels, can also positively influence and improve patient satisfaction scores. This, too, can ultimately result in improved reimbursement rates received by the hospital.

A replication study examining staffing levels, using a quantitative methodological approach and correlational research design to determine the strengths of the relationships between these same variables and patient satisfaction, would further clarify the hypothesis pronounced in this study. Future research could also examine the relationship between nurse communications and patient satisfaction scores within larger ED departments. Additional research should further examine the relationship between nurse communications and patient satisfaction scores in other hospital units. The correlation between ED nurses’ workplace satisfaction scores and patient satisfaction scores should also be explored.

**Limitations**

There are several limitations to this study. First, this study was limited to one community hospital emergency department in Suffolk County, New York. Second, this study was limited in its sample size (N = 104). Third, this study used data collected in a short timeframe (two months). Fourth, this study was limited in that it did not assess how ED nurse satisfaction within their workplace setting can influence patient satisfaction scores. Finally, this study was limited in that it did not assess the nurse-to-patient ratio at the time of the data collection.

**Implications for Emergency Nurses**

Registered nurses have long acknowledged and continue to emphasize that staffing issues are an ongoing concern that significantly influences the satisfaction of patients and the nurses. Research supports the belief of many nurses that features of the hospital work environment, particularly better nurse-to-patient staffing ratios, are significantly and positively associated with improved patient outcomes, including patient satisfaction. (Aiken et al., 2012; Kutney-Lee et al., 2009). Reductions in nurse staffing have contributed to challenges in maintaining direct and continuous communications between patients and nurses. Reductions in nurse staffing have been positively correlated to reductions in patient satisfaction scores as well (Kalisch et al., 2012).

As patient satisfaction becomes integrated into more P4P reimbursement programs and public reporting plans, hospitals will have further incentives to improve patient satisfaction scores by improving nurse work environments. A hospital’s investment in nursing could ultimately result in improved patient outcomes, including better patient experiences. Currently, health care administrators and leaders have an opportunity to develop staffing solutions that can improve nurse work environments as part of an overall plan to improve communications between nurses and patients with concomitant increases in patient satisfaction scores. In our new regulatory environment under the Affordable Care Act, health care administrators and leaders should recognize that investments in higher nurse staffing and appropriate numbers and skill mixes of RNs and other ancillary staff can be a potential system-level intervention to improve CMS P4P reimbursement rates (McHugh, Berez, & Small, 2013).
The information derived from our Path Analysis model can serve as a foundation for nurses’ advocacy for optimal nurse-to-patient ratios to maximize patient satisfaction scores. This can be achieved by lobbying for legislated nurse-to-patient ratios and/or negotiating contractual ratios. The information derived from our path analysis model can also serve as a foundation for restructuring emergency departments and other patient care units within hospitals to facilitate maximum communications among and between patients and patient care providers, particularly nurses. The information can also serve as a basis to empower hospital administrators to adopt a consumer-oriented approach to healthcare and patient needs.

Conclusions

This study provides a practical visual model for assessing significant components of patient satisfaction in hospital emergency departments. By establishing closer links between the communications of healthcare service providers and the environment of care to patient satisfaction, healthcare providers can positively influence healthcare reimbursement rates. This may serve to refocus health services to a broader consideration of individual patient needs and outcomes.

Appendix A:
Dowling IRB Approval

TO: Elsa DeGoias, Doctoral Candidate
Dr. Stephanie Tatum, Chairperson, Assistant Professor of Educational Administration, Leadership & Technology

FROM: Kendall C. Thorton, Ph.D.
Chair of Human Subjects Research Committee

DATE: August 29, 2005

RE: Project titled: Patient satisfaction relationship among spoken language, translation services, and staff attitudes towards training.

This letter is to serve as your written permission to proceed with your research project titled “Patient satisfaction relationship among spoken language, translation services, and staff attitudes towards training” at Dowling College. Upon review of your research proposal, it was determined that your project did not meet the criteria requiring consideration and written approval from the Human Subjects Research Committee (HSRC).

Your research appears to be in compliance with Dowling College and Federal Standards for research involving human subjects. If you have any questions regarding ethical guidelines, or if you significantly change the procedures of your research, please contact me to determine if further consideration by the committee is warranted.

Appendix B: ENGLISH PATIENT SURVEY PART II

PATIENT SURVEY PART II (continued)

Directions: Please answer the questions by circling and answer using the following key:

1 = Slightly Disagree (SD)  2 = Mildly Disagree (MD)  3 = Slightly Agree (SA)
4 = Mildly Agree (MA)  5 = Strongly Agree (SA)

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>MD</th>
<th>SA</th>
<th>MA</th>
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<tr>
<td>1. The Interpreter translated everything.</td>
<td>1</td>
<td>2</td>
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<td>2. Overall, I was satisfied with the interpreter.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>3. Interpreter explained in a way I understood.</td>
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<tr>
<td>4. I was confident in the correctness of the interpretation.</td>
<td>1</td>
<td>2</td>
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<td>5. I would use the interpretation services again.</td>
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<td>2</td>
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<td>6. The doctor made me feel confident in his/her ability.</td>
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<td>7. Overall, I was satisfied with the doctor.</td>
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<td>2</td>
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<td>8. Procedures were clearly explained by the doctor.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>9. The doctor took my problem seriously.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>10. The doctor spent sufficient time with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>11. The doctor listened to what I had to say about my illnesses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12. Overall, I was satisfied with the nurse(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>13. The nurse(s) made me feel confident in their ability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>14. The nurse explained the procedures done in the Emergency Room clearly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>15. The nurse(s) took my problem seriously.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>16. The nurse(s) spent sufficient time with me.</td>
<td>1</td>
<td>2</td>
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<td>17. The nurse(s) listened to what I had to say about my illnesses.</td>
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<td>2</td>
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<td>18. Overall, I was satisfied with the staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>19. I was treated with courtesy and respect by the staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>20. The staff took my problem seriously.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. The staff spent sufficient time with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>22. The staff listened to what I had to say.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>23. Overall, I was satisfied with the emergency room care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>24. The waiting time in the emergency room was brief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>25. The emergency room was clean.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>26. I would be willing to return to this emergency room for care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>27. The doctor used medical words that were not clear to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>28. I had trouble understanding the doctor because he/she spoke too fast.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>29. The doctor gave me enough time to say what I thought was important.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>30. The doctor explained why I was having test done.</td>
<td>1</td>
<td>2</td>
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REFERENCES


Introduction

The nursing profession is based on core values of caring, integrity, diversity and excellence (Tagliareni & Perkins, 2008). Of these, integrity, which is an adherence to moral and ethical values, may well symbolize the very heart and soul of the nursing profession. In simplest terms, it is the intrinsic value which guides nurses on a daily basis to always do the right thing. Therefore, any degree of misconduct or dishonesty within the nursing profession is of great concern. Academic misconduct and unethical behaviors in practice by nurses and nursing students can have potentially serious effects for patients. Associations between academic misconduct and professional ethics have been and will continue to be an area of significant concern for both nurse educators and nurse administrators in the practice area.

Research data continues to indicate students engage in a wide variety of academic misconduct behaviors and nursing students are not immune to participating in these behaviors (Bailey, 1990; Harnest, 1986; Hilbert, 1985, 1987; McCabe, 2009; McCrink, 2008; Russian, 2003). Not only has the incidence of academic misconduct behaviors in the general educational system increased, but the level of sophistication and type of misconduct has dramatically increased over the last two decades. Academic misconduct behaviors and specifically cheating have become more common and today’s students may not only use traditional methods of cheating but now may take advantage of information technology, such as the internet and cell phones to aid and abet their dishonest behaviors (Kececi, Bulduk, Oruc & Celik, 2011). Not only does the internet provide easy access to materials and written papers, it has an extraordinary and complete guide to cheating methods.
Insight into the impact and relationship between academic misconduct and clinical misconduct behaviors may provide information that nurse educators can use to thwart forms of academic misconduct. Additionally, if a relationship exists between academic and workplace misconduct, the impact of such would be detrimental not only to patients, but to the nursing profession as a whole. For this study, academic misconduct was defined as the deceptive and dishonest practices regarding one’s academic work in the classroom or clinical setting and one’s professional clinical practice.

Theoretical Framework

Guiding this study were the works of Kohlberg (1981) and Watson (1979, 1988). These two conceptual rationales, Kohlberg’s Stages of Moral Development and Watson’s Theory of Human Caring, became the underpinnings of this study.

According to Watson (1979, 1988) the nursing profession has a moral commitment to others that is expressed in an ethic of caring that allows nurses to demonstrate behaviors that reflect the social purpose of the nursing profession. The concept of caring within the nursing profession includes “values, a will and commitment to care, knowledge, caring actions, and consequences” according to Watson (1988, p. 29). Watson (1979, 1988, 1999) has further described caring as a moral ideal of nursing, a concept that is a universal need of all patients and a core value of the nursing profession. According to Watson, nursing is about the beauty, art, and humanity of being with patients, the ability of nurses to demonstrate an ethic of caring in any patient care situation. The demonstration of caring behaviors by nurses demonstrates a nurse’s concern for and dedication to the patient (Cook & Cullen, 2003). It is a complex concept that includes moral, cognitive, and emotional components. It is morally linked to the nursing profession as it calls for conscious actions by the nurse that will avert misconduct behaviors and ensure the safety and protection of patients in all healthcare settings.

Kohlberg’s (1981) perspective was that he considered moral principles as universal and believed they developed over time as individuals react to issues within their environment. The inability of individuals to move through Kohlberg’s stages of moral development reflects an individual’s inability to think about and resolve moral problems. He proposed that certain individuals possess an inability to fully develop moral behaviors, and thus, these individuals would be more likely to engage in unethical behaviors in any given setting.

