Oncology nurses' perceptions of their relations with family members in an ambulatory cancer care setting: A mixed methods study

by Michelle Lobchuk and Sonia Udod

Abstract

Trends signal an increasing prevalence of people living through and beyond a cancer diagnosis with an enhanced reliance on ambulatory cancer care services and family caregiving. Despite this trend, there has been limited focus on nurses' experiences with providing support to families who care for patients in the community. For oncology nurses in ambulatory care settings, job satisfaction has decreased significantly as they are concerned with their ability to consistently provide safe and quality care to patients and their family. Although other studies indicated that the lack of time and limited resources are regrettably accepted aspects of nurses' work environments, our mixed methods small-scale study addressed how work environments still can meet the growing need for enhanced support and relations among nurses, patients, and families in ambulatory cancer care.

In light of increasing trends toward ambulatory cancer care, oncology nurses are called upon to be efficient and effective in teaching patients and families principles related to supporting and caring for individuals with cancer (Canadian Association of Nurses in Oncology [CANO], 2001). Not only are nurses required to assess actual and potential health problems of people they care for, but also attend to the patient-family system as it impacts on the social, economic, physical, spiritual, and emotional care needs of patients (CANO, 2001). Bakker, Fitch, Green, Butler, and Olson (2006) revealed that despite significant challenges in their present work lives, oncology nurses are able to keep going "for now" (p. 84). Emergent findings are highly suggestive of the need for work environments to support oncology nurses, as they endeavour to strike a balance between clinical or more technical aspects of their role in ambulatory care settings and ability to preserve vital nurse-patient-family relationships (McIlpatrick, Sullivan, & McKenna, 2006; McLeod, Tapp, Moules, & Campbell, 2010).

Relationships that nurses establish in the workplace with nurse colleagues and other health care providers are "instrumental" to nurse job satisfaction (Baker et al., 2010, pg. 62). However, nurse relationships with family caregivers are often an overlooked feature of nurse satisfaction with their quality of work life (Laschinger & Finegan, 2005; Laschinger, Almost, & Tuer-Hodes, 2003). Eriksson (2001) and Lindholm, Makela, Rantanen-Siljamaki and Nieminen (2007) reported that family caregivers evaluate the content of care and the manner in which it is delivered, including professional skills, trustworthiness of staff members, and safety of care. Frustration in family caregivers is often caused by the paucity of health care providers and the lack of encouragement to engage in shared decision-making regarding patient care (Flanagan, 2001; Isikhan, Comez, & Danis, 2004; Tamayo, Broxson, Munsell, & Cohen, 2010; Vivar, Canga, Canga, & Arantzamendi, 2009). In their recent qualitative study, McLeod, Tapp, Moules, and Campbell (2010)

described one family member's response of feeling scared and isolated in a care environment that was perceived as being impersonal, uncaring and insensitive. This family member observed that nurses were challenged to offer relational aspects of care in a time constrained, task-oriented nursing work environment that contributed to his or her frustration and fears. It is generally known that family caregivers can feel overwhelmed with the pressure associated with caring for their loved ones, which can be compounded by their perceptions of a lack of relational support by nurses. This is affirmed by Greco, Laschinger, and Wong (2006) who stated that the organizational structures within the workplace shape nurses' work experiences, and that removing barriers between nurses and individuals to whom they provide care facilitates professional nursing practice. This underscores the importance of understanding factors in the environment in which nurses work, which can have an effect on outcomes nurses experience, as well as patient outcomes (McGillis Hall, Doran, & Pink, 2008).

Several compelling reasons underscore the need for the present inquiry. Cancer is a chronic disease that can have long-term impacts on patients and families. According to 2010 Canadian Cancer Society statistics, between 2009 and 2010 there has been a 1.6% increase in new cases of cancer and a 1.2% increase in cancer deaths that are attributed to the growing and aging population in Canada (The Canadian Cancer Society's Steering Committee, 2010). The Public Health Agency of Canada (2004) estimated that by 2020, the number of cancer patients receiving treatment in Canada will have doubled from 2001. Clearly, estimates of a growing incidence of cancer and the reality of an increasing older cancer population have major implications for nurses working in ambulatory care. Although policies in Canadian health care institutions are aimed at improving nurses' working conditions, those at the front lines, including oncology nurses, are experiencing little improvement in their quality of work life (Priest, 2006; Torgerson, 2007). Nurses in Canada face a serious nursing shortage that threatens to compromise care for citizens, including those living with cancer and their families (O'Brien-Pallas et al., 2005). Both the prevalence and chro-

About the authors

Michelle Lobchuk, RN, PhD, Associate Professor, Faculty of Nursing, University of Manitoba, Faculty of Nursing, Room 315, 89 Curry Place, Winnipeg, MB R3T 2N2.

Phone: (204) 474-7135; Fax: (204) 474-7682;
Email: Michelle.Lobchuk@umanitoba.ca

Sonia Udod, RN, MN, PhD(c), University of Saskatchewan, College of Nursing, 107 Wiggins Road, Saskatoon, SK S7N 5E5

nicity of cancer, the lack of improvement in the quality of nurses' work life, and the nursing shortage are impediments to construing families as "partners of care". Nurses' perceptions of the role of families as a client, a resource, and/or a collaborator in planning and providing patient care have not been explored in ambulatory cancer settings. Given that family caregivers are essential partners in patient care, as they are often experts in the patient's illness experiences, social situation, behaviours, attitudes, preferences and even risk factors (Hobbs & Sodomka, 2000), health care administrators need to find meaningful ways to support nurses in maintaining and facilitating safe and effective patient care, and family caregiver support. Supportive work environments benefit oncology nurses and ultimately the quality of care they provide to individuals diagnosed with cancer and their families.

