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Challenges Experienced by Registered Nurses when Working with Oncology Clients

by

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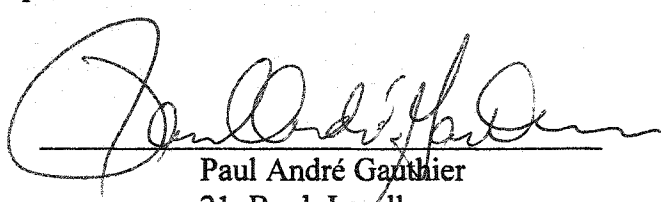

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Abstract

In health care, we face many challenges that are related to nursing care, such as the pathology and the treatment of clients, and the working environment. How do we know what is a challenge? How can we understand the challenges encountered in nursing practice? In the literature, the terms challenge and problem, for example, were used interchangeably without recognizing how each one gives a different perspective and thus how each results in a different response from clients and/or caregivers. In the articles reviewed, the authors did not describe how encountered "challenges" or situations were appraised.

In this qualitative exploratory-descriptive study based on the model of Miles and Huberman (1994), was used for data collection and analysis. The purpose of this inquiry was to identify the challenges experienced by registered nurses when working with oncology clients in out-patient clinics. The data was collected by interviewing seven registered nurses working in oncology with individuals living with cancer. Content analysis was used in the analysis of the data collected from interviews. The participants were all women with more than seven years of experience in oncology nursing with an overall average of 13.4 years practice in this specialty.

In the context of this study, a challenge is defined a situation or a phenomenon experienced as stimulating and as requiring individuals to spend time, energy and resources in order to face and to deal with it. Individuals learn to deal with challenges as they gain experience.

Considering that the number and the needs of individuals affected by cancer will continue to increase, nurses will always be busy with clients requiring oncology care

and services. The results of this study indicate the need for registered nurses to identify their challenges, and to select strategies that can assist them in managing their challenges. When challenges are too difficult to manage, nurses require further support from their colleagues and managers. Changes which eliminate or moderate the challenges are deemed to be necessary if nurse and client satisfaction with care are to occur in tertiary oncology health care institutions.

Keywords: challenge, strategy, facilitator, barrier, appraisal, coping, managing.

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Chapter 1 - Introduction

For over fifteen years, the researcher worked with individuals with life-threatening illnesses such as cancer and AIDS. He noticed that with some prompting within a nurturing and trustful environment, clients were able to express their concerns regarding what they were experiencing. Because the needs of clients could vary considerably from one to another, he found that working with these individuals challenged his nursing abilities and his level of knowledge. However, while challenged by working with clients either with cancer or AIDS, he expanded further his knowledge, abilities, and expertise in nursing care. How does this process of being challenged work? How does one become challenged? What happens when one becomes challenged? What is a "challenge"? Very little is known regarding what a "challenge" is for some professionals and what a challenge is not for others. In this study, the researcher explored challenges that nurses encountered while caring for clients living with cancer.

In the first section of this chapter, selected statistics about cancer and the author's interest in this topic of research are presented as the statement of the problem. The purpose of this research and its significance to nursing are also discussed.

Statement of the problem

Statistics Canada (1997) reported that the greatest cause of death in Canada was cancer (58,703 deaths) representing 27.2 % of all deaths, followed by heart (57,417 deaths), and cerebrovascular diseases (16,051 deaths). The three leading types of cancer resulting in death for men were lung, prostate, and colorectal cancer, and for women lung, breast, and colorectal cancer (Statistics Canada, 1999). The mortality rate for all

types of cancer in Canada in 1997 was 661 deaths per 100,000 population. The National Cancer Institute of Canada and the Canadian Cancer Society estimated that there were 132,100 new cases of cancer and 65,000 deaths in April 2000. These numbers increased slightly in April 2001, when there were estimated to be 134,100 new cases of cancer and 65,300 deaths. In 2002, these numbers were estimated to be 136,900 new cases and 66,200 deaths (National Cancer Institute of Canada, 2002). The lifetime probability of developing any type of cancer in 1999 for men was 41.8% and for women 35.6%. The lifetime probability of dying from cancer in 1999 for men was 27% and for women 22.8%. These numbers and percentages indicated that many individuals were being and would be affected by cancer. The number of clients affected by cancer remains high, and the demand for more oncology care will continue to grow. In addition, caring for clients and families affected by cancer represents a specific challenge because of the possible outcome: death.

From his clinical observations, the author noticed that, when individuals are diagnosed with cancer, they can experience situations which approach the limits of human endurance. Some stories were unique; all were filled with tremendous emotion for everyone involved. In order for clients to open up to health care professionals, clients needed some reassurance that professionals were caring and trustworthy. Professionals required time to provide this reassurance through a caring and competent bedside manner. Trust was not possible without some type of rapport between the two parties. Client's confidence could be developed during nursing care, in which trust was not a given, but was earned between individuals.

Discussions about life and death, about care and disease, and about other

phenomena encountered was a common occurrence in palliative care. Most surprisingly to novice nurses in this field, clients were willing to carry on a conversation about what they were experiencing, especially if the time was right for them. Some clients clearly indicated or implied that they were concerned about what would occur after death; some health care professionals might not feel comfortable discussing such topics as death, suffering, loneliness, the preparation of a will, or an authorization giving power of attorney to a significant other. For some health care professionals, discussion regarding these topics might represent a challenge. Anecdotal evidence from his clinical teaching indicated that many nursing students were uncomfortable discussing these topics with clients but he had also observed that if someone was prepared to help them, students were willing to attempt to provide such care for clients with cancer. First, we need to understand what challenges registered nurses face in the care of clients and their families living with cancer.

In this research, the author studied registered nurses' (RNs) perspectives regarding the challenges they encounter while working with oncology clients and families. Nurses still represent the largest group of health care professionals interacting with clients, and research has shown that nurses made a difference in their clients' lives (Halldórsdóttir & Hamrin, 1997). If nurses are preoccupied with their own challenges in these areas, they will be restricted in their abilities to provide optimal care. Furthermore, the obligation to improve the quality of care that registered nurses provide to clients still rests with the nursing profession. The researcher believed that through this study, he could assist nurses to identify and understand their challenges in caring for clients with cancer. This, in turn, might indirectly help clients to address their needs and to assist

other nurses to manage their own challenges in giving care.

Purpose of this Research

The purpose of this qualitative study was to explore the challenges registered nurses perceive facing them when working with oncology clients. The researcher wanted first to understand the challenges perceived by RNs, and then how these challenges were managed.

The Significance of this Research for Nursing

The present inquiry sought to provide a better understanding of the challenges encountered by registered nurses while caring for clients living with cancer. How would this inquiry contribute to nursing's body of knowledge? Rittman, Paige, Rivera, Sutphin, and Godown (1997) indicated that "entering the patient's world often involves dealing with death and dying and is a major challenge to oncology nurses" (p. 115). Despite the fact that there is a large body of knowledge describing the care and the issues of individuals faced with life-threatening illnesses, cancer, AIDS, oncology and palliative care, for example, dealing with death and dying remains a challenge. However, after reviewing the literature and trying to understand what was known about challenges, the author discovered that the word "challenge" was used, but only to indicate that "We have to meet challenges", that "We are challenged by the technology", or that "We have a challenge facing us". As the term is defined in the dictionary, challenges might also be associated with a stimulating task or with a major problem to be solved by individuals facing a specific situation (Webster's Dictionary, 1986).

The study by Rittman et al. (1997) describing only one situation involving a

challenge to nursing, that of entering the patient's world, did not include challenges in oncology nursing. Specific challenges identified between 1991 and 2000 have been studied, but the challenges were raised not by the research participants but rather by the researchers during the presentation of their findings. Questions remain, e.g., what makes a situation a "challenge" for one nurse and not for another nurse? The intent in this study was to examine the phenomenon of challenge and to better understand what is a "challenge" and how registered nurses who care for clients and families living with cancer deal with such challenges.

Research Questions

The research questions that guided this inquiry were:

- What constitutes a challenge for nurses in their oncology practice?
- What are the challenges experienced by nurses in oncology?
- How do nurses manage the challenges that they perceive?
- What assists nurses in managing the challenges encountered?
- Are nurses satisfied with their management of their challenges?

In nursing, little has been written regarding challenges and how nurses come to perceive a situation as challenging. The findings might not only be useful to practitioners but also to nurse managers and educators. These findings would provide a way of looking at situations, issues, concerns and difficulties encountered in oncology nursing, and inform us on perceptions that nurses might have of challenges. Also, the researcher would report how nurses working in oncology were managing their challenges. This study may open new doors to the understanding of nursing practices by providing a different perspective on concerns and issues in oncology nursing and how

they are managed.

In this chapter, the author explained what led him to initiate this study. Selected statistics indicated that cancer is still the most prevalent cause of death among men and women. As he has pointed out, the purpose of this inquiry was to explore the challenges experienced by RNs while working in oncology. Research questions pertaining to this inquiry were identified. Finally, the author posited that such a study might bring new understanding to the practices of nurses in oncology by shedding light on the nature of their challenges and how nurses were managing them.

Chapter 2 – Literature review

Health care professionals are confronted with a great variety of issues when nursing individuals diagnosed with life-threatening illnesses. Books, journals, and articles have been published on death and dying, palliative care, and oncology care since Elizabeth Kübler-Ross and Cicely Saunders in the 1960s' (Holland, 1998). In the palliative care and oncology literature, symptoms and pain management, psychosocial issues, ethical concerns, treatment options, and ways to deal with these aspects are widely discussed. Despite the abundance of information, Hanson (1994) reported from her investigation that common-sense knowledge and skills of cancer nurses in relation to psychosocial care of individuals with cancer remained hidden, little was visible considering the dominance of the medical model in oncology.

Palliative care associations, hospice associations, and oncology nursing groups at the provincial and national levels have formed to respond to the needs to improve health care services. For example, Ferris, Balfour, Bowen, Farley, Hardwick, Lamontagne, Lundy, Syme, and West (2002) worked in conjunction with the Canadian Hospice Palliative Care Association to prepare a model to guide hospice palliative care. They identified nine guiding principles providing a more standardized approach to hospice palliative care. This type of care should be patient and family focused, high quality, safe and effective, accessible, "adequately resourced" [sic], collaborative, and it should be based on knowledge, advocacy, and research (pp. 19-20). These efforts to improve the care of terminally-ill individuals will hopefully help to develop local best practice standards especially with the rapid changes in medical care.

Nurses might feel overwhelmed, however, when they consider their

responsibilities as they face problems in nursing practice. Could most of these problems be considered "challenges"? What are the implications for considering these problems as challenges? What were the challenges reported in the literature? The focus of this chapter is a literature review designed to examine previous research pertinent to this study. Relevant articles were those that examined challenges and identified research on nursing challenge. The search for articles was conducted using CINAHL, PsychoInfo, Cancerlit, and Medline for the period of 1984 to 2003. Additional sources of literature were obtained by reviewing reference lists in published articles. In the first section of this chapter, the author presents the concepts of stress, coping and challenge based on Lazarus and Folkman's (1984) model as well as other research that has focused on coping. In the second section of this chapter, selected non-research based articles which identify a specific challenge in nursing are discussed.

Stress, Coping and Challenge

In the literature, the concepts of stress and coping are often related. In the 1960s and the 1970s, the emphasis on stress shifted to an emphasis on coping (Lazarus & Folkman, 1984), and many articles and research discussed how individuals dealt with stress in their lives. In this section, the concept of coping is explored in relation to stress, to appraisal of stressors or demands, including challenge appraisal, and finally, to emotion-focused and problem-focused coping.

In 1974, Selye described stress as being a non-specific response of the body to any demand. This broadened the idea of stress from seeing it solely as a physical hardship to seeing it as affecting also the psychological dimension, which began the shift in the research to coping. Lazarus and Folkman (1984) discussed stress in their

book entitled "Stress, appraisal, and coping." It centred on how individuals appraise and cope with stressful encounters. They had noted from previous writings that stress, from a biological perspective, was considered an active process of fighting back, and this was followed by a different perspective of stress as a psychological process in which coping acts as a struggle to manage psychological stress. In 1984, they defined psychological stress as, "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19). Cohen, Haberman, Steeves, and Deatrick (1994) mentioned that "coping involves the interaction of the person and situation involved, and its results from the appraisal or perception of a situation" (p. 10). When faced with a stressful encounter, the individual is engaged in a process that is intended to bring a certain relief from the stress experienced. The process associated with the dealing of such encounters is called coping.

In defining coping, numerous authors discussed processes and efforts required to manage stressful encounters with the recognition that there is a dynamic between the individual and his or her environment. Grahn and Danielson (1996) argued that "coping as a process cannot be segregated from [its] context" (p. 186). In 1993, Lazarus referred to coping as the "efforts to manage stress that change over time and [these efforts] are shaped by the adaptational context out of which it is generated" (p. 234).

This element of dynamic change is also discussed by White, Richter, and Fry (1992). They described coping as "a process involving ongoing appraisal and reappraisal of the dynamic person-environment relationship" (p. 212). And, according to Frydenberg (1999), "coping is a complex phenomenon based on resources and the

relationship between the person and the environment" (p. 17). Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Based on Lazarus' definition of coping, Frydenberg (1999) argued that "coping strategies are defined by effort, which accounts for just about anything an individual does, in his or her transaction with the environment, that is purposeful. Therefore coping need not be a 'successfully completed' act but an attempt to deal with the problem" (pp. 17-18). All the authors above regard coping as a constant effort to deal with the encounter which takes into consideration the resources available and the environment.

Weisman (1979) stated that coping is a process of using specific tactics to bring about relief, quiescence, and equilibrium. This idea that coping is a process that changes throughout the course of illness or life is echoed by Lazarus (1993) who wrote that from "a process perspective, coping changes over time and in accordance with the situational contexts in which it occurs" (p. 235); an individual may change from one type of coping to another as the person-environment context changes (Lazarus & Folkman, 1984). Coping is so dependant on the dynamic between the individual and the situation that, as Lazarus (1993) noted, a coping strategy that produced a positive outcome in one context, or in one individual, may not in another one. Lazarus (1990) argued about the subjectivity associated with the appraisal of a stressful encounter and suggested that both appraisal and coping change over time and across encounters. The appraisal is based largely on past experience and is associated with the process of categorizing an encounter considering its meaning or significance (Lazarus & Folkman, 1984). From

this perspective, coping is viewed as a dynamic process influenced by a stressor or by an encounter and by the context or the environment in which it is experienced at a certain point in an individual's life.

There are a series of stages that take place when facing an encounter, from various levels of appraising to coping with the encounter. The first stage is to appraise it. Lazarus (1998) considered appraisal as an evaluation of the significance of what is happening for our well-being. He indicated that

> we are all constantly engaged in appraising and, therefore, distinguishing among conditions of harm, threat, challenge, and benefits. Doing this provides the opportunity to anticipate adaptational problems and cope successfully, thereby helping us to survive and flourish. (p. 113)

Sharts-Hopko, Regan-Kubinski, Lincoln, and Heverly (1996) confirmed that the individual's ability to cope with stress and to manage problems that arise from stressful situations depends on the appraisal the individual does in such situations.

Lazarus and Folkman (1984) identified this process of appraisal as having three stages, primary appraisal, secondary appraisal, and reappraisal. In primary appraisal, the individual, after being faced with a stressor, evaluates the possible impact on him or her. In secondary appraisal, the individual decides if anything can be done (Mahon, Cella, & Donovan, 1990; Koop, 1994; Fredette, 1995). The following example illustrates how these two appraisal stages relate to each other. The individual will select "avoidance coping" as a strategy if primary appraisal has led to the perception of a threat and if the secondary appraisal has led the individual to believe that there were insufficient resources available to deal with such a threat (Holahan & Moos, 1987). Given that the

initial action of primary appraisal affects subsequent appraisal and coping stages, it needs to be explored further to enhance its functioning.

Primary appraisal, as described by Lazarus and Folkman (1984), has three sub-categories: irrelevant appraisal, benign-positive appraisal, and stress appraisal. When there is no felt implication for the person's own well-being, it is considered to be an irrelevant appraisal. When the outcome is perceived as promising and positive for the person's well-being, it is a benign-positive appraisal. And, finally, if some damage has already been sustained by the individual, if harm is anticipated, or if a challenge requires an individual to mobilize his or her coping efforts while dealing with an encounter, it is considered to be a stress appraisal. This third sub-category, the stress appraisal, can be seen as positive and helpful, or negative and harmful. Whether it is positive or negative depends on whether the individual perceives his or her encounter as a challenge or as a threat. Lazarus and Folkman (1984) tried to distinguish challenge from harm, loss, and threat:

> The main difference is that challenge appraisals focus on the potential for gain or growth inherent in an encounter and they are characterized by pleasurable emotions such as eagerness, excitement, and exhilaration, whereas threat centers on the potential harms and is characterized by negative emotions such as fear, anxiety, and anger. (p. 33)

In some situations, an individual may feel either challenged or threatened. Lazarus and Folkman (1984) added that threat and challenge are not mutually exclusive and can occur simultaneously because a challenge entails also a risk, i.e., that the individual could be unable to respond well to the demands. Even though they may experience

some threat, individuals may also feel challenged, and experience emotions such as hopefulness, eagerness, and confidence. When perceiving a situation as challenging, individuals are more likely to feel positive about the encounters, feel more confident about him or herself, be less emotionally overwhelmed, and be more capable of using available resources compared to situations where they are inhibited or blocked (Lazarus & Folkman, 1984). These authors defined challenge as "a stressful appraisal in which an opportunity for mastery or gain dominates, but with some sense of risk too" (p. 96). A challenge "encourages venture and openness and increases the possibility of good communication and problem solving" (p. 191).

In secondary appraisal, Lazarus and Folkman (1984) indicated that the individual feels that something must be done to manage the situation, regardless of whether it is a perceived threat or a challenge; the individual concentrates on what might be done in such instances. During the appraisal process, the individual takes into account the options available and the likelihood of being successful in applying strategies.

Like the dynamic nature of the interaction between the individual and the environment during the appraisal, so too does the coping process require constant interaction. During the coping process, there are continuous appraisals or reappraisals of the person-environment relationship that take place in order to assess what is happening, its significance, and what response is required (Lazarus & Folkman, 1984). These reappraisals influence subsequent coping efforts, which thereby modify the previous appraisals. These three categories of appraisals, primary, secondary, and reappraisal, are a continuous and active part of the coping process and influence individuals in deciding how to deal with their encounters.

The dynamic process of coping can be categorized by two approaches in Lazarus and Folkman's (1984) model. Encounters can be managed by emotion-focused coping or problem-focused coping. In emotion-focused coping, the emphasis is on managing one's emotional stress and maintaining an emotional equilibrium (Krause, 1993). With this type of coping, the individual tries to change the meaning of a stressful situation (Fredette, 1995), or to reduce the emotional distress (Sharts-Hopko, & al., 1996). The emotion-focused coping strategies that were reported by Toseland, Blanchard, and McCallion (1995) were: avoidance, denial, detachment, magical or wishful thinking and religious faith. Krause (1993) identified having hope as a way of coping. And, Mishel and Sorenson (1993) mentioned acceptance as a strategy used for coping.

Lazarus and Folkman (1984) described the second type of coping, problem-focused coping, as "doing something to relieve the problem" (p. 44). Fredette (1995) stated:

> problem-focused coping centres around defining the problem, generating alternative solutions, weighing and choosing among alternatives, altering environmental stressors, changing goal expectation, finding alternative channels of gratification, and learning new skills and behaviors. (p. 37)

Sharts-Hopko et al. (1996) indicated that such coping is associated with the analysis of alternative solutions and with the selection of actions for a positive change. As Krause (1993) indicated, this type of coping focuses on eliminating the sources of stress through one's own behavior.

Lazarus has been consistent over the past two decades in arguing that emotion-focused coping is more important in stressful conditions when the individual is reticent

to change, and that problem-focused coping predominates when these conditions are appraised as controllable by action (Lazarus, 1993). Lazarus (1998) repeated his conclusions when he stated that "when the conditions of stress are unchangeable, problem-focused coping is associated with poorer outcomes than emotion-focused coping" (p. 116). Other researchers, such as Somerfield and Curbow (1992), and Mishel and Sorenson (1993), concur with Lazarus and Folkman (1984) that the persistent uses of problem-focused strategies when faced with uncontrollable situations may increase the distress experienced by the individual, which therefore requires emotion-focused coping to try to reduce such distress. This clarification illustrates the importance of both types of coping when dealing with stressful situations. In the coping literature, challenges were discussed mainly by Lazarus and Folkman. Below, the author presents literature sources on stressors and their impact on nursing.

Stressors in nursing.

Wilkinson (1995) acknowledged that nursing individuals living with cancer could be particularly stressful for professionals. Furthermore, she added that in her study, a major source of stress was their inability to provide quality of care that patients deserved because of their perceived lack of resources or staff. Also, Vachon (in press-a) reported that team conflicts and the lack of cooperation were seen as stressors in a working environment. And, the lack of participation in decision making and ethical dilemmas were sources of stress. Vachon and Benor (in press) and Vachon (2001, 2002, 2003) mentioned that role conflict in palliative care between nursing and physicians, for example, could increase nurses' stress level. Vachon (2001, 2002, 2003) reported other stressors such as, role overload, team conflict, lack of support, death and dying issues.

Cohen and Sarter (1992) indicated the legitimate stressors were those related to demands inherent in caring and that non- legitimate stressors were those related to "circumstances that prevent concerned nurses from caring adequately for patients" (p. 1486).

Costantini, Solano, Di Napoli, and Bosco (1997) added that, on the one hand, when staff experienced a moderate degree of stress, it might facilitate their operation at optimal levels and, on the other hand, excessive stress could cause a deterioration in their professional performance. When dealing with stress, Vachon (2002) discussed the need for role-balancing, and having a sense of control in their work environment. Papadatou, Anagnostopoulos, and Monos (1994) found in their investigation that oncology nurses who had a greater sense of personal control over the things, either in life and in their work environment, were found to be protected against emotional exhaustion, depersonalization and lack of personal accomplishment. Vachon (1998b) stated that having a sense of control, i.e., the ability to redefine particular situations as being a challenge instead of a threat, made a difference in coping with stress.

Individuals with certain types of personality, such as the hardy personality, were reported to deal better than others with stressful situations. Vachon (1998b, 2001, in press-a), DePew, Gordon, Yoder, and Goodwin (1999), and Costantini, Solano, Di Napoli, and Bosco (1997), for example, have discussed the three characteristics of hardiness as developed by Kobasa (1979) and other researchers, i.e., commitment, control, and challenge. Individuals with this type of personality would have a sense or a feeling of commitment toward one's activities, a sense of control and influence over one's life or events, and a sense that one has the ability to see change as a challenge and

as an opportunity for growth rather than a threat. Marsh, Beard, and Adams (1999) distinguished hardiness from social support, and mentioned that hardiness was associated with an internal or inner resource compared to social support which was associated with an external resource available to nurses.

Studies on the three hardiness' characteristics tended to indicate that individuals are more resistant to stress and less vulnerable to burnout (e.g., Papadatou et al., 1994; Costantini et al.,1997). DePew et al. (1999) mentioned that burnout was found in the helping professions such as nursing. Grunfeld, Whelan, Zitzelsberger, Willan, Montesanto, and Evans (2000) reported that health care professionals in Ontario were experiencing burnout and high levels of stress. As Papadatou et al. (1994) indicated, higher degrees of burnout were found when nurses had a sense of a lack of control over external events. For example, nurses said, "no matter how hard they try, their efforts will accomplish nothing," that "most of the time, it just doesn't pay to try hard since things never turn out right anyway" (p. 195). Papadatou et al. (1994) confirmed that oncology nurses were at greater risk of developing burnout because of the stressful and demanding nature of their work which was filled with constant uncertainties. In their study, Cohen and Sarter (1992) mentioned that nurses described their front line work with oncology patients as being complex demanding, and stressful, it is "a war against death, disfigurement, and intense human suffering... requiring multiple complex tasks... [and involving the handling of] unexpected crisis" (p. 1485). Vachon (2001, 2003, in press-a) mentioned that palliative care also could be stressful. She reported from her literature review that poor staffing, inadequate time, unexpected crisis, heavy workload, overworked nurses, and excessive demands could lead to difficulties. Cohen

and Sarter (1992) identified such nursing difficulties as a result of negative feedback, being short-staffed, and lack of symptoms control. Vachon (in press-a) pointed out that the stress experienced by professional caregivers may result from the work environment in which there are unrealistic expectations toward them.

Oncology settings can be stressful working environments, however, some researchers have identified sources of rewards. It seemed that the challenge of working with individuals with cancer might be a reward that counterbalanced the stress felt by nurses. Cohen, Haberman, Steeves, and Deatrick (1994) and Vachon (1993, 1998b) discussed three most important sources of rewards for oncology nurses: these were patients, co-workers, and new skills. And Vachon (2001, 2002) listed some of the satisfactions that might be identified when working in palliative care, for example: valuing individuals, assisting patients and families learn to cope, experiencing positive feedback from patients and families, witnessing the smooth termination of life, experiencing positive relationships and support from colleagues, and having professional status and esteem. The rewards mentioned in the literature were often related to human interactions, for example, when comforting individuals in distress and when receiving recognition from their peers (Cohen & Sarter, 1992). Finally, having a sense of being challenged or supported could be perceived as an incentive for growth and reducing stress. In the following paragraphs, the author presents challenges in contexts other than stress and coping.

Challenges in Nursing

In this section, a review of the publications on challenges will be presented. Many authors referred to nursing activities as being a challenge. They did not refer to

these issues as challenges in the same way as other authors, e.g., they did not talk about the potential for mastery or gain, or the pleasurable emotions associated with challenges described by Lazarus and Folkman (1984).

Armstrong and Gilbert (1998) provided an example where the authors used the word challenge but did not provide the link to theories of coping as described previously; they wrote, "It is the challenge of the oncology nurse caring for the patient with a malignant brain tumor to gain knowledge of the disease process, side effect management, and the most up-to-date treatment regimens" (p. 18). Similarly, Ingle (1995) saw challenges as arising from the quantity of information the nurse must know in order to care for a client:

> Developing the expertise needed to manage ... [various] types of [medical] complications is a continual challenge to the oncology nurse. Although managing rare complications is usually performed by a physician, recognizing the clinical manifestations will alert the nurse to seek medical advice immediately, thus decreasing the risk of mortality. (p. 184)

As well as dealing strictly with the medical demands of diseases, nurses are confronted with both the social and the emotional aspects of client-care. These demands are compounded when clients are limited in their ability to communicate. Banoub-Baddour and Laryea (1992) indicated "caring for preschool children suffering from cancer pain presents a major challenge for paediatric oncology nurses. These children have limited language and behavioural competencies" (p. 132). In another example, Beddar and Aikin (1994) stated "integration between these services, caregivers, and care settings is a major challenge. Barriers impeding successful coordination of care include

territoriality, reimbursement issues, minimal collaboration, and inadequate communication" (p. 254).

Dealing with clients' issues can also represent a series of challenges. Rittman et al. (1997), in a phenomenological study done with oncology nurses, provided further insight into their challenges. These authors reported that nurses are faced with a major challenge when they have to enter the patients' world and deal with their life-and-death issues. In the text, they mainly described the implementation of some interventions used with terminally ill clients, and how these interventions were important to them. In this study, each nurse was asked to describe a caring situation with a dying client; then, the researchers categorized the nurses' answers according to several common themes such as knowing the patient, the stage of illness, preserving hope, easing the struggle, and providing for privacy. These experienced nurses had a special relationship with their clients that helped them to develop a perspective on their response to the disease and to the treatment. These nurses were able not only to "accompany" their clients during their illness trajectory, but also to articulate the experience. These nurses knew how to preserve the clients' hopes while at the same time not instilling false hopes, how to talk to the clients and their families, and also how to provide support and comfort.

As well as these issues or interventions, the fears clients with cancer have could represent a challenge for nurses. A diagnosis of cancer can bring feelings of uncertainty, fear, and horror, and therefore, the expression of their feelings and concerns becomes vital (Krause, 1991). When chances of a cure are low, clients may be afraid that they will not receive the same medical attention or be as closely supervised as those under active treatment, and this perception can increase their fears and their concerns

(Fredette, 1995). They are afraid of being abandoned by the system.

Other authors referred to interventions as challenges. Harvey, Hobbie, Shaw, and Bottomley (1999) noted "providing appropriate, comprehensive follow-up care is a challenge for health care providers and one that can be met by developing quality follow-up programs for all childhood cancer survivors" (p. 117). They emphasized that follow-up care was important for recovery, yet hard to implement consistently.

In the literature, the emotional dimensions of care were vast, and it is reported that nurses responded not only to medical care needs but also to the psycho-social dimensions of the clients' care. As clients become overwhelmed by their situations, a nurse may feel compelled to assume the important role of a guide who accompanies clients and their families through the course of the illness (Fredette, 1995). Clients struggling with the difficulties of illness need a trusted and attentive listener who can guide them through all the decisions they must make. Pickett, Cooley, and Gordon (1998) asserted that increased sensitivity and compassion from professionals is needed regarding the human dimensions of care provided to individuals. Nurses could play a vital role in providing such compassion and also in providing information required or requested by these individuals. This dual role could also be a challenge because nurses need to achieve a balance between providing medical treatments and providing caring interventions, both of which are required and are considered important for clients.

Nurses are also challenged when assisting clients and their families to deal more effectively with their situation. First, they need to assess the clients' abilities to cope. Then, as suggested by Pasacreta and Pickett (1998), nurses can establish clinical goals which promote effective coping strategies for clients with cancer; these goals could

include minimizing the clients' distress, providing ongoing psychological support, increasing their sense of control and self-efficacy, discussing their existential concerns, providing information about what to expect regarding their cancer and their treatment, listening to their expression of fears and concerns, and providing a realistic reassurance. These authors focused on the manageable issue of providing information on factors affecting psychosocial adjustment of clients with their cancer diagnosis.

Fitch, Bakker, and Conlon (1999) reported on a study done with 249 oncology nurses where these nurses were questioned about 80 topics identified in previous research. These topics fell under the categories of biophysiological and psychosocial issues of clients, and also the professional issues of oncology nurses. At the beginning of the article, the authors cited the purpose of their investigation as that of identifying the current challenges oncology nurses face in their daily practice. They pointed out that "challenges emerge for nurses as they strive to provide quality care within the constraints and pressures of the working environment" (p. 151). However, instead of investigating these situations as challenges, they studied them as problems: they asked nurses to indicate the extent to which each of the eighty items posed a problem in their daily practice and the extent to which each item needed research attention. They continued by describing a problem as "an issue or situation needing a solution or better information" (p. 152). In their discussion of the findings, they said that this investigation "was undertaken to identify the *problem issues* [italics added] oncology nurses experience in their daily clinical practice" (p. 155). They found that of the ten clinical problems that scored the highest, nine were clinical problems related to clients in two sub-categories: psychosocial and biophysiological problems. The later were comprised

of five problems such as anxiety, coping / stress management, bereavement /death, quality of life, and recurrence of primary cancer. The former included four problems such as fatigue, metastatic disease, comfort, and pain control and management. And, the tenth problem identified was a professional issue, nurse burnout. Participants were not asked to indicate the challenges they encountered, but rather the clinical problems that were an issue for them.

In examining other articles, it seems that integrating active oncology treatments with palliative care services can represent another challenge for nurses working in oncology. It can be possible to achieve a balance between these two types of services if health care professionals strive to integrate them. Pickett et al. (1998) recommended that palliative care principles be used to guide care and to improve the quality of life of clients in oncology units. The World Health Organization (W.H.O.) emphasized the importance of a multidisciplinary approach to care, which combines symptom relief and psychological support, "suggesting that active palliative care be included as part of total care at the time of diagnosis rather than used as a last resort" (Pickett et al, 1998, p. 89). Since 1980, Dr. Stjernswärd, Chief of the Cancer and Palliative Care Unit of the W.H.O. in Geneva, has been promoting the position that clients and families dealing with cancer should be provided not only with oncology but also with palliative care (Stjernswärd, Colleau, & Ventafridda, 1996). In visiting many countries, Stjernswärd noticed that too many individuals were suffering physical and emotional distress while undergoing oncology treatments. Health care professionals in oncology and palliative care in Western countries were better equipped than before to assist clients, but these two types of care are not integrated. A typical scenario is that one service is emphasized

to the near exclusion of the other. Receiving appropriate comfort measures still remains a challenge for these clients when faced with pain and suffering.

In the articles referred to previously, the terms challenge and problems were used interchangeably without recognizing how each gives a different perspective and thus how each results in a different response from clients or caregivers. In these articles, the authors did not describe how "challenges" or situations were appraised as encounters; and nothing indicated how they could be described as a challenge using Lazarus and Folkman's perspective.

When authors identified situations as challenging, readers were lead to believe that they were opportunities for mastery and gain. But, how were these situations challenges? What were these challenges? How were nurses trying to deal with these challenges? Many questions existed that the literature was not answering. No articles were found to describe challenges as experienced by health care professionals in general or by oncology nurses in particular.

Chapter 3 - Method

The aim of this study was to identify the challenges experienced by registered nurses while working with oncology clients. A qualitative exploratory-descriptive design was used in this study. In this chapter, the research method, study sample, data collection, data analysis, ways for establishing rigour, and ethical considerations are described.

Research Method

In this qualitative study, the researcher used an exploratory-descriptive design. During the collection of data, interviews were done with all participants using semistructured questions. Then content analysis was accomplished using the strategies proposed by Miles and Huberman (1994) for qualitative data analysis and these strategies are described in the later part of this chapter.

Burns and Grove (2001) support the use of a qualitative approach when a need exists to generate new knowledge about concepts or a phenomenon. An exploratory study is conducted when a problem area or a topic has previously never been studied and when little or no literature exists on the topic (Brink, 1989), as is the case in the present study. The researcher examined the participants' perspective and used a small sample of participants knowledgeable on the topic of interest (Brink, 1989). Each of the seven participants had more than seven years experience in nursing oncology patients.

Brink and Wood (1989) indicated that in a descriptive study the researcher looks for a more "complete description of a single broad variable or concept within a given population" (p. 124). In this study, semi-structured questions were used, and each question was standardized and ordered in a preset manner, while permitting answers to

be open and unstructured. The questions of the interview guide were developed while keeping in mind the five research questions guiding this inquiry. As supported by Brink and Wood (1989), the researcher returned again and again to the data to ensure its correctness during the interviewing process. In this exploratory and descriptive study, content analysis was used to gain an understanding of the topic studied and its characteristics.

The researcher began his study by meeting the nursing management team and confirming that this research was acceptable at this health care institution, and also that enough participants (RNs) were available for this study. As of September 2000, there were more than 25 full-time RNs and less than five part-time RNs in the selected Canadian health care institution. Then, the researcher obtained authorization from the nursing managers to spend one day observing. Nurses were informed that he was familiarizing himself with the oncology clinics where the participants* were working by observing their work environment, which included the nursing station, as well as their interactions with nursing colleagues, other health care professionals, and with the clients. In some instances, the researcher needed to observe nurses' interactions with clients; subsequently thereafter, the nurse sought the permission of the client, and his/her family if they were also present, to have the researcher come in and observe them. Had the client and/or family refused, the researcher would not have proceeded with the observation. During the observation of the working environment that lasted less

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* The words: participants, and registered nurses (RNs) are used interchangeably in the text.

than four hours in total, the registered nurses who did not want to be observed were invited to inform the researcher. Flexibility was required in order to allow the researcher into this environment without creating further concerns for nurses or for clients who were being observed.