Based on these perspectives, nursing students and practicing registered nurses must have the ability to develop morally and choose actions that uphold the social purpose of the nursing profession.

Literature Review

In this focused literature review, studies relevant to the aims of the study, academic misconduct, and unethical professional behavior by nurses are reviewed. A number of studies have documented the engagement of nursing students in various behaviors in the classroom, and a few investigated clinical misconduct (Bailey, 1990; Harnest, 1986; Hilbert, 1985, 1987; McCabe, 2009; McCrink, 2008; Russian, 2003). Even fewer studies have investigated the relationship between academic misconduct and unethical behavior as registered nurses.

Academic Misconduct

Academic misconduct in institutions of higher learning within the United States is a long-standing area of concern for educators and recognized as a problem of epidemic proportions (Baird, 1980; Bonjean & McGee, 1965; Davis, Grover, Becker & McGregor, 1992; Haines, Diekhoff, LaBeff & Clark, 1986; Hard, Conway & Moran, 2006; McCabe & Trevino, 1996; Moeck, 2002; Parr, 1936; Polding, 1995; Stern & Havlicek, 1986; Wrightsman, 1959). This phenomenon has also been well-recognized in nursing programs (Harnest, 1986).

One might assume that students who enroll in a nursing program enter the caring profession of nursing with strong ethical values and would thus be immune to behaviors of academic misconduct. Unfortunately, this is not the case as multiple studies have documented the engagement of nursing students in various behaviors of classroom and clinical misconduct (Bailey, 1990; Harnest, 1986; Hilbert, 1985, 1987; McCabe, 2009; McCrink, 2008; Russian, 2003).

Several studies revealed various types of misconduct prevalent in nursing students and some studies highlighted faculty perceptions of this misconduct as a significant problem. Harnest (1986) surveyed nursing faculty and students in one school of nursing about behaviors of academic misconduct. The most common identified classroom behavior was the submission of a paper for multiple courses (36%). In the clinical area, students identified the following behaviors as acceptable behaviors to engage in: going to the clinical area without completing assigned preparatory work (34%), avoiding their clinical instructor to evade patient queries (22%), completing patient charting hours before the end of their assigned shift (13%), and recording inaccurate information into the patient’s chart (6%). Additionally, Harnest found significant differences between faculty and student perceptions of academic misconduct.

Hilbert (1985) researched the involvement of 101 senior-baccalaureate nursing students in classroom and clinical misconduct behaviors and reported various unethical behaviors. Respondents in this study copied sentences from a source without adding the appropriate reference (27%), cited bibliography sources that were not used in a paper (17%), and obtained test questions from a peer who had already taken the exam (9%). Additionally, the respondents in this study admitted that they took home hospital equipment (59%), divulged patient information in public areas or with non-medical people (54%), and recorded medications, treatments, or assessments that were not completed (19%).

In 1987, Hilbert expanded her previous research to gain additional insight into academic misconduct in nursing education. Data was collected from 210 nursing students enrolled in four nursing programs located in three states (Pennsylvania, California, and Wisconsin). Compared to her previous study, higher levels of academic misconduct by nursing students were reported. In the classroom setting, these included: (1) getting test questions from a peer who had already taken
In this study, nursing students reported that they discussed patients in public areas or with non-medical people (35.3%), paraphrased or copied material without providing appropriate references (35.2%), and obtained test questions from a peer without taking the exam (35%). Additionally, students in this study indicated they engaged in behaviors of academic misconduct to get good grades (44%) and succeed in the nursing program (25.5%).

Bailey (1990) queried nursing faculty and administrators to assess their perceptions of academic misconduct in nursing students. One hundred of the 261 respondents (38%) believed that faculty did not "deal with cheating in an effective or consistent manner" (p. 42). As a result, attitudes towards academic misconduct were explored by Russian in 2003. Students in this study divulged they cheated on exams (81%), plagiarized papers (59%), and falsified patient records (33%). Students who sensed faculty disapproval of academic misconduct behaviors were less likely to partake in these behaviors. However, 22% of the students believed that faculty did not "deal with cheating in an effective or consistent manner" (p. 42).

The prevalence of academic misconduct behaviors in 32 senior-baccalaureate-nursing students and their perceptions of faculty attitudes towards academic misconduct were explored by Russian in 2003. Students in this study divulged they cheated on exams (81%), plagiarized papers (59%), and falsified patient records (33%). Students in this study who sensed faculty disapproval of academic misconduct behaviors were less likely to partake in these behaviors. However, 22% of the students believed that faculty did not "deal with cheating in an effective or consistent manner" (p. 42).

McCrink (2008) found similar results when she surveyed 193 second-year-associate-degree-nursing students. In this study, nursing students reported that they discussed patients in public areas or with non-medical people (35.3%), paraphrased or copied source material without providing appropriate references (35.2%), and obtained test questions from their peers (21.8%). Additionally, 25 of the respondents (13.1%) revealed that they had reported and/or recalled vital signs that were not taken or recalled accurately, and 17 of the respondents (8.8%) disclosed that they had reported and/or recorded patient treatments that were not performed or observed. This study also revealed that while all of the identified behaviors were perceived by nursing faculty to be unethical, some of the study respondents did not perceive some of the identified behaviors to be unethical. Examples of behaviors not perceived as unethical were the students who believed it was acceptable to obtain test questions from another student (n = 37) and paraphrase or copy material without providing appropriate references (n = 32).

McCabe (2009) continued to find supporting evidence that undergraduate nursing students engage in various academic misconduct behaviors. In this study, nursing students continued to report that they collaborated with other students when not allowed (43%), failed to cite written sources appropriately (38%), obtained test questions from a peer prior to taking the exam (35%), and falsified or fabricated laboratory or research data (17%).

A convenience sample of 228 nursing students found a strong tendency by the students to view different forms of academic misconduct as normal and acceptable when they described academic cheating as an epidemic phenomenon (Balik, Sharon, Kelshe & Tabak, 2010). According to Balik et al., misconduct is occurring because personal success has become prized over social values. Students may go into a survival instinct to attain better grades through cheating and plagiarism. Participants in this study were able to stratify academic misconduct behaviors from an ethical perspective.

Of concern is the potential for nursing students to carry over misconduct behaviors into the clinical setting as registered nurses, which may result in negative patient outcomes.

### Workplace Unethical Behaviors Related To Academic Misconduct

According to McCabe (2009), no "definitive link has been established" between unethical behaviors by a nursing student and subsequent unethical behaviors as a professional registered nurse. The literature on the relationship between academic and workplace misconduct is scarce, especially in nursing, and available literature has focused on other professions such as business and medicine. However, in one nursing investigation, Hilbert (1985) studied 101 senior-baccalaureate-nursing students on classroom and clinical misconduct behaviors and reported various unethical behaviors. Respondents in this study copied sentences from a source without adding the appropriate reference (27%), cited bibliography sources that were not used in a paper (17%), and obtained test questions from a peer who had already taken the exam (9%). Additionally, the respondents in this study, senior students, admitted that they took home hospital equipment (59%), divulged patient information in public areas or with non-medical people (54%), and recorded medications, treatments, or assessments that were not completed (19%).

Schmidt (2006) addressed concerns in her article, “Cheating: an ethical concern for nursing educators” when she asked, “If a nursing student cheats on a test or plagiarizes a paper, will this behavior lead to other deceptions in nursing practice?” (p. 4).

Furthermore, nursing students who engage in behaviors of academic misconduct may become registered nurses who are ill-prepared to render safe, patient-oriented nursing care (McCrink, 2008).

Additionally, Jeffreys and Stier (1998) assert that academic misconduct in nursing education has the potential to harm the integrity of the nursing profession as a whole.
Why students engage in academic misconduct is not definitively understood. One reason may be the inconsistency between faculty and student definitions or perceptions of academic misconduct (Burrus, McGoldrick & Schuhmann, 2007; Faller, 1990; Nuss, 1984; Pavia, 1981). Therefore, it is important for faculty to continually assess student definitions and perceptions of academic misconduct as methods of academic misconduct continually evolve (Berger, 2007; Brown, 2002; Harper, 2006; Kenny, 2007; McCrink, 2010; Strom & Strom, 2007). Faculty need to provide students with more than ethical content. Students need materials that evoke professional attitudes and consequences (Bongiorno, Scotto, Brown, & Husted, 2008).

Grady et al. (2008), determined that nurses who reported no formal ethics education showed significantly lower moral action scores on a subscale of the Nursing Ethical Involvement Scale compared to those who had received ethical education. Confidence in ethical decision making also suffered among those not exposed to ethics education. In addition, external demands may create barriers to sound judgment (Mohr, Deatrick, Richmond & Mahon, 2001). Market forces support an environment where conflict occurs between the core values inherent in academic honesty and the gravity of failure. When students consider cheating, it may be difficult for them to determine what is and is not morally acceptable, in the absence of clear education about moral values and ethical comportment in patient-centered education.

Not only do today’s students copy answers from other students during exams, but it has been reported that students creatively copy academic information into the folds of pleated skirts, onto paper flowers and inside the label of water bottles (Brown, 2002; McCrink, 2010). Additionally, technological advances now allow students to download papers from the internet, surreptitiously use tiny cameras and micro-recorders to obtain protected class information and use programmable watches and cell phones during tests (Arhin & Jones, 2009; Berger, 2007; Embleton & Helfer, 2007; Harper, 2006; Kiehl, 2006).

