Original Article

Cancer Patients and Oncology Nursing: Perspectives of Oncology Nurses in Turkey

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Abstract

Background and Aim: Burnout and exhaustion is a frequent problem in oncology nursing. The aim of this study is to evaluate the aspects of oncology nurses about their profession in order to enhance the standards of oncology nursing. **Materials and Methods:** This survey was conducted with 70 oncology nurses working at Hacettepe University Oncology Hospital. Data were collected between January–April 2012. Each participant provided a study form comprising questions about sociodemographic information; about difficulties, positive aspects and required skills for oncology nursing; and questions evaluating level of participation and clinical perception of oncology nursing. **Results:** Mean age of nurses was 29.9 ± 5.7 years. More than half of the participants were married (51.4%) and 30% had at least one child. Percent of nurses working in oncology for their entire work life was 75.8%. Most frequently expressed difficulties were exhaustion (58.6%), coping with the psychological problems of the patients (25.7%), and frequent deaths (24.3%); positive aspects were satisfaction (37.1%), changing the perceptions about life (30%), and empathy (14.3%); and required skills were patience (60%), empathy (57.1%), and experience (50%). For difficulties of oncology nursing, 28.3% of difficulties could be attributed to job-related factors, 30.3% to patient-related factors, and 77% of difficulties to individual factors. The independent predictors of participation level of the nurses were self-thoughts of skills and positive aspects of oncology nursing. **Conclusion:** According to the findings of this study, nurses declared that working with cancer patients increase burnout, they are insufficient in managing work stress and giving psychological care to patients, but their job satisfaction, clinical skills and awareness regarding priorities of life has increased.

Keywords: *Cancer patient, oncology nursing, participation, perception*

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Introduction

The thoughts and feelings of nurses about patients affect the quality of their care. Also, nursing is known as a profession, which highly suffers from the negative aspects of occupational life.[1] Previous studies about the stressors of nursing revealed that the most important factors were overload, inter-professional conflict, lack of clarity, task ambiguity, and supervision problems.[2] A research on exhaustion in 1970s revealed the concept of burnout by Freudenberg,[3] and after introduction of this novel concept, Lavandero published the first literature review about burnout in nurses in 1981.[4] Since then, numerous researches figured out that burden of nurses' burnout is excessive in many parts of the world. According to the results of a previous study that evaluated burnout in more than 10000 nurses in five different countries, the incidence rates are ranged between 32% and 54%.[5] Another European

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epidemiological study reported the burnout affects approximately 25% across all nurses.[1]

Among the nurses in different settings of healthcare, oncology nurses suffer from the highest job-related stress as compared to other branches.[6] Oncology clinics are such work places that a worker at any level of service experiences extensive exhaustion due to environmental stressors. Emotional exhaustion is regarded as the key mechanism in development of burnout through depersonalization and decreased perceptions of personal accomplishment.[7] Initiators of these mechanisms are commonly based on, but not limited to, job and workplace-related issues. From this aspect, being nested with cancer is an excess physical and emotional load for health professionals as well as patients. There are some significant reports in the literature that reports nurses' burnout is related with the intensity of their patients' emotional demands[8] and with the patients' poor prognosis.[9] Both these factors are strongly associated with oncology settings, wherein the patients are devastated and needs to be supported emotionally, and prognosis in this patient group is unfortunately poor.

Nurses' experience of burnout is not solely an internal psychological distress, but also one of the major factors that affect quality of healthcare delivered to patients. Previous studies have reported that there is a close correlation between burnout and poor quality of care, decreased job satisfaction, and increased risk of failure to recognize patient distress.[5]

There are some mechanisms used by nurses to overcome burnout. Some of these methods include coping by problem solving strategies, getting help from other coworkers, and talking with other colleagues about their problems.[10] Coping can be defined as learned patterns of behaviors, which are influenced by personality, past relationships, and conditional stressors.[11] Since both burnout and coping are closely associated with workplace-related factors, it is essential to evaluate the work-related common thoughts, senses, and beliefs of workers, even when they are not experiencing an exhaustion. On this basis, the primary aim of this study is to evaluate the aspects of oncology nurses about both cancer patients and oncology nursing, which will be directive for the improvement protective and proactive measures in this group. Also, understanding the thoughts and feeling of nurses about their practices will contribute to improve the quality of care of the patients.

