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Caring for cancer patients in acute cancer care settings: Voices of South African nurses

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ABSTRACT

Little is known about the experience of nurses in Africa caring for cancer patients. This study was undertaken to provide a straightforward description of the experiences of South African nurses caring for patients in acute cancer care settings. Purposive sampling selected 20 nurses with whom there were in-depth interviews. Most of the participants were female registered oncology nurses with more than five years' experience. Three themes were identified: defining the cancer nursing experience, the challenges experienced in caring for cancer patients, and challenges imposed by the healthcare system. Most of the participants believed they were called by God to care for cancer patients. However, the challenges they experienced led to guilt feelings and believing the care they provided was insufficient. They were subjected to workplace violence, missed the support from senior nursing management, and displayed signs of burnout. Addressing these challenges could limit their emotional distress and prevent burnout.

INTRODUCTION

Like the rest of the world, cancer is a major healthcare problem in South Africa. According to the World Health Organization (2020), 107,467 people were newly diagnosed with cancer in 2020, while 57,373 cancer deaths occurred in the same year. This relates to 23.3% of deaths caused by non-communicable diseases. Breast cancer is the most common cancer in South Africa followed by cancer of the cervix, prostate, and lung. Unfortunately, most patients present with advanced disease due to limited education, lack of knowledge about cancer, and health system inefficiencies (Joffe et al., 2018).

South Africa hosts two healthcare systems, private and public. The public healthcare sector, providing government-funded healthcare to more than 80% of citizens (Stastistica, 2020), is under tremendous pressure and patients are subjected to long waiting times, rushed appointments due to the patient load, and poor clinical practices (Young, 2016). However, cancer treatment takes place in specialized departments of designated hospitals and patients have access to systemic anti-cancer treatments, radiotherapy, surgery, and stem cell transplants or a combination of treatments. Generally, patients receive treatment on an outpatient basis, but can undergo repeated admissions to hospital wards during the illness trajectory. A multi-professional team is responsible for their treatment and care. Most nurses forming part of this team are registered general nurses (RN), whilst a small percentage have completed a post-registration program in oncology nursing (RON).

Nurses practising in acute cancer care must have knowledge and expertise in order to render holistic care to patients, as their roles focus on assessment, education, symptom management, and supportive care. The nurses also care for and support the patients' families and caregivers, as they share the burden cancer imposes on the patients (Yates et al., 2020).

Currently, there is little known about the experiences of nurses caring for cancer patients in South Africa, as studies primarily focus on patient experiences. Only one South African study, conducted in 2008, could be found (Van Rooyen et al., 2008). New treatment modalities have developed since the publication of this study, and the challenges public healthcare is currently facing, could influence nursing care.

PURPOSE OF THE STUDY

The study was undertaken to provide a straightforward description of the experiences of South African nurses caring for patients in acute cancer care settings.

METHODS

Design

This study used a qualitative descriptive design that is especially suitable to answer research questions of special importance to practitioners, such as the case in this study. (Bradshaw et al., 2017; Sandelowski, 2000).

Setting

The study took place at an academic hospital in Gauteng Province, South Africa. The hospital has 1,088 beds, and more than 4,000 professional and support staff members, and serves as a referral hospital for South Africa and the rest of Africa. The Radiation Oncology Department treats approximately 3,500 cancer patients per year (Bingo et al., 2020), whilst 150 to 200 patients receive treatment daily in the medical oncology clinic. The radiation oncology ward has 25 beds, while the medical oncology ward has 23 beds. Nursing unit managers head the different units and are responsible for the nursing care, nursing staff members, and the resources needed for the delivery of healthcare (Armstrong et al., 2015).

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Population and sampling

The population consisted of all registered nurses practising in cancer care settings at the study setting. The inclusion criteria were having at least one years' experience in this field of nursing. The sampling method used was grid-based purposive sampling. The sampling grid ensured there was inclusion of nurses from all the cancer units in the study, whilst purposive sampling allowed the selection of participants experienced with the topic at hand and information rich (Gray & Grove, 2021; Palinkas et al., 2015).

Recruitment and data collection

After obtaining ethical clearance from the University (#M170846) and permission from the hospital, nurses meeting the inclusion criteria were approached while on duty and invited to participate in the study. After explaining the study, the nurses received an information sheet. Following this was the obtaining of written informed consent for both participating in and audio recording of the interviews, and agreement of a day and time for the collection of data. There were 25 nurses recruited, but only 20 interviews conducted as, the researchers deemed 20 interviews (n = 20) sufficient to achieve informational redundancy.