Nursing literature suggests that impaired moral judgment may be an underlying factor of student misconduct (Baxter & Boblin, 2007; Jeffreys & Stier, 1995). The lack of role models and inadequate socialization into the profession of nursing has also been suggested as a factor leading to student misconduct (Gaberson, 1997; Kenny, 2007; Roberts, 1999). Guidance from the National Student Nurses Association (NSNA, 2009) and the American Nurses Association (ANA) may help floundering students. NSNA adopted a Code of Ethics in 2009, which, in part, states that nursing students will practice veracity and adhere to the principles of ethics at the highest moral levels, while always acting under and within established ethical principles. The ANA provides a clear code of ethics. Both the ANA and NSNA have responded to the most pressing need in healthcare today, to be the agent of the patient, keeping the patient at the center of care (Husted & Husted, 2008).

Additional causes of academic misconduct in nursing students could be due to competition among students to achieve good grades, the emphasis nurse educators place on perfection, threats of punishment, and outside pressures to “be the best” and succeed in school. Other factors may include stress, classroom environments that do not thwart misconduct behaviors, a student’s ability to rationalize behaviors of academic misconduct and various interpretations of the definition of academic misconduct (Brown, 2002; Gaberson, 1997; McCabe, 2009; McCrink, 2008; Roberts, 1997).

Workplace Misconduct

According to Drake (1941), some faculty would find consolation in the rationalization that students who engage in dishonest behaviors only cheat themselves. However, nurse educators would find no consolation in this generalization about academic dishonesty, because the workplace of the nurse is the clinical setting.

The literature on any relationship between academic and workplace misconduct is scarce and has primarily been focused on business school majors, although other professions such as those in healthcare have also been studied. Sims (1993) analyzed academic dishonesty data from 60 graduate students enrolled in a master’s in business administration program and found that students who engaged in academic misconduct behaviors also engaged in workplace misconduct behaviors. Nonis and Swift (2001) investigated the relationship between academic and workplace misconduct in a multi-campus study of 1,051 undergraduate and graduate business students. The study revealed a positive correlation between the frequency of academic and workplace misconduct. More than 10% of the respondents believed in varying degrees that the following behaviors were not representative of dishonest workplace behaviors: calling in sick when you were not sick, withholding the total truth to cover up other people’s mistakes, doing less than your share of work in a group project, and coming to work under the influence of drugs, including alcohol.

Papadakis, Hodgson, Teherani, and Kohatsu (2004) examined the records of physicians disciplined by the State Medical Board of California from 1990 to 2000 for misconduct behaviors which included negligence, inappropriate prescribing, unlicensed activity, acts of endangering patients, fraud, conviction of a crime, and/or unprofessional conduct. Papadakis et al. (2004) established, after reviewing medical school records, that medical students who engaged in unprofessional behaviors were twice as likely to be disciplined by the State Medical Board of California as compared to control students in the study. Papadakis, et al. (2005) expanded the previous case-control study and found similar results.

Zhong, Kenward, Sheets, Doherty, and Gross (2009) investigated 207 nurses (registered nurses, licensed practical nurses, and advanced practice nurses) in six states who were disciplined by their respective state nursing boards in 2001; all were put on probation due to practice-related violations. They found a “striking association between a history of criminal conviction and the risk of requiring disciplinary action” (p. 54). Smith (2010) surveyed 167 online RN-BSN students to identify their perceptions of academic and professional dishonesty and to explore if a relationship existed between academic and professional behaviors and found a positive relationship between academic and professional dishonesty. These limited numbers of studies indicate a positive relationship between student engagement in academic misconduct and subsequent workplace misconduct.
METHOD: Design and Sample

This was a correlational, descriptive study that explored the frequency of academic misconduct behaviors of 166 registered nurses enrolled in four diverse graduate (master’s degree) nursing programs. These included two private schools of nursing and two state-supported schools of nursing. Institutional review board (IRB) approval was obtained from each of the schools/universities from which the sample was recruited. Following IRB approval for the study, graduate nursing students were asked to volunteer for the study by research assistants or college personnel unknown to the students who approached them during class time and distributed packets. Graduate nursing students were asked to participate regardless of academic status or program track. Students were assured of anonymity and confidentiality of the data and it was verbalized that if they did not wish to participate that there would be no impact upon their classes or grades. Completed questionnaires were obtained from those who agreed to participate. The researchers were cognizant of the sensitive nature of the questions and had colleagues or college personnel unknown to the students administer the survey and demographic data sheet. All surveys were collected in an envelope and sealed in the presence of the students. All data was entered into SPSS by a research assistant and analyzed by a colleague with expertise in statistical analysis.

Instrument and Data Collection:

The survey was developed based upon a recent survey developed by McCrink (2008) and the literature reviewed. The 24-item instrument had four subscales that were tested for internal consistency with alpha’s ranging from .72 - .91. The survey asked about beliefs (BI) regarding academic settings (AM), workplace settings (WM) and the frequency with which the respondent engaged in the item/behaviors (Bh). The Workplace Misconduct Beliefs (WMBl) subscale consisted of 5 items (α = .91), the Workplace Misconduct Behaviors (WMBh) subscale consisted of 5 items (α = .72), Academic Misconduct Beliefs (AMBl) subscale consisted of 7 items (α = .93), and the Academic Misconduct Behaviors (AMBh) subscale consisted of 7 items (α = .75). See Table 2 for the items for beliefs and behaviors.

Content validity was accomplished by review of the literature and educational expertise of the researchers. The survey asked RN-graduate students to indicate their beliefs about academic misconduct, “i.e., cheating on an exam, plagiarizing papers etc., as well as, familiarity with the American Nurses Association (ANA) Code of Ethics as a guide of behavior.” Nurses were asked to reflect upon their behaviors as a student. They were asked to indicate the frequency with which they engaged in academic misconduct behaviors on a Likert Scale from Often to Never with Not Applicable as an option. These students were also asked to indicate the frequency of unethical clinical behaviors (i.e., not reporting an incident, charting treatments not performed, etc.) on the same Likert Scale of often to never. The behaviors were also ranked on a scale indicating agreement from completely unethical to not at all unethical, with not applicable as an option.

Other questions referred to students’ beliefs about academic misconduct as a student, and they were asked to identify whether they Strongly Agreed or Strongly Disagreed with a statement related to academic misconduct when they were students. This also had an option of Not Applicable.

A demographic data sheet was administered asking for basic information related to age, gender, ethnicity, hours worked per week, and the graduate student’s initial nursing education. After finalizing the survey questions and the demographic data sheet, each researcher sought IRB approval from their own institution.

RESULTS: Demographic Data:

The ages of participating RNs ranged from 20 years to over 40 years. Seven of the registered nurses in the study reported being between the ages of 20-24 years, 43 responded being between the ages of 25 - 29, 30 nurses reported being between 30-34 years of age, 59 reported being over 40 years, and 27 did not respond to this question.

The identified and reported ethnic and racial background was: 8 Native American/Alaskan, 12 Asian, 16 Black or African American, one Hawaiian, 42 White/Cuacasian, 23 Hispanic, and 73 not identifying their race or ethnicity. Eleven RNs identified themselves as male, 141 identified as female, and 14 did not respond.

Education Levels for Nurses

Sixty-eight nurses reported that they had attended a baccalaureate degree in nursing program, and 69 reported attainment of an associate degree in nursing, prior to acquiring their bachelor’s degree in nursing. Thirteen respondents obtained a master’s degree in an area other than nursing, two reported having a doctoral degree, and 14 did not respond to the question.

Employment Status

In response to the number of hours that the registered nurses reported that they worked while enrolled in the master’s program, seven reported that they worked less than 20 hours a week, 122 worked more than 20 hours a week, four were not employed, and 33 did not respond to the question.

FINDINGS:

The survey responses were first analyzed using the four subscales to determine the relationship between beliefs and behaviors engaged in for both the workplace and academic settings. The mean of the response scores for each subscale was used for the Pearson’s $r$.

There was a significant correlation found between RNs who did not find cheating behaviors as undergraduate students unethical, and those who engaged in academic dishonesty as undergraduates, such as cheating on examinations and plagiarism. Findings between the nurses, who reported engaging in unethical academic misconduct as
students, and practice behaviors in the workplace environment as nurses, were also significant. A Pearson’s r was used to analyze the relationship between academic behaviors and beliefs and practice behaviors and beliefs. These are reflected in Tables 2 and 3, questions 8a 1-7 and 8b 1-7 and questions 9a 1-5 and 9b 1-5, with significance below .001.

Nurses who, when students, reported copying another student’s answers with the knowledge of the other student, also admitted to copying from students without their permission (r = .701). Furthermore, respondents reported that copying another’s answers without their knowledge was not at all unethical (r = .485). There was significant correlation in dishonesty related to academic ethical beliefs and ethical beliefs in nursing practice. Nurses who indicated obtaining test questions from another student prior to taking an exam also reported that these actions were not, in their opinion, at all unethical (r = .532).

There was a strong correlation between RNs who as students received test questions from another nursing student with or without their knowledge and their unethical behaviors in the clinical practice. The RNs reported that as students they considered copying another’s answers without their knowledge as not being unethical. Nurses, while students, who reported paraphrasing and or copying materials without referencing the source, also reported obtaining test questions from another nursing student prior to an exam (r = .376).

Significant results were found between nurses who engaged in unethical behaviors as students and RNs who practiced unethical behaviors. These including reporting that they recorded patient responses to treatments which were neither performed nor observed and/or documented medications which were not given (r = .506).

Nurses also reported recording vital signs which had not been taken or recalled accurately and reported that they felt that these behaviors were not unethical. Nurses who indicated medication not given as reported felt that this behavior was also not unethical (r = .279). There was also a significant correlation between nurses who indicated that they did not report an incident or error that involved a patient and their belief that it was not at all unethical not to report these errors (r = .506).

