Patient Experiences with the New Nurse Practitioner Role in New Brunswick Canada

Trudean Hahn

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PATIENT EXPERIENCES WITH THE NEW NURSE PRACTITIONER ROLE
IN NEW BRUNSWICK CANADA

by

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Date
The role of nurse practitioner (NP) has been flourishing in the US since the late 1960’s. In Canada, the implementation of the role was slower to get established and has experienced a new thrust in recent years with shortages of family physicians and the implementation of new NP programs. The role of the NP was given royal assent in the province of New Brunswick, Canada in June, 2002 and the first NPs were hired in 2003. The purpose of this interpretive description study was to examine patient responses to this new role of NP in New Brunswick. Purposeful sampling was used to recruit 17 participants who were patients of eight NPs who had practiced in New Brunswick for at least a year. Data were collected by interviews and interpreted using the constant comparative
method. Results showed that patients were more than satisfied with the service provided by the NPs. Initial findings revealed that participants entered the relationship unsure of what to expect and found themselves comparing the care provided by the NPs to previous forms of primary health care that they had experienced. The main themes identified were the dimensions of the relationship. These included knowledge, partnership, and respect. As a result of the experience with a NP, participants formed new expectations of the ideal primary health care relationship. Further research is recommended to examine the relationship between patient outcomes, nursing knowledge and partnership in health care decisions. Other implications for research include the examination of the role that expectations play in patient responses. These findings could provide a base for future policy planning on optimum delivery of primary health care services.
This experience of writing a dissertation would not have come to fruition without the support of many people. First of all, I would like to thank my husband, Guenter, for his continual interest and understanding. He is always there for me, pushing me to achieve my goals, and helping me out wherever possible – proofreading or providing technical guidance. My supervisor, Dr. Mary Ann Thurkettle, has provided considerable expertise into my first experience with qualitative research. She has a unique ability of giving feedback in an encouraging and non-threatening way. The other members of my committee, Dr. Carl Ross and Dr. Margaret Dykeman have also been a pleasure to work with and I appreciate their support. Dr. Sheryl Reimer-Kirkham was my expert methods advisor, and I cannot say enough about her prompt responses that were so full of wisdom regarding my journey through the use of interpretive description. She added a lot to the quality of the final product. Finally, I’d like to thank Dr. Linda Nugent, one of my colleagues, who was always there to help me through any rough times that I was having, and always encouraging me to push forward to the point that I have reached! Thanks to everyone! I’m here!
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Chapter 1

Introduction

Background

The past 20 years have brought about many big changes in health care. Cutbacks in services, shortages of medical personnel, escalating costs and an aging population are factors that are contributing to a search for new and innovative ways of delivering health care. Physicians who are gravitating towards specialist positions and are often unwilling to work in rural areas are creating a gap in primary care services.

One response to this dilemma has been the inception of the role of nurse practitioner (NP). The NP role was initiated in Colorado in 1965 in response to a need for pediatric primary care in rural areas. Since that time, the role has evolved and the numbers have greatly expanded in the US, United Kingdom and Canada. Although NPs are practicing in a number of settings including emergency departments, acute care units, nursing homes, and ambulatory clinics, approximately 85% of practicing NPs are delivering primary health care (Hooker & Berlin, 2002).
The terms ‘primary care’ and ‘primary health care’ are sometimes seen as interchangeable in the literature. There has been some intent to broaden the definition of primary care to include the notions of accessibility, partnership and community (Donaldson, 1996). However, primary care normally refers to the patient’s initial contact with the health care system, and primary care practice involves the diagnosis and treatment of disease, as purveyed in the medical model. The term ‘primary health care’ became a cornerstone of the WHO’s initiative for achieving acceptable levels of health for the world’s population by the year 2000. As a result of a major international conference held in the former USSR in 1978, The Declaration of Alma-Ata included the following definition of primary health care:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, cited by Wass, 2000, p.9)

The literature describing NP practice uses the term primary health care almost exclusively and most of the NPs in this study were educated and practice under a primary health care model. MacMillan (1999a) notes that the NP offers a nursing approach to primary health care, which includes much more than symptom management and writing prescriptions.
In Canada, the Romanow (2002) commission found that across the country an emphasis on primary health care was an absolute priority. This report provided support for the acceptance and promotion of the NP role in Canada. Several provinces have put appropriate legislation in place to allow for NP practice within the past ten years. In June, 2002, the New Brunswick government gave royal assent to the implementation of the role of nurse practitioner in New Brunswick.

New Brunswick is one of Canada’s smallest provinces at 28,357 square miles and is a largely uninhabited province with a population of 729,997 at the 2006 census. Approximately 34% of the population live in its eight designated cities, and the remainder live in small villages, towns or rural areas (Government of New Brunswick, n.d.). The Health Services Review that was conducted in 2001 in New Brunswick noted that there would need to be 329 additional physicians hired to bring the province to the national average of 190 physicians per 100,000 population (NB Government, 2001). In 2002 the claim was made that there were 36,000 New Brunswickers without a family doctor (Cyr, 2002). As a result, many patients had no access to primary health care services and relied on Emergency Departments for urgent and non-urgent care, as well as prescription renewals. In an attempt to alleviate this deficit, the province initially hired seven nurse practitioners to provide primary health care in collaborative health care centers. Implementation of this new service provided more New Brunswick people with access to a
primary health care practitioner. The people of New Brunswick had never been exposed to the role of NP. The experience of visiting a NP as primary health care provider was a new and different experience for this mainly rural population. Knudtson (2000) studied satisfaction with NP service in four rural primary care clinics, linking patient demographics, expectations, and characteristics and found that there was a very high level of patient satisfaction with the service. Following her search of the existing literature, she noted that research examining the quality of NP service to rural consumers is lacking and that which is in existence is methodologically weak.

The current study grew out of a need to learn more about patients’ experiences with receiving care from NPs. A qualitative methodology was used to examine of patients’ experiences with visiting a NP for primary health care. The findings provide information about aspects within the experience that have not previously been explicated through research.

Purpose of the Study

This study examined the patient experience of working with a NP in primary health care in New Brunswick. Patients who had been visiting a NP as a primary health care provider for a period of at least six months were interviewed. The information gained from this study provides an interpretive description of patient opinions, thoughts and feelings pertaining to their experiences of using a NP for primary health care in New Brunswick.
Research Question

The following research question guided the study:

What do patients think about visiting a nurse practitioner for primary health care in New Brunswick, Canada?

Significance

The purpose of the study was to examine patient responses to the new role of NP in New Brunswick, Canada. The knowledge gained from this study will inform health care practitioners about consumers’ preferences regarding primary health care. Findings include information on patient responses to the practitioner’s knowledge, on the experience of participating in health care decisions, and on system influences on health care relationships. The results could provide a valuable foundation for future theory development on consumer participation and inform policy and practice decisions in planning the need and placement of practitioners. This will serve as a practical benefit to people who have been living without access to primary health care.

The results of this study are also of interest to all NPs. Although there has been a great deal of quantitative research, there is little qualitative research examining patient responses to nurse practitioners. Reductionist methods draw inferences about what people are thinking from enumerating responses on practitioner-designed instruments. The qualitative approach provides a critical perspective that includes a fuller range of patient values and experiences. Qualitative exploration allows
participants the freedom to express their opinions and to tell stories about their experiences so that the researcher obtains a much clearer idea of how the phenomenon is experienced (Avis, Bond & Arthur, 1995). The interpretive method provided a rich understanding of the dimensions of the relationship that are the most meaningful for patients.
Chapter 2

Literature Review

This chapter presents a review of the salient literature related to the practice of NPs in order to provide an understanding of the identified research question. To access literature for this review, the CINAHL and Medline databases were used. Search terms used were: patient responses in primary health care, patient satisfaction, nurse practitioner, primary health care and research. Appropriate references from retrieved articles were also used to inform this discussion and to extend the search. Following a critical examination of all potential resources, a total of 83 references were reviewed, including 50 research studies and 33 theoretical and discussion articles that were germane to the question. English language publications from Canada, the United States, Australia, United Kingdom, and other European countries were included. For the initial search, the request was for articles published from 1990 to present. Older articles were accessed when it could be seen that they had
been cited multiple times or offered information that was instrumental to the topic.

Background

The NP role began in 1965 in Colorado when nurse Loretta Ford and physician Henry Silver identified a need for more accessible primary health care for children and young families. A shortage of physician generalists, coupled with an impetus from nursing to expand the role, provided fertile ground for the further development of the NP role (Brush & Capezuti, 1996). The beginning of the role was not without controversy. Physicians regarded NPs as threats to their livelihood (Birenbaum, 1994), and some nurses feared the ‘medicalization’ of nursing (MacMillan, 1999a). A Medline review of literature from 1967 to 1982 (Mason, Vaccaro & Fessler, 2000) indicated gradual acceptance by physicians of the NP as an adjunct to primary care rather than a threat to their practices.

The Canadian NP movement began in the early 70’s but has not flourished to the same extent as in the US (Imai, 1974; Spitzer, 1984). Since the early 90’s Canadian nursing associations witnessed a resurgence of interest in the NP role. Since then, provincial nursing associations worked tirelessly and made great strides in re-establishing the role. Factors such as higher consumer expectations for inclusion in health care decisions, a growing aging population, and mounting fiscal pressures made the NP role an increasingly attractive option for the
delivery of primary health care services in Canada (MacMillan, 1999b). In New Brunswick, during the late 1990s, the provincial nursing association partnered with the New Brunswick government to determine how the NP role would be addressed in this province. This partnership resulted in the implementation of the NP role in New Brunswick in July 2002 (Richard, 2002).

The role of the practicing NP evolved significantly over the past 40 years. Some of the highlights include: 1) the legislative changes that permitted greater autonomy (Johnson, 1990), 2) improving/strengthening educational standards (Towers, 2003), 3) public acceptance of the NP role (Steel, 1990), 4) research evidencing nurse practitioners to be competent and cost-effective (Brooten, Youngblut, Kutcher, & Bobo, 2004), 5) a shift in focus from a medical to a nursing model (Ford, 1990), and 6) an increase in the number of practicing NPs (Kaissi, Kralewski & Dowd, 2003).

There is a plethora of literature citing the positive regard held by the public for the work of NPs (Chang et al, 1999; Cintron, Bigas, Linares, Aranda & Hernendez, 1983; Enggist & Hatcher, 1983; Horrocks, Anderson & Salisbury, 2002; Haq, 1993; Kinnersley et al, 2000; Knudtson, 2000; Langner & Hutelmyer, 1995; Larrabee, Ferri & Hartig, 1997; Litaker, Mion, Planavsky, Kipes, Mehta & Frolkis, 2003; Mitchell, Dixon, Freeman & Grindrod, 2001; Ramsay, Edwards, Lenz, Odom & Brown, 1993). Meta-analyses of studies of NP practice have
shown: 1) greater patient satisfaction and resolution of pathological conditions (Brown & Grimes, 1995), 2) patients more satisfied with NP consultations than those with physicians (Horrocks et al., 2002), and 3) that NPs are “well accepted by patients and provide...primary care that compares very favorably with care given by the physician” (Sox, 1979, p.466).

Research Findings

To appreciate the complexity of literature surrounding patient experiences with health care, it is important to provide a framework as a lens to view the interactions of the concepts. Donabedian was recognized as the most influential thinker on the quality of health care (Frenk, 2000), and he suggests that three categories must be examined to draw inferences about the quality of care – structure, process and outcome (Donabedian1988). The review of the research findings about patient experiences with NP care will be organized around these three concepts. A grid of the studies is included as Appendix A.

Structure

Structure involves the variables that provide the context for the situation that is being studied. This includes the attributes of physical resources, organizational structure, and the human contribution (Donabedian, 1988). For this review, studies that focused on structure included those in which findings reflected on setting for practice, the influence of patient demographics, and patient characteristics.
Setting

Few studies looked at the influence of setting on patient responses to NPs. Four studies (Ramsay et al., 1993; Knudtson, 2000; Banahan & Sharpe, 1982; Zikmund & Miller, 1979) used questionnaires and surveys to examine rural populations because they are often underserved in health care resources and NPs are seen as an answer to providing primary health care in these settings. Samples ranged from 93 to 220 participants and results showed that patients were generally highly satisfied with the service provided, although in some cases they were not totally familiar with the expected role of the NP (Banahan & Sharpe, 1982).

Three studies (Barr, Johnston & McConnell, 2000; Chang et al., 1999; Rhee & Dermyer, 1995) examined NP practice in emergency departments and found overall satisfaction with care and no significant differences between the providers. When asked if the NP service could be improved, respondents noted that there should be more NPs available and that they should be in place all of the time. A study that compared acute care NPs’ practice to traditional care from medical residents found that patients under traditional medical care showed more satisfaction with explanations of test results, but there were no significant differences in patient responses regarding provider knowledge and skill or quality of care received at the hospital (McMullen, Alexander, Bourgeois and Goodman, 2001).
In a study looking at setting influences on NP practice, Hupcey (1993) found that primary health care was the arena that provided the greatest opportunity for NPs to practice according to their education, and in which they could “continue to be leaders in the field of preventive health care” (p.184). Way, Jones, Baskerville, and Busing (2001) studied how NPs and physicians share primary health care responsibilities in two rural Ontario primary care practices, and recommended that increasing access to primary health care demands that NPs be integrated into primary practice models. In a study of NP perceptions, Ontario NPs in primary health care settings identified “autonomy, independence, NP-client relationship, collaboration, and being part of a multidisciplinary team” as the most positive aspects of their role (Sidani, Irvine and DiCenso, 2000, p.17).

Several researchers studied NP practice in clinic or outpatient settings. Findings were all generally positive with variables such as, decreased waiting time and provider knowledge (Langner & Hutelmyer, 1995), better rapport (Cintron, et al., 1983), more time spent with patients (Drury, Greenfield, Stilwell & Hull, 1988) and more emphasis on patient education (Cintron, et al., 1983), being reported as traits more evident in the NP practice. Studies of patient satisfaction in clinics that are entirely run by nurses show similar results with high levels of acceptance and satisfaction with physical as well as psychosocial care (Bagwell, 1987; Pulliam, 1991; Ramsey et al, 1993).
Patient Demographics

Seven studies identified indicators/predictors of satisfaction with primary health care providers. Sample sizes ranged from 93 to 1251 participants and six studies used survey/questionnaire methodology while one study used focus groups to elicit patient preferences. A number of studies (Anderson, Weisman, Scholle, Binko, Schneider, Freund et al., 2001; Brooks & Phillips, 1996) showed that women preferred female practitioners with a tendency toward an emphasis on privacy, respect, empathy, listening, partnership, and empowerment. Three studies (Phillips, Palmer, Wettig & Fenwick, 2000: Smith & Shamansky, 1983; Knudtson, 2000) determined that younger, well-educated people had a more positive attitude towards NP care, while others (Haq, 1993; Pulliam, 1991) found that older patients were highly satisfied with the care given in nurse-managed clinics.

Patient Characteristics

Four studies showed a relationship between patient characteristics and response to the health care provider. Samples ranged from 93 to 1650 participants using questionnaire formats with statistical analysis of the results. One study showed that severity of complaint affected patients’ response to NP care, in that 93% of patients with non-serious complaints were accepting while only 68% of patients with serious complaints were favorable (Enggist & Hatcher, 1983). Two studies showed that familiarity with the provider increased satisfaction (Pope &
Mays, 1978; Phillips et al., 2000), while another study found a negative correlation between patient satisfaction and familiarity with the provider (Knudtson, 2000). In one study, willingness to recommend the provider to others was found to correlate positively with patient satisfaction (Peyrot, Cooper & Schnapf, 1993), while in another study, subjects who were more satisfied with their overall health were more satisfied with NP service (Knudtson, 2000). In a comprehensive literature review, Jung, Baerveldt, Olesen, Grol & Wensing (2003) aimed at identifying associations between various cultural and demographic factors and patients’ primary health care preferences. Jung et al. (2003) found that the factors that significantly related to preferences were age, economic status, education, health status, family situation, sex and utilization of health care.