Materials and Methods

This study was conducted between January and April 2012 with nurses working in the inpatient and outpatient settings of Hacettepe University Oncology Hospital. A total of 130 nurses were reached. After informing the participants about the study, some of them rejected because of their heavy workload or their shifts. After exclusions, 70 nurses that provided informed consent to participate, completed the self-evaluation scale and the study questionnaire. Face-to-face interviews were conducted with nurses.

Ethical approval for the research was obtained from the ethics committee of the Hacettepe University (approval#: 12/262-02).

Data collection

A participant information form that included demographic information and data-collection tools was prepared for the study. Details on age, marital status, number of children, and duration of employment in nursing and oncology-nursing separately were asked to gather the demographic information.

Perceptions and thoughts of nurses about the difficulties, positive aspects and required skills for oncology nursing were gathered with open-ended questions. Then, all responses were quantified according to frequency, and similar answers were standardized under the same phrase. The samples of responses to these open-ended questions are shown in Table 1. There were 13 common phrases for difficulties, 5 phrases for positive aspects, and 12 phrases for required skills. Each nurse was then scored according to the number of her responses for each cluster. For example, if a nurse's responses for difficulties of oncology nursing have fallen into 4 standardized phrases, then she got 4 points from difficulties cluster. Then, these scores were transformed into a 100-point scale to be used in multivariate analyses.

Along with standardizing and quantifying the responses about the difficulties of oncology nursing, these responses were also evaluated according to work-related, patient-related, and self-related difficulties. Some responses could reside in multiple domains and overlap with each other. This clustering was made to determine the nature of the expressed perceptions about barriers of oncology nursing, and for being able to making recommendations to enhance the satisfaction of nurses with their jobs.

The nurses' perceptions about important nursing care behaviors, and participations to patient care were evaluated by a custom questionnaire, which was primarily based on two main validated scales, the Caring Assessment Questionnaire (Care-Q)[12] and the Quality of Oncology Nursing Care Scale (QONCS).[13] The Care-Q was first developed by Larson in 1981, and it is the most frequently used scale to measure perceived importance of

Table 1: Sample responses for clusters of difficulties, positive aspects, and required skills about oncology nursing

DIFFICULTIES (What are the difficulties that you encounter most as an oncology nurse?)
Exhaustion
Working with patients with no hope
Witnessing the worsening prognosis of patients who we establish close contact wears us out
It is very tough to manage with heavy and long-duration working
Coping with the psychological problems of the patients
Being unable to enhance the satisfaction of hopeless, desperate, and exhausted patients
Being exposed to excess requests, and redundant anxiety and anger of patients
Because patients are always bemoan, my psychology affects negatively and I do always feel ill
Frequent deaths
Whatever we do, patients die
We are in close relations with patients, but we always see their worsened situations and death
Despite treatment, we loss the patient
POSITIVE ASPECTS (What are the positive aspects of oncology nursing according to you?)
Satisfaction
The glances of patients when I relieve the pain makes me happy
I feel satisfied when I help patients in their hard times
Happiness after positive feed-back
Changing the perceptions about life
I realize the worth of life better
We realize the value of living and being healthy
Facing death increases the worth of life, and all remaining negativities loss their importance
SKILLS (Which skills should an oncology nurse needs?)
Patience
I have learned not to loose hope
A huge patience
Should be patient and tolerant
Careful, patient, cheerful
Empathy
Helping patient makes me happy
Understanding patients
Feeling the thoughts of patients with a strong communication
Experience
Lots of vocational knowledge and skill
Being able to realize and meet the physical and spiritual needs of patients
Being skillful in technical abilities
Preventing decubitus wounds, and healing the already present ones
Having a satisfactory level of theoretical knowledge

nursing care behaviors of oncology patients and oncology nurses. The latter scale, QONCS, is a valid and reliable scale that evaluates the quality of nursing care within the oncological settings and to patients with a variety of cancer diagnoses and at different phases of the cancer trajectory. Experienced oncologist authors of the study evaluated these scales and determined 17 questions, to evaluate the participation, clinical skills, and perceptions of nurses. Then these questions were asked with a Likert-type response range from 0 to 5, which corresponds from

never to always. The participation level of each nurse was calculated as [(Q1 + Q2 +…+ Q17) / 68] × 100. After determining the participation level, then determinants of this level was assessed in a multivariate regression model.