The understanding of the participants from their own perspective in the setting under study, i.e. the "emic perspective" (Brink, 1989; Morse & Field, 1995; Roper & Shapira, 2000), was taken into consideration in the research process. Such a perspective facilitated the researcher's understanding of what happens in their working lives from their point of view. An emic view or perspective enabled the researcher to develop an insider's view of the individuals studied (Guba & Lincoln, 1994; Merriam, 1998) and to understand participants' perspectives on their challenges.

Study Sample

Participants were selected because they were experts in the area studied. Roper and Shapira (2000) stated that "You choose people to interview in a deliberate way to obtain data ... [and] some individuals [are] better able to enlighten [the researcher]" (pp. 78-79). There was a need to be discriminating when choosing participants for the sample in order to maximize opportunities for analysis. Such selection was made in respect to the inclusion criteria.

Criteria for inclusion.

The inclusion criteria for selecting participants were: they must be registered nurses (RNs) with a minimum of two years' experience in caring for clients diagnosed with cancer. In these two years or more, nurses were presumed to have accumulated more expertise than those with fewer years of experience. As indicated by Rittman et al.

(1997), nurses with more than five years of experience were considered to have acquired a high degree of expertise in oncology. These inclusion criteria were expected to enhance the opportunity of obtaining various types of information regarding what actually represented a "challenge" and for whom specifically. All RNs who came forward to participate in this research met the eligibility criteria except for two nurses. One had less than a year experience in oncology, and the second one considered herself not involved in client care at all.

A convenience sample was sought in four ways. 1) The nurse managers' assistance was obtained in gaining access to staff who fit the sample criteria. They were asked to seek the permission of RNs to submit their names and telephone numbers to the researcher for follow-up contact. RNs were also invited to contact the researcher directly for more information about the study. 2) Information about the study was posted on the nurses' bulletin boards. 3) A presentation was made to nurses working in the selected oncology clinics. 4) RNs who agreed to participate in the study were asked to contact other RNs working in oncology who might be interested in becoming involved in the research (snowballing). In this study, four nurses were recruited by the participants themselves. An information sheet describing this study was provided to interested RNs (Appendix B "Information Sheet for Registered Nurses"). A meeting was scheduled to provide further information about the study and to obtain a signed consent form if the participant agreed to be interviewed for the study. Participants were informed that they could withdraw at any time during the research process, and no participant was coerced into taking part in this study. All seven participants who had worked more that than two years in oncology (a condition of the recruitment criteria)

were accepted and interviewed, and there was no attrition during the process of data collection.

Data Collection

Miles and Huberman (1994), in their book on qualitative data analysis, focused on data "in the form of words" (p. 9). This approach required that interviews be done and transcribed in order to proceed with a detailed content analysis. These authors asserted that in qualitative research the phenomenon studied is perceived to be embedded in its context and they expressed the need to gain an overview of such context. During the collection of data, the context in which participants were working was taken into consideration. Observation of the health care institution helped the researcher understand the context of the phenomenon being examined.

After participants agreed to be interviewed and had signed the consent form, the first interview was scheduled at a time and location convenient to the nurse and the researcher, i.e. most of the time these interviews were held in their institution. Participants were asked to partake in a maximum of three tape-recorded interviews for this research. The first series of interviews lasted approximately 60 to 90 minutes, the second series about 30 to 60 minutes, and the third series approximately 30 minutes. Individual interviews were tape-recorded to promote accuracy of the information provided by participants. The interviews, done between November 2000 and June 2001, involved a substantial amount of time from their busy schedules. The researcher was sensitive to the time constraints with which they were confronted. Participants were given an opportunity in the second and third interviews to comment on their previous interview and to look at their transcripts if requested. Unclear data obtained during

previous interview(s) was clarified, and participants were encouraged to provide further information which they might have thought of since the preceding interview(s).

Each initial interview began with an open-ended question, i.e., "What is your day like when working in oncology?" Other open-ended questions were used in order to provide opportunities for participants to describe their perspective on the phenomenon studied, i.e., challenges.

During the interviews, participants had time to reflect on the topic and on the questions that were asked. In qualitative inquiries, the researcher learns from the participants. Weber (1986) referred to interviewing participants as an invitation to reflect jointly on a phenomenon. A conversation allowing the interviewer to understand the participants' experience was considered important during the interviews (Weber, 1986). When such a process occurs, it stimulates further reflection. The researcher wanted to elicit the most relevant information during the interview (Merriam, 1998). Morse (1994) referred to this as "maintaining a spirit of inquisitiveness" (p. 28) which encouraged the participants to provide frank and detailed responses, and which helped the participants to focus on the object of the interview.

Researchers must be good listeners while assimilating a large amount of information (Yin, 1994). Moreover, researchers must be alert for inconsistencies and must obtain clarification either during the interview or in the following one. By comparing the information collected during the interviews and by understanding what occurred during the interviews, the researcher was able to seek clarification. For example, this was possible when he asked participants at the end of the second series of interviews to comment on the challenges they had raised and on those discussed by

other participants. In this last instance, they were asked to provide examples to support the challenges they felt were present in their work environment.

In the event that some participants did not find working with oncology clients challenging, the researcher was prepared to ask them the question "Why do you find that oncology nursing is not a challenge for you?" Asking such a question would have provided some data regarding the difference between what did and what did not constitute a challenge.

In qualitative research, the researcher is the main instrument for the data collection (Miles & Huberman, 1994; Merriam, 1998). His role in preparing the interview is to select key participants, to develop specific questions that would help participants during the discussion to elaborate on the topic at hand, and to create a supportive environment during the interview. The researcher had to ensure that he was influenced as little as possible in order to remain open and objective about the phenomenon and the data. Without evaluating the answers of the participants, the interviewer encouraged participants to talk; consequently, he was less likely to corrupt the data collected. In this study, when the researcher identified his own biases and pre-conceptions, he began to reflect on how they might influence him during the whole research process (Miles & Huberman, 1994; Roper & Shapira, 2000).

Pre-conceptions in this research.

As a researcher, the author was aware that he could bring or become aware of biases or preconceptions during the research process that might limit the process itself or the analysis of the data, ultimately affecting the findings. He had identified his expectations and biases toward the problem studied, and he was aware that more could

be uncovered during the research. By being aware of the possible biases, the researcher intentionally put them aside during the collection and the analysis of the data.

His own pre-conceptions regarding the present research were related to his observations and to his experiences with individuals with cancer and AIDS. The author believed that nurses working with clients who are facing cancer might have fears and problems related to their personal or professional experiences with clients or with family members. He also surmised that, nurses might not perceive that they could lack knowledge, education, or experience with cancer clients. They might believe myths regarding cancer, maintain common stereotypes or possess prejudices against individuals with cancer. The beliefs of RNs might prevent them from looking at and addressing the challenges they encountered while working in oncology.

Addressing these preconceptions is important as Merriam (1998) explained, given the researcher is the instrument of research. The possibility exists for personal interference with the collection of data and its analysis. Personal biases could be introduced during the research process (Merriam, 1998). Morse and Field (1995) suggested that researchers should identify their own biases via memos in order to increase the trustworthiness of their findings. Streubert and Carpenter (1995) indicated that researchers should identify their personal perceptions, thoughts, personal experience, and biases regarding their research. Once they have been identified, they should be "bracketed" (Streubert & Carpenter, 1995, p. 22). "Bracketing" means that the researcher puts aside his or her own beliefs and suspends his or her judgement regarding the phenomenon studied. The purpose of bracketing is to become more aware of what could influence the judgement of the researcher, and also to prevent such

judgements from influencing the findings. This process should increase the researcher's neutrality, which ensures a more complete or pure description of the phenomenon studied (Streubert & Carpenter, 1995).

In this study, the researcher identified his pre-conceptions before starting to recruit participants (Miles & Huberman, 1994). During the interviewing period, he realized that the participants had tremendous experience with clients' care in oncology. By being aware of his own beliefs, he facilitated the exploration of the whole situations and contexts that were described by participants regarding their challenges. Between the interviews, the researcher wrote down his thoughts. While doing the analysis, he recorded in memos aspects that required more attention on his part as well as ideas, concerns, and possible biases. Bracketing helped to prevent the limiting of the collection of data and the analysis to what he perceived to be important, which allowed what the participants considered to be important to be revealed. During the analysis, he looked at all the concepts identified and considered many different ways to cluster them until a meaningful picture became apparent and made sense from the participants' perspective. He continuously asked himself if there were other factors or elements that were not there and went back to participants with his preliminary findings to ensure that they were accurate and to encompass as much as possible the whole phenomenon studied, i.e. the challenges encountered. Even when writings about the concepts were identified, he went back and forth to look at the data to ensure that the perspectives of the participants were at the forefront.

Interview guide.

The interview guide (Appendix A) was prepared by developing a series of

questions that were closely examined by the researcher's doctoral supervisor and his supervisory committee. The questions for the study were also pre-tested in an interview with a nursing colleague working in oncology. This process confirmed the appropriateness and the sequencing of questions and their potential for exploring various perspectives on challenges as experienced by nurses in oncology. The pre-test helped to reduce ambiguity and to facilitate the flow of the interview (Morse & Field, 1995).

These questions were to be used as a guide for participants in exploring the aspects under study and in expanding on the various aspects of the challenge phenomenon. This guide ensured that the researcher covered a list of topics with the participants (Roper & Shapira, 2000). The sequence of questions and the wording were decided in advance (Patton, 1990). Hutchinson and Wilson (1994) reminded researchers that "Interview questions are linked to an overriding research question" (p. 305) and must be on the topic of interest. In an attempt to gain the maximum amount of information about what constitutes a challenge for oncology nurses, the researcher asked them to provide a definition of a challenge only at the end of the first interview in order to facilitate their reflection on the topic and to develop a clearer representation of what is a challenge. This decision was based on readings and after listening to the suggestions of other researchers. As the rounds of interviews progressed, the questions of the interview guide continued to guide the process, and the researcher probed further during the interviews to ensure clarification of the participants' statements.

Redundancy.

The researcher ceased to collect data when no new categories were generated

during the analysis. According to Roper and Shapira (2000), when a researcher realizes that the research question has been answered, the data collection stops. Lincoln and Guba (1985) referred to "redundancy" and established that when the data collected was redundant, no new categories would emerge and the researcher could terminate the data collection process.

In this study, redundancy was achieved with the fourth research participant. During the analysis of her transcript, the last new concept identified was the challenge "situations affecting nurses at an emotional level." The information shared by this participant confirmed the presence of this concept. When reading again the transcripts of the three previous participants, this concept was also found in these interviews but was recognized as a challenge only by this fourth participant. No other concepts were identified during this fourth interview. The researcher continued to recruit and interviewed three more participants in order to confirm the data were in fact saturated. The last three participants provided descriptions of the same concepts reported by previous participants. They provided rich examples that confirmed the challenges, strategies, and factors identified by the first four participants.

Card sorts.

The card sort process, also called Q-sort, was used and each participant was given cards to sort into piles (Morse & Field, 1985). Burns and Grove (2001) stated that the Q-sort method can be used to determine the most important items in developing a scale. In the present research, the concepts to be sorted consisted of challenges, strategies, facilitators, and barriers. Participants were provided with each of the 45 concepts on a 5 by 9 cm card and asked, in their third and last interview, to sort each

card under one of the five challenge categories, which were "easy," "not-too-easy/not-too-difficult," "difficult," "huge," and "unachievable," or under a sixth category, that of "not a challenge."

Once the participants had completed this task of clustering all the concepts under the categories provided, they were asked to further classify those concepts that they had placed under the column "not a challenge" into three other sub-categories: "strategies used to deal with challenges," "what makes a challenge easier to deal with (buffer♦)," and "not classified." After they had sorted all the cards, they were asked to identify differences and commonalties among each column (Morse & Field, 1985). Results of card sorting are presented in Chapter 4.

Data Analysis

In this section, the researcher describes the method of analysis, memos, and the mapping of each concept.

Method of analysis.

The method of analysis presented by Miles and Huberman (1994) guided content analysis. These authors believed that analysis consists of 3 concurrent activities: 1) data reduction, 2) data display, and 3) conclusion drawing/verification.

In data reduction, the researcher was involved in "the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear[s] in ... transcriptions" (p. 10). During this process, data reduction occurs. The data was sharpened, sorted, focused, discarded, and organized in order to lead to the drawing of

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♦ The term "buffer" was using during the card sorts and changed to the term "facilitator." A facilitator acts as a factor that makes it easier to deal with a situation.

conclusions and their verifications.

In data display, the researcher may opt to use either matrices, graphs, charts, or networks to display and to organize the information in a way that permits conclusion drawing. Miles and Huberman (1994) pointed out that "Looking at displays helps us to understand what is happening and to do something -- either analyze further or take action -- based on that understanding" (p. 11).

In the conclusion drawing and verification activity, the following process takes place. At first, conclusions are vague and inchoate, and as the process evolves, conclusions become more explicit and grounded. The analyst can then identify the regularities, patterns, possible configurations, and propositions (Miles & Huberman, 1994).

In this study, the researcher used a consistent approach in dealing with the data and the findings. First, all interviews were tape-recorded and then transcribed verbatim by a professional transcriber. The researcher read the transcripts and then read them again while listening to the tapes of the interviews and made the appropriate corrections, for example, he corrected the spelling, or added a missed word. He kept familiarizing himself by reading these transcripts over and over, identifying the concepts that were appearing in the data and writing them in the right margins of the texts. This process was done for all the first interviews (seven participants).

Content analysis was the process used to code the data collected into categories, and a coding scheme was developed. During the analysis, the data was coded by segment, e.g., words, phrases, lines, paragraphs, and codes or key words were assigned to meaningful segments (Miles & Huberman, 1994). Brink (1989) pointed out that

content analysis involves making decisions about the categories of content and assigning code labels to those categories.

While keeping in mind the five research questions, some words became more significant than others. As these words appeared regularly and across the transcripts, meanings began to take shape from the data. The researcher was consistent in the process used to collect the data and did the coding during the analysis from the first to the last interview. He went back and forth reviewing previous transcripts while developing the codes. As these were created, he ensured that a similar descriptor and / or example was identified in order to be tagged with the same code. For example, during the interview and the initial proof reading, the researcher began to develop a sense of the content of the interview as a whole. This identification captured the common ideas regarding each challenge. Some codes such as "lacking time" were selected from the exact words the participants used, as in "in vivo" code. All codes were written in pencil in the right margin of the transcripts. The content associated with challenges described under "side effects" and "symptoms management" were circled and given another code name such as "medical problems." Such codes were related to phrases or sentences that described a common idea or concept. The transcripts were read several times when trying to achieve an understanding of the patterns that were developing. As the codes were identified, the researcher began to cluster and link them together into categories. The code "lacking time" and "having a heavy workload" were grouped together under the same category, e.g., "being always busy." This category was then placed under the heading "relating to self" (nurse).

In some cases, some concepts evolved throughout the analysis. For example,

from the first two transcripts, the concept "negative situations" had been identified; with following transcripts the concept changed to "negative attitude," and finally became "perceived negativity among colleagues." In doing so this concept, when identified as a barrier, reflected more precisely what had been expressed by participants. Key words prompted the researcher to question further the transcripts. A list of codes, including challenges, strategies, and factors, were developed, and progressively, relationships among categories began to emerge.

As the researcher looked at the codes identified, he developed drafts to try to "make sense" of all his codes. As the analysis progressed, an approach to dealing with these challenges was developed by taking into consideration the challenges and their classification, the strategies used by nurses, and the factors encountered either as barriers or as facilitators. The representation of this approach described the process oncology nurses used when they dealt with challenges.

Before starting the second series of interviews, the researcher identified for each participant the concepts that each had described in the first interview and those that other participants had mentioned. Then, he proceeded with the questions prepared for the second interviews (Appendix A). At the end of that interview, he asked the participants to comment on and to provide examples of each concept that was mentioned by participants other than themselves. Participants were able to provide rich data in support of the information provided by their colleagues. These interviews were also transcribed, reviewed for accuracy, and then coded.

Once all codes and categories were identified, the researcher examined the connections between codes and developed a higher order of classification and categories

through a clustering process. The strengths of qualitative data rest centrally on the competence with which their analysis is carried out (Miles & Huberman, 1994). The researcher looked for recurring patterns and themes, by identifying linkages and the relationships between categories, and by validating these relationships. Tentative propositions were formulated which postulated the relationship. For example, during the analysis process, groups of codes were clustered together under one category as they were connected. This is demonstrated with the three following codes: "difficulty in developing a relationship with clients," "distances travelled by clients," and "difficulty in remaining in contact with clients" had a connection, e.g., communication, and the overall category became "having communication problems."

Finally, during the third series of interviews, all participants were given an opportunity to Q-sort the concepts identified by all the participants and were able to comment about the relevance of these concepts to their own situation of working in oncology. The researcher developed the categories for the Q-sort using the participants' own words.

Memos.

Roper and Shapira (2000) used the expression "paper trail" when referring to keeping track of the analysis process. During the analysis of the data, annotations were made in the form of memos regarding ideas, hunches, insights, and information that came to mind and that might identify possible relationships between categories that needed to be explored further. Also the researcher identified how he was planning to classify these concepts. He looked for evidence that supported or refuted the potential relationships. These memos were used to question the understanding that the researcher

had of the data and to provide for other directions which required further exploration (Roper & Shapira, 2000). As the researcher interviewed participants and read the transcripts, he kept taking notes of his thoughts as they came to mind. These writings were reviewed periodically when developing the coding scheme and while doing the clustering of the concepts. Writing memos also assisted the researcher in keeping track of the analytic process.

Mapping each concept.

When reading the transcripts, the researcher referred to the research questions to guide him in the identification of the concepts that the data was presenting. He made a separate list of all these concepts and then kept referring to them when coding the transcripts of other participants.

The process used to code each concept was the same. For example, when reading the transcripts, the researcher noticed that oncology nurses were facing ethical situations. The examples participants provided during the interviews illustrated the issues that they faced in their work environment. When these situations were found in the transcripts, they were then labelled "ethical dilemmas." This process facilitated the clustering of the data bits of this concept. Then, the researcher made a decision to classify this concept as a challenge because it was associated with situations that required the time, energy, and resources of nurses in order to deal with them. The challenge "ethical dilemmas" was defined by taking into consideration the data bits collected and examples were identified from the interviews as illustrated in Chapter 4.

As the codification of the interviews was completed, the codes of the transcripts were entered in the N-Vivo computer program, and the text was also coded on the

screen. This process facilitated the retrieval of the data bits from all the interviews done in this research for over 45 codes. Then, all the data bits for each code were read and re-read to develop a greater understanding of the data bits. The researcher began to write the text under each code supported by rich examples provided by participants. Concurrently, the researcher developed the mapping of the challenges, the strategies, and the factors influencing nurses when dealing with these challenges (facilitators and barriers). These three charts were refined during the whole writing process in order to ensure they represented as accurately as possible the information shared by participants. The concepts that were closely related were clustered together under the appropriate headings. The comments provided by participants during the card sorting were taken into consideration while finalizing the mapping.

Ways of Establishing Rigour

In this section, the author explains how rigour was achieved through various means by referring to credibility, fittingness, auditability, and confirmability (Guba & Lincoln, 1981; Morse & Field, 1995; Sandelowski, 1986; Streubert & Carpenter, 1995; Morgan & Steward, 1999).

"Credibility" is associated with rigour when the researcher follows and reports as closely as possible the perspectives of participants. During the data collection, all participants were asked the same overall questions with the intent of eliciting information regarding their work and experiences with individuals with cancer. For example, by asking participants to describe what they found challenging and what the main challenges in oncology were, the researcher kept the participants thinking and talking about challenges in the interviews. It was important to remain consistent during

and across interviews in order to develop a better understanding of the topic studied. Rigour was also ensured during data collection, for example, by using the same questionnaire, by having the same interviewer do all the interviews, by proceeding in the same way with participants while asking them to elaborate on their answers and their comments.

Also, to ensure credibility during this research, participants had opportunities in each interview to add information about what was missed or conceptualized incorrectly. For example, during the second series of interviews, the researcher asked each nurse if they had anything to add from the first interview and then, at the end of the second interview, to provide comments and examples about the concepts (challenges, strategies, and factors) that were not disclosed during the first interview but were mentioned by nursing colleagues in their interviews. Such a process provided examples and/or feedback which confirmed the presence of these concepts. Finally, in the last interview with each participant, they indicated that all the concepts identified were relevant to their own situations in various degrees and pointed out that they believed that there was nothing else they could add to the list of concepts that had been presented to them. Addison (1989) stated that participants' comments can help to refine the researcher's "account" of what is identified.

Furthermore, in this study, two research participants reviewed the mapping (the four charts found in Appendices D-E-F-G) developed by the researcher during the analysis. Both of them agreed with the mapping, and one participant suggested a different sequence for one strategy, a suggestion which was integrated into the revisions. For all the other concepts identified in the charts, participants indicated that

the charts represented what they had said. They also added that the charts were "complete," and that the fourth chart on the approach used by oncology nurses to deal with challenges was accurate with respect to what they have been experiencing in oncology nursing. Thus, the relevance of the findings was confirmed by participants, which therefore ensures the validity of the interpretations with research participants (Roper & Shapira, 2000). Validating the representativeness of his findings added to the rigour of the qualitative research process. Sandelowski (1993) pointed out that member validation enhances not only the validity but also the quality of the findings.

"Fittingness" refers to the ability to apply findings where they could be meaningful elsewhere. Rigour could also be achieved when a certain level of confirmation is met, for example, when individuals (e.g., syntax reviewers and fellow nursing colleagues) read part of the text and found that they could relate to it and were able to give similar examples from their lives. These examples helped to support the significance of the challenges identified not only in oncology but also in other areas of nursing. As indicated by Morse (1992), when findings are presented to individuals or groups, they should be recognizable and should intuitively make sense.

Many concepts identified in this study are found in the literature. Examples include writings on stress, coping, burnout, job satisfaction, cancer, and health care resources. The literature thus provided many points of comparison to support and to corroborate the findings of the present study. In Chapter 5, the researcher compared and discussed the similarities of his results with the theory on stress, appraisal, and coping of Lazarus and Folkman (1984).

"Auditability" is associated with the decision trail a researcher uses and about

which he or she writes. In this study, in order to ensure rigour, the researcher adhered to a decision trail while collecting data, and doing the analysis. For example, the researcher made notes of his observations during the visits to the clinical site, after meeting potential participants, after the interviews, while reviewing the transcripts for accuracy, while coding the transcripts, and while writings about the findings. He wanted to ensure that the ideas that came to mind were saved for later verification. He was able to refer to them while writing about the challenges and while developing the mapping.

"Confirmability" refers to the findings themselves. It is achieved through rigour in the methodology and by being as free as possible from biases during the research process. In this study, rigour was also enhanced by having the researcher's supervisor review the interview transcriptions and the data analysis, as well as the data bits identified under various concepts, which thereby ensured the relevancy of the codes used. His supervisor was kept informed of how the findings were coming together and of the process used to map the concepts identified as challenges, strategies, and factors affecting nurses when dealing with challenges in oncology. Her monitoring of the research process ensured that appropriate procedures were followed by the researcher. Meetings with the supervisory committee members were arranged in order to keep them posted on the study and on the preliminary findings.

Moreover during the card sort process, the participants were able to classify the challenges on the five-item scale presented, as "easy" to "unachievable" challenges. In doing so, they were confirming that the challenges presented to them were accurate and were relevant in their own context of practice, which therefore confirms that these challenges, strategies, and factors were present in their day-to-day lives in oncology.

Another means by which the researcher ensured rigour was to be conscious of his own biases. As described in the previous section, bracketing was done during the data collection and the analysis to ensure that his personal or professional biases influenced as little as possible the process in order to remain as true as possible to the perceptions of the participants. Throughout this study, the researcher found that his previous experience in palliative care was similar and found that participants were not afraid to discuss their abilities and their limitations in dealing with oncology challenges, which therefore reduced to a minimum the influence of his own bias.

In this section, actions taken to optimize rigour in this research were discussed. These actions were interconnected which ensures that the participants' perspectives were taken into consideration from the beginning to the end of this study.

Ethical Considerations

In view of the need for anonymity and respect for participants' right to withdraw from the research at any time, a consent form was developed and signed by each participant (Appendix B). Access to the raw data (participant transcripts) was restricted to the researcher, the transcriber, and the doctoral supervisor in the event she needed to consult the transcript. The study data will be kept in a secure place for at least five years after the study is completed. accessible only to the researcher. The names of participants and other details identifying them were removed to protect their anonymity. Furthermore, anonymity is preserved in this thesis and will also be preserved, for example, in published papers and in presentations of the findings. Pseudonyms were used for each participant and for individuals identified during the interviews. Name of locations and other specific information that could lead to the identification of the

participants were removed or changed. Participants were informed that an exception to anonymity would be made when professional codes of ethics and/or legislation required reporting. The tape recordings and the transcripts are stored in a locked cabinet separate from the consent forms.

There was no known risk for participants in this study. The benefit of participating in this research was an increased awareness of challenges RNs were encountering. If the interview experience raised any concerns and if the participants wished to discuss them further with a counsellor, the researcher was prepared to provide them with the names of professionals they could contact.

Ethics approval was received by the "Health Research Ethics Board: Biomedical and Health Research" of the University of Alberta (Appendix H) in June 2000 and from the local Ethics Committee on August 11, 2000.

In summary, the author discussed in this chapter the research method, study sample, data collection, ways for establishing rigour, data analysis, and ethical considerations.

Chapter 4 - Findings

The purpose of this study was to explore the challenges that registered nurses encounter while working with clients diagnosed with cancer and with their families. By using a qualitative approach based on Miles and Huberman (1994), the researcher developed a series of questions that would allow the exploration of the concept of a challenge because this topic was never studied before. In respect to the qualitative research process, participants who had personal knowledge about challenges in oncology were recruited to be part of this study. In addition, the intent was to identify challenges and to describe what they were from the data provided by the participants. Once the data was analyzed and the categories derived, it became possible to report on the challenges experienced in oncology, the strategies nurses used, and the factors influencing their dealing with challenges.

During the study, interviews were tape-recorded, transcribed verbatim, and then analyzed. Findings are derived from a series of three interviews with each of seven experienced registered non-unionized nurses who worked in out-patient clinics in an oncology setting. The mean age of participants was 50-59 years, and they were all women with more than ten years of nursing practice with an average of 25 years as registered nurses. Furthermore, all participants had more than seven years of experience in oncology nursing with an overall average of 13.4 years practice in this specialty. To ensure the research participants' anonymity, names and specific descriptions have been changed or removed.

In this chapter, the findings are presented as follows: first, the challenges encountered by nurses while working with clients and families affected by cancer

(research questions 1 and 2); second, the strategies used by nurses to deal with challenges while working in oncology (research question 3); third, the factors that affected nurses, either as facilitators or as barriers, when they faced challenges in an oncology setting (research question 4); fourth, the classification of the concepts identified in this study; fifth, the findings concerning the satisfaction of nurses with the management of challenges (research question 5), and last, the summary of the findings.

Context

Before giving the details of the findings, the author provides a brief description of the context in which these nurses were practicing. Participants were working in a tertiary care centre providing care to clients diagnosed with cancer. Most of them were primary nurses working in collaboration with medical or radio oncologists. The main roles of primary nurses were to consult with clients, to assess their physical and psychological needs, to ease their symptoms and side effects, to provide support to clients and families, and to monitor the clients' condition during and after the treatments have been completed. Nurses were assigned to work with oncologists who, in return, were choosing clients affected by a specific type of cancer, for example, GI cancer, breast cancer, prostate cancer, and clients receiving either chemotherapy, radiotherapy or both types of treatments.

In the medical or radio oncology clinics, primary nurses were seeing 45 to 50 clients a week. An oncologist tried to see about seven new clients a week which added to his or her existing workload. Participants indicated that they were so busy that they started at 09:00, often had no breaks and no lunch time, and finished around 16:30 or 17:00. In the radio-therapy department, therapists treated one client every 15 minutes

for an approximate total of 100 clients per day. The caseload of nurses and other health care professionals varied greatly depending on their responsibilities. For example, each chemotherapy nurse consultant was responsible for two to three clients in the administering of their chemo that lasted from one to five hours depending on the specific cancer treatment protocols. Betty illustrated her perspective on working in the chemotherapy delivery area by stating,

> I feel myself that the most stressful place to work in oncology is chemo, and I think it's NOT like it is psychological in a way because you're worried about what you're going to do but I just think it's the... technical skills and that kind of thing that they have to deal with and... the room... is full of patients and you're trying to talk to them, [the] place is busy and the TV is going and there is (sic) people waiting at the door to come in and they're anxious and they want to head home. Betty (1, 68) *

Also, nurses had to check blood results and vital signs to ensure that clients met the requirements to receive their treatments. If not, the oncologists were notified and asked to decide whether to hold the treatment or not.

Above and beyond the active caseload of clients being treated, nurses had to spend time contacting clients who completed their treatment and make the follow-up verifications required under a specific protocol or according to the specific needs of each client. For example, a participant mentioned that a call of seven minutes with a

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* Legend: After each quote, the reference includes a pseudonym for each participant, the interview number (1, 2, or 3) and then the line number(s) as provided in the N-Vivo program.

client could generate six other calls over a period 45 minutes.

Regarding the clients' consultations, a series of small rooms were used to meet and to examine clients. Four or five oncologists were using the same anti room where they consulted the X-ray and the files of clients, and where they dictated the information concerning each client. Such areas were seen as crowded by participants and as very small considering the number of professionals having to share the same space.

Primary nurses collaborated with the physicians in order to develop a treatment plan and to refer clients to other professionals as required. The health care team was comprised of psychologists, social workers, dieticians, physiotherapists, speech language pathologists, and clinical researchers as well as primary nurses and chemotherapy nurse consultants. Other nurses were working in education, in research, in genetics and in liaison with other local cancer clinics which were affiliated with the tertiary care centre.

The waiting for cancer treatment was between one and four weeks depending on the type of cancer. And, approximately forty percent of clients were receiving chemotherapy in their own communities outside of the tertiary care centre which provided some relief to the waiting list.

Challenges

In this section, a definition of a challenge is presented, which corresponds to the first research question (What constitutes a challenge for nurses in their oncology practice?). Then, concepts related to challenges as identified in the interviews are described, which corresponds to the second research question (What are the challenges experienced by nurses in oncology?). In regard to these two research questions,

participants were invited to talk about what constituted a challenge for them as oncology nurses, to describe what they found challenging in their work, and to explain how they felt challenged by them.

The challenges identified in this study are classified under four headings, i.e., those nurses described in relation to themselves, those related to clients and families, followed by those challenges related to health care professionals, and finally, those related to management and/or to government (Appendix D). Each challenge is briefly defined, then supported with pertinent data from the tape-recorded interviews.

Definition

From the interviews and the analysis of the transcripts, the researcher developed and refined the definition of a challenge that was emerging from the data. For example, participants talked about "things" or situations that required their attention. A nurse mentioned that "the challenges can be many different things" (Della, 1, 123). To do something about these challenges, one has to work on them. Anne stated that "it [a challenge] is the things that make us excel, you know, I think it is the thing[s] that make us better... it is rewarding and so you try and do it again" (Anne, 1, 64). The nurses felt a need to continue to do something. At the end of Anne's first interview, in response to the question, "How do you see challenges, after everything we have talked about today?" She summarized her answer in these terms, "I see it is a good thing and I do think it is the thing that keeps us going and it is the thing that keeps us learning and what you learn from one patient you can apply so easily to another ... [challenges] are fatiguing and satisfying... in the end" (1, 119-120).

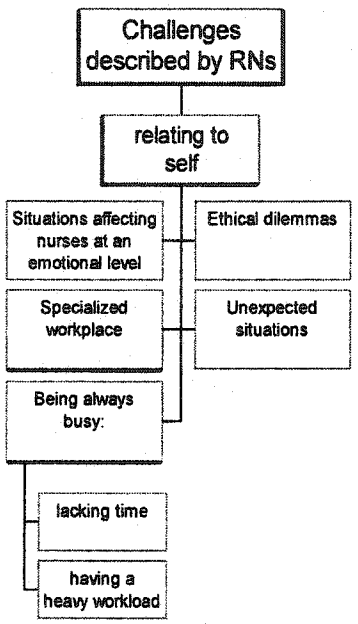
Della (1, 123) and Betty (1, 155) also mentioned that learning is present when

dealing with challenges. Christiane (1, 130) and Sue (1, 130) stated that challenges are good because they teach you how to deal with them. Sue explained, "you learn to deal with situations and how to overcome them" (1, 130). She added that it is "something that doesn't come easy, that you have to either work at it, or you have to actually think about it and how are we going to tackle this" (Sue, 1, 139). And, she went on to say that it is exciting to consider the end results. Similarly, Anne (1, 120) indicated that even though challenges are fatiguing, once they have been met, hopefully they are resolved satisfactorily.

Diane (1, 161, 183) described a challenge as associated with the belief that something can be done to deal with the situation. The challenge can be difficult and require the nurse to work harder and to try different approaches. Louise (1, 123) talked about having to work at the challenge to solve it. She stated that she measures the challenge by how many resources she would have to utilize in order to meet it (Louise, 1, 131). Likewise, in determining to what degree a situation is challenging, Sue needed to ask questions regarding the resources that are required to deal with this situation, e.g., how much research was required on her part, how much information or knowledge she had to get, how intense is the challenge, its size, and the time require to deal with it (Sue, 1, 144-146). As the interviews continued, participants were describing the work involved in dealing with their challenges.

Finally, in the context of this study, a challenge is a situation or a phenomenon experienced as stimulating and as requiring individuals to spend time, energy and resources in order to face and to deal with it. Individuals learn to deal with challenges as they gain experience.

Challenges Experienced by Participants Relating to Themselves



Situations Affecting Nurses at an Emotional Level

In this study, an emotional challenge is defined as an intense affective reaction that one may experience while working with cancer patients. These emotions may influence the manner in which a nurse communicates or interacts with others, e.g., peers and clients.

As experienced by nurses.

Working with clients diagnosed with cancer could evoke various emotions in RNs because their clients face a very uncertain future (Della, 1, 51). Doubts were raised about the clients' lifespan and about their trajectory during the course of treatment. Nurses were constantly exposed to cancer clients who were receiving negative diagnoses. Anne pointed out that for her, the saddest time was when a client or a family member was facing this type of reality. She went on to illustrate this feeling:

> We have a very young lady from outside of town who, you know, who we really are just, you know... I mean... it is devastating to us... we have had to tell her in the last couple of weeks that her disease has recurred and that it is not... it is a really bad situation and she is in her early 40s and she has young children. And she is the nicest, nicest and her husband sobbed, and sobbed, and sobbed but we had to tell them, we had to tell them, I mean, they need to make plans for their future. And we are giving her palliative radiation right now. (Anne, 2, 74)

This example reveals how difficult it can be to have to face such situations.

Other participants used different words to describe how they were affected emotionally in their work. Diane spoke of feeling very tired and drained. She added that she could be one of those nurses who became very emotional and who had a very hard time controlling herself when clients were receiving bad news (Diane, 1, 117). She stated, "the devastation that happens to families over a diagnosis like this is incredible" (Diane, 1, 52). Three participants used this word, in the form of devastated, devastating, devastation, repeatedly to describe the feeling associated with their work with these clients. Louise stressed that a lot of emotional energy was involved during her work in oncology (Louise, 2, 27). Anne talked about the attachment that they could develop with clients and about being in tears in some instances when meeting clients. She insisted on the need to be careful and on not becoming too attached to clients.

