

Oncology nursing: Finding the balance in a changing health care system

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Abstract

Health care restructuring has resulted in significant changes in the workload and work environment for oncology nurses. While recent studies describe the impact of these changes on the general nursing workforce in several countries, there have been no published studies that have focused on worklife issues of Canadian oncology nurses. Therefore, a qualitative study was conducted to gain insight about how oncology nursing has changed over the past decade and how Canadian oncology nurses are managing these changes. Analysis of telephone interviews with 51 practising oncology nurses employed across Canada revealed three major themes. The first theme, "health care milieu", portrayed a picture of the cancer care environment and patient and professional changes that occurred over the past decade. The second theme, "conflicting demands", reflects how the elements of change and social forces have challenged professional oncology nursing practice. The third theme, "finding the way", describes the patterns of behaviour that nurses used to manage the changing health care environment and make meaning out of nurses' work in cancer care. Overall, the findings portray a picture of Canadian oncology nurses in "survival mode". They face many workplace challenges, but are able to keep going "for now" because they find ways to balance their responsibilities on a daily basis and because they know and believe that their specialized nursing knowledge and skills make a difference in patient care.

Over the past decade, both health care reform and restructuring have resulted in significant changes in the work environment of health care professionals. Cancer care occurs in a variety of clinical settings that include in-patient hospital units, ambulatory care clinics and home care. The nature of work in each of these settings has been challenged since the 1990s by several factors that include implementing organizational changes to manage shrinking resources while facing an increasing incidence and prevalence of cancer patients in the system. Additionally, advances in scientific knowledge

and technology have contributed to an increased complexity of cancer treatment modalities being delivered in both inpatient and outpatient care settings.

There can be little doubt that changes within the health care and cancer care systems have affected oncology nurses and impacted on their work experiences. However, what is unclear is how Canadian oncology nurses perceive these changes and the impact on their work environments and clinical practice. To explore what it has been like to be an oncology nurse over the past decade and how oncology nurses are managing in a changing health care system, a qualitative study of Canadian oncology nurses was conducted. An increased understanding of the changes and challenges oncology nurses face in their daily practice, together with additional information regarding how they are managing within the realities of the current system are needed to identify interventions to support nursing staff.

Literature review

The experience of being an oncology nurse

In the early 1990s, research exploring the essence of oncology nursing was initiated by Cohen and colleagues as part of the Oncology Nursing Society Life Cycle Task Force in the United States (Cohen, 1995; Cohen, Haberman, Steeves & Deatrick, 1994; Cohen & Sarter, 1992; Haberman, Germino, Maliski, Stafford-Fox & Rice, 1994; Steeves, Cohen & Wise, 1994). Thirty-eight cancer nurses throughout the United States were interviewed for the purpose of describing the meaning of oncology nursing, how nurses find meaning in their work, and their perceptions of the rewards and difficulties experienced in oncology nursing. The nurse participants highlighted the challenges of managing complex patients, assessing multiple priorities and dealing with frequent and unexpected psychological and/or physiological crises. They used war metaphors in describing the "battle" against the effects of cancer such as disfigurement, suffering and death. Factors that made oncology nursing special were the professional and personal rewards that came with knowing how to care for patients with a complex disease, and establishing helping-trusting relationships that allowed the nurse to "be there" to provide comfort and support to patients and their families. The findings of these qualitative studies indicate that the nature of oncology nursing is both rewarding and emotionally demanding. How oncology nurses perceived the meaning of their work and how they understood their role appeared to be shaped by personal and family experiences with cancer, professional experiences such as influential role models and the realities of supporting cancer patients through their heartaches and triumphs (Haberman et al., 1994). Information gained from studies that explore cancer nurses' work and how they perceive meaning and a sense of purpose in their professional role can provide insight about oncology nursing as a subculture and the unique attributes, behaviours and skills required in caring for cancer patients (Gambles, Wilkinson, & Dissanayake, 2003; Haberman et al., 1994; Steen, Burghen, Hinds, Srivastava, & Tong, 2003). Learning more about the nature of nurses' work with cancer patients and how they explore and reflect on their work can reveal ways that nurse managers and nurse educators can best support nurses in developing and enhancing specialty practice as well as sustaining nurses in their work (Corner, 2002).

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Stressors experienced by oncology nurses

The literature identifies oncology nurses as a health professional group that experiences high occupational stress simply due to the nature of their daily work (Escot, Artero, Gandubert, Boulenger, & Ritchie, 2001; Hinds et al., 1990; Larson, 1992; Lewis, 1999; Medland, Howard-Ruben, & Whitaker, 2004; Wilkinson, 1994). Research examining job-related stress in oncology nursing has, for the most part, focused on identifying and measuring specific determinants of stress (Bond, 1994; Emery, 1993; Escot et al., 2001; Florio, Donnelly, & Zevon, 1998; Hinds et al., 1990; Hinds, Quargnenti, Hickey, & Mangum, 1994; Kushnir, Rabin & Azulai, 1997).