In this exploratory descriptive study, we asked (1) What are oncology nurses' perceptions of their care and relationships with patients with cancer and their families in an ambulatory cancer care setting?; (2) How do oncology nurses' perceptions of their care and relationships with patients and families serve as facilitators or barriers to nurse satisfaction in quality of work life?; (3) What are oncology nurses' perceptions of their work environment in their care and relationships with patients and families?

Methods

This was an exploratory descriptive study where we employed both quantitative and qualitative methods study with a purposive sample of nine nurses working in a variety of disease site clinics at a cancer agency in a western province in Canada. Ethical approval was obtained from the Education/Nursing Research Ethics Board and access approval was granted from the Resource Impact Committee at the cancer agency. The chief nursing officer invited us to meet with clinic nurses during their rounds at two sites and invite them to participate in the study. Letters of invitation were left with the nurses that requested they indicate whether they would agree or not agree to participate in the study. The research nurse then collected the invitation letters and proceeded to contact nurses who agreed to participate to schedule an after-hours focus group interview at a date and time that was agreeable to participating nurses at two respective recruitment sites. At both sites, the nurses agreed to attend the respective focus meetings immediately after their workday in an off-agency conference room for one recruitment site, and in the staff conference room at the other recruitment site. In appreciation for their time and efforts as participants in our study, we offered participating nurses a \$25.00 honorarium plus provided a full meal prior to commencing the focus group interviews. The research nurse led the focus group questions and the first author (ML) attended, as a participant observer, during the focus group interviews. To ensure that the recording device was operational, a research assistant also attended the first focus group, but did not participate in the data collection protocol.

After obtaining informed consent, the research nurse had asked participants to complete an investigator-developed 18-item Nurse Demographic Questionnaire, followed by the 17-item, four-point (3, Yes I did this; 2, Yes, another nurse did this; 1, No, not done or don't know; 0, Does not apply to families here) Nurse Activities for Communicating with Families Questionnaire (Activities), the 14-item ("Yes" or "No" response items) Barriers to Care Questionnaire for Nurses (Barriers), and the three-item, 11-point (0, not at all satisfied to 10, very satisfied) Meeting Family Needs—Nurse Questionnaire (Satisfaction). These tools were originally developed to capture nurse perceptions of helping families of patients in intensive care units (Downey, Engelberg, Shannon, & Curtis, 2006). To ensure appropriateness and clarity of nurse demographic questions, instrument items, and focus group interview questions we consulted with the chief nursing officer, an advanced practice

nurse, and one clinic nurse at the cancer agency. Several minor revisions were made to incorporate appropriate response options only on the demographic tool.

After completion of the questionnaires, the research nurse conducted the audio-recorded focus group as guided by an investigator-developed interview schedule. The questionnaires and focus group interviews held with two groups (Group 1, $n=7$; Group 2, $n=2$) took two hours for participants to complete. After the research nurse spoke with nurses who were interested in participating in the study, we had planned for eight nurses at one site and three nurses at the second site to participate in respective focus group interviews. We were not able to identify reasons for non-participation of two nurses. Although the sample was small for the second focus group, we decided to proceed as these nurses could speak to their relationships with families in their nursing role and work environment at that recruitment site.

Descriptive statistics were employed to capture the socio-demographic characteristics and questionnaire responses by participants. Content analysis was employed to address study questions one to three. The audio-tapes of nurse responses to the semi-structured interview guide were transcribed and the resulting transcription was analyzed by two investigators (ML and SU) and a research assistant using content analysis and constant comparison techniques to identify, code, categorize, classify, and label the primary patterns in the data (Lincoln & Guba, 1985; Patton, 2002; Strauss & Corbin, 1998).

Findings

Table 1 identifies that all participant nurses were Caucasian and female. The majority were between 35 and 44 years of age and had attained either a baccalaureate degree or graduate-level education. Most nurse participants had received certification in oncology nursing. Seventy-eight per cent were employed in permanent, full-time positions and all participant nurses worked eight-hour day shifts. Nurse participants worked either in clinical education, the clinical investigations office or a range of clinic areas, including benign hematology, thoracic, bone marrow transplant, surgical oncology, head and neck, or multiple clinic sites. On the day of the respective focus groups, eight nurses reported having worked eight hours. Over the last seven days, seven nurses worked 35 to 40 hours, and two nurses worked between 40 and 45 hours. The majority worked one or more years in their respective current cancer clinic and mainly with medical oncologists in caring for their patients; one nurse reported that she worked with *both* medical oncologists and hematologists; and two nurses reported they worked with medical, radiation, *and* surgical oncologists. The majority of participants had worked as a nurse between 10 and 35 years.