Process

Studies that focused on process issues included those that centered on what was actually done in giving and receiving care. This includes the patient’s activities in seeking and participating in the care, as well as the practitioner’s participation in making a diagnosis and recommending and implementing treatment (Donabedian, 1988). This review will include studies on the work of NPs and the influence of patient expectations on the relationship.
Work of NPs

Fifteen studies were found that investigated the work of NPs, 13 of these used quantitative methods, including eight that had used questionnaires only, and five used a combination of questionnaires with some clinical measurements or record reviews. The samples ranged from 15 to 1368 participants. Two studies used interviews and qualitative analysis to study primary care patients and NPs.

Comparisons between primary health care providers have been the focus of much research surrounding the work of NPs. Some studies found no differences when comparing the practices of NPs and physicians (Mark, Byers & Mays, 2001; Mundinger et al., 2000; Pinkerton & Bush, 2000; Rhee & Dermyer, 1995).

Other studies showed differences in the practice of NPs and physicians. Way, Jones, Baskerville, & Busing (2001), in a study of primary health care services, found that NPs were shown to place more emphasis on disease prevention and support while physicians’ visits were more focused on curative and rehabilitation services. Health promotion services were shown to be provided similarly by both. Some studies showed that NP care included more evidence of teaching and preventive care (Litaker, Mion, Kippes, Mehta, & Frolkis, 2003), more time spent with patients (Oerman & Templin, 2000), more attention to psychosocial issues (Campbell, Mauksch, Neikirk & Hosokawa, 1990), higher levels of caring, attentiveness, and comprehensiveness (Cole, Mackey & Lindberg,
1999), and that NPs provided service that was more helpful and knowledgeable with better continuity of care (Langner & Hutelmyer, 1995). Other significant findings included increased access to care (Perry, Thurston, Killey & Miller, 2005), longer consultations (Kinnersley, Anderson, Parry, Clement, Archard, Turton et al., 2000), and decreased waiting times (Cintron, Bigas, Linares, Aranda & Hernendez, 1983) in NP practice.

Setting aside debates about which practitioner does the best job in patient care, the best practice models call for a collaborative approach in which the best of both practices can be combined for more complete patient care. In a review of studies that compared NP practice to primary care physicians, Mundinger (1994) concluded that the best model – one that reduces costs while enhancing quality and comprehensiveness – is collaborative practice [in which NPs] bear the principal responsibility for the diagnosis and management of uncomplicated illness and provide the education, counseling, and management of disease prevention and health promotion, using primary care physicians as consultants and referral sources (p. 213).

There were three studies looking at the work of NPs that used qualitative methods. In an exploratory study, through interviews with seven NPs practicing in a variety of acute care specialties, Geier (2000) found that these practitioners saw the strength of their role in a holistic nursing perspective, but they admitted that medical knowledge was an important part of their work and they saw their relationship with physicians as collaborative rather than subordinate. In another study, 14
patients, 10 staff and 1 NP were interviewed regarding access to care. Findings showed that, with the NP present, there were more appointments available, appointments were longer and were available at different times of the day, thus an increase in access to care (Perry, Thurston, Killey & Miller, 2005). A focus group study of eight NPs revealed differences between the nurse-patient relationship and doctor-patient relationship. The NPs revealed that they had the ability to get to the root of a problem more easily because of their nursing problem-solving skills, and that they practiced with more emphasis on empowering patients to be involved in their own health care (Torn & McNichol, 1998).

**Patient Expectations**

Patient responses to the health care provided are often influenced by expectations. It is important to look at the dynamic interaction between the consumer’s expectations entering the health care system and how this relates to the subsequent experience. The relationship between patient expectations and satisfaction was examined in a systematic review (Ross, Frommelt, Hazelwood and Chang, 1987). The studies examined included case studies, retrospective and prospective surveys, and randomized evaluations of interventions. Four issues were addressed 1) the theoretical basis, 2) definition and measurement of expectations, 3) definition and measurement of satisfaction and 4)
evidence supporting the relationship between expectations and satisfaction. The findings included:

1) There was little regard for theory.

2) Expectations varied greatly, ranging from considerations of time spent and costs incurred to improvements in physical health.

3) Definitions and measurement of satisfaction accounted for the most variability in the studies. Direct measurements of satisfaction included bipolar Likert-type scales measuring a variety of constructs including extremely satisfied to extremely dissatisfied, willingness to return or refer a friend, and ratings of good/bad, pleased/disappointed, or regret/happiness. Other means of assessing satisfaction included documenting lack of complaining behavior, regarding outcome measures as indicators, and using behavioral cues such as patient continuance/dropout as evidence of satisfaction with service provided.

4) There was substantial support for the interaction between patient expectations and satisfaction, however the relationship needs to be studied in much more depth and many suggestions for future research were provided following this review.
Four studies not listed in the above review included patient expectations as variables in assessing quality of care. These studies used questionnaires and surveys in populations ranging from 180 to 2000 participants. The researchers noted the complexity in measuring a concept that can range from preparation of the health care provider and expected laboratory tests, referrals and new medications to the relationship elements of care – trust, interpersonal treatment, knowledge of the patient and communication. Oberst (1984), examining the potential of visual analogue scales in measuring patients’ perceptions of care, recognized the link between expectations and satisfaction and noted that expectations may change considerably during the course of an illness and treatment. She noted the differentiation between ideal and realistic expectations, and observed that the linkage between expectations and satisfaction is not always direct.

Kravitz, Callahan, Paterniti, Antonius, Dunham and Lewis (1996) identified sources of patients’ unmet expectations of physician care as: inadequacies in physician behavior around preparation for the visit, history-taking and physical examination, diagnostic testing, prescriptions, referral to specialists, and communication. They noted that findings may have been confounded by current condition and previous experience. Peck et al. (2004) studied the relationship between fulfillment of expectations of a primary health care provider and satisfaction. They found that satisfaction was not related to whether
expectations were met or unmet, except that patients who did not receive desired medications reported lower satisfaction. McKinley, Stevenson, Adams & Manku-Scott (2002) found that the match or mismatch between the service that patients hope for and the service they receive is strongly related to satisfaction. Other authors noted that some patients may not have had enough previous experience to form realistic expectations and also that expectations change over time (LaMonica, Oberst, Madea & Wolf, 1986; Mahon, 1996).

**Outcomes**

Outcome denotes the effects of care on the health status of patients and populations. Changes in knowledge level and behaviors are considered as well as the patient’s satisfaction with the care received (Donabedian, 1988). Many of the studies reviewed examined outcomes in relation to patients’ responses to health care. Twenty studies were found that reported on patient outcomes resulting from interactions with NPs. In 19 of these, questionnaires and statistical analysis were used to elicit patients opinions about the services rendered. Samples ranged from 15 to 1368 participants. Clinical outcomes were measured in four studies. Only one study used qualitative methods in examining patient responses to NP practice (Rico, 1997). A few of these studies looked at patient clinical outcomes, while the main focus for most of the studies was on patient satisfaction as the primary indicator of outcome.
Clinical Outcomes

Four studies using sample sizes ranging from 15 to 1316 examined clinical outcomes related to NP practice. Results included marked diminution in the number of hospitalizations and hospital days following being treated by the NP in a congestive heart failure clinic (Cintron et al., 1983); lower diastolic blood pressure readings in patients receiving primary care follow-up by NPs (Mundinger et al., 2000); better HDL and HBA1c levels in patients treated by NPs in a chronic disease management program (Litaker et al., 2003); and significant differences in weight loss and lowered blood pressure in patients of a hypertension clinic run by NPs (Ramsay, McKenzie, & Fish, 1982).

Patient Satisfaction

Patient satisfaction is often identified as an indicator of the quality of health care (Fitzpatrick, 1991; Linder-Pelz, 1982; Mahon, 1996; Williams, 1994; van Campen, Sixma, Friele, Kerssens, & Peters, 1995) and is a widely investigated subject.

Patient satisfaction as a concept. With a stronger consumer orientation in health care, assessments of quality of care cannot ignore the patient’s perspective. Patient satisfaction with care has been measured in medicine and nursing over the past 30 years. Bond & Thomas (1992) noted the difficulties in isolating what is meant by the term ‘patient satisfaction’. They argue that patient satisfaction as it is discussed in research studies has no congruency in definition, and there
Mahon (1996) conducted a concept analysis of patient satisfaction and listed eight defining attributes: art of care (including interpersonal qualities and actions), technical quality of care, access/convenience, finances/cost, environment (physical, organizational, general milieu), availability of providers/resources, continuity of care, and efficacy/outcomes.

Researchers interested in patient satisfaction need to be more specific about what is actually being studied. Bond and Thomas (1992) discuss the diversity of patient perceptions and whether patients are able to distinguish between the technical care that is given and the interpersonal aspects of the care. In other words, if the health care provider is regarded as ‘nice’ and ‘friendly’, does this translate into good overall care in the mind of the patient? In a study of patient experiences in visiting a neurology clinic, Fitzpatrick and Hopkins (1983) noted that patients often judge a doctor by the behavior exhibited rather than the technical competence, which they may not feel qualified to assess. In describing the development of an instrument to gauge patient experiences in primary health care, Steine, Finset, and Laerum (2001) found that interaction, emotions and outcome were valued the most in patients’ assessments of the doctor-patient relationship. Other influences in the situation that may have an impact on the way patients will respond in satisfaction research include 1) restricted knowledge of
services that can/should be provided, 2) low expectations in relation to standards that have been established by the health professionals themselves, 3) wishes to please staff and fear of repercussions for negative appraisals, and 4) patient characteristics such as age, gender, and previous experience with the health care system (Bond & Thomas, 1992).

The researcher must be clear on “Who is being assessed? What are the activities being assessed? How are these activities supposed to be conducted? [and] What are they meant to accomplish?” (Donabedian, 1988, p.1745). Donabedian believes that patient satisfaction is an important quality indicator that must be considered indispensable when assessing quality of care. Erikson (1987) disputed this connection and conducted a study that found an inverse relationship between quality of care and patient satisfaction. The discussion included an observation that patient satisfaction is more often a reflection of the individual patient’s values and expectations for care, and cannot be “used as the sole evaluation mechanism regarding quality of care” (p.35).

While formulating a tentative theory of patient satisfaction, Linder-Pelz (1982) presented a conceptual definition as “the individual’s positive evaluations of distinct dimensions of health care” (p. 580), with antecedent social psychological variables of expectations, values, entitlement, occurrences, and interpersonal comparisons identified as probable determinants. In a more recent study of patient satisfaction,
taking into account increasing consumerism and managed care, the top ten determinants for patient satisfaction were similar to what had been identified in previous research. They included items related to patients’ confidence, ability to discuss questions or worries, inclusion in care, and likelihood of recommending the provider to others, as well as provider attributes of providing privacy, giving instructions and explanations, being friendly and courteous, and allowing enough time for the visit (Drain, 2001). Sitzia & Wood (1997) noted that although some attention has been paid to identifying components of satisfaction, research is often based on criteria set by management and professionals. In their article, these authors pointed out that several authors have advocated for different approaches to the evaluation of patient care, including patient-centered, qualitative methodologies.

*Measurement of patient satisfaction.* Attempts to measure patient satisfaction have used a number of tools and methods. Because of the difficulties discussed above with defining patient satisfaction, many instruments tap into only one aspect of the patient-provider relationship. In addition, many researchers have found that measures of patient satisfaction are universally positive, perhaps related to “social desirability, implicit threat, hesitancy to express negative opinions, location of testing, and item wording” (Oberst, 1984, p. 2368). Mangen and Griffith (1982) attempted to overcome some of these obstacles by using an interviewer-rated questionnaire including opportunities for
open-ended responses and a self-report schedule to compare patient satisfaction with community psychiatric nursing and psychiatrists. Their findings indicated higher levels of satisfaction in groups of patients treated by nursing, but all groups reported high levels of satisfaction with care. LaMonica, Oberst, Madea, and Wolf (1986) attempted to establish a tool that would discriminate satisfaction with distinct nursing behaviors. They found that factor analysis did not support the construct validity of the three dimensions of nurse performance that they had initially identified – technical/professional, trusting relationship, and provision of information. They attributed this to the possible erroneous assumption that patient expectations remain stable over time. They recommended that instruments be developed that could measure concomitant patient expectations and caregiver behaviors.

Fitzpatrick (1991) discussed the use of surveys in measuring patient satisfaction, and, although cognizant of the pitfalls, he recommended that a well-designed questionnaire with specific questions would allow the researcher to ascertain which aspects of care are related to higher or lower levels of patient satisfaction. Several researchers have designed tools for use when assessing patient satisfaction with NP care. Some were adapted from instruments used to rate the care of physicians (Poulton, 1996), and others were specifically designed to include the full scope of NP practice (Cole, Mackey, & Lindenberg, 1999; Bear & Bowers, 1998; Knudtson, 2000). The instrument that was adapted from a
previously used medical instrument described satisfaction as consisting of professional care, depth of relationship, and perceived time spent with the health professional (Poulton, 1996). Descriptions of the facets of satisfaction that informed the development of the NP instruments included: the patient’s judgment of the quality of service and the degree to which patient expectations of health care are being fulfilled (Knudtson, 2000); adherence to treatment, user perceptions of quality, fulfillment of expectations, and willingness to recommend the service to others (Bear & Bowers, 1998); and an important outcome measure of quality (Cole et al., 1999).

Studies of patient satisfaction with NP services. A number of studies have been conducted to assess patient satisfaction with the services of NPs. Several meta-analyses have been completed to examine patient responses to NP care. In an early review of 21 studies looking at comparisons between NPs and physician’s assistants with physicians, Sox (1979) reported that the care given was indistinguishable among the groups with patient satisfaction results showing a high level of acceptance of NPs and physician assistants. An evaluation of patient outcomes (Brown and Grimes, 1995), as indicated by 53 NP and nurse midwife studies, showed greater compliance with treatment recommendations, greater satisfaction levels and more resolution of pathological conditions under NP care as compared to that of physicians.
Horrocks et al.’s (2002) review of randomized controlled trials (n=11), and prospective observational studies (n=23) compared NPs and doctors treating patients at first point of contact for undifferentiated health problems. The study focused on the outcomes of patient satisfaction, health status, costs, and process of care. Results showed more satisfaction with the care provided by NPs, longer consultations, and more advice on self care and management from the NPs. There were no differences in health status noted between the two groups of practitioners. In a response to this article, Scott (2002) emphasized that the reason for increased patient satisfaction with NPs was related to the longer consultations, more information provided, and better communication. She notes that these are core skills in nursing practice and that NPs should never sacrifice this nursing role at the expense of increasing medical functions.

A total of 20 studies (Barr et al., 2000; Bear & Bowers, 1998; Chang et al., 1999; Cintron et al. 1983; Cole et al., 1999; Drury et al., 1988; Engisst & Hatcher, 1983; Haq, 1993; Kinnersley et al., 2000; Knudtson, 2000; Langner & Hutelmyer, 1995; Larabee et al., 1997; Mangen & Griffith, 1982; McMullen et al., 2001; Mundinger et al., 2000; Pinkerton & Bush, 2000; Poulton, 1996; Ramsey et al., 1993; Rhee & Dermeyer, 1995; Rico, 1997) examined patient satisfaction as an outcome in response to NP services. All of the studies reported high satisfaction
with NP care. Nineteen of the studies used quantitative methodology in sample sizes ranging from 15 to 1368 participants.

