THE EXPERIENTIAL WORLD OF THE ONCOLOGY NURSE

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ABSTRACT

In her[1] experiential world, the oncology nurse experiences unique, challenging and rewarding relationships in a multidimensional, dynamic way. The aim of this study was to describe, from her viewpoint and perspective, how she experiences and reacts to this world. Through this study the researcher wants the oncology nurse's voice to be heard, the richness of her story acknowledged and the derived data to be applied to the benefit of the field of oncology. In-depth, unstructured phenomenological interviews provided the saturated data from which the uniqueness of the world of the oncology nurse unfolded as the uniqueness of the oncology patients and their world emerged clearly. Findings show that the oncology nurse, attending to the cancer patients and their family, experiences many different relationships. The uniqueness of the oncology nurse-patient relationship is described as unlike any other nurse-patient relationship. The challenging interpersonal relationships with management and other members of the multiprofessional team, as experienced from the perspective of the oncology nurse, are also highlighted. Furthermore, a unifying intrapersonal relationship with the self was identified. This enables the oncology nurse to be both on the giving and receiving end of the intensely emotional environment she works in, explaining, at least partly, the high job satisfaction that permeated the interviews in this study. Recommendations for nursing practice, education and research were formulated.

OPSOMMING

In haar leefwêreld ondervind onkologieverpleegkundige unieke, uitdagende en belonende verhoudinge op 'n multidimensionele en dinamiese wyse. Die doel van hierdie studie was om 'n beskrywing van die onkologieverpleegkundige se ervarings van en reaksie op haar leefwêreld vanuit haar oogpunt en perspektief. Deur middel van hierdie studie wil die navorser die stem van die onkologieverpleegkundige gehoor laat word, die rykdom van haar verhaal erken en die verkrëe data toepas tot voordeel van die onkologieveld. In-diepte, ongestruktureerde fenomenologiese onderhoude het die versadigde data verskaf waaruit die unieke eienskappe van die onkologieverpleegkundige se wêreld ontvou het soos wat die uniekheid van onkologiepasiënte en hulle wêreld duidelik na vore getree het. Die resultate toon dat die onkologieverpleegkundige wat na die kankerpasiënte en hulle familie omsien, 'n verskeidenheid verhoudinge ervaar. Die unieke aard van die verhouding tussen die onkologiepasiënt en die verpleegkundige word beskryf as anders as enige ander pasiënt-verpleegkundigeverhouding. Die uitdagende interpersoonlike verhoudinge met bestuur en ander lede van die multiprofessionele span, soos ervaar deur die onkologieverpleegkundige, word ook uitgelig. Voorts is 'n unieke, saambindende intrapersoonlike verhouding met die self ook geïdentifiseer. Hierdie verhoudinge

stel onkologieverpleegkundiges daartoe in staat om beide te gee én te ontvang in hierdie intens emosionele wêreld waarin hul werk. Die hoë werksbevrediging wat uit die onderhoude na vore gekom het, word ten minste gedeeltelik deur hierdie verhoudinge verklaar. Aanbevelings ten opsigte van verpleegpraktyk, onderrig en navorsing is geformuleer.

[1] The feminine gender is used at times in this article to refer to the oncology nurse. It is acknowledged, however, that there are both male and female oncology nurses.

INTRODUCTION AND BACKGROUND

The National Cancer Registry estimates that one in four South Africans will develop cancer in their lifetime (Fördelmann, 2001:2). The percentage increase in cancer deaths in South Africa since 2000 is estimated at between 50 and 75% (Global Action Against Cancer, 2003:7). The vast majority of nurses, in all practice settings, will feel the impact of the disease personally and/or professionally at some time during their career (Otto, 1997:xii). The trained cancer nurse has a key role to play in the incidence of certain cancers with regard to their prevention and early detection. Major ongoing advances in both diagnostic and treatment modalities have changed the face of cancer and cancer care dramatically. The oncology nurse is further challenged by the fact that every cancer case is different, every type of cancer is different and the course of every cancer illness is different from every other. Now, more than ever, with all the changing practices in cancer care, compassionate, competent and conscientious nursing care is a basic right of cancer patients and their families alike.

Nurses in oncology, more than any other field, recognise the potential for discovering and giving; the recognition that an important dimension of being human is the lasting dignity and growth that can continue throughout the weakness and losses that often accompany cancer. The nurses, in their skilled competence and compassion, are uniquely placed to impart this essential message to each person, namely that people matter because they are who they are and they matter to the last moment of their life. These nurses do all they can to help oncology patients, not only to die peacefully, but to live until the very moment they die (Saunders, 1976:1004).