On the Activities scale (Table 2), 100% of participating nurses endorsed that they engaged in the following eight of 17 activities with families: they explained medical equipment, discussed things that the patient valued in life, the illness and treatment, patient's feelings, reminisced about the patient, reassured the family that it is all right to talk to and touch their loved one, discussed what the patient may want, and assured families that the patient would be comfortable. The least frequent item endorsed was discussing spiritual or religious needs of families although the majority of nurses stated they attended to this family need. On the Barriers scale (Table 3), the majority of nurses endorsed the following items as barriers in addressing families' needs: dealing with angry families, unrealistic expectations, lack of privacy, language difficulties, and not enough nursing staff. No nurse participants identified the visitation policy as a barrier and only one participant identified the lack of support from nurses or social work as a barrier. Barriers that were least endorsed by nurse participants were physicians who discouraged communication with families, families who

Table 1. Sample characteristics of oncology nurses		
Characteristic	No. of Nurses	%
Gender: Female	9	100
Age: 35-44 years old	6	67
45-64	3	33
Caucasian	9	100
Education		
Hospital Diploma	2	22
College Diploma in Nursing	1	11
Bachelor Degree in Nursing	2	22
Bachelor Degree in Different Field	2	22
Master Degree in Education	1	11
Missing	1	11
Length of time in Nursing		
≥6 and < 10 years	2	22
≥10 and <15 years	3	33
≥15 and ≤35 years	4	44
Certification		
CON(C)	5	56
CNCC(C)	1	11
Missing	1	11
Not applicable	2	22
Employment Status		
Permanent Full-time	7	78
Permanent Part-time	2	22
Regular work shift		
Days, 8 hour shift	9	100
Length of time working in current disease site clinic		
≤1 year	2	22
> 1 year, ≤5 years	4	44
> 5 years	2	22
Missing	1	11
In your clinic, who provides medical care to patients		
Medical oncologist	6	67
Radiation oncologist	3	33
Surgical oncologist	1	11
Hematologist	4	44
# hours worked in the past 7 days		
<35 hours	2	22
≥35 hours, ≤40 hours	5	56
>40 hours, <45 hours	2	22
# hours worked in the past 24 hours		
<7.75 hours	1	11
≥7.75 hours, ≤8 hours	6	67
>8 hours	1	11
Missing	1	11
Shift worked today		
8 hour day shift	8	89
Missing	1	11
Position at cancer agency		
Staff Nurse	6	67
Clinical Educator	1	11
CNS	1	11
Other	1	11

did not visit or call, patients were too sick, conflicts with physicians, and dealing with families is outside scope of practice. Within a theoretical range of zero to 10 units, mean scores for three items on the Satisfaction scale were: satisfied that nurses met the family's emotional needs ($m=6.77$, $SD=1.98$), physical needs ($m=7.33$, $SD=2.06$) and that the health care team met the family's needs ($m=7.0$, $SD=1.66$). The mean score for the Satisfaction (total) scale was 7.04 ($SD=1.46$; theoretical range: 0 to 10 satisfied).

Focus group findings

Several overarching themes emerged from this pilot study. Both positive and negative factors influenced nurses' relationships with patients and their families in the environments where they worked.

Table 2. Activities Questionnaire (17 items)				
Item	% (n) Endorsed	Mean (SD)	Median	Range
ACTIVITIES				
1. Explain medical equipment	100 (9)			
2. What to expect during conferences	89 (8)			
3. Spiritual or religious needs of family	67 (6)			
4. Action to address spiritual/religious needs	78 (7)			
5. Specific cultural needs	89 (8)			
6. Action to address cultural needs	78 (7)			
7. What patient valued in life	100 (9)			
8. Patient's illness and treatment	100 (9)			
9. Talk with family about feelings	100 (9)			
10. Reminisce about patient	100 (9)			
11. All right to talk and touch their loved one	100 (9)			
12. Discuss what patients may want	100 (9)			
13. Locate private place for families	78 (7)			
14. Disagreement among family	78 (7)			
15. Changes in patient plan of care	78 (7)			
16. Support decisions families made re: care	78 (7)			
17. Assure families patient would be comfortable	100 (9)			
Total Activities Scale		15.33 (1.94)	16.00	11 to 17

Workplace factors. Participants described the structural environment as lacking satisfactory conditions to provide effective patient and family care. Participants expressed a lack of time, space, and occasionally, control over their work environments to adequately meet patient/family care needs. Nurses overwhelmingly referred to a lack of space to meet with patients and families to provide privacy and comfort in helping them effectively respond to potentially life-threatening situations. One participant described this in the following manner:

Yeah, and I wonder how much it opens up for them to be able to feel comfortable to ask questions when there is a roomful of strangers there, like I think sometimes they wait a little bit too long to ask about something maybe because they don't want to be in front, in front of everybody asking.

Participants also described the workplace as frequently lacking physical and human resources to satisfactorily meet patient/family care needs. Limited financial resources and time often precluded nurses from attending educational workshops to enhance their knowledge and skills, for example:

... how do we continue to support [patients], you know sometimes it's nice to go to education sessions, but there's often no time... and there's no money and there's nobody to replace and so that's a barrier too because sometimes whether you go or

not it's, you walk out feeling that you know what you may be doing exactly what they've told you but you now know that you are making a difference 'cause they're reaffirming that you're doing the right thing. So that's kind of a support as well.