Statistical analyses

Statistical analyses were carried out using SPSS 21 software (IBM Corp., Armonk, NY). Descriptive data were presented as frequency and percentage, and mean and standard deviation, where appropriate. A Venn diagram was used to show the overlapping clusters of difficulties about oncology nursing. The levels in this diagram reflected the level of match of a particular nurse's responses with the overall study group in percent.

The predictors of participation and perception level of nurses' about oncology nursing were evaluated in a multivariate linear regression model. Dependent variable in this model was level of participation, and independent factors were age, percent of time passed in oncology nursing in overall nursing experience, agreement levels of difficulties, positive aspects, and skills with general study group. The independent factors that were shown to be significantly correlated with primary dependent variable in univariate analysis at a 10% Type-I error level were included in the multivariate analysis. Results were given with relevant 95% confidence intervals. A type-I error level of 5% was regarded as the statistical significance level in the study.

Results

This study included 70 nurses with a mean age of 29.9 ± 5.7 years (range: 24–51 years). More than half

Table 2: Sociodemographic characteristics

	Mean±SD / n (%)
Age (years)	29.9±5.7
Work years	
Overall	7.1±5.9
≤5 years	37 (52.9)
>5 years	33 (47.1)
Oncology	4.6±3.4
≤5 years	45 (64.3)
>5 years	25 (35.7)
	n (%)
Marital Status	
Married	36 (51.4)
Single	34 (48.6)
Children	
Yes	21 (30)
No	49 (70)

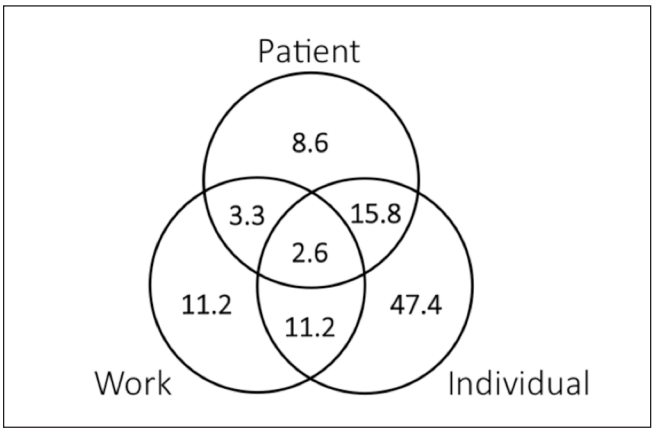

Figure 1: Evaluation of nature of perceived difficulties of oncology nursing (in percent)

Table 3: Standardized phrases for three main clusters of oncology nursing

	n (%)
Difficulties	
Exhaustion	41 (58.6)
Coping with the psychological problems of the patients	18 (25.7)
Frequent deaths	17 (24.3)
Poor-response to treatment	15 (21.4)
Hopelessness	14 (20)
Patient and relatives' meddling to the care	12 (17.1)
Can't speaking clearly with the patient	4 (5.7)
Patience	4 (5.7)
Exposure to chemotherapy	4 (5.7)
Heavy work-load	4 (5.7)
Sacrifice	3 (4.3)
Fear of being cancer	3 (4.3)
Rejecting the failure	1 (1.4)
Positive Aspects	
Satisfaction	26 (37.1)
Changing the perceptions about life	21 (30)
Realizing the priorities in life	8 (11.4)
Realizing the spiritual values	6 (8.6)
Inspiring from the life energy	3 (4.3)
Skills	
Patience	42 (60)
Empathy	40 (57.1)
Experience	35 (50)
Knowledge (symptom control)	34 (48.6)
Interpersonal communication skills	27 (38.6)
Tolerance	18 (25.7)
Mindfulness	8 (11.4)
Skill to solve problems	5 (7.1)
Scrutinizing	3 (4.3)
Body language	3 (4.3)
Team spirit	2 (2.9)
Leadership	1 (1.4)