The multifactorial effects of cancer have a serious impact on the psychological wellbeing of the oncology patient. For oncology nurses who want to render holistic care to patients and their family, these have important implications. Consequently, it is evident that professionals working with cancer patients will need the necessary knowledge and skills to acknowledge and explore patients' feelings if they want to be able to give them the reassurance and care they need. Against this background, the unique role of the oncology nurse emerges clearly. It is obvious that significant demands are placed on her skills, knowledge and emotional resources.

Nash (1989:37) wrote there are few more stressful areas in nursing than the care of the oncology patient, whatever the phase of his/her treatment. Despite this observation made 18 years ago, there remains a dearth of research regarding the actual experiences of oncology nurses. This study is an attempt to address this urgent need, as the researcher explored and described the experiential world of the oncology nurse in an inpatient oncology unit at a private hospital in the Western Cape.

PROBLEM STATEMENT

Existing literature reveals clearly that the oncology nurse is subjected to unique challenges, demands and expectations. The researcher, according to her personal experience, has also found that nurses seldom have neutral feelings about oncology. The people who choose to work in this field are usually passionate about their work. On the other hand, people who are forced to work in this field, for example students or relief-staff, often experience discomfort and express extreme dislike for working in oncology. When discussing areas of speciality, few areas (if any) evoke such strong opinions, both positive and negative, as that of oncology.

It is evident that, in providing for the unique needs of cancer patients and their family, a broad variety of experiences and feelings can be encountered ranging from extremely stressful to extremely rewarding and from

extremely sad to extremely fulfilling. These experiences, and how oncology nurses cope with them, are illuminated in the interviews and their analysis.

In order to highlight the above problem statement, the researcher formulated the following research question: *What are the oncology nurses' lived experiences in a private oncology unit?*

The objective of this study was to accurately describe the lived experiences of the participating oncology nurses based on the identified themes as they emerged from the research interviews.

RESEARCH DESIGN AND METHODOLOGY

This study was based on a qualitative, explorative, descriptive and contextual research design and grounded in a phenomenological approach to inquiry.

Qualitative methods of research permitted the researcher to study selected issues regarding the experiential world of the oncology nurse in depth and detail. The researcher's background in oncology nursing increased her ability to be involved in the actual experiences of the participants and to have a substantial understanding of them and their physical world, as required by qualitative research (Creswell, 2003:181).

Explorative research into the experiential world of oncology nurses gave insight into the dimensions of the phenomenon, the manner in which it is manifested and other factors with which it is in dynamic interaction. A purposive sample enabled the researcher to analyse insight-stimulating examples, a typical characteristic of explorative research, together with the fact that the people studied all had practical experience of the chosen research phenomenon (Babbie & Mouton, 2001:80). New insights into the topic of research were thus obtained.

This study emphasised the in-depth description of a specific group of people and their experiences, namely oncology nurses and their experiential world. This world was described accurately in order to give a voice to the stories of these nurses. Interviews, which are one of the methods usually used in descriptive research, provided the researcher with accurate, intimate information, which was analysed to identify the emerging themes. A phenomenological researcher seeks to describe the meaning of lived experiences for several individuals with regard to a certain phenomenon. The phenomenological approach is, thus, primarily an attempt to understand empirical matters from the perspective of those being studied (Creswell, 1998:275).

Contextualism was acknowledged, as human behaviour does not occur in a vacuum. It is necessary to provide a comprehensive description and analysis of the environment or social context of the participants (Struwig & Stead, 2001:12). This study took place within the context of an oncology ward in a private hospital in the Western Cape. This ward only accommodates patients suffering from cancer, but who may be admitted for several different reasons, for example:

- treatment regimes that cannot be administered in an outpatient clinic;
- treatment of side effects that need supporting therapy that cannot be administered at home;
- diagnostic or staging tests and examinations;
- symptom control; and
- terminal care.

A non-probability, purposive sampling procedure was used in choosing participants for this study. Purposive sampling is concerned with providing a sample of information-rich participants (Struwig & Stead, 2001:122). As the purpose of this study was to understand the world as experienced by a very specific group of people, the very specific, although small, sample was sufficient (Kvale, 1996:102). When gathered data no longer yielded new insights and data saturation was reached after six interviews, sampling was stopped. Redundancy was thus the primary criterion for determining sample size (Patton, 2002:246).

The focus of the study, which was to explore the experiences encountered by nurses working in an oncology unit, guided the selection of the participants. All of the participants were, at the time of the research, working full time in the specified oncology unit. Four registered and two enrolled nurses were interviewed. The sample can be seen as homogeneous as it involved individuals who belonged to the same substructure, namely an oncology unit in a private hospital (Holloway & Wheeler, 2002:122).