All participants interviewed used the word "difficult" when describing emotional aspects relating to their work, for example,

> that is always difficult to tell the patient that there is no active treatment... for them. Uhm, I think it is difficult emotionally, you know, for the patient and it

> can be difficult for you to say that to them. Although I always find that we never say there is nothing [that] can be done. There is always something that can be done pain wise. (Anne, 3, 80)

Anne added that she found it hard when a client was told that he or she could not receive anymore treatment as a cure for the cancer. Another nurse questioned her ability to carry on her work because she was affected by the death of a client for a duration of a few months not only on a professional level but equally on a personal one. She talked about burnout and having reached a limit in her work.

When working with clients of a similar or a younger age, nurses had a more difficult time. Della supported this position:

> it is a little different when they are a little older like their 60s or their 70s. It is still sad and you still feel for them but... they've led a good part of their lives and for the most part, they're a little more ready to deal with that type of thing at that age that they are.... But, I mean, of course younger ones are always, you know, a little more difficult to deal with. (Della, 1, 63)

When a client is, for example, a young woman with breast cancer and with young children, it affects nurses especially if the nurses have children of their own (Della, 1, 64-65). Nursing children with cancer made nurses even more vulnerable to becoming emotional. Sue and Della indicated that children are a much more 'fragile' population with which to work. Working with children was compared to a roller coaster ride by one nurse. And, some of the nurses are mothers who found it too difficult to deal with children with cancer and with the possibility of their own children being sick (Sue 1, 61). By encountering situations affecting them at an emotional level, nurses felt

challenged in trying to deal with their own emotions while caring for their clients.

Specialized Workplace

Within the context of this study, a specialized workplace is associated with the need to have experts in the field of a particular health care institution. To achieve and to maintain the specific knowledge and expertise required in a specialized environment represent a challenge for nurses.

Specialized workplace in relation to self.

All participants consistently spoke of oncology as being a specialty. Nurses acknowledged that oncology was becoming more complex and that sub-specialties were developing within that specialty (Diane, 1, 58; Anne, 1, 51; Della, 1, 137-139; Della, 3, 42; Christiane, 1, 23; Betty, 1, 71, 75, 127*; Louise, 1, 25; Sue, 2, 100). Betty and Louise pointed out that if nurses did not constantly keep up with their practice, they were in danger of being unable to carry out their duties in such an environment (Betty, 1, 75; Louise, 1, 25, 41-43). In some situations, the condition of some clients required intensive monitoring from nurses (Sue, 1, 29). Anne echoed the perspective that there are special challenges to their work sites (Anne, 1, 51).

Christiane (1, 49) affirmed that the procedures in oncology were much more complex now than years ago. Often there was new equipment that was added to the delivery of cancer treatments, and it became more difficult for nurses to move from one area to another. Diane (1, 58) expressed the notion that they tend to stick to their own

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* Legend: For this reference, it was Louise's first interview and she referred to the topic discussed in the text in these line numbers (71, 75 and 127) as provided in the N-Vivo program.

areas of comfort, areas in which they are familiar with the equipment and the procedures. Nevertheless, it was hard for them to do the work and to feel comfortable in their practice. Betty (1, 75, 127) verbalized that they had to keep learning all the time in order not to lose competency with various aspects of the practice in question and that they had to focus on that sub-specialty. Nurses said that they could not know everything about cancer and cancer care.

The majority♦ of the participants raised the following concern: nurses' work in oncology was not recognized in their institution as a clinical specialty (Christiane, 1, 23, 30; Diane, 1, 58; Louise, 1, 25, 44; Della, 2, 137-139; Della, 3, 42). Nurses were concerned and viewed such a position from management as a contradiction when considering the type of skills and knowledge required (Della, 2, 137, Della 3, 42; Louise, 1, 25, 44). Participants expressed the need to update themselves regularly because of the complexity of the care they delivered and to keep up with changes as they occur. Working in oncology, in such a specialized environment, continued to represent a challenge for oncology nurses.

Ethical Dilemmas

A dilemma occurs when a situation or an action conflicts with principles and values that one holds dear. When encountered, dilemmas create an internal conflict between what an individual believes is right and what an individual believes is wrong. An ethical dilemma can be associated with situations or actions that may be detrimental to an individual. Often a question may come up such as: "Is it proper to do this or that?"

♦ In this study, the majority means that a minimum of four participants out of seven were in support of the statement.

One participant stated that a dilemma arises "when anything affects your morals and your values... and you have to remain true to... what your values are" (Louise, 2, 78).

Nurses' dilemmas relating to clients' situations.

One nurse described feeling caught in the middle of a family situation where the daughter with cancer refused any disclosure to her mother regarding her condition. The nurse had to make a decision about how to handle this situation and the associated confidentiality issue. She said,

> there was a young woman who didn't... have a great diagnosis,... and has young children at home, young family and her mother escorted her here and... [the] patient didn't want [her] mother in the room. She said, "I am going to be asking difficult questions and I don't necessarily want you to hear what I am asking" so the mother waited outside and when the young woman went in for her x-ray then the mother was very cheerful and I was comforting her and she said, "I really need to speak to the doctor I need to know what is going on." Not that the daughter wouldn't have shared and she probably would have, but... uhm... I guess ethically I didn't really have permission to allow her to talk to the doctor about [it].... so bottom line, I approached the doctor and it ended up that he did speak with the mother. (Louise, 2, 78)

Nurses faced a multitude of situations where they had to make decisions regarding how best to address a situation. In this mother-daughter situation, considering that the daughter was unlikely to live very long, the nurse decided to assist the mother to get the information she needed. Regarding confidentiality, the mother already knew that her daughter had cancer and had little time left to live, but not all details had been shared

with her. The nurse felt compelled to help not only the client but also her mother.

Two other examples of nursing dilemmas arose regarding pain relief. This participant described her dilemma as follows:

> Sometimes you have family who would want the patient to be alert and, you know, talkative right to the end and the patient was suffering and in so much pain and all you wanted to do was, you know, increase the pain medication. Or you would have the opposite effect where the family wanted them like comatose, you know, right from day one [chuckle] and it was like oh, we can't do that; it doesn't work that way, you know, so you have to explain to them what the medications were and how they worked. (Della, 2, 60)

When a family makes such requests about pain relief, nurses are confronted with an uncomfortable situation. Such requests or similar ones from family members or health care professionals were referred to by nurses as stressful dilemmas.

In some cases, the physician proposed treatments in order to cure the clients with cancer, and in other cases, he proposed palliative treatment to control the symptoms arising during the disease trajectory. When a person was faced with an incurable cancer, a physician might offer chemotherapy even when the treatment would bring many side effects and very little chance of success. Christiane pointed out, "we've made the advancements in research with drugs and treatment at the cost of what though? What about supportive care?.... [W]e're not curing clients here. We are perhaps extending their life by 3 months" (Christiane, 1, 82). Other research participants raised similar concerns such as this one: "How can they offer them a bit of hope when that hope is SO

LITTLE* and will cause the quality of life not to be as good as it could be" (Sue, 2, 126). There were also concerns with the public's expectation. Christiane pointed out that we live in a society that is very doctor-driven which leads some clients and family members to ask for and to receive treatments even though they are not effective. Clients would say, "fix me, you can make me better" (Christiane, 1, 33). In these instances, the issue of lack of knowledge and of expertise on the part of clients might lead to decision making that did not take into consideration the whole situation. Sue stated, "some families will go to the 'n-th' degree to do everything for their" loved one (Sue, 2, 126). "Ethically [speaking] is this proper to do?" (Sue, 2, 122). Christiane (1, 27) wondered to what extent health care professionals should go in order to prolong lives, and at what financial cost? She asked, What about the quality of life of clients receiving such treatments? Was it appropriate to offer a treatment with all its side effects that did not offer a cure? In some instances, nurses were concerned with the quality of life that clients would have.

Other dilemmas were shared by RNs. For example, they could be called upon after work hours by individuals who wanted their opinions regarding their cancer, their treatment or lack thereof, and their physicians. Nurses felt quite uncomfortable with these situations. One participant gave this example:

> I think that not even just a family member but even maybe friends of family and then they sort of rely on you .... [S]ometimes, they call you at home, at night

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* Legend: In the quotes used from participants, the words appearing in capital letters meant that there was an emphasis placed on them by the participants during the interviews.

> [p][♦], you know, when you're at home and you're off duty and... because they know you or they know your brother-in-law or whatever and they call you from home and they ask you for your advice. (Betty, 1, 164)

Betty explained her concerns, "That's very hard. I had a lady she is a friend of my sister-in-law, ... and her family called me all the time.... you don't have the WHOLE STORY.... [Y]ou're saying to yourself: 'Well, I don't really know the answer because I don't know the whole picture' " (Betty, 1, 166, 176). This nurse was afraid of giving a wrong answer to this family member and felt she was also placed in a dilemma of having to answer questions or to provide information when not privy to the whole case.

When participants were faced with ethical dilemmas, they had an internal conflict that needed to be addressed in order to avoid overly increasing their stress level.

Unexpected Situations

Unexpected situations are those which are unplanned that can interfere with the regular scheduled activities of working with cancer clients.

Nurses' challenge relating to clients' situations.

Despite the research on various types of cancer and their treatments, health care professionals could not predict how clients would react to their diagnosis, their treatments and their outcomes. Diane pointed out that "nothing is straightforward about it" because individuals reacted differently to similar situations (1, 29). She went on to add that the delivery of "bad news is exceptionally difficult" and was judged to be one of the biggest challenges the staff faced (Diane, 1, 31). The doctor who did the delivery

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♦ [p] means a short pause of less than 3 seconds and [P] means a long pause (of more than 3 seconds).

of such news was placed in an unfavourable situation, especially when he had to present their treatment plan to newly diagnosed clients. Della said that clients, in some instances, were angry and not coping well: "Sometimes you'll still have the odd person who, despite everything you do, will still be, you know, not adjusting well to the situation, which is understandable" (Della, 2, 72). Diane described that it was a real challenge when they encountered non-accepting clients because what came afterward was likely to be more difficult. When in denial, clients were "not likely to accept any of the advice given to her [or him] by the oncologist" (Diane, 1, 78). Nurses acted as a buffer in these situations and listened to clients' concerns.

Anne presented a situation where clients were showing up with health problems at the end of the day. For example, individuals with minimal blood pressure, a hemorrhage or a myocardial infarction were seen when they were closing the clinic for the day. RNs were faced with these situations without a moment's notice. Some of these could have developed into a crisis or a disaster (Sue, 2, 118). These situations required resources with which a nurse was not familiar, and it was then necessary to involve other staff members in order to respond appropriately to the situation developing (Louise, 1, 121). Anne stressed that these situations were quite frightening and required decisions to be made promptly (Anne 3, 86, 94). When oncology nurses had to deal with unexpected situations, they were confronted with their limitations; then, they had to try to deal with them in the most appropriate manner.

Being Always Busy

In this study, this category refers to a state where nurses are constantly on the move in order to complete the work that has to be done. Two sub-categories were

identified: lacking time and having a heavy workload.

Lacking Time

Lacking time is associated with the inability to accomplish everything that is expected within the time allocated.

In relation to the work done by nurses.

Nurses who participated in this study indicated that they found it difficult to complete all of their assigned work, such as managing each client as required and attending all required meetings during the week. Anne identified this difficulty when she described rounds, nursing meetings, co-ordination meetings, and various other committee meetings:

> [It] is a lot of work, and that is aside from... your clinical work, which is intensive. We are in clinic four days a week and we have two half-days that we set aside for what we call administrative work and... I try to keep one of those strictly for my phone calls and my papers on my desk, in trying to sort through and making sure that I am on top of all of the things.... The other half-day is often taken up with just meetings and we are always very early in the mornings with meetings. Uhm... you know, there could be two or three days a week in the mornings that you are in an hour early for some form of a meeting or other. (Anne, 1, 54)

Anne also indicated that, in addition to the above-mentioned, there was preparation time for the work to be done for the following day. Betty and Diane pointed out that they might have to work through lunch time and breaks in the hope of finishing by 4:30 p.m. (Betty, 1, 13; Diane, 1, 71).

Betty (1, 34) talked about referring clients to other health care professionals because they needed further assistance. She reviewed the past seven years and concluded that she no longer had the time required to adequately teach clients about medication use, for example. Sue attributed the inability to complete her work to both lack of time and a heavy workload, a workload which also involved researching information and providing clients with Internet sites that were deemed useful and appropriate to their needs (Sue, 1, 45). Another participant questioned her ability to keep current in oncology when she could not find the time to up-date herself with some basic information about cancer (Louise, 1, 46). Nurses were challenged to provide all the care required by their clients and more but felt limited with so little time to do so. Five participants out of seven, in doing the card sorts, classified the lack of time to be either a "difficult" or a "huge" challenge. The burden was on the nurses to see more clients and to do more as time went on.

Having a Heavy Workload

A workload is defined as all activities that one must accomplish during work hours. A 'heavy' workload pertains to an inordinately large amount of work; such is the case when nurses must contend with clients and meet individual needs, as well as complete all other nursing duties.

In relation to nurses themselves.

The higher incidence of cancer and the lessened amount of human resources contributed to the constant workload increases (Christiane, 1, 30). She pointed out that the waiting room for chemotherapy was always full of anxious clients. Louise added that workload had always been an issue in oncology. Christiane added the following,

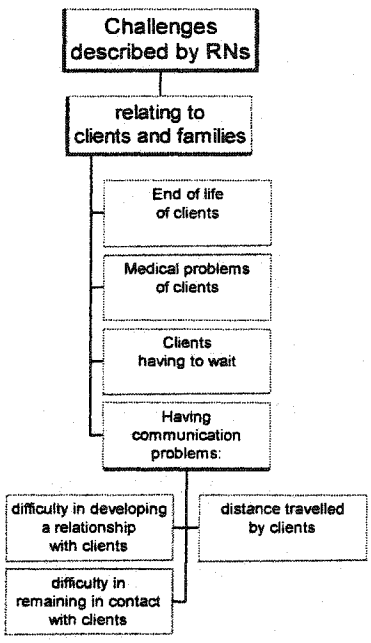
> You know, if [during] one of your caseloads you had at any given time 100 active clients, meaning on treatment today, you might have 200 but you are still, you know, you are still [the] same staff.... So it impacts, it impacts on the main way perhaps the organization decides to deliver because of the workload increase as the models of care change so for instance collaborative practise may be compromised. (Christiane, 2, 87)

Thus, nurses were obliged to see more clients throughout the day. Sue and Diane echoed this statement, stating that they often felt rushed all day long and frequently had to accelerate their pace in order to see all of the waiting clients (Sue, 1, 104; Diane, 1, 10). Participants indicated that the extraordinary amount of work to be accomplished presented a huge challenge for them. Anne often encouraged discussions with clients and liked to explain the use of various ways to control pain, but she said that more than ever, she was lacking the time to do such teaching (Anne, 1, 30). She believed that it was probably one of the biggest limitations in her everyday duties (Anne, 1, 74). She went on to explain that she was unable to provide the same quality of nursing care as she once did.

Louise described her job as not only seeing clients, but also as involving other related work: "[We] do a lot of peripheral work via telephone and uh... and we look after our caseload in that way so, and that is just one example of capturing workload" (Louise, 1, 29). All participants indicated that being always busy – having a heavy workload – posed a challenge, and the majority characterized this challenge as "difficult" or "huge." Louise emphasized that nurses' workloads are not being recognized and are not being measured properly by administrators (Louise, 1, 35).

Diane warned that the increase in workload could eventually lead to a number of nurses experiencing burnout because they were becoming extremely tired and felt that they could not cope anymore (Diane, 2, 16). She observed that more nurses took sick days or leaves, and these nurses were not replaced. Consequently, nurses' attitudes were changing, and the day-to-day workload was becoming unmanageable (Diane, 2, 24). Della drew a similar parallel with duties she performed in a hospital a few years ago when working conditions became difficult to cope with (Della 1, 107). Nurses were so busy that they felt unable to deliver the care that clients required.

Challenges Experienced by Participants Relating to Clients and to Families



End of Life of Clients

End of life is associated with clients who are or will be dying. Working with clients with cancer becomes a challenge when one is faced with the mortality of the individuals placed in one's care.

End of life in relation to clients.

The perception of clients in oncology is that having cancer was equivalent to imminent death. Louise used the following words to describe this belief:

> [I]f anybody is diagnosed with cancer they face their mortality …[It is] different than the way they face their mortality with something else; for example renal failure or… uhm… cardiac problems or, I mean, we have patients that come in all the time [with] …, for example a slow growing prostate cancer or the guy is or the gentleman is, say, in his late 70's etc., etc., but he has got a raging heart problem. He's got heart disease, but he is worried about his prostate cancer but it isn't his prostate cancer necessarily that is going to kill him. So it is, you know, it, it is the 'persona' out there that cancer is the bad guy. I am not saying, it is not, I am just saying that they are not all equal and uhm, and that is a teaching thing that we have to do. And nobody is ever going to change anybody's mindset once they've got the diagnosis of cancer, the fear for their life is there and all we can do is reassure. (Louise, 2, 70)

Similarly, Betty talked about people in our society having a mindset about cancer. In some cases, clients were still receiving treatments even though there was no chance of being cured. Christiane suggested that our western society has a problem dealing with death issues (Christiane, 1, 33). When clients and families refuse to face these issues, they are not enjoying life when they still can and have the time to do so (Anne, 2, 13).

Della spoke of death as always being in the back of her mind when thinking of cancer, especially when the clients' conditions were deteriorating, and when she felt the need to suggest to clients to prepare themselves for their death because they were not

going to get better (Della, 2, 68). Participants felt challenged to work with clients who put themselves through very toxic treatments and consequently, some rough times, without facing their coming death and without living their lives.

Medical Problems of Clients

When faced with cancer, clients may encounter many complications from or side effects of their treatment. The clients' condition may deteriorate while clients try to survive the disease, and nurses have to help them through the course of treatment.

Nurses' dilemmas relating to the clients' medical problems.

In some cases, clients were receiving chemotherapy and radiation therapy. Anne indicated that it was a problem to try to determine what was producing the side effects and which medical specialist should be dealing with a particular medical problem (Anne, 1, 33). Health care professionals might be faced with a combination of side effects that necessitated specific attention. Sue stated that oncologists were trying to find a balance between curing the disease and addressing the side effects (Sue, 1, 37). She reminded us that it was not only the side effects but also the disease itself that required monitoring.

The selection of the proper treatment was also challenging (Sue, 1, 125). Being affected by cancer did not protect individuals from suffering from diseases other than cancer. Participants discussed examples where clients had diabetes, pulmonary problems, renal or heart diseases. Anne indicated that physicians other than oncologists needed to continue to be involved in order to address these diseases. When other medical problems "crept up" during the course of the cancer treatment, it became a difficult challenge to handle (Sue, 3, 43). In some cases, these other medical problems

meant that clients had to go to the emergency department to receive immediate medical attention (Anne, 1, 39).

For example, when the GI system was affected by cancer or chemotherapy, feeding might become difficult, and clients might also experience nausea, vomiting, dehydration, and pain. Anne explained that with some types of cancer,

> treatments have become far more intense in these five years because the combined modality together increases the patients' side effects extremely, and so the support that you need to give these patients to get them through it is a lot more intense, even though the studies have shown the results may be better, you might have a 10% better chance of more cures doing it this way, but it is 75% worse side effects. (Anne 1, 45)

This nurse felt that more attention had to be directed at symptom management in order to deal with these side effects. Betty (1, 80) mentioned that pain control in cancer care was probably the most difficult side effect to manage in comparison to other diseases. Diane (1, 65) stated that pain and aches were always going to be concerns and that cancer clients would never receive a completely clean bill of health. Some clients would suffer side effects or would become ill from their treatments and others would die (Della, 1, 98). The challenge remains for nurses and other health care professionals to find better ways to tackle these medical problems that prevent the achievement of a better quality of live.

Clients Having to Wait

In this study, clients having to wait longer than expected or than usual to go for testing or treatment or other type of activities is perceived as a challenge.

Nurses' challenges relating to clients' situation.

Six participants out of seven indicated that it was a "difficult" or "huge" challenge to be faced with clients who had to wait longer for treatment than in the past. It was a dilemma that Louise raised in this manner,

> I am not so sure it is as much of a challenge for us as it is for the patients to wait for results. Um, although there are some decisions that have to be made quickly and then waiting for those kinds of urgent stat results are difficult but everybody understands the process. I think that the patients find it really difficult to wait a week for a CT scan report or two weeks or whatever. (Louise, 2, 120)

For clients, it could mean more uncertainties and more stress. Betty (3, 184) found that having to wait could be a negative thing for clients. Similarly, Christiane (1, 86) questioned the fact that clients waited for months before their treatments were initiated. Diane was convinced that it made nurses look "somehow inefficient" (1, 40). They waited for results of blood tests that should be ready half an hour after the test was done but were still not ready after two hours. Diane (1, 40) pointed out that the treatment process was slowed down. This slowdown became a greater challenge for nurses when clients were embarked in this process and even more so when the nurses' goal was to move clients as quickly as possible through the treatment process and send them home (Sue, 2, 72).

Having Communication Problems

This concept is related to the difficulty of being in contact with individuals and of informing each other about what is happening or about what can happen. It is comprised of three sub-categories: difficulty in developing a relationship, distance

travelled by clients, and difficulty in remaining in contact with clients.

Difficulty in Developing a Relationship

Health care professionals may find themselves in situations where they experience problems in building up or in being unable to establish a satisfactory relationship with clients during treatment.

Nurses' challenge relating to clients' situations.

The difficulty in developing relationships with clients might be affected by the lack of time for each appointment and /or by the different expectations that clients had. For example, a client might not...

> like that doctor because the news they received is not, is not acceptable to them and so they say, "Well I want a second opinion, I don't like what you have told me," so they, they see somebody else. So that is a challenge because likely the pathology is not going to change. The doctor may change but the pathology is going... to be the same. So then they go to the, the next doctor down the road and he basically tells them the same but maybe in a different fashion. (Diane, 1, 88)

If cancer clients had unrealistic expectations, they might not accept what the oncologist said to them (Diane, 1, 88). So, the professionals had to tailor the news or the information to suit each client. If they were unsuccessful, clients did not develop a trust in their oncologist or in their nurse.

Louise mentioned that clients have to trust the professionals (Louise, 1, 109). She explained, "if you don't develop that bond it is really hard to work around, ya it is hard to help them get through their treatment or whatever that, you know, the course of

treatments been decided" (Louise, 3, 54). Furthermore, when clients came in to see their health care professionals, they brought with them their phobias, their myths and their stories, and that made nurses' work more difficult (Louise, 1, 109). Having to deal with these situations represented a real challenge for nurses. Two participants classified this challenge of 'difficulty in developing a relationship with clients' as being "difficult" while three others described it as "huge."

Distance Travelled by Clients

The distance travelled by clients can represent a challenge for nurses who plan the clients' visits to health care facilities for diagnostic tests and treatments. It is more challenging to plan visits when clients have to drive long distances (for example more than 300 km).

Nurses' dilemmas relating to the distance travelled by clients.

Louise suggested that some co-ordination needed to take place in order to make clients' trips as efficient as possible:

> It is a real challenge to try and co-ordinate all of that. Um, and we try as much as we can to keep the patient's address in mind when we are booking things so that they are not making say for example an appointment to see the radiation oncologist this week and then back to see the medical oncologist in another 10 days. It just doesn't make a lot of sense if... they are driving 5 hours, you know, [we need to] make their trip as efficient as possible. Make sure that all the results are available, all the films, you know, everything that is needed to make timely decisions or whatever is necessary and, um, help the patient out. (Louise, 2, 116)

There was a need for nurses to be organized and to plan around the limitations of

clients. As Anne noted, clients became upset if they did not receive proper notices and explanations about their visits (Anne, 3, 72). They were not able to have a life because at any moment in the week they had to be in to see the physician or be in for various reasons. Louise added that it was especially important for nurses to be aware if clients had responsibilities at home such as children, or had to continue to work because these clients could not afford to be away for long periods of time (Louise, 2, 116). Della talked about trying to accommodate clients as much as possible when distance was involved (Della, 2, 111).

Sue likewise appreciated the great distances that clients had to travel and expressed her concerns about all the travelling that clients do because cancer clients were scattered all over the province. Sue reminded professionals that they "can't call [clients] up today and say be here tomorrow morning" (1, 27). They needed to talk to clients when organizing their visits at their centre and to consider their travelling and their health condition. Four out of seven participants indicated that the distance travelled by clients was a "difficult" challenge, and, in two cases, it was a "huge" challenge.

Difficulty in Remaining in Contact with Clients

In this study, this challenge is associated with the difficulty nurses have to stay in contact with clients as required from time to time.

Challenges related to client contact.

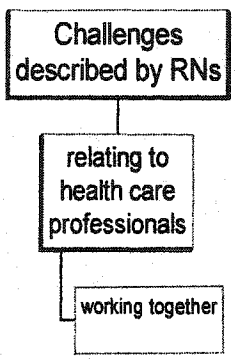
Anne pointed out that numerous clients lived far away from their tertiary cancer centre and that it became difficult to stay in touch with those who lived far away. They were often left relying on a telephone conversation when a visit would have been scheduled at the centre had they been in town (Anne, 1, 21). Louise (2, 110) said that

when oncologists met clients in local communities every 4 months, for example, it meant that nurses at the tertiary centre lost touch with these clients.

In addition, when local clients were admitted to the hospital, nurses at the out-patient clinic did not have enough time to visit or to call them because they were quite busy (Anne, 2, 15). Louise also described her difficulty in keeping in touch with clients unless she had to check "an ongoing blood test or a problem or anticipating a major skin reaction or something like that but even then I would expect because of the teaching that we do that the patients would call us if there was a problem or if they are concerned about something" (Louise, 2, 108). Nurses did not make follow-up calls for all clients (Louise, 2, 108).

Betty (1, 77) echoed similar concerns to those that other nurses raised and stated that the lack of time was adding to the challenge of difficulty staying in contact with clients. Three participants out of seven indicated that this was a "difficult" challenge for them while the others said it was either an "easy" or a "not-too-easy / not-too-difficult" challenge.

Challenges Experienced by Participants Relating to Health Care Professionals



Working Together

Working together encompasses the relationships, attitudes, and tensions among staff members who work in oncology. Conflicts may arise and further develop between the workers themselves when confronted with heavier workloads.

Nurses' dilemmas relating to health care professionals.

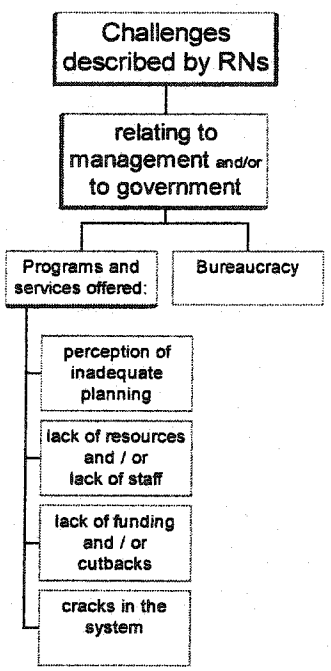
It was noted that there might be conflicts among the nurses themselves in some areas of work. As one participant indicated, some staff might have a negative personality, and those members fed off each other (Anne, 1, 33). Betty (2, 13) raised the issue that it was difficult to be positive with a negative person. She stated that she found it difficult to work with the negativism of her colleagues (Betty, 2, 26) and explained why:

> Negative people are negative people. When they see, you know, they see the cup is this much... empty... instead of full this much. But [chuckle] we are with patients... you deal with it and it seems to be you've dealt with it and it gets put past you and even with a colleague that problem might be dealt with but then there is another one the very next day and whatever. (Betty, 2, 134)

It seemed that workers could spend a lot of energy trying to deal with negative individuals. This participant rationalized this negativism of staff members by saying, "I think that with people feeling overworked and under appreciated and everything, I am finding there [are] more and more complaints among... [my] colleagues than there used to be" (Betty, 2, 13). The deteriorating working conditions were having an impact on nurses. Christiane raised the issue that nurses were faced with the dilemma of disagreeing with the treatment plan, or lack of, in which clients were constantly being

sent back and forth to receive their treatments, and although they felt the need to say "look, let's sit down and look at everything," they could not (Christiane, 1, 33). Nurses could find themselves in direct conflict with physicians, for example, because of their attitude, or their lack of dialogue with them. This participant went on to state her apprehension concerning the lack of a "true team" approach in her work environment. Even among nurses, the polarizing of viewpoints regarding activities raised the tension between nurses (Christiane, 1, 75). The challenge was to be able to work together with a more collegial approach in which various views on how to handle specific situations could be shared (Betty, 1, 44).

Challenges Experienced by Participants Relating to Management and/or to Government



Bureaucracy

Within the framework of this research, bureaucracy is defined as the administrative influence that slows down decisions and other related processes. When a RN encounters bureaucracy, most commonly referred to as "red tape," he or she is faced

with a frustrating process that may not provide any answer or any support to the issue at hand.

Bureaucracy in relation to administration and government.

Participants discussed the internal bureaucracy that raised the staff frustration: for example, "We can go to them [administrators] and talk to them but it seems it takes FOREVER to reach any kind of assurance that maybe this is going to be dealt with" (Diane, 2, 88). Diane further stated that the case in question could be presented, but the actual problem would not be addressed. A temporary solution could be implemented, but the problem became greater as time passed. During meetings organized by the administration, staff found it difficult to have items added to the agenda because of the already long list of administrative items submitted (Christiane, 1, 75). Anne pointed out that she was quite irritated by the frequency of scheduled meetings when so few staff concerns were being addressed or duly noticed.

In addition, nurses were coping with the governmental bureaucracy regarding treatments' and medications' approvals. Diane gave the following example:

> I can think of instances where medications would be withdrawn because if you don't meet the following criteria or if you are not 65, if you are young and not on welfare, you don't meet the criteria, so you don't have coverage for certain drugs that say an oncologist would prescribe for this patient. So you have to go and kind of work around the system, you know. You have to kind of, kind of mould a dictated letter to sort of meet the needs of the government, so that you can actually achieve what it is the patient really deserves in terms of treatment. So doctors learn how to cope with the bureaucracy more than we do, but we have to

> deal with it because we are dealing directly with [the] patient,... "well we have to wait for the Ministry of Health's approval so that we can get, you know, coverage for this drug because it is far too expensive for you," so in that sense it is a big frustration. (Diane, 2, 82)

It took quite some time to receive an answer from the Ministry when a client's treatment was placed on hold.

Another "negative" aspect of bureaucracy was the way treatment forms were filled. Sue provided the example of the travel grant requests,

> when I sit with a family now and I'll say okay, "Now I'm going to show you how we fill out these travel grants," it's really important [that it be done] exactly the way THEY want it to be done. So I know how THEY want it to be done. "So let's do it this way, so that you don't get letters saying that you have been denied the travel grant, so you don't get frustrated about it. If you do get a letter call me right away, I'll deal with." So that's in that time, sort of [dealing] with that sort of challenge of government [red] tape. (Sue, 1, 111)

By handling the request in this manner, this nurse tried to avoid delays in getting the funding that would enable clients to continue receiving their treatments out of town. Correspondingly, Betty mentioned that in dealing with the government, things took time and were done slowly. In some cases, she added, it might take up to one or even two years before a situation was addressed.

All seven participants identified bureaucracy as a negative challenge that was classified as either "difficult," "huge" or beyond their reach, i.e., "unachievable." Also mentioned was the little control that RNs had over this type of challenge. Nevertheless,

even though it was difficult, the challenge is to find a way to deal effectively with these situations.

Programs and Services Offered

In this study, this category related to what is available or not to the clients and families of those who have cancer. There are four sub-categories: perception of inadequate planning, lack of resources, lack of funding, and "cracks" in the system. When any of these situations was present, they become a challenge for RNs working in oncology.

Perception of Inadequate Planning

Participants perceived the inability of management or the government to develop or to implement health care programs or changes in a structured manner as inadequate planning.

Perception of planning done by management or the government.

Funding to hire staff appeared to be limited, which represented a dilemma when an employer needed to increase staffing. "So planning when you are hiring staff is absolutely the most important thing that you should enter into" and becomes a key consideration when completing a request for funding (Diane, 2, 108). This participant added that there can be long-term benefits to this kind of planning. She emphasized that without careful planning in the present, the future of the nursing profession would be bleak (Diane, 2, 116).

Another participant argued for further planning when faced with limited funding and with the uncertainties engendered by such a situation, as well as prioritizing in the allocation of funds (Christiane, 1, 82). For example, money might be provided for

medications but not for supportive care. Christiane described the negotiation process that was necessary when funding was limited:

> There are a lot of agendas around all of that kind of "Who yells the loudest?", "Who gets on the media?", and "Who leaks information to the media?", which then snowballs into a, you know, a major issue that then forces the government. It's a form of lobbying really to force the government to have to take a stand. (Christiane, 1, 85)

This example illustrates the complexity of the situation regarding how services were planned.

Participants shared their perception of what long-term planning was taking place in the area of human resources. A nurse questioned the quality of planning when, in fact, there was actually a 'lack' of human resources and an 'increase of people with cancer' (Christiane, 1, 38). This participant was concerned that, without prevention, the number of individuals with cancer will grow. She found that priorities were poorly addressed when one thinks only of the number of clients treated in a day (Christiane, 1, 30). She expressed grave concerns about long-term planning, especially in light of the existing nursing shortage, as well as in recruitment and in retention problems. She observed that structural or organizational changes which were implemented "severely impacted" on the role of nurses and on their ability to carry out their work (Christiane, 1, 49). Another participant noticed that within a few months, the work situation deteriorated further. She went on to say that nurses "were being affected by this tremendous lack of planning" (Diane, 2, 24). This nurse added,

> It is just getting to a point where we won't be able to cope with the days that are

> coming because today we are very busy but in the future where we are going to be more busy because that is the way we tend to go so... uh... when you are stressed to the point of burnout, then you know that you have to do something now or it is going to be too late down the road. (Diane, 2, 24)

Nurses alluded to imminent burnout and ultimately to leaving oncology nursing. Diane suggested that changes would have to take place soon. The challenge was how to improve the perception of inadequate planning when facing so many changes.

Lack of Resources and / or Lack of Staff

Lack of resources takes various forms such as not enough equipment to perform tests or to provide treatment, and not enough staff, be it nurses or physicians.

Lack of services offered to clients and families.

Nurses participating in this study reported that oncology is an expanding field. Sue (1, 69) pointed out that the number of cancer cases was constantly increasing and that we should expect more individuals with cancer considering the trend to longer life expectancy. With more clients, more services were required. Participants reported a lack of space used for oncology consultations and treatment. Diane described her environment:

> Patient numbers have increased for the most part,... [the departments] haven't changed because physically we are the same, you know, that the institution hasn't changed, we have the same chemo room, the same number of chairs, the same nurse numbers as far as staff... but the numbers of patients that have to be treated have increased. So therefore the frustration because you're trying, you're working in an area that at one point in time was adequate and now we have

> outgrown it and it has been a long time coming. We need a new and larger area to work in. But that is coming, so therefore [there is] frustration because we know it is coming but we need it TODAY and so you're doing your best with basically limited... area to work in and people get frustrated.... But at the same time you have to understand that maybe we can't accommodate them in the same way because the numbers are increasing, so we have to make patients wait. (Diane, 1, 56)

Nurses warned that their overcrowded clinics were getting to be a bigger challenge than ever before (Diane, 1, 33, 130). Participants explained that "things" were not done as quickly anymore because they did not have the same support system and because they found that getting beds for clients being admitted had become much more difficult than before (Anne, 1, 42; Betty, 1, 94).