The most systematic work has been conducted by Hinds and colleagues (Hinds, 2000; Hinds et al., 1990; 1994) who studied the stress-response sequence in pediatric oncology nurses. Their findings indicated that pediatric oncology nurses experienced moderate to high role-related stress and that the intensity of stress varied with the years of experience in the specialty of pediatric oncology as well as the type of practice setting. The main sources of stress identified were: witnessing patient deaths, seeing patients and their families suffer, working with colleagues who seem inadequately involved with or concerned with patient care, and practising in settings where the contributions of pediatric oncology nurses were not recognized or valued. In further examining pediatric nurses' responses to work-related stress, Hinds and colleagues (Hinds, 2000; Steen et al., 2003) found that nurses remained in these "high-stress roles" if they perceived the work to be meaningful.

Early studies (McElroy, 1982; Stewart, Meyerowitz, Jackson, Yarkin, & Harvey, 1982; Wilkinson, 1994) examining stress in nurses caring for adult oncology patients identified sources of stress that were similar to those experienced by pediatric oncology nurses, as well as other occupational stressors. These other sources of stress include conflicts with staff members, physicians, and administration, feelings of inadequate preparation to deal with the emotional demands of patients and their families, ethical issues related to patient care and research, work overload, and balancing work and home life (McElroy, 1982; Wilkinson, 1994). While these sources of stress are not unique to health professionals in cancer care, it has been suggested that these stresses occur more frequently in oncology than in other care settings because the nature of nurses' work in cancer care is largely emotion-focused (Corner, 2002; Stewart, Meyerowitz, Jackson, Yarkin, & Harvey, 1982).

The number of daily stress factors identified suggests that oncology nurses are vulnerable to "burn-out". Burn-out is described as a work-related syndrome resulting from prolonged high levels of stress, characterized by exhaustion, depersonalization and a sense of low personal accomplishment (Maslach, 1976; Maslach, Schaufeli & Leiter, 2001; Penson, Dignan, Canellos, Picard, & Lynch, 2000). It occurs in settings where job demands exceed the support and resources available for workers (Maslach et al., 2001). However, studies examining burn-out in nurses caring for adult cancer patients found no statistically significant differences in the level of stress or degree of burn-out between oncology nurses and nurses working in other specialties (Jenkins & Osthega, 1986; Papadatou, Anagnostopoulos & Monos, 1994; Yasko, 1983). As all these studies are at least a decade old, it may be that the studies were conducted in settings where the impact of health care reform was not an issue. As well, the findings may reflect the method of measuring stress at only one point in time. More recent research on burn-out indicates that while personal characteristics and daily exposure to patient suffering can contribute to burn-out, it is equally important to examine the social environment and organization factors in the workplace (Corner, 2002; Garret, & McDaniel, 2001; Maslach, & Leiter; 1998). Further studies of stress and burn-out in oncology nurses within today's changing health care environment are warranted since the consequences of burn-out may negatively affect those giving care as

well as those receiving care (Corner, 2002; Grunfeld, Whelan, Zitzelsberger, Willan, Montesanto, & Evans, 2000; Grunfeld, Zitzelsberger, Coristine, Whelan, Aspelund, & Evans, 2005; Leiter, Harvie, & Frizzell, 1998).

Nursing workplace studies

In recent years, published studies of nurses' work environments describe the impact of health care restructuring on the nursing workforce in Canada and several other Western countries (Aiken, et al., 2001; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Armstrong-Stassen, 2003; Armstrong-Stassen, Cameron, Horburgh, 1996; Baumann, Giovannetti, O'Brien-Pallas, Mallette, Deber, Blythe, Hibberd, & DiCenso, 2001; Blythe, Baumann, & Giovannetti, 2001; Burke & Greenglass, 2000; Cummings & Estabrooks, 2003; Laschinger, Sabiston, Finegan & Shamian, 2001; Laschinger, Shamian, & Thomson, 2001; Maurier, & Northcott, 2000). The studies report that nurses perceive a loss of control over their personal lives, their jobs and career opportunities and that these changes may lead to a compromised ability to provide effective care to patients. To date, research on nurses' work environments has mainly focused on nurses as a collective group and little work has been directed toward the field of oncology nursing. An assessment of the status of the oncology nursing workforce in the United States was initiated in 2000 by the Oncology Nursing Society (Buerhaus, Konelan, DesRoches, Lamkin, & Mallory, 2001; Lamkin, Rosiak, Buerhaus, Mallory, & Williams, 2002a,b). Oncology nurses, oncologists and nursing executives of cancer facilities were surveyed to gain their perspectives about current nurse staffing patterns in oncology care settings in the U.S., the changes in work environments and the impact of staffing shortages on the quality of patient care. However, no nursing workplace studies have been conducted in Canada that focus specifically on the specialty of oncology nursing.

