# The Meaning of Being an Oncology Nurse: Investing to Make a Difference

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# Abstract

The landscape of cancer care is evolving and as a result nursing care continues to develop and respond to the changing needs of oncology patients and their families. There is a paucity of qualitative research examining the experience of being an oncology nurse on an inpatient unit. Therefore, a qualitative study using an interpretive phenomenological approach has been undertaken to discover the lived experience of being an oncology nurse. In-depth tape recorded interviews has been conducted with six oncology nurses who worked on two adult inpatient oncology units. Van Manen's (1990) interpretive phenomenological approach has been used to analyze the data by subjecting the transcripts to an analysis both line by line and as a whole. The overarching theme of the interviews is: Investing to Make a Difference. The themes that reflect this overarching theme are: Caring for the Whole Person, Being an Advocate, Walking a Fine Line, and Feeling Like You are Part of Something Good. Oncology nurses provide care for their patients through a holistic lens that further enhances how they come to know their patients. Over time, relationships with patients and families develop and these nurses share that balancing the emotional aspects of their work is key in being able to continue to invest in their work and in these relationships. Their investment is further evident as oncology nurses continuously update their knowledge, for example, of treatment regimes, medication protocols, and as they champion their patients wishes and needs. As nurses develop their own identities as oncology nurses, they in turn enhance the team with their emerging skill and knowledge. These research findings serve to acknowledge the meaning of oncology nurses' work and inform the profession's understanding of what it means to be an oncology nurse.

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# Chapter 1: Introduction

Oncology nurses bring clinical expertise and knowledge to the care of cancer patients and their loved ones as they assess, plan and implement a wide array of nursing interventions. Each patient's cancer journey is different, with its own challenges, as well as refreshing and uplifting moments. It is the nurse's role to help shape and facilitate these journeys through the establishment and development of therapeutic relationships and communication between patients, fellow nurses, allied health and medical professionals.

My interest in the meaning of being an oncology nurse arose from my experience working on an adult inpatient surgical oncology unit. These experiences have helped to shape my professional and personal roles and values. As an oncology nurse, I have been deeply inspired, challenged and connected to raw human experience as I have journeyed with patients and their loved ones through their cancer experiences. These experiences have led me to wonder how other oncology nurses feel, think and live out their roles as oncology nurses.

## 1.1 Background

Cancer care has developed over time in response to advances in knowledge about cancer and its treatments. As the population ages, more people may live with cancer or be touched by the disease than ever before. By 2017, the Canadian Cancer Society (CCS) (2009) estimates that there will be a 40 percent increase in the number of people with the disease. Of these, men and women aged 70 years and older will account for 43 percent of new cancer diagnoses and 60 percent of all cancer deaths (CCS) and therefore, a rising need for oncology nurses.

A review of the literature reveals limited research devoted to understanding the experiences of oncology nurses. In particular, there is a paucity of research examining what it means to be an oncology nurse in an adult inpatient setting in a Canadian context. The intent of this study is to inform the profession's understanding of what it means to be an oncology nurse on an adult inpatient oncology unit.

## 1.2 Operational Definition of Oncology Nurse

Oncology nurses work in a variety of clinical settings such as, cancer clinics and inpatient care units. Although the experiences and meaning of nurses in other settings may be both similar and different, in this study, the term oncology nurse refers to those nurses whose work occurs on an adult inpatient oncology unit.

## 1.3 Purpose of the Research

The purpose of this research investigation is to seek to understand the lived experience of being an oncology nurse on an adult inpatient oncology unit.

## 1.4 Research Questions

The research study is guided by the following questions;

1. What is the lived experience of being an oncology nurse on an adult inpatient oncology unit?

2. What are the factors that facilitate or hinder being an oncology nurse?

# Chapter 2: Review of the Related Literature

In the following chapter a review of the literature of cancer care, nursing and oncology nursing work is presented. A brief history of oncology and oncology nursing is followed by a review of the literature that examines the work of oncology nurses. This chapter will conclude with a summary of the reviewed nursing literature.

## 2.1 The Cancer Journey, Statistics and Aging Challenges

The cancer journey is a unique experience for individuals and their loved ones (Canadian Association of Nurses in Oncology [CANO], 2006). Treatments can include combinations of modalities such as chemotherapy and radiation therapy with broad goals ranging from curative through to palliative care. The influence of developing sciences and technologies has had an immense impact on cancer treatment (Sabel, Diehl, & Chang, 2006), and patient experiences as well as approaches to nursing patients with cancer (American Cancer Society [ACS], 2010; CANO; Haylock, 2008; Wicklin Gillespie, 2005; Henke, 1980). Given the higher rates of cancer in older individuals and an increasingly older Canadian population, the cancer care system will be further challenged to respond with advanced knowledge and skill sets (Mick, 2008).

Provincial and national statistics provide a glimpse into the presence of cancer in Canada (CCS, 2009) and cancer care requirements. It is estimated, that 45 percent of males and 40 percent of females will develop cancer in their lifetimes (CCS). According to cancer statistics, by 2017 the incidence of cancer is expected to increase by 40 percent and older men and women, above 70 years of age, will comprise the biggest group affected (CCS). At the same time, mortality rates are

likely to continue to decline by 11 percent for males and six percent for females by the year 2017 (CCS). This suggests that more people will live with cancer as a chronic illness.

Aging and older patients bring to their cancer diagnosis unique challenges (Monfardini & Yancik, 1993; Newcombe & Carbone, 1993; Pal, Katheria, & Hurria, 2010; Puts et al., 2010). Older oncology patients are more likely to have comorbid conditions (Puts et al.) that can potentially limit functioning (Monfardini & Yancik; Pal et al.), which include but are not limited to respiratory, renal and cardiac decline (Puts et al.). Pre-existing comorbid conditions, changes in functioning, and limited social and financial resources may also compromise the effects of cancer treatment such as chemotherapy and surgery, and result in patients experiencing further decline in health status (Puts et al.).

## 2.2 Evolution of Cancer Care

Surgical intervention was the earliest form of cancer treatment. North America's first evidence of cancer surgery occurred in the 1890's when the radical mastectomy procedure was developed by Stewart Halsted (ACS, 2010). The goal of cancer surgery was primarily curative in nature, removing the tumour and lymphatic structures in close proximity to the tumour (ACS; Sabel et al., 2006). The development of knowledge led to multi-faceted treatment modalities to maximize the potential benefits of each treatment regime. Research within the clinical setting emerged as did a greater understanding for, and support of, different approaches to cancer care. Clinical trials led to the development of protocols to treat increasingly

complex disease, combining one or more chemotherapeutic agents, with or without radiotherapy or surgical intervention (Wicklin Gillespie, 2005).

Current treatment goals focus on oncology screening, prevention, diagnosis, cure, and palliation. They include: surgery, radiation, chemotherapy, and watchful waiting - usually in combination. The evolution of science and technologies within the cancer care continuum has facilitated early detection and prevention strategies which has resulted in less invasive diagnostic procedures and improved treatment protocols. These changes have also led to increases in survival rates in Ontario over the last two decades (Cancer Care Ontario [CCO], 2009a; CCS, 2009; Statistics Canada, 2009).

The evolution of cancer care has led to more patients living with cancer for longer periods of time. However, the increased number of patients being treated has placed greater demands on health resources and led to a decrease in the length of time patients remain in hospital. Advances in the treatment and management of cancer have, and will continue, to expand and challenge the professional and clinical expertise of oncology nurses. Oncology nurses need to be well informed of advances in cancer care and incorporate this knowledge into their clinical practice to provide specialized nursing care to patients with cancer (Henke Yarbro, 2000).

## 2.3 Evolution of Oncology Nursing

Oncology nursing was once heralded as a bleak experience because of poor survival rates for patients and their ensuing suffering. Care in patients' homes consisted mainly of traditional bedside interventions such as bathing and dressing changes (Haylock, 2008). With surgical intervention being a major modality of

treatment, nursing care for oncology patients in hospital was directed towards care of surgical patients. This included interventions directed toward pain relief and comfort measures (Hilkemeyer, 1985). Limited resources and unregulated educational requirements further challenged the provision of oncology care. Popularity, interest, and recognition of the scope and role of the oncology nurse emerged in the 1980s and 1990s as the development of nursing journals dedicated to oncology nursing and related interest groups emerged. These resources paved the way for the introduction and communication of standards of care (Haylock).

Contemporary evidence-based oncology nursing reflects a shift, from unregulated and poorly supported nursing care, to standardized cancer care with improved patient experience and professional satisfaction (Haylock; Kendall, 2006a; Zichi Cohen, 1995). Oncology nursing practice today is based on nursing knowledge that continues to develop from the physical, behavioural, social and biological sciences (CANO, 2006). This knowledge is shaped and further refined by personal and professional experiences (Kendall 2006a; Quinn, 2003; Zichi Cohen). Oncology nursing mandates professionals to be knowledgeable of how cancer affects individuals, family and society. In addition, there is recognition that holistic approaches to care are required to meet patients' physical, psychosocial and spiritual needs.

### 2.4 Standards of Oncology Nursing Care and Education

The movement to formally educate oncology nurses began in the mid 1980's (Henke, 1980). The Canadian Association of Nurses in Oncology, established in 1984, and its American counterpart, the Oncology Nursing Society (ONS) have

supported the development of oncology nursing. The goal of CANO is to support excellence in oncology nursing practice in Canada within the following domains: clinical practice, education, research and leadership. The organization achieves this through communicating the requirements of oncology nursing set out in competencies and standards of patient care (CANO, 2006).

The Canadian Association of Nurses in Oncology (2006) describes the role of the specialized oncology nurse as a registered nurse whose primary focus is the care of oncology patients or those at risk of developing cancer, and who has advanced skill and knowledge in cancer care. Nine standards of care for oncology nursing have been developed by CANO. These standards state that patients and their families have the right to nursing care that emphasizes: 1) holism and individualization, 2) family centered 3) self-determination and decision making, 4) assistance in navigating the various health care systems, 5) seamless and coordinated, 6) supportive and therapeutic relationships, 7) evidence based professional knowledge, 8) professionalism, and 9) patient focused care and professional leadership.

Currently, oncology nurses are registered nurses (RNs) who receive and meet the minimum regulatory requirements, a Bachelor of Science in Nursing, in Ontario. Advanced training and knowledge is facilitated through employer sponsored education events, courses at accredited schools of nursing and other organizations such as the deSouza Institute and CCO. An advanced skill such as chemotherapy administration requires additional education that includes theory and practical components.

The Canadian Nurses Association (CNA) certification program is a national and voluntary program that demonstrates a value for the knowledge and expertise that is required of an RN working in areas such as oncology. This certification process is one of the many resources that provide opportunities for advanced knowledge and skill for oncology nurses. Of the 3,351 RNs who work in oncology (Canadian Institute for Health Information, 2010), 42.7 percent have obtained Oncology Certification with the CNA (CNA, 2009).

## 2.5 The Oncology Nursing Environment

There are over 200 different forms of cancer (CCO, 2009b). Each cancer has a unique disease trajectory and treatment plan that can include care in both outpatient and inpatient settings. Patients are met by nurses at each juncture of their cancer experience. Oncology nurses provide care to patients on in-patient units in hospital, at home, in outpatient (ambulatory) chemotherapy clinics as well as in nuclear medicine and diagnostic imaging departments where very specific treatment is given to patients.

Outpatient care often includes follow up appointments after surgery where the nurse provides direct clinical care. For example, the removal of drains following a modified radical mastectomy is a common procedure conducted by nurses. Outpatient nursing care also can include administering chemotherapy, monitoring blood work, and helping patients to cope with their cancer experience. For example, chemotherapy or radiation treatments can be conducted on an outpatient basis. This involves weekly visits by patients to have their blood work monitored and can

require daily, or weekly, visits for treatment, which can last for up to months at a time. Outpatient care tends to provide less face to face time with a nurse.

Inpatient care takes place in a range of contexts, from a small rural health care facility, where oncology patients may share a unit or even a room with patients who do not have cancer, to a large hospital where units are designed to provide care for specific groups of patients. Patients are admitted to inpatient care for a variety of oncologic related experiences including active treatment, symptom management, end of life care, and for treatment of complications such as infections. For example, a patient with lymphoma may be admitted for an abnormal blood test result and may require a blood transfusion, or a patient with advanced cancer may be admitted because of a pathologic fracture.

To meet the ever changing needs of oncology patients, care is provided by an interprofessional health care team with differing areas of expertise. This team may be comprised of physicians, nurses, radiation therapists, speech therapists, registered dieticians, physiotherapists, and social workers. Although nurses make up only one part of this team, they represent the greatest number of individuals within the oncology care team and have the most contact with patients in inpatient settings (Brennan, 2004).

The delivery of interprofessional care is designed to maximize the effective use of health care resources to meet the needs of cancer patients. In a large teaching hospital, inpatient oncology units are often organized by a common theme such as treatment requirements or by the site of the cancer. For example, patients with cancers such as leukemia and lymphoma may be cared for on one unit because their

nursing care needs are similar. Considering the many and varied types of cancer, each requires nurses to have specific knowledge and skill in order to care for their patients. The "…scope and depth of knowledge and skill of the specialized oncology nurse should pertain to the particular patient population that the nurse is caring for, not to all populations of oncology patients" (CANO, 2006, p. 23).

### 2.6 The Work of Oncology Nurses

In the direct patient care role in the inpatient setting, the oncology nurse coordinates patient care and collaborates with the interprofessional care team. The oncology nurse's shift begins with receiving report on a patient assignment, which at some institutions may be comprised of four or five patients. Following the assessment of their patients' status, the nurse responds with evidence based interventions to promote, restore, and or maintain physiological and psychological balance of patients and their family. The physical status of the patient can change rapidly within the acute oncology environment and well developed assessment skills guide prompt interventions to treat life threatening situations such as a hypercalcemia crisis. The concerns of a patient or the quiet sigh from the daughter of a dying patient are additional cues that guide the daily work of an oncology nurse. Responding to these cues supports patients and families and helps them with their experiences with cancer. The nurse's assignment may change over the course of the shift as patients are frequently admitted and discharged.

Patients are admitted to inpatient oncology units from a variety of settings such as the emergency room, the operating room, or from a medical oncologist's office. The nurse facilitates cancer care for patients at different points along the

course of their illness trajectory. For example, the nurse may provide health teaching to a patient being discharged home and prepare another patient for a diagnostic test, while comforting a dying patient and their family. No two shifts are ever the same.

In a phenomenology study of thirty-eight oncology nurses, Steeves, Zichi Cohen, and Wise (1994), examined the perceptions that oncology nurses have of their work. The areas of oncology nursing practice, although not specifically identified by the authors, occurred in a variety of oncology nursing settings across the United States of America. Nurses were asked to recall a critical incident, which highlighted the meaning of oncology nurses' work. Reflecting on these incidents provides "a unique view of the nature of oncology nursing" (p.19). From an analysis of participants' narratives, three roles emerged which highlighted the identities that the nurses held of themselves. The first role, "maintaining the goals and values of health care," (p.20) highlighted value in the knowledge and skill as a health care professional and the use of these skills and knowledge in protecting patients. This role included the assessment and monitoring of patients, teaching about the disease and aligning patients' goals with the goals of the health care facility. The second role, "participating in patients' experiences," (p. 22) was concerned with nurses' participation in the lives of patients. The authors characterised this role as being present with their patients, being a part of their families and being with them during death. The third role, to "reconcile the goals of healthcare professionals and the experiences of the patients" (p. 23) described nurses' attempts to align the first two roles. Nurses accomplished this through educating their patients along their cancer journey, and by "telling the truth" (p. 23) to patients. Truth telling often posed ethical

challenges for the oncology nurse. Nurses described sharing and clarifying information with patients so they had enough information to make decisions that were meaningful for them. Knowledge of the regional and clinical practice environments of the participants could have enhanced these findings through clarifying further the context of their experiences. There are many approaches to oncology nursing care.