In the only study that used a qualitative method to study patient responses to NP care, Rico (1997) used interviews to study ten patients from four community health centers in Toronto. She reported on four themes that came from the analysis; 1) NPs’ existential presence, 2) amiability of approach, 3) individualized concern, and 4) co-working in care. The results from this study gave a much clearer picture of patients’ individualized preferences in receiving care from NPs, as opposed to the enumerative findings from the instruments in quantitative research.

Summary

Through the review of the literature, concepts were identified that may influence patient responses to the role of the NP. These concepts, which include setting, patient demographics, patient characteristics, patient expectations, and patient satisfaction, provided a framework for the data collection and analysis in the current study. They reflect the categories of structure, process, and outcome that were identified by Donabedian (1988) as being the necessary focus for research into quality of care. In general, it has been found that younger, female patients with higher education levels show more preference for NP care, although studies that focused on the elderly also reported high levels of patient satisfaction. Patient characteristics that influenced the relationship included familiarity with the provider, severity of complaint, and
willingness to recommend the provider to others. Results of research that examined patient expectations as being related to satisfaction with care were not conclusive because of confusion regarding the explication of the role of expectations. Patients may not have the experience or expertise to form realistic expectations, and may be more adept at identifying unmet expectations. Studies that focused on clinical outcomes indicated that health care decisions resulted in positive outcomes for patients being treated by NPs. Patient satisfaction was identified as an indicator of the quality of care in several studies. Satisfaction with NP care has shown consistently high ratings in quantitative research.

From the research that has been reviewed, the conclusion can be drawn that NPs are well respected by patients and are providing care that is competent and comprehensive. Still, we do not know how and why patients make choices about health care providers, which aspects of the relationship are most important to them, whether they do have expectations of a health care provider that are met or unmet, and how they feel about their own participation in health care.

Conclusions

This review of the literature illuminated the current state of knowledge surrounding patient responses to NP practice. Although many studies reported significant outcomes and patient satisfaction with the practice of NPs, most of the research has been conducted using quantitative and provider-oriented methodologies. There is controversy
as to how well satisfaction measurements accurately present patient views. When completing an instrument that has been chosen or designed by the researcher, patients are funneled into answering questions that have been devised from the provider’s perspective on the healthcare situation and this may or may not represent the spectrum of the patient’s perspective. While the studies reviewed here reported on patient outcomes following treatment by a NP, the patient’s perspective has not been fully explored. Many authors call for research that will expand the knowledge surrounding patients’ views about their care, providing insight into experience and preferences (Avis, Bond & Arthur, 1995; French, 1981; Thomas & Bond, 1996; Schneider & Palmer, 2002).

Although ample quantitative research studies have shown that patients are satisfied with the service that NPs provide, there is evidence of only one qualitative study that examined patients’ experiences with visiting a NP for primary health care (Rico, 1997). The call for more qualitative research into patient responses to primary health care services is clear throughout the literature. It has also been noted that there has been no Canadian research regarding the health consumer’s comfort level with NPs in primary health care practice (Mitchell et al., 2001).

This study examined patients’ experiences with visiting a NP for primary health care through the use of interviews and qualitative data analysis. This approach allowed participants the opportunity to talk
freely about their experiences, to ask for explanations if necessary, and to express their opinions about this new experience in health care. The information gained expanded knowledge about how people make choices when seeking health care services, which aspects of the care that they value, how their expectations about health care are met or unmet, how valued they feel in being included in health care decisions, and how they negotiate relationships with the provider.
Chapter 3

Methods

Design

Interpretive description methodology was used in this study to explore the experiences of patients visiting a NP for primary health care in New Brunswick. Thorne, Kirkham, and MacDonald-Emes (1997) suggested that nursing’s unique interest in the health and illness experiences of patients calls for a methodology distinct to nursing. They proposed ‘interpretive description’ as an alternative approach with a strong base in nursing. It has been recognized that qualitative nurse researchers are often confined by the qualitative methods that have arisen in other disciplines because of a desire for epistemological credibility. They have opted for methods like phenomenology, which is grounded in philosophy, or grounded theory that has its base in social sciences, or ethnography which has its roots in cultural anthropology. The rising popularity of the use of the method of interpretive description has been attributed to the increase in the number of researchers who
have been doctorally prepared in nursing rather than another discipline such as philosophy, sociology, or anthropology.

The foundation of interpretive description is the smaller scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004, p.5).

The method has been used and published by several researchers. Topics of study have included: women who have been battered (Irwin, Thorne, & Varco, 2002), the client-nurse relationship as experienced by public health nurses (Paavilainen & Paivi, 1997), patients’ experiences of receiving iodine-131 therapy (Stajduhar et al., 2000), health care communication in multiple sclerosis (Thorne, Con, McGuinness, McPherson & Harris, 2004), and cultural influences on breast-feeding choices (Chen, 2002).

Morse and Richards (2002) wrote that methods must be chosen that discover and do justice to perceptions and their interpretations when studying participants’ experiences in a setting or process. Qualitative methods are deemed to be appropriate when assessing health care services in times of reform, particularly from the patient’s point of view (Pope & Mays, 1995). The goal for this study was to understand some of the dynamics that are present in a new health care provider situation.

In designing a qualitative research study, it is imperative to locate the decisions regarding methodology and methods in an epistemological
framework and theoretical perspective. Many nurse researchers have presented confusing results because of the failure to discuss the philosophical underpinnings of their chosen research methods (Lowenberg, 1993).

**Epistemology Underlying This Study**

This study was situated under the umbrella of naturalistic inquiry and based on constructionist beliefs about knowledge development. Epistemology is a “way of understanding and explaining how we know what we know” (Crotty, 1998, p.3). The constructionist epistemology can be described as the belief that knowledge is constructed from human living, particularly from the interactions between human beings and their world (Crotty). The constructionist view exists under a paradigm of what has been termed *naturalistic inquiry* in which the researcher works in a natural setting, uses self as the instrument, appreciates tacit knowledge, elects to use qualitative methods with purposive sampling, and conducts inductive data analysis (Lincoln & Guba, 1985). In this way, the researcher is uncovering the constructed knowledge of the participants as they share their experiences. The aims of natural inquiry are to explore unknown phenomena or to re-examine them in a new light, and to bring the findings to other researchers or practitioners to illuminate meanings, or provide a basis for instrumentation and theory development (Sandelowski, Davis, & Harris, 1989).
Theoretical Perspective

After an affirmation has been made regarding the epistemology that drives a study, it is important for the researcher to identify the theory that drives the choice of methodology and methods (Crotty, 1998). The theory provides a context for the process, and the assumptions of the theory guide the course of the research. The theoretical perspective that guided this study is interpretivism, which emerged in contradistinction to positivism as interest in discovering human reality grew. “The interpretive approach emphasizes the importance of understanding the overall text of a conversation and, more broadly, the importance of seeing meaning in context” (Rubin & Rubin, 1995, p.31).

In studying the human sciences, the concept of verstehen or understanding is a primary building block (Crotty). The individual and his/her actions are seen as the primary focus, and it is the task of the researcher to bring understanding to these actions. One tool used in qualitative methodology is symbolic interactionism which is recognized as a branch of interpretivism (Crotty). Symbolic interactionism allows the researcher to uncover the meanings that are put forth by the participant through dialogue and interaction. The basic assumptions outlined by Blumer (1969) provide explanations for the use of this theory in this study. These assumptions include:

- that human beings act toward things on the basis of the meanings that these things have for them;
that the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows;
• that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters (p.2).

Language is the most obvious symbol by which we communicate and create meaning. Through dialogue, the researcher becomes aware of the perceptions, attitudes and feelings of others and goes on to interpret these meanings so that knowledge can be built in a constructivist fashion (Crotty, 1998). Although symbolic interactionism has been a mainstay in grounded theory research, it provides epistemological framing for this interpretive description study. The approach will be an account generated through guided questioning, with the opportunity for reflective critique, and the generation of themes and patterns that can be used to inform clinical practice (Thorne, 2004).

Another theoretical framework that underlies this study is the foundation of nursing knowledge. Loretta Ford (1990), one of the original founders of the NP movement, posits that the roots of NP practice are in professional nursing and that professional nursing knowledge continues to form the framework for the preparation of the NP. This underpinning is also basic to the interpretive description method. Basic nursing knowledge includes the recognition that:

human health and illness experiences are comprised of complex interactions between psychosocial and biological phenomena, that common patterns within such experiences represent the core of our disciplinary practice knowledge, and that the practical application of principles derived from such common patterns will
always be individualizable in the context of a particular case (Thorne et al., 1997, p.172).

The ways that the interpretive description approach was used in this research are as follows:

1) Naturalistic inquiry guided the generation of data. There was a large amount of data from individualistic accounts which offered an extremely rich data set.

2) The data that was gathered was influenced by the interaction between the researcher and the interviewee and the context of the interview.

3) The categories and themes which were identified came from the participant’s experiences.

4) Replicability of the results is not an objective of qualitative research. Interpretive description provided a tentative truth claim that is common within a clinical phenomenon and that may be applicable to other similar contexts (Chen, 2002).

Setting

Participants were drawn from practices in New Brunswick in which NPs had been practicing for at least one year. The settings for data collection (interviews) were chosen by each participant with most of the interviews taking place in the participant’s home. Two interviews took place in the Community Health Center in the community. The setting for conducting interpretive description studies is ideal when participants are in situations where they normally operate. This enables the researcher to establish a relationship with the participants that will allow a more complete understanding of the phenomenon from the participant’s perspective.
Sample

Qualitative research is typically carried out with small sample sizes based on the number required to provide saturation of data to the point where no new information is being obtained. The sample size consisted of two patients from each of eight NPs who have been practicing in New Brunswick for at least a year. The sample was stratified to include a variety of ages. Both genders were included. This technique is recommended for illustrating subgroups and facilitating comparisons (Miles and Huberman, 1994) and to provide variation and richness to the data. “The power of purposeful sampling lies in selecting information-rich cases for study in depth” (Patton, 1987, p. 51-52). Although there was some redundancy in the findings after the first several interviews were conducted, the decision was made to include patients from all eligible practicing NPs to allow for possible discrepancies or outliers. To be included in the study, participants needed to meet the following criteria:

1) be at least 18 years of age
2) speak English
3) have visited the same nurse practitioner for primary health care for a period of at least six months.

Data Collection

Instruments

Interviewing was the primary means of collecting data in this study, and thus the researcher was the primary instrument. Because the researcher collected, analyzed, and interpreted the data, it is important
to account for my values, beliefs, experiences and biases as they may affect the study findings. I am a registered nurse with 20 years of experience as a nurse and 20 years of experience teaching nursing. I was originally educated in a 3-year hospital-based program, received a Bachelor of Nursing in 1985 and a Master’s degree in Nursing in 1997. I taught communication courses for a number of years and I am therefore comfortable with interviewing techniques and principles. In my doctoral program, I took a number of NP courses with the intention of graduating as a PhD and NP. I did not continue with the NP part of the program, but part of my heart remains attached to the role. My assumptions (see Appendix B) are provided to situate myself in the research process, as my own beliefs and biases will have an effect on the interpretation of the data. In addition to these assumptions, I also believe that participants are story tellers by nature and are most comfortable in their own environments. In this study, the stories that the participants shared allowed a glimpse into their inner worlds. The purpose of using of interpretive description as a method was to explore and understand these inner worlds. The exploration and the interpretation provide information about these participants’ values, beliefs, feelings, and how they construct their social world. Following the guidelines of interpretive description, participants were chosen who were representative of the population and who shared elements of the experience.
A generalized interview guide (see Appendix C) was used which outlined areas that were explored. Although the interview guide was available to the researcher, ideas were allowed to emerge from the interview. The participants were encouraged to tell stories about their experiences with nurse practitioners because it has been recognized that people often create meaning and make sense of their experiences through the telling of stories (Mishler, 1986). In addition to interviews, the researcher kept reflective memos in the form of post-interview comment sheets. These included information such as time of day, description of the setting and the informant, the emotional tone, any difficulties encountered, and the feelings of the researcher following the interview (Lofland & Lofland, 1995). A framework (Paterson, 1994) to critically examine the behaviors of both the researcher and the participants, including emotional valence, distribution of power, goal of the interaction, and normative or cultural criteria was used to guide the writing of the reflective memos in this study. The use of these reflections is discussed in the data analysis section of this study.

**Procedures for Data Collection**

The researcher contacted NPs who had been practicing in various areas in New Brunswick for at least a year individually to explain the purpose of the study. The NPs distributed an informational page (see Appendix D) to adult patients who had been visiting them for at least six months for primary health care. The NPs briefly described the study and
asked for their willingness to participate. Completed forms were kept in a locked filing cabinet by the NPs until they were given to the researcher. The completed forms arrived to the researcher in stages, which allowed for purposive sampling after the initial interviews were complete. The researcher chose two possible participants from each NP that represented both genders and a variety of ages across the study. All of the people contacted agreed to take part in the study. During the call, the researcher explained the study and arranged a time and location for the interview to take place. At the time of the meeting, demographic data was collected before the interviews took place (see Appendix E).

Procedures for Protection of Human Rights

IRB approval was obtained from Duquesne University, University of New Brunswick, and the hospital corporations wherein the nurse practitioners were practicing (see Appendix F). The study was explained to the participants by the principal researcher and informed consent was obtained before data collection began (see Appendix G). The potential benefits from this study included: 1) an opportunity for patients to verbalize their responses to a new type of health care delivery, 2) the excitement and satisfaction of being included in a study concerning changes in health care delivery, and 3) satisfaction that they were involved in a process that could influence health care decisions. The risks for participation in this study were very minimal. They included a
loss of privacy or time, or the possibility of psychological distress if the experience had been negative for them.

All papers associated with the study were kept in a locked filing cabinet and interviews were password protected on the researcher’s computer. The information will be maintained under these secure conditions for a period of five years and then either shredded or deleted from the computer.

Procedures for Data Analysis

In searching for the essence of patients’ experiences, interpretive description was the qualitative analytical method used. Data analysis began with the recognition that complex coding systems would not be used. Rather, the intention was to get an overall picture of “What is happening here?” before any analysis began (Thorne et al, 1997). The analysis began with the first interviews and continued throughout the process of further interviewing and writing. Interviews in this study were recorded on a digital tape recorder and transferred as an audio recording through a USB port to a computer where they were protected under password. This method allowed the interviews to be preserved in three-dimensional character so that the data could be accessed in its original form. In addition, the interviews were transcribed verbatim and stored on a computer as text under password protection.

The data analysis was guided by the constant comparative method (Lincoln & Guba, 1985; Thorne et al, 2004) which includes five steps.
First, a sense of the overall data was developed. The transcripts were listened to and read several times to get a feeling for what the participants were trying to say. Repeated immersion in the data allowed synthesizing to occur and the identification of abstract themes (Thorne et al, 1997). Second, notes were taken that recorded my initial feelings and hunches about the data. Third, the reflective memos were consulted to aid in any discrepancies that may have arisen in the interpretation of what was being said. Fourth, a strategy was developed for coding the data. Data analysis occurred concurrently with interviewing and began with reading the transcripts and highlighting certain segments that conveyed a meaning to me. Different colored highlighters were used to differentiate meaning units as they had been described by the participants. These meaning units were kept in mind as future interviews were conducted.

Later the interviews were entered into NVivo and a more official process of coding began. The initial headings that had been used to sort and highlight the data coalesced to reveal the emergent themes that identified the dimensions of the relationship between the NP and the patient; knowledge, partnership and respect. Therefore the nodes were named according to the themes that were evident in these dimensions. In addition to the complex revelation of relationship dimensions, there were also underlying messages that pervaded all of the interviews. These have been identified as initial findings in the data analysis. Fifth, the patterns
were synthesized, theorized and reconstructed into a descriptive structure of categories and themes that portrayed these patients’ experiences of visiting a NP for primary health care. The categories and themes produced a picture of what elements are valued in a primary health care relationship, how these relationships with NPs compared to previous primary health care relationships, and what role expectations play in health care relationships.