Supportive care was affected also. For example, social workers, psychologists, volunteers, home visitors, all who help to support clients were not receiving sufficient funding anymore (Christiane, 1, 82). Christiane raised the point that clients might not have access to health care professionals who could deal with their situations and with their health problems, and subsequently, the outcomes might bring more uncertainties for clients who were left with fewer resources to deal with their situations (Christiane, 1, 79).

Finally, Diane highlighted the need for more oncologists. She said that it was still a constant issue to recruit and to keep these specialists (Diane, 1, 37). The challenge for nurses was how to provide the same services when they were short of resources and staff. All participants agreed that the lack of resources and staff was a "difficult" or a

"huge" challenge and that it was a negative thing they were experiencing.

Lack of Funding and / or Cutbacks

Within the context of this study, lack of funding and /or cutbacks pertain to the perception that the government or the health care institution is not investing more money or is decreasing allocation of funds in the health care system.

Work done by administrators or the government.

Della talked about a "staffing crunch" related to finances and to budget allocations (Della, 1, 109). RNs spoke of the relationship between the lack of staff and the lack of funding. They said that because institutions were faced with low budget allocations, they were less able to hire new staff members in oncology. As the workload increased, the funding was not adjusted to meet the demand on services.

There existed the perception among nurses that nursing was not a valued service and that the profession must endure cutbacks when there was in fact a need for funding. Louise described that sentiment:

> Funding for staff, I mean... when the Ministry of Health says you need to cut money, ... a lot of times the perception is that administration looks at nursing to cut money. Oh, you know, if we need to save $200,000 well that's x number of nurses, let's lay off the nurses type thing. Again we have been fortunate here that, that hasn't necessarily happened but I know in other places that it has and, I know, that, that is a challenge in terms of and again, I think, that stems back to workload and it stems back to be valued as a profession. (Louise, 1, 117)

She added that there were periods over the years where nurses were afraid to apply for other nursing positions and were afraid of losing their positions in the event of internal

cutbacks in programs or services. Such perception was shared by other participants.

Anne claimed that cutbacks were a big challenge facing the entire medical community. She reported that the staff struggled to get CAT scans done and to get appointment dates for clients (Anne, 1, 21). It seemed that "things are not done as quickly anymore" (Anne, 1, 42). Examples were given describing the domino effect of cutbacks constantly taking place in other areas of health care which were then influencing the services delivered in oncology. Participants indicated that it took longer to get tests and results in comparison to few years ago. The downsizing elsewhere in the health care system was felt within and outside oncology services. Betty suggested that nurses might return to previous ways of providing chemotherapy and radiotherapy, i.e., providing the treatment but not the care that went with it (Betty, 2, 98).

All participants agreed that lack of funding and cutbacks represented a negative challenge. One nurse said it was a "difficult" challenge, while four of the seven RNs interviewed indicated that it is a "huge" challenge, and yet another two described it to be an 'unachievable' challenge.

"Cracks" in the System

A system can be defined as "a set or arrangement of things so related or connected as to form a unity or organic whole" (Webster's NewWorld Dictionary, 1984, p. 1445). When this unity is broken, "cracks" appear and services or activities become disjointed similar to when these services are unavailable to clients or families.

Nurses' challenges in relation to managerial and government decisions.

Nurses who participated in this study cited examples of individuals who did not have family physicians because of a doctor shortage. When clients have been diagnosed

with cancer, Della pointed out that, "booking them for things like tests and whatnot" could be difficult, and there were often challenges such "as how quickly a patient can be seen by the oncologist." And, arranging their homecare services might also be a problem (Della, 2, 103). In these instances, clients lack the crucial services required for their care. Furthermore, Anne surmised that "things [may] become more and more complicated" and eventually "fall apart" (Anne, 1, 45). When nurses were so preoccupied with large quantities of details, they were unable to go back and check on every client as frequently as was needed. Louise illustrated this limiting of service:

> Nothing is foolproof and we have, you know, computer systems to track patients but the odd patient gets kind of... "lost in the system."... We deal with a lot of paper and uh... even if we didn't deal with paper, I don't think that a paperless system would be foolproof either. It is only as good as the person who is... supplying the information to the person who is entering it. So, we deal with people, and it is a reality that things get lost, things get misplaced, people's appointments get missed for whatever reason. (Louise, 2, 114)

RNs in this study observed that the increasing workload and number of clients, as well as the lack of staff, raised the level of difficulty encountered when providing services to oncology clients. Christiane discussed threats to the current system:

> "Cracks" are developing because of pressure like the workload, maintaining staff-patient or nurse-client ratios that are optimal to provide... good oncology care... the lack of human resource when you have not enough physicians to, you know, to support the workload... it impacts on nurses as well and the care they are able to provide. (Christiane, 2, 95)

She added that "when you've got the pressures on... the workforce, medication errors do occur, you know. We know that. Uhm, things [do] get missed" (Christiane, 2, 103). Diane discerned an increasingly serious situation:

> Lately we are seeing that there are more, there is more potential for "cracks" in the system. Given the fact that there are fewer doctors, we are absolutely not able to see all of the patients that are coming into the system.... [W]e are at a very critical point in the process where we are getting so busy, so quickly, we can't keep up and it is at a critical stage right now. We need medical oncologists... and we don't have the space [to accommodate them]. (Diane, 2, 98)

In some other instances, "some families... don't qualify for this or they don't qualify for that because of... what appears to be just absolutely stupid reasons, but it's like you have to live with it and... try to work around it and that's very challenging" (Sue, 1, 27). Nurses found that when clients fell through the "cracks," there was "a challenge to pick them up and hope that they don't fall through the system. It's scary sometimes" (Anne, 1, 21).

Participants also stated that when there were administrative overhauls or structural re-organizations, it was likely that certain things fell by the wayside before someone identified these as requiring attention. One nurse indicated that changes were made by management and that they did not put "all the stepping stones in place" before implementing these changes (Anne, 2, 110); these changes inevitably lead to chaos. There might even be some responsibilities which were not assigned as they were before changes were implemented.

Diane raised the fact that more clients and excess work per individual created an inability to track everything for every client. Therefore, sometimes important oversights occurred, and in turn, adequate and appropriate assistance was not provided as needed, according to Christiane. Faced with system deficiencies, nurses found it increasingly difficult to provide services to individuals in need, especially when time was a critical factor in responsive and adequate medical interventions to stop cell growth before metastases developed. With all these gaps in the system, clients were left with few services or without the medical attention that was required. RNs working in oncology repeatedly witnessed such situations and found they lead to dissatisfaction and frustration among the staff.

Strategies

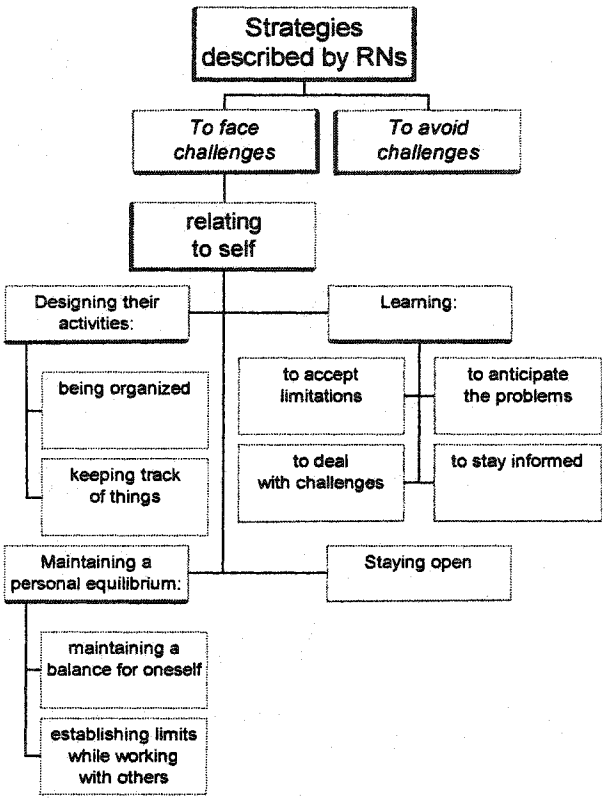
In this section, a definition of a strategy is presented. Then, the concepts identified as strategies are described, which corresponds with the third research question (How do nurses manage the challenges that they perceive?). In this research question, participants were asked to describe what they did to manage their challenges. These strategies are also classified under four headings, i.e., those strategies described by participants as being used by themselves in order to be able to perform their duties, those strategies described by participants relating to clients and to families, followed by those relating to health care professionals, and finally those relating to management and/or to government (Appendix E). Each strategy is first described by a brief definition, then supported with the appropriate text from the interviews.

Definition

A strategy is associated with action involving the development of a goal or a plan with the expectation of overcoming a challenge and achieving a positive outcome.

Strategies Used by Nurses Relating to Themselves

Avoiding Challenges



To avoid challenges is a direction or a strategy which can be used by individuals who refuse to face specific situations considered too difficult to handle. These situations require too much time or energy when considering all other activities or tasks to be accomplished.

A strategy used by the self, to avoid challenges.

While working in oncology, nurses faced uncomfortable situations. For example, having to face sick children with cancer was considered too much to handle, and nurses

decided not to think about it, not to talk about these children, and not to work with them. As pointed out by this participant,

> most nurses are females, most nurses are MOTHERS and so when they look at a child and look at that they can relate to it as perhaps... potentially being their child, they just don't want to look at it. They don't want to face that issue ... no don't go there, don't even think about your kids, don't even, don't pull that into it because it just makes it harder. (Sue, 1, 61)

This strategy was used by nurses when their emotions threatened to overwhelm them. Some nurses specifically stated a preference for working only with the adult population.

Sue also pointed out that when things became too difficult, she refused "to go there" and to deal with it (Sue, 1, 130). She added that when she fell down, she started to question her own abilities and so on. As the situation became too negative to handle, it made her sadder (Sue, 2, 112). Diane tended to avoid all negative situations because she considered herself incapable of dealing with the negativity (Diane, 1, 163-165, 169). She refused to listen to negative comments, and she stayed away from negative colleagues. When dealing with challenges, the two main directions available were either to avoid them, as previously described, or to face these challenges and use more specific strategies such as those uncovered in this study.

Facing Challenges

To face challenges is a direction or a strategy used by individuals willing to face situations and to address them. The following strategies are related to this mode of dealing with challenges overall.

Designing their Activities

In this study, the category "designing their activities" encompasses a series of actions that nurses perform to ensure that these activities were completed in a satisfactory fashion. Two sub-categories were identified: being organized and keeping track of "things."

Being Organized

Being organized is the action of ordering one's activities or tasks in a systematic fashion. An organized person looks at the activities and plans the way these activities are going to be executed.

A strategy used by self.

Betty said that she started her work by planning her day's activities and by dealing with urgent messages. And, during the day, for example, she would check her voice mail frequently because some clients might require a prescription from an oncologist which the nurse had to obtain before the physician left the building (Betty, 1, 13). Throughout all of the activities of the day, this experienced participant said that she only had so much time in the day, and in order to do her best, she just had to be organized (Betty, 1, 91). Similarly, Diane reported,

> we have a very busy practise, so we are trying to organize ourselves and I am very organized and I like to have everything right at my finger tips and I don't like having to go through different things to find what I need because we are very busy and it just makes for a much more disorganized day. (Diane, 1, 130)

By being organized, Diane (3, 60) felt that she could focus on her activities.

Betty indicated that being organized helped her to feel better when she went

home because she knew "things" were in order (Betty, 2, 19). She added that if she was not organized, she would be unable to be in control of the tasks she had to perform (Betty, 2, 23). Anne claimed that having a system helped her to keep on top of things (Anne, 1, 21, 24). Similarly, Louise had developed a system that helped her to be able to keep track of everything (Louise, 2 58). Betty alluded to the fact that being organized made her life easier (Betty, 3, 141). Diane summarized her perspective by saying "if you're lacking in organizational skills then everything represents a challenge" and added to the level of difficulty (Diane, 3, 60). Della concluded that being organized "makes a challenge easier to deal with" (Della, 3, 86). This strategy seemed to be essential in doing one's work, especially when one is quite busy.

Keeping Track of Things

In this study, keeping track of things means that health care professionals are acting on aspects that need to be followed up either by them or by other staff in their institution. Furthermore, they are ensuring that every activity or task that is supposed to be monitored or accomplished will, in fact, be monitored or accomplished as planned.

Nurses are keeping track of things during their activities.

Participants described the numerous elements or aspects which they must keep in mind concerning the care and treatments of their clients. Christiane said that she used tools to keep track of the clients' "journey with the disease" (Christiane, 2, 75). Anne mentioned that she had developed a system where she wrote things down for herself and also used a telephone call form on which she wrote specific details or notes regarding each client. These processes enabled her to be on top of things and helped her not to forget things at hand (Anne, 1, 8, 21). Also, she made mental notes about clients who

might need to be seen more frequently. She mentioned, "you can sort of predict who the patients are that will be in touch with you over and over and over again, depending on the stage of disease that they are at" (Anne, 1, 21). The needs of each client were considered different and unique by nurses.

Nurses had to keep track of the calls received in order to provide the relevant follow-ups. Anne added that she liked to listen to the physician talking to clients because she received more accurate information than when she spoke to them herself and knew better what aspects she needed to track. Nurses gave a long list of things they needed to keep track of such as, white blood count, platelets level, and hemoglobin results. If any of the numbers were too low, clients were not able to receive their chemotherapy or their radiation therapy that day, and the physician had to be informed (Anne, 1, 33; Della, 2, 48). Another participant explained how she kept track of thing when she worked with two physicians:

> I had an assignment where I had two physicians and I had to juggle their schedules and I had to develop a system that would work in terms of keeping track of whose patients I was looking after at what time and what results I was looking after and which doctor I had to report back to and what clinic I was supposed to be in now. It was a real challenge and hopefully I did it effectively. Um, but I developed a system that seems to STILL BE working for me even though I am with one physician now. (Louise, 2, 58)

This participant was able to develop a system that maintained her effectiveness.

Another nurse provided a detailed example of what she went through with a specific client. She described how the research studies of the past two to five years and

how the complexity of protocols were impacting her clinical work with oncology clients which lead to lengthy procedures:

> And then these people, the head and neck people [cancer clients] for instance, need to have a G-tube put in, that has to be organized. It is done under fluoroscopy, but you need to get a cardiogram, they have to have blood work done ahead of time, the history has to be dictated, they have to know whether they have allergies, all of these requisitions, all of this has to be faxed to them before they give you a date for it, and then they give you the date for it, it happens to be the first day of chemotherapy, and so how do you get them to have this long chemotherapy and this. So you have to change the DATE of putting in the G-tube, but you want it done early on so that when their blood counts are low a week later or two weeks later, you can't be having minor surgery, OR, you can't be waiting so long that their throat starts to get sore about the third or fourth week into radiation that they can't swallow and they don't have a G-tube you see. So you have got to do all of these things and you've gotta, there is so much information that needs to be given to everybody. We used to be able to do these G-tubes, send the requisition and it was done. NOW, no, no, no, no, it is not only a requisition anymore, then they send them back.... but it is falling apart, it's falling apart... and then they have a PICC line put in for the chemotherapy, a special line put in, so that has to be coordinated, so you are talking about one patient, the hours on the phone back and forth, making sure that this patient from outside of town, that he has ECG, INR, all of this STUFF that is supposed to be done so that they can book him and then try and

> coordinate it with your radiation. The planning for your radiation, get the shell made, get the CAT scan done, in the shell, get to simulation, you know, it just snowballs, it snowballs. (Anne, 1, 45)

This quotation illustrates how busy nurses could be with each cancer client. RNs had to keep track of the steps followed by clients in order to avoid any undue delays in their treatments. One participant was concerned with her ability to remember everything to be done (Betty, 1, 137). Another one stated that she had learned to keep track of things and that she wished it would be easier (Sue, 1, 37, 39). Diane pointed out that their work was quite demanding "because once you see that patient, you follow them from the beginning to the absolute end" (Diane, 1, 52). She said that these situations

> are very demanding because along with them goes the complete follow-up because once you are a cancer patient you have to be followed up, so... uhm... for the most part they are comparable to other chronically ill patients. Demanding follow-ups, they are never just [a follow-up], you don't get the treatment and then bye-bye, you have to follow them up because there is always the, you know, the dreaded progression of the disease and the follow-up is important. (Diane 1, 63)

These examples illustrate how important it was to keep track of all things required because any change in the clients' condition often meant to nurses that the disease was progressing (Diane, 1, 65).

Maintaining a Personal Equilibrium

In this category, professionals have to make a constant effort to ensure a certain equilibrium is present in their lives. In doing so, two sub-categories were identified:

maintaining a balance for oneself and establishing limits while working with others.

Maintaining a Balance for Oneself

This strategy is used to ensure that the person keeps a certain equilibrium in his or her life, especially when it becomes stressful or chaotic.

A strategy used with self.

Betty discussed the problem of becoming too attached to clients and pointed out the need to be careful. In some instances, she had to leave the room for a few minutes when a situation became too emotional for her (Betty, 1, 34, 38). This participant suggested that she should not take it too hard when someone dies (Betty, 1, 44). Also, when off duty, she received requests for advice on situations relating to cancer that made her feel quite uncomfortable. She found ways to refuse to provide such advice (Betty, 1, 164, 166). Another participant questioned her ability to continue to do her work. She alluded to the need for a change and to the need to take more care of herself (Christiane, 1, 59, 72). Sue (1, 81, 84) learned to take care of herself by knowing her limits, by setting new ones, and by distancing herself from situations. She found these strategies to be helpful. While Diane (1, 69) had learned to keep her overtime work to a minimum in order to make time for herself:

> You can do a much better job if you are WELL rested and focused on OTHER things over and above your work. Keep yourself busy. Have your own hobbies or whatever, whatever it is that works for you, because then when you are on the job then you are much more READY and ENERGETIC too because it demands a lot you need to be certainly not burned out. If you're starting to feel burnt out then, you know, you need to look into your own situation because it would be

> almost impossible to work in oncology for very long if you felt burnt. So you really have to watch... your own health. (Diane, 1, 71)

She described how she maintained a balance for herself by establishing limits. Diane (1, 102, 117) also related how some clients drained her energy because of their negativity and how it was important to take action in order to keep her effectiveness at work. In her second interview, Diane (2, 29) talked about coming closer to a burnout and the need to have a better equilibrium in her work. If that was not possible, she would leave. She said a change could be better than a rest if her stress and fatigue continue to increase (Diane, 2, 44). Going elsewhere to work might represent the only way to achieve a balance in her own life (Diane, 2, 44, 100).

Anne stated that she had learned that she could not be everything for clients or for their families. She pointed out that nurses should delegate things to do to them. She said that she paid the price for not delegating responsibilities earlier in her career (Anne, 1, 18). These examples help to show how nurses kept a balance for themselves in order to be able to carry on with their work.

Establishing Limits while Working with Others

This strategy means that when dealing with clients and families, some boundaries are set which prevent undue burden on health care professionals.

A strategy used with clients.

Diane indicated that nurses and physicians could only give so much and that she could not spend time with and energy on clients who did not listen and who were non-compliant. She considered them to be adults who were making their own decisions. She needed to move to other individuals who required her help (Diane, 1, 112). She

described the following strategy:

> Do everything that is necessary but learn to kind of know when... you've gone too far and draw back because you have to protect yourself... to continue to be strong and healthy and effective in your job, you have to know when to draw the line. And you also have to give back... to the patient, you have to say to the family, "well this is what is expected of you." (Diane, 1, 117)

She had learned to set limits and to ask clients to help themselves. Anne mentioned that she had learned to do that also, but some of her colleagues had not yet done so which concerned her:

> There are certain problems that these patients should call you about, but there are a lot of other problems that they should be calling their FAMILY DOCTOR about, that they should be, you know, looking after themselves. You cannot say this to patients and I think with the physicians that I have worked with through the years, they have also learned that, that you just do not set yourself up to be everything for the patient,... you cannot be that for the hundreds and hundreds of patients that you have to see in a year, you cannot be that, and you have got to learn that. (Anne, 1, 18)

She insisted that health care professionals should set limits. Betty supported this position by stating that some professionals might be trying to be everything to everybody, and that was not possible (Betty, 1, 114). She had a hard time caring for children in oncology and she could not do it. She had to work with adult clients (Betty, 1, 44). She knew her limits. Sue had tried her hand at various aspects of nursing during her career and noticed that when she crossed the line; she needed to re-establish limits

(Sue, 2, 32-34). She provided support and guidance to clients and families, but no more did she do what they could do for themselves. This strategy prevented the reoccurrence of difficulties she had previously encountered (Sue, 2, 86). Anne indicated that she recognized her own limits too:

> But I will be the first to admit [that] I am not an emergency nurse. And yes I can do CPR, I probably cannot do it as efficiently as an emergency nurse but we do... our certification every year and I go through the thing and it refreshes my memory and I practise it a little bit and hope to God I never have to use it BUT if I have to use it, I'll use it. (Anne, 2, 108)

This participant reported that she was keeping up to date with the skill set required of a nurse, even though she was not an ER nurse and might not have the technical skills such a nurse would have in the event of a cardiac arrest.

Other participants, like Louise, intimated that they had experienced some difficulty in trying to establish limits in their work. She indicated that the list of things to learn could go on forever and that "you have to draw the line" and limit yourself (Louise, 2, 74). This participant stated that she had difficulty saying no for herself; however, she mentioned that she did not have any trouble establishing limits for her clients (Louise, 3 20).

This strategy, to establish limits while working with others, could be difficult to implement. However, participants stressed the importance of using this strategy in order to continue to work in oncology.

Learning

This category refers to acquiring the knowledge, the skills, and the expertise that

are required to better manage work. Learning is comprised of four sub-categories: to accept limitations, to anticipate the problems, to deal with challenges, and to stay informed.

Learning to Accept Limitations

In this study, the concept "to accept limitations" means that one acknowledges that very little can be done and that one recognizes what is being faced without seeking to resolve it. Participants use this strategy because they have exhausted other appropriate means in trying to deal with the situation.

A strategy used by self.

Della (1, 98) discussed the fact that eventually clients died and that even though she did her best, the majority of them will be dying over time; nurses had to accept this limitation. In the following example, Louise referred to the choices of clients and stated that they might choose the option that was not the best one of those presented:

> Sometimes it is difficult but [the] bottom line is that you have to accept there is nothing you can do. For example a patient who... has a certain diagnosis and... all the statistics point to if they take it XYZ treatment then they are cured [at], I don't know, 98 % or I am just throwing figures out but very high rate of cure, or at least a very good remission and patient refuses treatment. What do you do? There isn't anything you can do. I mean, what can you do? You know [the] physician spoke to the patient, you know... all the I's have been dotted and the T's have been crossed and it is informed consent. It is informed consent and the patient still refuses what he, you know, you have to accept that there is limitation to what you can do. Um, and that the responsibility falls to the patient[s] for the

> decision they have made. (Louise, 2, 46)

She went on to say that it might be difficult to accept but that this was the client's decision despite the fact of a good chance for a cure (Louise, 2, 46). Nurses learned to accept these decisions and to move on.

Another example provided by Anne described the need to accept that clients might seem angry at nurses:

> It is a difficult situation. You have to learn right from the beginning that... you are here to help the patient, you haven't given them this disease. Even though they are angry... at the disease and everything, you have to have this confidence in yourself that tells you, "I am here to help them, I will do what I can to help them and that, I know, that I am not at fault." And that you, right from day one,... you are repeating in fact what the doctor has told them [about the] prognosis. (Anne, 3, 67)

For clients, receiving a cancer diagnosis might lead them to feel anger toward the health care professionals delivering the message. This last participant emphasized the need to be honest with clients despite their reaction and to try to gain their trust (Anne, 3, 67).

This strategy, learning to accept limitations, could be difficult to implement. For example, professionals cannot know everything about cancer and about what could happen to clients, and they needed to be honest about their limitations (Betty, 1, 123). Participants stressed the fact that nurses "cannot solve the problems of the world" and that they should not let their limitations bog them down (Anne, 1, 77); they needed to move on (Christiane, 1, 72). Nurses could only try to make things better and make a difference, and this realization was part of acknowledging their limitations in their work

(Betty, 1, 152; Sue, 1, 19). In some cases, success could be achieved despite the odds against it (Sue, 1, 111), and that they had to accept also.

Learning to Anticipate the Problem

When anticipating a problem, one looks at what is known and at the potential problems that may arise when faced with a specific situation and then makes decisions about what actions would be most appropriate in order to avoid further problems or complications.

A strategy used by self.

While working in oncology, Diane viewed a need to do something when clients were dealing with bad news. She emphasized the importance of having and making a plan with the options available to clients, especially in the circumstance of clients facing bad news (Diane, 1, 80). She went on to add that in order to maintain the psychological well-being of the client, "you have to tailor it [the plan] to meet that person's needs" (Diane, 1, 88). The role of the medical oncologist was important in delivering the bad news in a "very, very, very kind fashion" (Diane, 1, 90). Professionals reported better and more positive results with clients compared to the early days when they originally opened their health care institution (Diane, 1, 102). Participants in this study spoke of the importance of taking into consideration the clients' diagnosis, prognosis, and situation when preparing the treatment plan. And, the knowledge of nurses and their experience with problems or complications were used to the clients' benefit during the course of their treatment.

Furthermore, Sue encouraged clients and families to prepare themselves financially for the eventuality that they would be required to use their private insurance

or that they would be unable to continue to work. In doing so, clients and families were better prepared to deal with the challenges ahead of them and possibly avoid a crisis further along (Sue, 1, 117). In her work, Sue looked at numerous situations where she could anticipate what might happen and took appropriate actions to reduce the potential problems and the stress of clients and families.

Anne (2, 44) reported that she could anticipate the questions that clients might have and what might worry them. She could predict where problems might lie by asking a few questions about their social environment (Anne, 2, 62). Another participant considered it part of her routine to anticipate the problems and to act on them, and said that clients perceived health care professionals as intelligent when they were doing that (Betty, 2, 57). This strategy could be learned over time and with experience as reported by participants.

Learning to Deal with Challenges

This strategy signifies that a nurse can gain knowledge concerning how to face situations and problems effectively, and concerning how to act on problems as they arise.

A strategy used by self.

Sue was convinced that every day brought a new challenge. She talked about opportunities that arose, and she described how she took them on as challenges (Sue, 1, 142). This participant considered each situation from a different angle. Knowing that she could not change the reality, she opted to make it easier for those having to go through the ordeals (Sue, 1, 19). She suggested to clients and their families that they deal with one thing at a time, to take one day at a time, to enjoy each day, and to deal

with bad news only when it appeared (Sue, 1, 23). She learned "to hit the Internet" before clients and families did, to get to the proper information and to provide them with directions (Sue, 1, 37). She acknowledged that unknown or unexpected situations could be scary for nurses, but with experience, one could learn not to be afraid (Sue, 1, 59).

Other participants suggested that they tried "to go with the flow," to not fight their own ups and downs or those of clients and families, to accept what happened, and to learn from it (Sue, 1, 111; Christiane, 2, 82-83). By learning from what happened, their work could get easier and their own frustrations could decrease as could these of the clients or families (Sue, 1, 111-112, 115). Diane (1, 78) advised taking the lead by talking with clients, getting to know from where they were coming, and by developing a plan in accordance with their desires when possible. In her judgement, she felt that nurses were doing much better than before, and she commented that she received constant reinforcements about the positive results achieved (Diane, 1, 181).

Furthermore, another nurse pointed out that she used strategies that she learned when she was younger, such as being organized. She found that when she was organized at work, she could sleep at night without worrying as much. It made her life easier (Betty, 2, 21-23). She also learned to deal with "gossip" by gaining an understanding of the situation, by acknowledging the person's position, by increasing the person's sensitivity to what had happened during such a process, and by trying to curtail and to bring closure to the gossip itself (Betty, 2, 26).

Learning also took place by doing the same things over and over again and by experiencing similar situations: "You are building on your previous experience.... You

are using how you coped in other situations, pulling it in and adapting it to the situation" (Louise, 2, 39-41) Two experienced nurses said that they had gained a lot of experience over the years from which they could draw (Anne, 1, 71; Sue, 1, 39). Another participant stated that she learned by trial and error, by falling into pits and getting out of them, and by becoming aware of what had happened, etc. She added that such learning, "saves you a lot of trouble, like backtracking" (Sue, 2, 48). Sue (2, 54) considered that even though the same type of thing happened again and again, she could almost make "a roadmap of different scenarios" she encountered. Betty (1, 111, 114) reminded the listener that nurses had to put things into perspective in order to learn from challenges, to avoid a routine approach or to avoid being stressed by challenges.

Learning to Stay Informed

Staying informed means, for the purpose of this study, that RNs keep learning and upgrading regarding information pertaining to cancer, e.g., procedures, treatments, and the clients themselves.

Staying informed: a strategy used by nurses.

All participants indicated in various ways their need to keep up-dating themselves. Louise mentioned that her goal was to serve her clients better (Louise, 1, 35). And, the better nurses were informed, the better able they were to meet the challenges they faced (Della, 2, 101). In oncology, one participant stated that professionals had to use the Internet in order to be informed on what was available to the public via this mode of communication (Sue, 1, 37).

Anne stressed that they were always learning something while working in oncology and always facing changes (Anne, 1, 54; Anne, 2, 23-27, 44). She described

that there was a way to liquify the very thick mucus that some clients had in their throats in the morning. The concoction was comprised of "unseasoned meat tenderizer in a cup of warm water and rinse their mouths and gargled with it" (Anne, 1, 30). This example represented a different way of helping clients dealing with a specific problem.

Participants mentioned that it could be difficult to know everything about all cancers (Betty, 1, 44, 68, 71; Louise, 1, 21, 25, 31), pain management, protocols, IVs, technology, treatments, and chemotherapy (Della, 1, 20, 24, 27, 85); in addition, Christiane (1, 70) pointed out the need to know more about the clients themselves and not only about their disease. Staying informed represented a difficult strategy to implement. But certainly, it remained another strategy that made a difference in oncology care.

Staying Open

Staying open means that an individual maintains an open mind about what has happened, what is happening, or what may happen in the future.

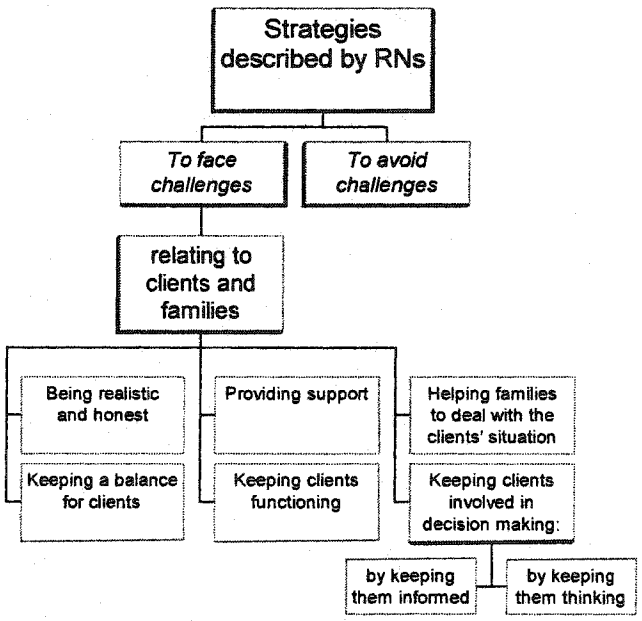
A strategy used by self.

Diane regarded herself as being positive and as having faith, and she considered that there were always options to present to cancer clients (Diane, 1, 78, 80, 96). In the interviews, participants provided other examples of open-mindedness. For example, Louise (2, 37, 140) saw having an open mind as being flexible and non-judgemental in order to look at situations and to find ways to solve them. Anne (1, 30) talked about remaining open about the various things that clients could try in order to make themselves better. Betty (1, 94) alluded to a situation where they had problems finding a bed for a client, but in the end, they found a solution. It seemed that by staying open,

nurses were able to achieve good results (Sue, 1, 139).

This strategy, staying open, could be difficult to implement, especially when nurses had little faith for the resolution of certain problems. Still, despite the limits encountered with cancer care, Diane believed that they could offer clients other options if a cure was not possible. For example, they could still provide them support in maintaining a good quality of life (Diane, 1, 183).

Strategies Used by Nurses Relating to Clients and to Families



Being Realistic and Honest

This strategy signifies that a health care professional has to take the facts into account when considering a situation and/or when developing a plan of action and to decide what is reasonable to expect from the client's situation and to share his or her perspective with that individual.

A strategy used with clients and families.

Della talked about being honest and about being able to say to clients that "these are issues you need to discuss with the physician [and] it is important that you know these things" (Della, 2, 52). In some cases, nurses were pointing out to clients and to families that they need to prepare because death was close by. Della provided the following example:

> We would tell them, you know, "have you made, do you have a will? You know, have you made arrangements?" We would approach it a bit with the family say like, "do you have things organized?" Sometimes we would ask the doctor if there was a way they could get a pass so they could go home and finalize things. That was important and it is not a pleasant thing we had to deal with, but it happened at times that, you know, we had to take those steps so that the patients and the families would come to terms with how things were going to be developing and that they were prepared, you know, for that eventuality. (Della, 2, 68)

By taking these actions, clients and families were not caught unprepared (Della, 2, 68-70). This participant insisted on the need to let clients know, if it was the case, that despite any treatment the health care team could offer, he or she would not do well with it (Della, 2, 131-133). Anne suggested a similar way of dealing with such a situation that one could say to clients, "this treatment cannot cure you, we cannot take away this disease but we may be able to keep it in check for a while. We don't know what that while is" (Anne, 3, 67). Participants expressed many ways of being honest and realistic with clients and families, especially when their prognosis was poor.

Louise (1, 82) mentioned that some clients may have unrealistic expectations but that nurses had to provide clients and families with the proper information about their cancer. However, the information had to be delivered in a proper fashion, not by lying but in a way that would "soften the blow" (Diane, 1, 90). Health care professionals could almost predict the outcome of the clients' disease or treatments and spoke of putting a plan in place to help them (Louise, 1, 183). Anne added,

> when you are honest right off the bat with a patient, it pays off again in dividends because they trust what you say and... they will believe you and you can get gradually with them to a point where you can talk about palliation and you can more easily talk about do-not-resuscitate orders and you can more easily talk about, you know, when the time comes "do you want to die at home," "do you want to be admitted" but it comes right from day one. (Anne, 2, 64)

By being honest and by talking about the clients' problems, nurses continued to be trusted until the end. Diane raised the importance of the clients' trust in developing a rapport with them (Diane, 1, 86-88).