Hughes, Hodgson, Muller, Robinson, and McCorkle, (2000) carried out a content analysis of interviews conducted with 148 patients who had surgery for prostate, breast, gastrointestinal, lung or head and neck cancer. They inquired about the informational needs of patients while transitioning home post operatively. The researchers found that when nurses provided health education to patients, this helped patients to know how and when to navigate and access the system following discharge, and to care for themselves safely and confidently (Hughes et al.). While attempting to identify patients' needs during the transition home, this study illustrated the range of oncology nurses' role while caring for a variety of patient care needs across the cancer care continuum.

In providing care to patients and families, oncology nurses may use their physical selves to bring warmth, comfort and humanness to the experience of suffering that can accompany cancer (Ferrell & Coyle, 2008). Parse (1998) suggests that presence is a special way of being with others as they live their experience and is integral in nursing. In being with others the nurse is open to the patients' experiences as they understand them. Only by abandoning any preconceived ideas of the patient experience is the nurse then able to share in the experience with patients. Nurses'

physical presence helps them to build rapport with patients and their families (Dunniece & Slevin, 2000; Steeves et al., 1994). Through touch, eye contact and body language and by using themselves as therapeutic tools nurses build relationships and connect with patients and their families. The physical act of being present, over time, assists nurses as they begin to help patients explore and understand their cancer experiences (Dunniece & Slevin; Quinn, 2003).

In their phenomenological study, Dunniece and Slevin (2000) investigated being present, from the perspective of six inpatient oncology nurses caring for patients receiving either an initial diagnosis of cancer, or a diagnosis involving a recurrence or terminal condition. Semi structured in-depth interviews were used to gather narrative data from nurses who had worked in oncology for a minimum of eighteen months. From the data, seven themes emerged: 1) "what if it were me?", 2) "divergent feelings," 3) "being there," 4) "becoming closer," 5) "method of disclosure," 6) "time as an influence," and 7) "learning by reflection." The researchers found that these experiences were profoundly moving and touching for the nurses involved. Nurses' framed these experiences in terms of their own mortality and attempted to perceive these experiences from the patient's point of view. Professionally, these events prompted reflection from which growth and development occurred. These findings indicated that being present with patients was experienced both on professional and personal levels.

Oncology care is directed toward "the relief of suffering and support for the best possible quality of life for patients facing serious life-threatening illness…" (Heidrich, 2007, p. 603). Although caring for dying patients occurs regularly for

oncology nurses it still may pose a challenge. A hermeneutic investigation, by Rittman, Paige, Rivera, Sutphin, and Godown (1997), sought to describe the experience of oncology nurses caring for dying patients. In-depth interviews were conducted with six oncology nurses with at least five years of oncology nursing experience who had cared for dying patients. Four themes emerged 1) “knowing the patient,” 2) “preserving hope,” 3) “easing the struggle,” and 4) “providing for privacy.” The researchers concluded that nurses managed the emotional demands of their work by establishing varying degrees of closeness with patients as they were dying. Nurses developed close bonds with some patients and despite not developing these relationships with all patients; they did however feel as if they provided good care for all of their patients who were dying.

Grief, a natural response to loss is not only experienced by patients and their loved ones but also by nurses providing their care (Haberman, Germino, Maliski, Stafford-Fox & Rice, 1994). Given the terminal and limiting characteristics of some cancers and treatments, dealing with death and dying and the experience of grief is not uncommon for oncology nurses (Brown & Wood, 2009). Through caring for dying patients and experiencing the grieving process with others, oncology nurses may come to recognise their role in facilitating patients’ search for meaning (Quinn, 2003), as well as supporting a positive attitude (O’Baugh, Wilkes, Luke, & George, 2008). Caring for patients who are dying can also challenge nurses to reflect on their own mortality (Dunniece & Slevin, 2000; Quinn, 2003; Rittman et al., 1997).

Haberman et al. (1994) sought to identify why nurses specialize in oncology and explored the dimensions of oncology nursing practice. From the analysis, several

findings emerged including; 1) influential factors leading the nurse to oncology nursing, 2) factors that make oncology nursing special, 3) things that make caring for cancer patients challenging, and 4) key role dimensions of practice and caring behaviours. Nurses' personal experiences with cancer, their role models, the perceived challenges and rewards of oncology nursing are identified as support for nurses' decisions to pursue oncology nursing as a career. For some participants, their experiences in oncology often exceeded the ideas they had prior to becoming an oncology nurse. Haberman et al. found that the personal and professional rewards of oncology nurses' work such as dealing with life and death, dangerous medications, making a difference in peoples' lives and the relationships formed with colleagues, patients and their families, are some of the many facets of oncology nursing that made it special. Some challenges in caring for cancer patients were also viewed as rewards. For instance, although caring for dying patients and getting to know them and their loved ones was seen as a reward, it was also one of the most difficult aspects for oncology nurses as they grieved the loss of patients.

Johnson, Zichi Cohen, and Hull (1994), examined the role of mentoring and role modelling in the development of clinical expertise as an oncology nurse. Effective role modeling and mentorship promotes nursing expertise, personal and professional commitment to oncology nursing and patients. Self-directed learning includes "a variety of source-finding and self-tutoring strategies" (p.33) and also facilitates nursing and clinical expertise. These findings suggest that personal and professional growth within oncology nursing is supported by peers and is associated with one's own willingness to personally commit to oncology nursing education.

Administration of chemotherapy to patients is often considered a hallmark of oncology nursing care. Chemotherapy agents are cytotoxic and potentially harmful (Otto, 2007). Administration requires strict adherence to safety criteria including the donning of personal protective equipment, gown, gloves, protective eye wear, as well as the safe disposal of the drug and body fluids of the patient following administration. The receipt of such treatment regimens can be physically and emotionally challenging for patients. For example, debilitating side effects such as fatigue and nausea can occur. Chemotherapy can be given in conjunction with other treatment modalities and the goal of treatment may be curative or palliative, or preventative (Otto). Administering chemotherapy can facilitate hope, "give[ing] people another chance at life" (Saltmarsh & De Vries, 2008, p.502) while simultaneously impeding it due to unfavourable or life threatening side effects. Bearing witness to the patient suffering that ensues can be eased through nurses' therapeutic use of the self, with empathy (Fall-Dickson & Rose, 1999), and by being physically present (Ferrell & Coyle, 2008).

## 2.7 The Meaning of Being a Nurse

Nurses work in many different areas within health care environments. The meaning, as an interpretation of the experience of, being a nurse has been researched from a variety of different areas in nursing and as such there may be many understandings of being a nurse. Each unit and health care organization creates the backdrop for nurses' experiences to unfold, informing the meaning of their work. A phenomenological lens supports this way of understanding what it means to be a nurse because it seeks to interpret nurses' experiences, each in their own contexts.

Spence and Smythe (2008) researched the meaning of feeling like a nurse. At the heart of nursing is the caring encounter with patients. It is only after these encounters with patients that the meaning of feeling like a nurse is understood. This meaning is described through the call, the response to the call and the aftermath of these encounters. The call is described as something needing their attention that can occur at any time for example, a patient crying out for help or even a call to become a nurse. After an encounter, the nurse reflects upon the event to further understand it. Responding to others is embedded in nurses' everydayness and nurses are attuned to the calls of their patients.

The meaning that nurses assign to their experiences is contextualized by their environments (Edvardsson, Sandman, & Rasmussen, 2006) and areas of nursing in which they work. Edvardsson et al., in a phenomenological study of the oncology environment, suggest that the meaning of being in an oncology environment is implicated in the care oncology nurses provide because caring occurs within the physical environment. The physical environment can communicate either caring or uncaring messages to those within it. An example from their study is a comfortable chair conveying positive messages of caring.

The lived experience of neonatal nurses is described in Hall, Kronborg, Aagaard, and Ammentorp's (2010) study and is used in this literature review as an example which illustrates the meaning of being a nurse. Using a phenomenological approach the researchers uncovered the essential theme "walking the line between the possible and the ideal" (p.307). The meaning of being neonatal nurses unfolds through accountability to the patient, the health care team, and respecting the

physical environment while trying to empower parents. Teamwork and trust in the team is integral in being able to care for patients.

A key element in the work of nursing is the development of skill and knowledge amidst the changing backdrop of health care. Nurses are required to respond to patients needs armed with the skill and knowledge to be able to meet those needs. Burhans and Alligood (2010) suggest that nurses meet their patients' needs through six artful practices of nursing including; caring, responsibility, intentionality, empathy, respect and advocacy. These six practices highlight the essence of being a nurse.

The meaning of being a nurse is varied in that the unique areas where nurses work help to shape and form this meaning. However, central to the meaning of being for nurses is a focus directed toward patients and their needs. Nurses meet the needs of their patients through developing their knowledge and skill which can include the use of technology. The caring experience is embedded within their interactions with patients as nurses respond to patient needs. Ultimately the meaning of being a nurse is understood by those who live it, wherever and however their experiences unfold.

## 2.8 Summary of the Related Literature

Oncology nursing is a deeply personal experience where "oncology nurses live fully the cancer experience by embracing their patient's triumphs and heartaches" (Haberman et al., 1994, p. 47). Oncology nursing can be characterised as continuously dealing with the unexpected where the unusual becomes the norm (Deatrick & Fischer, 1994). Inherent challenges such as sadness and facing death with patients and their loved ones are also viewed as professionally and personally

rewarding (Zichi Cohen, Haberman, Steeves, & Deatrick, 1994). Personal and professional growth and development are inherent in oncology nursing and through phenomenological investigation nurses are enabled to reflect on their own experiences. In response to a lack of current literature describing the meaning of being an oncology nurse, a phenomenological investigation is warranted.

# Chapter 3: Methods

The purpose of this research study is to seek to understand what it means to be an oncology nurse. In this chapter, the qualitative approach chosen, the setting and sample, data collection and analysis, and the protection of human rights will be discussed.

## 3.1 Study Design

A qualitative research method, specifically interpretive, or Heideggerian, phenomenology was used to explore and further understand the meaning of being an oncology nurse as this approach provides a way for the experiences of nurses to be accessed and expressed.

Heidegger (1927/1962) asserts that questioning *Being* is the initiative for scientific inquiry and that the meaning of *being* is fundamental to the investigation of human experiences. A former student of Husserl, Heidegger challenged the notion of epistemology in *Being and Time*. He proposed that in order to understand the world from an epistemological perspective, or why the world exists, we must first understand the meaning of existing in the world (Audi, 1995; Drew, 1999; Heidegger). The following is a review of the core elements of Heideggerian phenomenology, which includes the conceptualisations of dasein, person, space, time and forestructures.

### 3.1.1 Dasein (being in the world).

Heidegger asserts that people, or entities, are "capable of wondering about one's own existence" (Mackey, 2005, p 182). Heidegger called this state of wondering, dasein. Dasein refers to an entity that exists within a context where

understanding of that entity is only possible with regard to such context. Dasein is used to illustrate and illuminate human beings or entities that are situated and immersed in their everyday lives. Dasein moves us beyond a mere description of people, for example, a young boy is standing beside a young girl who is crying, to a more layered and contextual understanding that their mother is dying. Dasein is also concerned with the possibilities, or the potential, of those siblings.

This state of dasein*,* is individual and expresses not only the existence of something, but the being of something. The universal conceptualisation of being means that things, or entities, are understood as they relate to each other. This emersion in life, the experience of everyday phenomena, is the fulcrum for understanding human experience (Heidegger, 1927/1962).

The concept of being in the world acknowledges that the context of people's lives is crucial in the interpretation of their life experience. It is not possible to uncover, interpret and explore such experiences if the experiences themselves have not occurred or been lived. Furthermore, it is of great importance that one be willing and able to engage and share his or her experiences. Understanding what it means to *be* involves acknowledging the relation of dasein to the past, the future and its situated-ness in the current world. It is bound by the nature of the situation and the way the individual is in it. By examining what it means to be an oncology nurse, the meaning attributed to this phenomenon is revealed through one's own context.

#### 3.1.2 The Person.

The person is not divisible into subjective and objective parts, and exists within a world from which s/he cannot be separated. In the previous example, both of

the young siblings' entire lives will change now that their mother is dying, and not simply the part of their lives that was connected with their mother. The person is characterised as being able to understand themselves through their surroundings and where they are situated in relation to these surroundings. According to Heidegger (1927/1962), the person is self-interpreting and experiences their worlds each in their own unique and individual ways.

#### 3.1.3 Space.

Being is dependent on the context which involves the space and the time within and between both of these entities. Space, also known as spatiality, refers to physical space and entities (Heidegger, 1927 / 1962). Phenomena are accessed, interpreted and understood in a way that is reflective of their context. For example, a nurse experiences the death of an oncology patient who did not wish any life saving measures. The patient does not appear to be in any distress, family members are present and the patient's respirations slow down and eventually stop. The frame of this experience vastly differs from an oncology patient who dies after multiple attempts at resuscitation and the patient's room is full of many health care providers working in one room feverishly to save the life of the patient.

#### 3.1.4 Time.

Time is a constant, fluid, and essential element of understanding the human experience (Mackey, 2005). Time exists at the very beginning of, and is situated in, the understandings of human experiences. It is not the linear passage of time but the way in which the person is embedded in the present that is made meaningful by the past and the possibilities that exist in the future (Benner & Wrubel, 1989). These

experiences of time-situated meaning and understanding are elemental to being and as such to dasein. For example, the experiences and knowledge that oncology nurses have at the beginning of their career is different from the end of their professional career. Many experiences help to frame nurses' knowledge so that by the end of their career, and at different points of time over the span of their careers, experiences are meaningful to them in different ways.

### 3.1.5 Forestructures.

People live with previous knowledge and interpret their experiences based on this knowledge. Heidegger named this phenomenon forestructures. Forestructure is the "prior awareness" of which "interpretation already exists fully formed, but in need of expression" (Mackey, 2005, p 182). For example, a young girl's mother dies. This young girl grows up and decides to become a nurse. The experiences and knowledge that the young girl accumulated throughout her mother's dying process will set the stage for how her nursing practice will develop. These previous experiences influence the way phenomena are lived out. It is this notion that supports the inclusion of the researcher's meanings into his/her research, as researchers are experiencing and interpretive beings, and as such are incapable of separating their meanings from the research world. Heidegger (1927/1962) asserts that the only way a researcher can in fact carry out interpretive phenomenology is to have prior knowledge of the phenomenon (McConnell-Henry, Chapman, & Francis, 2009) and judgement of the phenomenon. This, he called priori (Heidegger). The challenge to researchers lies in the questions – when, and how, is this knowledge and judgement to be used. The researcher, interpreting the meaning of being, can only participate in

research from a lens that acknowledges and utilises the researcher's knowledge and assumptions.