In-depth, unstructured interviews were used as the data collection method, since a comprehensive description of what it is like to work in an oncology unit was the aim of the study. By using such interviews, the researcher managed to identify the essence of the human experiences, as described by the participants in this study (Creswell, 2003:15). These interviews provided a complex and holistic picture, painted by participants in their own words, seen through their own eyes and experienced by their own beings. Participants were informed about the aim of the study, the voluntary and confidential nature of their participation, as well as of the possible benefits and outcome of the study. Permission to do this study and, more specifically for conducting the interviews, was granted by all relevant authorities and informed consent was signed by all participants. Normal ethical considerations, such as informed consent, no deception, right to withdraw, confidentiality, principle of beneficence and principle of justice, were maintained throughout the study to protect participants from harm.

Although a predetermined, general opening question was posed to each participant, they were all given the opportunity, and encouraged, to discuss issues beyond the confines of the question (Struwig & Stead, 2001:98).

The following opening question was used in all the interviews: "*I would like you to tell me how you really experience it to work in this oncology unit*".

This question yielded rich, spontaneous descriptions of the phenomenon being investigated. To keep the interviews focused on the research question, the researcher used the following subquestion if the necessary information was not volunteered: "*How would you like to be prepared and/or supported to enable you to render optimal nursing care to the oncology patient and his family*?"

Data analysis was done using Tesch's method (Creswell, 2003:190-197) of reducing data into themes or categories. The researcher, with the help of an independent coder, then organised and brought meaning to the raw data. The potential risk of oversubjectivity on the part of the researcher did not pose any problems as the independent coder identified themes similar to those identified by the researcher.

The broad principles provided by Yardley (2000:215-218) were used to assess trustworthiness in this study. The value of Yardley's model is derived from the following two characteristics of the model: firstly, the suggested criteria are wide-ranging and offer a range of ways of establishing quality; secondly, the criteria can be applied irrespective of the particular theoretical orientation of the qualitative study (Smith, 2003:232). In accordance with an acknowledgement of the diversity of qualitative methodologies, the suggested criteria are not in the form of rigid rules or prescriptions, but are open to flexible interpretations. The following broad principles, as suggested by Yardley (2000:232), were adhered to:

Sensitivity to context was demonstrated by the following:

- **An awareness of existing literature:** The findings of the study were placed within the context of the limited literature available on the topic of investigation.
- **The degree to which the study is sensitive to the data itself:** This was demonstrated by the manner in which the unfolding essence of the experiences of oncology nurses was derived purely from the data drawn from participants.
- **The influence of the study's socio-cultural milieu on its conduct and outcome:** The context, being that of a specified oncology unit, was described earlier. The experiences of the participating nurses were described within that socio-cultural setting and understood against that background.
- **The relationship between investigator and participants:** Sensitivity to the linguistic and dialogic context of each utterance was seen as crucial to interpreting its meaning and function.

Commitment, rigor, coherence and transparency

- Commitment was ensured because of the researcher's prolonged engagement with the topic, immersion in the data and the development of competence and skill in the methods used.
- Rigor was reached by obtaining saturated data, triangulation of data collection and the use of an independent coder.
- Coherence was maintained because the phenomenological analysis provided a consistent and complete descriptive answer to the research

question.

- Transparency was evident in that all relevant aspects of the research process were disclosed.

DISCUSSION OF FINDINGS

The oncology nurse, attending to cancer patients and their family, experiences many different relationships. The uniqueness of these relationships involves not only challenges, but also rewards. As nursing is an interpersonal event, both nurse and patient engage in a dynamic relationship of mutual impact. Participants described the uniqueness of this relationship as unlike any other nurse-patient relationship. The challenging, interpersonal relationships with management and members of the multiprofessional team, as experienced from the perspective of the oncology nurse, were highlighted. The interviews also identified a unique, unifying intrapersonal relationship with the self. This enabled the nurses to be both on the giving and receiving end of the intensely emotional environment in which they work. The identified central theme and subthemes are presented in Table 1.

The participants in this study shared many different experiences, both positive and negative, but one central theme permeated them all. Without exception, all of the participants experienced the relationships in the field of oncology nursing as unique, challenging and hugely rewarding. Difficulties and frustrations that they

Table 1: Identified themes related to the experiences of the oncology nurse

Central theme	Subthemes
In their experiential world, oncology nurses experience unique, challenging and rewarding relationships in a dynamic, multidimensional way.	1. Oncology nurses experience the relationship with their patients unlike the relationship with any other patient because of the: • uniqueness of the oncology patient; • intense, long duration of the nurse-patient relationship; and • close involvement with the family of the oncology patient. 2. Oncology nurses are faced with special challenges in their relationship with: • members of the multiprofessional team; • the physical environment of the oncology unit; and • management, based on a need for recognition of oncology as a specialised field. 3. Oncology nurses' intrapersonal relationships are grounded in a unique personal and nursing philosophy, which provides the cornerstone for the manifestation of their: • ability to accept the concept of death as a normal process of life; • ability to deal with personal issues of life and intense emotional experiences; • personal growth and inner peace; and • awareness of a need and effort to live each day meaningfully.

encountered were dealt and coped with, because of the fulfilment they experienced in their relationships with their patients. A participant expressed this feeling of fulfilment as follows: "*That which I do for my oncology patients is a need deep from within my heart. When I go home at night, I want to say to myself that I have given my patients a 100%. Then I have job satisfaction*".