There are several immediate reasons to support research, such as the current study that investigates oncology nursing work life in Canada. Firstly, the extensive reorganization of health care systems that began in the mid-1990s has created unpredictable practice environments for nurses in general (Aiken et al., 2001, 2002; Armstrong-Stassen, 2003; Baumann et al., 2001; Blythe et al., 2001; Burke & Greenglass, 2000; Cummings & Estabrooks, 2003; Laschinger et al., 2001; Maurier, & Northcott, 2000). Secondly, the widespread nursing shortage and cancer statistics indicating a steady increase in the cancer patient workload pose real threats to sustaining a quality oncology nursing workforce that will contribute to cancer control in our country. In 2002, a report by the Canadian Nursing Advisory Committee recommended that improving the worklives of nurses should be a key focus for addressing the nursing shortage. Therefore, as a starting point to address work life issues of oncology nurses in Canada, a qualitative study was conducted to gain insight about how oncology nursing has changed since health care restructuring began in the mid-nineties. Learning how oncology nurses make meaning and behave in the cultural context of caring for cancer patients within a changing and uncertain health care environment will provide a better understanding of how organizational restructuring and demographic trends have affected this nursing specialty in Canada. Study findings will provide valuable information to health care managers, administrators and policy-makers that can be used to inform the development of interventions or resources needed to support oncology nurses to maintain and facilitate safe and effective patient care as well as sustain a quality oncology nursing workforce.

Method

Research design

A focused ethnographic approach (Fetterman, 1998; Morse & Field, 1995; Roper & Shapira, 2000; Spradley, 1979) was taken to explore the meaning and experience of being an oncology nurse

within a changing health care system. As a methodology for inquiry, focused ethnographies of subgroups of nurses are used to “study the practice of nursing as a cultural phenomena” (Roper & Shapira, 2000, p. 9). Oncology nursing as a subculture is evident in the way nurses express a learned body of knowledge and clinical skills, share experiences of caring for cancer patients and their families, understand practice norms such as professional standards and legal mandates, and participate in activities related to power and interpersonal relationships. For this study, ethnography was chosen in order to learn from oncology nurses how their cultural understanding as a specialty of nursing (i.e., knowledge, beliefs, ideas, values, customs) informs their behaviours (i.e., managing their nursing work and interactions with health care professionals and cancer patients/families) during a time of health care system uncertainty and transition.

Sample

Using purposeful sampling, oncology nurses were identified through the clinical networks of the research team members who worked in different regions of Canada (British Columbia, Alberta, Ontario and Nova Scotia). Study participants sought were registered nurses who provided direct care to cancer patients and had a minimum of four years experience in oncology nursing. The criterion of four years was selected as a means for ensuring that participants would be informed through their nursing experience of the knowledge, values, and skills specific to the subculture of the nursing specialty (Benner, 1984). As well, it was important that the participants had several years of nursing experience within provincial cancer care systems that were undergoing change. Initially, all research team members recruited seven oncology nurses from cancer centres in their provincial region. More participants were included as the study progressed in order to gain a thick description of oncology nursing across Canada. Therefore, to meet sampling criteria of appropriateness and adequacy (Morse & Richards, 2002), participants were actively sought that worked in naturalistic settings where nurses provide care to cancer patients (out-patient clinics, in-patient units, community/home-care services) and that were “senior” or “junior” nurses in terms of oncology experience so that perspectives representing differing clinical settings, age, and experience could be obtained and compared. Potential participants were approached by individual research team members who provided information about the study and answered questions about participation. Upon receiving signed informed consent, research team members forwarded the participants’ contact information to two trained interviewers who then arranged with each participant a convenient time for a telephone interview.

Data collection

As participants lived and worked in cancer care settings across Canada, data were collected by telephone interviews. The interview format was designed to be relatively unstructured to allow participants to provide descriptions of their work lives and professional practice. Questions for the interview were developed by the research team and evolved from informal discussions in the late 1990s about Canadian health care reform and cancer control strategies. Prior to their interview, participants were mailed a list of questions to consider when reflecting on their experiences as an oncology nurse. These questions formed the guideline for the telephone interview. At the onset of the interview, each participant was asked a global question, “What is it like to be an oncology nurse today and how does it differ from five or 10 years ago?” Subsequently, interviewers asked questions that prompted participants to provide more specific descriptions of events, behaviours, relationships and/or interactions. For example, participants were invited to describe what was most meaningful or important in their nursing practice, what frustrations and pressures

were experienced in daily practice, and what was the impact of system changes on their personal and professional lives. Demographic data (age, number of years in oncology nursing, education, and type of practice setting where employed) were collected to describe the sample. All participants were interviewed once and interviews lasted anywhere from 30 to 60 minutes in length. Each interview was audio-taped and later transcribed verbatim.

During the time of the data collection, all research members held nursing positions that allowed them to be “part of the oncology nursing world”. The researchers, in the course of their own work responsibilities, had free access to oncology nursing workplaces where they had frequent (some had daily) interactions with oncology nurses, participated in (e.g. health team meetings, rounds, in-service education), and observed oncology nurses work (e.g. interactions with patients/families or other health care providers). Therefore, while there was no planned, formal participant observation, the researchers’ observations and experiences within the oncology nursing world aided in gaining a better understanding of the taken-for-granted every-day events, and practices and beliefs of oncology nurses. These insights became part of the overall data as the team analyzed and interpreted the participants’ interviews.

Data analysis

Descriptive statistics were used to provide a summary profile of the group of participants. The qualitative results are based on a thematic analysis (Coffey & Atkinson, 1996; Fetterman, 1998; Morse & Field, 1995; Luborsky, 1994) where the emphasis was on gaining an understanding of participants’ meaning and experience of the oncology nursing world within a changing health care environment. Topics, patterns and themes were identified from the transcripts to describe oncology nurses’ ways of practising, believing and adapting to changes in their work places.