### 3.2 Researcher's Assumptions

Heidegger's (1927/1962) conceptualisation of the person includes the capability of assigning meaning to life events. Through the interpretation of one's life, events and experiences, meanings arise. In the current study, the researcher's assumptions reflected the interpretivist paradigm similar to those reflected through the philosophical underpinnings of the research methodology. The researcher's knowledge and realities have been constructed through her experiences and identity as an oncology nurse. She approached the inquiry with the following assumptions:

1. Oncology nurses make spiritual connections with patients
2. Death is ever present in oncology nursing
3. Oncology nurses learn about hope from journeying with their patients
4. Oncology nurses learn and grow from sharing their experiences with each other.

### 3.3 Setting

Registered nurses were recruited from medical oncology and hematology oncology inpatient units at one site of a 1040-bed, multi-site tertiary care teaching facility located in a large urban centre in eastern Ontario. The two nursing units are specifically designed to provide care to oncology patients at various stages along their illness trajectories. The medical unit has thirty-eight full-time nurses and twenty-seven part-time nurses (Personal communication, unit manager, January 4, 2012). Of these, only two are male nurses. The hematology oncology unit employs

thirty full time and twelve part time nurses in addition to two casual nurses (Personal communication, unit manager, March 19, 2012). There are three male nurses employed on this unit.

#### 3.3.1 Physical Environment and Patient Population.

The health care environment in which oncology nurses work situates their care within an interprofessional culture and context. The interprofessional teams, on each of the units, consist of oncology physicians, nurses, nutritionists, physiotherapists, occupational therapists and unregulated care providers. In addition there are ward clerks who are responsible for the administrative functions of the units. Should patients require the expertise of health care professionals not physically located on the unit, they can be consulted over the telephone.

Patients often become quite familiar with the environment of these units as some are admitted and discharged many times over the course of their disease trajectory. In addition, their lengths of stay can range from days through to weeks or months. They are admitted for diagnoses, pain and symptom management, end of life care, and for the management of health crises such as critical systemic infections or treatment reactions.

The hematology oncology unit is a twenty-three bed inpatient unit with only private single rooms. Patients admitted to this unit may be diagnosed, for example with acute leukemia. Entry to the unit is restricted to authorised hospital staff, patients and visitors over the age of twelve to ensure compliance with precautions to promote patients' safety through the protection of their immune systems. Visiting hours are strongly enforced to ensure compliance as patients' immune systems are

compromised as a result of treatment such as chemotherapy and bone marrow transfusions. The unit has a communication centre with patient charts, computers, telephones and a ward clerk. There is a designated family room often used for family conferences or by family for quiet time during or after the death of a patient.

The medical oncology unit is a 35-bed inpatient unit that admits patients with a wide array of cancer experiences. Treatment and nursing care is centred on diagnostics, chemotherapy and palliative care. This unit has 13 private single-bed rooms, 10 double-bed rooms, and one four-bed ward rooms. The rooms line the outside of the unit where the unit communication centre is located.

#### 3.3.2 Model of Care.

Nursing at this large urban hospital is facilitated through, and guided by, a specific model of clinical practice. The model of care identifies three categories of nursing personnel which includes registered nurses, registered practical nurses and unregulated care providers. Guiding principles support care that is: safe and competent, seamless and continuous, respectful of culture and beliefs, where patients are encouraged and assisted to participate in decisions affecting their care. These principles, supported at various levels within the organization, inform the structures and culture of care within the organization.

### 3.4 Participants

Polit and Beck (2008) suggested that the sample size of phenomenology studies have fewer than ten participants. This study collected data from a purposive sample of six participants whose interviews revealed similar experiences, and were thick and rich in their descriptions, at which point recruitment was terminated. A

pilot interview was conducted before the main study and this interview was included in the analysis. Participants were assigned surrogate names in order to protect their anonymity.

### 3.4.1 Criteria for Inclusion.

Participants were eligible for inclusion if they:

1. Were able to speak English fluently
2. Were a Registered Nurse currently working on at least one of the aforementioned oncology units
3. Had a minimum of two years of work experience as an oncology nurse
4. Identified themselves as an oncology nurse.

The limitation of the researcher as a unilingual Anglophone required the participants to speak fluently in English. For the purpose of this investigation the second criterion was necessary so as to exclude other unit staff such as orderlies and administrative personnel. The third and fourth criteria ensured that nurses participating in this study had ample clinical experience as an oncology nurse.

### 3.4.2 Description of Participants.

A total of six oncology nurses participated in the study, all of whom were female. Ages of the participants ranged from twenty-three years to over fifty years. The total years of experience in nursing ranged from two years to over thirty years, and the number of years in oncology nursing ranged from two to over thirty as well. Four of the six participants began their professional careers on the same oncology

unit used in the study. The remaining two nurses had previous experiences on different oncology units.

### 3.4.3 Recruitment.

Following a review of the study with the Director of the oncology program at the selected institution, the two nursing unit clinical managers received a brief overview of the study proposal. Recruitment strategies targeted the oncology nurses and included brief presentations to the RNs on both of the oncology units on a variety of occasions. The purpose of these presentations was to describe the study including the purpose, a description of what participation involved, and eligibility criteria. Potential participants received a combined information sheet and consent form in English (Appendix A) or in French (Appendix B) and those interested provided the researcher with their contact information. Posters communicating the focus of the study, in English (Appendix C) and in French (Appendix D), were also placed on bulletin boards in each of the units staff rooms. Participants did not receive compensation for participating in this study.

### 3.4.4 Data Collection.

Appointments made for the interviews occurred by phone and through the use of email. The initial interviews occurred over 30 - 60 minutes in various locations including participants' homes and office space at the researcher's university. Informed consent in English was obtained at the beginning of each interview following an overview of the study. At this time any questions were addressed.

Individual unstructured face-to-face interviews, with the researcher, guided the exploration of the lived experience of being an oncology nurse. Unstructured

interviews allowed the interviewer to encourage participants to express and reflect upon their experiences without focusing on a rigid question and answer guide (Polit & Beck, 2008) (Appendix E).

Field notes and reflexive journal entries containing descriptions of emotions, and body language were collected immediately after each interview. These field notes enriched the data collected providing comprehensive descriptions that enhanced understanding of the contexts of the interviews.

Each interview was transcribed by the investigator within 24 hours of the interview. Accuracy of the transcripts was verified through a comparative process of listening to the audio tape while reviewing a copy of the transcripts line by line. Member checking interviews occurred upon completion of data collection and analysis. A total of two participants took part in the member checking interviews. These interviews verified that the interpretations of the researcher accurately reflected the realities of the participants. This second interview took 15 – 20 minutes to complete.

### 3.5 Data Analysis

Consistent with Heideggerian phenomenology, van Manen's (1990) approach provided a framework to analyse the collected data to facilitate an understanding of the essential meaning of the phenomenon. Using van Manen's method to analyze the transcribed interviews, the essential structure of being an oncology nurse unfolded. All three of van Manen's approaches were used which included the holistic, detailed, and selective approaches. The researcher reflected upon the transcripts while they were being read and reread. In order to extract significant themes from the

transcriptions, the researcher read them as a whole (holistic approach) initially and then line by line (detailed approach) which further immersed the researcher in the data. As the researcher began writing descriptions of these identified themes, greater clarity and understanding of these themes emerged. The researcher regularly returned to the transcripts as the writing process unfolded to situate these themes within the phrase and statements shared by the participants (selective approach). The researcher revised the text as each theme took shape. The identification of major themes came about by looking at the meaning of participants' narrative text and the text throughout the writing process. Consideration was given to the many contexts that included time and space. Regular collaborative analysis and dialogue with the research committee facilitated clarity of essential themes. The research committee met regularly to discuss meaning units, gradually clustering the aggregate of formulated meaning into clusters of emerging themes. Once identification of the themes was complete, member checking interviews occurred with the participants.

## 3.6 Methods to Ensure Trustworthiness

Trustworthiness refers to the quality and value of research findings (Lincoln & Guba, 1985). Lincoln and Guba's four criteria of trustworthiness were used, namely; credibility, dependability, confirmability and transferability.

### 3.6.1 Credibility.

Credibility refers to approaching the research experience in a way that ensures the findings, in this case the meaning of being an oncology nurse, are reflective of the participants' shared lived experiences and are believable (Lincoln & Guba, 1985). Member checking ensures credibility through follow up interviews with

participants. Only two participants were available for the member checking interviews, however both stated that the researcher's interpretation of their experiences accurately reflected what it means to be an oncology nurse. Participants were provided with a summary of the findings which included key quotes that represented each theme. For each theme, each participant was asked "Is this what the meaning of being an oncology nurse is really like?" One participant responded, "It fits with my experiences very well." Prolonged engagement of the researcher with the data and with the study also served to meet the criterion of credibility.

### 3.6.2 Dependability.

Dependability is the degree to which the data collected is stable over time and findings are consistent. An audit trail was developed to account for all of the decisions made by the researcher during the analysis so that another researcher could follow those decisions made. This made the research process transparent and accounted for the interpretations and thematic analysis of the transcripts and included the transcript notes detailing the themes and categories.

### 3.6.3 Confirmability.

Confirmability is reflected through research where findings are shaped by the participants themselves and not by the influence of the researcher (Lincoln & Guba, 1985). Ensuring objective or neutral findings can be accomplished by bracketing, or separating, one's personal interpretations of experiences from those of the participants. This strategy however, does not correspond with interpretive phenomenology as Heidegger asserts that the researcher's preconceived understandings and experience of a phenomenon cannot be separated from the

findings of the research. Heidegger asserts further that in order to research a phenomenon, the researcher must have experience with the phenomenon. The findings of this current study are further enhanced by the researcher's understanding of the meaning of being an oncology nurse as she has experience as an oncology nurse. However in order for the findings to reflect the experiences of the participants a reflexive journal documenting the researcher's own beliefs and assumptions was maintained throughout the research process. In addition, the development and agreement on the themes was carried out with the thesis committee, who have expertise in both qualitative research and the clinical context.

#### 3.6.4 Transferability.

Transferability refers to the degree to which findings can be applied in similar situations (Lincoln & Guba, 1985). Interpretive phenomenology is primarily concerned with understanding the experiences of those participants in the research study and not necessarily with transferring the findings to others' experiences. However, the findings have transferability in the sense that they further enhance the nursing profession through adding to our understanding of the meaning of being an oncology nurse. This was achieved and made evident through rich and thick descriptions of the themes and clear and detailed descriptions of the participants and the context of their care.

## 3.7 Protection of Human Rights

Prior to beginning the research, the researcher applied to and obtained approval from the ethics review board of the health care institution. Subsequently the research project also received approval from the University of Ottawa Research

Ethics Board. Participants received information at the outset of the study that withdrawal of their participation could occur at any time and that declining to participate had no bearing on their employment with the organization.

Unique identifiers, assigned to each participant, and the use of surrogate names for verbatim quotes ensured anonymity. Storage of the link and study files occurred separately from the consent forms. All electronic records stored on the personal laptop of the researcher were protected by an encrypted user password.

# Chapter 4: Findings

In the following chapter the meaning of being an oncology nurse, as described through the experiences of oncology nurses working on an adult inpatient oncology unit, is presented. Several themes emerge from analysis of the data. Factors that the nurses find challenging and factors that facilitate the experience of being an oncology nurse are threaded throughout the themes. To maintain and protect anonymity of the study participants', surrogate names have been assigned to them and any identifying information has been omitted from the text.

## 4.1 The Meaning of Being an Oncology Nurse as "Investing to Make a Difference"

The meaning of being an oncology nurse is described in an overarching theme, Investing to Make a Difference. What becomes clear, from an analysis of their experiences, is that oncology nurses invest in the lives of patients, in themselves as nurses, and in colleagues. These nurses, who identify themselves as oncology nurses, emphasize a commitment to journeying alongside and with their patients and families as they experience the effects of cancer. At the same time, they bear witness to the suffering of patients and families and try to connect with patients to facilitate cancer care in ways that they perceive are meaningful to patients.

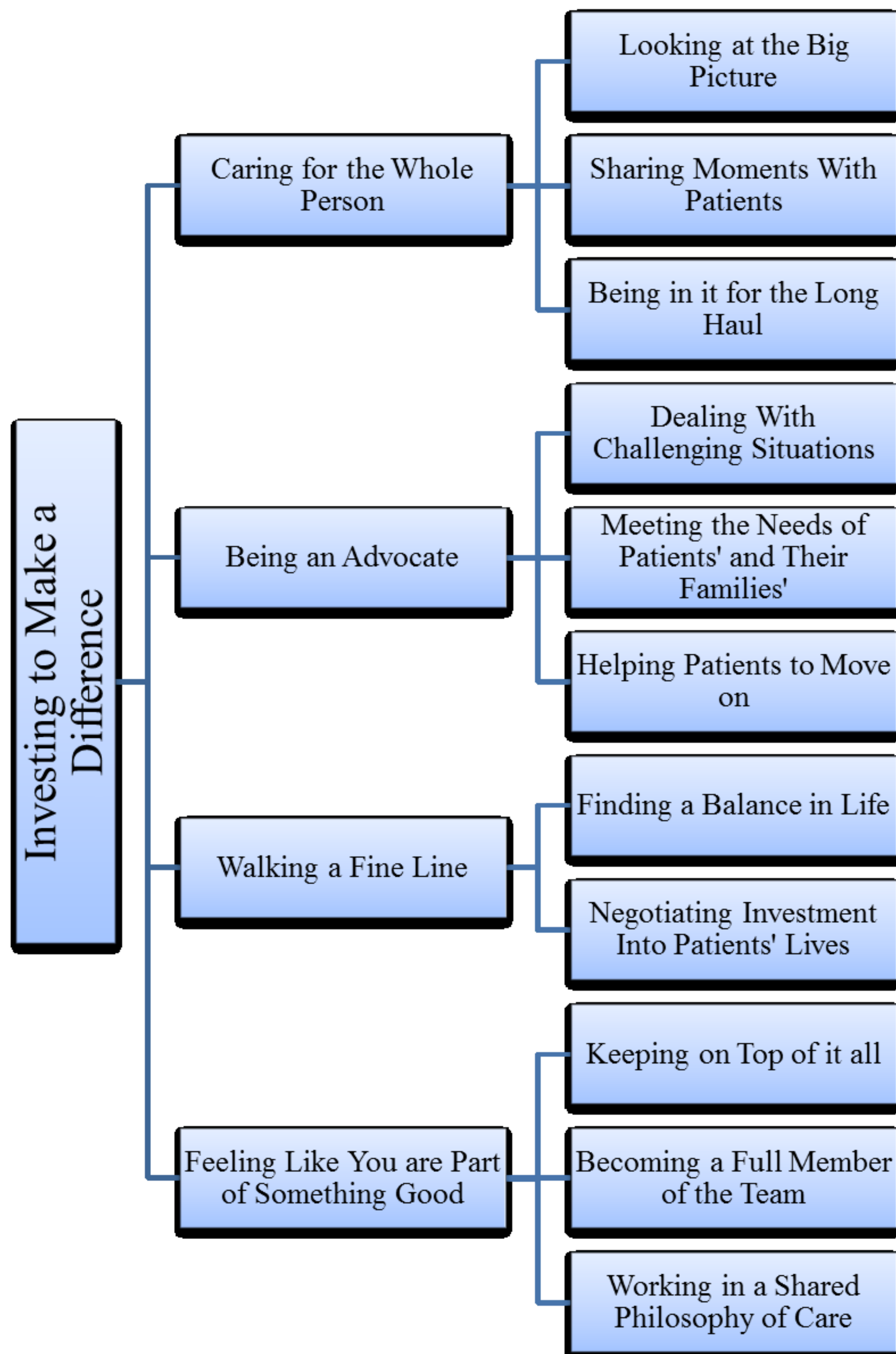
Participants also recognise the growth in themselves and the investment that is required to ensure they have the necessary clinical knowledge to nurse the increasingly specialized needs of oncology patients. The nurses describe the investment made as they take on mentoring roles for each other as they work to develop their ongoing knowledge and skill.