Since this experience of satisfaction and fulfilment is so pervasive throughout all of the transcripts and is inextricably linked to all the other themes, it is of the utmost importance to view the identified themes against this background.

CENTRAL THEME: IN THEIR EXPERIENTIAL WORLD, ONCOLOGY NURSES EXPERIENCE UNIQUE, CHALLENGING AND REWARDING RELATIONSHIPS IN A DYNAMIC, MULTIDIMENSIONAL WAY

During discussions between the study supervisors, the independent coder and the researcher, the many different experiences that were shared by the participants were summarised, as set out in the above central theme. These experiences can be related to the many different relationships encountered in this unique world. Fitch (*in* Sevean, 2003:10) contends that quality of life is an important dimension of cancer care and much of the satisfaction that oncology nurses experience in their practice emerges from matters related to attending to quality of care issues. One participant verbalised this as follows: "*It is not important for me to say the patient must live for another 2 years. It is important for me that the patient has still got a week to live, but it is the quality I give him during that week! And that is where my satisfaction lies*".

When the researcher asked the same participant later during the interview whether she experienced most of her patients' disease, and often death, as a positive process, she answered as follows: "*Oh, definitely. We recently had a number of very anxious patients. And for me there is nothing that equals seeing that patient peaceful and calm, his family with him and him being supported and at peace".*

The identified subthemes clearly reveal that the experiences in the field of oncology nursing are not always positive. Feelings of intense sadness, frustration, exhaustion, helplessness and lack of support and understanding, especially from management, were reported frequently by the participants. What is it, then, that makes the field of oncology nursing so unique as to enable these nurses to experience such a high degree of job satisfaction in spite of the negative emotions that they encounter there? What constitutes these unique, challenging and rewarding relationships, as identified as the main theme?

Satisfaction and good mental health are seen as more than passive contentment with the status quo. The healthy person aspires to better himself/herself and makes active efforts to achieve this (Newell, 1995:96). Need theories, like those of Maslow and Herzberg, consider what motivates human behaviour and emphasise a healthy person's need for, amongst other things, job satisfaction. Herzberg (*in* Newell, 1995:97) suggests that the features of work that determine motivation are aspects that enable the individual to grow psychologically. He calls these factors motivators. Motivators are intrinsic features of the job that give the person a feeling of achievement, responsibility and recognition, and these allow scope for personal growth.

If Herzberg's two-factor theory is to be believed, then the intrinsic features of the oncology field must enable the nurses who work there to grow psychologically. However, all of the participants shared a sense of lack of recognition by management, a factor, according to Herzberg, necessary to allow scope for personal growth. In spite of this important need not being met, strong evidence of personal growth was found in all participants. One participant described it as a "*very personal journey with incredible emotional enrichment*" and as an "*unbelievable spiritual road*". Another participant saw the personal growth potential in experiences of pain and loss in the following light: "*It is a pruning thing. You must be pruned to be able to grow. But sometimes you feel you have been pruned enough now, you don't want to grow anymore. And other times you are so enriched by it that you think, wow, I am actually in a situation that benefits me*".

It seems, therefore, that the uniqueness of the field of oncology promotes personal growth and feelings of job satisfaction, even in the absence of certain supposed prerequisites. "*The care for my oncology patient is a*

bigger priority to me than the routine or structure of the ward set-up. And that is sometimes problematic because there is no understanding for that from higher up".

Because of a shortage of staff, the necessary resources to deal with the demands of the oncology environment are very often not available. Every single participant felt very strongly about management's lack of insight into the unique demands of the oncology patient, leading to insufficient staff allocation based on numbers alone. "*It is only numbers that matters, nothing else. They [management] have no idea of the intensity of care that these patients need. But I understand this is a business and they must show profit*".

It appears, nevertheless, that the participants experienced a high degree of meaningfulness. The demands posed by the oncology environment are seen as challenges worthy of being taken up. One participant reflected on how she coped with the perceived lack of support and recognition from management: "*But in the end, the only thing that matters for me is that I don't do it for the hospital, I don't do it for the charge-sister, I do it for my patient. You get recognition from your patient and his family. And that is enough for me*".