The implementation of this strategy, being realistic and honest, could be difficult for nurses and clients. For example, Christiane noted that we lived in a "fix-me society" and that some physicians were having difficulty deciding when to stop treatments. She explained that some clients would go on indefinitely taking new drugs and could spend the rest of their lives trying treatments (Christiane, 1, 33). She said that clients need to hear the reality of their situation:

> like two out of five patients live two months longer... but these are the side effects you're going to have if [you] get this drug... How many patients would

> choose that? But we don't talk in that language, we talk about percentages and, … this looks like a promising new thing, and we feed the hope, and I feel definitely that hope is an important part of… the care. But not this, you know, [it can represent] false hope. (Christiane, 1, 84)

It could be difficult if a client was unable to accept his or her own cancer diagnosis (Louise, 1, 78). But, being realistic and honest with clients and families helped them to avoid developing false expectations regarding their treatments.

Providing Support

Providing support signifies the role of nurses in accompanying and guiding those clients and their families who are in need of assistance regarding their situation.

A strategy used with clients and families.

The oncology nurses provided support to clients and to their families through their cancer journey; while some clients were at the beginning of their active treatment, others were in remission, and finally, some were at the end stage of cancer (Christiane, 1, 30, 33). This strategy was particularly important for some clients who had not much family nearby to help them at home (Sue, 1, 104).

By providing support, nurses were perceived as sharing the clients' and families' burden (Sue, 1, 113-115). When facing cancer, every individual coped differently and needed assistance in making choices (Louise, 1, 133). Providing support took various forms; for example, nurses were listening to clients (Sue, 1, 47; Diane, 1, 78), presenting their situation to oncologists (Anne, 1, 24), assisting clients in interpreting what was told to them (Betty, 1, 89), informing them about the resources available (Louise, 1, 83; Sue, 1, 37; Della, 1, 121), providing advice regarding choices (Betty, 1,

164), meeting their needs during their treatments (Louise, 1, 83, 109), and offering health teaching (Louise, 2, 62).

In doing all these interventions and more, nurses provided physical, emotional (Louise, 1, 109), and psychosocial support (Betty, 1, 89; 2, 86). As two participants noticed, many clients required encouragement during their treatments (Anne, 1, 58; Diane, 1, 92).

Participants discussed ways to relieve various symptoms that clients were having such as pain, nausea, and other physical symptoms (Betty, 1, 89; Anne, 1, 27). Having a plan about these symptoms, for example, made nurses feel good because they were able to offer something to clients (Diane, 1, 80). They emphasized that they tried to keep clients well as long as possible (Christiane, 1, 23), and to give them some quality of life (Della, 1, 20). Throughout the interviews, nurses described their dedication in helping cancer clients and their families. Betty (1, 98) observed that when nurses provided their clients with extra attention, family members, in particular, appreciated it. And, relatives themselves needed reassurance and help dealing with one thing or another at the time (Sue, 1, 101). Also, they worried less when nurses listened to their concerns (Anne, 1 27).

This strategy, providing support, was used on a day-to-day basis with clients and could become difficult to implement because of the varied needs and expectations of clients and their families. Also, this support depended on the nurses' workload and on the resources available.

Helping Families to Deal with the Client's Situation

This strategy is associated with how nurses assist relatives experiencing hardship

because their loved one has cancer and/or is not doing well.

Strategies used with family members.

Nurses could reassure family members by making suggestions and by sharing their goals with them, thereby guiding them through what the nurses were doing. Anne said to the daughter of a sick woman,

> 'our aim is to keep her [your mother] comfortable and to make life pleasant for her, not to make life unpleasant for her, ... WHATEVER we do, we know we are not curing her,' and so our aim is to keep her pain-free and to keep her at home as long as she can with her husband. (Anne, 1, 27)

The daughter responded, "You have no idea how much better I feel when I talk to you" (Anne, 1, 27). With such a response, the nurse knew that she had managed to provide some relief to the daughter. While speaking with family members, RNs could advise them right away about their difficulties in dealing with a cancer diagnosis. For example, Anne shared the following:

> I can tell you that patients want you to be honest always. Uh, relatives will say, "don't tell him," "he is not going to be able to cope with this," "don't tell him," "I don't want my mother to know" and, you know, I will say, "I understand, I understand how you feel." I always use this same approach with them, "but your mother knows, or your father knows. You think they don't know, they know." And, "they have to make decisions for themselves and they have to be given the information to make an informed consent. They are the ones that have to sign on the line, not you, and so you are bringing your relative here [for cancer treatment], do you not think that they know what they have?" [The relative's

> response was:] "Don't tell them if it is bad, don't tell them if it's bad." [Anne:] "You know, we have to tell them the truth. They have to trust us and you have to trust us, that we will tell them in a way that they will be able to cope and we want you there, so that you will hear it, how we tell them and how we talk to them, so you will learn how to talk to them about it." And invariably, invariably, I have never ever had a patient that has come to this Centre that hasn't been told, because of a relative... doesn't want that. They're trying to protect themselves and you explain that to them and talk to them about it and they do, they come around. (Anne, 1, 105)

With her experience, this participant was able to help family members who wanted the diagnosis kept secret from the clients themselves. Della stressed the need to talk to family members. When she spoke with them, they would know what could happen; she would clarify their misconceptions and tell them what to expect from the treatments, thereby avoiding unrealistic expectations (Della, 1, 64-66).

Furthermore, Christiane confronted family members who were irate with her about not being informed about the cancer of their father. During the first visits of the father, this nurse asked him where his daughters were, and he replied that they were busy. This participant had a discussion with the daughters after the death of their father:

> So my question back to them was, "well, where did you think your father was and why didn't you come along?" you know. So it was an issue between the family and the father yet the anger was coming out that we did something wrong [and I said,] "you didn't need permission from me to come... and talk to your father..." [Relative's response:] "we didn't know he had cancer of this [type], we

> didn't know that it was terminal." Well, you know, some of the questions [or comments] they were saying to me were they knew he had cancer, they knew he was coming for treatment. He may not have told them.... [He was in for treatment] over a period of about 6 months. So there, you know, is an example... that you respect [the] patient's wishes but you address the family. NOW you can imagine had I NOT addressed [that with the father], well where is your family...? how I would have felt in front of those family members. (Christiane, 1, 65)

By clarifying her position and her actions, this nurse was reassured that she had acted as was expected of her in such a case (Christiane, 1, 65).

In another situation, Diane discussed with family members what to do or what was expected of them, and what were their responsibilities. Sometimes, they expected nurses to do more than they could (Diane, 1, 117). For example, Louise was faced with a situation where a family member refused to stay at home with a client who was unable to manage by herself; then, the medical team had to request that someone from the family did stay home (Louise, 1, 88). This participant was concerned that some relatives were not supportive in trying to find a solution to the situation.

The implementation of this strategy, helping families to deal with the client's situation, could be difficult for oncology nurses. For example, parents could get quite emotional when they had to deal with children that might die from cancer and might require assistance to deal with their issues (Sue, 1, 23). Betty talked about families sometimes being more challenging to work with than clients. They might get angry and have problems accepting the cancer diagnosis of their loved one (Betty, 1, 52). Family

members could be very demanding because they were scared and because they might not be realistic (Betty, 1, 55). Betty and Anne added that there were also issues about confidentiality that needed to be addressed with family members, which made these situations harder to deal with than those of clients (Betty, 2, 86-88; Anne, 3, 69).

Helping family members to deal with the client's situation remains a strategy necessary for the relatives in enabling them to continue to support individuals affected by cancer.

Keeping a Balance for Clients

Keeping a balance is a strategy used with clients to ensure that a certain equilibrium is maintained in their lives especially when they have to face their diagnosis, prognosis and, or treatments.

Strategies used with clients.

Anne was concerned that sometimes we, as a society, "over-helped" clients with cancer, that we did not have them do enough "things" for themselves, and that we needed to encourage them to stay active (Anne, 1, 18). Similarly, Louise described a situation where clients were limiting their activities because of their cancer:

> And they come in and I say to them, and [while] they are changing [and getting ready] to see the doctor, "well how are you doing?" And they'll say, "well you tell me." And I'll say, "well what do you mean?" and then they say, "well how was my blood?" [Louise's response was:] "Well if you're waiting to enjoy your life until what you hear what your blood level is, you know, you are not enjoying your LIFE." ... But again it is the mindset that they have [about] cancer that this result is going, you know, open the doors for them and if it is normal it is fine

but if it is up 0.2 then they are going to panic and again it is the teaching thing. (Louise, 2, 102)

She added that clients put their lives on hold while waiting for their test results (Louise, 2, 104). As was done in this example, clients needed to be encouraged to continue to participate in any activities they enjoyed as they did before being diagnosed with cancer.

Furthermore, in trying to keep a balance for clients, Christiane warned health care professionals to keep clients close to their home while receiving their treatments, which therefore limited their travelling and which developed further the use of local health care services. She stated that clients talked about travelling, about the financial cost involved and also about how being away from home was limiting the clients' availability for work (Christiane, 1, 12, 85). Such interventions could help clients to balance their own personal activities and could prevent the cancer activities taking over the clients' lives.

With this strategy, keeping a balance for clients, the nurses' goal was to encourage clients to have a life without restricting too much the activities that they once had. The nurses philosophy was that clients still have lives to live. The following strategies also try to elicit the same behavior in clients.

Keeping Clients Functioning

This strategy is used to motivate clients to become more active or to continue to be active despite the fact that they are sick.

Strategies used with clients and families.

Louise advised clients that there should not be any restrictions on their activity,

their enjoyment in life, their functioning or the kind of social activities they do because they are waiting to hear the results of a blood test they had two weeks ago (Louise, 2, 102). Della supported this position by saying that clients should have as normal a life as possible despite the fact that they had cancer (Della, 2, 76). Christiane encouraged clients to have normal activities during their treatments and not "to make their whole survival of their last 6 months focused around treatment and sickness," and she added that they should return to normal functioning and to work between treatments if they could (Christiane, 2, 71).

Diane (1, 119) indicated that she provided information on what clients needed in order for them to manage once they went home. She also believed in giving clients the opportunity to be independent. They should not put their lives on hold because they have cancer. Finally, Anne stressed that keeping clients functioning could be difficult, especially if they were in remission; they might be paralysed and sitting at home waiting for their cancer to recur. This strategy should be implemented to help clients to enjoy life; that they have a chance of living longer.

Keeping Clients Involved in their Decision Making

In this category, the goal is to help clients to take charge of their situation and to stay engaged in the process. With such strategy, two sub-categories were identified: keeping clients informed, and keeping clients thinking.

Keeping Clients Informed

This strategy is associated with health care professionals who need to provide clients with appropriate details and with information regarding their disease, their prognosis and their treatment.

Strategies used with clients and families.

Christiane discussed the need "to teach [about]... the treatment regimen and what to expect [about] side effects and what to do about side effects" (Christiane, 1, 72). With regard to teaching, Louise (1, 21) felt that clients needed to be educated at their own level in order to ensure understanding of their situation. In out-patient clinics, Della found that more education had to be done:

> You are doing a lot of teaching with the patients... because a lot of them are new to chemo, they are just starting their treatments and, you know, they are coming in but then they go home so you have to prepare them for, you know, how to look for side effects when they are at home and ... have to monitor for fever, ... they have to be aware of... when to return for lab works and more follow-ups with the physician and more treatments, ... that kind of a [thing], like there is a lot of teaching that way. (Della, 1, 87)

She found her role to be giving clients the right kind of guidance and teaching in order to ensure that clients knew what to expect and were well informed (Della, 1, 121). She emphasized that clients might become forgetful and overwhelmed, and nurses might have to repeat their teaching as time went on (Della, 2, 89). Similarly, Anne (1, 24) said that she wrote things down for clients in order to ensure that they received accurate information about their cancer. During their visits to the cancer clinic, and once the physician had left the room, this participant then provided more information that she felt clients might require. For example, she said,

> I will answer then any other questions for them and make sure that the practical things are sorted out. We have a lodge, we have travel grants, we have Canadian

> Cancer Society volunteer drivers, we have, you know, this sort of a thing, a psychosocial department, "do you need to see social workers?" and these are the sorts of things that I try to look after... the practical things. (Anne, 1, 24)

This nurse gave clients information about this disease, about the treatment and about the services available internally or in the community. Often clients were not aware of this information.

The implementation of this strategy, keep clients informed, could be difficult to do. For example, Diane mentioned that some clients might refuse to accept their diagnosis, which makes it even more difficult to keep them informed and to help them to understand what they have to face. Furthermore, it also was difficult to discuss treatment options when clients were in denial (Diane, 1, 78). In some instances, clients needed more time before the information could be integrated. By being informed, clients were able to proceed to the next step, and to decide what they should do to meet their own needs, which is the purpose of the next strategy.

Keeping Clients Thinking

In this study, this strategy is associated with the process of keeping clients involved in examining the information available and in making decisions regarding their situation.

A strategy used with clients and families.

Anne pointed out that health care professionals might think that clients could become dependent on the system and on them, and could become unable to think for themselves (Anne, 1, 18, 21). Betty warned professionals that one had to be careful not to let oneself become "caught up in –if this was you– or –if this was your mother or

father–, what would you do?" because those situations would probably be quite different (Betty, 2, 84). All nurses interviewed tried to put the onus on the clients themselves. Louise reported telling her clients about her expectations regarding the decision process:

> But um, one of my philosophies, and I tell my patients this, you know, "this is your body, these are your rights and you make the choice." "You know, we don't make the choices for you." Um, so I am not, I think, that is one of the tools that helps me to work through things with clients because they realize that I am not making those decisions for them and .... [I am] involving the client or the patient... in the decision making, their plan of care, all of that gives them autonomy, and... [therefore, a] conflict with patients is very rare. (Louise, 1, 69)

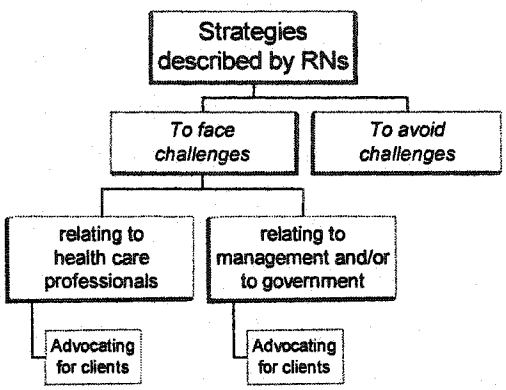
In this example, Louise emphasised the clients' responsibilities regarding their care and the choices they had to make. Moreover, Betty advised nurses that clients should know the "pros" of doing something, as well as the "cons," which helps them to think about their choices (Betty, 2, 86). Diane also discussed how clients were encouraged to take charge of their situations. She found that her responsibility was to give them the tools and the information, to let them decide (Diane, 1, 112). Similarly, Della (2, 91) acknowledged that clients had to be aware of their options in order to choose. Sue and Christiane spoke about empowering clients and about giving them some control over what was happening in their lives (Sue, 2, 73; Christiane, 2, 68). Anne highlighted a situation where a client appeared without much notice at the closing time of the clinic and had to be reminded about the time of office hours:

> I had one fellow who came the other day at 4:30 [p.m.] and he had been feeling unwell for two days and I said "4:30, the lab is closed, the doctors are leaving,

> you are going to be in big trouble with me, you know." [The patient's response:] "I know, I know." So anyway, we laughed about it after but I said, when Dr. X-2 came in, I said, "I have already given him hell, you don't have to, you know." He said "huh" because he had to come down and examine him and he had this abdominal pain... for a couple of days and had been in the day before for his treatment and hadn't said anything and then chooses to come at 4:30 [p.m.] and our lab closes at 3:30. Can't even get blood work on him, you know, so anyway, we jolted him along until the next day and he didn't do that again [laughing]. He didn't do that again, but I do, I give them hell sometimes, you know, but I do it in a way that they take it as, you know, they know I am serious and they know I mean well and that I have their best interest at heart and because I do. (Anne, 1, 111)

This participant was concerned with the care this client would receive but also wanted to encourage him to think further and to raise his health problems or concerns when he had opportunities to do so, or earlier in the day when the services were at his disposal. Nurses could encourage clients to think about their care by expecting them to be in charge of their situation (Diane, 1, 119). The strategies of keeping clients informed and thinking discussed in this section were used throughout their cancer care and promoted the active involvement of clients in the medical decisions made. In the following section, nurses described how they have been advocating for clients who are receiving oncology care.

Strategies Used by Nurses Relating to Health Care Professionals & to Management and/or to Government



Advocacy

Advocacy refers to the act of a person speaking in support of someone who is unable to speak for him or herself, or in support of situations of interest. In health care, advocacy may be undertaken by a nurse who is negotiating with other health care professionals on behalf of client services or who is defending the interests of clients or family members.

Advocating with health care professionals.

Clients might feel intimidated, or they might forget information when they met the oncologist. All participants in this study provided examples in which they had to advocate on the behalf of clients when dealing with physicians. Anne provided an example of how she helped a client in such a situation:

> [I like] to be able to get in and see a patient before the doctor comes in and get a sense of where that patient is at... find out a little bit about them in their personal lives. It is probably the most valuable time that you spend with a patient because you can advocate for them. Doctor comes in, he kind of dives right into the clinical things, the "what took them to the doctor" this sort of a thing. And I find

> that it is always a, you know, say, "he wanted to tell you this, doctor. He is worried about that. He has just started a new job." Uhm, if he is here for 6 weeks [for treatment], he is worried about his job. (Anne, 2, 58)

Another nurse used a similar process as the previous one; she said, "I find that I stand in the room and I listen and I watch the client and you can tell by a frown or something that they don't quite understand, so I intercede and, uh, you know, I don't care... if the doc gets mad at me or not that's not my big deal" (Betty, 2, 50). Diane also spoke to the fact that nurses must advocate for their clients when working with physicians.

RNs indicated that some clients asked to be cared for in their community instead of having to drive, one way, for three to eight hours in order to receive their treatments. For example, Christiane indicated,

> sometimes [she] act[s] as a third-party mediator when there are some issues that come up... uhm... with, say, a patient [who] wants to have treatment close to home or in their home community... uhm... but, uh, that clinic might not be up to standard to carry out THAT particular chemotherapy regimen so it would be MY... uhm... my role would be to, to make it clear to the health care professionals.... [O]ur role in nursing has got to be one [of] advocacy for that patient and in regards to the impact that, that kind of care is bringing to the patient. (Christiane, 1, 12, 27)

Sue (1, 27) also expressed how she was very concerned that some health care professionals were not "getting the message" about the distances that clients had to travel to receive their treatments. These examples illustrate the difficulty that participants encountered in trying to help clients. The level of difficulty seemed to have

increased when dealing with management and the government as it is described in the following section.

Advocating with management and government.

Christiane and Sue stressed also that we needed to educate managers about the need for clients to remain closer to their communities. Christiane also pointed out the issue of travel costs. Some clients and families must travel great distances and must assume, up front, the financial costs of these trips. She continued,

> why then would we not say that for those patients who actually have to put out money to travel to get that treatment that they shouldn't be reimbursed 100 % for the cost, like they are with the waiting list elsewhere. [p] You know, so it's what's driving the system... uh... you know, it's, it's... a lot of it is political. (Christiane, 1, 86)

This example alluded to the discrepancy about refunding expenses that existed across the province. Christiane spoke in support of establishing a standard policy which is the same for everyone, regardless of geographical location.

By speaking out on behalf of clients, nurses acted as "third-party mediators" (Christiane, 1, 12) and advocated for improvements to ensure that concerns were addressed in an appropriate manner. In doing so, nurses tried to negotiate between the difficulties encountered by clients and by their families, and their financial burden.

Factors

In the previous section, the investigator identified the strategies used by nurses to manage their challenges, however, with this fourth research question, "What assists nurses in managing the challenges encountered?", the intent was to identify factors that

make it easier or difficult to implement strategies when participants were dealing with challenges. The RNs were asked during the interviews to identify what helped and what prevented them from carrying out their work in oncology nursing. These factors are presented under two headings, i.e., the facilitators and the barriers to successfully implementing strategies used, to deal with challenges described by participants. Each factor is described first with a brief definition, then supported with the appropriate text and quotations from the tape-recorded interviews. In addition, in Appendix F, these factors are presented in a chart to illustrate their classification.

Definitions

From the analysis of the transcript, factors were identified that could be classified as either a facilitator or a barrier. These factors influenced the way registered nurses working in oncology faced challenges: they either facilitated or prevented nurses dealing effectively with challenges. In this study, a facilitator is defined as any factor which makes it easier to deal with a situation. And a barrier is defined as any factor which prevents individuals from dealing with a situation, or which impedes its progress.

Facilitators Described by Participants

Having a Positive Attitude

This factor, considered a facilitator, is related to the promising or constructive position that individuals can take when looking at situations. In this study, having a positive attitude can enable individuals to deal more effectively with challenges.

Having a positive attitude in relation to self.

Betty (1, 180) said that in order to work in oncology, a nurse had to care about people and had to be perceived as caring. Diane chose to have a positive attitude in her

work and refused to let problems of others bring her down, which, as she pointed out, would make her less effective (Diane, 1, 69, 78, 178). Being positive in life helped this nurse to accomplish her work in oncology (Diane, 1, 96). When professionals had a positive attitude, Louise stated that they were better capable of dealing with whatever was "thrown at them" (2, 148).

Anne (1, 58) argued that working in oncology was not depressing, and that a nurse needed to be a positive person to work in oncology. Then, she suggested that having a sense of humour and that being able to laugh were part of the positive attitude that professionals should have (Anne, 1, 102). Betty gave an example of how she brought humour to work. When faced with more difficult workdays, she told other nurses and physicians that it was her birthday, which implied that they had to be nice to her. If the difficulties experienced at work continued for a long period of time, Betty (2, 30) said to her colleagues that she made a mistake and that her birthday was that week instead.

Having a positive attitude helped Diane to see her limitations not as often, but enabled her to see the light at the end of the tunnel, and that things would get better (Diane, 1, 108, 128, 134).

Having Hope

In this study, hope is perceived as a facilitator, it is associated with the expectation that something could happen or could be done in order to resolve a situation or an issue, or that something can bring some relief when faced with uncertainties. Having hope facilitates the way individuals deal with challenges.

Having hope in relation to self.

Participants felt that having hope made a challenge easier to deal with (Louise, 3, 69; Christiane, 3, 69). Diane stated that when she saw clients surviving their cancer, their survival reinforced her faith that there was hope for other clients too (Diane, 1, 92). She added that if she did not have hope or faith, she would not be as effective in her work (Diane, 1, 96).

Having hope in relation to clients and families.

Louise (2, 92) talked about their sense of hope that the clients' cancer will respond favourably to treatments. Participants observed individuals who had survived their cancer for five years or more. They had hoped for more individuals to live longer with cancer (Louise, 2, 92). And, Della mentioned that they joined clients in hoping for the best while receiving cancer treatments (Della, 2, 68). During treatments, Diane stressed the need not to douse the hope of clients for any reason; as long as they were well, this hope helped them to keep their hopes up for success (Diane, 1, 92).

Della explained that "it is linked with positive attitude, positive outcome, I mean, even if we know that... the prognosis is poor, there is hope that you can give the patient comfortable days or quality of life that kind of thing. It is belief in hope, it is hope and belief in what you are doing" (Della, 3, 79). Hope was the belief that there was always something that could be done to help clients (Anne, 1, 58; 3, 86), and that cancer research would bring more possibilities (Christiane, 3, 18). Also, while in remission, clients' hopes kept rising concerning the possibility of being cured. The whole notion of survivorship came up with "the feeling of hope that the disease has been eradicated" (Christiane, 1, 23).

Christiane talked at length about the hope of finding more cures for cancer through research (Christiane, 1, 18, 27, 68, 86). She gave the example of a client having a 20% chance of success with his treatment, but she stressed that he might be one of the 20 people out of 100 that would be cured (Christiane, 1, 23). By getting good news on cancer research, one could anticipate that there would be more possibilities or options ahead (Christiane, 1, 27).

Clients continued to nurture their hope when they stopped their cancer treatment by trying alternative therapy (Diane, 1, 98). Diane reported that, "even if it is a pill, God knows, green tea every day, they are taking something that is reinforcing in their minds, 'I am doing something active to keep my disease under control.' So psychologically, that is nurturing their... feeling for 'I have hope' " (Diane, 1, 98). In order to avoid despair, Diane (1, 104) talked about giving hope in "small doses," especially when there was no hope for a cure. She presented hope in various forms such as, being alive today, feeling good, controlling the symptoms and hoping that things would not become too difficult to withstand (Diane, 1, 104, 108). Furthermore, there was hope that clients would still enjoy the time they had left before they died by making them more comfortable (Anne, 2, 70; Sue, 2, 95-98).

Having hope in relation to management.

Diane (1, 140, 145) talked about having hope for the improvement of the nurses' workload, the work environment, and clients' care through advocacy because positive outcomes were still possible.

Having Experience in Oncology

This factor, considered a facilitator, is related to the knowledge acquired through

formal or informal education, knowledge which encompasses the expertise acquired by working in a specific environment for many months. In doing so, the nurses gain a high level of self-confidence and a high level of competency. Having acquired experience enables professionals to deal more effectively with challenges.

Having experience in relation to self.

Participants explained in detail how they learnt throughout their lives while working in oncology nursing (Diane, 2, 136; Betty, 1, 33; Christiane, 1, 44; Anne, 1, 61). Experience was associated with spending time doing "the real thing" (Christiane, 1, 33). The majority of participants in this research had 14 years or more of experience in oncology. All of them worked in nursing for a minimum of 10 years. Christiane (1, 33) reported that the numerous years accumulated in oncology gave her a certain expertise. Della believed that she acquired her self-confidence with time. For example, she noted that when she started to work in oncology, she did not know anything and had to learn all of these "things." Oncology was a very intense area in which to work. She had to be certified in a number of areas such as, chemotherapy administration, vascular access lines, etc. Once she became familiar and comfortable with all of those "things," she felt more confident in herself (Della, 1, 95). Experience was associated with practical learning in that learning took place through trial and error (Anne, 1 61), and as a result putting things into perspective, as Betty said (1, 111). By having acquired such knowledge, nurses experienced less stress with similar situations and developed self-confidence in their abilities (Betty, 1, 111, 114, 164, 180). Having acquired experience, Betty reported that she did not find her tasks very difficult to accomplish and that she "could do about anything" (1, 47). She added, "when you first start, you're not too sure

[of] what to do and you kind of rely on other people to show you, but after awhile... it just comes with" time (Betty, 1, 104). Another participant mentioned that with experience, she could deal differently with clients' situations because she felt in control (Diane, 1, 136).

The experience acquired by nurses helped them to develop new strategies that were invaluable when dealing with the challenges they encountered (Diane, 1, 101, 114, 128; Sue, 1, 101, 117). This acquired experience was considered valuable not only to the nurses themselves but also to clients and families (Anne, 1, 71). Anne reassured nurses recently hired in oncology that experience would come with time and with maturity and that they needed to be patient with themselves and with others (Anne, 2, 52-55). Della confirmed that she learned to use her background knowledge and her previous experience to mould her responses and to solve whatever the challenges were (Della, 3, 73); with experience, challenges were also perceived to be easier to deal with (Della, 3, 74; Christiane, 3, 56).

In reference to Appendix E (Results of five-item classification), it can be noted that participants had identified "experience" as an easy challenge, a strategy, and a facilitator. During the analysis of the transcript, participants thought that to get their experience in oncology was an easy challenge for them. However, it became apparent that "experience" in the transcript was more related to "having experience" and was considered as a facilitator when dealing with their challenges. It seemed that some participants also falsely interpreted "experience" as "gaining experience," a strategy. In this research, this strategy was covered under the strategy "learning: to stay informed."

Having a Feeling of Satisfaction

Satisfaction, as a facilitator, is seen when individuals feel good about work situations because they are able to achieve some form of accomplishment. Experiencing such feeling facilitates the way individuals deal with challenges.

As experienced by nurses.

Human contact in their work was appreciated by nurses. For example, Diane talked about her ability to establish a good rapport with clients. And, Christiane (1, 18) felt that the interaction with her clients was far more interesting and satisfying than simply filling out forms. She extrapolated, "the nature of the relationship for many of my experiences, it was a privilege to be with these people walking their journey and sharing... their highs and their lows, and if we know about the cancer trajectory, we know that often we are in the peaks and valleys" (Christiane, 1, 23).

Knowing what to expect and what to do seemed to be satisfying for nurses working in oncology. Christiane felt that the nurse-client relationship brought her much fulfilment because she was able to gain a valuable understanding of her clients' journeys. Furthermore, she found that relationships developed with clients were "very rewarding" for her (Christiane, 1, 72). Similarly, Diane felt that her relationships with clients were exceptional when compared to those with her own relatives (Diane, 1, 179-180). She qualified these interactions with clients as being "well above and beyond any kind of nurse-patient relationship" (Diane, 1, 181). Anne (2, 60) said that the hour she spent with each client during their first visit gave her great satisfaction and allowed her to "grab them;" moreover, she felt these relationships made a difference when compared to interactions with other clients with whom she was unable to sit and talk. She claimed

that the time first spent with clients paid off later because she got to know them well and was better able to provide the required assistance. Sue (1, 15) mentioned that the strength of clients and families was evident when struggling and dealing with all the various issues associated with a cancer diagnosis, and this strength is what kept her working in oncology. This nurse genuinely appreciated that the clients' challenges were enormous compared to her own (Sue, 1, 94).

Diane mentioned that she felt rewarded when helping to relieve clients' pain because she felt that she was "indeed doing something very positive" (1, 102). It was also satisfying for nurses to see clients trusting them and responding to their suggestions (Diane, 1, 86, 102). This last participant was amazed to observe how clients reacted strongly to bad news given on one day, and then were able to come in the following day and ask to have treatment initiated as planned or proposed (Diane, 1, 176).

When working in oncology, Betty (1, 26) felt better about herself when she was able to improve things for clients. She added that she was also satisfied when she realized the number of clients she saw during the day and that she was able to make them feel better and more comfortable compared to when they came in; these accomplishments provided a deep feeling of satisfaction (Betty, 1, 118). She claimed that when a nurse worked in oncology for some time, she could observe or witness several successes (Betty, 1, 180). Similarly, one participant indicated that when a child survived cancer, it was considered a "bonus" (Sue, 1, 69). Also along these lines were the huge rewards resulting from work in oncology, such as witnessing individuals who survived their cancer, as was inferred by Sue (Sue, 1, 136). Furthermore, knowing that nurses have made a difference in their clients' lives and that they were successful in

dealing with their challenges was perceived as a reinforcement (Diane, 1, 182-183; Della, 1, 92-93).

Anne mentioned that it was very satisfying to be able to help clients, especially when they faced the end of their lives. Anne (1, 27) said that giving useful advice to families was also satisfying for her. Satisfaction was also reported when outcomes were positive and when clients were making it through their treatments (Betty, 1, 26, 68; Anne, 1, 58). Experiencing a feeling of satisfaction made it easier to deal with challenges and enabled participants to carry on in oncology.

Feeling Appreciated by Clients and Families

This factor is identified as a facilitator when dealing with challenges. When clients demonstrate or indicate how they esteem the nurses' work and assistance, nurses feel encouraged to continue the provision of a high level of care.

As encountered with clients and their families.

All nurses in this study indicated that their clients appreciated them. Della announced, "they are just a very nice group of patients in general, very appreciative of all the care you give them" (Della, 1, 20). Anne stated, "Oncology patients were always, ALWAYS, bar none, the most appreciative and the most patient people that you would ever find" (1, 14). She explained that these clients have learnt to smell the roses and were not in big hurry. She went on to describe how clients and families appreciated even the little things done for them (Anne, 1, 48, 58).

Clients showed appreciation by their words, thank-you cards, notices in the newspapers, small gifts, messages transmitted to nurses through other people (Sue, 1, 84; Diane, 1, 92, 181; Anne, 1, 58; Louise, 1, 54) and, in some cases, by giving nurses

hugs (Diane, 1, 92). Participants mentioned that these signs of appreciation were touching. For example, Anne (1, 99) said that it was wonderful and Betty (1, 98) mentioned that it made her feel good. Diane described her feelings regarding the appreciation received:

> People are constantly coming back and reinforcing... "you've taught me so much," "you have been there for me you are constantly my support," "you are my guardian angel," "you are always watching over me," "we appreciate you," "we love you," you know. And you get that we get Christmas cards that, you know, you would read them and you would think my God I don't [get] Christmas cards like this from my relatives. It's true, and they constantly reinforce, so, you know, it does give you that feeling, of wanting to re-energize. (Diane, 1, 178)

Clients were not the only ones who thanked nurses, there were also family members. Even when clients died, they returned to see nurses to say thank you (Diane, 1, 181, 183). Despite the deaths, nurses felt encouraged to continue their work.

Betty (1, 118) discussed how their assistance helped clients to be at ease, especially when they were quite anxious. Also, she talked about how she personalized her interaction with clients. She said she had a system where she took notes about, for example, their pet and made a point of inquiring about it during following visits. These inquiries had a positive impact on clients (Betty, 1, 180). Furthermore, clients and family members appreciated "that gentleness and just that time that is all they needed and that is all they wanted, you know, to be looked at as people, human beings and... to sit down and spend a few minutes talking to them" (Anne, 2, 70). In some cases, the

appreciation was expressed not at the time they received care but a few months later (Sue, 2, 106). These examples show how the clients' appreciation made it easier for participants to deal with challenges.

Feeling Valued by Colleagues and/or Managers

Feeling valued in this study means that nurses are esteemed and appreciated for their work by their colleagues and by their managers. When present, this factor facilitates the way individuals deal with challenges.

Feeling valued by other health care professionals.

Christiane claimed that the stimulation, appreciation and support received from her colleagues were greatly appreciated (Christiane, 1, 23, 30, 67, 72). She talked about how she enjoyed the nurturing of her nursing colleagues (Christiane, 1, 68). Diane (3, 48) reported that when she felt valued, she automatically felt confident in her ability to act in various situations. Louise (3, 48) mentioned that feeling valued improved her self-esteem and self-confidence. Participants said that feeling valued by their colleagues made challenges easier to deal with.

Feeling valued and appreciated by managers.

Nurses wanted "to be appreciated a bit" (Betty, 2, 128). Anne presented an example in which she was told by one of her supervisors that she could not leave her position without taking the doctor with her because they formed a good team together. She took this order as a compliment because it indicated to her that her contribution was helping the doctor be more efficient in his work (Anne, 1 84). Christiane (1, 70) mentioned that one of her supervisors was exceptional in supporting the nurses. She said that her supervisor had an open door policy, in which nurses could come in and discuss

issues. She described the supervisor as accessible and as open, even during a performance appraisal. She indicated that such a relationship with her supervisor enabled her to do even better in her work. When appreciation was shown by a supervisor, nurses knew that their supervisor recognized their late working hours and their diligence; this recognition made a difference. Appreciation received from supervisors and administrators did indeed have a positive impact on nurses, which made challenges easier to deal with.

Feeling Supported by Colleagues

In this study, support of colleagues is defined as the assistance received by nurses from one another when information, help or feedback are required, particularly in difficult situations. Registered nurses who receive such support feel positive and empowered to continue their work, and perceive themselves to be in the right direction. Feeling supported enables individuals to deal more effectively with challenges.

Feeling supported by health care professionals.

All research participants indicated that they received support. Christiane stated that her nursing colleagues encouraged her to ask questions. Della mentioned that she received a lot of feedback from her co-workers, which helped to minimize her stress. There were always people on whom she could count for support when things were stressful or sad, depending on the situation (Della, 1, 69).

In the case of consultations, Betty said, "when you first start, you're not too sure what to do and you kind of rely on other people to show you, but after a while" you have to learn how to do it more by yourself (Betty, 1, 194). Such support seemed to be a response to a need to reduce stress and seemed to encourage nurses to carry on with

their duties and responsibilities with clients and families.