**DISCUSSION**

Clear correlations are evident between misconduct beliefs and actions in practice behaviors in this study. The results indicate strong positive relationships between reports of unethical student behaviors and current unethical practice behaviors. Of great concern is how those student behaviors impact the resultant behaviors of the clinician. We know the stakes are high in the educational arena with poor grades resulting in the decimation of a student’s educational program. The stakes are equally high in the workplace. Multiple variables may account for nurse’s failure to refrain from engagement in unethical behaviors. A culture of blame pervades nursing and the pressure to be error-free is intense. Students and nurses are subject to an evaluative environment even before they reach competency of a skill set. Nurses and students may use their reasoning that a behavior is ethical (when it is not) to create a false sense of rightness, which serves to protect their own sense of self-worth. When such a behavior becomes ingrained, it also becomes normalized, so that nurses may no longer even recognize what is and is not ethical.

Other questions remain, including whether students are as well socialized into the profession as previously thought and whether students actually are taught how to make an ethical decision. Most curricula are infused with ethical theory and students generally understand they are to abide by the Nursing Code of Ethics, but what may be lacking is stepwise instruction in patient-centered ethical decision making. Most nurses simply use their feelings and own moral code to make “ethical decisions,” which in itself is unethical. Instead, the patient’s desires, life, and worldview need to be at the center of all decisions, including academic conduct. The results of this study beg the question of whether this is well taught. Ethics education needs to occur at the beginning of the educational experience - not as an afterthought. Decision making matrixes also should be part of every workplace orientation and annual review.

Significant correlations found between academic misconduct in students and workplace misconduct as practitioners was evidenced. These behavioral practices are detrimental to patient care and the nursing profession.

**RECOMMENDATIONS**

A toolkit for sound ethical decision making may help students and nurses to connect their daily actions with fidelity to the patient, serving as a barometer for both academic and practice behaviors. Furthermore, in a recent article, James M. Lang (2013b) indicates that according to research frequent assessments helps improve long-term retention of course material and may relieve stress for students. This, along with a “firm and consistent academic integrity policy” according to Lang, may help reduce cheating. Lang (2013a) reports, that researchers Hoi K. Suen and Lan Yu argue, in a 2006 article from the Comparative Education Review, state “that cheating on the civil-service exams stemmed precisely from their infrequent and high-stakes nature assessment, brief and low stake quizzes may help to create less stress in taking an examination.”

In order to reduce classroom cheating faculty might wish to give frequent quizzes and pop-up exams so that studying to support classroom materials becomes a daily ritual rather than an enormous task at the end or mid-semester. Use of clickers in the classroom to help the educator with feedback so that, in areas that are weak for students, faculty may remediate right away.

Cheating in the classroom or at the bedside is unacceptable, and we must find ways to eliminate these behaviors.
### Table 1: Frequencies of Demographics for Nurses

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Table 2: Correlations Nurses Only Academic Dishonesty Behaviors and Beliefs and Practice Dishonesty Behaviors and Beliefs  

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Table 3: Correlations Nurses Only Practice Dishonesty Behaviors and Beliefs  

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Demographic Data Questions

Please indicate your current degree level (please check one): □ Baccalaureate □ Master’s □ Associate

If you are enrolled in a master’s degree program, please indicate your field of study (please check one):
□ Administration □ Education □ Clinical nurse specialist □ Other (please specify): ________

Prior to enrollment in the current nursing program, what was your highest degree attained?
□ Baccalaureate □ Master’s □ Associate □ Doctoral □ Not Applicable

I am currently taking (please check one):
□ Less than 12 credits in the undergraduate □ 12 or more credits in the undergraduate
□ Less than 6 credits in the graduate □ 6 or more credits in the graduate

Gender: □ Male □ Female

What is your age? □ Less than 20 □ 20 to 24 □ 25 to 29 □ 30 to 34 □ 34 to 39 □ 39 and above

What is your ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino

What is your race? (Check all that apply)
□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White

How many hours per week do you work? □ Less than 20 hours □ 20 or more hours □ Unemployed

In what line of work are you currently employed?
□ Acute healthcare □ Long term healthcare □ Outpatient/community healthcare □ Unemployed □ Other (please specify): ________
Survey Questions—Nurses

Please answer all questions honestly, as your results are anonymous and confidential, and cannot be tied to you in any way.
Please fill in the circle that best reflects your answer. You may use a blue or black pen or a pencil.

Please indicate your agreement level with the following statements:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As a student, I believed cheating on an exam was:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better than failing a course</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Justified if the Instructor gave unreasonably difficult assignments or tests</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Justified if everyone else in the class was doing it</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Justified if others made no attempt to cover their answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Justified if it was between you and a good friend</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Justified because it did not hurt a patient</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Pressure to succeed is reason for cheating</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. As a student, I believed it was okay to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put personal commitments before studying/preparing for clinical assignments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Copy work from another source (text, internet, journal, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. I am familiar with the American Nurses Association Code of Ethics for Nurses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. The American Nurses Association Code of Ethics for nurses is important to the nursing profession</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. I adhere to the American Nurses Association Code of Ethics for nurses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Nurses are accountable for their own nursing practice</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

The following questions refer to student’s behaviors that some people might consider to be forms of academic misconduct in either the classroom or clinical setting. Please remember that this survey is anonymous and cannot be connected to you in any manner.

<table>
<thead>
<tr>
<th>How frequently have you engaged in the following Academic behaviors since entering the nursing program?</th>
<th>How unethical do you find these behaviors, if at all?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Got test questions from another nursing student who had taken the exam/quiz at an earlier time.</td>
<td>☐</td>
</tr>
<tr>
<td>Copied from another nursing student’s test without their knowledge.</td>
<td>☐</td>
</tr>
<tr>
<td>Copied from another nursing student’s test with their knowledge.</td>
<td>☐</td>
</tr>
<tr>
<td>Received answers from another nursing student during a test.</td>
<td>☐</td>
</tr>
<tr>
<td>Allowed a nursing student to copy my answers during a test.</td>
<td>☐</td>
</tr>
<tr>
<td>Brought notes, books, cell phones, etc. during a closed book test to use on the day of the examination.</td>
<td>☐</td>
</tr>
<tr>
<td>Paraphrased or copied material from another source (i.e. text, journal, internet) without referencing the source.</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How frequently have you engaged in the following clinical behaviors since entering the nursing program?</th>
<th>How unethical do you find these behaviors, if at all?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Not report an incident or error that involves a patient.</td>
<td>☐</td>
</tr>
<tr>
<td>Reported and/or recorded treatments that were not performed or observed.</td>
<td>☐</td>
</tr>
<tr>
<td>Recorded medications as given, when they were not given.</td>
<td>☐</td>
</tr>
<tr>
<td>Recorded patient responses to treatments and/or medications that were not assessed.</td>
<td>☐</td>
</tr>
<tr>
<td>Reported and/or recorded vital signs that were not taken or recalled accurately.</td>
<td>☐</td>
</tr>
</tbody>
</table>
REFERENCES


Perspectives on Academic Misconduct: Implications for Education and Practice


Smith, C. (2010). The Relationship Between Academic and Professional Dishonesty in Online RN-BSN Students (Doctoral dissertation). Medical University of South Carolina, Charleston, SC.


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Introduction

While the number of rural areas in the United States is decreasing, the quality of health of rural residents is declining as well. The health consequences of living in a rural area are well documented in the National Healthcare Disparities Report mandated by Congress and produced by the Agency for Healthcare Research and Quality (U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, 2005). A summary of the report’s findings states that “residents of rural areas report fair to poor health, more often have chronic conditions such as diabetes, and more often die from heart disease” (USDHHS, AHRQ, 2005, p.1). Research studies have shown that cancer patients in rural areas have unique barriers to obtaining quality treatment and support as they face the challenges of dealing with this serious illness. These include but are not limited to reduced or fixed incomes, lack of access to resource, and limited social supports (Beck, Towsely, Caserta, Lindau & Dudley, 2009; Katz et al., 2010). A systematic review of 37 studies that assessed the psychosocial and supportive care needs of cancer patients in rural populations concluded that most patients preferred to stay at home during treatment and had worse outcomes than non-rural patients as well as unmet supportive care needs. (Butow et al., 2012). “National and state goals to reduce cancer morbidity and mortality will not be achieved without implementing effective interventions aimed at rural populations” (Beck et al., 2009, p. 368). However, there are a limited number of studies of cancer patients in rural areas and there is a need for more well designed studies. Many of the current studies focus on breast cancer patients and do not define what is meant by rural which limits the generalization of the results (Butow et al., 2012).

Rural Health Inequity

In a study examining the differences in mortality of urban and rural lung cancer patients, researchers concluded that while there was not a statistical difference in mortality (although their sample size of
An Aging Demographic

The demographics of rural populations also contribute to the health inequities and lack of access to healthcare services. Rural populations have a higher percentage of older residents than urban areas (Hartley & Gale, 2003). This results in rural areas having more patients on Medicare, which adversely affects the revenues of healthcare facilities because of the lower Medicare reimbursement. The Adirondack Park Regional Assessment Project (APRAP), completed in May of 2009, provides a tremendous amount of data on the specific demographic trends of the Adirondacks. According to an analysis of U.S. Census data by the Adirondack Park Regional Assessment Project, the percentage of older residents in the Adirondacks is higher than both the state and national averages. There are several factors that contribute to this including an exodus of younger residents, an influx of older residents, and the aging baby boomer population. The net effect is that the aging trend of the Adirondack population is three times the national rate. Their report states: “the Adirondacks will rival Florida’s west coast as the region with the oldest population in America” (Adirondack Park Regional Assessment Project Steering Committee, 2009, p.12). Since “more than half (approximately 60 percent) of individuals who have ever been diagnosed with cancer are 65 or older” (Institute of Medicine, Board of Health Care Services, Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting, 2007, p.25), the additional layer of age-related health issues adds to the complexity of care for those treating patients with cancer. The New York State Cancer Registry statistics clearly show that the incidence of cancer diagnosis and mortality in New York State, similar to national data, increases with age. The average annual number of new cases in age groups below 40 years of age are in the hundreds, while the numbers for those above 40 are in the thousands, beginning with the 40 to 44 age group, which has 1,234 annual cases, to the highest incidence age group, 70 to 74 years, which has 7,219 cases per year (New York State Department of Health, New York State Cancer Registry, March 2010). This statistic only provides the incidence of cancer cases diagnosed each year, but cancer is a chronic disease and many patients will receive treatment for many years following diagnosis (IOM, BHCS, CPSCP/FCS, 2007). The net result will be an increase in the prevalence of cancer patients in the Adirondacks.