In the first stage of data analysis, two of the researchers reviewed five interviews and made notes in the margins about topics that surfaced from the data. These topics were then used to formulate coding categories. The other team members then reviewed the same interviews to provide feedback on the identified topics and contribute to developing an overall coding scheme for analysis of the remaining transcripts. Two members of the research team continued to review all 51 interview transcripts. These members reviewed and coded the transcripts independently and then met to compare coding. Using a systematic process of reviewing transcripts line-by-line, text passages were coded and compared across cases for patterns in the participants’ beliefs, responses, and behaviours. In addition, as these two researchers coded, analyzed and interpreted interview data, periodic discussions with the rest of the team members and sharing of observations and experiences in oncology work environments led to further clustering and reordering of identified patterns. In this way, the etic and emic perspectives contributed to the emergence of patterns and themes related to being an oncology nurse in a changing health care environment.

Results

Sample characteristics

In total, 51 oncology nurses across Canada participated in the study. The demographic characteristics of the sample are displayed in Table One. The age of the participants ranged from 24 years old to 60 years old with the mean age of the group as 45.9 years old. Almost three-quarters (73%) of the nurses were diploma-prepared and 37% of the nurses had acquired specialty certification in oncology nursing. The number of years of oncology nursing experience of the participants ranged from four years to 26 years and the mean was 13.8 years. While the sample of oncology nurses included nurses from inpatient and outpatient care settings (ambulatory clinics and community/home-care), there was an over-representation of nurses

working in ambulatory care clinics. This distribution reflects the fact that sample recruitment began within these workplace settings and oncology nurses practising within provincial cancer care agencies were more easily identified and accessible. For the majority of nurses interviewed, their nursing practice focused exclusively on providing direct care to cancer patients. Approximately 10% of the sample indicated that besides direct patient care responsibilities, their workload also included activities in the domains of education, leadership and research.

Themes

Analysis of the data unfolded a cultural picture of “what the world (a changing and uncertain environment) is like to people (oncology nurses) who have learned to see, hear, speak, think and act in ways that are different” (Spradley, 1979, p.3). The first theme, “the health care milieu”, reflects the context for nurses’ work in the specialty of oncology in Canada. The second theme, “conflicting demands”, relates to the impact of the elements of the health care milieu on oncology nurses, and evolved from the self-reflections and meanings participants gave to events and social interactions in the oncology nurse environment. The third theme, “finding the way”, reflects behavioural patterns, beliefs and values and how oncology nurses made sense of, reacted to, and managed the environmental change and their professional responsibilities.

I. The health care milieu

When describing how their work environment had changed over the decade, participants identified three areas of change: patient profiles, system reorganization and professional nursing practice.

Patient profiles

Several changes in the patient profile were identified that had a direct impact on nurses’ work. Participants from inpatient, outpatient and community settings reported an increased volume of cancer patients and increased patient acuity. Some nurses estimated the increase in patient numbers in their work setting to be as great as 30% to 50%. In describing the acuity of patients managed in ambulatory care settings, one participant stated:

“We treat the patient in the community a lot longer and simply because we don’t have the bed space in the hospitals anymore. Now they [patients] continue to try and maintain a normal lifestyle so they are ambulatory and in and out of the clinics for a longer period of time as opposed to years ago. At some point they would stop attending the clinics... now we’re seeing patients till their dying day.”

Nurses also reported that patients’ and families’ expectations had changed. They were more knowledgeable than 10 years ago, had more access to information and used it to be more effective consumers of health care. While participants reported that patients generally were appreciative of the care they received, they stated that patients seemed more aware of the “cutbacks and shortages” in the health care system. Patients were more vocal about their concerns and experienced “discontent or frustration because there was not enough staff, and not enough time for them.”

System reorganization

Participants described many changes that occurred in the work setting as a result of the widespread restructuring of the health care system throughout the 1990s. Independent of their geographical location across Canada, all participants reported a decrease in staff (both nursing and support staff) along with a resulting loss of qualified personnel. In all cases, the shortage of nursing staff and the increased numbers of cancer patients translated into an increased patient workload for the nurses who remained employed in these settings.

As well, the downsizing of support staff created workplace situations that required nurses to take on additional work. All participants indicated that they had more responsibilities that did not relate directly to patient care or nursing practice. One participant stated:

“I think we’ve picked up a lot of slack from other jobs that aren’t functioning... they no longer exist because of government cutbacks. I think that nursing has always been sort of a catch-all where if somebody can’t take the patient here or do that or fill this or stock that supply or get this or, you know, then the nurses end up doing it. There are a lot of invisible jobs that nurses do and I think people often don’t realize invisible and intangible things. When you no longer have this person who used to do that job, then it becomes the nurse’s job or else it is not done.”

However, no participants indicated that they had refused to accept non-nursing work. They stated that nurses accepted these additional responsibilities in order to “keep systems running smoothly” and to make sure that patients received the services required.