Time is an interwoven thread throughout all of the stories as the participants reflect upon their experiences. It is identified as a key element in establishing and developing relationships with patients and their families, since patients often return to hospital, many times over several years, for treatments. As nurses come to know their patients over time this helps them to gain insight into their needs. Nurses use this time to provide physical and emotional comfort to patients over the course of treatment and trajectory of the disease. Time is also important for these nurses to gain experience, and also to build a repertoire of skills and knowledge. With time, their identities as oncology nurses emerge and as such, feeling as if they are part of the team.

Within the overarching theme of Investing to Make a Difference, are four themes: Caring for the Whole Person, Being an Advocate, Walking a Fine Line, and Feeling Like You are Part of Something Good. The theme of Caring for the Whole Person is comprised of three categories: Looking at the Big Picture, Sharing Moments With Patients, and Being in it for the Long Haul. This theme highlights the holistic nature of oncology nursing and how nurses come to know those they care for in such intimate and familiar ways over the course of their often lengthy illness. Being an Advocate is comprised of three categories: Dealing With Challenging Situations, Meeting the Needs of Patients' and Their Families, and Helping Patients to Move on. In this theme the challenges nurses face in caring for patients' and their families' and how they go about meeting their needs are described. This theme incorporates how the nurses support patients in their cancer journey. The theme Walking a Fine Line refers to how nurses deal with the emotional nature of oncology

nursing and the balance that is required. It has two categories: Finding a Balance in Life and Negotiating Investment Into Patients' Lives. The final theme, Feeling Like You are Part of Something Good, divides into three categories: Keeping on Top of it all, Becoming a Full Member of the Team, and Working in a Shared Philosophy of Care. This theme reflects the experiences of these nurses working toward shared goals in a team environment. See Diagram I for a schematic of the themes.

*Diagram I: Diagram of Analysis*



## 4.2 Caring for the Whole Person

Caring for the Whole Person includes three categories; Looking at the Big Picture, Sharing Moments With Patients and Being in it for the Long Haul. It includes time with patients for the "little" things as well as time in the long term. Nursing in a cancer context is all encompassing and the participants characterised it as "very holistic," and a "whole person fix" directed at "the whole person" and as Annie clarifies, "we are focusing on everything and not just on the body systems….You are always dealing with the whole person."

### 4.2.1 Looking at the Big Picture.

When people are diagnosed with cancer it can quickly affect every aspect of their lives such as their roles within their families or their social circles. The participants also note that they saw cancer affect the psychosocial, physical, spiritual, and social aspects of their patients' lives. Kelly adds,

> not only are you dealing with the patient with the disease you are dealing with the family and the effects of the disease.…it impacts their whole life…there's no subject of your life that your cancer doesn't touch so by the same token there is no subject of your life that we are not going to address with you...

The nurses' incorporate these ways of framing the care they provide in how they view the person in a cancer context. Because the nurses understand that cancer affects their patients' lives in many and varying ways, they provide nursing care that is in line with these effects. Kelly shares how she provided care for a patient who required physical and emotional comfort from the effects of the disease:

> your palliative side comes out in terms of symptom management and you just want to make this person comfortable as well. She would wake up scared and crying – oh – and she loved loved loved having her head rubbed… you'd just rub her head and her eyes would close and she'd lay back again. I feel like I did a lot of that.

A holistic view provides a better understanding of patients both in and out of the hospital contexts as it is a basis for planning for discharge. It is important that patients are prepared for discharge, while still in the hospital, so that their many complex needs continue to be addressed once they are discharged. Kelly shares that, "…it's like looking at all parts of them and making sure everything is going to work for them [patients] when they go [are discharged from hospital]. And that's important…"

#### 4.2.2 Sharing Moments With Patients.

Sharing Moments With Patients describes the nurses' experiences during the meaningful moments they spend with their patients. Mary said "when we left at the end of the day, I made a difference and I found it very rewarding. I had satisfaction of working."

The nurses describe making a difference in their patients' lives when they feel as if their patients' days are different or perhaps better because of their care. Mary shares that oncology nurses, "…want to make a difference in that person's [patient's] life." Whether the outcome is bad or good, nurses come to work prepared and open for what the day will bring. Regardless of the outcomes, they find satisfaction from feeling as if they make a difference in the lives of oncology patients.

Nurses describe the impact of small gestures, or the "little things," on their perception of their work. These small things refer to a quick hello to a patient or organizing a walk in the hallway for a patient who had previously been too ill to get out of bed. The participants reflect upon these moments as being very rewarding. Kelly reflects, "It is a rewarding place to work but it's not easy." Feeling rewarded comes in the form of satisfaction with their work and as they recognise that they have made a difference in the lives of their patients.

Nurses feel that the "small things," which one nurse describes as "not technically a nursing skill," like watching a hockey game with a patient or being with a patient who is unable to sleep are integral elements in relationship building with their patients. Stephanie shared, "it is those times, in the middle of the night that the person is up wondering what the day is going to bring and you spend that time with them. That's the important stuff." These times are examples of how the nurses make connections with their patients. Often the participants see patients at their most vulnerable points. Annie shares, "They are just human beings like the rest of us."

Sharing these moments with patients helps to take the focus off the patient's cancer diagnosis. Holly recalls a time that she shared a passion for hockey as she sat with a patient and watched an Olympic gold medal game, "…stuff like that which normalizes them [makes patients feel a sense of normalcy] but the focus is always them and that for me, being present, is making sure that I can always give my full attention to that focus."

#### 4.2.3 Being in it for the Long Haul

Being in it for the Long Haul refers to how the nurses journey with their patients over time. Patients and their families endure many and lengthy hospital stays and are accompanied by the nurse throughout each admission to hospital which can include diagnosis, and treatment through to death. Oncology nurses make a commitment to being with their patients over time throughout treatment for their disease. Mary illustrates this when she says, "…wanting to make that voyage…it was like a privilege to journey with somebody who is dying... You know you have to be committed to it."

The development of trust, for patients and families, is a key element of the nurse-patient relationship throughout these hospitalisations. This trust develops over time for patients. Kelly speaks of trust building through being physically present:

> it develops with time, partly because our patients are in and out through treatment for at least a year and they stay on the unit and I think they see a lot. They [the families] see so much of what you do on a day to day basis and not just what you are doing for their loved ones but they see you physically. Most of them are there around the clock…it's not just like they come in and catch a brief glimpse of you for an hour visit. They see you for twelve hours.

Patients are admitted to hospital many times over many years. And treatment for cancer does not occur quickly. The participants are aware of the time that is required in order to provide nursing care for the whole person. Annie says, "I don't want the quick fix. I don't want to be a part of the quick fix."

## 4.3 Being an Advocate

The theme Being an Advocate, describes the challenges and difficult situations that oncology nurses find themselves dealing with daily. Despite these challenges the nurses persevere to provide for the needs of patients' and their families'. Being an Advocate includes three sub themes; Dealing With Challenging Situations, Meeting the Needs of Patients' and Their Families', and Helping Patients to Move on.

### 4.3.1 Dealing With Challenging Situations.

The nurses face many challenging situations on their inpatient oncology units. For example, there can be a lengthy period in which patients are waiting for their results. One participant shares a particularly challenging experience in her practice related to who has information, who communicates it to patients, and when. As Holly explains,

> You know why they are on the unit….the patient is sitting here all weekend waiting to find out that they have leukemia and to start treatment and no one has actually gone in and talked to them about their bone marrow biopsy…letting them sit there for three or four days pining over what is going on.

Stephanie further elaborates about the challenge of being limited in what to say to a patient because they have not been informed of their prognosis,

> you know usually before them [the patient] that probably this isn't going to have a good outcome…when the health care team knows and the family doesn't know you're still offering hope because that's what their knowledge

> is at the time but knowing that it's kind of a false hope but you can't share that as a nurse. It's physicians that have to bridge the gap first, right?

Wanting the best possible outcome for their patients despite an often poor prognosis is another challenge that left the participants feeling frustrated. Kelly was challenged when a patient who had knowledge of the disease and her prognosis had not come to accept changes to the plan of care that were more appropriate. She describes the internal struggle as follows:

> when they told her there was nothing else that they could do for her, she shut down … there are things that she still wants in her treatment that aren't going to do her any good anyway, and that's hard… you worry about how the end will be for that person. You know it could be so peaceful and I'm afraid it won't be, like, I am afraid I am going to code this woman [initiate cardio pulmonary resuscitation] I am afraid it's going to be a painful experience and a frightening experience for her instead of a comfortable experience with family.

In contrast, Kelly also reflects on a time when she did not think that the plan of care was helpful for the patient. She describes what she felt,

> There are times when that internal struggle happens when people are so sick and you feel like they are suffering and what you are doing isn't helping them it's just making them suffer more and that's a struggle when you feel you feel like I am torturing them.

When faced with these challenging situations, participants focus on doing anything to help patients to understand the situation better. Annie felt as if she would

do anything to help her patient, “if I could have sat down on top of him that’s what I would have to do to keep him in bed and try to keep him comfortable”. Stephanie shared that she is, “cautiously optimistic…you say vague things…but still looking at the positives…and you try not to focus on next week or when the therapy will kick in”. Kelly remembers questioning the treatment approach for a patient, which was affecting the goals of care for the patient. In the following quote the nurse asks herself several questions,

> I felt as though I liaised between her and her partner and the physicians a lot because you know like - part of it was me trying to get my head around it…I kept saying “Prognostically what is going on?” I asked this question to the physicians a lot, “Do you think what we are doing is going to make her well? Is what we are doing reasonable? Is it helping or is it harming?” I asked that question to physicians a lot.

Mary elaborates about the challenges, saying:

> you become a better nurse and a better person…You’ve got be very strong and have a love for what you do…because even though you are going to help that person it’s not going to be very easy.

#### 4.3.2 Meeting the Needs of Patients’ and Their Families’.

The needs of patients and their families change over the course of their hospitalisations. When patients are initially admitted and first diagnosed with cancer they are likely to be more independent than if they have been in the hospital for many months. Kelly illustrates that the focus of her care is different at different points

along their disease process, noting that "when someone is first in for treatment they are pretty independent…I think your focus of care becomes different…"

In working to meet the needs of patients and their loved ones, participants spoke of nursing care that focuses on providing them with appropriate information. This information sharing process serves as a way to prepare their patients with realistic plans of care. For example, Mary recalls having someone come to speak to a patient's niece who was nervous about pain medication. She states that, "This helped Ruth and she was able then to say "okay, I understand where you are coming from." Sharing knowledge with the family helps them to understand and prepare for what occurs in the hospital environment. Holly describes facilitating patients' participation in their hospital experiences, "I find a lot of patients really don't know what is going on" and providing them with information makes it "so they're a part of it too."

Tailoring the information to each patient requires an awareness of individual patient and family member perspectives and pasts. As Mary explains, "sometimes a lot of the way the family reacts is history. They have history." Information about cancer and its management is widespread and readily available to the public. This is reflected in Diane's response regarding her role in the management of information.

> peoples' beliefs are rooted in what they've seen on TV and they know what their grandmother's experience was from fifty years ago…one part of the oncology nursing role is to bring them to the current time and help them understand the current system.

Often patients are not aware of what their options are. Diane explains that part of her role is, "helping people to access those options or be aware of them so you can co-

define with the family what is considered good care…at least you can explain… so that they know where they have to go next."

Nurses assess the needs of their patients through their interactions with them. Annie shares what helped her to know her patients' needs: "It's plain and simple….Just ask them. Ask them. What it is that they want? What is it that they want to achieve?" Holly views her role as helping her patients understand their realities, for example, when "you are helping people through the realization that they are going to pass away." Stephanie helps her patients by "trying to make some sense out of it for them." The participants all speak of acting on behalf of their patients as far as possible "in giving them what they need and what they want" as Annie describes. Annie continues to reflect on how she approaches providing nursing care for her patients. She shares the following, "I don't nurse people because *I* think that is what they [the patients] need….you can use your own strategies based on what you see [occurring with the patient]." While nurses use their judgement in providing nursing care it is based on their patients' needs and wants.

Acting on behalf of patients includes suggesting a medication from which a patient can benefit or helping to reconcile a family issue. For example, Holly recalls helping a family to decide if they would allow the estranged son of a patient to see his mother as she lay dying. She remembers thinking to herself "what would I want in this situation." The ability to advocate for the best possible care for their patients includes an element of self-reflection. Kelly explains, "you have to sort of figure out where your biases begin and end because you get to thinking not that you know what's right for this person but you know what is futile for them."

#### 4.3.3 Helping Patients to Move on.

Participants also view their role as facilitating a journey with and for their patients. Their role within these journeys is seen as helping patients to achieve personal goals or at least moving towards their personal goals. Participants describe helping patients' progress toward reaching their goals. Annie describes moving on in the following way,

> by moving on that means moving on towards their death, if it's moving towards going home or going home to die, or if it's moving on just toward getting better and getting out of there [the hospital] ....it's always helping the patient towards what they need…it's their goals.

Being able to journey with patients as they move on is facilitated by time and is valued by the participants. Annie states, "you can't just sit down and have a five minute conversation, you have to be able to listen to people to know what it is they need." The participants characterise the time spent with their patients on these journeys as a privilege. Kelly describes that, "it is such a privilege to be a part of these families' lives….You are let into these peoples' lives in such an intimate way." She also adds, "There is such a trust to be part of their family and part of their lives and know the intimate details of them.…I think it develops with time."

The nurses feel as if their work is of value when patients and families are happy with their care. Annie reflects, "It feels great because that's what I am doing it for…and if it means they can function or move on then that is important." Diane describes being overcome with emotion when her patient was discharged home after watching her deal with many challenges throughout her hospitalisation.

After patients are discharged from the hospital, the nurses may not always be aware of changes in their condition. As Stephanie says, “It would be nice to rotate down there [in the cancer clinic where they do follow up appointments] because it would be nice to see if they lived or died to wrap up [the nurses’ experience].” This kind of continuity would provide closure for the nurses. Another experience that provides closure is attending funerals of patients who have died. For Mary, closure comes from being able to say goodbye, “at least you have said goodbye. Nurses need closure…otherwise we would never last in this profession.”

## 4.4 Walking a Fine Line

Walking a Fine Line is a tightrope walking metaphor and is composed of two categories; Finding a Balance in Life and Negotiating Investment Into Patients’ Lives. The theme reflects the skill required by oncology nurses to keep work and home experiences separate, in addition to balancing the emotional connections with, and into, their patients’ lives. The participants support one another because, at the end of the day, as Mary explains, “we have to be able to go home – we have done a good job. We walked that line.” Yet, although the balance between investing and becoming too emotionally involved with their work is maintained, Stephanie shares, “I think in any job you take out of it what you put in, and there’s a fine line always between investing too much of yourself in your job.”