Psychosocial and Related Factors

According to the National Rural Health Association, rural residents have lower incomes and lower education levels when compared with non-rural residents. Rural residents have greater transportation difficulties including the need to travel long distances for medical care, poor road conditions, and a lack of access to public transportation (Baltic, Whedon, Ahles & Fanciullo 2002; Beck et al., 2009; Schultz & Winstead-Fry, 2001). The increased availability of new technologies such as telemedicine, remote monitoring and specialist consultation via monitors could help improve the health of rural citizens and provide state-of-the-art healthcare in remote locations, but often the low volume of patients make these improvements cost prohibitive. In addition, access to the internet and cell phone reception is limited in many rural areas (APRAPSC, 2009, p. 61).

There is a significant body of evidence that demonstrates the negative effects of psychosocial problems on both mental and physical health of patients (IOM, BHCS, CPSCP/FCS, 2007). The physiological cascade of events occurring in the body creates a state of prolonged stress that has negative effects on both the mind and the spirit. “The diagnosis of cancer creates an acute stress response and contributes to additive stressors over time that can generate a chronic stress response” (Post-White, 1998, p. 354).

Cancer patients with complex medical and psychosocial issues...
benefit from care provided by a coordinated team of professionals from a variety of therapeutic disciplines, including social workers. Oncology nurse specialists coordinate the care provided by interdisciplinary teams and help patients navigate the treatment process (Stevenson, 1998). These professionals, however, are not always available to patients in rural areas. For example, the majority of social workers (81.39%) are practicing in tertiary settings such as hospitals, academic medical centers, or long-term care facilities that are primarily located in urban (57.7%) and suburban (29.2%) versus rural settings (13.2%) (Association of Oncology Social Work, 2006). This information is important when considering the availability of professionals to provide psychosocial services to rural cancer patients.

As cancer treatment continues to advance increasing survival rates, the concomitant psychosocial needs and quality of life issues of oncology distress become a prominent healthcare need. This adds to the array of rural healthcare needs and requires persistent advocacy.

**Purpose of the Study**

The purpose of this study was to describe the self-reported psychosocial needs of rural cancer patients living in the Adirondack region of New York State.

**Methodology**

The sample population included current or previously treated adult cancer patients who live in the Adirondack region of northern New York (see map). A convenience sample of subjects was solicited from cancer patients who visited the Adirondack Medical Center’s Merrill Oncology Center, from an otolaryngology outpatient office, and from attendees of the “Circles of Life Cancer Support Group” which meets weekly at the Adirondack Medical Center. In addition, network or snowball sampling was utilized which made the response rate impossible to accurately calculate. Surveys were hand-distributed by the investigator or office staff, and collection took place over three months in the spring of 2010. There were no exclusions; any potential participant who has ever had a diagnosis of cancer was eligible to participate in the survey. This research study was approved by the Institutional Review Board of The Sage Colleges.

**Instrument**

The survey instrument was a 20-item questionnaire designed by the researchers to inquire and elicit information about the psychosocial needs and potential barriers of rural cancer patients. The survey questionnaire was developed after a review of the current literature revealed no existing appropriate research tool. The researcher met with oncology nurse experts, nurse researchers, and public health research experts to solicit their input during the development of the questionnaire. The survey was two pages long and estimated to take 3-5 minutes to complete based on sample survey testing. The language and vocabulary included in the cover letter and survey were carefully considered and chosen for simplicity and readability. The researcher administered sample surveys to a small group of adult subjects including one non-native English speaker, and no vocabulary or direction problems were identified.

The questionnaire consisted of seven demographic data items, eight Likert-scale items, two dichotomous questions each with a follow-up question for more specific information, two checklist items about services that respondents thought would help them cope with cancer, and one asking how they would prefer to receive information on cancer. Subjects were then invited to add any comments, suggestions, or problems they had encountered to help improve cancer services for patients in the northern Adirondack region of New York State.

**Results: Demographics**

A total of 47 surveys were collected. The average number of patients being followed at the Merrill Oncology Center at the time of the survey was estimated to be 300, but only approximately 50 patients were currently receiving regular treatment. The remaining cases were being seen only once or twice a year and therefore may not have had an appointment during the survey collection period. The age range of participants was 27 to 88 years of age with a mean of 62 years of age and standard deviation (SD) 13.4. Just over half of the participants were under 65 years. Other demographic characteristics of the survey sample are summarized in Table 1.

**Table 1: Demographic Characteristics of Survey Sample**

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Number (Total N=47)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Receiving Cancer Treatment</td>
<td>32</td>
<td>68.1%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>40.4%</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>59.6%</td>
</tr>
<tr>
<td>Live in the Adirondack Park</td>
<td>46</td>
<td>97.9%</td>
</tr>
<tr>
<td>Race – White (as identified by respondent)</td>
<td>46</td>
<td>97.9%</td>
</tr>
<tr>
<td>Type of Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>13</td>
<td>27.7%</td>
</tr>
<tr>
<td>Colon</td>
<td>3</td>
<td>6.4%</td>
</tr>
<tr>
<td>Lung</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Other or multiple types</td>
<td>19</td>
<td>40.4%</td>
</tr>
</tbody>
</table>

To evaluate how many patients had the potential to use the...
Internet, the survey asked respondents if they had access to the Internet. Of the 47 respondents, 80% responded yes. The majority of people indicated that they had access at home and 12% circled more than one of several locations: home, work, library, friends, or relative.

When asked how often participants used the Internet for health information, 10% left the item blank and 12% circled never. The most frequent response circled was several times a month. The total expressing some interest in using the internet for health information was 72%.

The survey also asked subjects how interested they were in attending group sessions on dealing with cancer. A majority, 47%, said they were interested. When asked if they had attended a cancer support group, 46% indicated yes. In response to the question it was helpful, 13 said no and two wrote comments which included: “yes, very,” “Definitely the response of two participants, “for added support,” “absolutely,” and one stated it was “first time.” Two participants mentioned that they had attended a weekend workshop in Plattsburgh, and one of these said the Doorway to Healing Retreat through CVPH Medical Center was “awesome.”

The second follow-up question to whether subjects attended a support group asked: If no, why not? There were 24 respondents who circled “No” (51.1%), and 20 of these wrote comments in response to this question. Most often cited was: “did not know where/when they are” or “never advised of one.” A second reason was not having time or “working full time – no evening group in the area.” There were eight comments related to “not being interested” or “not thinking of locating a group” or “family and friends support me.” One respondent said they would need someone to drive them, but that they also did not have the energy, one stated it was “too far,” and another said “no transportation.”

The results from this survey indicated that in this population most cancer patients rely on their families and friends for daily or monthly help. Churches and community organizations provide some assistance, but not as frequently as family and friends.

The researchers used five Likert-style questions to assess what types of psychosocial stressors and needs participants were experiencing. The results displayed in Table 2 indicate 25% revealed that they were often anxious or scared at least weekly. One third indicated that they would like to try yoga or a relaxation class.

<table>
<thead>
<tr>
<th>SURVEY QUESTION</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you feel scared, anxious, sad or worried?</td>
<td>10.6% (n=5)</td>
<td>42.6% (n=20)</td>
<td>21.3% (n=10)</td>
<td>12.8% (n=6)</td>
<td>12.8% (n=6)</td>
</tr>
<tr>
<td>How often do you get support from family and friends</td>
<td>4.3% (n=2)</td>
<td>6.4% (n=3)</td>
<td>12.8% (n=6)</td>
<td>12.8% (n=6)</td>
<td>61.7% (n=29)</td>
</tr>
<tr>
<td>How often do you get help from your church or any community organization?</td>
<td>53.2% (n=25)</td>
<td>6.4% (n=3)</td>
<td>8.5% (n=4)</td>
<td>27.7% (n=13)</td>
<td>2.1% (n=1)</td>
</tr>
<tr>
<td>Have you ever been interested in talking with a counselor about coping with cancer?</td>
<td>42.6% (n=20)</td>
<td>21.3% (n=10)</td>
<td>25.5% (n=12)</td>
<td>8.5% (n=4)</td>
<td></td>
</tr>
<tr>
<td>How interested are you in trying yoga or relaxation classes?</td>
<td>36.2% (n=17)</td>
<td>12.8% (n=6)</td>
<td>17% (n=17)</td>
<td>31.9% (n=15)</td>
<td></td>
</tr>
</tbody>
</table>

The survey also asked respondents to check from a list of eleven services those that they thought would better help them deal with their cancer. The results from this item are displayed in Figure 1. Two participants commented on how helpful the yoga and visualization classes were and that “they made a big difference in my recovery.” One person commented that there needs to be better publicity regarding available services, and another requested an evening support group for patients who work full-time.