The collection of demographic data occurred first, followed by in-depth interviews asking a single broad question, *"Please tell me, how do you experience caring for patients with cancer*?" Using probes and asking prompting questions was to enhance an in-depth discussion of experiences and encouraged participants to reflect on their experiences openly. The interviews were conducted in English, in a private room in the hospital during participants' off-duty times and lasted between 45 and 60 minutes. A distress protocol applied and, in two instances, the interviews had to stop due to the emotional distress of the participants. However, both participants declined referral to the psychologist arranged for the purpose of the study and preferred to continue the interview, as they felt it allowed them the opportunity to debrief.

Data management and analysis

Demographic data were entered onto an Excel spreadsheet and analyzed by means of descriptive statistics. The audio recorded interviews were transcribed word for word and the names of the participants replaced with numbers. Data analysis utilized qualitative content analysis, (Sandelowski, 2000), using an inductive approach (Bradshaw et al., 2017; Elo & Kyngäs, 2008). The steps followed were reading the transcripts various times, while making notes and headings in the margins. The headings were transferred to coding sheets and subthemes were generated. The sub-themes were grouped under higher order headings to create themes. All three researchers were involved in the data analyses and used reflexivity in regular discussions, to become aware of how their knowledge and experiences could influence the findings of the study.

Trustworthiness

The principles of Lincoln and Guba explained by Bradshaw et al. (2017) and Shenton (2004), were used to enhance the trustworthiness of the study. Credibility was enhanced by adopting well-established research methods, peer scrutiny of the research project, and member checks. The background and experience of the research team also enhanced credibility, as the team had more than 10 years' experience in the field of oncology nursing, on average, while two members were experienced qualitative researchers. Confirmability was enhanced by means of an audit trial and a description of the demographic characteristics of the participants. Describing the research design and its implementation enhanced dependability, while using purposive sampling and describing the limitations of the study enhanced confirmability.

RESULTS

The participants

Most participants were female (18 of 20), and half (10 of 20) were married. Most (14 of 20) were older than 45 years, five were between the ages 35 and 45 years and one was younger than 35 years. More than half (13 of 20) were registered oncology nurses, whilst the rest (7 of 20) were general nurses; 10 had more than 10 years' experience in the field of cancer nursing, five had 5 to 10 years' experience, whilst the rest (5 of 20) had less than five years' experience.

Themes identified

There were three themes and six sub-themes identified. Each theme will be described briefly below and additional illustrative quotes are provided in Table 1.

Theme 1. Defining the cancer nursing experience

Subtheme 1. Cancer nursing is a calling

Most participants were of the opinion God chose them to care for cancer patients. The participants agreed that not all their colleagues had a calling and those not chosen by God struggled to cope with the challenges of cancer nursing. They thought not staying in cancer nursing for a prolonged period and resigning was a sign there was no calling from God. The participants said:

> *"I think this is my calling to look after cancer patients..." (P19, RN).*

> *"Some of them resign, because they see that they don't belong here, I think it must be a calling ... (P3, RON).*

Subtheme 2: The qualities of a cancer nurse

The participants were of the opinion nurses require certain qualities to care for the patients appropriately. Most agreed a nurse should be passionate about her profession, empathetic, sympathetic, loving, peaceful, emotionally strong, and calm. One participant said:

> *"In oncology you need somebody who is caring and somebody who has listening skills, somebody who sympathizes with the patients." (P6, RON).*

The participants also agreed that knowledge and experience play a vital role in caring for cancer patients. The majority regarded specialist education and training as superior to experience only as it enhanced their ability to function as an independent practitioner and consultant, which boosted their self-confidence. This was described as:

> *"After oncology training, I was more confident because now I knew what I was doing, I understood why things were happening the way they were happening." (P20, RON)*