The results of a meta-analysis study by Blegen (1993:39), which considered over 200 published and 50 unpublished studies on job satisfaction experienced by nurses, indicated that job satisfaction for nurses is most strongly related to stress (negatively) and commitment to the organisation (positively). The previous quote clearly reveals that oncology nurses experience job satisfaction as a result of their commitment to their patient, even in the total absence of commitment to the organisation. It seems, thus, that the oncology setting exhibits unique characteristics that explain job satisfaction in terms that differ significantly from those applicable to the nursing profession in general.

Oncology nurses are clearly faced with a unique world with which they seem to be dealing in a way that is not explained by most existing models and theories, especially those explaining job satisfaction or dissatisfaction.

Subtheme 1: Oncology nurses experience the relationship with their cancer patients unlike the relationship with any other patient.

There are several reasons for this.

1.1 Uniqueness of the oncology patient

Many participants explained that the specific needs of the oncology patient provide them with a unique opportunity to be there for the patient, to really make a difference. Not only the needs but also the characteristics of the oncology patient are unique, as reflected in the following comment: "*Cancer patients are special people in the first place. They radiate a different passion and the needs of a cancer patient are definitely bigger than those of ordinary patients, the needs are totally different. They don't ask for a thing, but you know, you know the need is there. The oncology patient asks less than the ordinary patient. But you, as a person, know their needs because you have a passion for them*".

Studies by Lamkin, Rosiak, Bauerhaus, Mallory and Williams (2001:1548), Sand (2003:177) and Miller (2001:383), amongst others, all support the notion that the uniqueness of the oncology patient allows for greater job satisfaction. This closeness in the oncology patient-nurse relationship, with the intense needs of the patients on the one hand and the passion and empathy of the oncology nurse for her patients on the other, seems to at least partly explain the high level of satisfaction.

1.2 Intense, long duration of the nurse-patient relationship

The period of intense contact with the patient and his/her family stretches over weeks, months and sometimes even years. All participants commented on this truly unique characteristic and its impact. One participant, in particular, commented: "*You know, in other wards, people come in and they go home and they forget about you. Our people don't forget about us … they always come back, the patients and their families. Then you feel happy to work there because you can mean something in someone's life and you can see you are being appreciated*".

It became clear that it is not only the long-term relationship with the patient and family during the course of the illness that is valued. The continued contact with

family members of the deceased, long after his/her death, is seen as something almost sacred. Many touching stories of this continued contact with bereaved family members were shared.

The long road of cancer holds many crises, including the initial devastating diagnosis, the treatment with its side effects, the relapses, facing death and many physical, emotional and spiritual crises. The oncology personnel share all the ups and downs with the patient and family while they travel the cancer road. Very often the sharing is of an intense, deeply emotional and/or spiritual kind. Staff and patients become like family. *"Somebody said the other day, but patients die in other wards too. But these patients in the oncology ward become like family, like family of the personnel because they come in and out, in and out*".

Because of this close bond between staff members and patients, the unique need for continuity becomes apparent. The newly diagnosed cancer patient is often in a state of bewilderment and emotional turmoil. An empathic and compassionate nurse, who deals with the patient at that crucial stage, can have a deep and lasting impact on that patient's life. Whenever he/she comes back to the ward, he/she will look for that specific nurse. There is, thus, in the oncology environment an extraordinary need for continuity and stability with regard to specific staff members. As one participant put it: "*They [oncology patients] need stability; they want to go where somebody knows their name*".

Statistics and numerous studies, however, suggest that there is not only a serious shortage of oncology trained nurses, but that retaining such nurses also poses significant challenges (Lamkin *et al*., 2001:1550; Malan, 2004:19; Sevean, 2003:10.)

1.3 Involvement with the family of the oncology patient

In the oncology ward the situation regarding family members is quite different from that in any other ward. Family members are allowed in the ward 24 hours a day and are actually welcomed and encouraged to be as involved with the patient as possible.

One participant verbalised this close contact with families and what it meant to her: "*Yes, one has much more intense contact [with the family]. And one sees it with families coming back after the patient has passed away, they come back, they bring flowers, [and] they come to see how we are. I mean, every day a family member of a deceased walks in that ward. I cannot tell you how unbelievable that is for me!*"

In the life-shattering event of being faced by a terminal illness, relationships of trust and openness are needed. The oncology nurse not only has to allow for those relationships to be enjoyed in an unrestricted way, but must also actively encourage and facilitate such relationships. A good relationship with the family enables the nurse to provide better nursing care to the patient. This was expressed in numerous ways: "*For me it is hugely important to build a relationship of trust with the family, because in that way you can learn what is important to the patient. And in that way you can give so much better care. Some patients like for instance soft music – then you can play music*".