Participants also indicated that a lack of nursing staff compounded their heavy workloads, for example:

What happens with the research nurses in our department is we often end up going beyond what our job description entails... We are supposed to be like study coordinators conducting the trial, consenting the patients, doing the work-up to get them on the trial and following their treatment on the trial and focusing when you're with the patient, grading their toxicities and you know getting all their meds and doing the paper-work part of it. But the problem is we've all come from clinic, so we still have that in our background and we all tend to take over the role of the primary care nurse, which we are not supposed to be doing. I always slap the other nurses' wrists when they do it, and then I go do it myself, because the thing is we can't afford the time... We have sixty-two open trials right now, and we don't have enough staff nearly to cover that.

Yet, participants cited a positive reliance on other nurses, health care team members, and had earned physicians' trust in addressing patient and family needs. Nurses relied on these supportive relationships to facilitate the coordination and achievement of patient/family care needs in the cancer clinic. In addition, participants spoke positively of a support group that assisted nurses in dealing with traumatizing events such as the loss of a patient. Most important, supportive relationships with colleagues were instrumental in enhancing the quality of nurses' work life and enabled nurses to respond more effectively to the challenges they encountered with oncology patients and their families. Despite the shortcomings in the physical environment, the relations nurses had fostered and maintained with colleagues provided the leverage needed to focus on the patient/family unit.

Patient/family factors. Participants characterized families as having a range of emotions and behaviours, and portrayed families as: not engaging with the patient's treatment, not being open to receive information, not asking questions, and refusing the assistance of various health care team members. Some participants' inability to help patients/families was not necessarily due to a lack of competence, but because patients/families did not want to access the support services of other members of the health care team. When this occurred, nurses assumed the additional task of caring and responding to the anxiety patients and their families were experiencing, for example:

I think sometimes you just get stuck with patients too; sometimes patients don't want to be referred off, especially if they have mental health kind of issues that are like ongoing anxiety concerns. Sometimes those patients are just not willing to be referred to someone to help them and sometimes you feel stuck, because of [the] timeframe, because you know their needs are just too draining on you [...] the amount of resources that you would have to put in to the person is just too much and you can't refer them on.

While active family involvement was strongly supported and valued, participants noted families wanting to be actively involved in their loved one's care was cumbersome and time-consuming for participants. Challenges arose when multiple family members independently approached the nurse about a patient's treatment plan or when distance among family members made it difficult to interact and convey key information about a patient's treatment plan; for example:

Item	% (n) Endorsed	Mean (SD)	Median	Range
1. Not enough nursing staff	100 (9)			
2. Patients too sick	33 (3)			
3. Conflict with physician	33 (3)			
4. Physician discouraged communication with families	22 (2)			
5. Lack support from nurses/social work	11 (1)			
6. Outside scope of practice	33 (3)			
7. Visitation policy limits time with families	0 (0)			
8. Families do not visit/call	22 (2)			
9. Lack of communication between professionals	22 (2)			
10. Angry families	56 (6)			
11. Unrealistic expectations	67 (6)			
12. Personal difficulties with families	78 (7)			
13. Lack of place to communicate privately	44 (4)			
14. Language difficulties	78 (7)			
Total Barriers Scale	78 (7)	6.55 (3.47)	6.00	1 to 12

But distance can be an issue too, because especially people living farther away can feel quite helpless and out of touch and they're not contributing, so it's to spend some time with people [who] may not be right there in that clinic room but still part of the family.

Participants noted that regardless of whether families were actively engaged or not engaged in the patient's care, patient and family expectations were frequently incompatible with the time, energy, knowledge, or skill available to nurses. Despite these constraints, participants spent considerable time and commitment providing comfort and being sensitive in responding to patients/families given their stage of coping in dealing with the cancer diagnosis. In essence, nurses characterized themselves as juggling multiple family/patient needs and demands, and significant time was spent tending to relational issues.

Satisfaction with quality of work life. Participants overwhelmingly described satisfying activities that involved developing and maintaining trusting relationships with patients and their families as critical to the quality of their work life. Establishing rapport, dealing with challenging patient and family dynamics, engaging in ongoing contact, and witnessing progress post treatment and post bereavement were described as integral to quality of work life. Three participants share their perspectives:

Because you sit and sometimes [during] the first cycle, you sit and do small talk just to sort of ease things, so you're learning about their family, how many children do they have, where are they from and kind of just making chit chat and that sort of relaxes them... and then they ask you about your family, so you get, you get to know each other well. I mean not everybody, but a lot of them.

And, and it's funny [...] because we're a small group [...] I think they have to feel like they do know us because they put so much trust into us.

I love them because it's a challenge to me to bring them from here right down to here, bring them on, any crazies or [those] that are really stressed out and they're angry and they want to come in and ...they're going to tell you what for and this is going to happen and ... I love it...

Helping patients and families navigate their treatment options and systemic changes required time and commitment, yet participants found assisting the patient/family unit to cope more successfully in their cancer care rewarding and gratifying. Participants also experienced job satisfaction when verbal or written acknowledgements were offered in appreciation of their nursing care by colleagues, patients and families. Participants described a sense of being respected and valued for their knowledge and skill in working with this specialized patient population, which positively influenced their relations with patients and families.

Equally important, participants described job satisfaction as having some autonomy in structuring tasks and activities in their workday. Participants' ability to make decisions and determine their workloads in a manner that met both their needs and patient/family needs was indicative of their ability to have control over practice. For example, a participant stated:

I can choose how to spend a good majority of my day, there's the must-do's, but sometimes I can set some of the must-do's aside to do the things that I want to do for satisfaction, as well too, the icing on the cake so to speak.