Rigor

Rigor in qualitative research is assessed differently than the positivistic aims of reliability and validity. Lincoln and Guba (1985) suggested that methodological rigor in qualitative research be evaluated according to credibility, transferability, dependability, and confirmability. The interpretation of the findings in this study was based on the themes that were identified from patient experiences. The interpretive description method allowed the participants to reveal their truths to the researcher.

Credibility

Credibility of the findings in this study is situated in the transparency of the description of the research process. Complexities have been made visible and the results are presented as ‘tentative truth claims’. The position of researcher must be understood. The researcher affects and is affected by the process of coming to understand another’s experience. Because researcher bias can threaten the credibility of a study, my position as researcher was established through the statement
of assumptions (see Appendix B). I examined my own feelings going into the research and came to terms with the ways in which my beliefs might influence the process. I also recognized that the interactions themselves could influence the results. I introduced myself as a nurse researcher who was interested in the new role of NP in New Brunswick. My interviewing skills were acknowledged and played a role in allowing participants to share their experiences credibly. Also, by allowing the participants to choose the location for the interview, it was assumed that the participant would be more comfortable and therefore the information would flow more freely and clearly.

During the research process, I wrote reflective memos after each interview that recognized environmental and power issues (Thorne et al., 2004). During data analysis, these memos were consulted regularly to allow for further interpretation of any discrepancies in the data. This added to the credibility of the findings.

Using member checks is one of the most crucial techniques for establishing credibility (Lincoln & Guba, 1985). In interpretive description, it is important to bring initial conceptualizations representing the entire sample to participants for their critical consideration. This allows the participants to examine and comment on the findings and to provide feedback as to whether the researcher has represented their known realities (Thorne et al, 1997). In this study, after the initial analysis of the data, patterns were identified within and across
participants’ experiences and a model account of the experience of visiting a NP for primary health care in New Brunswick, incorporating the dimensions uncovered, was written (see Appendix H). Care was taken to include examples of identified relationship themes in the description. This document was sent to each of the participants and they were asked for input as to whether their experiences were accurately reflected in the description (see Appendix I). The responses provided reassurance to the researcher that the themes that had been identified were reflective of individuals’ actual experiences.

Transferability

In naturalistic investigations, the responsibility of the researcher is to present the findings in such a way so that the reader can make judgments about the transferability of the data (Lincoln & Guba, 1985). This study has provided details about the researcher, the participants, the environment, the methods, and the findings. Every effort was made to include a rich description of the data. Results of this study may be transferable to other situations, but the responsibility for this transfer lies with the reader.

Auditability

Auditability refers to the trustworthiness of the findings (Lincoln & Guba, 1985). It implies a traceable trail so that a new researcher could identify sources and easily follow the same path. In this study, the interpretive description approach was clearly explicated, and a decision
trail was made obvious so that it could be replicated in a similar research situation.

**Confirmability**

Confirmability also refers to the objectivity of the findings. The findings must be seen to be grounded in the data. Again, the audit trail is important as a means to establishing whether the findings reflect the true lived experience of the participants. The findings of this study included quotes from participants, the process of analysis, synthesis, and the identification of the themes and categories that provided an interpretive description of the essence of the experience.
Chapter 4

Results and Discussion

Description of the Sample

A total of 17 participants were interviewed for this study. All potential subjects contacted by the researcher were willing to participate, and in fact were eager to talk about their experiences. Two patients of each of eight NPS were included, as well as a husband of one of the participants who was present for the interview and also a patient of the NP.

Patient participants ranged in age from 25 to 84 years. There were 11 female and 6 male participants. Education levels ranged from two participants with Grade 7 education to two participants with university undergraduate degrees. Three participants had Grade 10 or 11 completion and all other participants had high school education, including some who had technical or college training. There were 6 single, 9 married and 3 widowed participants. Only 2 participants stated that they had no ongoing health concerns while the others had a variety
of problems including allergies, hypertension, diabetes, elevated cholesterol levels, arthritis, hypothyroidism, obesity, diverticulitis, cancer, depression and epilepsy. All of the participants described their present state of health as acceptable – ranging from “hangin’ in there” to “excellent”. Eight of the participants lived in rural areas while 12 lived in cities. All participants were Caucasian.

The average age of the NPs who provided participants for the study was 46, and the average number of years of experience working as a nurse before becoming a NP was 22 years. Six of the NPs were recent graduates of the first NP program in the province, and two had received their education elsewhere. All of the NPs had worked in their present positions for approximately two years. Seven of the NPs were working in Community Health Center settings, and one NP was working in a collaborative practice with a family physician.

Major Categories of the Experience

The lived experiences of the patients who had visited a NP for primary health care in New Brunswick revealed dimensions in the relationship most meaningful for them. Interwoven with the recognition of these dimensions were comparisons with previous encounters in primary health care and the role that expectations played in regard to the actual experience.
Comparisons

Comparisons with previous health care experiences became evident throughout the interviews. Although there was a question included in the interview guide that asked informants to compare this form of health care to other health care experiences, this question had already been discussed before it had been asked.

Time

One of the major comparisons was the time factor. Participants believed that the NP always took the necessary time to listen to their concerns, and to do the appropriate teaching and discussing. One participant described it as “it's almost like an assembly line, if I can produce 129 Fords today, you know. You don't want to feel like one of those Fords. But you don't feel that with K. That’s one thing I have to say about her is you have her undivided attention for as long as it takes for you to express your concerns or whatever.” Other responses reflected the same tone: “when you go to a GP if you get 10 minutes of his time you're lucky”; “I was in his office a total of about 10 minutes. Just in and out, there's another Ford out the door, you know. I think if it was K. doing that work I'd have been in there an hour”; “Well with the doctor you went in there and you were out in 5 minutes”; and “Like my other Dr. you'd have a foot in the door and a foot in the office but with her she takes her time which is why it takes a little bit longer to see her.”
Focus of visit

Another comparison was the difference in what was accomplished in a visit. Patients felt that time allotted to the visit guided what could be discussed. They described it this way: “if I was going to a doctor that I would expect him to take at least 15 minutes with me and listen to me and answer my questions that I would have and I would accept his answers”; “I’ve gone to doctors who will just basically rubber stamp the form and charge you $80.00 and away you go. With K. she spent a whole lot more time with me and she didn’t charge me.”

In describing previous encounters with health care providers, one participant said “you know, get you to touch your nose with your eyes closed and they’d take your blood pressure and sign the forms and you’re out the door.” One informant summed up the differences in this way:

Now the difference that I found with going to her and my previous doctor was, he would say, you can only ask me one question and if you have any other questions you’re going to have to make another appointment. And I said Medicare is going to get awful rich off of you and I had to shut up. That was it. He put his hand up. With S., she asks me the questions. When I leave her office there is no stone unturned.

The felt lack of attention in previous health care situations was evidenced in this excerpt: “And I was talking to some doctors and well, I suppose they’re only trying to do what they feel is necessary to be done, but there was not much dialogue, not much explanation. And all of a sudden I was taking this kind of pill for something and that kind of a pill for something and I wasn’t really sure.”
Differences in Attitudes

Differences in personalities or attitudes between the different types of practitioners was noticed by some participants. Taking their concerns seriously seemed to be an issue for a few participants: “Well if you've been a doctor for 25 years you've seen it all and the little problems I guess don't matter or don't alarm you, whereas if you see a nurse practitioner or nurses in general [they] will take every little thing more seriously or look at it more seriously. So in that sense I prefer to see a nurse practitioner”; and “In fact for many years I felt I had a problem possibly with diabetes and was never tested, and she was the one who actually tested me for the fasting glucose, so I'm ahead of the game. Because doctors after awhile they become less sensitive.”

Differences in interpersonal skills

Participants commented on the differences in the ways that the NPs interacted with them: “Some doctors, I find, particularly those who specialize, are intimidating”; and “I think a nurse practitioner would have more bedside manner because they’re used to dealing with patients on a different level than the doctor. It seems like M, you know, you can tell she cares. She wants to do the best to get you better and she'll take the time.”

Differences in environment

A few participants commented on differences in the environment. One young participant described it this way:
the way you're put at ease. Not only her as a person but even her own environment. She has things to make you comfortable. She plays music, quiet stuff just to relax you whereas I find most offices, growing up too, it's like a hospital. You never know them that well, you've got too many nurses and doctors floating around. Very sterile, you don't feel comfortable at all. There's no way I would go to my doctor's and have a physical done.

An older male patient described his previous health care environment as he said: “I've been going to doctors before, you wait in that little cubicle room there. You waited, you waited and all of a sudden they showed up and said what’s wrong, well I think this is what’s wrong, okay, let’s try this medication, have a good day.”

Educational differences

Comparisons were also made regarding educational preparation. Participants were aware that NPs had not received the same education as a doctor: “... let’s face it the mandatory training for a doctor is more intense than it is for a nurse practitioner”; and “There's the odd person who's hung up on the roles. They want to see a doctor.” However, many participants expressed the idea that educational preparation was not a big issue for them: “Well I would rather her have her own degree as a doctor, you know why? So she doesn’t have to get somebody else’s permission, because she’s good at what she does. There’s some doctors I wouldn’t go night or day to and she seems to care. It makes a big difference”; “No, they’re both on the same level. I haven’t had any issues where she hasn’t fulfilled a need that I had. So to me she’s on the same level as a doctor”; and “I think to me she's just exactly the same as a
doctor but the only thing she can't do is prescribe heavy narcotics, sleeping pills, which probably 99.9% of the people don't need anyway.”

Patient Expectations

Throughout the interviews, the role that expectations played in the nurse-patient relationship became more evident. Although there was a specific question in the interview guide regarding expectations, participants had a difficult time articulating what they would expect in a health care encounter.

Vague or Unknown expectations

When asked directly, patients were hesitant and often vague about what they should expect in a health care situation. One patient said: “I want to find out what’s going on”, and another: “In very easy terms, just to be taken care of”. When asked how they felt about seeing a NP for the first time, they expressed feeling unsure: “I didn’t know what a Nurse Practitioner was at first”; “Oh yes, I thought, oh gosh, here I go. First I go from a doctor who really didn’t care to a nurse practitioner who won’t have two clues about what to do”; and “I didn’t know. I was uneducated as to the education a nurse practitioner really has.”

Emerging Expectations

As the participants described their encounters with the NPs, they were clearer in expressing the qualities that they had come to expect from the visits following the experience. In other words, their expectations were formed by the experiences that they had with the NPs.
They identified qualities such as “warmth”, “you want to be comfortable”, “follow-up”, “to take the time”, “to have everything ready”, “to have a good rapport with them.”

The meaningful finding was that although the participants were not able to clearly articulate what their expectations were when asked directly, these characteristics were identified as important attributes that they had come to expect from their interactions with NPs.

Dimensions of the Relationship

The identification of the dimensions of the relationship encompassed the greatest proportion of coded data. These dimensions were the themes identified as present across all participants and reflected the essence of the new relationships with visiting a NP for primary health care. Three predominant themes were identified: knowledge, partnership, and respect.

Knowledge

The predominant theme was the recognition of the knowledge that the NP brought to the role. Two sub-themes contributed to this identification – confidence and being informed.

Confidence

Patients commented often on the thoroughness of the NP’s practice, recognizing that the goal of the NP was to get to the bottom of things: “She asks a lot of questions”; “tries to get as much information as possible”; “she doesn’t like something unclosed”; and “she leaves no
stone unturned”. At the same time, they recognized that the NPs were not afraid to admit that they didn’t have all of the information: “there’s no problem with going to them because they know their limits”; and “as I said before, she’s not afraid to say ‘I don’t know’ and that means a whole lot to me”. In this vein, patients often expressed their reassurance that a doctor was readily accessible for consultation by the NP: “then she always has a backup to talk it over with another doctor”; “she works side-by-side with the doctor which is good”; “I know I feel more secure knowing that she has gone to the doctor and discussed it with the doctor and come back”; and “she has direct access to Dr. X and it’s almost like you get a second opinion right then and there”. The patients also felt that the NP used whatever resources were required to access information, commenting on things like “getting the books out”, “researching”, and “accessing the Internet”. Another source of confidence comes from the feeling that the NP will go to any lengths to find the answers to the patients’ problems: “If she can’t figure out the problem she’ll send you to someone else who can. And if they can’t she’ll send you somewhere else until someone can”; and “I find that she’s right in there pushing for what she thinks should be done, and you feel very good about it”. One participant felt that the high level of confidence stems from the close relationship that is established: “you’re more confident and secure about going to her when you know more about them as a person, both ways”. A younger male participant summed up his confidence in the NP as
follows: “excellent follow through, great bedside manner. I’m blown away. I haven’t seen that before”.

**Being Informed**

Participants reported that for the first time, they were getting all the answers regarding their health care. One patient said: “when I leave her office, I have no questions. I don’t come home with all these questions going around in my mind. She answers them all. And if there’s anything that I need to ask her, guaranteed she’s going to give me the answer or she’s going to get it from one of the doctors.” They talked about the types of information that they received: “they are actually explaining the medication to you and what you can do about it”; “She goes over every aspect of my blood tests with me, everything, she really does”; and “she explained to me why it’s not good to eat some things and why it’s better to eat these things.” The patients felt that the NPs took the initiative to explain the health care plan to them and they were also concerned about any further questions that the patient may have: “Like I said, she’ll say have you got any questions? Do you understand what I’ve explained to you? And like I told her, I said, I don’t know what I’d do without you now. Really.” One participant expressed the feeling of being fully informed this way: “So I leave there and I’m not carrying any baggage. If I want to talk to S. about anything, I can do it and all that garbage is gone off your shoulders. I can ask her anything I want.”
Partnership

The second theme identified in relationship dimensions was that of partnership. Sub-themes that explained this aspect were the feelings of being included and being validated.

Being Included

Many participants spoke of their inclusion in the health care decisions that were being made. One young woman put it this way: “these days you have to be active in your own care because sometimes you know better than they would or where you both research, okay this is the condition, what can we do about it.” Other participants expressed the same sentiments: “together you agree on your treatment, not just you know, they don’t just set it for you”; and “it’s usually well we can do this or this and what do you think we should do and you decide together how you should approach it and I really like that.” Some patients talked about the satisfaction of being in control of their own health care: “It’s in your control. It’s like okay, I don’t want this and that’s fine, we’ll come back to it later. You don’t feel like you have to do something you’re not comfortable with”; and “if I’m not satisfied with what’s she’s telling me, she’ll say, sure I want to ease your mind.” One participant summed it up this way: “it’s my health that you’re dealing with, nobody else’s health. You know you’ve got to put your foot down in some places sometimes. If you don’t, other people are going to make decisions for you.” Patients also often commented on the availability of the NP, either by phone or e-
mail. They felt that they could contact the NP with any concerns without necessarily having to make an appointment: “actually she has her own private number you can call and leave a message”; and “it never takes more than half an hour for her to call back.”

**Being Validated**

The patients felt that in the partnership, they had a very active role. The NPs were actively listening to them and their opinions were sought and were important. One patient said “of course you have to tell her your problems, and she works them out” and another said “she’ll sit down and go over things with you and ask you what your problems are.” Listening was the skill that was highlighted: “She asks me like what’s wrong with you...She listens”; and “They seem to be very thorough and they’re very interested in what you’ve got to tell them and they’ll listen.” Again, the time factor seemed to be a strong influence: “She actually takes the time to sit and listen to you and talk over the thing that you’re there for.”

**Respect**

The third theme that was evident in participants’ descriptions of the relationships was that of respect. They felt that they were treated as individuals with legitimate feelings and concerns. There were two sub-themes that contributed to this reaction – personal recognition and the feeling of being valued.