Because of long-term, intimate contact, nurse, patient and family get to know one another well. The nurse, who is visibly engaged in caring activities around the ward all day, is also perceived as an easier person to approach with problems than other members of the medical team who 'enter the ward from outside'. Because of this the nurse is very often the one who has to relay bad news received by a patient to the rest of the family. One participant reflected on this as follows: "*The message often doesn't sink in the first time. Then it has to be relayed a second time. And then you are the one to relay the message. And that is very stressful … uhm … sometimes I come to work with a headache and I go home with a headache and I wake up in the middle of the night and I think about them*".

Subtheme 2: Oncology nurses are faced with special challenges in their relationships

These relationships are with the parties and/or elements mentioned below.

2.1 Multidisciplinary team

With a few exceptions, the overall experience of the participants was one of very satisfactory relationships with the different members of the multiprofessional team and they were very aware of the benefits a multiprofessional team approach holds for their pa-

tients.

Through the interviews it became clear that the participants in that specific oncology unit experienced very positive interpersonal relationships with the oncologists, in particular. These doctors made them feel valued and comfortable with regard to sharing ideas and information. Although all participants mentioned the "open relationship" they had with the doctors, the doctors' own needs did sometimes place extra demands on the oncology nurses. The oncology nurses surveyed felt a responsibility to support and sometimes protect the doctors.

One difficult issue that was often mentioned was the lack of open communication between doctors and families, especially with regard to the seriousness of a patient's condition. Very often this lack of open communication was, in fact, a case of bad news that just did not 'sink in'; but it still left the oncology nurse with the predicament of conveying the bad news. "*Sometimes it is quite difficult for me to convey that message. It happens, sometimes, that they weren't informed. But there are times when you were present when the doctor told them, but it didn't sink in. Then the message has to be conveyed for a second time and then you are the one to do that. And that is very stressful*".

With regard to fellow nursing colleagues, both positive and negative experiences were shared. As with doctors, the lack of opportunities for open communication, sharing of ideas, thoughts, concerns, suggestions and patient details were seen as important and almost all of the participants referred to these.

Some of the positive aspects mentioned about relationships between nursing colleagues were:

- team members supporting one another;
- sharing a passion for the oncology patient;
- being finely attuned to one another's needs and emotions; and
- understanding one another's emotional needs in spite of personality differences.

On the negative side, the following were mentioned:

- Lack of loyalty and confidentiality.
- Fear of showing vulnerability to one another.
- Little belief in potential for things to change.

Numerous studies show the positive implications of peer support, both among nursing students, as well as more broadly (Carlson, 2002:53-55; Davis & Thorburn, 1999:16-23). It is clear that, although participants found the various members of the multiprofessional team very helpful and readily available, there is considerable scope for improved team functioning.

2.2 The physical environment of the oncology unit

Five out of the six participants expressed the need to have a separate rest area or tearoom where they could experience peace and quiet while 'recharging their batteries'. The hustle and bustle of the general tearoom was very often totally unacceptable for the emotionally drained oncology nurse. One participant shared: "*When I go for tea or lunch, I don't want to talk to people. I normally look for the furthest corner. You wish you had a kind of a 'safe' place to get yourself together again. But there's nowhere …*".

Another aspect of the physical environment that contributed to stress for the oncology nurse was the isolation area for patients on radioactive iodine. In sharp contrast with their normal high level of physical and emotional involvement, oncology nurses are forced to have minimal contact with radioactive patients. A participant expressed this as follows: "*It is bad for me; I feel I did not care for that patient, because you cannot get emotionally involved at all*".

Here, the experiential world of the oncology nurse exemplifies the conflicts that the physical world of oncology can impose on the people living and functioning within it. The oncology nurse experienced conflict between what she wanted to do for her patient, and what she was actually able to do.

2.3 Management, based on a need for recognition of oncology as a specialised field

Without exception, all participants expressed strong feelings of dissatisfaction with the lack of support and understanding from management, who they perceived as having very little or no true understanding of the uniqueness of the oncology environment. Issues around management were by far the most frequently reported topic during the interviews. This perceived lack of support and recognition results in staff experiencing feelings of powerlessness, frustration and despondency

about potential for change. "*Management sees only numbers on paper – that's all that makes sense. They think it's only eight patients, but they cannot understand it feels like forty*".