Figure 2 displays the preferred method for receiving cancer information. Several respondents added written comments specifically
about their need for information: “I need someone to explain all the medical information” and “the biggest issue I have encountered during my cancer issue is having to be my own healthcare advocate.” Two subjects requested more information and services on nutrition — “it’s overlooked as part of our treatment and care” — and natural remedies. Another wrote: “Young survivor issues are different than older issues, how to balance start of career, family, buying a house, college with cancer.”

Transportation Challenges

Transportation difficulties and travel time have frequently been cited as barriers to cancer care. The researchers collected information from respondents on the length of time in minutes to reach their family doctor, cancer doctor, chemotherapy, and radiation therapy. The range in minutes for respondents to travel to their cancer doctor was 5 minutes to 480 minutes (8 hours), and the number of patients traveling more than 15 minutes was 57%.

Another question asked patients if they had missed an appointment due to transportation problems, and 98% circled never. As reported in Figure 1, when asked to check services that would better help you deal with your cancer, only 6.4% checked help with transportation. One respondent stated next to the question on missing appointments due to transportation problems that it “is an issue, never missed.” Several respondents wrote that transportation was a reason for not attending support groups — “too far” and “I would need someone to drive me.”

![Figure 1: Preferred Services to Help Deal with Cancer](image1)

![Figure 2: Preferred Method for More Information on Cancer](image2)
Discussion and Recommendations

This survey was specifically designed to assess the unique rural population of cancer patients living in the Adirondack region of northern New York. The survey results indicated that the sample technique met this objective, as 98% or 46 of the 47 participants self-reported that they lived in the Adirondack Park. There are few published research studies on the psychosocial needs of rural cancer patients; therefore, this will add to the body of knowledge on this population.

Transportation

Transportation is frequently identified as a potential barrier to treatment for cancer patients (Baltic, Whedon, Ahles & Fanciulllo, 2002; Beck et al., 2009; Schultz & Winstead-Fry, 2001). The nurses at the Merrill Oncology Center also shared in the survey-tool-development phase what they observed and heard from patients about the challenges and stress of traveling to appointments. However, the nurses had completed a needs assessment survey a few years earlier and were surprised at how few patients identified transportation as a problem. The availability of cancer services at the Merrill Oncology Center reduces the travel time for many cancer patients in the Adirondack region, as the next closest oncology practices are one to two hours away.

The researchers worded questions on transportation carefully and gave subjects three opportunities to identify transportation as a problem. Although the number of respondents who indicated that they needed help with transportation was low and the majority had not missed appointments, it does not eliminate this issue as a potential cause of concern as there were several written comments referring to transportation issues. Transportation could be a source of stress for patients, but did not prevent them from getting to their medical appointments. However, transportation issues might significantly affect patients’ access to psychosocial services more than their medical or treatment appointments. A possible explanation might be that psychosocial services may not be perceived as essential treatment. Other research has identified the cost of travel and the burden on family members as recurring barriers for rural patients (Hughes, Ingleton, Noble & Clark, 2004), and considering the difficult winter weather and the rising cost of gasoline, the researchers would conclude that this question did not adequately assess the difficulty of coping with travel issues; rather, it demonstrated that respondents are coping with transportation challenges and not letting it interfere with their treatment. Perhaps a question worded differently would have elicited a better understanding of the problem. For example, we might have asked, “How much stress do you feel about getting a ride to your cancer appointments or treatments?” and questions to discover how this impacted the utilization of supportive and psychosocial services.

Travel to radiation therapy is a unique issue as the treatment is administered daily over a number of weeks and the closest facility is in Plattsburgh, New York, which is an hour from the Adirondack Medical Center. In a study examining geographic and transportation barriers to treatment in New Hampshire, the researchers found that travel time to radiation therapy affected women’s breast cancer treatment decisions: women living further from a radiation treatment facility were less likely to have breast conserving surgery, and women living > 20 miles from a facility were significantly less likely to receive the recommended post-operative radiation treatments (Celaya, Ress, Givson, Riddle & Greenberg, 2005). The radiation oncologists from Plattsburgh provide a daily van Monday through Friday at no cost from Saranac Lake to Plattsburgh, and many patients use this service. One participant commented, “Traveling every day (5 days a week) to Plattsburgh was tiring but with the help of a driver and van, manageable. It would be nice to have a radiation facility closer.” Therefore, for cancer patients living in the Adirondack Region who are receiving radiation treatments, this van service helps eliminate a significant barrier to treatment.

Information Needs and Internet Access

One of the disadvantages of living in a rural area in the “age of the Internet” is the lack of access to “the Net.” Many people live in areas with no Internet service provider or high speed access, and this is especially true in the “forever wild” Adirondack Park (APRAPSC, 2009, p. 61). The data from this survey confirmed that, although the 80% of respondents reported that they had access to the Internet, a significant number (19%) reported that they did not have access. And only slightly less than half of the subjects (49%) indicated that they preferred the Internet as a method to get more information on cancer. So, although the Internet may be a new method to reach cancer patients for support and education, health professionals need to keep in mind that there will continue to be a small but significant population who do not have access to the Internet or prefer to receive information in other ways. The majority of participants in this study reported that one of the methods they preferred to receive information was through written materials, followed by the Internet, and the third was talking with a former cancer patient.

Recommendations

Possible future strategies to increase access to Internet resources could include providing laptops or computer pads with wireless access for patients to use the Internet while they are in the cancer center or receiving their treatments. In addition, if the information was available in electronic formats, such as on a computer disc, those patients with computers but no Internet access could still review the information at home. Another strategy would be for the information available on the Internet to be designed in a printer-friendly format so that health professionals and patients could print information out as written materials instead of having to view online. Providing computer stations with printers at convenient locations in healthcare facilities where cancer patients are treated and visit often could provide increased access to this information. Other ways to increase access to written information might be to expand the selection of books available at the clinic and/or local libraries for cancer patients to borrow and read in the privacy of their home. New technology could be utilized by purchasing devices that download books and making e-books available to patients for use at the clinic or at home.
Psychosocial Needs of Cancer Patients Living in the Adirondacks: A Needs Assessment

Psychosocial Factors

It is interesting to note that the third highest method for obtaining information on cancer was talking with a former cancer patient. This need to talk to someone else who has been in the same situation has resulted in the formation of support groups and peer support programs for all types of situations and diseases. In this survey, a high percentage of the subjects (72%) reported interest in attending a support group, and written comments from the survey affirmed that the participants felt that this was a beneficial service for them.

The majority of respondents who had attended a support group found it helpful while others indicated that one reason for not attending was lack of knowledge about the group and meeting times. This suggests that information about current groups could be evaluated for better dissemination. Another reason for not attending was the time these groups were offered, including the lack of an evening meeting time as well as transportation issues. Expanding the number of support groups and offering weekend retreat programs locally would make these services more accessible, but would require personnel and resources.

Almost half of the survey respondents reported feeling scared, anxious, sad, or worried more than once or twice, and 55% had some degree of interest in talking with a counselor about coping with cancer. Another psychosocial service that a majority of survey respondents indicated a high degree of interest in was yoga or relaxation classes. For the past two years, yoga and guided imagery classes have been offered in Saranac Lake to cancer patients at little or no cost through a grant from the Adirondack Medical Center Foundation. Several written comments stated how helpful these classes were for coping with their cancer, “I already attend @Inner Quest (yoga) via your grant, it’s a godsend - the guided imagery has been helpful too.”

Support groups, exercise classes specifically designed for cancer patients (such as Reach for Recovery), yoga classes, relaxation classes, and guided imagery are often available at tertiary cancer care centers, but not in rural cancer clinics. This creates a lack of equity in cancer treatment for patients treated at rural oncology clinics. The number of rural oncology clinics that administer chemotherapy and provide oncology specialists for follow-up visits to the rural patient are increasing (Schultz & Winstead-Fry, 2001). This has the potential to reduce transportation barriers and lower costs for the patient and family, but it is imperative that this model of care consider how these patients can access psychosocial and informational cancer services. The results from this survey demonstrate that cancer patients find these services helpful and would like them to be available. It is possible that although patients did not miss their medical appointments due to transportation issues, these could be preventing patients from accessing other supportive services. Future research could examine how transportation problems impact the utilization of psychosocial services, as well as the perception that psychosocial services are adjunct rather than part of total oncology care.

Limitations

The survey collection methods did not include patients who live in the Adirondacks but receive their treatment outside of the Park. This could be a significant population for a follow-up study. Yoga and guided imagery classes were used for participant recruitment and the instructors of these programs did encourage their participants to complete the surveys, creating a potential bias in the data.

Conclusion

The population of cancer patients living in rural areas and the challenges to provide quality cancer care will continue to increase as the first of the “baby boomers” turn 65. This survey has identified several psychosocial services that cancer patients living in the Adirondacks have indicated are valuable to the healing process and quality of life. Potential future uses of this data could inform the need for psychosocial supportive services such as counseling, support groups, peer networking, yoga, and guided imagery and to guide the planning of expanded services for rural cancer patients. Information from the survey can be used by healthcare providers to identify barriers that prevent rural cancer patients from accessing available services. The data may also be used by healthcare professionals applying for grant funding to provide additional services to this population. The current healthcare economic climate demands quality cost-efficient care while also reconciling adequate attention to under-served groups. Rural oncology clinics need to both advocate for and provide psychosocial and medical services for this unique population of chronic disease patients.
REFERENCES


The Answer is Questions: Accelerated-Nursing Students Report Practice Questions are Fundamental to First-Time NCLEX-RN Success

Barbara B. Blozen, Ed.D, MA, RN-BC, CNL

Abstract

There are a number of anecdotal reports on demographic characteristics and academic success of accelerated-nursing students; yet few empirical studies have examined accelerated-nursing students’ NCLEX-RN success. Applying Knowles’ adult learning theory as a guiding framework, the purpose of this qualitative study was to explore, from the accelerated-nursing students’ perspective, the factors reported as contributing to their success on the NCLEX-RN. The research questions aimed to elicit participants’ descriptions of their experiences and factors contributing to their success via individual interviews. The most significant finding the participants identified as the factor that contributed to their success was the practicing of NCLEX-RN questions. The findings of this study have several implications for educational policy and practice for universities and schools of nursing as the information gained from this study applies to recruitment and retention as well as curriculum and educational strategies in an accelerated-nursing program.