In community care settings, system changes such as bed closures in hospitals and layoffs of nurses resulted in larger caseloads and a noticeable increase in complexity of care demands. Yet, despite the fact that more patients were being cared for in their homes, there was no noticeable difference in funds and resources available to provide the needed care for these patients and their families. Nurses described difficulties in their attempts to mobilize the system, and coordinate services for patients and families. There appeared to be little support available for community nurses when their patients required referral or services. Most notable was the frequent breakdown in communication that occurred between health care providers who

Table One. Characteristics of study participants (N=51)

Characteristic	Frequency	Percentage (%)
Age (years)		
≤ 30 years	1	2.0
31-40 years	11	21.6
41-50 years	22	43.1
≥ 51 years	17	33.3
Education		
Diploma	34	66.6
BScN	17	33.3
Master’s	3	5.9
Oncology Certification	19	37.2
Years in oncology (N=49)		
≤ 10 years	12	24.5
10-15 years	22	44.9
16-20 years	9	18.4
21-25 years	5	10.2
≥ 25 years	1	2.0
Clinical setting		
Ambulatory Care	39	76.5
In-Patient	9	17.6
Community	3	5.9

were employed in different care delivery systems but who were involved in managing the same patient. Study participants perceived fragmentation and fragility in patient care and in the linkages between hospital/agency and community care services.

In most care facilities, management models were restructured to focus on programs that supported interdisciplinary teams of health care professionals rather than on programs that emphasized separate disciplines and professional practices. Several nurses talked about the loss of nursing departments from the organizational charts and the shift to incorporating nurses into program teams. They indicated there was no visible nursing leadership and there appeared to be no “defined line as to whom [nurses should] report to about nursing concerns”. Given the new responsibilities of former nurse administrators beyond nursing, some staff nurses felt abandoned and unprepared for their new decision-making roles. As well, many nurses were disillusioned by the lack of value placed by senior administrators on nursing work life issues. Participants indicated that they sought other staff nurses as their main support system for both patient care and work environment issues. But the time for collegial support was severely constrained due to workload. Many staff nurses indicated that regular staff meetings to discuss issues of concern had been discontinued. In fact, the perception of many participants was that “nursing was not high on the institution’s oncology agenda”.

However, other nurses stated that the change to a program management model from that of a discipline-focused model was a positive change. They believed that the change encouraged nurses to network and negotiate with other health care providers in the system. These nurses stated they did not want someone to solve their problems independently nor be “in charge” of their practice, but they desired more autonomy and guidance in decision-making especially around patient care issues. They believed that the system now empowered nurses to be team players with other disciplines in planning programs and models for cancer care delivery. The role of the manager as facilitator is illustrated in the following comment:

“Nurse managers are evolving to change how they see themselves. I think they see themselves now much more as enablers and coaches and mentors. They’re seeing the staff nurses as the clinical experts more and more. And listening to staff nurses more on issues of operation... they’re doing a lot more consulting with the people who are actually doing the job.”

Professional nursing practice

The overall perception was that oncology nursing practice had changed significantly over the decade. Many of the changes were viewed as positive because they enabled the oncology nurse to practice more autonomously as a member of the cancer control team. Several nurses talked about a transition in nursing where nurses had moved from “worker” status to “professional status” and that nurses were now encouraged to become “involved in critical thinking and disband a lot of traditions about the way nursing work is done”.

However, some nurses found no change in how others viewed nurses in the system. They commented that other disciplines did not value nursing knowledge, did not understand the interaction between the nurse and patient and believed the nurse’s role was to facilitate the work of other health care professionals.

“There’s still a lack of clarity about the scope of my work and what is expected... physicians really not understanding what nursing is... They just don’t understand why you might need a nurse [in a particular setting]. It’s not for them, but it’s actually the patients that need the nurse. They don’t understand what happens between patients and nurses...”

All participants described how the expectations concerning their scope of nursing practice had changed. Several factors contributed to this change such as the shifting model of cancer care delivery to one that is now predominantly based outside of acute care hospitals, the

implementation of primary nursing or case-management models in many inpatient and outpatient care settings, as well as advances in science and technology that contribute to new cancer treatment protocols. Nurses reported the need to acquire specialized knowledge and skills. In providing care to complex patients, oncology nurses required not only physical care skills and techniques, but needed to gain further knowledge about assessing and monitoring patients living in the community, educating and counseling patients and families, and advocating for and coordinating supportive care services for their patients. As well, to survive the reformed health care work environment, nurses required skills in computer literacy, the ability to manage other health care workers, and collaborate and negotiate with other health professionals about patient care issues. One milestone described by nurses was the implementation of the oncology nursing specialization exam in 1997 by the Canadian Nurses Association. Many study participants indicated that they had attained the specialty certification and that there was an emphasis among their nurse colleagues to achieve this goal. They expressed the belief that the establishment of the oncology nursing specialty increased the status of oncology nursing within the system.

II. Conflicting demands

The second theme that emerged from the data was conflicting demands. It relates to how the cultural norms (professional oncology nursing practice) and the social forces (elements of the health care milieu) were often not compatible. There was a consensus among the participants that the system changes that had occurred often created conditions of conflict for professional nursing practice.