Dissatisfaction with quality of work life. Participants described a range of experiences with patients and families that decreased their quality of work life, including dealing with challenging patients/families and recognizing their lack of skill or training in responding to patient/family issues:

The people that actually require counselling I'm red flagging, yes you need... someone who can work with you here beyond what my scope is, and support you. And I think it, you know there's the general support you can give your general patient, but I think it's important to, to realize what our limitations are and those patients that need help beyond what we can provide, as well, and I think sometimes we get in over our head not realizing that... but to catch yourself and refer them on... we want to help people that's why we're in nursing, we want to please people, we know this is a bad experience, we want to make it as livable as possible.

While participants recognized their limitations, at times they experienced a sense of powerlessness and frustration in not being able to deal effectively with patient/family issues, and frequently felt their care was compromised, as several participants aptly stated:

... but you do think of a few negative cases where either the husband and wife themselves didn't get along, and there was always conflict when they came to the clinic... They brought a lot of their problems with them and they'd be fighting right there in the exam room... It certainly does happen and it's something that we do need, some help and support in how to deal with that.

The majority of participants described numerous aspects of moral distress, including balancing patient/family needs with nurse needs; dealing with clashes with patients', families', or physicians' opinions on the care plan for patients; questioning whether the patient or family are truly informed about the treatment plan; and advocating for the patient about the family decisions about treatment or care:

'Cause if basically you're there and you're hooking them up to their treatment and you've asked how they are and you're off and going to another patient that you don't really feel like you're actually listening to what they're saying about how they are. So I think the biggest factor is time, being able to spend the time.

... there's the odd time where we really have to wonder if the patient has been totally informed and so there's that conflict there... do they really know that they can stop this [the treatment], or you know their side effects are so horrendous that you wonder has anybody told them that they can stop [the treatment] or maybe the little old lady that's somewhat demented, like does she really know what's going on here, or is she being dragged by her daughter or her son because this is the thing, that we want to hang on to mom.

And sometimes it's actually advocating for the patient about the family... Like you know, do they really know that they need to do this?

Nurses overwhelmingly placed the needs of patients and families above their own, yet balancing competing needs compounded workplace limitations. Other instances of moral distress were depicted by nurses as situations where patients'/families' wants, needs, or expectations exceeded nurses' resources or their capacity to effectively meet patient care:

Some people do a lot of research on the internet and come in with what they think is the knowledge about what to expect from us and maybe a little bit disappointed with what we give them, I don't know [...] what they really expect from us, but it's definitely probably not what they get, more time I think is what they, I think, are looking for from us. We don't have time, and there's no privacy.

Discussion

In this pilot study, limitations were related to recruitment and the small study sample in two cancer clinic settings. In this small convenience sample, it is likely that nurses interested in participating in focus groups on nurse-family relationships might have introduced a bias in their responses, thereby making it difficult to generalize findings to nurses across other cancer clinic settings and cancer agencies. However, our interview questions were well received by participants who provided rich and varied responses to their experiences in working with families in various clinical areas. Following the focus-group interview and the research nurse's prompt for feedback, the participants shared that they found the questionnaire items to be acceptable and they were able to complete the questions with limited difficulty. Due to the small sample size, Cronbach's alpha reliability estimates were not conducted on the Activities, Barriers, and Satisfaction scales. One interesting observation was that the research nurse had to frequently redirect participants' responses to the family versus their care of the patient. This suggests that the nurses' primary focus was to meet patients' needs, which came more readily to mind than identifying how they specifically addressed families' needs. McLeod, Tapp, Moules, and Campbell (2010) also reported that nurses in their study regarded the family as the context for patients that helped them to offer sensitive patient care. However, once prompted to focus on their care of families, participants provided us with rich and deep responses to interview questions.

Although nurse participants ranged in their length of experience in the nursing profession and length of time employed at the cancer agency, all nurses described their various *activities* in attending to families' needs as part of their care. The participants spoke about the value in active listening, empathy, and respect for family members and patients as "units of care." They were sensitive to the complexity of relationships among patients and family members, challenges that families faced with a cancer diagnosis, and differences between responses and coping by patients and families due to ethnicity, age, and sexual orientation. The participants also expressed that families often came with their own expectations about cancer care. Leahey and Harper-Jacques (1996) documented this as an "interface between the patient/family system and the nurse system" (p. 134), and is supported by recent qualitative findings by McLeod, Tapp, Moules, and Campbell (2010). The participants exhibited a curiosity about patients' and families' lives denoting their recognition of the human side to dealing with cancer. They talked about normalizing the illness experiences, which McLeod, Tapp, Moules, and Campbell (2010) also described and Morse (1991) labelled in early literature as a therapeutic relationship where the nurse embraces the ill individual as a patient and a "person with a life 'outside'" (p. 458). Non-hierarchical relationships were promoted by participants, as revealed in their descriptions of how they shared of themselves and valued or acknowledged the contributions of cancer patients and families in the care. Madsen (2009) would identify this approach as "highlighting client wisdom" where nurses did not privilege their professional knowledge over the patient and family's knowledge. Similarly, Leahy and Harper-Jones (1996) might say that these nurses embraced a "non-problem saturated lens" to talk about things that families and patients do well when faced with cancer. "Attending" activities are empathy-based, communicative behaviours that were used by nurses in this study (Kruijver, Kerkstra, Bensing, & van de Wiel, 2000). Intended to bring comfort to patients and families and support family strengths, this study's participants extended a special touch and took time to talk about life in general and fun events in the patients' and families' personal lives.