Table 4: Participation and perception levels of nurses to oncology nursing

	Rarely	Sometimes	Often	Very Often
	n (%)	n (%)	n (%)	n (%)
I can cooperate efficiently in the care of the patient	-	1 (1.4)	7 (10)	62 (88.6)
I can communicate efficiently with the family and relatives of the patient about the care	-	1 (1.4)	14 (20)	55 (78.6)
I evaluate the patient (physically, socially, and emotionally) when delivering the nursing services	-	1 (1.4)	5 (7.1)	64 (91.4)
I have enough knowledge about the disease and treatment courses of the patients in my clinic	-	2 (2.9)	4 (5.7)	64 (91.4)
I find myself adequate for clinical skills	-	3 (4.3)	10 (14.3)	57 (81.4)
I can cooperate with the family for the care of the patient	-	3 (4.3)	15 (21.4)	52 (74.3)
I find myself sufficient in the symptom control	-	3 (4.3)	11 (15.7)	56 (80)
I think that I have adequate experience in oncology nursing	-	4 (5.7)	21 (30)	45 (64.3)
I can evaluate the care process of the patients and I can direct the care	1 (1.4)	3 (4.3)	8 (11.4)	58 (82.9)
I can support the patient emotionally in the treatment process	-	4 (5.7)	12 (17.1)	54 (77.1)
We work as a team in the care of the patient	-	4 (5.7)	5 (7.1)	61 (87.1)
I use my body language effectively	-	4 (5.7)	11 (15.7)	55 (78.6)
I can conduct leadership in health team	2 (2.9)	8 (11.4)	17 (24.3)	43 (61.4)
I recognize the spiritual needs of the patients and I help them totake support in this issue	1 (1.4)	9 (12.9)	14 (20)	46 (65.7)
I participate in the decisions about the treatment and care of the patients	-	12 (17.1)	19 (27.1)	39 (55.7)
I think that I am good in managing work stress	1 (1.4)	11 (15.7)	20 (28.6)	38 (54.3)
I give information to the patient about the condition during the care	1 (1.4)	12 (17.1)	14 (20)	43 (61.4)

Table 5: Multivariate analysis of predictors of participation in oncology nursing

	Unstandardized Coefficients		Standardized Coefficients	t	p	95,0% Confidence Interval for B	
	B	SE	Beta			Lower Bound	Upper Bound
(Constant)	79,734	2,881		27,672	0	73,982	85,485
Skills (%)	0,24	0,084	0,32	2,853	0,006	0,072	0,408
Positive aspects (%)	0,248	0,102	0,272	2,424	0,018	0,044	0,453

of the participants were married (n = 36, 51.4%), and 30% of participants (n = 21) had at least one child. Overall, mean occupational experience of nurses was 7.1 ± 5.9 years (range: 1–29 years), and mean duration of working in oncology clinics was 4.6 ± 3.4 years (range: 1–21 years). Analyses revealed that mean proportion of working in oncology to entire work life was 75.8% for nurses in the study population (range 14.3–100%). Demographic characteristics of patients were presented in Table 2.

The perceptions of nurses about the difficulties, positive aspects, and skills needed for oncology nursing are summarized in Table 3. According to the evaluations, most frequently expressed difficulties for working in oncology departments were exhaustion (58.6%), coping with the psychological problems of the patients (25.7%), and frequent deaths (24.3%). Most frequently expressed positive aspects of oncology nursing were satisfaction (37.1%), changing the perceptions about life (30%), and realizing the priorities in life (11.4%). The nurses also evaluated the skills needed for oncology nursing, and the most frequently expressed skills were patience (60%), empathy (57.1%), and experience (50%).

The difficulties of oncology nursing reported by nurses themselves were clustered under three main domains as "work related," "patient related," and "self-related" difficulties. Some of the items belonged to multiple domains, so the results are presented as a Venn diagram [Figure 1]. According to this grouping, nurses declared that 28.3% of difficulties could be attributed to job-related factors, 30.3% of difficulties to patient-related factors, and 77% of difficulties to individual factors.