The perception that management looked at numbers without any insight into the emotional issues concerning staff or the emotional and/or physical needs of the patients was shared again and again by all participants. The following quote encapsulates a very specific, emotional issue shared by two nurses: "*The road you walk with your patient is very often a long one – even two to three years. When that patient dies, it has a huge emotional impact on you. And what you then get from management's side is that it's one statistical number less, the patient load in the ward is lighter, so you are sent out to work in another ward! It works terribly on me!*"

All participants felt that the everyday load in the oncology unit, where death and dying is part of the daily functioning in some way, is hugely underestimated by management.

In the third group of subthemes, the personal characteristics and relationship with the self, as portrayed and shared by the participants, are explored and described.

Subtheme 3: Oncology nurses' intrapersonal relationships are grounded in a unique personal and nursing philosophy, which provides the cornerstone for the manifestation of certain abilities

Most participants stated that oncology nurses are born; some skills can be learnt, but the passion that makes a nurse an oncology nurse cannot be taught. One participant described this 'passion' as follows: "*This passion for oncology, I don't think it can be acquired. You are either an oncology nurse or you are not. We oncology personnel don't get used to sick and dying patients, but you start to deal with death and the disease*".

It is sometimes said, "*You are what you do*". Considering the previous quote, it would indeed appear that oncology nurses do what they do because of who they are. Of all the things people do, their work probably defines them, their life goals and their relationships with other people most clearly. Oncology nurses truly love their work and numerous participants referred to how much they had gained, grown and learnt through association with their patients. The work of the oncology nurse, rather than being separate from her being, flows from her being, while her being is also formed, moulded and enhanced by it. On the one hand, her life philosophy determines how she does her work, while on the other her life philosophy is a product of her work experience.

3.1 Ability to accept the concept of death as a normal process of life

Dealing with people can be very demanding. It takes a lot of energy to be calm in the midst of crisis, to be patient in the face of frustration, to be understanding and compassionate when surrounded by fear, pain, anger or grief. While most people can find the energy to do this occasionally, and some people have the resources to do it often, it is very hard to do it all the time. And yet, 'all the time' is what is expected from oncology nurses. What in the oncology nurse's being enables her to function in this environment?

Although many nurses rate talking with a dying patient as one of their most difficult tasks (Earl, Argondizzo & Kutscher, 1976:5), all of the participants in this study seemed to have a comfortable acceptance of death as part of the normal process of life. This acceptance of, and comfort with, death is embodied in their life and nursing philosophies and was clearly expressed in various ways: "*You don't get used to the dying patient, but you start to deal with death …, you start understanding it, uhm …, you start developing as a person in that situation, but there are times where you feel helpless*".

Although all participants displayed great sensitivity towards the different religious orientations of their patients, their own religious beliefs played a significant role in their handling of the death concept. One participant verbalised the effect of faith in her acceptance of death as follows: "*The process of death is a natural thing to me. Sometimes I get very sad, get tears in my eyes. But God has put me there. You feel as if you were put there, you are only a bridge between God and the patient. And it gives me satisfaction and it is a privilege to be so close to people*".

Through the interviews it became clear that oncology nurses' personal philosophies help them to accept the

concept of death as a natural phenomenon, thereby enabling them to assist the cancer patient and their family to also accept and deal with the prospect of death.

3.2 Ability to deal with personal issues of life and intense emotional experiences

Effective ways of living their demanding lives, being at peace with the concept of death, plus managing to deal with emotional issues are all needed to enable oncology nurses to really be there for their cancer patients in a holistic manner. Most participants reported managing effectively to leave 'home at home' when they came to work, although they found it more difficult to leave 'work at work' when they went home. One participant stated: "*It's difficult sometimes. After a difficult day you feel like crying, but you have to keep your pose at home*".

It became clear during the interviews that the way in which these nurses cope with all the intense emotional experiences they have is intricately interwoven with their life philosophy in general and their nursing philosophy more specifically. Even the people with whom they are in close contact learn to see life differently.

The value of peer support in reducing occupational stress experienced by nurses has been documented extensively in literature. Results of most of these studies indicate that, regardless of the level of work stress, nurses who had, and were satisfied with, their support experienced less stress and burnout than those nurses without support or who were not satisfied with their support (Davis & Thorburn, 1999:17).

The role of religion in forming a philosophy about death has already been described. Religion also plays an important role in helping nurses to cope with everyday issues and intense emotional experiences. Regarding a question about spiritual wrestling with God concerning, for example, the death of a teenager, a participant responded as follows: "*To work here make me more mature, deeper. It makes you grateful for your health and makes you realise life is precious and you have to ensure that your spiritual life is in order*".

Apart from the life philosophy and support from partners and family, many other ways of coping were shared with the researcher, which all seemed to work for these nurses, but which will not be mentioned here.