Enacting the full scope of practice versus working within a restrictive restructured system

Conflict was especially evident when organizational changes were perceived by the nurses to be barriers to maximizing the full scope of nursing practice. In describing the oncology nurse’s role, participants described clinical practice, research, education and leadership responsibilities and that oncology nursing included more than providing physical care to cancer patients, but also included psychosocial care for patients and their families. Nurses described how the restructuring process had resulted in changes, such as “not enough nurses”, “the dismantling of nursing departments” and “lack of visible nursing leadership”, that directly impacted on professional nursing practice. These conditions were regarded as obstacles to maximizing the full scope of professional nursing practice and influenced how nurses’ knowledge and contributions to patient care were perceived and valued by other health care providers.

Nurses described the introduction of the primary nursing model into cancer care settings in the 1990s and how it visibly promoted the nurse’s role within the health care team as a knowledge worker. Unlike other traditional models of nursing care that predominantly focused on technical skills and the delegation of tasks, nurses expressed how the primary nursing model legitimized nursing’s professional autonomy and accountability to other health care providers. Thus, the implementation of primary nursing in cancer care settings was viewed as an opportunity to maximize scope of practice and “show how nurses can make a difference to the quality of patient care”. However, nurses described their frustrations and disappointments when restructuring brought changes to the system that failed to provide the infrastructure and resources to support or promote the primary nursing model.

For example, in some cancer care settings, nurses were disheartened when the primary nursing model was discontinued because it was viewed as “too expensive”. In other cases, primary nursing was not formally discontinued but, because of staff lay-offs, nurses were expected to take on ancillary tasks that prevented them from using their nursing knowledge to care for patients and participate in clinical decision-making. The restrictions to maximize

nursing's full scope of practice may be a result of power issues between the "system" and the "profession". Participants often expressed the view that nurses were bound to a system where expectations for nurses' work did not necessarily support or promote nurses' professional autonomy and accountability.

"It is extremely frustrating to see nurses in an ambulatory care setting not able at all times to be in contact with patients as they should because the nature of work for ambulatory nurses here has become so clerically driven... these nurses are extremely good and they've demonstrated that if they were allowed to be involved in giving nursing care for the majority of their time they can make a significant difference to the quality of life of individuals. A lot of nurses, for the most part of their day, their expertise is not utilized for patient care."

Meeting individualized patient needs versus managing time

The other conflicting demand that surfaced concerned how little time nurses had to provide individualized patient care. Nurses described going to work as "doing firefighting" or "just fixing things". The day-to-day emphasis was on keeping the workplace intact rather than on connecting and knowing patients. Nurses were being told to prioritize and make decisions about what really needed to be accomplished during the workday. For nurses who were overworked, this meant the time constraints made them decide between comprehensive care or focusing only on the care priorities presented that day.

"Time constraints make us decide between comprehensive care and focusing on only the priorities. We're looking at re-assessing and reducing our expectations of care. Like what is it that we can realistically offer within the amount of time there is to the patient volume that we're seeing? Can we give permission to ourselves to say 'I won't be able to do that anymore'? And that's going to be very difficult because nurses want to do the full task, the comprehensive task, and they just don't have the time anymore."

III. Finding the way

The third theme, finding the way, reflects the behavioral patterns, beliefs and values of oncology nurses within the changing health care culture. When describing what it was like to be an oncology nurse in today's world, nurses described ways in which they adapted to the demands of the workplace and made sense of their work in the cancer care system.

The balancing act

Participants described how they learned to survive the conflict between their desired professional nursing role and the limited resources offered by the system. They described the need to "juggle" the pressure of time with accomplishing their patient care workload and non-nursing workload. Nurses maintained a daily "balancing act" as a way to gain a sense of satisfaction in knowing they had met the needs of their patients yet kept the operations running smoothly.

"There are two things that go on in a clinic area. You've got the pressure... the personal pressure of trying to get the clinic going and patients being seen in a timely fashion and there is the pressure of the patient's individual needs. So it's trying to balance that off. You're still trying to deliver the same type of care and you can't possibly do it. So you have to sort of balance out what you can give."

Many indicated that they needed to come to a personal understanding that when they failed to provide what they perceived to be "good quality nursing care" to individual patients it was not necessarily a personal failure but a "system problem". They simply just did not have the time.

As well, several nurses reported a constant need to maintain a balance between their professional work life and personal home life. It was often difficult for nurses to detach themselves at the end of the

day from the emotional workload that came with caring for patients with a complex disease. Furthermore, several participants commented that their current work situations were not healthy and that they were struggling to maintain an acceptable balance between work and home.

Making a difference

Despite the frustrations associated with their daily work, all nurse participants spoke passionately about oncology nursing. They believed that oncology nurses were different from other nurses. They described the specialty of oncology nursing as "unique" and that caring for cancer patients was a "privilege" due to the relationships and connections nurses made with patients and their families over the course of the illness. They believed oncology nurses had a stronger sense of commitment to patients and that each day they learned from their patient encounters. Nurses made sense of their role and their work environment challenges by making comparisons to the cancer experience.

"It's just a very gratifying experience... a very humbling experience to be an oncology nurse. You sort of reflect on the major pressures and frustrations in your life and then you compare it to what a patient goes through here with their cancer experience and you pretty much forget about your little troubles. So many times when I am sort of getting frustrated and sort of being angry about this [work environment]... it really helps me bring perspective back into my life and work-life when I see what patients go through."