### 4.4.1 Finding a Balance in Life.

Finding a Balance in Life describes the participants’ need to create space or maintain a balance between their experiences, however challenging or routine, of work and their home life. The tightrope walker carries a balance bar to help to

maintain balance across the tightrope. If the bar begins to lean too far on either side, the tightrope walker can lose their balance. For the oncology nurse, the bar is balanced on one side by their work and on the other by their home lives. If unable to balance the emotional aspects of their work then oncology nurses will be challenged to continue with their work. This separation, or balance, is required because of the emotionally-laden and challenging aspects of oncology nurses' work.

Cancer affects every facet of peoples' lives and oncology nurses bear witness to these effects of the disease whether it be spiritual, financial, physical, social or emotional aspects. As Diane states, "The truth is it does impact your life." Mary also describes working with novice nurses. From their time on that unit they come to, "have quite an appreciation for what this disease does to people and how it affects them."

Witnessing the challenges that patients face can have a lasting impact on the nurses' personal lives and finding a balance allows the nurses to continue to walk along the tightrope. Exposure to frequent death of patients causes participants to reflect on their own mortality. Kelly states that, "Oncology is hard. People die. That is challenging no matter what." An understanding and acceptance of death, based on their work experiences, lingers in their personal lives. Kelly also explains that facing death regularly gave her a "skewed view of life…you accept that everyone dies but on a whole other level" and that she is "hyper aware of death." Annie continues to share how facing so much death influences her personal life in that "it prepares you more for even your own mortality."

Because of the impact their work can have, maintaining a balance is important for the participants. These balances enable nurses to go home without being completely drained and to have capacity for their own lives outside of their work lives. The participants describe how these balances, or separations, are maintained. Since the effects of work linger after the shift has ended, Holly explains she would try not to focus on work once she left. She shares, “you are there for the patient when you are here and then when you are not here you try not to think about it. It doesn’t work that well sometimes.”

Diane describes putting herself in one of her patients’ shoes and in doing so she gains a different perspective. This different perspective helps her to appreciate the balance she is able to maintain in her personal life outside of work and not take things for granted. “Often I can think of much worse circumstances that are happening right now, you feel pretty lucky. I think that is a big thing.”

On this tightrope, if teetering to one side, sharing with others helps the nurses to maintain their course and stay on the straight and narrow. Participants describe sharing their experiences with other nurses because they feel understood as they have experienced similar situations. Diane shares, “you get the impression that people who aren’t oncology nurses, like other people in your life, don’t necessarily understand what types of things you see in a day.” Kelly continues to explain that “who” she shares with is important in feeling understood:

> It’s a big deal and to know that they [other oncology nurses] know what you are going through as a nurse…because people who don’t do it don’t always understand it. Whereas your team - they do, because they do it too….you can

> talk it out and that person gets it…they have that shared experience….and to know that there is not as much explaining as there would be to someone who doesn't work in the field, well - like that person can immediately get it, helps a lot. It's not always easy to do what we do but to have other people to share it with does help.

Holly also reflects, "Like the first time one of my patients died I had such a hard time keeping it together… I just wanted to burst into tears and my colleagues were good. They were like "you can go and take a minute." Taking a minute helped Holly to regroup so that she could then provide care for her patients.

The participants feel that patients and families rely on them to be able to do their job to the best of their ability. Holly states that, "you almost need to be the sturdy person to help the family keep it somewhat together as much as they can." Diane feels that, "You can't break down and sob every time a family goes through a hard time. I think that undermines your duties as a professional or makes you seem less professional."

#### 4.4.2 Negotiating Investment Into Patients' Lives.

Negotiating Investment Into Patients' Lives describes the relationships participants have with patients. In getting to know much of their patients' personal lives, the participants discuss how they manage these relationships so that they do not become overly emotionally involved. By balancing the demands of oncology nursing work, as described in the previous category, the nurses' experiences reflect the image of walking upon a tightrope. Walking along a tightrope is characterised by slow, calculated and gentle maneuvers which may include taking a few steps forward or a

few steps back all the while negotiating the tightrope itself and the wind under foot. This is similar to the nurses' experiences of managing the depth to which the nurses engage with their patients and doing so helps the nurses to continue to carry on with their work, along the tightrope. Diane shares that part of her work as an oncology nurse is to get to know patients and "enjoy getting to know peoples' stories and engaging with them over time." The nurses engage with their patients and their families as they get to know them, become close with them, and develop relationships with them over the course of their hospitalisations.

Oncology patients are often admitted to inpatient units for diagnoses or for various treatments and procedures. Some treatment regimens may necessitate that patients remain in hospital for some time. Mary explains that, "Patients come in and then go home and another event happens and they are back in….some of these nurses are dealing with patients for maybe one or two years." As the participants spend each day with their patients and families, their relationships develop further. Kelly states that, "we really get to know our patients and we support them through years of their life." She also reflects upon these relationships and says, "we know our patients so well, we all come to love them in our own way."

Knowing patients includes and prompts a curiosity of, and interest in, patients' lives outside of the oncology context. The participants are curious about their lives before they were being treated for cancer. Mary describes wondering about the hair of one of her patient's before she became sick, "I wanted to see what she was like before she got sick…because they had a life before all of this mess started."

As the nurses come to know their patients, their patients also become familiar with the nurses. Kelly describes how her patients come to know her while she maintains patient focused care, “they [the patients] say little things about your life like “how’s the wedding plans coming?” stuff like that which normalizes them…but the focus is always them.”

The connections with their patients further develop these relationships as participants reflect on their own experiences. Holly, a novice nurse, mentions a similarity that she notices often, “some of them are my age or around my age.” Stephanie also notes that, “it’s something everybody struggles with because you come across patients who are dying that you can really identify with.” Because the nurses identify with patients, Holly shares, “It is hard not to get too attached to them and their families…you try to keep a distance without being too far away from them emotionally.”

The participants share how connections with their patients can interfere with their effectiveness when a certain distance is not maintained. Mary feels that being overly subjective can be cause for concern. She states that, “you’ve got to be very careful. When you sense that you are becoming too involved and you’re not being as objective. That is a clue – back off!” Holly reiterates this,

> if you are too emotionally involved in something you don’t always think clearly about it where if you’re a little bit more away from the situation you are like okay – what is this, what needs to be done about this and this would be the most appropriate thing to do.

Maintaining this distance for one nurse comes in the form of establishing and maintaining professional boundaries. Holly shares, "I don't visit patients if they're not my patients…I won't go out of my way to say hi." She describes how not maintaining these boundaries "would make work harder" where she can "feel like I might drain myself emotionally after a couple of years of being attached to every patient who walks in [is admitted to the unit]."

One of the participants shares her observations of new nurses having difficulty with "crossing the line" in relationships. This phrase refers to not becoming too emotionally close with patients. Stephanie explains, "I see some of the really young people [nurses] that struggle with that initially because you know, they just don't have that experience of that separation." Mary feels that it is important "to be very careful you don't cross that line…you have to be objective." When the distinctions between the roles as a professional and as an individual are lost and boundaries become unclear, the participants warn of becoming too emotionally involved with patients, as Mary elaborates: "if you become too subjective then you are not functioning in your role and you are now a part of the situation."

Often the participants are able to identify for themselves that they are getting too close to their patients. Mary states that,

> the nurses recognise "I think I am a little too close to the family so I am not going to be as productive, I am too involved now"….they have recognised this and will back away from that patient to protect themselves because it is emotionally draining….you've got to protect the caregiver – care for the caregiver.

The participants also reflect on supporting their colleagues when their colleagues are becoming too close. Annie states that, "the nurses that I know…help each other out… and say okay well I'll do [care for] this patient for today."

The degree to which distances are maintained are different for each individual participant. Diane feels that it is important for nurses to be able to share both personal and professional sides with patients and families. She explains,

> you want to provide a professional service to families but you're also a human and you have emotion. Some families do appreciate realizing that their experiences are impacting you. It's a balance. You have to play that balance well. It would almost be insulting if you tried to be completely professional [impersonal] in those cases.

Patients and families come to rely on their nurses and, as Diane explains,

> there is no backing out when things become emotionally difficult…when you've engaged with the family…like it or not… when you go into work if things aren't going well...you can't opt out of caring for them…so you have to have a certain resiliency.

## 4.5 Feeling Like You are Part of Something Good

Feeling Like You are Part of Something Good is another major theme that emerges from the interviews. There are three categories: Keeping on Top of it all, Becoming a Full Member of the Team, and Working in a Shared Philosophy of Care. These categories refer to the growth and development that takes place over the course of the oncology nurses' careers and describes the team and work environment.

### 4.5.1 Keeping on Top of it all.

The knowledge that the nurses are required to maintain and develop is diverse. The ever changing knowledge about cancer and its treatment is what attracted one participant to oncology nursing. Diane states that, "What drew me to it was the blend between an interest in biology of the disease and the fact that there's a lot of work being done in cancer care. It's innovative, it's ongoing."

Nurses' knowledge is required to include the pathophysiological manifestations of cancer, laboratory values, related complications and treatment regimes. Kelly describes oncology nursing as "challenging to you intellectually" and Diane echoes, "…there's not a lot of academic coasting." The need to maintain and continue to build relevant skill is a welcomed challenge for Stephanie as she explains, "you should always be trying to improve your practice…nobody I don't think we'll ever know everything. But we can try." Annie adds to the sentiment as she notes the importance of maintaining knowledge of organizational policies and procedures. She states that,

> the biggest challenge is working with the new medications in the field and the new chemotherapies and trying to keep on top of all of those and on top of all the new policies and procedures… and there's always ways to improve your nursing practice.

For one participant, being part of the development of oncology nursing as a specialty enhances the nursing profession as a whole. Diane shares, "There [are] a lot of education opportunities that come up, so you never feel like you are spinning your

wheels. You always feel like you can develop your profession and that makes a big difference."

Developing skills and expertise is also important for providing safe care to patients, whose health status could change rapidly. Critical episodes of disease related illness can include for example, a system wide infection known as sepsis. When patients experience sepsis they can become near to death rapidly. Another is hypercalcemia crisis, although rare, which requires prompt intervention. Oncology nurses are required to stay alert to patient behaviours suggestive of impending or actual crises, including the aforementioned, for multiple patients simultaneously. These episodes of acute illness can prompt admission to hospital or develop while in hospital. Annie states, "The acuity on this floor since I started has probably doubled." Diane adds, "You have to be a nurse who enjoys being curious and probing. You can't be lazy on your job. It's too dangerous in your job when there's that acuity."

#### 4.5.2 Becoming a Full Member of the Team.

Becoming a Full Member of the Team describes the movement from being a novice nurse in oncology, through to embodying confidence and comfort in their role as valued team members.

Stephanie recalls beginning her career in oncology nursing, "I remember it being really difficult in the beginning, managing the patient load and getting your head around all of the therapies." She goes on to describe how, with more time spent in her role, she feels more comfortable. "It was probably not until a year into it at least that I started to feel comfortable." Holly recalls when she first felt like an

oncology nurse. This awareness of her transformation into the team came as she helped a nurse more junior than she was:

> I wasn't used to somebody asking me stuff….so it was difficult and then it was the realization that I had the experience and I knew what I was doing so then I felt more like a full member of the team versus the new person.

As Holly becomes more confident in her role as an oncology nurse she feels better able to support other team members as they develop their nursing knowledge. Stephanie also describes sharing her expertise with others:

> If you know something really interesting is going on and you know that the person is going to be a member of your team we always tend to take them with us so they can learn by actually seeing and being there.

Junior nurses have exposure to new clinical phenomena with the support of a nurse with that experience. Nurses also provide informal professional support to each other regarding how they handle certain situations as well as their input into certain difficult situations. This is helpful in preparing to face unknown or new situations. Annie explains, "you can go to others and say "has anybody had this?"…you go in and get a new assignment and say "has anybody found this?" Holly adds, "you need to share those experiences and say "well, in this other situation this worked" and then find a solution." This type of informal sharing and support often occurs at the nursing station.

#### 4.5.3 Working in a Shared Philosophy of Care.

Working in a Shared Philosophy of Care illustrates how the nursing team and other members of the interprofessional team come together to provide care that is

situated around one common focus, the patient. Priorities for care are always based on the patient – their needs, plans and goals. Annie reflects, “It’s their [the patients’] goals – not yours. It’s never yours.”

There are many different approaches to cancer treatments and one participant describes some of them as “creative.” The nurses interviewed are very clear about their roles as oncology nurses. They also recognise that, at times, they need to incorporate strategies and interventions from other disciplines. Annie describes: “You’ve got your bedside nursing and you’re doing physio [therapy], and you’re doing OT [occupational therapy].” Diane explains, “We tend to dabble in many aspects of their care and there is a lot of overlap between us and other disciplines where there may be less overlap between other disciplines and each other.”

Although the participants describe the overlap, they also recognise the roles of the interprofessional team member. The professionals on these units work together to address the needs of their patients. Stephanie reflects being part of the interprofessional team and shares, “it wasn’t only us that got the ball rolling but we did identify it early that this was a realistic goal for this guy.” Mary elaborates, “you are not alone with the patient…you become part of a bigger group of people whose main goal is to provide more quality of life for someone else.” Diane also shares, “Everyone definitely shares a vision and cares about what they do.”

Communication is identified as an essential element for the oncology nurses working in an interprofessional environment. Patient rounds bring together the many disciplines and are a venue for the team to share their philosophies of care. During

patient rounds all of the patients on the unit at the time are discussed and each team member has the opportunity to voice their plans for care. Stephanie explains,

> Well that you know people are on the floor or on the unit that you can actually talk to face-to-face in terms of the doctors and physiotherapy, OT [occupational therapy] and those people are focused on the same goal and that's important too right.

Diane describes the importance of communication, "there's the inter team communication which helps things like better continuity for care for patient." Being able to approach other team members promotes positive aspects of patient care.

## 4.6 Summary

Oncology nurses, working in the inpatient context, witness the ways in which cancer affects the lives of their patients and their family members. They provide nursing care that is grounded in this holistic understanding of their patients' cancer realities and describe being impacted emotionally by the challenges they face and by witnessing the struggles of others. Despite these challenges their stories illustrate how they develop relationships and connections with their patients as they negotiate or manage the extent of the emotional involvement with their patients. Over the course of their careers oncology nurses acquire knowledge and skill, growing as professionals and individuals from their experiences and give back to their nursing peers. Becoming an oncology nurse is marked by an increase of confidence and competence as, over time, they realize their identities as oncology nurses. Through working with like-minded professionals they receive and provide support in order to continue to be able to make a difference for patients and families.

# Chapter 5: Discussion of Findings and Implications for Nursing

The purpose of this inquiry is to seek to explore the meaning of being an oncology nurse in order to better understand the work of oncology nurses. In this chapter, a discussion of the findings and limitations of the research project are presented. This chapter also includes a review of the implications of the findings for nursing in addition to implications for each of the advanced practice nursing competencies as outlined by the Canadian Nurses Association (2008): clinical, research, leadership and consultation and collaboration.

The meaning of being an oncology nurse, for the participants of this study, is reflected through their investments in patient care, in colleagues and in themselves. The emotionally challenging nature of their work means balancing work and home life as well as how engaged they are with patients. They make a difference in the lives of their patients' over time as patients journey through the trajectory of their illnesses. As their identity as oncology nurses develops they also feel as if they are part of a team working toward a common goal. In being members of the team, these nurses also support other nurses' development.