**Personal Recognition**

The participants felt that the NPs’ personal characteristics added a great deal to the relationship. They identified qualities such as “caring”, “accommodating”, “understanding and a very nice person”, “just so personable”, “very helpful”, “honest”, and “easy to talk to” being expressed. The patients said that this personable attitude began with the first visit and had never wavered in the time they had been visiting the NP. A couple of respondents commented on their comfort in being addressed by their first names, rather than a more formal “Mrs.” or “Ma’am”. The positive feelings that patients expressed included the word ‘love’ a couple of times, and one elderly lady expressed her happiness with “I get a hug every time I leave”.

**Being Valued**

The theme of time that was discussed earlier allowed the patients to feel that they deserved to be listened to and that they could ask any question that they might have. They said “she seems to have all the time you need” and “Honestly, she just took the time that was needed”. One participant described it this way: “she'll take the time ... with any extra questions we might have or just refer back to anything you might have brought up or touch base on something else that we might have missed earlier at an appointment.”

Feeling valued was also reflected in comments regarding the interest in the patient’s condition that was shown by the NP. One
participant whose first visit to the NP was for the purpose of having a physical examination for work said: “she was I think more concerned with my general health than the people who produced that form,” and another said: “you get a little more attention or TLC or whatever from a nurse practitioner.” Other comments reflecting the feeling of being valued included those of being treated “like an equal”, and “like talking with family member”, or descriptions of mood or attitude “She’s not down-hearted or she’s not bitchy”... “she’s always polite.” One male patient talked about the way that he felt valued because of the way the NP presented information to him:

I think she can read your personality. I run a call centre. I’m an outsourcer, so it’s basically metrics...so for the first couple of times I went to see her she would give me my metrics...what she did one day is she actually went in and made a bar graph and charted it out for me. And I looked at it and automatically with my business sense and looking at graphs and charts every day...once I saw it in that format, that was it... I wanted to get everything down, get that chart going in the right way.

The themes identified in the data analysis are presented in Figure 1. The patient and the NP are shown in a primary health care relationship. The double-ended arrow signifies the relationship that existed between the patient and the NP. The dimensions of the relationship that were identified as important to the participants are depicted as pillars. At the base of each pillar are the sub-themes that were identified by the participants and contributed to the identification of each dimension. The dimension of knowledge represents the way that the patients felt informed and the confidence that they had in the NPs’
knowledge. The dimension of partnership signifies that the patients felt included and validated in the relationship. The dimension of respect illustrates that the participants felt that their opinions were valued and that they were being treated as individuals deserving of time and attention. The arrow moving from the patient through the dimensions and out the other side reflects that the patient entered the relationship with vague expectations and making comparisons with previous forms of primary health care. The experience of participating in the relationship results in new emerging health care expectations. All of the findings in this study came from the patients. Therefore, the themes and dimensions are reflected as the patient’s experience going through the relationship.

Figure 1. Patient Experiences with the New Nurse Practitioner Role in New Brunswick Canada
During data analysis, reflective memos were consulted regularly to examine the influence of reactivity in the process. Paterson’s (1994) framework, which includes attention to emotional valence, distribution of power, goals and the importance of the interaction, and normative or cultural criteria, was used to frame these notes. No areas of controversy were found between my observations and the interpretation of the data. I felt that I related well with the participants, and that a large part of my acceptance was due to the fact that I was a nurse. Part of the ease of the conversations may have arisen because of my experience and skill with interviewing, but the participants’ general high regard for nurses was also evident throughout the interviews. My assumptions going into the research (see Appendix B) may have had an influence on the data collection and interpretation as the findings corresponded to what was expected. Also, these findings raise a question about the kinds of responses that may have occurred in a sample of patients who did not have such a high regard for nurses.

After all of the interviews were completed and initial coding of the data begun, a short story was composed of a patient’s experience with visiting a NP for primary health care in New Brunswick based on information from the interviews (see Appendix H). I mailed this story to each of the participants and asked for their feedback on how the story related to their experience (see Appendix I). I received ten responses back. All ten respondents answered ‘yes’ to the first question as to
whether the story reflected their experiences. When asked if there had been any experiences that would change their opinion in any way, seven of the participants said no and added favorable comments. One participant was upset because her NP had left the area. One participant said that his NP was taking on too many patients and that because the wait time for an appointment had increased, he had registered with a new doctor in the area. One participant had this comment: “She is helpful as a NP in that my health needs are being met, but she can be judgmental when certain issues are addressed and I think this is not a good quality for someone in the health care field to have.” Nine of the respondents replied ‘yes’ to the question about whether the story included all of the important things they had told me, adding descriptors such as “service, promptness, thorough” and comments about “access to care, teamwork with doctor, and follow-up care”. The one respondent who answered ‘no’ to this question was the same one who had decided to move to the new doctor and he recommended that more NPs be hired for the area.

Discussion

Once the initial analysis was complete the focus shifted from one of description of the data to interpretation, asking “What have I learned from this?”(Thorne et al., 1997). The findings in this study correlate with findings from previous studies of patient experiences with NPs. However, in this study, patients were given more freedom to explain what the
The experience of visiting a NP for primary health care is like for the patient. The results give a clearer picture of the traits of a healthcare provider that can have an impact on the recipient of care.

Only one participant specifically identified the setting as being influential in her perception of ideal health care “She has things to make you comfortable. It’s fun sitting on a couch versus a hard chair...that just gives you courage.” Almost all of the participants visited the NP in Community Health Centers and they were pleased with the services that were provided in these centers. If they needed to have blood tests or x-rays done or a referral to a dietician, these centers had these services available. Collaborative care was a strong positive issue for them. They appreciated the close practicing relationship the NP had with a physician: “she works side-by-side with the doctor which is good” and “I know I feel more secure knowing that she has gone to the doctor and discussed it with the doctor and come back.” The literature also shows strong support for NP practice in collaborative primary health care.

Sidani, Irvine and DiCenso (2000) surveyed 166 NPs and found that the most positive aspects of their role were: “autonomy, independence, NP-client relationship, collaboration, and being part of a multidisciplinary team” (p.17). Hupcey’s (1993) survey of 91 practicing NPs showed that primary health care with collaborative support was the setting that was most conducive to their practice.
Patient demographics and patient characteristics were not examined for correlation with what patients said about their experiences with NPs in this study. Participants were most verbal when they compared NP practice to previous experience with primary care providers. The most common remarks were about the time that the NPs allotted to patient visits. Participants were surprised and pleased that the NPs took the time to listen to their questions and concerns and also devoted time to explanations and teaching: “She takes the time to talk to you, which we’re not used to really.” They also commented on not having to spend a lot of time in the waiting room: “They’re on time, all the time”; and “I don’t have to wait a long time.” Previous research looking at patient satisfaction with NP services has shown similar findings in that patients noted decreased waiting time and more time spent in consultations as being factors that positively influenced their satisfaction levels (Cintron et al., 1083; Kinnersley et al., 2000, & Litaker et al., 2003). This finding was well substantiated in the data, however, the reasons for it are more likely related to structural issues. The NPs were paid by salary, and their workloads were determined by the administration of the facilities in which they were practicing. Therefore, they were allotted ample time for each patient visit. Organization and priority setting were skills that still needed to be applied, but for the most part, the NPs did not feel pressured to compress patient visits into unreasonable time frames.
Many practicing physicians in New Brunswick receive their remuneration through Medicare and they bill according to the number of patient visits. This exerts control over a budget that includes office expenses and the bottom line of salary. As a result, physicians may book a large number of patient visits into their workday and patients may feel that they are cheated on time and attention. One participant noted that he had left the NP’s practice because of this very issue. He felt that the NP was being pressured to take on too many patients. This may be an unfortunate sign of future changes in the system that will undoubtedly affect the way that patients feel about NP practice.

The role of patient expectations was also a significant finding in this study. Expectations are often seen to be strongly related to patient satisfaction (Ross et al., 1987). Previous research that included patient expectations as variables when assessing patient satisfaction found conflicting results and advised that expectations are difficult to explicate and can range from interpersonal qualities to improvements in physical health (Oberst, 1984; Kravitz et al., 1996; Peck et al., 2004; McKinley et al., 2002). In this study, participants found it difficult to verbalize specific expectations when asked, but did explain what they had grown to expect from their visits with NPs. These expectations included traits such as warmth, good rapport, taking the time, allowing for patient decision-making, having everything ready for the visit, and follow-up.
The dimensions of the relationship identified the important concepts that made a difference when visiting NPs for primary health care in this study. The dimensions of knowledge, partnership and respect reflected patient outcomes of being confident, informed, included, validated, recognized as individuals, and valued. They were impressed by the knowledge of the NPs. The word “thorough” was used several times in describing the ways in which the NPs investigated their complaints. Again, the reassurance that the NP would consult whenever necessary was an important consideration: “if I have to go to a doctor, then she will sure get me to one”; “if I had to go to the hospital for anything…there would be a doctor [to] look after me”; and “if I needed a doctor or specialist or something, she could refer me to them…I have been to two.”

Being confident in the NPs’ knowledge and decision-making was a common thread throughout the interviews. They felt that the NPs had adequate preparation for the job, but they also frequently mentioned the collaborative relationship they had with physicians and that they knew that the NP would consult whenever necessary. The competence of NPs has been noted in previous research (Chang et al., 1999; Cintron et al., 1983; Mark, Byers & Mays, 2001; Mundinger, 1994; Ramsay, 1983), however, the patient’s perspective has not been well documented in the literature. The preference for collaborative practice was evident in research of NPs themselves, but this confidence in knowing that the NP could consult a physician at will is a new finding from this study.
Another feeling that the patients expressed in this study was that of being informed. They felt that they were given full and accurate explanations about any tests that they were having, any medications that they were prescribed, and the plan of care. This was also a common finding in previous research, particularly in studies that compared the practice of NPs to other primary care providers (Cintron et al., 1983; Kinnersley et al., 2000; Litaker et al., 2003; McMullen et al., 2001).

The partnership dimension was demonstrated by the participants’ recognition of feeling included and validated. The experience that the participants expressed of being included in the plan of care has also been evident in other studies of NP practice. Litaker et al. (2003) described one area of improvement in patient satisfaction as ‘self-management’, while Langner & Hutelmyer (1995) noted a significant difference between NPs and physicians (79.3%/47.4%) in “willingness to include them in the plan of care” (p.57). One of the younger participants in this study summed it up well when she said: “you actually get to know them and feel like you’re involved with your own treatment and that’s essential.”

The perception of feeling validated was a new finding from this study, although previous studies have reported such issues as longer consultations (Kinnersley et al., 2000) and taking the time to listen and communicate with patients (Brooks & Phillips, 1996) which may reflect the sub-dimension of feeling validated.
Under the dimension of respect, participants spoke of being recognized and treated as individuals. This came to be regarded as an expectation of their practice. Participants particularly noted attitudes such as “very nice”, “accommodating”, “easy to talk to”, “good rapport”, “helpful”, and “polite.” These findings may be related to the background of the NPs in this study. They had all practiced nursing for many years before becoming NPs and they brought many of the caring attributes of nursing to the role of primary health care provider. One participant noted “I think because she was a nurse before, she has more bedside manner”; and another said “they’re used to dealing with patients on a different level.” These traits have also been shown in previous research to be highly regarded by patients and indicators of quality care (Langner & Hutelmyer, 1995; Drain, 2001; Campbell et al., 1990; Brooks & Phillips, 1996).

Positive personal interaction is often recognized as desirable in health care relationships, often resulting in better health outcomes and increased likelihood of following advice (Walker, Arnold, Miller-Day & Webb, 2002). Previous research findings reported such things as ‘better rapport’ (Cintron et al., 1983), and ‘sensitivity to patients’ needs’ (Drain, 2001) as being indicators of patient satisfaction. Steine, Finset & Laerum (2001) conducted a study to look at patient experiences with physician primary care using focus groups and found that personal interaction rated very high in assessing satisfaction with visits. As one participant in
this study said: “she’s just so personable that you just feel comfortable right away.”

The perception of being valued that was expressed in this study has not been documented as such in previous studies. Because most of the studies that focused on patient satisfaction with NP care were quantitative and used survey questionnaires, this phenomenon was not included as part of the data collection. Future studies might examine how the dimension of feeling validated correlates with: availability of the NP, decreased waiting time (Cintron et al., 1983; Oerman, 2000), and access to the NP between visits (Langner & Hutelmyer, 1995).

The recognition of the dimensions of knowledge, partnership and respect could be seen as indicators of satisfaction with care. Patient satisfaction has been shown to correlate with quality health care (Fitzpatrick, 1991; Linder-Pelz, 1982; Mahon, 1996; Williams, 1994; van Campen et al., 1995) but has been studied almost exclusively through quantitative methods. This study helped uncover some dimensions which may underlie satisfaction or quality of health care.

The findings in this study have expanded greatly on themes identified in the one previous qualitative study (Rico, 1997) of patient responses to visiting a NP. In that study, themes of NPs’ existential presence, amiability of approach, individualized concern, and co-working in care were reflected in patients’ descriptions. This study provided information on the dimensions that patients value in a healthcare
provider–patient relationship, how the relationship compared to previous health care experiences, and the role that expectations played in responses to the relationship.

Interpretation

In interpreting the data, the exploration of patient expectations was a revealing dimension. When participants in this study were asked directly about their expectations of a primary health care provider, they gave vague and nonspecific answers: “Usually I have a specific reason and I just want somebody to deal with it”, “I don’t want to have to keep going, going and going and not getting answers”, and “to find out what’s wrong with me”. These patients had formed their expectations from the primary health care that they had received in the past. However, their revelations of describing the care that they had received from the NPs revealed that their experiences had been beyond what they had experienced in the past and as a result, new expectations were formed, for example “No, to take the time to say oh you might have another problem, let’s look into that, let’s get you in to see somebody. I’ve never come to expect that from a doctor”.

These new expectations became most evident when they compared NP practice to previous experience with primary care providers. The patients were most impressed with the time allotted to the visit. They thought that this provided the opportunity to discuss all of the issues that concerned them as well as to be informed about medications or tests
that had been ordered or completed. There were also differences in attitudes and personality traits of the NPs that were appreciated and mentioned as emerging expectations: “I always look for warmth”, to “have a good rapport”, to “follow up”. The collaborative nature of the practice was also an important element to the patients. They felt confident in the realization that the NP could consult a physician easily to discuss any areas of uncertainty and could also refer patients to a specialist when necessary: “if she can’t figure out the problem, she’ll send you to someone else who can.”

The finding that patients may base their expectations in primary health care on previous experience raised a question about sources of consumer education regarding health care. What do patients know about what they should expect in a health care relationship? An internet Google search on “quality health care” revealed 165,000,000 possible sites on this topic. A literature search of health and lay sources yielded some interesting insight into what patients may have been told about what to expect in primary health care relationships. An internet database *Health Source – Consumer Edition* listed many articles that would explicate the ideal provider-patient relationship, for example “When to Switch Doctors”, “Customer Comes First: Health Care’s Motto”, “Don’t Be a Wimp in the Doctor’s Office”, and “Did the Doctor *Hear* You?” (Customer comes, 1995; Did the doctor, 1997; Frishman, 1996; When to, 1993). In a study that looked at how the internet teaches consumers...
about quality health care, Oermann, Lesley, & Kuefler (2002) indicated that patients are able to use the internet to learn about what to expect from health care. They recommend that a list of credible web sites be provided to patients in physicians’ offices and clinic waiting rooms to ensure that the information they are accessing is valid. An example of a website that focuses on health care quality is a branch of the US Department of Health and Human Services – the Agency for Healthcare Research and Quality. This site gives the consumer a list of expectations that they should have in a health care relationship: the opportunity to talk to the practitioner about medications and x-ray or laboratory tests; the right to have all questions answered; the knowledge that the practitioner is aware of the latest scientific evidence surrounding the condition; and treatment options (Improving Healthcare Quality).