Table 1

Additional Narratives According to the Themes

Theme 1. Defining the cancer nursing experience
Subtheme 1. Caring for cancer patients is a calling *I feel like I am very fortunate that God chose to work through me to touch those patients and their families* (P15, RN). *I feel when I care for patients in need of help, I feel like I am serving the Great Man who is our God by helping those in need of care, especially when the patient is constantly in pain* (P17, RN).
Subtheme 2. The qualities of a cancer nurse *What is pushing me is that I am a nurse and I was born a nurse. I always collect myself and go to work. It's my passion* (P2, RN). *We don't want adrenalin; we need peaceful people. We need people that understand and is calm like they understand that they are in a different situation* (P13, RON).
Theme 2. The challenges experienced in caring for cancer patients
Subtheme 1. Providing end-of-life care in acute care settings *When you go to the acute [patient], they are like 'sister am I going to be like that?' So it's frustrating, really* (P13, RON). *I need to be honest with you, you stay with them until … I cannot tell you because in actual fact, it is not supposed to be happening* (P10, RON). *Still, it's painful watching people die each and every day and doing so much and it's still not helping* (P20, RON).
Subtheme 2. Coping with the family *You are being insulted … you have fingers pointing at you telling you how useless you are … It pulls you down like where did I go wrong?* (P13, RON). *That is the most difficult part dealing with the relatives because somehow they will be telling you that they are going to sue you. They will be angry at you, and they will keep telling you that they are going to sue you* (P2, RN).
Theme 3. Challenges imposed by the healthcare system
Sub-theme 1. The ever-increasing workload. *We have high number of patients [in the clinic] so the queue is very long… Short staff is not an excuse anymore for you to not render quality service …* (P16, RON). *I feel bad because most of the time, you have to babysit somebody who came on duty to work or to serve the patients, you have to babysit and look for what they are doing to the patient* (P6, RON). *It's exhausting and demanding… I don't have time to myself especially when it comes to mealtimes … but it's highly impossible at times.* (P 18, RON).
Sub-theme 2: The need for support *There is no one to say what you are going through in this ward …* (P8, RN). *We need to be supported a lot because sometimes you feel like now you are crushed and you also need someone to pick you up, but that is not happening … we should be able to debrief …* (P10, RON).

Theme 2. The challenges experienced in caring for cancer patients

Subtheme 1. Providing end-of-life care in acute care settings

The participants experienced the presence of patients treated with palliative intent only, as time consuming, physically and emotionally exhausting, frustrating, and discouraging. The participants agreed there was often neglect of patients receiving anticancer treatment, which evoked guilt feelings. They also believed witnessing the condition of the terminally ill patients caused fear and anxiety in those who were acutely ill. A participant explained:

> *"Sometimes you will admit a patient for supportive care and the doctor will tell you just make the patient comfortable… sometimes you feel like you end up neglecting other patients because of those patients because you are constantly looking after them" (P12, RN).*

Some participants had difficulty in caring for dying patients and accepting that a patient has died. Having to witness the deaths of three to four patients per day was overwhelming. However, support from colleagues, pastors, and psychologists, and days without a death helped the participants cope. In addition, nursing a patient with a good prognosis also helped to cope with the deaths of those terminally ill. A participant explained:

> *"There are some days where the day will go by without seeing patients dying in front of you… actually that again keeps us going when we see patient getting better" (P8, RN).*

Sub-theme 2: Coping with the family

Caring for the family was not easy and the participants experienced families as mostly rude, physically and verbally aggressive, and unappreciative of their work. They experienced their working environment as unsafe due to the aggressive nature of family actions and the threats of litigations posed on them. A participant described her experience:

> *"The other thing is our patients' relatives … there was a patient who passed on … the relative wanted to hit me with a fist. He ended up breaking the walls … if I didn't run away at that time, that relative was going to hit me …" (P6, RON).*

Even though the relationship between families and the participants was often poor, the participants agreed some relatives were appreciative and understanding, which encouraged them. One explained:

> *"Other families are very appreciative. It is so encouraging to get just a simple thank you … every single day they will be like, you are doing a good job" (P12, RN).*

Theme 3. Challenges imposed by the healthcare system

Sub-theme 1. The ever-increasing workload

The participants experienced a constant workload increase and a shortage of staff. They felt they had to make do with the available staff, but felt guilty about the time they spent with the patients. Having time to take a breather also became a challenge. A participant explained:

"I feel bad because we are always rushing, we don't have time to sit with the patient and try to allay her anxiety and make her feel at home … even when you are at home, you think about what you did, you feel like you didn't do enough" (P10, RON).

The high workload did not allow for the rendering of best quality of care and led to errors. Some participants corrected the mistakes other members of the multi-professional team made. In addition, some were so exhausted that they doubted whether they would return to work. A participant said:

"At the same time, you don't just nurse the patient, you nurse their family, you nurse your colleagues, you nurse the doctors, you nurse everyone in the hospital, so it's just too much … physically it takes a toll because it's really busy, when you knockoff you're so tired … you are like I don't want to go back tomorrow" (P8, RN).

Sub-theme 2: The need for support

The participants' opinions were that the senior nursing management added to their emotional distress. They needed debriefing opportunities and emotional support to stay motivated, but experienced management to be unsupportive, available only when adverse incidents occurred and constantly searching for mistakes. Management also failed to mentor or give advice when challenges were encountered. A participant said:

"The person you report directly to does not have a clue about nursing oncology patients, so she doesn't understand some of the things, so they don't offer any advises…" (P16, RON).