Two very important, but unmet needs, which were voiced by most of the participants, were to have their own rest area or "quiet place of safety" and the need for regular debriefing/counselling sessions. All participants felt that the general tearoom did not provide the kind of environment needed to rest, 'recharge their batteries' or regain control. It was suggested by participants that debriefing or counselling sessions should:

- be held on a regular basis;
- be handled by an outside counsellor; and
- be organised within job categories.

The mature and unique way of seeing and coping with life and death, coupled with the way in which they view their oncology patients, seems to enable oncology nurses to cope in the very stressful environment in which they function. Extensive studies by Hinds, Sanders, Srivastava, Hickey, Jayawardene and Milligan (1998:1146-1157) support this study's finding that the field of oncology manifests its own multifaceted structure and dynamics, which do not lend themselves to easy description or explanation by using any of the existing models.

3.3 Personal growth and inner peace

In this study, it was noted how oncology nurses, in spite of the absence of certain of Herzberg's motivators or supposed prerequisites, still managed to experience high levels of job satisfaction, as well as personal growth and inner peace (*in* Newell, 1995:96-99). The latter seemed to be a product of these nurses' personal attitude to life and death on the one hand and what they gained from their patients on the other. The following utterances testify to this:

"*I think, through the years, if you walk this road, you learn to stop asking why? Rather look forward to the end result. I experienced incredible personal growth in oncology*".

"*I can say: Let go. It is that acceptance that one gets. It is peace, peace, peace. Inner peace*".

3.4 Awareness of their need and effort to live each day meaningfully

Our lifespan in this world is limited. The participants in this study managed to put into words a very personal attitude and perspective, giving the reader some insight into their inner being. Sometimes meaning is to be found in the illness, sometimes in the life that is left and in its relationships and values that are prioritised. Terminal

illness forces us at some point to look directly at death, yet everything in us seeks life. The cancer patient's illness odyssey beckons the nurse to go beyond mere nursing assessment, diagnosis, intervention and evaluation to a place of vulnerability that allows for a shared connectedness. Only then can the oncology nurse not only cope in this challenging environment, but actually gain from it. "*One of the roads I walked in oncology was to learn to really live each day. To have no regrets. It has a big, big influence in my life with regard to decision making.*" Another participant remarked: "*To work here changes your outlook on life. It makes you grateful for health. It makes you realise you have to get your life and your faith in order. Your life can change drastically on one day!*"

The cancer patient's appreciation of the things other people take for granted helps him/her to prioritise the issues in life. His/her life-world develops a different meaning and quality. By sharing this life-world with the oncology nurse, his/her life-world also changes and expands and becomes enriched.

LIMITATIONS OF THE STUDY

As with all qualitative studies, it is recognised that the sample size and specific nature of the sample and research context prohibit generalisations. However, the richness of data provides an abundance of insight into the experiential world of the oncology nurse. The envisaged benefits of a phenomenological approach were therefore achieved.

Specific limitations that are acknowledged are as follows:

- Interviews were conducted in one private hospital oncology unit only. The study does not include experiences from nurses in out-patient settings, state hospitals and hospice-settings or from private nurse practitioners.
- Although confidentiality was ensured, the fact that only one hospital was involved could impair anonymity, leading to participants having been careful, even inhibited, when answering certain questions.

RECOMMENDATIONS FOR FURTHER RESEARCH

In the light of the research findings and limitations indicated, the following recommendations for nursing practice, education and research were formulated:

- A detailed support programme for oncology nurses needs to be developed and should be made available to all hospitals with an oncology unit.
- Management of institutions with an oncology unit need to be sensitised regarding the unique needs and challenges in the field of oncology to enable them to recognise it as a specialisation area with scarce skills.
- The nature and extent of the oncology/palliative care component of basic nursing courses in different educational institutions need to be assessed and supplemented where necessary.
- In-service programmes and workshops need to be developed to enhance the life skills of nurses working with terminally ill patients, as well as to enhance empowerment and leadership at ward level.
- A questionnaire, based on the themes identified in the interviews, could be developed for use in a quantitative study.
- A model for explaining and predicting job satisfaction as well as stress response and coping mechanisms in oncology needs to be developed.

CONCLUSION

The study provided evidence that the field of oncology is a unique field that differs in many respects from other areas of nursing. Very little understanding of this uniqueness exists outside of this field. Understanding, necessary to support, retain and recruit oncology nurses, was enhanced by this study, but much still needs to be done, specifically to imbed the theoretical field in a newly constructed framework and to address the unique needs of those working in this field. Finally, the researcher concluded this study with the poignant words of one of the participants: "*Every ward has its stress, needs its level of emotional support. But for me, oncology is an unbelievably personal journey. You cannot not do things right there. If you don't do things right there, it all comes back to the patient. You are the person who must make a difference in the last period of that person's life. You can give so much to that patient if you have a happy team*".

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