Federal health care initiatives in Canada tend to focus on system-wide issues such as the principles of the Canada Health Act, which are public administration, comprehensiveness, universality, portability and accessibility. When quality of patient care is discussed, access to health care services, shorter wait times for surgery and tests, and overcrowded emergency rooms seem to be the most popular topics. The federal government in Canada relinquishes much of the responsibility for health care to the provinces, so that concerns for the individual are seen to be in that realm.
The whole discussion of finances seems to be at the heart of reasons patients are not always receiving the full range of what is recognized as quality healthcare. Both health care systems in Canada and the US have become highly bureaucratized and highly impersonal with more focus on the bottom line than on patient care (Glennon, 2004). In the US, the advent of managed care in the late 20\textsuperscript{th} century has created a system in which physicians feel pressured to cut patient visits short and see more patients (Managed health care; Salgo, 2006). In Canada, the government controls health care dollars and physicians bill on a fee-for-service basis. In this system, the doctor-state relationship replaces the doctor-patient relationship, and physicians fit more and more patients into the daily schedule and are sometimes encouraged to perform unnecessary services to drive up their income (Canadian health care, 2002). As one informant in this study pointed out, many physicians in this province have instituted a practice whereby patients are allowed to talk about one complaint only per visit. If they have another symptom that they want examined, they must make a separate appointment. This allows the physician to bill separately for each visit. In direct opposition, one family physician in North Carolina wrote an article about his decision to establish a practice in which he would see only 10 to 12 patients a day and would require patients to pay for his services and later submit the invoice to health insurance plans. He has always invested ample time to really listen to his patients and his 16-year
practice is flourishing. His practice is an example of what primary health care should be (Dykes, J., 2004).

This examination of the interplay of forces in today’s health care system may explain why patients are not informed and do not experience the kind of health care that they should expect. The NPs in this study were true to the principles of primary health care that had been an underpinning of their education. The service that these patients received from the NPs was something that they had not experienced before. Because the NPs were paid by salary and were provided with ample time for each patient, patients were able to receive the benefits of individualized attention and information. Another reason may have been that all of the NPs in this study had practiced nursing for many years before becoming NPs and they brought many of the caring attributes of nursing to the role of primary health care provider. One participant noted “I tell them she cares. She’s very helpful and very thorough”, and another said “So I appreciated the fact that she was honest...I’m not sure doctors do that”. These traits have also been shown in previous research to be highly regarded by patients and indicators of quality care (Langner & Hutelmyer, 1995; Drain, 2001; Campbell et al., 1990; Brooks & Phillips, 1996).

Conclusion

The initial research question that guided this study has been answered. The role that expectations played was most surprising.
Patients were not aware of what they should expect in a primary health care relationship, however, new expectations were formed as they began to have more experience with the NPs who had been educated under the primary health care model. The patients’ initial responses to the role of the NP were somewhat guarded, but they soon became comfortable and confident with the collaborative practice model. The patients described in great detail what the experience of visiting a NP for primary health care was like for them and very often used comparisons to previous forms of health care to elucidate their feelings.

The findings from this study show that patients’ perceptions of NPs are strong and positive in the province of New Brunswick. The role of NP is very new in this province and very few patients have had the opportunity to visit a NP for primary health care. The patients who participated in this study are more than satisfied with the service that NPs provide. They have expressed that this type of primary health care should be more accessible throughout the province. In addition, this study has provided a comprehensive picture of patient preferences in primary health care. Although these patients were not aware of what they could expect in a primary health care encounter before they began seeing NPs, they formed expectations and opinions that would influence them in future decisions. These options may include; how and why they may make decisions about provider choice, their preferred level of
involvement in care, the extent to which they wish to be informed about their health care, and how they wish to be treated in the relationship.

Limitations of the Study

The findings from this study are based on a sample from a small province in Canada. Most of the NPs in this study were new graduates from a new NP program. The results of the study may have been different in a different population or if people who had had a negative experience with a NP had been sought out. However, because of the qualitative design of the study, the findings are grounded in actual patient experiences. Consumers of health care share many of the same opinions and values regardless of their place of residence or status.
Chapter 5

Summary and Recommendations

Summary

This study examined the experiences of patients visiting a NP for primary health care in New Brunswick, Canada using an interpretive description design. Seventeen patients who had visited one of eight NPs for a period of at least six months were interviewed. An interview guide was used, but participants were allowed to lead the conversation in whatever direction best reflected their experience. Findings showed that these patients were both surprised and satisfied with the service that they received while in the care of these NPs. The initial findings were comparisons with other health care providers, the role that expectations played in the relationship, and the dimensions of knowledge, partnership and respect that were recognized as central in the interactions with NPs. When revealing their responses to the service, the patients identified elements that have been discussed as being essential to a positive health
care provider-patient relationship. These patients had not experienced this type of health care before.

The findings of the study illuminated the role of expectations in relation to patient satisfaction. Although expectations may be clearly explicated in patients’ bills of rights and numerous other sources that are readily available to the average consumer, it appears that individual expectations are formed through experience. The participants in this study were vague and unclear when asked to enunciate their expectations in a primary health care relationship. However, they were generous in their comments concerning the aspects of the relationship that they had come to expect through visiting NPs for primary care. These patients will be much more discriminating if they are forced to choose different primary health care providers in the future because of the expectations that they have formed through these experiences. They will no longer be satisfied with the speedy checkout line – one item only, or waiting two or three hours for a 10-minute hurried visit.

The study also brought to the surface some of the problems that are infecting health care systems in Canada and the US. Finances have become the controller of the ways that primary health care is being delivered. In the US, it is the managed health care plans that are pushing primary care providers to be more productive – to process more patients in shorter time periods. In Canada, the government-run health care system encourages the same treadmill approach, as physicians are
remunerated based on quantity. The issue of quality of care has been taken out of the hands of the consumers of health care. If consumers controlled the purse strings, health care providers might be more inclined to earn remuneration based on service and respect, rather than quantity.

Recommendations for Future Research

The literature review showed that ample quantitative research studies have examined patient responses to NP practice. There have been very few qualitative explorations of the NP-patient relationship to provide a base for direction of quantitative study. The NPs in this study were new practitioners in the field of primary health care in New Brunswick, Canada. Six of the eight NPs in the study were new graduates of the first NP program in New Brunswick, Canada. Therefore, the principles that they had learned regarding ideal primary health care relationships were fresh in their minds and they also recognized that their practice would be scrutinized as to their abilities as new primary health care providers. The interpretive description methodology in the current study allowed participants to share their experiences with the researcher. That patients’ responses were spontaneous showed that their efforts were well received and appreciated. More qualitative research with a different population of NP providers may provide different outcomes.

This study unearthed dimensions through patient revelations that would not have come to light using previously existing questionnaires.
The relationship dimensions that were identified in this study were indicators of what patients value about NP care. Knowledge, partnership and respect were heralded by patients as being components of a successful primary care relationship.

The dimension of knowledge is particularly interesting based on the recent thrust to encourage nurses to own and celebrate their knowledge (Gordon & Nelson, 2006). Nurses are in a unique position in their interactions with consumers of health care. They are seen as experts in the field and as guides or advocates for patients as they steer their way through an unfamiliar system in which they may be feeling particularly vulnerable. Nurses must recognize their own education and experience and move towards adopting a knowledge-based identity (Gordon & Nelson, 2006). Nurse educators need to be more influential in promoting nursing as a knowledge-based profession. More research needs to be done in this area of exploring the influence of nurses’ knowledge on patient outcomes of being informed, confident and proactive.

The dimension of respect in the relationship has been researched extensively, but the dimension of partnership is gaining favor in considerations about the future of nursing. More research on patient/provider partnership could provide information on the influences of patient participation on health care outcomes, and patient perspectives on their roles in health care.
This study provided knowledge about the role that expectations can play in health care relationships. The literature surrounding primary health care expounds on the expectations that patients should have regarding care from a primary care provider. These are the kinds of expectations that these patients formed through their relationships with these NPs. This study showed that people base their expectations on what they have already experienced. More research is needed to examine this dynamic of expectations. If patients were fully informed as to what they should expect in an ideal health care relationship, would the levels of patient satisfaction show a dramatic decrease?

This study could be replicated in different settings in which NPs work; acute care, chronic care, or an emergency department, to examine whether patient responses were similar to the results found in this study. New studies could also focus on clinical outcomes and the correlation with partnering and self-care behavior.

Some health care policy issues were uncovered by this study. There needs to be more research in this area to further illuminate the effects of different models of health care delivery.
REFERENCES