The participants worked at maximizing families' informational and emotional supports by encouraging them to take a questioning

stance, providing information on how to navigate the cancer system, being sensitive to their stage of coping, providing reassurances about the health care team and, feeling their pain. The nurses were comfortable in teaching patients and families about basic communication skills to take an active role and promoting self-advocacy and assertiveness in addressing their questions at the medical consultation and even seeking resources in the larger system. Nurses were aware of the oppressive and constrained nature of the cancer care system and they frequently advocated with families to draw attention to patient and caregiver needs. Overall, these nurses described their range of interactions and interventions, suggesting their commitment to their relationships with patients and families while striving to balance priorities defined by the work place, for the good of patients and families, as well as establishing boundaries for the good of themselves. While these participants worked within a sickness-oriented system, they still defined the patient and family experiences within the context of their day-to-day existence. Despite the absence of a formal approach in the agency to assess family needs, circumstances, strengths and goals, the participants described their active pursuit of the family to determine their ability to cope and access services to meet their and the patient's needs.

Of note is that addressing spiritual or religious needs of families was endorsed least by 67% of the nurse participants in this study. However, this finding might coincide with Taylor's (2006) body of work that described patient and family need for spiritual assistance in cancer care was only moderate and varied. Moreover, Taylor (2006) argued that patient and family spiritual needs are represented by varied ways of being that include being positive, loving others, finding meaning, and relating to God. Ultimately, Taylor advised nurses to be prudent in approaching patients with spiritual care and only when there is an overt need expressed by patients and families who are likely dealing with hospitalization or a life-threatening cancer.

The most common perceived *barriers* identified quantitatively were: not enough nursing staff, unrealistic expectations of families, lack of private space, language difficulties, and dealing with angry families. Similarly, Bakker et al. (2010) recently reported that 39 percent of their nurse sample indicated there were not enough registered nurses on staff to provide quality care. In treatment or chemotherapy settings where particular emphasis is on tasks, skills, and the technical nature of cancer care, participants' qualitative responses revealed their challenges in achieving a balance between providing those types of nursing activities and emotional care for patients and families. As in McIlpatrick et al.'s 2006 study, participants expressed a keen sense of needing to "be with" patients and families, particularly those receiving treatment for the first time. To meet family and patient needs in spite of their constrained time, these nurses took initiatives in seeking solutions by relying on the support of other nurses as they attended to anxious "first cycle" patients and families. Kelly (1998) coined this as "real-world" caring where nurses negotiated relationship building and administration of treatments to patients. The lack of space was also captured by McIlpatrick et al. (2006) where nurses were limited in being able to develop relations with patients and families who may be reluctant to voice their concerns in open treatment areas.

Another major barrier was in having to deal with the anger of families, as reported in other studies (Beckstrand & Kirschhoff, 2005; Beckstrand, Smith, Heaston, & Bond, 2008; Heaston, Beckstrand, Bond, & Palmer, 2006). However, a number of experienced participants described their commitment to persevere in aiding to resolve or clarify misconceptions, and work through emotions until desirable responses or behaviours were achieved. Other nurse participants described the importance of teamwork that involved drawing on each other when either they experienced

time constraints or challenges due to personal issues with the family. Feelings of frustration and the need for support arose when participants questioned the treatment plan and whether families and patients had a good understanding of the appropriateness of the plan in terms of their goals, values, and ability to deal with the demands of the treatment plan.

Frustration is a signal of moral distress that nurses can suffer when their moral values are compromised by restrictions in the work environment, institutional obstacles, and interpersonal conflict (Corley et al., 2001; Peter, Macfarlane, & O'Brien-Pallas, 2004; Shepard, 2010; Zuzelo, 2007). Certain clinical events suggested the possibility of moral distress experienced by nurses. For instance, when nurse participants questioned whether the patient and family were truly informed about the care, they felt compelled to advocate for the patient by seeking reassessment by physicians of the patient's needs, values and goals. This finding is corroborated by Fitch's (1998) qualitative study where nurses described their mediating role when conflicts existed in goals between family members and patients. A number of nurses identified a need for more time during their work day to attend educational and support sessions where they feel "safe" to validate and share in their problem solving in morally charged situations or complex dynamics between patients and families. Nurses in Bakker, et al.'s (2010) study reported a similar need for active staff development and continuing education opportunities in their work settings.

The highest ratings of *satisfaction* with quality of work life and family relations were related to behaviours under the nurse's control and perceived as helpful, such as meeting the physical needs of families. Nurses described engaging in initiatives to find physically comfortable places in the clinic setting where families and patients can "safely" discuss their concerns and questions in comfort and privacy. Autonomy in the nurse role to meet families' needs was highly valued in relation to job satisfaction that is well supported in the literature (Bakker, Fitch, Green, Butler, & Olson, 2006; Cummings et al., 2008; Zangaro & Soeken, 2007). Clearly, participants were positively responsive to an autonomous, yet collegial work environment that supported them in caring for patients and families. The least satisfaction arose in meeting emotional needs of families. Challenging family dynamics at times required the nurse to remove or distance herself from angry patients and families. In this study, nurses who expressed less confidence in performing different communication tasks tended to distance themselves from uncomfortable or emotionally charged family situations. Some nurses expressed feeling guilty and had sleepless nights when family and patient needs were not appropriately attended to. However, these nurses competently referred these families for appropriate, skilled attention from other members of the health care team like social work and spiritual care. Sometimes personal opinions of nurse participants clashed with those of patients, families or physicians and, at other times participants were concerned that they were not able to meet expectations of patients and families. Similarly, Sivesind, Parker, Cohen, DeMoor, Bumbaugh, Throckmorton and Baile (2003), and Rask, Jensen, Andersen, and Zachariae (2009) found that addressing physical needs or complaints was least challenging, but meeting emotional needs by optimal communication skills was

desired by nurses to help them deal with conflicts about treatment decisions, managing overprotective families, and intervening with families who are angry.