According to the overlapping nature of this evaluation, only 2.6% of the difficulties about oncology nursing were attributed to all three domains.

The nurses' perceptions and participations to oncology nursing care were evaluated by the questionnaire, and results are presented in Table 4. Accordingly, all items were declared to be "often/very often" by the nurses with a participation rate ranging from 81.4–98.6%. Items that were reported to be "rarely/sometimes" with a participation rate over 10% are dominating leadership in team (14.3%), realizing and supporting patients' moral needs (14.3%), supporting patients' treatment and care with own decisions (17.1%), feeling sufficient in managing work stress (17.1%), and informing patients about their condition during care (18.6%).

The determinants of participation in oncology nursing was evaluated with a linear regression model, by considering participants' age, time passed in oncology nursing, and levels of self-reported skill, difficulty, and positive perception levels as independent factors. Results of regression model revealed that only self-thoughts of skills and positive aspects of oncology nursing were the independent predictors of participation level of the nurses. Results of the regression model are shown in Table 5.

Discussion

As a general summary of our findings in this study, nurses experience exhaustion and need support particularly for management of work-related stress and delivering psychological support. This was also mentioned by previous studies,[14] and ways of supports may include seminars, conferences, courses, group meetings, and counselling services, which will provide in-service trainings and also psychological support to nurses. Also, short-term pauses and inter-departmental rotations may also help reduce work-related stress.

Participants of this study emphasized the positive and negative aspects of working with cancer patients. According to them, working in the field of oncology increases the exhaustion and work stress, and it is too hard to give psychological care to these patients. On the other hand, nurses also reported that working in the field of oncology contributes to positive changes in perception of life, job satisfaction, and development of clinical skills.

In this study, majority of the nurses declared that working in oncology increases the exhaustion. For cancer patients and their families, difficulties are experienced particularly to the health team. For this reason, health professionals dealing with cancer patients are one of the groups experiencing difficulties in health care.[15,16] The current data suggests that signs of exhaustion are more frequent in health personnel working with oncology patients.[16-19] The factors that increase exhaustion in people working in oncology clinics include "working mostly with patients who do not give positive feedback," "the difficulties of disease and treatment," "the insufficiency of clinical experience," "the low levels of knowledge," and "the complexity of care of cancer patients" and "facing the feeling of death" that every patient reminds.[20] Studies on exhaustion revealed that people who have begin working recently and those who are young suffer more. Most of the nurses participating this study began working in the oncology hospital after a one-week orientation program. This short course of education and the lack of clinical experience may cause early burnout of young and inexperienced nurses. More experienced clinical skills that spread over time is needed for a better care of cancer patients. A study by Quin[21] showed that new recruited oncology nurses tried to answer every question of patients and found themselves insufficient, but their self-confidence and the quality of care increases with the increase in clinical skills. Nurses recognize that being together with the patient, understanding their despair, and empathic replies are more important than replying every question by their clinical skills improves. Likewise, we found in our study that emotional support and comprehensive assessment increases with the increased work years.

Cancer patient care requires a comprehensive approach that covers both the physical and psychosocial support. Unfortunately, the presence of psychological care is very limited in facilities delivering oncologic care in our country. But psychological care is most essential for oncology patients. In our study, nurses declared that they are insufficient for realizing and supporting the spiritual needs of the patients. Some studies found that nurses working in the oncology settings have problems in communication and emotional support in patient care, and they refer to ineffective ways such as escape, self-control, and aloofness for coping with this situation.[19,20] Nurses tend to stay away from psychological care because they do not know it. And psychological care, which is as essential as daily living activities, is missed out and ignored.[22]

Nurses utilize most commonly known physical care roles in their applications. Education and psychological support are also among the clinical roles of the nurses. But, the social and professional expectations and the educational levels are more related to their physical care roles. Nurses do not regard psychological care as their duty. After a certain time, this situation causes nurses to feel responsible for only the conventional care roles, and regard the support and psychosocial care out of their care field. In these studies, nurses most declared about

their care roles,[14,23,24] and they have to be informed in this issue. The studies by Arving and Holmström[25] and Maguire[26] reported that the nurses who were educated about the supportive psychological care techniques delivered better care to patients.