All participants believed firmly that their specialized skills and knowledge made a difference in cancer patients' lives. Each of the participants provided a positive story illustrating how through connecting with patients and families, providing physical and supportive care, and acting as advocates they could impact patients' quality of life. The sense was that these nurses stayed in the profession because of the patients and "put up with the work conditions" because of the personal satisfaction they received when they observed that they really had helped an individual and his/her family.

"...It's knowing that my role as the oncology nurse does make a difference in the patient's outcome. When I provide teaching and the fact that they run into very little problems or their symptoms are minimized, I know that I played a role and it helped."

The recognition that they made a difference to patients' quality of life and cancer experience brought personal job satisfaction. To nurses, indicators of effective therapeutic relationships were identified during the professional and personal interactions they shared with patients and their families throughout the cancer journey. Within the chaos of a system that presented daily resource challenges, positive patient-nurse encounters served to buoy up the nurses and sustain them. These experiences personified the real meaning of oncology nursing and reinforced for participants why what they did "day in and day out was all worth it".

Discussion

The descriptions of the study participants indicate that the world of oncology nursing has changed substantially over the past decade. Changes were evident within the health care system, the cancer patient profile, and in the professional role of the oncology nurse. These changes present daily challenges to oncology nurses as they strive to provide comprehensive nursing care to cancer patients in acute care, ambulatory and community care settings. Moreover, the study findings portray a picture of Canadian oncology nurses in "survival mode". They are able to keep going "for now" because they find ways to balance their responsibilities on a daily basis and because they know and believe their specialized skills and knowledge make a difference to patient care.

Valuing oncology nurses' work

Numerous studies of nurses' work environments over the past decade have reported the impact of health care reform on the worklives of nurses. In all studies to date, nurses have echoed the same concerns (Aiken, et al., 2001; Aiken et al., 2002; Armstrong-Stassen, 2003; Armstrong-Stassen et al., 1996; Baumann et al., 2001; Blythe et al., 2001; Burke & Greenglass, 2000; Cummings & Estabrooks, 2003; Laschinger et al., 2001a,b; Maurier & Northcott, 2000). The daily expectations of managing increased patient workloads with fewer qualified registered staff, along with added responsibilities of non-nursing work, have led to widespread feelings of loss of control among nurses. While most studies have focused on the overall nursing workforce, recent studies in the U.S. examining the state of oncology nursing (Buerhaus et al., 2001; Lamkin et al., 2002a,b) and the present Canadian study confirm similar attitudes and challenges experienced by nurses within the specialty area of cancer care. However, for Canadian oncology nurses, the sense of powerlessness and frustration in controlling their work environment was further exacerbated by concomitant developments in the oncology nursing professional role. Since the late 1990s, oncology nursing has been recognized in Canada as a specialty area of nursing with the acknowledgement that the role requires specialized knowledge and skills. Hailed as a landmark event, oncology nurses embraced this formal recognition and welcomed the opportunity to contribute to the cancer care team by providing comprehensive nursing care. However, system changes in many care settings placed constraints on oncology nurses from maximizing their full scope of practice because nurses were required to pick up the technical or clerical work of other health care providers lost to downsizing.

The multifaceted and complex nature of cancer requires that health care professionals caring for cancer patients possess special knowledge and skills to meet the needs of this group of patients. The oncology nurse plays an integral role in managing and coordinating the care of cancer patients throughout the disease trajectory. In light of the current RN shortage and the increasing numbers of cancer patients, it is vital that the full potential of oncology nurses' work be recognized. Furthermore, a recent study by Aiken et al. (2002) indicates that nurse staffing levels do affect patient outcomes and nurse retention. High patient-to-nurse ratios were significantly correlated to patient mortality and failure to rescue (mortality following complications), as well as high levels of emotional exhaustion and greater job dissatisfaction in nurses. Therefore, there is an urgent need for workplace decision-makers to consult with oncology nurses in order to structure work environments so that the expertise of oncology nurses is valued and used effectively within the care team to meet the needs of the growing cancer patient workload.

Stress and burn-out

Oncology nursing has been identified as a stressful profession due to the nature of working with patients with a complex disease that is often terminal (Larson, 1992, Lewis, 1999). Unstable working conditions that occurred as a result of health care reform have contributed to an even greater stress load for oncology nurses in Canada. In the present study, nurses indicated that their stress did not come from interacting with individuals with cancer, but came from not having the time to provide the desired level of care to meet patients' individual needs. This view is consistent with current literature that suggests that burn-out results from the gap between individuals' expectations to fulfill their professional role and the existing organizational structure (Leiter, 1991).

Past research indicates that lack of managerial and coworker support systems, lack of autonomy, and poor communication are predictors of burn-out (Albrecht, 1982; Leiter, Harvie & Frizzell, 1998; Leveck & Jones, 1996; Maslach & Leiter, 1998; Maslach, 1976; Oehler, Davidson, Starr & Lee, 1991; Robinson, Roth, Keim, Levenson, Flentje, & Bashor, 1991). From analysis of the interview

transcripts, it is evident that these factors are present in many oncology nurse work environments. Therefore, the descriptions of oncology nurses' work should be taken as a serious warning. In order to prevent nurse burn-out, workplace measures that support the work of oncology nurses are urgently required. It has been suggested that if one's social environment is supportive, burn-out will not occur, even if the work is very stressful (Pines & Kanner, 1982).