Many descriptives such as "very fortunate," "very lucky," "greatly appreciative" were used by research participants to express their appreciation of the support received from their colleagues. Based on the transcripts, it was obvious that nurses kept performing their duties in oncology knowing that they were not alone and that support was readily available.

Support can be manifested in various ways; for example, being asked: "How are you doing today?" (Diane, 1, 125) allowed others to vent and talk (Betty, 1, 37); similarly, requesting feedback, or helping others through a situation (Sue, 1, 79; Betty, 1, 94), being accessible when needed (Betty, 1, 70), "spin[ing] off of each other," and asking what would you do? or how would you handle this situation? (Anne, 1, 61) are also forms of support. Such support was provided during both informal and formal sessions or meetings (Christiane, 1, 72; Diane, 1, 71), or even within working groups (Sue, 2, 45).

Feeling supported by colleagues made facing challenges easier, made the challenges more acceptable, and facilitated the implementation of strategies that were deemed to be required.

Barriers Described by Participants

Having Limited Options

In this study, limited options are associated particularly with individuals who feel powerless when faced with difficult or problematic situations. This factor is considered a barrier because it prevents professionals from effectively dealing with challenges.

Having limited options in relation to self, clients and families.

When dealing with situations where available options were limited, participants found that working under such circumstances was very difficult and unpleasant (Betty, 1, 101), and Sue (2, 102-104) related that she easily became frustrated and even characterized such a situation as a failure because it was beyond her ability to effect a change. Another participant talked about being faced with hopeless situations, and the need when in these circumstances to move on to something else (Christiane, 1, 36, 59). Diane (1, 102) mentioned that such feelings were also present with non-compliant clients; participants felt with such clients, that they had no treatment plan options and felt that there was little they could do to resolve the situations.

Diane (1, 102) reported another situation in which clients were dying in pain or in agony; this situation was perceived as a limitation because nurses were not able to do their job of pain management as expected. When informed after the fact, nurses felt relatively helpless that such situations had happened. In her second interview, Diane stated that if one felt unable to do one's job effectively and if the problems were not addressed, nurses might lose hope (Diane, 2, 44). When attempting to help clients in presenting various options available to them, Diane reported that some clients, in some instances, might not qualify for assistance, at which point she felt she did not have much to offer them.

Furthermore, Louise (2, 144) reported feeling frustrated when she had no treatment options to propose to clients. Similarly, Della (2, 131) indicated that there seemed to be no point in offering treatments when considering the type of cancer and its progression. When one had no options, it became difficult to implement any specific

plan because obviously, there were limited alternatives remaining (Diane, 2, 144).

Lacking Expertise

In this study, lacking expertise means that individuals perceive themselves as not having enough knowledge or experience to deal with situations encountered while working with cancer clients. Lacking expertise prevents oncology nurses from dealing more effectively with challenges.

Lacking expertise in relation to themselves and to their practice.

Sue (1, 81, 84, 115) acknowledged that when she first started in oncology more than ten years ago, she found oncology to be a big challenge. But, little by little, she learned about oncology and about how to deal with challenges. Participants advised that oncology would not be a proper area to hire new graduate nurses because of the basic skills required with IVs, for example, and because of the complexity of protocols used in chemotherapy.

A nurse was concerned that she kept being reassigned to other work areas, and when she came back to her own work area, things had changed again (Louise, 1, 41). She hoped that they would stop having these changes all the time. Anne offered similar comments when she said that she felt comfortable and confident with those aspects she was doing over and over and that changes were not necessarily the best options for nurses (Anne 2, 106). Keeping RNs working in familiar areas of work was perceived as being less stressful for them. By moving nurses from one work area to another, participants felt they were unable to keep current in all aspects of care and treatment.

Experiencing a Lack of Appreciation or Lack of Support

In this study, this concept means that professionals may be getting little or no

acknowledgement for their work or their contributions within their organization. Such practice may lead employees to perceive that their work is undervalued or is not being recognized by their employer. Nurses described how the lack of appreciation for their work could become a barrier preventing them from dealing effectively with challenges.

Lack of appreciation from clients and families.

Participants pointed out that clients might not be appreciative of their assistance when they received a cancer diagnosis. Sue said, "you don't get a lot of appreciation initially" when clients get diagnosed (Sue, 2, 106). Meanwhile, Betty mentioned that clients might be irritable, argumentative, and very negative. She added that it was quite difficult for nurses to try to help these clients in those instances. However, most of the time, clients came around and showed appreciation (Betty, 1, 164).

Lack of appreciation in relation to colleagues and other health care professionals.

One participant mentioned that there were conflicts with a few nurses who were specifically "task-driven." It seemed that these few nurses had difficulties, interpreted their role in the narrowest perspective, and did not value nursing activities other than their own (Christiane, 1, 75). There was a lack of support for the various types of work in oncology because of the lack of understanding of each others' roles (Christiane, 1, 30, 36, 75).

It appeared obvious that "anybody" could have an 'off' day when dealing with co-workers or with other health care professionals (Della 2, 99). However, one nurse questioned the support provided to each other; she was uncertain of the ways nurses demonstrated their support and if it was appropriate or sufficient, especially to new nurses in oncology (Christiane, 1, 75). While addressing lack of support, Louise pointed

out that few opportunities existed for formal or informal discussion of their concerns (Louise, 1, 27, 76, 111).

Lack of appreciation in relation to managers.

A nurse stated that within her institution, oncology was not recognized as a specialty. Employers might not value the skills, knowledge and experience of oncology nurses (Christiane, 1, 30). This participant was trying to gain an understanding of the lack of representation of nurses at the senior management table. She expressed deep concern about nursing issues which were not being addressed within the organization (Christiane, 1, 49). She added that no one was available to articulate the importance of oncology nursing (Christiane, 1, 59). Another participant mentioned that she was also concerned about management's practice to continually reassigning nurses in oncology, and described the many sub-specialities which meant that not all nurses could work in all areas of oncology and still function at an expert level (Louise, 1, 89).

In some instances, regular meetings with staff were taking place in the middle of busy clinics, and nurses were unable to attend. This particular practice was perceived by nurses as inconsiderate (Anne, 3, 72). As time went on, a lack of reinforcement from the administrative level was underscored. That said, any appreciation shown was viewed as a morale booster, and, as one nurse said, "a small thank you goes a long way" (Diane, 1, 92). With little or no support, nurses found it quite difficult to carry on with their work (Christiane, 1, 36).

Perceived Negativity Among Colleagues

Negativity among colleagues is related to the lack of a constructive perspective from which individuals can suffer in various situations. It creates a negative work

environment. Perceiving negativity among the staff, which constitutes a barrier, may render situations more difficult to deal with and may prevent nurses from dealing effectively with their challenges.

Perceived negativity in relation to health care professionals.

A certain level of negativity among nurses was identified by participants (Christiane, 1, 75). Nurses were concerned about the effects of negative attitudes, particularly when speaking with clients and families (Louise, 3, 73; Sue, 2, 94). A nurse stated that it would be hard to resolve an issue if someone began the conversation negatively (Diane, 1, 161). Another participant indicated that she hated being involved in confrontational situations. For example, she mentioned that some nurse-oncologist teams were not working well and that some personalities were incompatible (Anne, 1, 122).

According to one nurse, the negative attitudes of employees were considered the thorniest situation to deal with (Betty, 2, 26, 130-132). Negativity displayed by clients seemed to be easier to cope with than that from colleagues. And, nurses seemed to be exposed constantly to the same negative individuals, who, in turn, ultimately transferred this negativity from one situation to another (Betty, 2, 133-134). This negativity in the work environment rendered challenges difficult to deal with in oncology.

Experiencing Frustrations

In this study, frustration is considered to be the state of disappointment in which one finds oneself when one encounters too many limitations or when one is deprived of an advantage or a solution that can be expected or provided. Frustration is felt when energy and time are spent non-productively on situations or issues. Experiencing

frustrations prevents individuals from dealing more effectively with challenges.

Experiencing frustrations in relation to clients and families.

Frustration was observed in many situations as previously indicated and it became a barrier when nurses had to experience it repeatedly. A participant revealed that some clients were literally draining her energy because they were very negative and because their feeling of hopelessness was too much for her to deal with (Diane, 1, 102). Nurses felt frustrated when clients disagreed with the options presented and refused to select any of them (Diane, 1, 82). In another case, Louise described her frustration when caring for clients:

> sometimes the frustration is that the treatment is not working or that we don't have anything else to offer people and it is very frustrating because they come to you looking for the answer, the treatment, the cure, the whatever and um you have to say sorry..., we can try this or we can try that but there really isn't any other option. That is very frustrating. (Louise, 2, 86)

These situations were frustrating not only for clients but also for nurses. For example, nurses felt frustrated when clients had to wait longer for services (Diane, 1, 140; Sue, 1, 113; 2, 72); this waiting was limiting their abilities to provide the care in a timely fashion.

Experiencing frustrations in relation to health care professionals.

Anne (1, 108) discussed her frustration and her annoyance when some procedures were done by other professionals who did not have respect for the clients' privacy. They exposed the individuals without covering various parts of their body while doing tests or treatments.

Christiane talked about her frustration when dealing with the treatment plans of clients who were receiving active treatment when so little chance of success was expected. Such frustration was related, in part, with the lack of dialogue of some physicians or other health care professionals with the rest of the health care team (Christiane, 1, 33). Moreover, participants discussed the negativity among the staff that was adding to the frustration already present (Anne, 2, 33; Betty, 2, 134). Having such frustration made it difficult to deal with challenges at hand.

Experiencing frustrations in relation to management or to government.

The frustration of participants and their inability to do anything about their situations were noticeable. Many more frustrating situations were mentioned by participants and were related to some previous situations presented in this chapter. For example, nurses felt frustrated... when they had a heavy workload and little time to provide nursing care (Diane, 1, 33, 40, 56, 136, 140; Diane, 2, 88-90; Louise, 2, 124; Christiane, 3, 31; Anne, 3, 92), when working in an overcrowded environment because more and more clients were seeking treatments (Diane, 1, 40, 56), when there was a constant turnover of staff (Sue, 1, 37), when management was perceived as lacking foresight in planning cancer care and in having the appropriate resources in place (Diane, 1, 58; 2, 32; Sue, 2, 128; Louise, 2, 124; Christiane, 1, 59, 82; 3, 31), when lacking resources (Anne, 1, 86; Diane, 1, 130). Also, participants were frustrated when little support was given to implement new changes or new programs (Christiane, 1, 51; Louise, 2, 62), when they were excluded from the decision making process (Christiane, 1, 72), when there were too many encounters with bureaucracy (Diane, 2, 88; Anne, 3, 90-92; Louise, 3, 40), when the message received was "We don't need you" anymore

(Christiane, 1, 55, 57), when nurses were made to look somehow inefficient in their work (Sue, 1, 40), when not recognizing oncology as a specialty while they were required to further their education because of the complexity of their type of nursing practice and oncology treatments (Christiane, 3, 31), and finally, when trying to obtain funding approval for clients' medications (Anne, 1, 86), etc.

Also, when further promises were made, nurses were distrustful and asked to see the changes and the results—a lack of trust seemed apparent from Diane second interview (2, 94-96). Nurses became more concerned when no improvements were noted (Diane, 1, 130). Such frustration could only grow because nurses felt that there was nothing that they could do in many of these instances (Diane, 1, 140). The frustration was evident in this example:

> Diane: ... but often times it doesn't work, even as hard as you try, so you, you put forth all of the energy that is necessary for you to accomplish what you need, but at the same time it doesn't always work.
>
> The researcher: ... I am getting the impression that when the challenges get bigger the frustrations increase to a certain point.
>
> Diane: Yes that is exactly right, yes indeed. Ya, and then what happens then is, you are more tired, your frustration level is greater because you can't cope with it. So you should just think, okay, this is the last straw, this is now the last straw because you have... more patients on your part because [you are] maybe in control of your clinic [and] it wasn't so busy that you needed to worry, so then you can take the time that is needed to call these other areas for your reports. But now we are too busy for this, so the frustration is there constantly. It, it, it is

greater because we are now busier, so are they. So it is obviously impacting on everyone. (Diane, 2, 147-150)

These frustrating situations had a negative impact on nurses. Experiencing frustration was identified as a barrier when dealing with the challenges preventing nurses from being more efficient in their nursing care.

In this research, the identification of all these concepts, e.g., challenges, strategies, facilitators, and barriers, lead to the development of an approach used by participants to deal with their challenges, which is described in the following section.

Findings on the Approach Used by Participants & on Card Sorting

In this section, first, results are presented to illustrate how the approach used by nurses when facing challenges in oncology unfolded. Participants were asked to describe the steps that they followed when dealing with challenges. Second, the card-sort results of the classification of concepts are provided. For these results, they were asked to rate the challenges under the two classifications developed by the researcher during the study, and then asked to explain the differences they perceived from the various columns or challenges (refer to Appendix I).

Approach Used by Oncology Nurses when Dealing with Challenges

From the descriptions provided by research participants, a list of steps was elaborated and can be found in Appendix G. Nurses participating in this study said that they had difficulty describing the process or the steps they used to deal with challenges because they did it more intuitively. During the interviews, there was no consensus among the participants about such a process. The researcher developed a list of steps consistent with the participants' comments that reflected what they had portrayed

themselves doing when being faced with challenges. The approach is described in the following.

During the appraisal of challenges, participants had to consider each challenge within its context while being influenced or affected by a multitude of factors, i.e., facilitators and barriers. Then, they rated the challenges on a five-item scale, which ranged from an "easy" challenge to an "unachievable" challenge. When challenges were classified as "difficult" or "huge," participants required more time and effort to resolve these challenges in comparison to those classified as "easy" or "not-too-easy/ not-too-difficult."

During the first two interviews, the registered nurses pointed out that the presence of negative factors which made it difficult for them to deal with some challenges. They went on to explain that not only were the challenges difficult to deal with, but also, the strategies were difficult to implement. On the one hand, some factors considered to be barriers prevented them from achieving a resolution to the situation in which they were, such as having limited options, feeling frustrated about their work, and experiencing a lack of appreciation from management. These factors created an environment that was unsupportive of health care professionals who were trying to deal effectively with their challenges. On the other hand, other factors acted as buffers in facilitating the approach in which they were engaged while dealing with challenges. These facilitators included displaying a positive attitude, maintaining hope, feeling satisfied with their work, and feeling supported by their colleagues.

Once the challenge was classified, nurses then decided whether to face it or not. If they avoided the challenge, they would not deal with it further and would move on to

other activities. However, if they chose to face the challenge, they then decided which strategy would be the most successful in achieving a successful outcome.

In the approach developed (Appendix G), the lines connect the strategies back to the challenges which indicates that the implementation of strategies may become a challenge depending if these strategies are difficult to implement or not. As previously identified, challenges and the implementation of strategies were also influenced by the presence of facilitators and barriers, therefore they were connected together in the diagram.

In summary, perceived barriers increased the level of difficulty faced by RNs in their efforts to deal with challenges. However, when faced with facilitators, nurses were positively disposed and felt confident that they could handle the challenges successfully. And, the following classification of challenges was also used in trying to gain a greater understanding of the difficulties which RNs faced when trying to manage challenges.

Classification of the Concepts Identified in this Study

In their first interviews, some participants mentioned positive challenges but were unable to talk about negative challenges (Diane, 1, 157). They talked about positive and negative "things." Anne stated, "it is not just like black and white because nothing is black and white; when you are saying positive-negative, it is black and white" (Anne, 3, 205). Similar comments to those supported the need for an additional classification level, aside from identifying concepts as positive or negative. It appeared logical to the researcher that a greater understanding could be achieved from the participants' perspective with the development of a scale comprised of words that they had themselves used during their first two interviews. From those words, the following

classification scale was proposed to participants to sort a list of concepts identified from their transcripts. The five-item scale consisted of: easy, not-too-easy/ not-too-difficult, difficult, huge, and unachievable challenges.

Participants classified all the concepts identified in this study under two scales, first the positive and negative categories (scale), and then under the five-item scale developed as they are described in the following paragraphs.

Positive-negative classification.

With this classification, the researcher had made a list of concepts in which he classified all codes as positive or negative before asking the participants to do so. Doing so provided a point of comparison afterward between his classification and that of the participants. When looking at the results (Appendix I- Results of positive-negative classification), he found that the "situations affecting nurses at an emotional level" was the only concept classified differently by the participants and the researcher. The majority (four out of seven) of participants considered this concept as a positive challenge, and not as a negative challenge, as was expected by the researcher.

In using the positive-negative classification in their third and last interviews, participants were unable to indicate if the concepts presented were challenges, strategies, barriers, or facilitators. Looking back at the result of the classification, the researcher noted that all strategies and all facilitators were identified as "positive" while all barriers as "negative." However, the majority of participants identified only three challenges as positive: "situations affecting nurses at an emotional level," "difficulty in remaining in contact with clients," and "specialized workplace." And, the majority of participants considered the other 15 challenges as negative. Furthermore, it was

impossible to distinguish between the barriers and the challenges when looking at the positive-negative classification because they were identified as negative. However, it was possible to discern the challenges from the barriers and also to discern the strategies from the facilitators when reading the examples and the descriptions in the interview transcripts.

Card sort.

During this classification, participants were asked to card sort each of the 45 concepts provided under each of the five challenge categories or under a sixth category, that of "not a challenge" (refer to Appendix I- Results of five-item classification- Q-Sort). Once they had completed this task, nurses were asked to classify further the concepts that were "not a challenge" into three possible sub-categories: "strategies used to deal with challenges," "what makes a challenge easier to deal with (buffer)," and "not classified."

For example, all participants indicated that "feeling valued" was neither considered a challenge, nor a strategy, but rather as "a buffer or a facilitator" because it made things easier to deal with. However, the majority were unable to classify "lack of appreciation" and left this concept in the "not classified" column. As the researcher explored further the concepts under the different headings, he was able to look at the differences and cluster together the challenges, the strategies, the facilitating factors, and the barriers. Progressively, the classification developed became more meaningfully and, as indicated by Miles and Huberman (1994), this process made more sense and felt right.

Additionally, when the participants classified strategies as challenges in the first

five columns, further clarification was requested in order to have them explain their rationale for selecting one column over the others. For example, three participants pointed out that the same challenges could have been classified differently depending on the situation or the context they were facing when dealing with these challenges (Della, 3, 64; Christiane, 3, 20; Diane, 3, 18). While using this classification, participants supported this position and asserted that it was difficult to classify challenges as they might represent a lesser or a greater challenge on certain days. However, this classification process helped Louise and others in understanding the complexity of challenges and the factors that might influence the decision-making process when they had to deal with their challenges (Louise, 3, 94).

Following the classification of each concept, and considering the approach nurses used when faced with challenges, participants explained that they perceived themselves as being able to deal with these challenges and in control, especially when these challenges were classified as "easy" or "not-too-easy/ not-too-difficult" and when these were related to themselves or to clients and families. Diane, as well as other participants, realized "that you can do something about [them and they] are not as stress related" which she would not have believed before doing this classification (Diane, 3, 12, 24-26, 49). Louise also felt comfortable dealing with easy challenges (Louise, 3, 25). Anne also indicated that she could deal more quickly with these challenges on her own and without the assistance of others (Anne, 3, 99). Then, they would identify strategies and implement them in an attempt to successfully deal with challenges. Such classification was done by taking into consideration the presence of facilitators and the lack of barriers involved.

Conversely, when participants were faced with challenges relating to health care professionals and to management and/or to government, they perceived themselves as experiencing more difficulties in dealing with these challenges, especially if they were classified as "difficult," "huge" or "unachievable." And, they were concerned with their abilities to influence the system and perceived themselves as not having much control over these challenges (Diane, 3, 22). In trying to deal with these challenges, it was possible that one might be unsuccessful in his or her effort. Christiane pointed out that there was seldom an easy pathway to follow when managing "difficult" or "huge" challenges. She struggled more with these challenges, and moreover, there were other "outside variables" to consider when trying to overcome such challenges (Christiane, 3, 22, 34). Participants explained that these last three categories of challenges required a lot more energy and time on their part, which made it almost impossible, in some situations, for them to be effective, especially when they were short of time and experiencing a heavy workload. Participants perceived that there was little they could do to overcome "huge" challenges (Betty, 3, 99; Diane, 3, 18, 32; Christiane, 3, 32; Della, 3, 68). Furthermore, participants indicated that often more frustrations were associated with these challenges (Della, 3, 76; Diane, 3, 18, 53; Christiane, 3, 43; Sue, 3, 28) and that they felt powerless in the face of such challenges (Christiane, 3, 38). The lack of facilitators and the presence of barriers had an important impact on deciding to act or not on these challenges. They would have to consider whether to face the challenge or not, and possibly would choose to avoid the challenge if too many factors were perceived as being obstacles in achieving a successful resolution of the challenge. Sue compared her dealing with "huge" challenges as knocking herself "against a brick wall"

(Sue, 3, 30).

By being aware of their limitations, participants emphasized their need to remain as effective as possible with the greatest number of clients. In doing so, they had to decide on which challenge to act. For example, Sue and Diane mentioned that they preferred spending their energy elsewhere when faced with things too difficult to handle (Sue, 1, 130; Diane, 1, 159-160). Anne maintained that when she was faced with a lot of concerns and frustrations, she felt that the challenges were unachievable, for example, when dealing with bureaucracy (Anne, 3, 71), and that she had to move on in order to continue to be effective in her work. When nurses were faced with overwhelming situations or challenges, they would choose to avoid them as a way of preserving their energy. At the same time, nurses could minimize their losses and avoid being faced with unsatisfactory outcomes. They knew that they were avoiding unmanageable challenges, but they had decided to continue helping others requiring assistance, and always bore in mind the greater good of all the clients for whom they cared.

Upon examination of the two ways of classifying concepts identified by RNs working in oncology, it appeared that using the five-item scale, ranging from easy to unachievable challenges was found to be more helpful by participants in understanding their challenges. Sue and Diane mentioned that this classification had improved their understanding of challenges because it helped them to conceptualize the challenges to be classified by looking at differences across the various columns (Sue, 3, 81; Diane, 3, 40). Such classification helped nurses ponder these concepts further (Christiane, 3, 85; Diane, 3, 40; Louise, 3, 94) and even assisted participants in determining which types of challenges they had control over and could act upon. The review of the charts by

participants confirmed that the process reflects their dealing with challenges.

In the previous sections, the researcher described the challenges that oncology nurses faced when working with clients and the strategies they used. Also, the factors were identified as either facilitating or preventing the nurses from coping when faced with challenging situations. All concepts were categorized as either positive or negative and classified on a scale from "easy" to "unachievable," or not a challenge. In the next section, the researcher considers if participants were satisfied with their management of these situations.

Satisfaction vis-à-vis the Management of Challenges

In this section, findings are presented in reference to the nurses' satisfaction with their management of challenges when working in oncology, which corresponds to the fifth research question (Are nurses satisfied with their management of their challenges?). Participants were asked to discuss if they thought of transferring from oncology to another area of nursing and to elaborate on their answers; they were also asked what kept them working in oncology throughout the years.

All participants indicated that they liked or loved their work in oncology; however, they expressed some concerns about what was happening in oncology. For instance, they mentioned how they felt appreciated by clients and families and how this appreciation helped them to carry on with their work despite their heavy workloads and responsibilities. Betty talked positively about her work with difficult clients:

> you can get the odd little crabby patient but I am telling you, you can bring them out of their crabbiness and most of the time it is because they are scared and if you give them some time to get used to their diagnosis you will see that they

will, they are the nicest patients. (Betty, 2, 34)

Nurses appreciated their contacts with clients and families and felt they were making a difference in their lives.

However, the stress level of these experienced registered nurses seemed to continue to increase at times, especially when changes were being introduced in health care as was seen in Ontario in the past few years (Louise, 2, 25). Nurses considered oncology to require an investment of time and energy (Louise, 2, 27; Diane, 2, 46). They had to face clients who received "bad news" all the time, who saw their cancer progressing and who faced end-of-life issues (Diane, 2, 44). Nurses pointed out that some other areas of oncology were considered more stressful than theirs (Della, 2, 28; Betty, 2, 34). For example, one participant described how she struggled because a client died and how she ended up questioning her personal abilities:

> To carry on and actually to be able, if this particular type of scenario happened again how could I deal with it? 'Cause I don't know if I dealt with it very well on that particular and I guess, then I felt, I mean, that was initial[ly]... and it... went probably went over a matter of, you know, maybe a number of weeks and even two months I think because that particular death affected me for quite some time and I thought no I can't do this anymore, you know, it is affecting me too much, it is affecting my personal life it is affecting other things and maybe I shouldn't be doing this. Maybe I have reached a limit of sort of burnout in that speciality. (Sue, 2, 32)

She expressed her concern that a similar situation could come up again. She found it too difficult to handle for the two months it lasted; however, she was successful in re-

establishing limits and distancing herself from these emotional cases (Sue, 2, 32).

Participants envisioned the need for management to provide more support (Christiane, 2, 27; Diane, 2, 44), to show more appreciation (Della, 2, 28; Christiane, 2, 27), and to address more of the issues nurses had to face (Diane , 2, 44). Diane affirmed that management had few options at hand with which to solve her concerns, and she felt she had to do something soon:

> I need a change and I know I'm not going to get a rest. I need to work but I also have learned in my past experience that sometimes a change is very good and if you start feeling that you are not doing the job effectively because you are very tired, you are not getting a response in terms of... addressing a problem, it is not being addressed in certain ways to give you the impression that maybe something will be done about it, [this is]... a HOPE BUSINESS, we lose that and we think well then the only alternative is we take this problem into our own hands and go elsewhere and find something else. (Diane, 2, 44)

As a good change, this participant was considering looking for a job elsewhere where the stress would be more manageable. Overall, participants expressed a certain feeling of disappointment. Their frustrations seemed to be increasing throughout their work and at all levels of their practice. They were even concerned about the newcomers to oncology whether they came with or without experience in nursing.

When asked about what a new nurse needed to know in order to start working in oncology, all participants provided various pieces of information and made suggestions. Overall, nurses indicated that it will take time for a new nurse working in oncology to learn what he or she needs to know (Louise, 2, 34; Anne, 2, 44). Betty and Della

recounted how they had to find out by themselves how things worked in oncology (Betty, 2, 37; Della, 2, 37).

Participants suggested that new nurses should have some basic knowledge (e.g., about cancer, the treatments) (Louise, 2, 34; Della, 2, 33; Sue, 2, 45; Christiane, 2, 31), or be certified in oncology (Christiane, 2, 36); they should get to know the clients themselves and their issues (Christiane, 2, 31); they should learn how to deal with ethical dilemmas (Christiane, 2, 33); they should assess their own beliefs and experience about death (Sue, 2, 39-41); they should gain experience in nursing and confidence in oneself before going into oncology (Della, 2, 33; Diane, 2, 46); they should become an advocate for the clients (Diane, 2, 52); and they should talk to their colleagues and obtain their support (Sue, 2, 45). These new nurses would need to have a better mentorship program in place to facilitate their adaptation (Christiane, 2, 38; Anne, 2, 44-46).

When describing their work, nurses spoke of various ways of learning to meet or to deal with challenges, as was discussed in a previous section (strategies). Overall, they said that, with time, they were able to gain the experience and the maturity that helped them through their difficult times (Sue, 2, 47; Anne, 2, 52-55; Christiane, 2, 54; Diane, 2, 58). Louise indicated clearly that nurses had to face any challenge, to "cope with it, deal with it, work with it," and to build the expertise from situation to the next (Louise, 2, 37, 41). But, this would require time. Participants recommended that nurses should not overextend themselves in their work and should have a personal life outside of oncology (Anne, 2, 49-51; Christiane, 2, 46).

Even though, nurses raised concerns about various issues, they seemed to be

satisfied with their own ways of dealing with challenges and were able to provide advice on how to help others. But, they said that more support from management was required in order for them to continue working in oncology.

In summary, in this chapter, the researcher provided a definition of a challenge. Then, he presented the challenges, strategies, factors (either facilitators or barriers) which were identified in this study. Also, he discussed the two classifications used by participants, either positive-negative and easy to unachievable, and the satisfaction of nurses in managing their challenges.

Chapter 5 –Discussion of Findings, & Limitations

The purpose of this qualitative-exploratory-descriptive study was to explore the challenges that oncology nurses perceived and the strategies they used to manage them. As indicated in the literature reviewed, the investigator was unable to find any study with a particular focus on challenges. Previous researchers have reported on most concepts identified in this study, but never in the context of challenges. In this chapter, the researcher discusses his findings for each of the five research questions, compares these with the Lazarus and Folkman's model, and also presents the limitations of his study.

Discussion

The study provided greater insight into the professional practice of experienced oncology nurses that had not been considered by the researcher or in the literature heretofore. In this section, the findings are discussed in terms of the five research questions used to explore challenges and strategies of oncology nurses. Also, comparisons are done between this study and Lazarus and Folkman's model on stress, appraisal, and coping. This research contributes to the nursing body of knowledge by adding an understanding of challenges and by presenting strategies for dealing with these challenges in oncology nursing.

First Research Question

The first question, "What constitutes a challenge for nurses in their oncology practice?" was developed to assist the researcher in defining a challenge from the perspectives of registered nurses working in oncology. A challenge is defined as a situation or a phenomenon experienced as stimulating and as requiring individuals to

spend time, energy and resources in order to face and to deal with it. Individuals learn to deal with challenges as they gain experience.

A challenge can be viewed as stimulating when nurses experience some hope and some control over it. A challenge may be difficult to manage, and in order to achieve a successful outcome, it could require more resources than are available to the nurse. In this study, participants identified most challenges (fifteen out of eighteen) as negative. Thus, a challenging situation may be associated with a higher level of difficulty because of its negative connotation when considering the limited resources with which nurses were faced. Similarly, Lazarus and Folkman (1984) argued that the way people cope depends heavily on the resources available to them and the constraints that prevent their utilization.

Second Research Question

The second question, "What are the challenges experienced by nurses in oncology?", was formulated to identify the kinds of challenges experienced by nurses working in oncology. The list of challenges identified in this investigation are presented under four headings.

The nurse herself.

The challenges related to self (to nurses themselves) were: the situations affecting nurses at an emotional level; the practice of nurses in a specialized workplace; the ethical dilemmas experienced by nurses; the unexpected situations with which nurses were faced; and the category of "being always busy" which included two components, i.e., lack of time and the heavy workloads of nurses.

Clients and families.

The challenges faced by nurses that related to clients and families were: the ending of clients' lives; the clients' medical problems; the limitations clients faced when they had to wait for tests or treatments; and, the category of "having communication problems" which included three sub-categories of difficulties: developing a relationship with clients; the travelling of clients; and, remaining in contact with them.

Health care professionals.

The challenge faced by nurses that related to health care professionals was the limitations that could be encountered while working together. In such case, participants described the tension that at times might exist among nurses and between nurses and other health care professionals.

Management and/or government.

The challenges related to management and/or to government were of two types. The first was the bureaucracy with which nurses had to deal. The second challenge involved "programs and services offered" and was comprised of four components, i.e., the perception of inadequate planning; the lack of resources or staff; the "cracks" in the system; and, the lack of funding in health care.

Comparison with the literature.

In the answer to the research question about the challenges experienced by nurses in oncology, certain concerns dominate, and repeatedly, nurses cited the following aspects as all essential to the satisfactory fulfilment of client care: the volume of knowledge required, in a specialized workplace, their "busy-ness" (and lack of time), and also, the lack of human and material resources. The same concerns are also found in

the literature.

As health care professionals, nurses need sufficient knowledge to practice. In their study, Roberts and Snowball (1999) found that diverse types of knowledge were required for informed practice by nurses in oncology. These researchers identified five types of knowledge: 1) knowledge of how to care, also called knowledge of nursing care, 2) knowledge about the clients, 3) knowledge of organizational and environmental factors which affect nursing care, also called knowledge of ward, 4) knowledge of nurses' coping skills, which include the strategies used by themselves or with others, and 5) the knowledge of involvement, which includes their closeness with clients, and their personal and professional boundaries. These five types of knowledge were observed in the descriptions that participants provide in this study. For example, in relation to the fifth type, participants mentioned the importance of establishing limits when working with clients and families. This establishing of limits became a strategy used to deal with challenging situations where their boundaries were perceived as violated. When nurses lack knowledge, they are faced with a serious challenge in the provision of care.

In this study, nurses were always busy with clients and lacked time to provide nursing care. In their research, Wengstrom and Häggmark (1998) uncovered problems associated with this lack of time. Their participants needed to find time to talk to clients, to treat scheduled clients, to carry out the nursing care that clients had a right to receive, and to document the nursing care. These problems were part of the ten greatest nursing problems experienced by nurses while providing care to clients receiving radiation therapy. This lack of time is increasing. As expressed by a physician in the study by

Penson, Dignan, Canellos, Picard, and Lynch (2000), the pressure to see more clients was increasing, and the "busy-ness" of caregivers had become, at times, overwhelming.

The lack of time will not likely resolve itself. In fact, the needs of individuals affected by cancer will not diminish but will only increase. As pointed out by the Canadian Cancer Society (April 2001), it was estimated that 134,100 new cases of cancer would occur, which adds more names to the already long list of Canadians affected by cancer. From the data provided by the Canadian Cancer Society, within the next five years, it can be estimated that more than 670,500 Canadians will be newly diagnosed with cancer and that 326,500 others will die of cancer. Until a significant reduction in the incidence of the disease is observed, the need for oncology nurses and other health care professionals will continue to rise as the demand for services increases. Furthermore, health care policies which have decreased clients' length of stay in hospital also affects the outpatient workloads (Wilkinson, 1995) of oncology nurses by increasing the number of clients who require care in outpatient clinics.

In Canada, we observed budget restrictions imposed by all governments on health care services and programs. In the UK, they have experienced similar budget cuts and found the following situation arose:

> It is disturbing that in the last 7 years there has been an increase in stress due to the lack of resources, including staff, which has left nurses feeling they are giving inadequate care.... [T]he recent health care reforms are the cause of the nurses experiencing increased workloads with fewer resources, ... nurses' increased workload may be related to an increased turnover of cancer patients. (Wilkinson, 1995, p. 74)

Cohen and Sarter (1992) also identified poor staffing as a source of difficulty. In the present study, participants also raised similar concerns regarding staffing and increased workloads. For example, when faced with a lack of resources or staff, nurses said that there was little they could do about it, classified this challenge as a "huge" challenge according to the card sorts exercise, and the challenge was left unresolved or unaddressed. In addition, when the level of difficulty was the greatest, nurses pointed out that they felt poorly supported and poorly equipped to deal with their challenges in these situations. Also, when working in a specialized workplace, nurses felt the challenges were less difficult as their level of expertise increased, their competency increased due to their regular exposure to similar disease entities or procedures.

Third Research Question

The third research question, "How do nurses manage the challenges that they perceived?", was developed to guide the researcher in identifying the strategies that nurses used to manage the challenges that they encountered. Two strategies were identified from the nurses' responses: avoiding challenges and facing challenges. The strategies of "facing challenges" are categorized under four headings (see Chapter Four).

The nurse herself.

This category can be divided further into four sub-categories: the first, "designing their activities" is comprised of two components, i.e., nurses being organized and nurses keeping track of "things"; the second, "maintain a personal equilibrium" includes two components, i.e., nurses maintaining a balance for themselves and nurses establishing limits while working with others; the third, "learning" was subdivided into

four components, i.e., nurses accepting the limitations that they faced, nurses anticipating problems, nurses learning to deal with challenges and nurses staying informed; and the fourth sub-category involves, nurses "staying open" about the situations that they faced.