Most of the nurses felt insufficient in managing work stress, participating in the decisions about treatment and care of the patients, providing information, realizing and providing support for the spiritual needs of the patients. Nurses experience uncertainty in delivering information to the patient.[27] The uncertainty in their job description, and their avoidance to give bad news and information about prognosis causes them to regard these tasks as the responsibility of the doctors, and they experience a dilemma. For these reasons, their job description must be clarified. Delivering information is not only the responsibility of the doctors, but also of the nurses who are a part of the health care team. Besides the conventional roles, nurses also have contemporary roles such as education, research, and patient rights advocacy.[23] Nurses can inform the patients and families with the health care team in the context of their education and counseling roles by taking the institutional policies into consideration.

Nurses dealing with cancer patients may experience problems with patients and their relatives about the treatment, stress associated with the losses, insufficiency in managing the stress, and psychological problems such as aggression.[19,21]

Situations that cause stress in oncology are nature of the disease, critical decisions regarding the disease course, management of treatment with severe adverse effects, the problems of patients such as overdependence, aggression, and treatment incompetence, observing the patients suffering from pain, difficulty of working with body-image deteriorated patients, terminal care, emotional challenges in relations with patients, insufficiency in establishing therapeutic communication, ethical issues, and conflicts in the team.[19,28-31]

Nurses are also aware of the positive aspects of working with cancer patients. The experiences gained by working with patients and families are more than a formal education, and enriches their overall perspectives of life. Literature data show that giving care to cancer patients enriches the professional life and have positive effect on social relations.[19,32,33]

Nurses think that working in oncology field increases professional satisfaction. Working with cancer patients increases burnout and job satisfaction.[34] These two situations seem opposite, but working 24 hours with patients causes a closer relationship. Nursing care of cancer patient sometimes requires remaining in and sometimes remaining outside of the events. This professional balance is important for helping patient and job satisfaction. In context of communication with cancer patients, developing transference and excessive worry prevents care, similarly desensitization for self-protection also prevents a qualified care and increase burnout. Self-awareness of nurses is essential for developing professional relations. Increases in professional experiences and personal success feelings, decrease in desensitization, development of coping strategies, and thoughts of being beneficial for the others richens the personal life.

According to the nurses, some clinical skills are needed for working with cancer patients. Being patient, empathy, experience, knowledge of field, and symptom control are the most prominent of these skills. According to the oncology nurse, "good nursing" requires professionalism and adequacy.[35] In our study, nurses found themselves clinically skillful. This result suggests nursing care should also be qualified. Some studies with oncology nurses showed that nurses use effective coping methods such as "problem solving."[19,20] Knowledgeable and skillful and experienced nurse educate patient on symptom management, adverse effects of treatments, pain control, and adaptation to physical changes due to the disease.[33,36,37]

In the study of Gurkan *et al*.,[38] student nurses declared that they had adequate knowledge, but they did not want to work with cancer patients. This contradictory situation is important for showing the value of experience as well as knowledge. In our study, a significant correlation was found between work years and giving emotional support to patient, communication skills, cooperating with patient's family, and holistic approach to patient. Experienced nurses may provide more help to cancer patients.

Conclusions

According to the findings of this study, nurses declared working with cancer patients increase burnout; they are insufficient in managing work stress and giving psychological care to patients, but their job satisfaction, clinical skills, and awareness about priorities of life has increased.

Nurses need education and psychological support in areas of difficulties. Interaction groups that cover all workers for coping with stress, and supervision and counseling from psychosocial support units for personal needs are suggested to nurses working in oncology settings.

Coping methods such as talking and sharing with colleagues, having a close person to consult, knowing

own limitations, healthy human relations, having supporting peers, physical activities, sports, and hobbies are also suggested.

Also, nurses should be supported by various activities such as postgraduate seminars, conferences, courses, group meetings, counseling, and researches on this issue.

Finally, further studies with larger number of participants will contribute to develop culture-specific guidelines about the psychosocial care. These guidelines will help nurses for delivering psychosocial support to patients, which will eventually increase the quality of care.

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Conflicts of interest

There are no conflicts of interest.

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