Organizational culture

Over the past decade, management models in health care institutions have been restructured to focus on programs that support interdisciplinary teams of health care professionals rather than on single disciplines. To many nurses in the present study, this meant a lack of visible nursing leadership that translated into organizational mistrust. According to Porter-O'Grady & Malloch (2003) there is a need to develop a new organizational culture for this century, with the emphasis on achieving the right outcomes rather than on simply performing the right processes. However, such change in the organizational framework can easily cause conflict between workers and managers and foster mistrust if leaders do not translate and communicate the changes for others. Operational realities of today's workplaces force nurses to view and present themselves differently to management (Porter-O'Grady & Malloch, 2003). Nurses must recognize themselves as "knowledge workers" and change how they can be "heard" by management. Nurses in the present study recognized that the specialized knowledge they possessed contributed to patient outcomes and wanted the chance to demonstrate this contribution by gaining more autonomy in patient care and control over their practice environment. However, for the most part, they did not know or were unsure on how to present a convincing voice within the organizational culture. In order to foster change and facilitate nurses' adaptation to a new organizational culture, managers must develop skills and knowledge to lead in a "fluid world" by acknowledging the impact change has on the ability of nurses to do their work (Porter-O'Grady & Malloch, 2003).

Organizational support has been shown to be one of the most significant factors in helping nursing staff handle difficult restructuring transitions. The findings of the present study suggest there is a clear need to articulate organizational goals and increase the visibility of leadership support (Burke & Greenglass, 2000). To gain organizational trust, managers need to focus less on control and more on the coordination, integration and facilitation of nurses' work. Leaders must embrace and champion efforts to revitalize work environments in their organizations.

Despite the organizational change that has occurred in the cancer care system over the past decade, the oncology nurses in the present study remained steadfast in their commitment to caring for their patients. Not one of the oncology nurses interviewed indicated that they had plans to leave oncology nursing. The opportunity to use their specialized knowledge and skills to care for cancer patients brought a great level of satisfaction. The personal satisfaction they received on an individual basis from interacting and caring for cancer patients and their families sustained them and provided them with the evidence that their nursing interventions did result in positive patient outcomes. In fact, there was an underlying sense, that some of the oncology nurses gained a sense of self-pride in their ability to both manage the chaos in the work environment and still make a difference in patients' quality of life. The findings of this study highlight the importance of creating environments that empower nurses to work to their full scope of practice and generate nurses' positive feelings and confidence about their work.

Implications for nursing

This qualitative study contributes to the overall growing literature about nurses work environments. The findings indicate that health care reform with its emphasis on restructuring, reorganizing and

downsizing has profoundly affected the quality of oncology nurses' work environments in Canada. Oncology nurses experience high levels of stress as they manage the changes and find meaning in their role as an oncology nurse. The picture of oncology nurses in "survival mode" is alarming and requires immediate attention. Given the nursing shortage (CNA, 2002) and the steady increase in the prevalence and incidence of cancer (NCIC, 2002), it is reasonable to suggest that a large part of the demand for nursing services in the future will come from the field of oncology. Therefore, it is important to focus attention on oncology nursing workplaces in order to maximize the skills and productivity of oncology nurses currently in the system, as well as attract new nurses into the field of oncology.

Improving the work lives of nurses has been identified as the key focus for addressing the nursing shortage and widespread job dissatisfaction across the country (CNAC, 2002). The results of this study provide some suggestions that can inform the kinds of interventions that could be developed to support oncology nurses in their work. For example, interventions that target nurses' workload should include how "time" is considered. Nurse leaders need to develop plans about "who should be used and how they should be used" rather than seeking more resources or time (Porter-O'Grady & Malloch, 2003, p. 274).

The results of this study and other research focusing on cancer care providers in general (Grunfeld et al., 2000; 2005) strongly suggest that strategies to reduce or prevent job-related stress or burn-out are needed within cancer care environments. These interventions should be designed so that they not only target the

workplace environment, but also the dynamics of the multidisciplinary cancer care team (Medland et al., 2004). In addition, nurses as the largest health care professional sector in cancer care, must learn how to use their collective voice to take ownership and responsibility to improve the culture of cancer care. Nurses at all levels must learn to critically analyze and use political action to change the nature and realities of nurses' work. It is not enough to identify the tensions and contradictions that exist, but action beginning at the grassroots level is required to actually reformulate policies and change practices that improve work environments for oncology health professions and, in turn, the quality of cancer care. Action at the grassroots level includes being well-informed and current, knowledgeable of sources of power and influence, visible through expanding nursing's powerbase on interdisciplinary committees, as well as participation in the evaluation of evidence- and outcome-based policies and guidelines at the unit and institutional level (Clarke, 2006).

At the research level, the findings of this qualitative study have served as the foundation for further studies by the authors. Research is now underway that examines the workplace in more detail and professional practice factors within oncology nurse work environments for the purpose of determining factors that influence the recruitment and retention of oncology nurses. Input from Canadian oncology nurses will be obtained through surveys and focus groups and will contribute to the development of workplace strategies that will address and inform policy about human resource planning in oncology nursing. ♣

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