Clients and families.

The strategies nurses used in this category were: being honest with clients and families; providing emotional support to clients and to families; helping families to deal with the client's situation; keeping a balance for clients; keeping clients functioning; and, "keeping clients involved in decision making" which, in turn, was comprised of two components, i.e., nurses were keeping clients informed, and nurses were keeping clients thinking about the type of care which would benefit them the most.

Health care professionals.

In this category, nurses felt the need to advocate for their clients for better services from other health care professionals.

Management and/or government.

In this last category, nurses were advocating also for improved health services for their clients within their health care institution and at the government level.

Comparison with the literature.

Among all the strategies used by participants in this research, four dominated in the everyday work of oncology nurses; they were constantly in the process of learning about "something;" they were keeping track of things; they were advocating for their clients, and they were trying to maintain a balance for themselves.

Learning is part of the oncology nurse's role. Obtaining practical knowledge is

not sufficient when practicing as a nurse; nurses must also obtain theoretical knowledge. However, when nurses have a heavy workload, they are unable to attend educational sessions, and consequently, they are prevented from reaching a level of comfort in terms of the knowledge and expertise that is required to provide a high quality of care to clients. Education or increase of knowledge has been found to contribute to the reduction of stress (Wilkinson, 1995).

"Keeping track of things" became an important measure to ensure that "anything" that was perceived as important that had to be done was not forgotten. This strategy was not identified as such in the literature. However, Wengstrom and Häggmark (1998) discussed the need to improve in the follow-up of clients in radio-oncology, i.e., the ability to keep track of clients and of the side effects experienced once their treatments were completed.

In this study, advocating for clients' needs was considered important by participants. However, as they pointed out, not only challenges but also the implementation of strategies proved to be "difficult" at times, especially when considering what was happening in their work environment. For example, when funds are limited, when one's workload is constantly increasing, and when more staff is required to provide services, it is more difficult to advocate for clients. In oncology, the heavier workloads appeared to be greater sources of stress and burnout, comparatively speaking, than palliative care (Vachon, 1997, 1998b). In his book, Kemp (1995) discussed the necessity of advocating for clients and of helping them "through 'the system' " (p. 72). One nurse described how she learned to deal with the bureaucracy of filling out government forms. She became so skilled at doing it well that her clients

were constantly receiving the financial assistance they requested.

In the opinion of Larson (1992), some individuals have a special sensitivity to the needs of clients and families. Therefore, these individuals feel the need to do more than what it is required in specific situations. The failure to accomplish specific helping goals is most stressful to these individuals.

Participants also emphasized the need to maintain a balance for themselves. Such a need has been documented in previous research. Roberts and Snowball (1999) mentioned that keeping a balance was important in order to provide effective psychosocial care to clients. These authors cited from other studies that showed that nurses kept a balance and protected themselves against stress and emotional involvement; and, in their study, participants found a need to limit their involvement with certain situations or with individuals in order to maintain professional objectivity and prevent burnout. Cohen and Sarter (1992) found in their study that there was a need to have balance in life. Cohen, Haberman et al. (1994) elaborated on the need to keep a balance and indicated that there was also a need to have a balance between organizational and personal coping strategies. They added that such balance would benefit nurses by providing them with the resources needed to give the care required.

Fourth Research Question

The fourth research question, "What assists nurses in managing the challenges encountered?", guided the researcher in identifying factors affecting RNs who are facing challenges in oncology. The factors were classified as being either facilitators or barriers.

The nurse herself.

The factors which facilitated the nurses' ability to deal with challenges involved nurses having a positive attitude, hope, experience in oncology, and a feeling of satisfaction regarding their work. The factors described as barriers consisted of nurses having limited options when faced with a challenge and lacking in expertise.

Clients and family.

The factors pertaining to the clients and families which facilitated the nurses' ability to deal with challenges were feeling appreciated by clients and families, and having hope. The factors connected to clients and their families described as barriers were having limited options, experiencing a lack of appreciation from clients and families, and experiencing frustrations.

Health care professionals.

The factors involving health care professionals which facilitated the nurses' ability to deal with challenges involved nurses feeling valued and supported by their colleagues, while those factors described as barriers stemmed from nurses experiencing a lack of appreciation or support from colleagues, perceiving negativity among colleagues, and experiencing frustrations.

Management and/or government.

The factors involving management and/or government which facilitated the nurses' ability to deal with challenges were nurses having hope, feeling valued and feeling appreciated by management. The factors described as barriers were nurses having limited options, experiencing a lack of appreciation or support from managers, and experiencing frustrations.

Comparison with the literature.

When faced with challenges, nurses were influenced by a multitude of factors present in the environment. Under the fourth research question, the researcher discovered not only "facilitators" but also "barriers." The facilitating factors identified by participants enabled them to work at meeting their challenges and to feel more confident in their abilities. However, barriers prevented them from feeling satisfied with their work. Frustrations, such as little hope to offer to clients about their oncology treatments, also when clients had to wait too long for their tests, or when a nurse did not agree with a physician about the treatments plans he developed, seemed to be one type of barrier that dominated nurses' lives. Frustration affected nurses at various levels, for example, in relation to clients' care, to their work with other health care professionals and to their interaction with management.

Cohen, Haberman et al., (1994) reported that the frustration encountered by nurses was a source of difficulty. Fitch (1996) also found in her study that frustrations were varied in nurses' work environment. For example, she indicated that nurses were frustrated when they could not meet the clients' needs. Moreover, the majority of her participants pointed out that these frustrations were related to work relationships and to work environments. In addition, she reported that nurses were frustrated because they were unable to meet their own needs, in regards to their need for knowledge.

In our study, it became evident that some barriers needed to be mitigated if nurses were to manage their challenges more effectively. Not only is there a need to decrease the impact of the barriers, but there is also a need to further nurture the facilitating factors mentioned by participants.

Fifth Research Question

The fifth research question, "Are nurses satisfied with their management of their challenges?", helped the researcher to assess the nurses' satisfaction with their management of challenges.

Nurses in this study expressed a certain satisfaction with their management of challenges, but they remained concerned about their abilities in being effective in an environment where they had too many challenges to manage and too little support or encouragement to do so. Participants also revealed feelings of disappointment. They raised concerns about their stress levels and signs of burnout. Five participants mentioned that they were thinking or had thought of transferring out of their positions. One of them even considered leaving nursing altogether. The other two participants mentioned that it was too late to transfer because they were close to retirement. In a study done with oncologists by Penson et al. (2000), frustration and a sense of failure were also reported in more than 330 participants, and this frustration and sense of failure was associated with burnout. Vachon (1995) pointed out that burnout could be related to poor relationships among professionals. Cohen and Sarter (1992) also found that conflicts with peers and physicians were sources of difficulties. These authors found that many of these difficulties were the results of human interactions and relationships. Similarly, Wengstrom and Häggmark (1998) reported that nurses felt they had a lack of comprehension of each other's work as health care professionals, and poor cooperation with other staff. In addition, they found that there was a lack of respect of each other's work and poor communication among professionals.

Despite the heavy stressors, facilitating factors, such as feeling supported,

appreciated or valued, can positively influence nurses who face heavy work responsibilities. When present, these feelings can improve nurses' satisfaction with the care they provide to clients. Participants described the need for management to provide more support and appreciation and to address more issues faced by nurses.

These needs were also discussed by the following authors. In research done by oncologists, Ramirez, Graham, Richards, Cull, and Gregory (1996), it was found that "global job satisfaction was positively related to high personal accomplishment and inversely related to high emotional exhaustion" (p. 726). Also, a "higher job satisfaction had a significant protective effect on the relationship between job stress and emotional exhaustion" (p. 726). Moreover, they reported that "work overload made the greatest contribution to overall job stress, followed by feeling poorly managed and resourced [sic]" (p. 726). In their study, these authors identified four factors that were perceived as sources of satisfaction: good relationships with patients, relatives, and staff; professional status/esteem; intellectual stimulation; and, good management and resources. Perhaps, it can be argued that these four factors are established when nurses work in a team. Penson et al. (2000) reported results of a study done with oncologists that indicated that an "effective health care team" was foremost in alleviating burnout. DePew et al. (1999) recommended that, in order to decrease burnout, employers need to provide creative ways to support their staff, to promote social support, and a sense of control. In her study, Wilkinson (1994) explained that if a positive work environment is not created, nurses will continue to experience more stress and less job satisfaction. Maguire (1986) provided an overall perspective on the work of the preceding authors when she stated that people are our most important asset in the workplace and that productivity begins

with respect for the individual.

However, it must be noted that Maguire's research, like this study, was done with experienced practitioners in oncology. One can ask if the same can be said about seasoned and beginner nurses working in oncology. Beginner practitioners would be expected to experience even greater difficulty in coping with challenges considering their lack of experience. Wilkinson (1995) cited research by Corner and Wilson-Barnett, 1992 in which newly qualified staff appeared to experience more stress than senior staff. Vachon (2000) stated that younger care providers seemed to be more vulnerable to stress. Rittman et al (1997) explained that experienced nurses develop more of a perspective of the clients' response to their disease than do inexperienced nurses. Furthermore, these authors added that a mark of expertise in nursing oncology practice is knowing how to accompany the clients and their families through the treatment process. Retaining senior nurses seems to be of the utmost importance in ensuring the orientation and mentoring of newly hired personnel. Having expertise within the institution represents a key to success in the continuity of expert care; this expertise is especially important in oncology. As mentioned by McCorkle, Frank-Stromborg, and Pasacreta (1998), "Nurses are one of the most significant professional support systems available to the patient with cancer because [they have] the most frequent contact with patient[s] and famil[ies]" (p. 1072).

After considering all five research questions, we need to look at how these findings are related to current theories found in the literature. The model described by Lazarus and Folkman (1984) offers many points of similarity to our study.

Comparison with Lazarus and Folkman's Model

The model of Lazarus and Folkman (1984) on stress, coping and adaptation is based on the appraisal and the coping processes that individuals used. These processes are influenced by the significance of the encounter within its context. The researcher will compare his findings with their model within the context of their four stages at the psychological level of interpretation: causal antecedents, mediating processes, immediate effects, and long-term effects. It is essential to note that this study was not developed from Lazarus and Folkman's model. After the analysis of his findings, the author realized that the participants were using coping strategies to deal with their oncology challenges. He reviewed the coping literature to explore further the understanding of his results.

Causal antecedents.

In the above model, "causal antecedents" were comprised of "person variables," (e.g., values and commitments, beliefs and assumptions, and cognitive-coping process), and the "environmental variables" (e.g., demands, constraints, and resources). In the current research on challenges, these antecedents have not been studied. However, the barriers and the facilitating factors identified could be viewed as part of these antecedents. Lazarus and Folkman's category of personal variables could be considered facilitators such as having a positive attitude and as experience, and barriers such as lacking expertise and experiencing frustrations. Environmental variables could include facilitators such as the feeling of being valued or supported by colleagues and by managers; and, barriers could be seen as having limited options to offer to clients and as experiencing continuous limitations in their work

Lazarus and Folkman (1984) identified four types of resources that were required to deal with encounters: physical resources (health and energy), psychological resources (positive beliefs), competencies (problem-solving and social skills), and environmental resources (social and material resources). The presence or the absence of these resources influences the coping abilities of individuals. The competencies of the participants in this oncology study were evident as shown by their high degree of self-confidence in their abilities and in their skills in potentially achieving successful outcomes; and, their success was probably due to their high level of knowledge and expertise accumulated over the years not only in oncology but also in nursing. Moreover, success served as a positive reinforcement (Lazarus & Folkman, 1984) which encouraged individuals to undertake encounters they felt they could handle. And, when individuals found themselves in situations where few barriers and many facilitating factors were present, they had greater opportunities to be successful in dealing with their challenges. Such potential environments stimulated and enabled individuals to undertake their challenges. Lazarus and Folkman (1984) stated,

> challenged persons are more likely to have better morale, because to be challenged means feeling positive about demanding encounters...The quality of functioning is apt to be better in challeng[ing situations] because the person feels more confident, less emotionally overwhelmed, and more capable of drawing on available resources. (p. 34)

However, when limited resources prevented participants from being successful, this circumstance resulted in negative reinforcement and in an unwillingness to undertake encounters. Lazarus and Folkman (1984) emphasized that the way individuals cope

depends heavily on the resources available. They indicated that effective coping depends on the relationship between the demands of a situation and the individual's resources. The consideration of the resources available is part of the appraisal done by participants. For example, as time progressed, the increasing workload (demand) acted as a greater source of stress, and as a consequence, the support system (resource) became insufficient. This situation affected the participants' ability to manage their challenges.

Mediating processes & immediate effects.

These two parts are discussed together because of their interconnectedness. On the one hand, the mediating processes include primary appraisal, secondary appraisal, reappraisal, coping, and the resolution of stressful encounters. On the other hand, the immediate effects include physiological changes, positive and negative feelings, and the quality of the outcome of stressful encounters. When appraising an event or a demand, these two parts, mediating processes and immediate effects, occur simultaneously and cannot be dissociated, i.e., that individuals are affected by the event, and their perception of the event constantly influences their decision-making, and the combination of the two ultimately affect the outcome. In the following paragraphs, the researcher examines the similarities between the appraisal and the model of Lazarus and Folkman (1984).

To begin, let us examine that what is considered stressful is directly associated with the perception that individuals have of their situation or of the personal significance of the meaning of changes. Given the same stressful situation, each individual will experience it differently. Similarly, nurses in oncology see situations in

terms of varying degrees of challenges. For example, the challenge of "lack of time" was perceived as a "not-too-easy-not-too-difficult" challenge by two participants as a "difficult" challenge by three participants, and as a "huge" challenge by two others. These differing appraisals of this challenge, lack of time, illustrate the differences in the perceptions of seven nurses regarding the same challenge. The whole process of appraising and selecting a strategy involves a multitude of elements that must be considered when trying to understand why nurses have responded differently to similar situations as they are described in the following pages.

In the primary appraisal, a stressful encounter could be classified into either of the three categories: irrelevant, benign-positive, or stressful (Lazarus & Folkman, 1984) as mentioned in the literature review in Chapter Two. The researcher did not identify the stressors that were considered "irrelevant" because of their nature, i.e., if they were irrelevant, they could not be viewed as challenging. The challenges identified were those perceived to be relevant or meaningful enough to be pointed out during the interviews by more than one participant. These challenges, in looking at Lazarus and Folkman's model, could be classified under benign-positive or stressful.

"Benign-positive" encounters could be compared to the easy and "not-too-easy-not-too-difficult" challenges of this study where the outcome can be seen as potentially positive. Such experience could bring not only joy or happiness (Lazarus and Folkman, 1984) but also satisfaction as was reported by participants in this study. The nurses are more likely to perceive the challenges as benign-positive if they receive support and if they believe that their care will benefit the clients. The support and the appreciation participants received from clients, families, and colleagues contributed toward their

work satisfaction, their self-esteem and their emotional well-being. Similarly, Cohen, Haberman et al. (1994) found in their study that such appreciation was considered a source of rewards. Cohen and Sarter (1992) mentioned that when clients went home well, nurses felt rewarded as they did when they were able to provide comfort to clients and when they received recognition from their peers.

However, Lazarus and Folkman (1984) indicated that as individuals become experienced in any life's situations, their behavior becomes "automatized." At the beginning, the coping process is used to deal with the situation, and as the behavior is mastered, there is no longer "coping" by the definition they had used because the demand is no longer taxing or exceeding the individual's resources. This progression can also be observed in oncology. Using the same analogy as Lazarus and Folkman (1984), when oncology nurses become familiar with challenges, they are viewed as no longer taxing their resources. However, experience does not seem to account for a reduction of stress when limited resources and heavy workloads are present.

Even though stress has been reduced by experience, there are remaining difficulties which continue to tax the individuals, for example, the "difficult" or "huge" challenges, especially when those encounters are appraised as "stressful." In Lazarus and Folkman's model, a stressor can be appraised by individuals as either a challenge, a threat, or a harm. In regard to the 15 negative challenges expressed by participants in this study, the author referred to appraisal process in trying to explain his classification. Depending on the past experience of participants reporting these challenges, they may have been appraised as having potentially a negative impact on them. On one hand, it is also possible that a negative challenge is not a threat if it is considered as an easy or not-

too-easy/ not-too-difficult challenge. On the other hand, these challenges could also be appraised as a threat if these negative challenges are identified as either difficult, huge, and unachievable, which were found in four instances: bureaucracy, "cracks" in the system, cutbacks and lack of funding, and lack of resources or lack of staff. Further study is required in order to gain a greater understanding between a negative challenge, a positive challenge, and a threat. Challenges seen as stressful limit the mobilization of coping efforts.

Lazarus and Folkman (1984) stated that excessive threat interferes with problem-focused forms of coping that are associated with cognitive functioning and with the capacity for information processing. Coping, as presented by Lazarus and Folkman (1984), is related to the constant efforts to manage demands that are appraised as taxing or as exceeding the individual's resources. Furthermore, perceived threats can also interfere with the individual's abilities to respond appropriately to the demands that are before him or her. Various authors, such as Cohen (1995), Faulkner (1996), Vachon (1986b, 1997, 1998a), Kemp (1995), and Watson and Greer (1998), indicated that nurses were using coping strategies in their work environment. Coping strategies are selected from a repertoire of strategies that have worked in the past (Cohen, Haberman et al., 1994), and thus experience is a great benefit; however, a myriad of variables constantly create unique situations and, therefore, a strategy that worked on one occasion may not in another (Lazarus, 1993).

The stress of an unresolvable challenge can lead to a perception of the self as unsuccessful with problem solving. According to Lazarus and Folkman (1984), individuals can be unsuccessful in their work in helping others through no failure of

effort or of imagination on their part. They gave an example of mothers helping disabled children to explain:

> Other women were equally unsuccessful in obtaining needed and appropriate assistance, and they often evaluated the environmental response as a reflection of their own incompetence, even though they had very little objective control over those institutional forces.... and [also] that the environment may respond to people's coping efforts in ways which negate their strategies. (pp. 166-167)

The authors added that some problems may be unresponsive to individuals' efforts and may require collective intervention instead. Collective intervention is supported also by Cohen, Haberman et al. (1994). In such instances, the individual realizes that other factors beyond their control affect the outcome. When facing such situations, the strategies used in their daily work can be insufficient or inappropriate (Grahn, 1996). When health care professionals experience frustration and feel ineffective, they may become personally affected despite the fact that they have done their best to provide the assistance or the care required. Somerfield and Curbow (1992) and Mishel and Sorenson (1993) wrote that the persistent use of problem-focused strategies when faced with uncontrollable situations may increase the distress of an individual.

In contrast, when stressful encounters are seen as challenges, individuals can feel stimulated to mobilize their coping efforts. When challenged, a person can experience "pleasurable emotions" or "challenge emotions," i.e., hopefulness, eagerness, confidence, excitement, and exhilaration (Lazarus & Folkman, 1984, p. 33). The authors also proposed that hope can sustain coping efforts in the face of obstacles. In this study, participants reported having hope and described their self-confidence in managing their

challenges. These emotions contributed to a positive attitude among the staff.

This type of challenge appraisal is different from that of threat appraisal where unpleasant feelings are experienced. In some other situations, encounters were believed to be "unachievable" challenges because participants felt that they had little hope seeing improvements. Lazarus and Folkman (1984) reported that the beliefs concerning control play a major role when appraising an event and when determining if the person feels challenged or threatened. The perception of control influences also the selection of coping strategies. These authors added that when a belief that something can be done is lost, hope may be supplanted by hopelessness, especially when there is the ability to predict the outcome and an inability to control it. According to the stress, coping, and adaptation's model, what was previously thought of as a challenge becomes a threat because of the anticipated negative outcome. The nurses could identify the challenges over which they had little control; consequently, they would direct their attention to areas that they could influence. In this study, participants maintained that they were experiencing many frustrations and had to preserve their energy in order to continue doing their work. Lazarus and Folkman (1984) discussed challenge appraisals where individuals have a sense of control over the person-environment relationship, such as that which was reported in this study. They considered the belief about the control and mastery as influential in the appraisal processes. The preservation of energy has been discussed by Edwards (1988) in these terms: when individuals consider alternative courses of action, they select the best alternatives considering what it is possible to do in a specific situation. This selection process was also seen in this study, e.g., when participants perceived that they could do something to help, it was an important factor

positively influencing them in their work.

During secondary appraisal, individuals used the coping process and assessed what could be done to overcome a challenging encounter. In doing so, they select strategies that assist them in responding as appropriately as possible to situations. Lazarus and Folkman (1984) referred to two types of strategies, problem-focused and emotion-focused coping, as being part of the analysis for alternative solutions and ultimately for the selection of appropriate actions (Sharts-Hopko et al., 1996).

When dealing with challenges, oncology nurses used an approach similar to the nursing process. They had to collect data about the challenge, appraise it, classify it and then decide on how to deal with it. When classifying the challenge, nurses had to consider many elements, such as the level of difficulty involved in dealing with each challenge and the factors that helped or prevented nurses from being effective. The approach identified in the current study helped the researcher to gain a better understanding of how participants dealt with their challenges. Most of the strategies used by participants in this investigation can be grouped under problem-focused coping strategies in which efforts are directed at dealing with challenges, i.e., gathering information and developing and implementing a plan of action. With regard to emotion-focused coping strategies, participants talked about avoiding certain challenges because they were "unachievable" or because they required too much energy on their part to deal with. Also, distancing was mentioned by two oncology nurses who were confronted with highly emotionally charged situations, such as working with children with cancer. They indicated that to prevent themselves from being too emotionally involved, they preferred to work only with the adult population. This behaviour had a positive effect on

these nurses. Another strategy used by one participant was to remain positive. She insisted that she needed to look at the positive in order to remain effective and to avoid becoming depressed from the limitations or the barriers she was encountering.

These two types of coping strategies, problem focused and emotion focused, are considered important especially when professionals are trying to do their job while at the same time experiencing limitations. Strategies used by participants fit well within the problem-focused coping of Lazarus and Folkman (1984). The rich examples shared by oncology nurses showed a relentless effort to manage their challenges. These findings are not surprising considering the level of professionalism and expertise acquired by the participants throughout the years. This finding is also supported by Holahan and Moos (1987) who reported that the more educated individuals were, the more likely they were to use problem-focused coping and the less likely they were to rely on avoidance coping.

Lastly, regarding the immediate effects, Lazarus and Folkman (1984) identified two elements: positive or negative feelings and the quality of outcome of stressful encounters. A few participants in this study were still having positive feelings and/or hope that would see improvements in their work environment. However, they had reservations regarding their abilities to achieve the same quality care (the outcome) as they did in previous years. They were not certain of the outcome expectancy, i.e., "the person's evaluation that a given behavior will lead to certain outcomes" (Lazarus & Folkman, 1984, p. 35). As participants were appraising and reappraising events, demands, or their options, they touched on the fact that they were concerned with what is called "efficacy expectation," i.e., the person's conviction that he or she can

successfully execute the behavior required to produce the outcome" (Lazarus & Folkman, 1984, p. 35). Such sentiment was felt among the participants who were becoming increasingly busy in their work and were experiencing limitations. Some indicated that they were becoming tired and expressed concerns for their own health while providing the best care to their clients given the limitations and the barriers they were encountering.

Long-term effects.

When Lazarus and Folkman (1984) described coping as the efforts undertaken to manage the encounter, the focus is placed on what the person does or thinks regardless of the outcome, successful or not. In the model developed, these authors discussed the long-term effects of stress, coping and adaptation. On a psychological level, the effects may be changes in the "morale" and a change in perception of their "functioning in the world" (p. 308).

In this study, the researcher did not look at the long-term effects of coping with stress or challenges. However, it was noted that the participants' morale was getting low, especially in the last few months of the interviews. Changes proposed and implemented in health care, such as limiting funding and further restructuring, led to increased concerns of the oncology nurses participating in this study. These nurses viewed their influence as decreasing while they were trying to improve oncology care, and they felt helpless in some cases to achieve good quality care for all of their clients. Similarly, Hughes, Ward, Grindel, Coleman, Berry, Hinds, Oleske, Murphy, and Frank-Stromborg (2001) stated that the downsizing and restructuring have fostered high levels of uncertainties among the health care professionals. And Grunfeld et al. (2000)

discovered that "emotional exhaustion was associated with an increased likelihood of personnel considering an alternative work situation, either by changing jobs or by reducing work hours" (p. 169). It can be extrapolated from our study that participants may have experienced a sense of failure in their efforts to seek improvements as indicated by their intention to seek a job elsewhere.

There are various and differing implications when facing a challenge and when facing a threat. There are more advantages to facing a challenge than a threat as indicated by Lazarus and Folkman (1984), especially when individuals feel positive about encounters, when they experience pleasurable emotions, and when they feel that they can draw on the available resources. This observation by these authors facilitates the understanding of differences between a challenge, a threat, and a stressful encounter. It supports the definition developed in this research that a challenging encounter offers opportunities to excel as expressed by Patton and Goldenberg (1999) who stated that a "challenge implies opportunities for growth, which may promote flexibility and openness as opposed to threats to security" (p. 159).

The model by Lazarus and Folkman had its limitations when trying to understand the differences between a stressor, a challenge, and a threat. The differences and similarities were not clearly explained in the model. Also, the researcher was not able to compare the steps followed when dealing with an encounter under their model because such a process was not delineated. This model is not a complete fit with the present work but does help one to understand the appraisal process used by participants.

Limitations of this Study

One of the limitations was that beginning nurses or part-time nurses in oncology

were not interviewed in this study. Nurses with less than two years of experience in oncology were excluded, and no part-time nurses came forward to be interviewed. Another limitation of this research was that no nurses working on in-patient oncology units volunteered to share their experiences. They indicated that they were already working overtime, were short of staff, were exhausted, and were unavailable to do the interviews each of which lasted longer than 15-20 minutes.

An additional limitation was that in the third interview, a nurse might classify the same challenge differently because challenges are context-bound. For instance, when a nurse faced a challenge that he or she has encountered before, the same challenge could be classified as "easy" in one context, and as "difficult" in another context. A challenge might be perceived as less difficult or more difficult to manage depending on its environment. Consequently, one would have to be cautious when considering the results of this classification.

Dealing with challenges was a process that participants felt compelled to get involved in especially when they thought they were able to manage the challenge itself. From the interviews, it became evident that the appraisal of challenges was a complex process that exceeded the scope of the present research and would therefore require further study.

Another limitation to this investigation was that the researcher was unable to compare his findings with those in other health care institutions because no previous study on the topic has been done elsewhere.

In this chapter, the author discussed his findings under the five research questions, compared his results with Lazarus and Folkman's stress, appraisal and coping

model, and considered the limitations of his study.

Chapter 6 –Summary, & Implications

In this chapter, a summary of the findings is presented, then implications are offered for nursing practice, nursing education, nursing administration, and nursing research.

Summary

The purpose of this exploratory-descriptive study was to uncover the challenges registered nurses perceive facing them when working with oncology clients, and how they manage their challenges.

Seven registered nurses working in out-patient clinics in a tertiary care centre in Canada were recruited to participate in this study. Data was collected in a series of three tape-recorded interviews. Transcripts were analyzed using the strategies proposed by Miles and Huberman (1994) for content analysis. From this study, a challenge was defined as a situation or a phenomenon experienced as stimulating and as requiring individuals to spend time, energy and resources in order to face and to deal with it. Individuals learned to deal with challenges as they gain experience.

Challenges were identified under four headings, those nurses described in relation to themselves, those related to clients and families, followed by those related to health care professionals, and those related to management and/ or government. Strategies used by participants to deal with their challenges were identified under these four same headings. Factors either facilitating (facilitators) or preventing (barriers) participants to deal effectively with their challenges were also identified.

Implications for the Nursing Profession

Implications for Nursing Practice

Oncology nurses in this study faced diverse challenges which affected their abilities to provide client care satisfactorily. Challenges were a concern because they were difficult to manage in a number of instances. A work environment with limited funds for health care delivery added to the difficulties nurses faced. Changes which eliminate or moderate the challenges are deemed to be necessary if the nurses' and clients' satisfaction with care is to occur in tertiary oncology health care institutions. Registered nurses need to consider the challenges they face while working in oncology. Once they have identified and assessed them, nurses have to decide if they will deal with these challenges alone, or where to seek assistance if it is required. RNs also need to identify strategies in their repertoire that have been effective in the past when dealing with challenges. They could adapt these strategies as needed before implementing them in other challenging situations. When challenges increased to the degree that they were classified as "difficult" or "huge," nurses could develop a plan of action and enlist appropriate assistance from colleagues to implement this plan successfully.

Furthermore, nurses need effective forums within which to cite their challenges, to discuss common concerns, to solve problems, and to ensure a sense of being heard, understood, and supported by their professional colleagues and administrators. Nurses mentioned also in the study by Cohen, Haberman et al. (1994) that having a voice in "fixing" a problem was important and even rewarding. Despite the fact that colleagues can be a major sources of stress, they have been found to be a major source of stress reduction also (Vachon, 1995, 2000; Cohen, Haberman et al., 1994; Cohen, 1995).

Plante and Bouchard (1995-1996) found in research done with nurses working in palliative care and in oncology units that the lack of professional support was related to burnout. Professional support was comprised of cohesion between nurses, head nurse support, and organizational assistance (i.e., group support, adequate training, knowledge update, anticipation of working days, fair distribution of difficult clients).

It is also recommended that those responsible for making ultimate decisions in health care institutions need to examine how to further their efforts to support oncology nurses in their relentless pursuit of quality care. For example, support group meetings (Cohen & Sarter, 1992; Vachon, 1995; Kash, Holland, Breitbart, Berenson, Dougherty, Ouellette-Kobasa, & Lesko, 2000; Hughes, 2000; Hughes et al., 2001) or administration-facilitated staff meetings could be beneficial to all if they raised awareness of nurses' situations and allowed them to identify their challenges and to work together in resolving these challenges. During these meetings, nurses can continue to educate themselves, learn new skills, meet specialists and monitor what is happening with their colleagues while providing support to each other. The intent of such meetings is to increase RNs' chances of achieving a successful outcome in their work with clients. These meetings could also expand nurses' expertise and creativity with more individuals involved in sharing options regarding the management of challenges. At the same time, nurses would have more formalized opportunities to support each other, to improve relationships and to collaborate among themselves. It can be emphasized that nurses have a responsibility to praise and to encourage each other also (Wilkinson, 1987). By being aware of the demand challenges place on them, nurses could choose to face their challenges together and to improve the collaboration among themselves to the

benefit of their clients. Knaus, Draper, and Wagner in 1986 (cited in Davis & Fallowfield, 1991) indicated that the recovery of clients in an intensive care unit correlated with the higher level of quality in interactions between physicians and nurses, which therefore suggests that consideration should be given to improving collaboration among health care professionals. Wilkinson (1991) also found that nursing managers had an important role in achieving a cooperative work environment.

Purposeful interventions are required at all levels of institutions and of the political and social society to address challenges of nurses; otherwise, these challenges may become unmanageable and may threaten the supply of dedicated, expert oncology nurses which would seriously impair the quality of client care. As one nurse said in Cohen and Sarter's (1992) study, "Everything falls apart when nurses fall apart..." (p. 1483).

As a society, we continuously need to improve cancer treatments. However, cancer prevention at all levels requires a greater emphasis in order to keep individuals as healthy as possible throughout their lives. Health promotion and illness prevention where practiced would not only reduce the number of individuals diagnosed with cancer but would also moderate the cost of cancer treatment and client care. Over time, the provincial Ministry of Health will save money and the population will lead healthier, and longer lives.

Implications for Nursing Education

In this section, recommendations are presented first for practicing nurses and second for nurse educators.

It was found in this study that nurses have two types of educational needs. First,

they need to keep abreast with the evolution of knowledge on the various types of cancer and their treatments. Secondly, nurses need to develop their abilities to think critically when appraising their challenges and so that they are able to learn various approaches which might increase their success of achieving positive outcomes in challenge management.

In trying to achieve this first category of educational needs, both theory and practice are necessary components of education for oncology nurses who view their specialty as an increasingly complex one that is moving toward subspecialties. Chemotherapy, radiotherapy, various types of medical clinics (such as those for head and neck cancer, central nervous system tumors, gastrointestinal cancer, lung cancer, gynecologic cancer, breast cancer, pediatric cancer), counselling, and palliative care are increasingly distinct oncology entities which require specialized knowledge and skill. A certificate in oncology and further specialization are required to enable nurses to respond more appropriately to this evolving field of health care. In trying to develop their psycho-social skills, both seasoned and less experienced nurses may need encouragement to seek and to engage in continuing education that assists them in identifying their challenges and in developing and applying effective strategies. Learning approaches could include group work to assist nurses in developing collaboration skills for the more complex challenges over which they perceive themselves to have little control and thus little hope of resolving. Facilitating access to continuing education through non-traditional modes of delivery might enhance interest in participating in continuous learning.

Moreover, in basic nursing programs, educators need to be aware of the work

environment of graduates and of the types of challenges they may encounter in order to prepare students to be able to respond accordingly. Curricula should provide opportunities for problem solving, critical thinking, leadership development, political action, stress management, and development of reasoned proposals for change when facing difficult situations or challenges. These learning activities could take various forms such as class debates on a specific topic, case studies, discussions about challenges encountered during clinical work, or interviews with nurses facing work challenges. Students could also develop their abilities in dealing with challenges by role-playing various scenarios and by having group discussions with their classmates and professors.

The above mentioned learning activities would better prepare neophyte nurses for the current realities of the work setting and would better equip them in managing the knowledge and skill demands of oncology nursing. Attracting new graduates to this specialty is critical given the shortage of nurses in general and in oncology in particular.

Implications for Nursing Administration

In this study, participants described how their roles in providing oncology care to clients and families were affected by the various challenges they faced. As indicated in the Chapter Four on Findings, participants discussed some challenges as being related to management and/or to government.

To be supportive of nurses, managers and administrators must anticipate and recognize challenges encountered in their workplace. Likewise, they must be aware that some specific challenges will require their assistance in order to manage them. For example, eleven out of eighteen challenges were classified either as difficult, huge or

unachievable by the majority of participants (a minimum of four nurses out of seven). These eleven challenges were: the bureaucracy, the ethical dilemmas, the heavy workloads, the "cracks" in the system, the cutbacks in or the lack of funding, the distance travelled by clients, clients having to wait longer for test results or treatments, the perceived lack of planning from management, the lack of resources and staff, the lack of time to provide care, and their inability at times to develop a relationship with clients. The scope of these challenges suggests that RN perceived intervention by management as imperative. There is potential for a major impact on challenges and the work environment if the administration/ management and the government could alleviate these difficult, huge, or unachievable challenges. It would probably decrease the stresses of not only nurses but also of all health care professionals, and ultimately improve the care of clients. Without it, little will be done to address these challenges, and the situation would then continue to deteriorate. It is possible that when challenges are perceived to be too difficult to dealt with or unachievable that they may become threats for all health care professionals.

Challenges represented an added stress for nurses, especially when they were considered difficult. In order to improve services to clients and families, managers would need to spend more time and resources in assisting nurses to overcome and/or to manage their challenges. They could host regular meetings with nurses to identify their challenges, monitor the resolution process, and assist nurses in developing plans of action. Also, if a closer relationship existed between management and oncology nurses, it would likely reinforce RN confidence and enhance their perception of management effectiveness. In addition, nurses may also learn about the challenges faced by

administration.