Background

The purpose of this qualitative study was to explore, from the accelerated-nursing students’ perspective, the factors they reported as contributing to their success on the NCLEX-RN. This article will focus on one of the findings as a result of this study. Accelerated-baccalaureate-nursing programs educate registered nurses in as quickly as 11 months. Over the past two decades, the number of accelerated-nursing programs has burgeoned from 31 in 1990 to 230 in 2013 (American Association of Colleges of Nursing, 2013). Despite the growing presence of these programs, researchers agree that there is little empirical evidence about accelerated students and their success, with only a small amount of research that engages the students themselves. Several research studies on the accelerated-nursing student population have generated comprehensive demographic/student characteristics (Bentley, 2008; Korvick, Wisener, Loftis & Williamson, 2008; Shier, DeBasio & Roberts, 2008; Youssef & Goodrich, 1996). Wu and Connelly’s (1992) classic research produced a thorough demographic profile of the accelerated nursing student. In their survey of 234 accelerated nursing students, they

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found accelerated students were older, mean age 28.7 years, than traditional college or Bachelor of Science in Nursing (BSN) students. They found almost one-third were married, the majority held a bachelor’s degree in biology (Weitzel & McCahon, 2008) and over two times as many were male students, when compared with traditional BSN students. The research by Cangelosi and Moss (2010) and Neill (2011) identify maturity, high motivation, and life experiences as attributes of the accelerated student, all of which contribute to their success in a rigorous, accelerated format. Meyer and her colleagues (2006) report that just more than half of their accelerated-nursing-student participants indicated that prior school experience, having already earned a bachelor’s degree, prepared them for the accelerated program. Cangelosi and Moss (2010) describe accelerated students as “challenging, demanding, and sometimes exhausting.”

### Accelerated Student Academics

The greater part of the research on accelerated students compares them to traditional nursing students on topics such as NCLEX-RN first-time pass rates, grade point averages (GPAs), critical thinking, stressors, and teaching/learning styles. The sparse literature that focuses exclusively on accelerated students found them to be mature, self-motivated, adult learners (Cangelosi, 2007b; Miklancie & Davis, 2005) who hold high standards for themselves and faculty (American Association of Colleges of Nursing, 2013). Bentley (2006) discovered that accelerated and traditional nursing students who had fewer C’s in nursing clinical courses were more likely to pass the NCLEX-RN on the first attempt. According to Meyer, Hoover & Maposa (2006) and Seldomridge and DiBartolo (2005), critical thinking scores and the NCLEX-RN pass rate were slightly higher than the rate of the traditional students. In comparing accelerated students with traditional BSN students, Seldomridge and DiBartolo (2005) identified no significant difference between the two groups, contrary to what Bentley (2006) and McDonald (1995) found. Furthermore, Seldomridge and DiBartolo (2004) found that the accelerated nursing students’ final GPAs were higher when compared to those of their traditional peers, akin to the findings of Youssef and Goodrich (1996).

### Theory

The theoretical framework used to interpret this study is based on Knowles’ theory of andragogy (1990). Knowles has explored and written on principles of adult learning and describes andragogy as the art and science of facilitating adults to learn. Andragogy is derived from the Greek word “man,” which Knowles uses in contrast to the word “pedagogy,” helping children learn. As adult learners, accelerated nursing students thrive in an environment where the principles of adult learning theory are embraced (Cangelosi, 2007b; Miklancie & Davis, 2005). Cangelosi (2007b) points out that nursing faculty must incorporate the accelerated students’ previous background/profession into their teaching and build on those experiences. Adult learning theory supports the self-direction of an adult learner (Knowles, 1990). It is essential that the learning environment of the adult-accelerated-nursing student be constructed utilizing the principles of Knowles’ theory of andragogy. His theory of andragogy asserts that adult learners perform best when they learn experientially, understand why they need to learn a concept, learn in a problem-oriented manner, and learn best when the concept can be applied immediately. According to Cangelosi and Whitt (2005), accelerated students want confirmation that assignments are supportive of their learning and do not want busy work, consistent with the principles of adult learning theory. Another of Knowles’ principles of adult learning is active involvement in the learning process. Active involvement maintains that individuals learn best by experience and action. This is accomplished with accelerated nursing students in their clinical experience by providing opportunities to deliver direct patient care.

### Methods and Procedures

The study participant population was drawn from all students who graduated from a Mid-Atlantic, private university, completed the NCLEX-RN, and whose exam results were received between December 2008 and May 2009. Using the snowball technique (which relies on referrals from initial subjects to generate additional subjects), 12 participants were recruited and participated in the study.

Accelerated nursing students were interviewed individually; the data was categorized (NCLEX-RN questions, clinical, supports, a review course), labeled, coded, and analyzed using a grounded theory method to explore the categories identified by the 12 accelerated nursing students as contributing to their first-time success on NCLEX-RN. A grounded theory approach informs this qualitative study due to the nature of the proposed question, “What are the factors identified by accelerated nursing students that affect the success in
Accelerated-Nursing Students Report Practice Questions

passing the national licensing exam (NCLEX-RN) on the first attempt?” The twelve face-to-face, semi-structured individual interviews were audio tape-recorded, lasted 60–90 minutes, were held over an eight-week period at a convenient site, and were conducted after the participants completed the NCLEX-RN. Eleven of the twelve participants were working as registered nurses in an acute-care hospital setting at the time of the interview.

Results

These findings are part of a larger study of accelerated students’ perspective. One of the interview questions asked the participants to identify what they perceived as contributing to their success in passing the NCLEX-RN on the first attempt. The overwhelming majority, 11 out of 12 participants interviewed, stated that completing practice NCLEX-RN-style questions was the factor that contributed most to their first-time success on the NCLEX-RN. “Studying with my friends helped and just doing a gazillion, gazillion questions,” declared one participant. Another stated, “doing questions over and over and over again since day one and just getting used to how to answer the questions definitely helped the most.”

Students in this accelerated program are exposed to NCLEX-RN-style questions beginning in their first semester of study and continuing to the end of their coursework. The professors construct exams using NCLEX-RN-style questions. As the program progresses, the difficulty of the questions increases challenging higher levels of cognitive function, moving from knowledge and comprehension to analysis and evaluation-style questions, analogous to Bloom’s taxonomy (1974). Students are required to do 100 NCLEX-RN questions all during each class, which helped prepare for the different subjects that were going to be on the NCLEX-RN.

“Our professors would ask NCLEX-RN questions all along and through each class, which helped us prepare for the different subjects that were going to be on the NCLEX-RN.”

The accelerated nursing student holds a previous non-nursing bachelor’s degree, thereby proving their academic success. They present with the need to learn nursing skills, theories, and concepts as an adult learner and must do so in a condensed amount of time (usually between 11 to 18 months). The participants reported that the accelerated-nursing program required their complete attention and they had little time or energy to devote to their friends, family, or routine tasks of daily living. As the participants in this study stated, the practicing of NCLEX-RN questions was the factor that most contributed to their first-time success on the NCLEX-RN. Based on
this research finding, the recommendation and challenge to professors teaching in an accelerated-nursing program is to incorporate the use of NCLEX-RN-style questions throughout the curriculum and on all nursing exams. There are many opportunities for accelerated-nursing professors to integrate NCLEX-RN-style questions into their teaching strategies, including during post conference, impromptu questions during class, and teachable moments in the clinical setting. One faculty member in this accelerated-nursing program created an assignment that required students to develop a case study with five NCLEX-RN-style questions. The students posted their questions on their common electronic site for viewing by the class, and all students were required to answer the questions related to that case study. The professor who created this assignment for the accelerated-nursing students reported that the students asserted it required “a lot more research than the students anticipated, was difficult to do and I felt the students learned a great deal from the assignment” (J. Wright, personal communication, January 6, 2012). The results of this research study suggest that the accelerated-nursing professor would be prudent to incorporate this new finding of assimilating analytical NCLEX-RN-style questions into the classroom, as the participants attest to its benefit.

Second, adults desire more than just knowledge and oppose pedagogical teaching strategies such as drills and rote memorization (Knowles, 1990); therefore, the learning environment of the adult-accelerated-nursing student ought to incorporate Knowles’ theory of andragogy, which asserts that adult learners learn differently from children. Knowles’ andragogical model focuses on the educator as a facilitator of learning who makes resources and procedures available to the adult learner. In the case of the accelerated-nursing student, the facilitator of learning is the clinical instructor, making clinical opportunities and experiences available for the students. One of the themes Rico and her colleagues (2010) identified in their focus groups of best faculty practices was that accelerated-nursing students desire to be appreciated as adult learners. As adult learners, accelerated-nursing students are balancing an accelerated curriculum and often have added personal obligations. Knowles (1990) states that adult learners, although self-directed, ought to have some control over their learning and must understand why they need to learn content before they are willing to invest the time to learn it. Discerning the learning qualities of the accelerated student can help faculty to design course requirements and prepare lecture and content using the theory of andragogy for this student population. Therefore, professors teaching accelerated-nursing students must evaluate the workload and assignments of the accelerated-nursing student to be certain that the assignments are supportive of the intended learning competencies.