# APPENDIX A
## Chart of Research Studies

<table>
<thead>
<tr>
<th>First Author</th>
<th>Study Title</th>
<th>Purpose</th>
<th>Setting</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson</td>
<td>A qualitative analysis of women's satisfaction with primary care from a panel of focus groups in the national centers of excellence in women's health</td>
<td>- to elicit women's views on primary health care needs, preferences for care, and definitions of quality</td>
<td>6 National Centers of Excellence in Women's Health</td>
<td>Focus groups = 18 N=137</td>
<td>Descriptive</td>
<td>Focus groups</td>
<td>Women's health viewed as being holistic, involving mental and emotional health and counselling Categories outlined in table</td>
</tr>
<tr>
<td>Bagwell</td>
<td>Client satisfaction with nursing center services</td>
<td>- to determine client satisfaction</td>
<td>Clemson University Nursing Center</td>
<td>N=78</td>
<td>Descriptive</td>
<td>23-item questionnaire</td>
<td>Clients satisfied to very satisfied with care</td>
</tr>
<tr>
<td>Banahan</td>
<td>Evaluation of the use of rural health clinics: Knowledge, attitudes, and behaviors of consumers</td>
<td>- to identify factors affecting the use of rural health clinics - to draw up recommendations for increasing their use</td>
<td>Four rural health clinics in Mississippi</td>
<td>Four study clinics N=100 users N=100non-users</td>
<td>Exploratory</td>
<td>Telephone Interview - schedule prepared by research institute</td>
<td>Favorable attitudes towards NPs, but reduced knowledge of role</td>
</tr>
<tr>
<td>Barr</td>
<td>Patient satisfaction with a new nurse practitioner service</td>
<td>- to gauge patient satisfaction - to compare reading of x-rays to Senior House Officers - to obtain other professionals’ assessments</td>
<td>Accident and Emergency department in UK</td>
<td>N=241 x-rays = 85 N=4</td>
<td>Descriptive</td>
<td>Self-developed questionnaire Comparison with radiologist report Non-structured interview</td>
<td>High levels of patient satisfaction High level of accuracy in x-ray interpretation Strong support from other professionals</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Study Objective</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Design</td>
<td>Data Collection</td>
<td>Results/Conclusion</td>
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<tr>
<td>Bear (1998)</td>
<td>Using a nursing framework to measure client satisfaction at a nurse-managed clinic</td>
<td>To investigate and evaluate the reliability and validity of the Client Satisfaction Tool – developed to measure client satisfaction with a nurse practitioner model of care</td>
<td>Senior’s Health Clinic</td>
<td>Convenience sample of 39 clients</td>
<td>Descriptive correlational</td>
<td>5-minute telephone interviews by non-clinic staff</td>
<td>Satisfaction high Elements of client-professional interaction demonstrated Results supported reliability and validity of instrument</td>
</tr>
<tr>
<td>Brooks (1996)</td>
<td>Do women want women health workers? Women’s views of the primary health care service</td>
<td>- to explore key aspects of women’s views of women GPs and practice nurses in primary health care settings</td>
<td>UK northern industrial city</td>
<td>N=1251 for postal questionnaire N=70 for in-depth interview</td>
<td>Exploratory</td>
<td>Postal questionnaire Interview</td>
<td>Having access to female provider important in matters of reproductive or sexual health, or intimate discussions of psychosocial issues Most important was having a worker who was approachable, understanding and took time to listen</td>
</tr>
<tr>
<td>Campbell (1990)</td>
<td>Collaborative practice and provider styles of health care</td>
<td>- to examine provider’s style of interaction with the patient and to compare styles of NPs and physicians in joint practice</td>
<td>60 ambulatory clinic sites (US)</td>
<td>412 provider/patient clinic visits 276-physicians 136-NPs</td>
<td>Quasi-experimental</td>
<td>Examining videotaped encounters in examination room Bales Interaction Process Analysis System - objective-oriented taxonomy developed for study</td>
<td>Somatic diagnosis/treatment received most attention. Little difference between NPs and physicians, but NPs exhibited significantly more concern for psychosocial issues</td>
</tr>
<tr>
<td>Study</td>
<td>Title</td>
<td>Methodology</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Design</td>
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<tr>
<td>Chang (1999)</td>
<td>An evaluation of the nurse practitioner role in a major rural emergency department</td>
<td>- to compare work on wound management and blunt trauma between NPs and medical officers - to assess patient satisfaction</td>
<td>Emergency department Australia</td>
<td>N=169</td>
<td>Experimental</td>
<td>Documentation of treatment received</td>
<td>Very positive outcomes of treatment</td>
</tr>
<tr>
<td>Cintron (1983)</td>
<td>Nurse Practitioner role in a chronic congestive heart failure clinic: In-hospital time, costs, and patient satisfaction</td>
<td>- to compare in-hospital time, medical costs and patient satisfaction before and after the introduction of a NP in a cardiac/congestive heart failure clinic</td>
<td>San Juan Veterans Administration cardiology clinic</td>
<td>N=15</td>
<td>Quasi-experimental</td>
<td>Compared numbers of hospitalizations, total hospital days and medical costs, Satisfaction measured by mailed questionnaire</td>
<td>Most dramatic change was marked diminution in number of hospitalizations and hospital days, Marked increase in education by NPs, Satisfaction increased because of availability of NP, decreased waiting time and better rapport</td>
</tr>
<tr>
<td>Cole (1999)</td>
<td>Search and research: Quality improvement: Psychometric evaluation of patient satisfaction with nurse practitioner instrument</td>
<td>- to determine psychometric properties of an instrument designed to measure satisfaction with care provided by NPs</td>
<td>University of Texas Health Services at Houston</td>
<td>N=182</td>
<td>Psychometric evaluation of instrument</td>
<td>Anonymous questionnaire developed for this study</td>
<td>Scale showed high internal consistency and reliability estimates, Validity also supported, Mean scores showed satisfaction with NP care</td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Setting</td>
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<tr>
<td>Drain (2001)</td>
<td>Quality improvement in primary care and the importance of patient perceptions</td>
<td>Pilot study - 85 physician offices with 270 care providers across five states. Full study – 658 medical practices with 1130 care providers in 20 states.</td>
<td>N=5196</td>
<td>N=84,290</td>
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<tr>
<td>Drury (1988)</td>
<td>A nurse practitioner in general practice: Patient perceptions and expectations</td>
<td>General practice in UK</td>
<td>N=126</td>
<td>Exploratory, Mail-out questionnaire. 60% approved on concept of NP 53% willing to see NP again 54% couldn’t differentiate role.</td>
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<tr>
<td>Author (Year)</td>
<td>Title</td>
<td>Research Questions</td>
<td>Study Sample</td>
<td>Study Design</td>
<td>Data Collection</td>
<td>Findings/Conclusion</td>
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<td>Geier (2000)</td>
<td>The evolving role of the acute care nurse practitioner</td>
<td>- to obtain acute care nurse practitioners’ perceptions of their role</td>
<td>5 acute care specialties</td>
<td>N=7</td>
<td>Descriptive</td>
<td>Interviews</td>
<td>Revealed emphasis on collaborative relationships, Increased visibility, value, power and prestige, Blending nursing and medicine</td>
</tr>
<tr>
<td>Haq (1993)</td>
<td>Understanding older adult satisfaction with primary health care services at a nursing center</td>
<td>- to describe the levels of satisfaction &amp; relationship between satisfaction levels and demographic characteristics</td>
<td>Geriatric Nursing Center in small southwestern city (US)</td>
<td>N=156</td>
<td>Correlational</td>
<td>Risser Patient Satisfaction Survey</td>
<td>Subjects generally satisfied, Positive response bias evident, Demographics not an issue</td>
</tr>
<tr>
<td>Hupcey (1993)</td>
<td>Factors and work settings that may influence nurse practitioner practice</td>
<td>- to explore whether work settings were more conducive to practice - to see what factors helped or hindered practice</td>
<td>State of Pennsylvania</td>
<td>N=80</td>
<td>Descriptive</td>
<td>Mail-in questionnaire</td>
<td>Primary care settings appeared to be the most favorable, Presence or absence of support most influential</td>
</tr>
<tr>
<td>Kaisser (2003)</td>
<td>Financial and organizational factors affecting the employment of nurse practitioners and physician assistants in medical group practices</td>
<td>- to analyze the financial and organizational factors associated with employment of NPs and PAs</td>
<td>Medical group practices in Minnesota</td>
<td>N=128</td>
<td>Exploratory</td>
<td>Mail-out questionnaires</td>
<td>Employment of NPs and PAs is related to organizational characteristics of group, but not by degree of financial risk, Large practices, rural, and not-for-profit practices more likely to hire</td>
</tr>
<tr>
<td>Kinnersley (2000)</td>
<td>Randomized control trial of nurse practitioner versus general practitioner for patients requesting “same day” consultations in primary care</td>
<td>- to ascertain any differences between care from nurse practitioners and that from general practitioners for patients seeking “same day” consultations in primary care</td>
<td>General practices in South Wales and southwest England</td>
<td>N=1368</td>
<td>Randomized control trial</td>
<td>Consultation satisfaction questionnaire</td>
<td>Outcomes –</td>
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<tr>
<td>Knudtson (2000)</td>
<td>Patient satisfaction with nurse practitioner service in a rural setting</td>
<td>To assess levels of satisfaction To examine relationships between satisfaction and demographics, patients characteristics, expectations, and likelihood of recommendation to others</td>
<td>Four rural primary care clinics</td>
<td>N=93</td>
<td>Descriptive Correlational</td>
<td>Nurse Practitioner Satisfaction Instrument developed by researcher</td>
<td>Overall high levels of satisfaction</td>
</tr>
<tr>
<td>Kravitz (1996)</td>
<td>Prevalence and sources of patients’ unmet expectations for care</td>
<td>- to examine the factors that influence patients’ expectations for care in office practice</td>
<td>Internal medicine practices in northern California</td>
<td>N=688</td>
<td>Descriptive</td>
<td>Telephone interview</td>
<td>Unmet expectations for care noted</td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Instrument and Methodology</td>
<td>Findings</td>
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</table>
| La Monica  | Development of a patient satisfaction scale                           | Instrument development to produce a more valid, reliable and sensitive measure of patient satisfaction— three studies | N=75 N=45 N=710 | Instrument development and testing Risser Satisfaction Scale Factor analysis                 | - greater sensitivity was not achieved  
- did not support 3 dimensions of practice identified  
- expectations change over course of illness                                                                                                                                                                  |
| Langner    | Patient satisfaction with outpatient human immunodeficiency virus care as delivered by NPs and physicians | to evaluate patients’ satisfaction with overall primary care and to compare satisfaction on specific issues between NPs and physicians | N=52        | Descriptive Questionnaire developed for study                                                 | Process issues - NPs- Better waiting time, more helpful and knowledgable, & better continuity of care                                                                                                     |
| Larabee    | Patient satisfaction with nurse practitioner care in primary care     | To compare patient satisfaction scores among NPs working in four primary care clinics | N=43        | Descriptive DiTomasso-Willard Patient Satisfaction Questionnaire (designed for assessing satisfaction with physicians) | High satisfaction with care  
Questions raised about possible influences of patient and provider characteristics                                                                                                                                                                          |
<table>
<thead>
<tr>
<th>Author</th>
<th>Study Title</th>
<th>Research Question</th>
<th>Department/Setting</th>
<th>N</th>
<th>Study Design</th>
<th>Outcomes</th>
<th>Findings</th>
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<tr>
<td>Litaker</td>
<td>Physician-nurse practitioner teams in chronic disease management: The impact on costs, clinical effectiveness, and patients’ perceptions of care</td>
<td>- to compare selected outcomes for a new chronic disease management program using NP-physician team to traditional care</td>
<td>Department of General Internal Medicine – Cleveland Clinic</td>
<td>157</td>
<td>Quasi-experimental</td>
<td>Clinically observable parameters (HbA1c, HDL and BP) Health Survey Short Form Diabetes Quality of Life Questionnaire Patient Satisfaction questionnaire</td>
<td>In team-treated group- - More evidence of teaching and preventive care - Better HDL and HbA1c levels - More time spent with patients - Satisfaction levels higher - Higher costs and number of visits</td>
</tr>
<tr>
<td>Mangen</td>
<td>Patient satisfaction with community psychiatric nursing: A prospective controlled study</td>
<td>- to compare satisfaction levels of outpatients visiting community psychiatric nurse or psychiatrist</td>
<td>Large psychiatric hospital in south London</td>
<td>71</td>
<td>Quasi-experimental</td>
<td>Interviewer-rated questionnaire Self-report schedule</td>
<td>Nurses more approachable and sympathetic Satisfaction with nurses greater</td>
</tr>
<tr>
<td>Mark</td>
<td>Primary outcomes and provider practice styles</td>
<td>- to evaluate change in patient outcomes as a function of practice styles of primary care providers</td>
<td>Nine primary care clinics in three US army installations</td>
<td>226</td>
<td>Prospective, repeated-measures, correlational</td>
<td>Demographic and symptoms questionnaire Four outcomes questionnaires – health status, functional status, information seeking and satisfaction</td>
<td>Equivalent health outcomes for variety of practice types No significant difference in satisfaction levels</td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Objective</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Study Design</td>
<td>Data Collection</td>
<td>Findings</td>
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<tr>
<td>McKinley (2002)</td>
<td>Meeting patient expectations of care: The major determinant of satisfaction with out-of-hours primary medical care?</td>
<td>- to determine the effect of patient expectations of care on satisfaction with the care provided by an out-of-hours service</td>
<td>Large English Health Authority</td>
<td>N=2000</td>
<td>Descriptive</td>
<td>Mail-out questionnaires</td>
<td>Match or mismatch between the service that patients hope for and the service that they receive is strongly related to levels of satisfaction</td>
</tr>
</tbody>
</table>
| McMullen (2001) | Evaluating a nurse practitioner service                               | - to determine the effects of nurse practitioner service on patients’ health status  
  - to determine levels of satisfaction of patients, referring physicians and staff | University of Massachusetts Medical Center | N=405 patients from traditional service  
  N=296 patients from NP service | Evaluation | Functional Health Status Short Form  
  Satisfaction questionnaires used for patients, physicians and staff | Overall satisfaction  
  -traditional patients more satisfied with explanations of test results and less healthy overall  
  No significant differences on provider knowledge/skill or quality of care |
| Mundinger (2000) | Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial | - to compare outcomes for patients randomly assigned to nurse practitioners or physicians for primary care follow-up and ongoing care after an emergency department or urgent care visit | Four community-based primary care clinics (17 physicians) and 1 primary care clinic (7 NPs) at an urban medical center | N=1316 | Experimental | SF-36 instrument for health status  
  Satisfaction questionnaire  
  Physiologic measures – BP, peak flow, and HBA1c | - No difference in most satisfaction rates  
  - Although health status improved, no differences between practitioners  
  - No differences in peak flow or HBA1c measurements  
  - Diastolic BP readings lower for NP patients |
<p>| Oberst (1984) | Patients’ perceptions of care: Measurement of quality and satisfaction | - to provide baseline data about patients’ perceptions of the facility, quality of care, completeness and quality of information provided, and anxiety level. - to test visual analogue scales for the same purposes | Large urban cancer center | N=180 | Descriptive | Self-completed questionnaire | Showed some potential utility for the use of analogue scales to measure various facets of satisfaction |
| Oerman (2000) | Important attributes of quality health care: Consumer perspectives | - to identify attributes of health care quality and nursing care quality - to examine the relationship of consumer perspectives to health status &amp; selected demographics | Large metropolitan area of Midwestern US – waiting rooms of clinics and neighborhoods | N=329 | Exploratory | Quality Health Care questionnaire SF-36 Health Survey | Most important indicators of high-quality nursing care: - Being up to date and well informed - Communication - Enough time - Health teaching - Availability to call |
| Peck (2004) | Do unmet expectations for specific tests, referrals, and new medications reduce patients’ satisfaction? | - to describe the nature and prevalence of patients’ specific expectations for tests, referrals, and new medications, and to examine the relationship between fulfillment of these expectations and patient satisfaction | VA general medicine clinic | N=253 adult male outpatients | Prospective cohort Descriptive | Structured interviews Patient Satisfaction questionnaire | Patient satisfaction very high Satisfaction not related to whether expectations were met or unmet, except for patients expecting certain medications |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Title</th>
<th>Research Question</th>
<th>Sample Data</th>
<th>Study Design</th>
<th>Data Collection Method</th>
<th>Findings</th>
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</thead>
<tbody>
<tr>
<td>2005</td>
<td>Perry</td>
<td>The nurse practitioner in primary care: Alleviating problems of access?</td>
<td>- to explore whether the provision of a NP facilitated access to care that met the needs of patients</td>
<td>N=14 patients&lt;br&gt;N= 10 staff&lt;br&gt;N=1 NP</td>
<td>Exploratory</td>
<td>Semi-structured interviews</td>
<td>Role of NP has much to offer in improving access – several issues need addressing</td>
</tr>
<tr>
<td>1993</td>
<td>Peyrot</td>
<td>Consumer satisfaction and perceived quality of outpatient health services</td>
<td>- to examine the relationship between consumer satisfaction and willingness to recommend the provider</td>
<td>N=1366</td>
<td>Exploratory</td>
<td>Instrument development&lt;br&gt;Survey questionnaire&lt;br&gt;Factor analysis</td>
<td>Very high levels of satisfaction and willingness to recommend provider</td>
</tr>
<tr>
<td>2000</td>
<td>Phillips</td>
<td>Attitudes toward nurse practitioners: Influence of gender, age, ethnicity, education and income</td>
<td>To determine if gender, age, ethnicity, education or income influence attitudes toward using an NP</td>
<td>Four sites in Pennsylvania N=238</td>
<td>Descriptive</td>
<td>Survey&lt;br&gt;Self-developed questionnaire</td>
<td>More positive attitudes towards NP services among: - younger - higher education - previous NP experience</td>
</tr>
<tr>
<td>2000</td>
<td>Pinkerton</td>
<td>Nurse practitioners and physicians: Patients’ perceived health and satisfaction with care</td>
<td>- to ascertain whether there were differences in perceived health status or satisfaction with care between physicians and NPs</td>
<td>Managed care setting N=160</td>
<td>Quasi-experimental</td>
<td>Sf-20 Health Survey&lt;br&gt;Knudtson’s Nurse Practitioner Satisfaction Instrument</td>
<td>Perceptions of health for both groups was the same, Patient satisfaction was the same for both groups</td>
</tr>
<tr>
<td>1978</td>
<td>Pope</td>
<td>Consumer satisfaction in a health maintenance organization</td>
<td>- to examine consumer satisfaction in a single Health Maintenance Organization</td>
<td>Portland Oregon N=1650</td>
<td>Descriptive</td>
<td>Mailed questionnaire</td>
<td>Satisfaction highest in those with regular doctor, older, and rate health as excellent</td>
</tr>
<tr>
<td><strong>Poulton (1996)</strong></td>
<td><strong>Use of the consultation satisfaction questionnaire to examine patients’ satisfaction with general practitioners and community nurses: Reliability, replicability, and discriminant validity</strong></td>
<td>- to examine the feasibility of using a patient satisfaction questionnaire designed for use with general practitioner consultations as an instrument for measuring patient satisfaction with community nurses</td>
<td><strong>Three general practices in Britain</strong> - urban - suburban - deprived</td>
<td><strong>N=728</strong></td>
<td><strong>Instrument testing</strong></td>
<td><strong>Consultation Satisfaction Questionnaire</strong></td>
<td><strong>Principle components analysis</strong></td>
</tr>
<tr>
<td><strong>Pulliam (1991)</strong></td>
<td><strong>Client satisfaction with a nurse-managed clinic</strong></td>
<td>- To evaluate client satisfaction in a nurse-managed clinic</td>
<td><strong>Nurse-managed clinic Delaware</strong></td>
<td><strong>N=9</strong></td>
<td><strong>Descriptive</strong></td>
<td><strong>Focus Groups</strong></td>
<td><strong>High levels of satisfaction with meeting physical and emotional needs and location of clinic</strong></td>
</tr>
<tr>
<td><strong>Ramsay (1983)</strong></td>
<td><strong>Physicians and nurse practitioners: Do they provide equivalent health care?</strong></td>
<td>- To compare treatment outcome variables and compliance in patients treated by NPs and physicians</td>
<td><strong>Two hypertension clinics – one run by NPs and the other by physicians</strong></td>
<td><strong>N= 40 + 40</strong></td>
<td><strong>Quasi-experimental</strong></td>
<td><strong>Telephone survey</strong></td>
<td><strong>Measurements: Appointments kept, Weight reduction, Blood pressure</strong></td>
</tr>
<tr>
<td><strong>Ramsay (1993)</strong></td>
<td><strong>Types of health problems and satisfaction with services in a rural nurse-managed clinic</strong></td>
<td>- to investigate the satisfaction of clients with care provided by family NPs - to describe common health problems for which NP services were sought</td>
<td><strong>Rural nurse-managed health center in Tennessee</strong></td>
<td><strong>N=101</strong></td>
<td><strong>Descriptive</strong></td>
<td><strong>Daily records for health problem</strong></td>
<td><strong>Short questionnaire</strong></td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Research Question</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Findings</td>
</tr>
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<tr>
<td>Rhee (1995)</td>
<td>Patient satisfaction with a nurse practitioner in a university emergency service</td>
<td>To compare overall satisfaction with ER care of patients seen by NP with that of patients seen in usual fashion</td>
<td>Emergency department in Nebraska</td>
<td>N = 30 for each group</td>
<td>Quasi-experimental</td>
<td>Telephone survey researcher developed questionnaire</td>
<td>ED patients as satisfied with care provided by NP as that provided by physician</td>
</tr>
<tr>
<td>Rico (1997)</td>
<td>The experience of visiting a nurse practitioner</td>
<td>- to identify, from the perspective of the patient, essential themes of a NP-patient interaction - to describe the opportunities and limitations which arise in the visit - to identify the degree of satisfaction experienced by the patient</td>
<td>Toronto Ontario Four community health centers</td>
<td>N = 10</td>
<td>Descriptive</td>
<td>Interviews</td>
<td>Four themes identified – - NPs existential presence - Amiability of approach - Individualized concern - Co-working in care</td>
</tr>
<tr>
<td>Schneider (2002)</td>
<td>Getting to the truth? Researching user views of primary health care</td>
<td>- to obtain users’ views on the same set of primary care providers</td>
<td>19 sites in South Africa</td>
<td>N = 337</td>
<td>Descriptive</td>
<td>- Facility exit structured interviews - Focus groups</td>
<td>- Focus groups more critical of service provided - Results highly context specific - User opinion is a dynamic social phenomenon</td>
</tr>
<tr>
<td>Sidani (2000)</td>
<td>Implementation of the primary care research role in Ontario</td>
<td>- to examine the implementation of the NP role in primary care settings</td>
<td>Ontario N = 166 practicing NPs</td>
<td>Descriptive</td>
<td>Mail-out questionnaire</td>
<td>Most positive aspects of role – - Autonomy - Independence - NP-client relationship - Collaboration - Being part of interdisciplinary team</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Study Type</td>
<td>Instrument Development</td>
<td>Findings</td>
<td></td>
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</tr>
<tr>
<td>Smith (1983)</td>
<td>Determining the market for family nurse practitioner services</td>
<td>To investigate the relationships between consumer values and consumer intentions to use FNP services</td>
<td>Seattle</td>
<td>N=239</td>
<td>Exploratory</td>
<td>Structured telephone interview Self-designed instrument</td>
<td>Users are more affluent, better educated and younger women</td>
</tr>
<tr>
<td>Steine (2001)</td>
<td>A new, brief questionnaire (PEQ) developed in primary health care for measuring patients' experience of interaction, emotion and consultation</td>
<td>- to develop a new consultation-specific questionnaire on patient experiences</td>
<td>Norway</td>
<td>N= 660 for first questionnaire N= 1092 for 2nd questionnaire</td>
<td>Instrument development</td>
<td>Final questionnaire developed with 18 items based on five dimensions: - Communication - Emotions - Short-term outcome - Barriers - Relations with auxiliary staff Emphasized – interaction, emotions and outcome</td>
<td></td>
</tr>
<tr>
<td>Way (2001)</td>
<td>Primary health care services provided by nurse practitioners and family physicians in shared practice</td>
<td>- to determine what primary health care services are provided to patients by NPs and family practitioners</td>
<td>2 Eastern Ontario rural primary care practice sites</td>
<td>N= 2 NPs and 4 family practitioners 122 encounters with NP and 278 encounters with family practitioner</td>
<td>Descriptive</td>
<td>Patient encounter form Patient interview</td>
<td>Health promotion – similar for both groups Curative services – lower for NPs Disease prevention and supportive services – more for NPs Effectively Recommended incorporating NPs into collaborative practice</td>
</tr>
<tr>
<td>Zikmund (1979)</td>
<td>A factor analysis of attitudes of rural health consumers toward nurse practitioners</td>
<td>- to identify the attitudinal factors or dimensions associated with nurse practitioners (people had no experience with the role)</td>
<td>10 rural health communities in Oklahoma</td>
<td>N=205</td>
<td>Exploratory Interviews with questionnaire</td>
<td>Attitudes identified: Competency, Interpersonal, Relative performance</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B