DISCUSSION

The participants in the study were typical of nursing in South Africa in terms of age and gender. However, what was surprising, was the sample consisted primarily of registered oncology nurses, as only 699 of approximately 400,000 nurses on the register are registered oncology nurses (South African Nursing Council, 2021). Irrespective of being a registered oncology nurse or general nurse, the participants believed their work was a calling, and that God had chosen them to care for cancer patients. Raatikainen (1997) found nurses who believed they were called, practiced on a high professional level, and had a good understanding of the patients' needs and the importance of the patients' families. In addition, these nurses were able to support their patients well and offered support to the families.

As evidenced from the study, the participants were subjected to workplace violence inflicted by some family members. Family members have been found to be the primary perpetrators of workplace violence against nurses (Choi & Lee, 2017). Similar to what was found in the current study, Granek et al. (2019), in a study focusing on oncologists, described incidences where family members behaved in a violent manner toward the staff. Radiation therapists also described workplace violence, but the perpetrators were not family members, but the patients themselves (Sperduti et al., 2018), which could be related to the fact that family members are not allowed in the treatment room.

The study provided evidence that caring for dying patients in acute cancer care settings was not easy. Manicom (2011), when investigating the place of death of South African cancer patients using private healthcare, found that irrespective of having good access to hospice care, 34.2% of the 424 recorded deaths took place in medical wards under the care of an oncologist. How this relates to public healthcare is not known. However, McWhan (1991) reasons that the main responsibility of nurses practising in acute care settings is to care for patients receiving active treatment. Burt, et al. (2008) found caring for palliative patients unpredictable and time consuming, and that it leads to additional pressures if added to the care load of generalist nurses. Fuly, et al. (2016) also found the more compromised the functional ability of the patient is, the higher the nursing care activities are. This was also evident from the current study, as the participants found the time spent in caring for dying patients resulted in neglecting the care of acutely ill patients, a situation that led to guilt feelings, as they believed they did not provide optimal care to the acutely ill patients.

As seen from the study, the participants experienced the workload as increasingly overbearing. The fact that they were always rushing and did not have time to provide the best quality nursing care, added to the emotional distress they experienced. Lawler et al. (2020), when investigating the perceived results the workforce pressure has on the nursing care of cancer patients, found psychosocial care to patients and their families one of the most forsaken aspects of care. As seen from the current study, not having time to sit with patients and allay their anxiety, indicates the opportunity for nurses to provide psychosocial support and care, an aspect of cancer care that limits suffering (Maree et al., 2021), has already been eroded by the workload.

In addition, as evident from the study, the workload has led to errors that demanded correction from some participants. Having to be the watchdog over the practices of nursing colleagues and other healthcare professionals and having to care for colleagues, patients, and their families was so exhausting that some participants doubted whether they would have the strength to return to hospital the next day, which could indicate burnout syndrome. Workload and the nature of oncology nursing have been identified as the major contributors to burnout syndrome (Cañadas-De la Fuente et al., 2018), which is related to emotional and physical fatigue due to long-term job stresses (Wentzel & Brysiewicz, 2018). Although colleagues provided social support, the participants experienced the senior nursing management as unsupportive, which is not in the best interest of either the participants or the patients, as burnout has a direct influence on patient care (Velando-Soriano et al., 2020).

Lastly, as evident from the study, the participants expressed a need for debriefing opportunities. Wenzel et al. (2011), when investigating barriers and facilitators to the loss of cancer patients, found debriefing sessions were helpful to some nurses, but not all benefited from it. However, McCorkle (2016) urges nurses to form a group to share their stories in the absence of regular debriefing sessions, in order to gain insight into their experiences, to stay healthy, and to be able to care for cancer patients.

LIMITATIONS

The study took place in one academic hospital forming part of the public healthcare system, and the majority of participants were registered oncology nurses. Considering the differences in the provision of cancer care across South Africa, the findings of this study might not reflect the experiences of nurses practising in other cancer care settings. In addition, no qualitative study presents the only truth, as other researchers could interpret the raw data differently.

CONCLUSION

Most nurses who participated in this study believed God called them to care for cancer patients. However, they experienced various challenges that hindered them from providing high quality of care to the acutely ill patients. They experienced guilt feelings as they believed the care they provided was insufficient. They were subjected to workplace violence, missed the support from senior nursing management, and displayed signs of burnout. Addressing the staff shortages, providing support, coaching nurses how to manage abusive family members and providing debriefing opportunities could limit their emotional distress and prevent burnout. Lastly, for a better understanding of the experiences of nurses practising in cancer care settings in South Africa, future research should include nurses from a variety of cancer care settings – public and private, urban, sub-urban, and rural.

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