## 5.1 Caring for the Whole Person

The findings of this study suggest that oncology nurses in this care context view their patients through a holistic lens and use this lens to guide their nursing care. The nurses recognise that cancer affects every aspect of patients' lives and their family members. This supports a traditional conceptualisation of holism in nursing that, as described by Clark (2012), portrays patients as multidimensional beings

where a disruption to one dimension affects the others, such as in the psychosocial, physical, and emotional dimensions.

Caring for each dimension of the patient is noted as having importance for nursing care the participants provided. Although the nurses describe using similar strategies to provide emotional, psychological and physical care, they recognise that these strategies are interconnected and need to be individualized to each patient. An example of this interconnection from this study is the nurse taking a patient for a walk in the hallway. This strategy can provide physical care for the patient in mobilizing him/her but also can have a potential social and emotional impact in helping the patient to socialize outside the hospital room. Taking the patient for a walk can sooth an aching hip which could have resulted from limited mobility or the patient was made to feel safe as the nurse laid hands upon the patient to help get up from the chair. Another example from the study is the story of a participant who watched a hockey game with her patient. She provided comfort to him with her physical presence as they watched the hockey game together. The patient later shared with her that, although briefly, sharing a love of hockey with her helped him to have a break from his cancer. Steeves, et al. also found that oncology nurses participate in patient experiences and are present with them.

The holistic lens also forms the basis for how nurses in the present study come to understand and know each individual patient and the nursing care they provided. These oncology nurses got to know and develop relationships with their patients and families over time, sometimes over several years, as patients are often admitted to hospital on several occasions, for example, for diagnostic testing,

treatments and or for the management of complications. Getting to know patients, as Tanner, Benner, Chesla, and Gordon (1993) suggest, includes knowing them not only by expected patterns of response but as individual people. Nurses understand the depth and complexities of their patients through their involvement and engagement in the nurse-patient relationship (Whittmore, 2000) and gain additional insight into their needs (Wu & Volker, 2009) which can help to guide nursing decision making and judgments (Benner & Tanner, 1987).

Carter (2009), in a literature review of trust, suggest that trust is central to the development of the nurse-patient relationship. Trust serves to develop further these relationships as patients over time come to know that their nurses act with their patients' best interests in mind (Carter). The nurses interviewed in the current study identified that trust is an integral component of the relationships with their patients. It is developed over time through being physically present and visible for patients and their families and through understanding patients' experiences, such as, their fears. It is through being present at the bedside providing care and conversing with patients that nurses in the present study, came to understand the experiences of their patients. Benner (1984) refers to nursing presence as "presencing" which reflects a way of being there and where nurses use their physical selves to comfort patients through, for example, listening. Covington (2003) situates nursing presence within the art of caring as it is through nurses' physical acts and their presence that caring and connections with patients occur. Consistent with findings from the current study, La Cava Osterman, Schwartz-Bancroft, and Asselin (2010) found, in their study on

nursing presence on an oncology unit, that it is embedded during daily care activities and in routine interactions with patients.

Participants in the current study describe feelings of satisfaction and of making a difference in the lives of others, which arise from the shared moments that occur in their work. Shared moments include stroking a patients head, taking a patient for a walk in the hallway, or watching a hockey game together. These moments sometimes create an aspect of normalcy in patients' lives in which cancer was not the primary focus. Bottorf and Morse (1994), in their qualitative study on the experiences of thirty-two cancer nurses' patterns of behavior, describe this as "doing for". Bottorf and Morse describe this type of attending as responding to patient care that is not directly related to treatment and often involves extras where the approach is personalized. In the current study, these individualized approaches to nursing care reflect nurses' investment into the many dimensions of their patients' lives.

### 5. 2 Being an Advocate

Patient advocacy can be characterised by care that is focused on and situated within the needs of the patient. Being an advocate for patients is revealed through a commitment to providing care for patients and family members (Burhans & Alligood, 2002; Foley, Minick, & Kee, 2002). This advocacy is evident in the stories shared by the oncology nurses in the current study. Advocacy is mentioned in relation to access to information about such as, the disease, treatment outcomes, progress, prognosis and assistance in navigating the health care system. The participants carry out the role of advocate as they speak with their patients to assess, plan, and implement care. They also discuss acting on behalf of their patients and

family members, when they communicate with the interprofessional team, with patients' best interests guiding the care they provide. They do so as they dialogue about medication regimes, question plans of care that do not align with the wishes of their patients, and including the patient's goals in the planning of patient care. One example from this study is of a nurse who facilitated the discharge for a patient who wanted to go home to die. Vaartio-Rajalin and Leino-Kilpi (2011), through a comparative analysis of the literature on advocacy in oncology nursing, identify three overall advocacy activities: analysing, counselling and responding. These occur through assessing and understanding patients' care preferences and in counselling patients on their care experiences.

Over time, patients' needs and goals might change and this can occur over a few days or a period of weeks to months. Cramer Bertram and Magnussen (2008), in their study on the information needs of women with abnormal papanicolaou smears, assert that patients' informational needs are different at various points along the cancer trajectory. They emphasize that oncology nurses are well suited to assist in patients' making decisions about their illness experience. For example, oncology nurses in this study have discussed with patients where they would like to die in addition to who they would like to be present. In comparison to other health care practitioners, nurses spend the most time with patients and over time they come to know and understand their patients through a holistic lens and incorporate these understandings into the care they provide to patients.

Participants describe times when patients are not told of their diagnoses or are made to wait for information when perhaps other members of the health care team

know of their diagnoses. Pavlish and Ceronsky (2009), in a study of oncology nurses' perceptions of the palliative care role, discovered that oncology nurses feel that one of the five attributes of care is honesty. Honesty sets the stage for a plan of care that reflects respect, a key component in the nurse-patient relationship. It is a "prerequisite to patient advocacy" and furthermore was the "foundation to a cohesive treatment plan" (Pavlish & Ceronsky, 2009, p. 407). Oncology nurses in the current study share how the inability to communicate honestly limit the investment they can make into their patients and leads them to be vague in their interactions with their patients. Kendall (2006b) describes that this type of care limits nurses' abilities to "provide effective holistic care to patients" (p. 1154).

Participants discuss addressing patients' care issues partially by either avoiding questions or changing the topic of discussion altogether. Nurses are challenged in their role as advocate, by the limitations imposed upon their nursing care. When patients are not provided with all of the relevant knowledge they need to make a fully informed decision they cannot be active and equal partners. Participating in the care planning and decision making facilitates patients to cope with their illness (Ramfelt & Lutzen, 2005) which for some patients and families, can make a difference in how cancer affects their lives.

Although nurses in this study are opposed to withholding information from patients they do not discuss whether they engage with physicians responsible for this communication. By investing in a collaborative approach through sharing their concerns with physicians, perhaps these situations can instead create a positive outcome making the difference between uncertainty and certainty for patients rather

than feelings of frustration. McGrail, Morse, Glessner, and Gardner (2009) in their qualitative analysis of nurse and physician narratives of collaboration, suggest that emotional triggers for collaboration are underpinned by the professionals' feelings of worry or feeling vulnerable. The emotional triggers for nurses are characterised by concern for patients' progress. These findings support the current study's findings, as the nurses' stories also reflect concern for patients who, for example, are admitted to hospital on an oncology unit but are kept waiting for days to receive information. Cohen and Erickson (2006) state that unresolved dilemmas can lead to frustration but by collaborating with physicians and other members of the team nurses can work to limit these challenges.

### 5. 3 Walking a Fine Line

Findings from this study reveal that oncology nurses get to know their patients and family members over several years and over several hospital admissions. The relationships and the emotionally charged nature of the work of an oncology nurse means that they need to balance work and home life as well as how engaged they are in these relationships with patients. Nurses invest in their patients' lives as they provide nursing care for, patients and families as they are diagnosed, treated, and either experienced remission or face death. Through getting to know their patients, the nurses in this study give of themselves as they share stories and information about their own lives with patients. Bottorf, Gogag, and Engelberg-Lotzkar's (1995) in a qualitative study which examine comfort in an oncology setting find that social exchange is among the comforting interactions described by a sample of eight oncology patients. Other interactions include gentle humour, physical

comfort, providing information, emotionally supportive statements, choices regarding care, increasing proximity, and touch. Social exchanges are characterised by friendliness and mutual conversation between the patient and the nurse and provided comfort to patients who are not in acute crisis. The weather is a common topic and leaves patients feeling as though they are more than simply the sick patient for a brief moment in time.

In a descriptive phenomenological study in which twenty adult inpatients on an oncology unit were interviewed about talking about their emotions, Kvale (2007), found that patients do not always wish to talk about their disease and emotions. Findings from Kvale's study suggest that normalizing their experiences occurs through dialogue of everyday occurrences and of personal hobbies and interests unrelated to their cancer. These findings support the findings of the current study. The oncology nurses interviewed discussed similar exchanges about upcoming weddings and sharing anecdotes of pets and children. These conversations can facilitate patients' connections with their nurses (Shattell, 2005).

However, the development of these informal relationships with patients make necessary the creation of a working balance within and between the emotional aspects of their work and how much they invest of themselves into their work. Included in the theme Walking a Fine Line, is establishing and maintaining an emotional distance within the nurse-patient relationship. The nurses in the present study reflect on achieving this through a balance, so as to avoid carrying the emotional aspects of their work home with them. They describe strategies to limit the effects of being too emotionally close with their patients which includes seeking a

change in their patient assignment, or caring for the patient of a colleague. Sharing with their oncology nursing peers, those patient experiences that are emotionally taxing, also facilitates this balance. The oncology nurses who have shared in similar experiences as their colleagues feel as if others understand and emotionally support them. They do not share their experiences with others who are not involved in oncology nursing care as they feel they are unable to understand. Similar findings have been reported by others (Wenzel, Shaha, Klimmeck, & Krumm, 2011). In a study of both adult and pediatric inpatient and outpatient oncology nurses and their experiences with professional bereavement, participants feel that those who had not shared similar experiences are not as helpful as someone who has.

The participants in the current study routinely witness the suffering of others and are prompted by their work to identify with and self-reflect on their own lives. In an interpretive phenomenological study, Sabo (2011) examined the experiences of twelve nurses working with patients who had hematopoietic stem cell transplants. Sabo found that as a way to protect themselves from the adverse effects of sharing in the suffering of patients, a self-protective method involved separating themselves from their patients. However, Sabo also found that when nurses engage in the practice of distancing themselves from their patients they feel less fulfilled. The nurses in the present study also are required to manage the emotional impact of their work on their personal lives and on their ability to continue to invest in and meet patient care requirements.

Carter and Tourangeau, (2012) found that the biggest predictor of nurses' intention to remain employed is the physical and psychological responses to work.

The authors found this is directly linked to nurses being able to find a balance between their personal and work lives. The nurses in the current study discussed this balance as being important so that they can continue to invest in their work. This balance not only serves as a protective mechanism for the work they do, but supports their ability to be able to return to work each day.

### 5.4 Feeling Like You are Part of Something Good

Although oncology nursing work has inherent challenges, such as, often witnessing death or not agreeing with a proposed plan of care, these challenges can be managed through supportive structures embedded within the practice environment. For the nurses in this present study, a supportive practice environment is created by nursing colleagues, a supportive unit manager and interprofessional team, all of which they describe as “being part of something good”.

For nurses in the present study, these aspects of a supportive environment facilitate the development of their identities as oncology nurses. Wengstrom and Ekedahl (2006) suggest that the professional nursing team helps individual nurses to develop professionally with support, which facilitates sharing with and learning from, and respect for others. In the current study, nursing colleagues provide mentoring and offer support to each other in dealing with complex clinical situations. They also support each other with the emotional aspects of their work such as in the care of dying patients. A survey of Canadian oncology nurses found that, in general, oncology nurses were satisfied with their work environments (Bakker et al., 2010). In the study, the nurses were satisfied in being nurses and felt they had positive influences on the lives of their patients. Although these positive influences were not

provided in detail, the nurses felt competent in providing care to patients and their families. In addition, in the study by Bakker et al., oncology nurses felt that "a clear philosophy of nursing" (p. 55) was apparent and was present in their work environments.

The "professional network", according to Haavardsholm and Naden (2009) assists in nurses' confidence when this network of colleagues is supportive. Feeling supported by other members of the nursing team is an aspect of the nursing environment that enhances development as an oncology nurse. As nurses begin to develop confidence, their identity as an oncology nurse and member of the oncology nursing team emerges. For example, one participant reflects on when she first identifies herself as an oncology nurse as the point when she realizes that she is confident in her knowledge and shares it with a nurse more junior. The Healthy Work Environment Best Practice Guideline (Registered Nurses' Association of Ontario, 2006) lists sharing of expertise as an attribute of teamwork and suggests that enhancing a healthy work environment is a responsibility that falls to all members of the nursing team. As full members of the nursing team, nurses in the current study are able to give back to their profession as they are exposed to a culture of support and as part of the nursing team recognise that giving back is achieved through supporting new nurses. Hayes et al. (2005) cites that as oncology nurses develop they became concerned with using their expertise to influence the practice environment.

For nurses in the present study, these aspects of a supportive environment facilitate situational transitions they experience. Situational transitions are those that occur in response to situations or events (Schumacher & Meleis, 1994) and in this

study are reflected in the transitional experiences from a novice nurse working in oncology to being an oncology nurse and a full member of the team. For one participant the ability to communicate assertively characterises this development. Benner (1984) suggests that as nurses develop they are able to further engage and become more involved with their team. For example, one participant recognises her identity as an oncology nurse through her involvement in and contributions to patients, the unit and professional culture. However, Wengstrom and Ekedahl (2006) suggests that when nurses are not cognizant of their contribution to patient care, their professional identity is not fully developed. Recognition of and becoming part of, the nursing team occurs over time as competence and confidence develop for this group of oncology nurses. This finding supports Casey, Fink, Krugman, and Propst's (2004) research findings that competence and comfort begin to occur around the one year mark of nursing practice. The transition into becoming a full member of the nursing team coincides with the realization that they feel they can meet the needs of their patients and the demands of their roles. In a study of pediatric oncology nurses' first year of nursing, Linder (2009) finds that in addition to confidence and competence, participants perceive that they are legitimate members of the team, as do the nurses in the present study.

Underpinning the transitional experiences of the participants into full members of the team is communication. Findings of the current study suggest that communication with other team members plays a role in nurses' development. Apker, Propp, and Zabava Ford (2009) describe open team communication as encouraging team synergy. Team synergy is explained through seven communication

practices of nurses in their work environment. Of particular relevance to the current study are the practices of mentoring peers and coordinating the patient care team because communication practices such as these, as Apker, Propp, and Zabava Ford finds, can influence nurses' intent to remain employed. Participants in the current study feel satisfied and supported to continue to develop and be part of the team that provides nursing care to oncology patients. Indeed, most of the participants began their nursing and oncology careers on the units utilised for this study.