My Assumptions

1. Many people in New Brunswick have been left with no family doctor. Their doctors have either left the province or have dropped their practices. This creates a need that can and should be partially met by hiring NPs. I was on the Board of Directors of the Nurses Association of New Brunswick when the initiative was pushed to allow NPs to practice in New Brunswick. I am aware of the accomplishment that was felt in the nursing community when the legislation was finally passed and the first NPs were hired.

2. The people of New Brunswick may be somewhat skeptical about visiting a NP for primary health care. They would never have had this experience and have normally always had access to a physician.

3. Nurses are held in high regard by the public. They are always named as one of the top professions as far as trust is concerned. Because of this, people may be more accepting of the role of NP.

4. I have worked with a few of the practicing NPs and I have a great deal of admiration for their work. I was in the NP program for a brief period and I am aware of the challenges that they have faced in becoming certified in New Brunswick. In many instances, I feel envious of their positions. If I were 20 years younger, I would definitely pursue a career as a NP.
APPENDIX C

Interview Guide

What led up to you visiting a nurse practitioner for primary health care?

What were your thoughts and feelings about being asked to visit a nurse practitioner rather than a physician for primary health care?

Tell me about what you see as the role of the nurse practitioner.

Tell me about how the nurse practitioner meets your expectations for health care.

Tell me what the experience is like when you visit your nurse practitioner.

Talk about your satisfaction or dissatisfaction with the way that the nurse practitioner includes you in your plan of care? Give me an example.

What is different about visiting a nurse practitioner compared to other types of health care providers?
APPENDIX D

Information Page

You have been identified as a potential participant for a research project entitled “Patient Experiences with Visiting a Nurse Practitioner for Primary Health Care in New Brunswick”. This research will be carried out by Trudy Hahn, a Senior Instructor in Nursing at UNBSJ and a doctoral student in Nursing at Duquesne University in Pittsburgh. Your participation would consist of an interview lasting 1 to 1 ½ hours in a location of your choice. You will be discussing your experiences with visiting the nurse practitioner for your health concerns.

If you are willing to be a participant in this study, please sign below and add your contact information. A variety of participants will be selected throughout the province based on age and gender. If you are chosen as a participant, you will be contacted by Trudy Hahn within the next few weeks to arrange a time and place for the interview.

Thank you for considering taking part in this important research.

Name (please print) _______________________________________________

Male _______________ Female _______________ Age __________

Signature _______________________________________________________

Phone number __________________________________________________
APPENDIX E

Demographic Information

Patient Initials: ______________________

Birth Date: _______________________

Address: _____________________________________________________

______________________________________________________

Phone Number: ______________________

E-Mail (if applicable): __________________________

Race: ______________ Gender: ________________

Marital Status: ______________________

Educational Background: _____________________________________

Date of first encounter with Nurse Practitioner: _______________

Frequency of visits with NP: ___________________________________

Chief medical problems: ______________________________________

_______________________________________________________________

Perception of current health status: ___________________________

_______________________________________________________________
APPENDIX F

Ethical Consents

November 7, 2005
Ms. Trudy Hahn
Department of Nursing
P.O. Box 5050
University of New Brunswick
Saint John, NB Canada E2L 4L5

RE: “Patient experiences with visiting a nurse practitioner for primary health care in New Brunswick” Protocol #0590

Dear Ms. Hahn:

Thank you for submitting your research proposal.

Based upon the recommendation of IRB members, Dr. Kathleen Sekula and Dr. Joan Masters, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45 Code of Federal Regulations 46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, under rules 46.101 and 46.110, your proposed research is approved on an expedited basis.

In accordance with federal guidelines, the IRB stamps consent forms with an approval date and one year expiration date. This stamp appears on the front page of the consent form. You should use the stamped form as the original for your copies. Please remember that there should be two copies with original signatures, one for you and one for the subject.

This approval must be renewed one year as part of the IRB’s continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form, you will need to have it approved for another year’s use.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB Chair of those changes and wait for approval before implementing them. In addition, if any procedural complications or adverse effects on subjects are discovered before the annual review, they immediately must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study’s Abstract suffices. Please keep a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study’s completion.

Thank you for contributing to Duquesne’s research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

Paul Richer, Ph.D.
Chair, IRB

C: Dr. Kathleen Sekula
   Dr. Joan Masters
   Dr. Marianne Thackeray
   IRB Records
APPENDIX F – cont’d

Institutional Review Board

January 18, 2006

Ms. Trudy Hahn
Department of Nursing
PO Box 5050
University of New Brunswick
Saint John, NB
E2L 4L5

Dear Ms. Hahn:

Re: “Patient Experiences with Visiting a Nurse Practitioner for Primary Health Care in New Brunswick”; Ms. Trudy Hahn, Department of Nursing, UNB.

Protocol: N/A

Our File 2 0905-1131

The above noted study has been reviewed and has received Final Approval by the Medical Ethics Review Board of the

Institutional Review Board, ABSC.

APPROVED:

1. Protocol (received December 6, 2005).


The Institutional Review Board for the Atlantic Health Sciences Corporation is organized and operates according to the principles of the IEC Harmonized Triptite Guidelines: Good Clinical Practice, Tri-Council Policy Statement and Division 1 of the Food and Drug Regulations.

Please note: Annual Re-Approval is due on January 18, 2007.

Please do not hesitate to contact the office, if we can be of further assistance. Best wishes as you proceed.

Sincerely,

[Signature]
Chair, Institutional Review Board

Atlantic Health Sciences Corporation.

University of New Brunswick
PO Box 5050
Saint John, NB
E2L 4L5

Research Ethics Board

December 7, 2006

Trudy Hahn
Dept of Nursing, SANE
UNB

Project Title: Patient Experiences with Visiting a Nurse Practitioner for Primary Care in New Brunswick

RBB File Number: 28-95

Dear Professor Hahn,

This is to inform you that your project has been approved as submitted.

Approval is valid from the following period: December 7, 2006, to December 7, 2006.

Informed you that the Board requires yearly updates and a final report at the completion of the project.

Since your application received an expedited review, for your information I am providing a list of current Research Ethics Board members.

Good luck with your research.

Sincerely,

[Signature]
O.C. Frisé, Chair, RED Board
Research Ethics Board

RED Members: Jean-François, Faculty of Business

EXPEDITED REVIEW

PROTOCOL STUDY TITLE: Patient experiences with visiting a Nurse Practitioner for primary health care in New Brunswick.

PRINCIPAL INVESTIGATOR: Trudy Hahn

PROTOCOL/STUDY NO.: N/A

RSR: 2006-007

DOCUMENTS REVIEWED:

- Cover letter, Expedited Review Request Form and Application Form
- Access Agreement for Non-SERHA Staff
- Research Protocol
- Approval Letters from Duquesne University and UNB
- Sanction Proposal
- CV for Trudy Hahn

DATE OF APPROVAL: February 14, 2006

On behalf of the Committee:

Diane Bishara-Loughlin, B Sc, Pharm, Chairperson
SERHA Research Ethics Board

South East
Regional Health Authority
Région de santé de l'est

February 1, 2006

Trudy Hahn
Senior Instructor
Department of Nursing - UNB
PO Box 5050
Saint John, NB E2L 4L5

RE: Patient Experiences with Visiting a Nurse Practitioner for Primary Health Care in New Brunswick

Dear Ms. Hahn:

The Research Ethics Committee has conducted an expedited review of the above-mentioned study. The Committee is pleased to grant this study ethical approval. This approval is for one year from the date of this letter. If the project extends beyond February 1, 2007, you will need to submit a written request for an extension of the approval. That letter should be accompanied by a summary of the project to that time and number of participants involved.

The Research Ethics Committee has assigned a reference number to your study. Your reference number is RSR 2006-001.

You are reminded that this Committee must be notified if any changes are made to the protocol. Once the study has been completed, please send the committee a copy of the final report on the findings of the study.

The Research Ethics Committee for River Valley Health complies with the Tri-Council Policy Statement, the IEC Harmonized Triptite Guidelines: Good Clinical Practice, and Division 1 of the Food and Drug Regulations.

On behalf of the committee, I would like to wish you success with this project.

Yours sincerely,

[Signature]
Ron Harris, PhD, L. PsyD
Chair, Research Ethics Committee
River Valley Health
RFS

Learning Services
River Valley Health
P.O. Box 996, Princesse Street
Fredericton, NB E3B 1B7
Phone: (506) 452-6100 Fax: (506) 452-6777
E-mail: learning.services@rvh.nb.ca
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

This consent form is being administered to you by the researcher. It will be read to you and any questions that may arise will be answered by the researcher.

TITLE: Patient Experiences with Visiting a Nurse Practitioner for Primary Health Care in New Brunswick

INVESTIGATOR: Trudy Hahn
Department of Nursing
University of New Brunswick, Saint John NB
(506) 648-5613

ADVISOR: Dr. MaryAnn Thurkettle
School of Nursing, Duquesne University
(412) 396-1817

SOURCE OF SUPPORT:
This study is being performed as partial fulfillment of the requirements for the Doctoral degree in Nursing at Duquesne University. You are being asked to participate in a research project that will examine patient experiences of visiting a nurse practitioner for health care. In addition, you will be asked to allow me to interview you. The interviews will be audio recorded and transcribed. When all interviews are complete and the analysis is being done, you will be contacted again by the researcher to provide an opportunity for you to confirm or refute the findings.

RISKS AND BENEFITS:
The interview will give you the opportunity to share your experiences related to visiting a nurse practitioner for health care. The only risk that may occur in this study is that talking about your experiences may be upsetting to you. If this happens, the interview will be terminated and if you wish further discussion you may contact Lana Davis, a counsellor at UNB in Saint John at (506) 648-5557 to discuss your concerns.
COMPENSATION:
You will receive $25 for your time and inconvenience in taking part in this interview. Participation in the project will require no monetary cost to you.

CONFIDENTIALITY:
Your name will never appear in any written report of the study. Your interview will be stored on my computer, which is password protected. Nobody else will have access to these files. If I need to share information with my committee, I will not share parts of the interview that will identify you in any way. I will be the person who will transcribe parts of the interview to include in the write-up of my study, and again, none of these parts will identify you in any way. All written material (the information page you completed, the consent form, and my own reflective journals) will be stored in a locked cupboard. All materials will be destroyed five years after completion of the research.

RIGHT TO WITHDRAW:
You are under no obligation to participate in this study. You are free to withdraw Your consent to participate at any time and your interview data will be withdrawn from the study. There will be no penalty to you and your decision to participate or not participate will not affect your care.

SUMMARY OF RESULTS:
A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:
I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call the investigator above or Dr. David Flagel, Chair of the Ethics Review Board at the University of New Brunswick in Saint John (506 – 648-5610).

Participant's Signature ___________________________ Date ____________

Researcher's Signature ___________________________ Date ____________
A couple of years ago, my family doctor left his practice and I was left with no primary health care provider. I started inquiring about getting a new family doctor, and eventually I got a call asking me if I would be willing to see a nurse practitioner. I didn’t really know what to expect of a nurse practitioner, but I really wanted to talk to someone about my health concerns, so I decided to take a chance and go for it.

During my first visit with the NP, I was really surprised by the time that she took in getting to know me. She examined me, and asked about my concerns. I couldn’t believe it! She was really listening to me and was actually interested in my opinions. She seemed to be very professional and she knew what she was doing. Yet she reassured me that she was working very closely with a doctor, and that she would consult with the doctor whenever she needed help. That made me feel confident. She ordered some blood tests and an x-ray for me and she said that she would like to see me again in another week.

When I came back for my second appointment, I didn’t have to wait very long to get in to see her and she was ready for me! She had all the results of my tests there and she went over each of them with me. She explained what each one of them meant in language that I could understand and she kept asking me if I had any questions. She decided that I needed to start taking a couple of new medications and she explained all about what they were for and when I should take them.

I have been seeing her now every month or so for the past two years and I still feel the same way about her. There is no problem getting an appointment with her and I don’t have to wait long in the office when I go for my appointment. She always greets me in a friendly way and asks about me and my family. She never seems to be in a rush and she makes me feel like my time is as valuable as hers. She listens to all my concerns, and if I have a question that she can’t answer, she either looks it up and gets back to me or she consults the doctor who is right next door. She has told me that I can call her at any time with any problems that I might have, and she has called me at home as well with test results or to see how I am doing after having an infection or something. When she wants to try something new, like sending me to a clinic or a specialist or even a new medication, she always asks my opinion and how it will fit into my life.

I love this new form of primary health care. I would have no hesitation in recommending this kind of health care to anybody – even someone with more serious illnesses than I have. I finally feel like I am involved in my own health care and I am not afraid to ask my nurse practitioner about anything. She makes me feel important. If all of the nurse practitioners are like the one that I see, then I think that they should be available everywhere so that people could have the opportunity to experience the kind of health care that I’m getting now.
APPENDIX I

Did the experience that was outlined in the story sound like the experience that you have had in visiting a nurse practitioner for health care?

Yes__________  No_______

If you answered No to the above question, could you explain why?

Have you had any experiences with your nurse practitioner since I interviewed you that would change your opinion in any way?

Do you think that this story included all of the important things that you told me about visiting a nurse practitioner for health care?

If not, are there some things that you think that I should add when I write up the findings?