Professors taking part in seminars that teach and challenge them to develop analytical and evaluative type NCLEX-RN-style questions is one method they could use to learn to incorporate this high-level cognitive type of question on exams and quizzes. Throughout the curriculum, questions developed for exams and quizzes could reflect the higher cognitive level of Bloom’s taxonomy (1974), as participants recounted this question design as contributing to their success. Professors could make blueprints for their exams whereby they calculate the amount of analytical and evaluative-type questions on exams and increase that number as the semester progresses.

Thirdly, it is key for the professor to know their accelerated nursing students’ previous backgrounds, abilities, and careers so that they can build upon them (Cangelosi, 2007a). Accelerated-nursing students come from a variety of occupations and backgrounds, bringing with them life experiences and, in some cases, expertise from their previous profession upon which the nursing professor may draw and incorporate into the learning environment. Students with a pharmaceutical or psychology degree, for example, could be encouraged to share their knowledge and experiences when appropriate. Knowles (1990, p.144) describes the adult learner as a “resource for the rest of the group, and as such, he or she becomes a partner or peer to the instructor in the process.” The nursing professor could attend to students’ former experience by incorporating this knowledge into the classroom discussion. Cangelosi and Whitt’s (2005) research has shown that the accelerated-nursing students do favorably academically when their previous experiences are integrated into their learning.

Conclusions

Given the findings of this study, it is evident that additional research needs to be conducted on the accelerated student as the literature remains sparse. As Weitzel and McCahon (2008) acknowledge, there has been relatively little research on accelerated-nursing students’ perceptions to date. Similar multisite studies could be conducted examining the accelerated-nursing students’ perspective on the lived experience of an accelerated-nursing program, as the findings of this study are unique and significant. Further research could examine other variables that would help explain additional factors that lead to first-time NCLEX-RN success, such as an examination of the significance of specific teaching strategies in the clinical and classroom setting of the accelerated-nursing student.

Few studies have been conducted from the perspective of the accelerated-nursing student, and as accelerated programs flourish data could be collected about accelerated-nursing students and how they befall success in this intensive, fast-paced program. One of the initial intents for the creation of accelerated-nursing programs was to address and quell the nursing shortage. Future research could also examine how many accelerated-nursing graduates remain in nursing if they transition to yet another career. An examination of this inquiry would help to further our understanding of long-term success of accelerated-nursing programs. Such a study would also help to ascertain if more funding would be justified for accelerated-nursing programs.

In summary, the results of this study can serve to educate faculty who teach in accelerated-nursing programs as to the factors their students believe have helped them pass licensure exams. This study’s findings broaden the body of nursing literature and support some of what is already known about accelerated-nursing students. Researchers can utilize the findings of this study to develop future research endeavors that may enhance the quality of accelerated-nursing education.
Accelerated Nursing Students Report Practice Questions

REFERENCES


Call for Papers

The Journal of the New York State Nurses Association is currently seeking papers.

Authors are invited to submit scholarly papers, research studies, brief reports on clinical or educational innovations, and articles of opinion on subjects important to registered nurses. Of particular interest are papers addressing direct care issues. New authors and student authors are encouraged to submit manuscripts for publication.

Information for Authors

For author’s guidelines and submission deadlines, go to the publications area of www.nysna.org or write to journal@nysna.org.

Call for Editorial Board Members

Help Promote Nursing Research

The Journal of the New York State Nurses Association is currently seeking candidates interested in becoming members of the publication’s Editorial Board.

Members of the Editorial Board are appointed by the NYSNA Board of Directors and serve one 6-year term. They are responsible for guiding the overall editorial direction of The Journal and assuring that the published manuscripts meet appropriate standards through blinded peer review.

Prospective Editorial Board members should be previously published and hold an advanced nursing degree; candidates must also be current members of NYSNA. For more information or to request a nomination form, write to journal@nysna.org.
Major cardiovascular disease events


Omega-3 polyunsaturated fatty acids (PUFAs) have been used in the past to assist in the prevention of cardiovascular events. Previous studies have both supported and opposed the effects of omega-3 PUFAs on cardiovascular health. The purpose of this meta-analysis was to resolve the contradicting evidence of the effect of omega-3 PUFAs on major cardiovascular events.

The selection consisted of randomized studies in which treatment with omega-3 PUFAs had lasted longer than one year and analyzed relationships to strokes of all types, all-cause mortality, myocardial infarction (MI), sudden death, and cardiac death. Studies eligible for inclusion were controlled with diet or placebo, randomized, and performed in primary or secondary prevention settings for cardiovascular disease. Databases included Cochrane Central Register of Controlled Trials, EMBASE, and PubMed. The study analyzed the effects of dietary omega-3 PUFAs and supplemental omega-3 PUFAs separately. The meta-analysis used the Begg-Mazumbar test to determine if publication bias was present. Relative risk and absolute risk reduction was computed and appraised, and the results were explained using random effects models.

From the randomized studies that were collected, 20 were used consisting of 68,680 patients. Cardiovascular incident rates were 7,044 mortalities, 3,993 cardiac mortalities, 1,150 sudden deaths, 1,837 MIs, and 1,490 cerebrovascular accidents (CVAs). Dietary intake of omega-3 PUFAs demonstrated contradictory results; therefore quantitative research was not conducted. Supplementation with omega-3 PUFAs showed no significant correlation of absolute risk reduction and major cardiovascular events. The Begg-Mazumbar correlation test demonstrated a low risk of bias in terms of publication. Omega-3 PUFA supplementation did not have a significant effect on cardiovascular health for strokes, all-cause mortality, MI, or sudden death. The relative risk for cardiac death was \( P = 0.01 \). The meta-analysis included studies from the 1980s, which may have impacted the statistics.

Practitioners should be questioning current practice. Patients need to discuss the use of omega-3 PUFA supplementation with their healthcare providers, and decisions about supplementation should be made on an individual basis. Nurses should take an evidence-based approach to educating cardiac patients on the supplementation and dietary intake of omega-3 PUFAs.

Carolyn Dudden, Hartwick College, Oneonta, NY
Peggy Jenkins, Hartwick College, Oneonta, NY
Ronald Brzenk, Hartwick College, Oneonta, NY
Thank you for your participation in Psychosocial Needs of Cancer Patients Living in the Adirondacks: A Needs Assessment, a new 0.5 contact hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

INSTRUCTIONS:
In order to receive contact hours for this educational activity, participants are to read the article presented in this issue of the Journal, complete and return the post-test and evaluation form, and earn 80% or better on the post-test.

This activity is free to NYSNA members and $10 for non-members. Participants can pay by check (made out to NYSNA, and please include CE code R1352P on your check) or credit card. The completed answer sheet and evaluation form may be mailed or faxed back to NYSNA; see the evaluation form for more information.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

GOAL:
To increase awareness of the growing population of rural cancer patients and the unmet needs for psychosocial services in this underserved population.

OBJECTIVES:
By completion of the article, the reader should be able to:
1. Identify common factors that adversely affect the health of rural residents.
2. Describe some of the psychosocial needs of rural cancer patients.
3. Explain the impact of improved cancer treatments and a growing aging rural population.
4. List the 3 most preferred psychosocial services by rural survey respondents.
5. List the 3 most preferred methods for receiving cancer information.

Please answer the questions below. Remember to complete the answer sheet by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer.

The 0.5 contact hours for this program will be offered until September 19, 2017.

1. Health care for cancer patients is primarily provided at:
   a) Inpatient tertiary cancer centers
   b) Specialized cancer hospitals
   c) Outpatient cancer clinics
   d) Primary care provider offices

2. The highest incidence of new cancer cases occurs in which age group?
   a) 0-15 years of age
   b) 16-30 years of age
   c) 31-50 years of age
   d) 51-80 years of age
3. Factors adversely affecting the health of rural cancer patients include:
   a) Limited social supports
   b) Transportation challenges
   c) Lack of access to resources
   d) All of the above

4. A significant number of cancer patients have no access to the Internet or prefer to receive information in another way:
   a) True
   b) False

5. The psychosocial service preferred the most by survey respondents is:
   a) Help with transportation
   b) Financial help
   c) Talking to another cancer patient
   d) Information on what happens after treatment

6. Who do these rural survey respondents primarily rely on for help?
   a) Family and friends
   b) Religious organizations
   c) Cancer resource centers
   d) Community organizations

7. The information method most preferred by survey respondents is:
   a) The Internet
   c) Video presentations
   c) Written materials
   d) Talking to another cancer patient

8. Psychosocial services that respondents reported a high degree of interest in were:
   a) Yoga classes
   b) Support groups
   c) Guided imagery classes
   d) All of the above

9. Medicare reimbursement for services for rural providers pays the same rate as it does for urban hospitals.
   a) True
   b) False

10. Which of the following factors relating to improved cancer treatments and socioeconomic influences over the last decade have contributed to the increase in the population of elderly cancer patients living in the Adirondack Park?
    a) Increased incidence of cancer in people over age 65
    b) Increased proportion of elderly residents in the Adirondack Park
    c) Cancer has become a chronic disease requiring long term treatment
    d) All of the above
The contact hours for this program will be offered until September 19, 2017.
Please print your answers in the spaces provided below. There is only one answer for each question.

Psychosocial Needs of Cancer Patients Living in the Adirondacks: A Needs Assessment

1. ________ 6. ________
2. ________ 7. ________
3. ________ 8. ________
4. ________ 9. ________
5. ________ 10. ________

Please complete the answer sheet above and course evaluation form on reverse. Submit both the answer sheet and course evaluation form along with the activity fee for processing.

Mail to:
NYSNA, attn. Nursing Education and Practice Dept.
131 West 33rd Street, 4th Floor, NY, NY 10001

Or fax to:
212-785-0429
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