As nurses develop into full members of the nursing team they also become part of the larger interprofessional team, providing care to oncology patients. As part of an interprofessional team nurses are required to represent their expertise to other members of the team (Vyt, 2008). According to the study participants this usually occurs during, what is commonly referred to as, rounds. During rounds each discipline contributes through an ongoing dialogue regarding individualized plans of care for each patient. The goal is to plan, evaluate care and to determine the next steps in patients' care. Rounds are planned occurrences and generally more formal in nature. They are however enhanced with ongoing unplanned and informal communication as necessary about acute patient care issues. For example, if a patient has an abnormal blood test result, a nurse may telephone a physician to discuss the most appropriate plan of action. When nurses are cognizant of their own professional identity they can then begin to understand their role, support nursing colleagues and work with the interprofessional team, for example during rounds. The nurses in this study reflect on the interprofessional teams and recognise that in order to meet the

complex needs, shared goals of patient care and patient wishes they are dependent on this team.

## 5.5 Conclusion

The findings of this study contribute to the nursing profession's understanding of the meaning of being an oncology nurse. Oncology nurses invest in their personal and professional lives in order to make a difference in the lives of those patients and families who face cancer. Oncology nurses witness the effects of cancer on patients and their families as they journey with them along the cancer trajectories. The experiences of oncology nurses mark by the time spend with patients, connecting with patients and families and in sharing their cancer experiences. These relationships give the nurse insight about the patient which helps them to guide nurses' decision making in the provision of care.

Oncology nurses, over the course of their careers, commit to their own knowledge and skill development and in supporting the development of their fellow nurses. They also become contributing members of the team. In giving back to their team they continue to give and receive support within the structure of the hospital unit. It is the structure of a supportive team environment that sustains oncology nurses ability to continue to make a difference in the lives of others.

## 5.6 Implications of Findings for Nursing Clinical Practice, Education and Research

The findings of this study are relevant for nursing clinical practice, education and research. Implications for further work are outlined.

### 5.6.1 Clinical Practice.

The majority of participants in this study began their practice of nursing on the selected units. Feeling part of the team occurred over time and was marked by the development of their identity as an oncology nurse. As these nurses refine their skills and acquire knowledge, they feel more like a team member. The oncology nurse participants express a value for knowledge and skill development and utilise nursing team members in helping to further shape their development as an oncology nurse. Units that foster knowledge and skill development of their staff, can do so through the use of nurse educators and opportunities to attend courses and conferences, to facilitate staff development of clinical expertise.

The participants reflected on becoming a full member of the team and when nurses feel as if they belong they are more likely to remain employed (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010). By creating and maintaining a supportive work environment that promotes knowledge and skill development, hospitals in turn work to attract and retain nurses and invest in oncology nursing.

It is made clear, from the findings of the current study, that this particular group of oncology nurses appraise the time spent with patients as integral in the provision of nursing care. These nurses recognise, that the time required to carry out the physical skills and care requirements, such as the manual turning and repositioning of patients, facilitates the connections made with their patients. These connections, are developed over, and are strengthened by, the moments nurses share with patients which can occur during a bed bath. It is during these moments where nurses learn about their patients and gain insight into how cancer has impacted their

lives. It is of utmost importance to ensure that nursing curriculum is designed to assist nursing students to capture the significance of these moments. Students need to be given ample opportunities to provide care such as bathing patients so they can understand the impact of basic nursing care on knowing their patients.

#### 5.6.2 Education.

Nurses in this study discuss communication as integral to their work. For example, communicating with members of the interprofessional team may be required to facilitate pain relief for a patient. Communication has been implicated in the provision of patient safety (Leonard, Graham, & Bonacum, 2004) and can be used as a predictor of quality nursing care (Un˜a Cidon, Martin, Hijas Villaiza´n, & Lo´pez Lara, 2012). Nurses in this study do not describe how they communicate and speak up in situations in which they feel challenged such as when patients do not know about their diagnosis. Speaking up is defined by Sayre, McNeese-Smith, Leach and Philips (2012) as "using voice to make specific information that is privately held known to someone - with positional power or authority - to take action" (p. 154). In this study, nurses provide each other with specific support for helping themselves to speak up in challenging situations. Nurses can engage in advocacy such as, speaking up and support each other to speak up which can facilitate their ability to make a difference in the lives of patients. These findings can be used to inform the orientation of new nurses working in oncology as well as experienced oncology nurses in that they can be given coaching to speak up during challenging situations.

Nurses in the present study show a commitment to the care of patients and their families as they develop their knowledge and skill. This includes keeping up to

date about treatment modalities, hospital policies and procedures, and about medication regimes. The complexities and effects of cancer require that nurses continue to develop themselves in order to meet the changing needs of their patient populations. Maintaining competency, for these nurses, reflects a commitment to their patients. The College of Nurses of Ontario (2002) states that it is the responsibility of the individual nurse to ensure they have the necessary knowledge, over the course of their career, to meet the needs of patients. While nurses are responsible to continue to develop their own abilities, in doing so nurses also develop their profession and expand nurses' roles in different clinical settings, as one participant noted.

As learned from the nurses of the current study, hospitals need to provide opportunities for nurses to take courses, have sessions with clinical educators, and attend conferences. Hospitals can pair with an education and mentorship organization, such as the deSouza Institute, to promote oncology nursing knowledge and development through mentoring initiatives.

#### 5.6.3 Research.

Nurses in this study characterise their development as nurses through gaining experience over time, and by a transition into identifying themselves as oncology nurses. The transition into becoming an oncology nurse requires further exploration, from a research perspective, in order to inform the profession's understanding of these transitions and how they may relate to the meaning of being an oncology nurse. Research of these transitional experiences can be used to develop education and orientation sessions for new oncology nurses. Research energies, for example, can be

directed toward emotional support needs of new nurses working in these contexts given the emotion-laden nature of oncology nurses' work.

Nurses in the present study discuss maintaining a balance between their professional and personal lives and its significance in being able to continue to invest in their work. Strategies that facilitate this balance for nurses include seeking, receiving and providing emotional support from peers with similar experiences. The participants do not however, discuss how the environment supports them to invest in themselves which can help them to be present, attend to their work and continue to balance the demands of oncology nurses. Further research needs to be done on how work environments can help nurses to find this balance and to support nurses holistically through, for example, the mechanisms which allow nurses to discuss issues with colleagues.

## 5.7 Implications of Findings for Advanced Practice Nursing

The findings of this research inquiry are significant for the advanced practice nurse (APN). A hallmark of advanced practice nursing is practice that is situated in a specialized area of care (CNA, 2008). Having advanced education and training in oncology situates the APN to support oncology nurses who work in a variety of patient care areas. Implications of the findings are discussed in relation to the Canadian Nurses Association competencies of advanced nursing practice; clinical practice, research, leadership and consultation and collaboration.

### 5.7.1 Clinical Practice.

The oncology APN has expert clinical knowledge supported by clinical experience in providing direct and indirect patient care over the course of the cancer

trajectory. With advanced knowledge and clinical skill, the APN can role model care clinical practice in complex patient situations. They can also assist in discussions about ethical dilemmas and challenging situations such as those faced by the nurses in the present study. Specifically at the inpatient unit level, APNs can provide nurses with strategies towards enhancing collaboration, and ultimately patients' experiences, through communication with interprofessional team members when faced with challenging situations. It is clear those situations, where patients are not aware of their own health situation, create uneasiness for the participants as to how to proceed with nursing care or how to approach the team. Collaboration initiatives can serve to help nurses build comfort in the face of the unknown in challenging situations.

Through their stories it becomes clear that nurses in the present study recognise the need for and value their ongoing professional development. For example, the orientation of a nurse new to oncology that also is a novice nurse can include basic oncology nursing elements. This nurse can be closely partnered with a nurse with more clinical experience at first and over the first year of practice, as the novice nurse begins to gain experience the partner, or mentor, slowly withdraws leaving the nurse feeling as though she is becoming a full member of the team. Mariani (2012) suggests that mentoring is important for both novice and experienced nurses and that the bulk of mentoring occurs informally.

Advanced practice nurses can also advocate for the importance of spending time with patients because of the relationships that develop over time between the nurse, patient and family. Advocating for the importance of time in the clinical environment can include having discussions with nurses about the time they spend

with their patients and in helping nurses to secure time with patients that serves to develop the nurse-patient relationship.

### 5.7.2 Leadership.

One of the functions of the APN in the leadership domain is to support others to deliver effective patient centered care. This is accomplished through role modeling and living the vision and mission of the organization, regulatory bodies, and oncology nursing organizations. Leadership is also reflected in care that advocates for quality of life and health for patients (CNA, 2008). Advanced practice nurses can help others to navigate challenging situations.

In their professional positions, APNs are able to view and understand the organizational structures of cancer care including implications for the alignment of services between community and hospital providers. As a result, oncology APNs are able to anticipate the needs of patients as they move throughout the continuum of care including while they are on the unit as well as when they are discharged home or when they attend oncology outpatient clinics. Findings from the current study suggest that it is common for oncology patients to return to the inpatient nursing unit multiple times throughout their cancer trajectory and a focus on their changing needs is important.

The CNA (2008) suggests that advanced practice nurses also demonstrate the leadership competency through this identification of and assistance with meeting the educational needs of nurses. The findings of this study suggest that oncology nurses are concerned with establishing and continuing to develop their knowledge and how this is translates into the clinical environment and impacts patient care. For example,

the participants note that by continuing to develop their own knowledge base they can then help other nurses to develop their knowledge and skill. The APN can facilitate nurses' learning which may include developing education sessions with nurse educators where topics are pulled from and based on current needs of nursing staff.

APNs can advocate for nurses in their pursuit of professional development by establishing and maintaining a clinical environment supportive of oncology nursing professional development. They can support this type of environment through ensuring, promoting and assisting nurses to access funds to support attendance at oncology conferences, workshops and skill development. APNs can further invest in the development of clinical oncology nurses as they mentor nurses interested in participating in, for example, patient safety initiatives on their unit. By supporting this type of environment that values nursing development, it in turn creates additional ways for clinical oncology nurses to invest in their patients' experiences.

APNs can further promote national standards of oncology nursing care on each unit in which they work. They can do so by introducing standards of oncology nursing practice when nurses are first hired to the unit and continue to assist nurses to incorporate standards of care in creative ways that reflect the uniqueness of each oncology unit. Furthermore, through their presence with both provincial and national organizations such as the CCO and CANO, they can bring forth and represent the experiences and needs of the inpatient unit nurses.

### 5.7.3 Research.

The APN as a researcher can initiate and participate in research projects that support oncology nursing practice and patient care. APN's are able to promote nurses' use of evidenced based practice at the bedside as they are able to access, analyze and assist nurses to incorporate research findings into practice (Gerrish et al., 2012). Furthermore APN's can assist nurses in the appraisal of research relevant to their practice. This research project serves as a basic foundation for a current understanding of the meaning of oncology nursing. Most of the study participants began their oncology nursing careers on the study units and remain working there. Advanced practice nurses can further explore the role of supportive oncology nursing environments and oncology nurse retention.

Time, within the nursing context, is commonly considered a quantitative measure of productivity and skill or for determining appropriate staffing mixes. The notion of time, however, weaves its way through the many and varied experiences of the oncology nurses interviewed and took on a less quantitative meaning. It serves as a conduit for the many aspects of oncology nurses' work.  It is integral in developing relationships with patients in addition to understanding their experiences of cancer. Over time, professional expertise and identities also develop. An APN can conduct research to further understand the role of time in nurse-patient relationships, in addition to researching creative ways to protect this time for nurses to be with patients.

Further suggestions for research include investigating the experiences of nurses as they advocate for their patients. Nurses in the current study describe patient

advocacy as integral to their nursing care however, at times are challenged to do so for their patients. Research can focus on what type of support systems need to be in place to assist nurses in these challenging situations to be able to advocate for their patients effectively.

The nurses in the present study do not discuss the self-care practices that they engage in their personal lives. Oncology nurses work to find a balance in their professional lives and it is feasible to consider that they also require a balance in order to avoid their own personal lives interfering with their work. APNs can examine further the role of self-care practices by nursing staff in finding a balance in personal lives and being able to continue to invest in their work as oncology nurses.

#### 5.7.4 Consultation and Collaboration.

The APN in this competency provides services for the nursing team and the interprofessional team members. In this role of consultant he or she is well matched to situate care within a patient centered sphere by acting as a resource to both professionals and patients as they make complex decisions. Findings from this study suggest that oncology nurses face complex issues in their practice such as dealing with oncology emergencies like hypercalcemia crisis. In providing consultation and collaboration across the cancer care continuum, the nurse in the APN role is able to work with oncology nurses to determine the most appropriate plan of care for these situations.

Oncology nurses feel understood when they share with other nurses who have had similar experiences. It is feasible to consider that the oncology APN, having shared in similar experiences and having expert clinical knowledge, can be an

additional resource to oncology nurses who provide nursing care at the bedside. Loftus and McDowell (2000) suggest that the counseling role of the oncology APN is not clearly defined and Bryant-Lukosius et al. (2010) suggest that a lack of clarity of the consultant role of the oncology APN promotes individual interpretation of the APN as consultant. This can provide APNs with opportunities for reflecting upon his or her own experiences, growth, and development over the course of their career as he or she shares of their own experiences with nurses who work at the bedside.

## 5.8 Limitations of the Research Investigation

Phenomenological research is primarily concerned with gaining a profound understanding of the phenomena at hand, in this case, the meaning of being an oncology nurse and as such may not be reflective of nurses' experiences working in other nursing environments, for example, rural settings. In addition, findings can also be different in environments that are not as supportive as the oncology nurses in the present study described. These findings also may not be reflective of the experiences of nurses who do not work in specialty care areas but rather on general surgery inpatient units.

Specific limitations, relevant to the particular group of nurses who participated in this project requires reflection. The analysis of the interview data collected is based solely on the experiences of female oncology nurses, most of who are from one of the two oncology units used in this study. Given the limited number of male nurses employed on both of the units and since no male nurses volunteered their participation in the research project, the experience of being a male oncology nurse was not represented through the findings.

The findings derived from phenomenological investigations, such as this one, do not claim to capture the understanding of the phenomena in its entirety. The findings of this research project do however seek to further understand the meaning of being an oncology nurse for six oncology nurses working on an adult inpatient oncology unit. These findings can be used further as a stepping stone to continue to understand the meaning of being an oncology nurse.

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Appendix A: Information Sheet and Consent Form English

**Information Sheet and Consent Form**

***The Lived Experience of Being an Oncology Nurse***

**Principal Investigator:**

Lindsey Ann Davis, R.N., B.Sc.N.
M.Sc.N. Student,
University of Ottawa, Faculty of Health Sciences
School of Nursing

Co-Investigators:
Dr. Frances Fothergill Bourbonnais, R.N., Ph. D.
Full Professor,
University of Ottawa, Faculty of Health Sciences
School of Nursing

Dr. Christine McPherson, R.N., Ph.D.
Associate Professor /Assistant Director, Undergraduate Programs,
University of Ottawa, Faculty of Health Sciences
School of Nursing

**Introduction**

You are being asked to participate in this study because you are an oncology nurse. Please read this information sheet and consent form carefully and ask as many questions as you like before deciding whether to participate. You must be able to speak fluent English to participate in this study.

**Study Purpose**

Little is known about what it means to be an oncology nurse. The purpose of this qualitative study is to inform the nursing profession's understanding of the experiences of oncology nurses. Approximately ten participants will be sought for this study, on two inpatient oncology units, at the General Campus of The Ottawa Hospital.