Conclusions and implications

The purpose of this mixed methods design study was to explore nurse-family relationships in an ambulatory cancer care setting, and to determine how these relationships relate to nurse satisfaction with quality of work life. The nurse participants were open to describing the impact of their workplace on their readiness and desire to attend to the impact of cancer on family members. Nurse participants were not ensconced in task-focused models of care, but instead engaged in genuine participatory care to meet the needs of families. However, the participants reported least satisfaction in meeting the emotional needs of challenging family situations. Nurses require support in overcoming barriers to take a relational approach with families by allowing them to focus on their capacity for connection and developing relationships to enhance the patient/family "units of care" and their satisfaction with quality of work life. The participants offered numerous practical recommendations for administration to enhance the quality of their satisfaction in relating to families in ambulatory care.

The first recommendation was for support programs for nurses to discuss difficult cases and support one another to reduce uncertainties in caring for families and moral distress. Second, nurses recommended more staff development to enhance their knowledge and skills in family-centred care, particularly in dealing with family expectations, patient-family conflicts, family anger, and emotional needs. Third, ongoing attention is recommended for leadership to help nurses achieve a better balance between technical aspects of nursing (e.g., efficient operation of the clinic and administration of chemotherapy) and relational aspects of patient and family care in the workplace. For instance, the nurses spoke extensively about the need for private spaces and increased staffing that allow more time for nurses to engage in active listening and expression of empathy and respect for patients and family caregivers. Fourth, despite work environment constraints on time, space and resources, these nurses expressed pride in their ability to attend to patient and family needs. Environments that empower nurses by allowing for more autonomous practice can promote their ability to work to their full scope of practice (Bakker et al., 2006). Given the identified gaps in theory on nurse quality of work life concerning their relationships with families, a logical next step would be for researchers to conduct interviews with nurse administrators regarding work environments and workplace philosophies on family-centred care that support or hinder nurses' ability to care and develop relationships with families of patients with cancer.

Acknowledgement

This research was supported by a CANO Research Grant, and a National Cancer Institute of Canada Research Scientist Award with funds from the Canadian Cancer Society held by the first author. We would also like to thank Dr. Carmen Loiselle for her invaluable assistance with the planning of this project and her constructive comments on the draft manuscript.

References

Bakker, D., Conlon, M., Fitch, M., Green, E., Butler, L., Olson, K., & Cummings, G. (2010). Canadian oncology nurse work environments: Part I. *Nursing Leadership*, 22(4), 50-68.

Bakker, D., Fitch, M.I., Green, E., Butler, L., & Olson, K. (2006). Oncology nursing: Finding the balance in a changing health care system. *Canadian Oncology Nursing Journal*, 16(2), 79-98.