Management needs to take a leading role in supporting nurses in order to ensure continuous quality care to clients and to prevent nurses from reaching a point of exhaustion. Moreover, administrators could gain insight from studies such as those done on "Magnet" hospitals in the United States (Havens, & Aiken, 1999; Scott, Sochalski, & Aiken, 1999; Aiken, Havens, & Sloane, 2000). These hospitals are attracting and retaining more nurses than the non-magnet hospitals. They have organizational features that promote professional nursing practice. These studies consider the characteristics of magnet hospitals that make them a satisfying and cost-efficient place in which to work. As well, managers could consult other studies related to leadership and to staff support roles. Knowledge and skill development in this area might positively affect the staff nurses' level of work satisfaction and ultimately might improve the quality of care (Osguthorpe, 1997; Maguire, 1986; Vachon, 1986a; Cohen & Sarter, 1992; Wilkinson, 1995; Laschinger & Havens, 1996; Laschinger & Havens, 1997; Lederberg, 1998; Irurita, 1992).

In our study, RNs mentioned their need to be supported, acknowledged, and better appreciated for their work and expertise from managers and administrators. Hughes et al. (2001) stated that nurses tended to be more committed and satisfied when they worked in a setting where the value of nursing was overtly demonstrated. Our participants also desired more control in the resolution of their challenges. Addressing these issues may increase nurse work satisfaction and quality of client and family care, and may decrease RN frustration and stress.

More fully involving nurses in decision-making which stands to affect their

professional work would increase their satisfaction. Murphy (1988) mentioned that participation in decision-making enhances the feeling of influence and of control. He added that perceived control is an important ingredient of coping itself. Management needs to value RN comments and to promote partnerships in resolving challenges of mutual concern. For example, the continuous increase of the nurses' workload and the number of clients requiring oncology care is reaching critical levels. As Wilkinson (1995) and Vachon (2000) pointed out, workload, staff shortages, and lack of resources were considered to be the biggest stressors in the 90s, and they need to be addressed.

A possible solution to this situation, as suggested by participants, is to develop further local cancer clinics outside of the tertiary care centre. Local clinics already providing chemotherapy treatments to clients would help to decrease the number of clients, the number of visits and the nurses' and the physicians' workloads at the tertiary cancer care institution. Furthermore, these clinics help to shorten the waiting lists and the length of time that new clients have to wait before starting their treatments. This solution could help to alleviate partly the lack of space and the lack of staff that were reported by research participants in their institution. If these local clinics are not expanded, the waiting lists and the workload will continue to increase at the tertiary care centre. Furthermore, having to wait longer, once clients have been diagnosed with cancer, can only increase their stress and fears regarding their cancer.

Even though our study focused on oncology nurses, the role of clients, their families, professional colleagues, and management must not be overlooked when considering the challenges experienced by RNs. All of these individuals can influence the quality of services, programs, and the stress experienced in oncology nursing. If

management would seek further support and collaboration with oncology nurses, physicians, and other health care professionals, such a collective intervention could enhance their efforts to improve oncology services when seeking reforms in the Ministry of Health. Interdisciplinary collaboration has been seen to improve staff retention and recruitment, and to decrease inter-professional tensions (Vachon & Stylianos, 1991).

Without improvements in oncology care settings, management will find that experienced and knowledgeable professionals, such as oncology nurses, will leave their positions and seek new positions elsewhere where workloads are more manageable or leave nursing altogether. Management will experience greater difficulties in retaining their nurses and will be unsuccessful in recruiting sufficient qualified oncology nurses to provide nursing care to an ever growing number of individuals diagnosed with cancer.

Implications for Nursing Research

Results of this study indicate that nurses in oncology practice experience challenges in their daily work. These challenges affect the level of their satisfaction in their work and ultimately the quality of services they provide to clients and families. Participants pointed out that they were having difficulty providing the quality care to clients that they once did. Listening to nurses describe their challenges in oncology practice has stimulated ideas for further research.

Considering the limitations of this investigation, it could be replicated with RNs working in in-patient oncology units, and comparisons could be drawn between the challenges identified by nurses working in out-patient clinics and in-patient units. It

would provide useful information for other nurses who have to deal with their own challenges. Other studies could be undertaken with RNs working in nursing environments other than oncology in order to look at commonalties and at differences in the approaches used by nurses when dealing with challenges. Also, further study is warranted to clarify the difference between a negative challenge, a positive challenge, and a threat.

Pursuing these studies could provide greater insight on challenges and on how to deal with them, not only in oncology but also in other fields of nursing practice.

Conclusion

This research on challenges is considered unique although many of the concepts identified appear in the oncology or in the palliative care literature. As noted in Chapter Two, no research was found that investigated the nature of challenges nurses faced generally or with respect to oncology. This is also true of the strategies nurses used to deal with their challenges. The model of Lazarus and Folkman (1984) on stress, appraisal, and coping offered interesting points of comparison with the present findings. This method of dealing with stressful encounters is similar to the one of dealing with challenges. It is important that a challenge remains a stimulating experience and an opportunity to excel. If it becomes a stressful encounter, "threat emotions" may predominate, which increased anxiety instead of decreasing it. As indicated in the previous section, further research is required to gain a greater understanding of challenges, strategies, and the process used by professionals in such instances.

Finally, in this study, the researcher was able to answer his five research questions by defining a challenge, by identifying challenges encountered by oncology

nurses, by describing the strategies used by these oncology nurses to manage the challenges, by describing the factors influencing nurses' ability to deal with challenges, and by reporting on their satisfaction with their management of challenges. As a participant said, when one is faced with difficult challenges, one struggles because there is no easy path for nurses to use (Christiane, 3, 21-22). Moreover, by being aware of the difficulties involved when dealing with challenges, nurses could select strategies that would improve their chances of achieving a successful outcome and subsequently increase their sense of accomplishment.

Furthermore, it is imperative that health care administrators and the government undertake further action which would assist in the retention and in the recruitment of nurses by improving their work environment and ultimately the clients' care. These nurses would, in turn, have a greater sense of effectiveness when dealing with their challenges and would feel that they could achieve positive outcomes.

In this chapter, the author summarized his findings, and discussed the implications for the nursing profession.

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Appendix A

Interview guide

- What is your day like when working in oncology?
- What was it that attracted you to work with cancer patients?
- What keeps you working in oncology?

A. A challenge is: (*N.B.* this section was asked toward the end of the first interview)

- When I use the word challenge with respect to care of oncology patients, what do you think of ?
- When talking about challenges, what positive and negative things that come to your mind? (Is there a difference between positive and negative challenges?)
- What constitutes a challenge for you as a nurse in oncology?

B. Identification of challenges :

- Can you describe what you find challenging in oncology?
- What are the main challenges in oncology today? or

  If there are no challenges; Why do you find that oncology nursing is not a challenge for you?
- Can you describe how they are challenges for you?
- Are your challenges different from those in other units or departments of this hospital? (Can you elaborate?)
- Are challenges you experience today the same as or different from those of 5 years ago. How are they different?
- Is working with oncology patients comparable to working with patients with different diagnosis? Does working in oncology present specific challenges? (Can you elaborate?)
- How would you rate or prioritize the challenges you have identified? [Q-sort was done in the 3rd interview].

C. Management of challenges:

- How do you handle or manage these challenges?
- What steps do you follow when you deal with challenges? (Process)
- Do you think RNs are affected by challenges when working with patients in oncology? (Can you elaborate?)
- In your 1st interview, you have described positive challenges such as ..., what impact have these challenges had on you? (2nd interview)
- You also described negative challenges such as ..., what impact have these challenges had on you? (2nd interview)

D. Elements helping to manage the challenges:

- What helps you to carry on your work with cancer patients? (If so, can you elaborate?)
- What do you see as limitations in your work with patients in oncology?
- Ideally, how would you like to see these limitations changed in order to make the job easier?
- Which of these things would be possible given the current situation?

E. Satisfaction with the management of challenges: (2nd interview)

- Have you ever thought of transferring from oncology to another area of nursing? (If yes, what lead you to think of making such a move?)
- If I were a new RN working here, what types of challenges would you want to prepare me for?
- For example, you talk about ..., how do you learn to meet challenges in oncology?
- In talking to some of the other participants in this study, they have told me about ... that they see as challenges. Some of these challenges seem to be common such as ... but you have not mentioned them. Can you tell me whether you have experienced them or not? (Can you elaborate?)

Characteristics of RNs

Code name: _____

Gender:

Male ___ Female: ___

Age range:

Less than 30 ___, 30-39 ___, 40-49 ___, 50-59 ___, more than 60 ___

Education (nursing):

Diploma ___

Baccalaureate ___

Certificate / diploma in nursing oncology ___

Master ___

Other (specify) _____

Work status:

Full time ___

Part-time ___

Job title:

Staff nurse ___

Charge nurse ___

Other (specify) _____

Year of graduation: 19___

Years of experience since graduation: ___

Years of experience in oncology: ___

Years of work in this institution: ___

Years of work in-patient unit: ___

Appendix B

Consent Form

Investigator:
Paul-André Gauthier, Ph.D. Candidate in Nursing, Faculty of Nursing, 3rd floor, CSB, University of Alberta, Edmonton, AB. Tel. xxx (office) E-Mail: gauthier@ualberta.ca
Supervisor at the University of Alberta, Edmonton:
Dr. Lillian Douglass, Ph.D. Supervisor & Associate Dean Nursing xxx (office) E-Mail: lillian.douglass@ualberta.ca

I, _____, am aware that the purpose of this research is to look at the challenges encountered by registered nurses working in oncology. In interviews, I will be asked to describe my experiences in as much detail as possible. I understand that Paul-André Gauthier is working under the supervision of Dr. Lillian Douglass, professor at the Faculty of Nursing, University of Alberta, in Edmonton.

I agree to participate in the study, and I am willing to share my experience with Paul-André Gauthier. I am aware that the interviews will be approximately 60 to 90 minutes in length and that they will be tape-recorded and then transcribed for later analysis. I understand that my participation in this research process is entirely voluntary and that I am free to withdraw at any time. If I choose to withdraw, any information about me and any data that I have provided will be destroyed.

I am aware that my identity, and that of any person(s) whom I mention, will be known only to Paul-André Gauthier and will not be revealed at any time. When transcribing the interview recordings, the researcher will use a pseudonym (i.e., a false name) for my name and for the name(s) of any other person(s) whom I mention. These pseudonyms will also be used in preparing the written report for the study. Any details in the interview recordings that might identify me or any person(s) whom I mention will also be changed during the transcription process. Paul-André Gauthier and a professional transcriber will be the only ones who will have access to the taped recordings, and once these interviews have been transcribed, Paul-André Gauthier's supervisor will have access to these transcripts in order to confirm the analysis that will be done. The tape recordings and the transcripts will be stored in a locked cabinet separate from the consent forms.

I am also aware that the information obtained from the interview will be used by Paul-André Gauthier for the purpose of his doctoral thesis and for the publication of the findings of his research.

Signature: _____
Dated at the city of _____, this day _____ of _____ 2000.
Signature of the researcher: _____

Information sheet for registered nurses

Investigator:
Paul-André Gauthier, Ph.D. Candidate in Nursing, Faculty of Nursing, 3rd floor, CSB, University of Alberta, Edmonton, AB. Tel. xxx (office) E-Mail: gauthier@ualberta.ca
Supervisory Committee Members at the University of Alberta, Edmonton:
1. Dr. Lillian Douglass, Ph.D. Supervisor & Associate Dean Nursing
E-Mail: lillian.douglass@ualberta.ca
2. Dr. Peggy Anne Field, Faculty of Nursing
3. Dr. Ceinwen Cumming, Faculty of Medicine, Oncology Department.

Title of the study:

"Challenges experienced by registered nurses when working with oncology clients."

Description of the study:

The purpose of this study is to identify challenges that RNs are encountering during their work with cancer patients.

Interviews are taped recorded and will last approximately 60 to 90 minutes. A maximum of three interviews either face-to-face at the work place or at a convenient location for you and/or by telephone will be done.

The data collected in this research is part of my Ph.D. research and studies at the University of Alberta. Afterward, the analysis of the data will be done and a graduate thesis will be written.

Benefits:

Taking part in this study will be of no direct benefit to you. The findings of this study, however, may be helpful to registered nurses to identify their educational needs and to understand the challenges encountered in oncology.

Risks:

There is no known risk associated with taking part in this study. Sharing personal information can make you uncomfortable. If the interview experience raises any concerns that you wish to discuss further with a counsellor, the researcher will be pleased to provide you with available professional resources in the community that you can contact for assistance.

Anonymity:

Access to the raw data (individual's transcripts) will be restricted to the researcher, the transcriber, and my Ph.D. supervisor. The study data will be kept for at least five years after the study is completed in a secure area accessible by only the research team. The names of participants and other details identifying them will be removed to protect their anonymity. An exception will be made when professional codes of ethics and or legislation require reporting. The participants will be asked to

Initials of the participant: _____

suggest the pseudonym they would like to be identified with in the study. When transcribing the interview recordings, the researcher will also use a pseudonym (i.e., a false name) for my name and for the name(s) of any other person(s) whom you mention. These pseudonyms will also be used in preparing the written report for the study. Any details in the interview recordings that might identify you or any person(s) whom you mention will also be changed during the transcription process. You are assured that anonymity will be respected by all persons involved in data collection and in the handling of transcripts and analysis of data. Excerpts from the transcriptions may be used in the reporting of the findings but the identity of participants will not be revealed in any way ensuring the protection of your anonymity.

Freedom to withdraw:

Participation in this study is entirely voluntary. You are free not to answer any questions. You can decide to withdraw from this study at any time without prejudice to yourself. Participating or not in this study will not affect your employment in any way. You will receive a copy of the information sheet and the consent form.

Observation will take place in the nursing units where RNs are working. The researcher will observe the work environment of RNs including the nursing station, their interactions with nursing colleagues and other health professionals and with the clients. The researcher will not be observing the nursing care given to clients as such. However in some instances, it may mean that the researcher may need to enter the client's room to observe nurses' interactions, then the nurse will seek the permission of the client, and his/her family if they are also present, to have the researcher come in and observe. If the client and/or family refuses, the researcher will not go in and observe. During the observation of the working environment, the registered nurses who do not want to be observed would be invited to inform the researcher.

Other:

If any secondary analysis is conducted with the study, further ethics approval will be sought first.

Any questions that you have about this study will be answered by the researcher so that you are able to understand what is expected during the research process. If you would like to be a participant in this study, please contact the researcher at 492-9044 (office) and leave a message with your telephone number and the time at which you can be called or contact me by e-mail: gauthier@ualberta.ca

Once the taped interviews have been typed, you will be given an opportunity to view your transcripts if you request it and add comments.

If you have any concerns about this study, please contact the Associate Dean of Research (Faculty of Nursing), University of Alberta at 780-492-6763.

Initials of the participant: _____

Consent Form Questionnaire

Part 1 (to be completed by the investigator):

Title of Project: What are the challenges experienced by nurses in oncology?

Principal Investigator: Paul-André Gauthier
Ph.D. Candidate, Faculty of Nursing, University of Alberta, Edmonton, AB.
Telephone: xxx (home).

Include Affiliations and phone number:
Dr. Lillian Douglass, Associate Dean (Faculty of Nursing) and PhD Supervisor
3rd Floor, Clinical Sciences Building, University of Alberta, Edmonton, AB. T6G 2G3
Telephone: xxx (office)

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Sheet? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and withdrawing will not affect your job status. Yes No

Has the issue of anonymity been explained to you? Yes No

Do you understand who will have access to the information that you have provided? Yes No

This study was explained to me by _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator	Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Appendix C

Poster

Would you like to talk about your experience as a registered nurse working in oncology?

If so, you may be interested in volunteering in my research study.

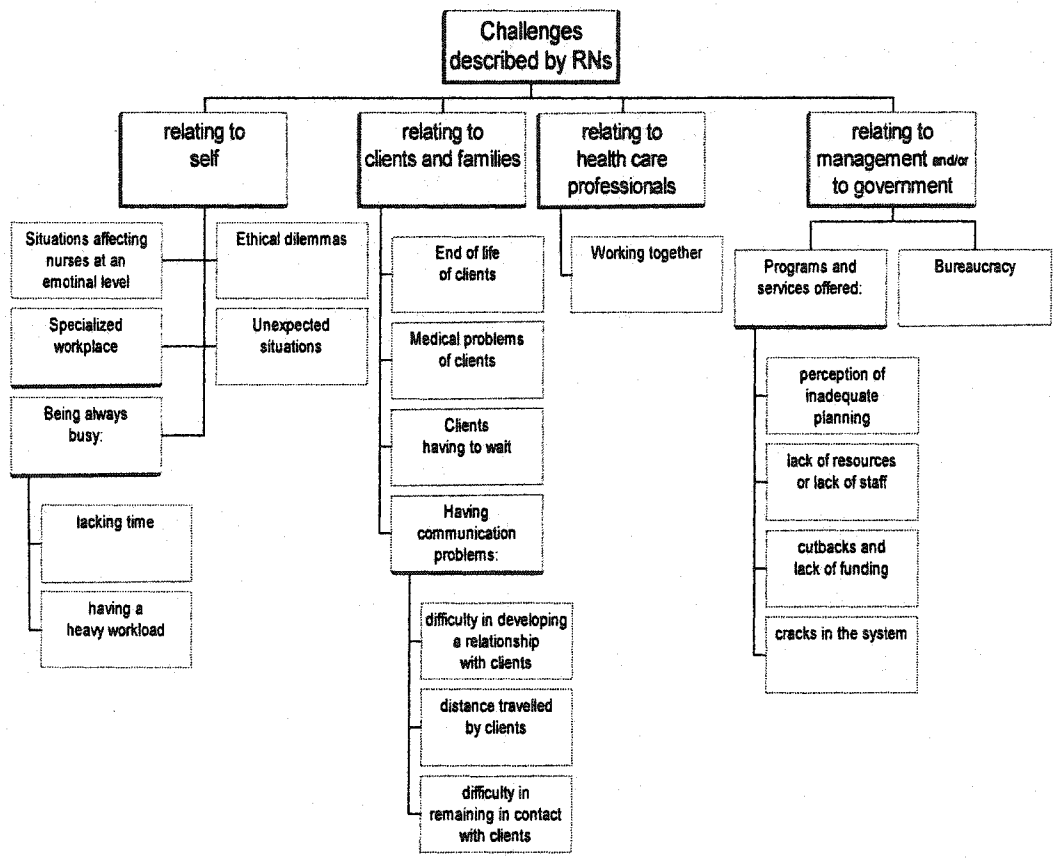
My name is Paul-André Gauthier. I have been working as a nurse over the last 20 years. I have been involved in various clinical settings such as medical, surgical, and palliative care units. As part of my doctoral studies in nursing at the University of Alberta, I am conducting a study to explore challenges that nurses encounter while working in oncology.

The oncology nurses involved in this study are asked to participate in a maximum of three interviews. Each interview may last approximately 60 to 90 minutes. The interview takes place at a location that is convenient to the nurse when off duty. Any details in the interview that might identify you or any person(s) whom you mention will be changed in order to ensure that anonymity is respected.

If you are interested and want to receive more information about this study, please call me at xxx or E-mail: andr321@yahoo.com and leave your phone number and name.

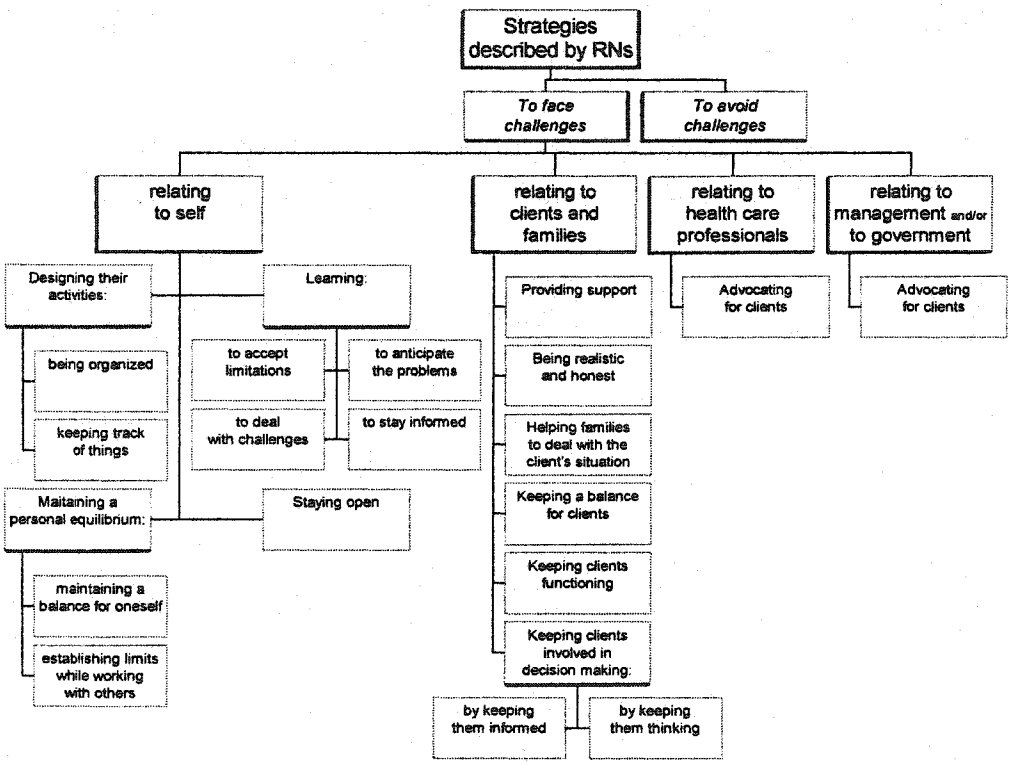
Appendix D

Challenges Identified by RNs Working in Oncology



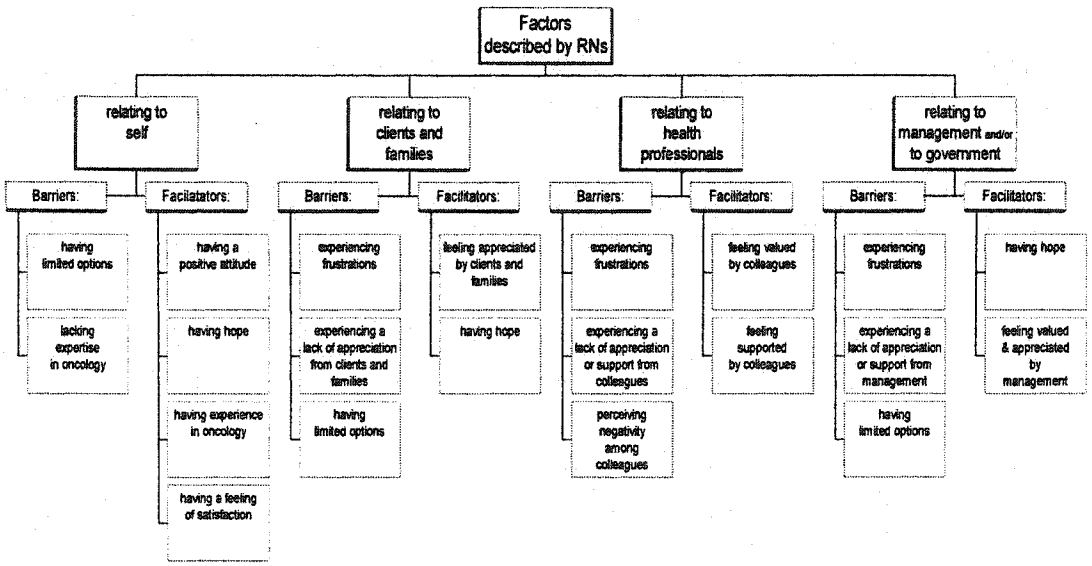
Appendix E

Strategies Identified by RNs Working in Oncology



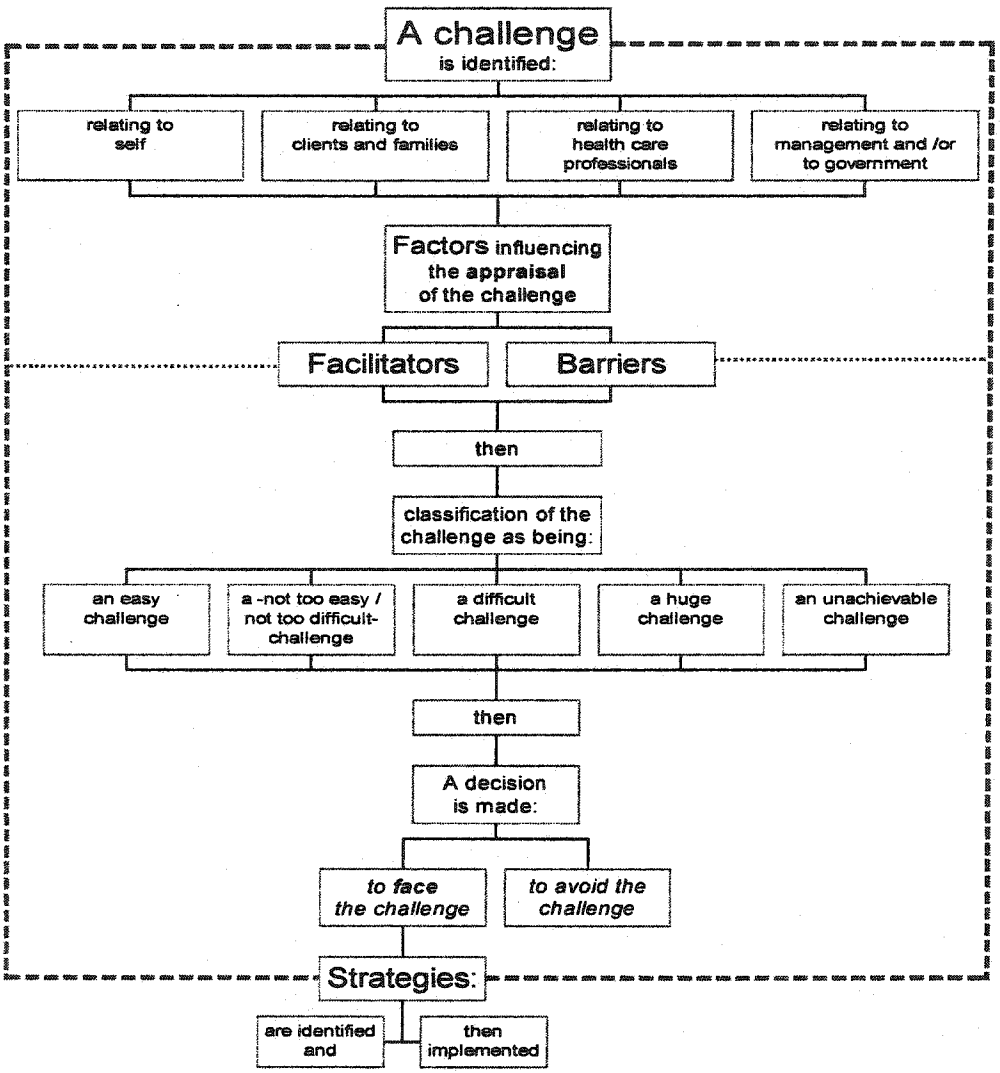
Appendix F

Factors Influencing RNs while Facing Challenges in Oncology



Appendix G

Approach Used by Oncology Nurses when Dealing with Challenges



Appendix H

Ethics Approval – HREB – University of Alberta

Health Research Ethics Board | biomedical research | health research

2J2.11 Walter Mackenzie Centre
University of Alberta, Edmonton, Alberta T6G 2R7
p.780.492.9724 f.780.492.7303
ethics@ualberta.ca

3-48 Corbett Hall, University of Alberta
Edmonton, Alberta T6G 2G4
p.780.492.0839 f.780.492.1626
ethics@ualberta.ca

UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date:	June 2000
Name(s) of Principal Investigator(s):	Mr. Paul-Andre Gauthier
Organization(s):	University of Alberta
Department:	Graduate Studies; Nursing
Project Title:	Challenges Experienced by Registered Nurses When Working with Oncology Clients

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the research participant information material and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

Karen Turpin

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-050600-NSG

University of Alberta | Capital Health | CARITAS HEALTH GROUP

Appendix I

Results of Positive-negative Classification

	Research Participants:		
Code:	Positive	Negative	Both
	RN #	RN #	RN #
Accept limitations	3, 5, 6, 7	4	1
Advocacy	1, 3, 4, 5, 6, 7		
Anticipate the problem	1, 2, 3, 4, 5, 6, 7		
Appreciative patient	1, 2, 3, 4, 5, 6, 7		
Be organized	1, 2, 3, 4, 5, 6, 7		
Being realistic with patient	1, 3, 5, 6, 7	2, 4,	
Bureaucracy		1, 2, 3, 4, 5, 6, 7	
Emotional level	1, 5, 6, 7	4	2, 3
End of life of patient		1, 2, 4, 5	3, 6, 7
Establish limits	2, 3, 4, 5, 6	1	7
Ethical dilemma	1	4, 5, 7	3, 6
Experience	1, 2, 3, 4, 5, 6, 7		
Feel valued	1, 2, 3, 4, 5, 6, 7		
Frustration		1, 2, 3, 4, 5, 6, 7	
Helping family to deal with patient	1, 2, 3, 4, 5		6, 7
Hope	1, 2, 3, 4, 5, 6, 7		
Keep a balance for patient	1, 2, 3, 4, 5, 6, 7		
Keep a balance for self	1, 2, 3, 4, 5, 6, 7		
Keep in contact with patient	2, 4, 5, 6, 7		1, 3
Keep patient functioning	1, 2, 3, 4, 5, 6, 7		
Keep patient informed	1, 2, 3, 4, 5, 6, 7		
Keep patient thinking	1, 2, 3, 4, 5, 6, 7		
Keep track of things	1, 2, 3, 4, 5, 6, 7		
Lack of appreciation	4	1, 2, 3, 5, 6, 7	
Learn to deal with challenges	1, 4, 5, 6, 7		3
Limits-always busy or heavy workload	6	1, 2, 3, 4, 5, 7	
Limits-cracks in the system		1, 2, 3, 4, 5, 6, 7	
Limits-cutbacks or lack of funding		1, 2, 3, 4, 5, 6, 7	
Limits-distance travelled by patient		1, 2, 3, 4, 5, 6, 7	
Limits-having to wait		1, 2, 3, 4, 5, 6, 7	
Lack of expertise		2, 3, 4, 5, 6, 7	1
Limits-lack of planning		1, 2, 3, 4, 5, 6, 7	
Limits-lack of resources or lack of staff		1, 2, 3, 4, 5, 6, 7	
Limits-lack of support		1, 2, 3, 4, 5, 6, 7	
Limits-lack of time		1, 2, 3, 4, 5, 6, 7	
Limits-working together	2, 4	1, 5, 7	3, 6
Medical problems	1, 6	2, 3, 4, 5	7
Negative situation		1, 2, 3, 4, 5, 6, 7	
No option		1, 2, 4, 5, 6, 7	3
Positive attitude of RN	1, 2, 3, 4, 5, 6, 7		
Provide support	1, 2, 3, 4, 5, 6, 7		
Satisfying for RN	1, 2, 3, 4, 5, 6, 7		
Specialized area of work	1, 2, 3, 4, 5, 6, 7		
Stay informed	1, 2, 3, 4, 5, 7		6
Stay open	1, 2, 3, 4, 5, 6, 7		
Support of colleagues	1, 2, 3, 4, 5, 6, 7		
The unexpected	2	4, 5, 6	1, 3, 7
Unable to develop a relationship		1, 2, 3, 4, 5, 6, 7	

Results of Five-item Classification (Q-Sort)

	Reseach Participants' classification					Not a challenge:		
Code:	an **easy** challenge	Challenge that is **not** too easy or not too difficult	A **difficult** challenge	A **huge** challenge	An unachie-vable challenge	Stategies used to deal with challenges:	What **makes** a challenge easier to deal with: (Buffer)	Not classified
	RN #	RN #	RN #	RN #	RN #	RN #	RN #	RN #
Accept limitations	6	1, 4, 7	2, 3, 5					
Advocacy	1, 3	2, 4, 5, 6, 7						
Anticipate the problem	2, 3, 4, 7	1, 5, 6						
Appreciative patient	3, 6, 7	5					1, 2, 4	
Be organized	5	3, 6				1, 2, 4, 5	1, 7	
Being realistic with patient	6	1, 3	2, 4, 5, 7					
Bureaucracy			2, 6	3, 4, 5, 7	1			
Emotional level		1, 2, 4, 6	3, 5, 7					
End of life of patient		1, 2, 3, 6	4, 5, 7					
Establish limits	2, 4	1, 7	3, 5, 6					
Ethical dilemma	1, 2		3, 4, 6	5, 7				
Experience	2, 7					1, 4, 5, 6	1, 3, 5, 6	
Feel valued							1, 2, 3, 4, 5, 6, 7	
Frustration	2		1, 3, 5, 7	4, 6				
Helping family to deal with patient	2	3, 6, 7	1	5		4		
Hope	3	2, 4, 7	5				1, 6	
Keep a balance for patient		2, 3, 4, 7	1, 5, 6					
Keep a balance for self	2	1, 7	3, 4	5, 6				
Keep in contact with patient	2, 4, 7	5	1, 3, 6					
Keep patient functioning		2, 3, 4, 5, 7	1, 6					
Keep patient informed	2, 3, 4, 6, 7	1, 5						
Keep patient thinking	3, 4, 7	1, 5	2, 6					
Keep track of things	4	2, 3, 5, 6, 7	1					
Lack of appreciation		2, 7		3				1, 4, 5, 6
Learn to deal with challenges	1, 3	2, 6, 7	4, 5					
Limits-always busy or heavy workload	6	2, 4	5, 7	1, 3				
Limits-cracks in the system			2, 4, 6	1, 3, 5, 7				
Limits-cutbacks or lack of funding			6	1, 4, 5, 7	2, 3			
Limits-distance travelled by patient	6		1, 2, 5, 7	3, 4				
Limits-having to wait	6		2, 3, 4, 5, 7	1				
Limits-lack of expertise	1, 2, 5	4, 7	3	6				
Limits-lack of planning		2, 4, 7	1, 6	5	3			
Limits-lack of resources or lack of staff			2, 4, 6, 7	1, 3, 5				
Limits-lack of support			1, 2, 5, 7	3, 4, 6				
Limits-lack of time		4, 7	1, 2, 5	3, 6				
Limits-working together	7	1, 2, 4, 5	3, 6					
Medical problems		1, 2, 6, 7	3, 4, 5	4				
Negative situation		1	3, 4, 6, 7	2	5			
No option		3	1, 2, 6, 7	4	5			
Positive attitude of RN	5, 7	3				1, 2, 6	1, 2, 4, 5	
Provide support	2, 6, 7	3, 4, 5	1					
Satisfying for RN	3, 5	4, 7					2, 5, 6	1
Specialized area of work	1, 2	4, 5, 6	7	3				
Stay informed	2, 5, 7	1, 4	3	6		5		
Stay open	1, 3, 6, 7		4			2, 5	5	
Support of colleagues	2	5	3			1, 6	4, 6, 7	
The unexpected		2, 3, 5, 6	1, 4, 7	4				
Unable to develop a relationship	1	5	3, 4	2, 6, 7				