**Study Procedure**

Your participation in this study will consist of two interviews in person with the Principal Investigator. These interviews will be conducted at a time convenient for you outside of your working hours.The first interview will be 30-60 minutes in length during which you will be asked about your experiences as an oncology nurse. The interview will be audio recorded in order to verify the accuracy of the information you have shared. You may at any time choose to not answer any questions or terminate the interview at any time.

You will also be asked to participate in a second interview, about 3 months later. In this second interview, you will be asked to review the findings from an analysis of the first interviews. The second interview will require about 15-20 minutes of your time and will be audio recorded. The end of the second interview will mark the end of your participation in the study.

**Risks of Participating and Compensation**

Your participation in this study will require that you share very personal information which may cause you to feel emotional or distressed. Although this risk is minimal, every effort will be made to minimize these risks. The interview may be paused, terminated, and or reinstated at any time if you choose. You will be assisted to contact the Employee Assistance Program should you feel that it is necessary.

In the event of a research-related injury or illness, you will be provided with appropriate medical treatment/care. You are not waiving your legal rights by agreeing to participate in this study.

**Benefits of the Study**

You may not experience any direct benefit from participating in this study. However, your participation may benefit other oncology nurses as information collected during this study will help to inform the nursing profession's understanding of the experiences of oncology nurses.

**Withdrawal from the Study**

You have the right to withdraw from the study at any time without any impact to your current and future employment at the Ottawa Hospital.  If you decide to withdraw, please contact the Principal Investigator (see page 1 for coordinates).

**Study Costs**

You will not be paid to participate in this research study.

**Confidentiality**

All personal information will be kept confidential, unless release is required by law. Representatives of the Ottawa Hospital Research Ethics Board, as well as the Ottawa

Hospital, may review your original records under the supervision of Ms. Davis, Dr. Fothergill Bourbonnais and Dr. McPherson for audit purposes.All of the information that you share will be held in confidence and will not be shared with anyone else outside of the research team.

You will not be identifiable in any publications or presentations resulting from this study. The consent form you will be required to sign will be stored separately from the responses you give and stored in the office of, Dr. Fothergill Bourbonnais. All information which leaves the hospital will be coded with a unique identification number. Verbatim quotes, collected during the interview, will be used however any identifying information will be omitted. All audio recorded data will be transcribed within 24 hours of the interview and then will be deleted. Transcribed interview reports will be stored electronically.

The link between your name and the independent study number will only be accessible by Ms. Davis, Dr. Fothergill Bourbonnais and Dr. McPherson. The link and study files will be stored separately and securely. All files will be kept for a period of 15 years after the study has been completed. All paper records will be stored in the security protected office of Dr. Fothergill Bourbonnais, in a locked file, at the University of Ottawa. All electronic records will be stored on the personal laptop of Ms. Davis and will be protected by a user password and encrypted, again only accessible by Ms. Davis and Drs. Fothergill Bourbonnais and McPherson. At the end of the retention period, all paper records will be disposed of in confidential waste and shredded, and all electronic records will be deleted.

**Voluntary Participation**

Participation is voluntary and you are not obligated to participate. If, at any time, you wish to no longer participate you may choose to do so without any impact to your current or future employment with The Ottawa Hospital.

**Questions about the Study**

If you have any questions about this study, please contact Lindsey Ann Davis, R.N.

The Ottawa Hospital Research Ethics Board (OHREB) has reviewed this protocol. The OHREB considers the ethical aspects of all research studies involving human subjects at The Ottawa Hospital. If you have any questions about your rights as a research subject, you may contact the Ottawa Hospital Research Ethics Board.

***The Lived Experience of Being an Oncology Nurse***

**Consent to Participate in Research**

I understand that I am being asked to participate in a research study about what it means to be an oncology nurse. This study has been explained to me by Lindsey Ann Davis, R.N., B.Sc.N., M.Sc.N. student.

I have read this 4 page Information Sheet and Consent Form (or have had the document read to me). All my questions have been answered to my satisfaction. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

I voluntarily agree to participate in this study. A copy of the signed Consent Form will be provided to me.

**Signatures**

______________________________
Participant's Name (Please Print)

______________________________ ___________________
Participant's Signature Date

**Investigator Statement (or Person Explaining the Consent)**

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study. I acknowledge my responsibility for the care and well-being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to applicable Good Clinical Practice guidelines and regulations.

________________________________________
Name of Investigator/Delegate (Please Print)

________________________________________ ___________________
Signature of Investigator/Delegate Date

Appendix B: Information Sheet and Consent Form French

**Les expériences relatives au travail d'infirmière en oncologie**

**Chercheuse principale :**

Lindsey Ann Davis, inf. aut., B.Sc.inf.
M.Sc.inf. Étudiante,
Université d'Ottawa, Faculté des sciences de la santé
École des sciences infirmières

Co-chercheuses :
Frances Fothergill-Bourbonnais, inf. aut., Ph.D.
Professeure titulaire,
Université d'Ottawa, Faculté des sciences de la santé
École des sciences infirmières

Christine McPherson, inf. aut., Ph.D.
Professeure agrégée / directrice-adjointe, Programmes d'études de premier cycle
Université d'Ottawa, Faculté des sciences de la santé
École des sciences infirmières

Introduction

On vous invite à participer à cette étude parce que vous êtes une infirmière en oncologie. Veuillez prendre connaissance de cette fiche de renseignements et de ce formulaire de consentement et n'hésitez pas à poser toutes vos questions avant de décider de participer ou non. Vous devez être capable de parler couramment l'anglais pour participer à cette étude.

L'objet de l'étude

On en sait peu sur ce que comporte la profession d'infirmière en oncologie. Le but de cette étude qualitative est d'enrichir la compréhension de la profession infirmière en ce qui concerne l'expérience vécue des infirmières en oncologie. Environ dix participantes seront sollicitées aux fins de cette étude, provenant de deux unités d'oncologie pour patients hospitalisés, au Campus Général de L'Hôpital d'Ottawa.

Méthodologie
Votre participation à cette étude se composera de deux entrevues en personne avec la chercheuse principale. Ces entrevues seront menées à un moment qui vous conviendra, en dehors de vos heures de travail.

La première entrevue sera d'une durée de 30 à 60 minutes au cours de laquelle on vous posera des questions au sujet de vos expériences en tant qu'infirmière en oncologie. L'entrevue sera enregistrée sur bandes sonores afin de vérifier l'exactitude de l'information dont vous nous ferez part. Vous pouvez à tout moment choisir de ne pas répondre à toutes vos questions ou de mettre fin à l'entrevue. On vous invitera également à participer à une deuxième entrevue, environ trois mois plus tard. La deuxième entrevue durera environ 15 à 20 minutes et sera également enregistrée sur bandes sonores. On vous invitera à examiner les conclusions de l'analyse des entrevues réalisées ultérieurement et ce moment marquera la fin de votre participation à l'étude.

Risques et indemnisation
Votre participation à cette étude comportera la divulgation de renseignements très personnels, ce qui pourrait occasionner des problèmes émotionnels ou de l'anxiété. Bien que ce risque s'avère minime, nous prendrons les mesures nécessaires pour minimiser ces risques. Vous pourrez interrompre, mettre fin à ou reprendre l'entretien à tout moment si vous le choisissez. Au besoin, on vous indiquera comment communiquer avec le Programme d'aide aux employés.

Dans le cas d'une blessure liée à la recherche ou de maladie, on vous fournira les soins/traitements médicaux appropriés. Vous ne renoncez nullement à vos droits légaux en acceptant de participer à cette étude.

Avantages de l'étude
Il est possible que vous ne retiriez aucun avantage en prenant part à cette étude. Votre participation pourrait par contre s'avérer bénéfique à d'autres infirmières en oncologie pour qui les renseignements recueillis au cours de cette étude auront servi à enrichir les connaissances en soins infirmiers oncologiques.

Retrait de l'étude
Vous aurez le droit de vous retirer de l'étude à tout moment et sans que votre décision n'influe sur votre emploi actuel et/ou futur à L'Hôpital d'Ottawa. Si vous décidez de vous retirer de l'étude, veuillez toutefois en informer la chercheuse principale.

Coûts de l'étude
On ne vous paiera pas pour participer à cette étude de recherche.

Confidentialité
Tous les renseignements personnels seront gardés confidentiels, sauf si leur divulgation était requise par la loi. Les représentants du Conseil d'éthique en recherches de L'Hôpital d'Ottawa ainsi que de l'Institut de recherche de l'Hôpital d'Ottawa, pourraient examiner vos documents originaux sous la supervision de L. Davis, et des professeures F. Fothergill Bourbonnais ou C. McPherson, uniquement à des fins de vérification.

Toutes les informations que vous partagez seront confidentielles et tout ce que vous partagez ne sera pas partagé avec quiconque en dehors de l'équipe de recherche. Aucune publication ou présentation résultant de cette étude ne pourra servir à vous identifier. Le formulaire de consentement que vous serez tenue de signer sera conservé dans un lieu autre que ceux des réponses recueillies, dans le bureau de F. Fothergill Bourbonnais. Aucune information permettant de vous identifier ne sera transmise à l'extérieur de L'Hôpital d'Ottawa. Tout renseignement transmis à l'extérieur de L'Hôpital sera codé à l'aide d'un numéro d'étude indépendant. Des citations textuelles, recueillies au cours de l'entrevue, seront utilisées cependant, les informations servant à vous identifier seront exclues. On fera plutôt appel à numéro d'identification unique. Toutes les données audio enregistrées seront transcrites au cours de 24 heures suivant l'entretien, après quoi elles seront supprimées. Les rapports d'entretien transcrits seront conservés sous forme électronique.

Seules L. Davis, et les professeures F. Fothergill Bourbonnais et C. McPherson pourront accéder au lien entre votre nom et le numéro de l'étude indépendant. Ce lien et les dossiers de l'étude seront entreposés en lieu sûr et séparément. Ces dossiers seront conservés pour une période de 15 années suivant la fin de l'étude. Tout dossier papier sera entreposé au bureau sécurisé de la professeure F. Fothergill Bourbonnais, dans un classeur verrouillé, à l'Université d'Ottawa. Les fichiers électroniques quant à eux seront stockés sur le portable personnel de L. Davis et protégés par un mot de passe, auquel seules L. Davis, et les professeures F. Fothergill Bourbonnais et C. McPherson auront accès. Une fois la période de rétention terminée, tous les dossiers papier seront déchiquetés ou jetés aux rebuts confidentiels, et les fichiers électroniques seront supprimés.

Participation volontaire
La participation est volontaire et vous n'êtes aucunement obligée de participer à cette étude. Si à tout moment vous souhaitez mettre fin à votre participation, vous pouvez choisir de quitter l'étude sans que votre décision n'influe sur votre emploi actuel ou futur à L'Hôpital d'Ottawa.

Questions sur l'étude
Si vous avez des questions concernant cette étude, veuillez communiquer avec Lindsey Ann Davis, inf. aut.

Le Conseil d'éthique en recherches de L'Hôpital d'Ottawa (CÉRHO) a révisé ce protocole. Le CÉRHO est chargé de l'ensemble des aspects éthiques de toutes les études de recherche portant sur des sujets humains effectuées à L'Hôpital d'Ottawa. Pour toute question au sujet de vos droits à titre de sujet de recherche, veuillez communiquer avec le Conseil d'éthique en recherches de L'Hôpital d'Ottawa.

*L’expérience vécue relative au travail d’infirmière en oncologie*

**Consentement à participer à la recherche**

Je comprends que l’on sollicite ma participation à une étude sur ce que comporte la profession d’infirmière en oncologie. Lindsey Ann Davis, inf. aut., B.Sc.inf, étudiante, M.Sc.inf., m’a fourni les renseignements nécessaires au sujet de cette étude.

J’ai pris connaissance des quatre pages de cette Feuille de renseignements et de ce Formulaire de consentement à l’intention du patient. On a répondu à toutes mes questions de manière satisfaisante. Si je décide plus tard au cours de l’étude de retirer mon consentement, il me sera possible de le faire en tout temps.

Je consens volontairement à prendre part à cette étude.

On me remettra un exemplaire signé de cette Feuille de renseignements et de ce Formulaire de consentement.

**Signatures**

___________________________________

Nom du participant (en caractères d’imprimerie)

___________________________________ _________________

Signature du participant Date

**Énoncé du chercheur (ou de la personne chargée d’obtenir le consentement)**

J’ai expliqué soigneusement au participant de la recherche la nature de l’étude susmentionnée. Pour autant que je sache, le participant apposant sa signature à ce consentement reconnaît la nature, les exigences, les risques et les avantages que comporte sa participation à l’étude. Je reconnais ma responsabilité envers le soin et le bien-être du participant susmentionné, le respect des droits et des désirs de ce dernier, et le déroulement de cette étude, conformément aux directives et aux règlements relatifs à la bonne pratique clinique.

__________________________________________

Nom du chercheur/délégué (en caractères d’imprimerie)

__________________________________________ __________________

Signature du chercheur/délégué Date

Appendix C: Poster English

***University of Ottawa***

***Faculty of Health Sciences***

***School of Nursing***

***ONCOLOGY NURSES NEEDED FOR PARTICIPATION IN A RESEARCH PROJECT***

I am looking for volunteers to take part in a study exploring the experience of being an oncology nurse. To be eligible to take part you will need to:

- identify yourself as an oncology nurse
- be currently working on 5 East and or 5 West at The Ottawa Hospital, General Campus
- have a minimum of two years of experience as an oncology nurse
- be English Speaking

As a participant in this study, you will be asked to participate in two confidential interviews at a time convenient for you.

The first interview is expected to take 30 - 60 minutes followed by a short second interview of approximately 15-20 minutes at a later date.

For more information about this study, or to volunteer for this study, please contact:

Lindsey Ann Davis, R. N., B.Sc.N., M.Sc.N. student

*University of Ottawa, School of Nursing*

*Under the supervision of Dr. F. Fothergill Bourbonnais and Dr. C. McPherson*

This study has been reviewed by, and received ethics clearance through, the Office of Research Ethics.

Appendix D: Poster French

***Université d'Ottawa***

***Faculté des Sciences de la Santé***

***École des Sciences Infirmières***

***INFIRMIÉRES EN ONCOLOGIE***
***DEMANDE(E)S DANS LE CADRE D'UN PROJET DE RECHERCHE***

Je suis à la recherche de bénévoles pour participer à une étude en explorant l'expérience d'être une infirmière/er en oncologie.

En tant que participant à cette étude, il vous sera demandé de participer à deux entretiens confidentiels à un moment opportun pour vous.

Votre participation implique une entrevue qui serait d'environ 30 - 60 minutes suivies par une deuxième entrevue courte d'environ 15-20 minutes.

Pour plus d'informations sur cette étude, ou pour devenir bénévole pour cette étude, contactez s'il vous plaît:

Lindsey Ann Davis, I. A., B.Sc.Inf., M.Sc.Inf. étudiante

Université d'Ottawa, École des sciences infirmières

Sous la supervision des Dres F. Fothergill Bourbonnais et C. McPherson

Cette étude a été examiné par, et a reçu l'éthique clairance par le biais, le Conseil d'éthique en recherches.

# Appendix E: Question Guide

1. Do you describe yourself as an oncology nurse?
2. When did you start feeling like an oncology nurse?
3. What does it mean to be an oncology nurse?
4. Can you describe the factors that facilitate or challenge you as an oncology nurse?
5. Are there any events that stand out in your mind that have occurred over the duration of your professional career?