- Beckstrand, R.L., & Kirchhoff, K.T. (2005). Providing end of life care to patients: Critical care nurses' perceived obstacles and supportive behaviors. *American Journal of Critical Care*, 14(5), 395-403.
- Beckstrand, R.L., Smith, M.D., Heaston, S., & Bond, A.E. (2008). Emergency nurses' perceptions of size, frequency, and magnitude of obstacles and supportive behaviors in end-of-life care. *Journal of Emergency Nursing*, 34(3), 290-300.
- Canadian Association of Nurses in Oncology. (2001). *Standards of care, roles in oncology nursing and role competencies*. Kanata, ON: Author.
- Canadian Cancer Society's Steering Committee. (2010). *Canadian Cancer Statistics 2010*. Toronto: Canadian Cancer Society.
- Corley, M., Elswick, R., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing*, 33, 250-256.
- Cummings, G.C., Olson, K., Hayduk, L., Bakker, D., Fitch, M., Green, E., ... Conlon, M. (2008). The relationship between nursing leadership and nurses' job satisfaction in Canadian oncology work environments. *Journal of Nursing Management*, 16, 508-518.
- Downey, L., Engelberg, R.A., Shannon, S.E., & Curtis, J.R. (2006). Measuring intensive care nurses' perspectives on family-centered end-of-life care: Evaluation of 3 questionnaires. *American Journal of Critical Care*, 15(6), 568-579.
- Eriksson, E. (2001). Caring for cancer patients: relative's assessments of received care. *European Journal of Cancer Care*, 10, 48-55.
- Fitch, M.I. (1998). Quality of life in oncology: Nurses' perceptions, values and behaviours. *Canadian Oncology Nursing Journal*, 8(1), 24-30.
- Flanagan, J. (2001). Clinically effective cancer care: Working with families. *European Journal of Oncology Nursing*, 5(3), 174-179.
- Greco, P., Laschinger, H.K., & Wong, C. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nursing Leadership*, 19 (4), 41-56.
- Heaston, S., Beckstrand, R.L., Bond, A.E., & Palmer, S.P. (2006). Emergency nurses' perceptions of obstacles and supportive behaviors in end-of-life care. *Journal of Emergency Nursing*, 32(6), 477-485.
- Hobbs, S.F., & Sodomka, P.F. (2000). Developing partnerships among patients, families, and Staff at the Medical College of Georgia Hospital and Clinics. *Joint Commission on Accreditation of Healthcare Organizations*, 26(5), 268-276.
- Isikhan, V., Comez, T., & Danis, M.Z. (2004). Job stress and coping strategies in health care professionals working with cancer patients. *European Oncology Nursing Society*, 8, 234-244.
- Kelly, D. (1998). Caring and cancer nursing: Framing the reality of using selected social science theory. *Journal of Advanced Nursing*, 28, 728-736.
- Kruijver, I.P., Kerkstra, A., Bensing, J.M., & van de Wiel, H.B. (2000). Nurse-patient communication in cancer care: A review of the literature. *Cancer Nursing*, 23(1), 20-31.
- Laschinger, H.K., & Finegan, J. (2005). Empowering nurses for work engagement and health in hospital settings. *Journal of Nursing Administration*, 35(10), 439-49.
- Laschinger, H.K., Almost, J., & Tuer-Hodes, D. (2003). Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration*, 33(7-8), 410-22.
- Leahy, M., & Harper-Jacques, S. (1996). Family-nurse relationships: Core assumptions and clinical implications. *Journal of Family Nursing*, 2(2), 133-151.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications, Inc.
- Lindholm, L., Makela, C., Rantanen-Siljamaki, S., & Nieminen, A.L. (2007). The role of significant others in the care of women with breast cancer. *International Journal of Nursing Practice*, 13, 173-181.
- Madsen, W.C. (2009). Collaborative helping: A practice framework for family-centered services. *Family Process*, 48(1), 103-116.
- McGillis Hall, L., Doran, D., & Pink, L. (2008). Outcomes of interventions to improve hospital nursing work environments. *The Journal of Nursing Administration*, 38(1), 40-46.
- McIlpatrick, S., Sullivan, K., & McKenna, H. (2006). What about the carers?: Exploring the experience of caregivers in a chemotherapy day hospital setting. *European Journal of Oncology Nursing*, 10, 294-303.
- McLeod, D.L., Tapp, D.M., Moules, N.J., & Campbell, M.E. (2010). Knowing the family: Interpretations of family nursing in oncology and palliative care. *European Journal of Oncology Nursing*, 14, 93-100.
- Morse, J.M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing*, 16, 455-468.
- O'Brien-Pallas, L., Tomblin-Murphy, G., White, S., Hayes, L., Baumann, A., Higgin, A. ... Wang, S. (2005). *Building the future: An integrated strategy for nursing human resources in Canada. Research synthesis report*. Ottawa: The Nursing Sector Study Corporation. Retrieved from <http://www.buildingthefuture.ca/e/study/phase1/reports/Research-Synthesis-Report.pdf>
- Patton, M. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Peter, E.H., Macfarlane, A.V., & O'Brien-Pallas, L.L. (2004). Analysis of the moral habitability of the nursing work environment. *Journal of Advanced Nursing*, 47(4), 356-367.
- Priest, A. (2006). *What's ailing our nurses? A discussion of the major issues affecting nursing human resources in Canada*. Retrieved from http://www.chsrf.ca/research_themes/pdf/what_sailing_ourNurses-e.pdf
- Public Health Agency of Canada. (2004). *Progress report on cancer control in Canada*. Ottawa: Health Canada.
- Rask, M.T., Jensen, M.L., Andersen, J., & Zachariae, R. (2009). Effects of an intervention aimed at improving nurse-patient communication in an oncology outpatient clinic. *Cancer Nursing*, 32(1), E1-11.
- Shepard, A. (2010). Moral distress: A consequence of caring. *Clinical Journal of Oncology Nursing*, 14(1), 25-27.
- Sivesind, D., Parker, P.A., Cohen, L., DeMoor, C., Bumbaugh, M., Throckmorton, T., ... Baile, W. (2003). Communicating with patients in cancer care: What areas do nurses find most challenging? *Journal of Cancer Education*, 18(4), 202-209.
- Strauss, A., & Corbin, J. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. London: Sage.
- Tamayo, G.J., Broxson, A., Munsell, M., & Cohen, M.Z. (2010). Caring for the caregiver. *Oncology Nursing Forum*, 37(1), E50-56.
- Taylor, E.J. (2006). Prevalence and associated factors with spiritual needs among patients with Cancer and their family caregivers. *Oncology Nursing Forum*, 33(4), 725-735.
- Torgerson, R. (2007). *Not there yet: Improving the working conditions of Canadian nurses*. Ottawa: Office of Nursing Policy, Health Canada.
- Vivar, C.G., Canga, N., Canga, A.D., & Arantzamendi, M. (2009). The psychosocial impact of recurrence on cancer survivors and family members: A narrative review. *Journal of Advanced Nursing*, 65(4), 724-736.
- Zangaro, G.A., & Soeken, K.L. (2007). A meta-analysis of studies of nurses' job satisfaction. *Research in Nursing & Health*, 30, 445-458.
- Zuzelo, P.R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, 14(3), 344-359.