

# Why exemplary oncology nurses seem to avoid compassion fatigue

by Beth Perry

## Abstract

*The goal of this phenomenological study was to explore what within the lived experiences of exemplary oncology nurses facilitates the avoidance of compassion fatigue. A purposive sample of seven oncology nurses (RNs) who were identified by their colleagues as exemplary caregivers was recruited. Data were collected through semi-structured conversations that were subsequently transcribed. Transcripts were analyzed for recurring themes using three points of reference: recurrence of ideas, repetition of ideas, and forcefulness with which ideas were expressed (Owen, 1984). Findings focus on three themes: moments of connection, making moments matter, and energizing moments. Discussion highlights practical implications for clinical nurses, nurse educators, and health care administrators.*

The topic of compassion fatigue (CF) is increasingly common in nursing literature. LaRowe describes CF as “a heavy heart, a debilitating weariness brought about by repetitive, empathic responses to pain and suffering of others” (2005, p. 21). Potentially, CF brings with it many negative personal and professional consequences ranging from apathy and depression to hypertension and errors in judgment (Jackson, 2003, p. 22). Although the literature suggests that CF is a reality for some caregivers, I observed that CF did not seem to be a problem in the specific group of nurses I studied during a previous research project focused on “exemplary oncology nurses” (Perry, 1998). In this project, “exemplary nurses” were defined as those nurses who did their work in a remarkable way and achieved outstanding outcomes for their patients and for themselves (Perry). The goal of the phenomenological study reported here was to explore if there was something within the lived experiences of exemplary oncology nurses that facilitated the avoidance of CF. In the following paragraphs, I outline the background literature, research process, findings, and implications for practice.

## Background literature

### What is compassion fatigue?

The concept of CF first appeared in nursing publications in 1992. It was used to describe nurses who were worn down by daily hospital emergencies (Figley, 1995). Figley (1995) noted that CF tends to be a problem for caregivers such as nurses, physicians, and social workers. CF has been referred to by other names such as “provider fatigue” (Conant, 2007, p. 34). Some authors identify CF as something quite different than burn-out. For example, Schwam (1998) says that unlike burn-out, which

results from the stress in one’s work setting that can be reversed by a vacation or a change in settings, CF is often more insidious with long-term consequences that are difficult to reverse.

Figley (1983) defined CF as a “state of tension and preoccupation with the cumulative impact of caring” (p. 10). Others have defined CF as “a recognized stress response for individuals emotionally overcome by providing care to others,” or a “feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate pain or remove its cause” (Webster’s Dictionary, 1989, p. 229).

It is beyond the scope of this paper to attempt to differentiate between and or fully describe burn-out, stress, moral distress, and post-traumatic stress, all concepts that have appeared in the literature related to, or equated to compassion fatigue. For the purposes of the study reported here, the author attempted to achieve a modicum of conceptual clarity by using the LaRowe (2005) definition of CF. As noted in the introduction, LaRowe defines CF as “a heavy heart, a debilitating weariness brought about by repetitive, empathic responses to pain and suffering others” (p. 21).

### Causes of CF

The causes of CF noted in the literature include, “emotional burden of being exposed to traumatic events of patients” (Schwam, 1998, p. 1), a buildup of “moral residue” that can result in anguish (Hanna, 2004, p. 73), the “cost of caring without reward or results,” (Tunajek, 2006, p. 24), “caring too much for others and too little for one’s self,” (Tunajek, 2006) and “absorbing and internalizing the emotions of clients and, sometimes, coworkers” (LaRowe, 2005, p. 21). Maslach and Leiter (1997) target a breakdown in community that occurs when fast-paced work destroys the sense of togetherness between coworkers, and a conflict in values when employees are asked to perform tasks that are unethical or go against personal values as primary causes of CF. Musick (1997) blames self-conflict as a source of stress that causes CF. Musick claims that self-imposed demands and unreasonable expectations create pressure for nurses. In Espeland’s (2006) words, “Nurses can be their own worst enemies and set themselves up of CF” (p. 180).

### Symptoms of compassion fatigue

Conant (2007) states that even though it is not “listed as an illness in many diagnostic manuals...it can be seriously debilitating” (p. 34). Symptoms of CF vary, but research reports on the condition mention nightmares, anxiety, insomnia, hyper vigilance, dread of work, absenteeism, errors in judgment, emotional numbness, religious doubts, and difficulty concentrating (Conant, 34). Tunajek (2006) writes that CF is an “evolving syndrome encompassing multiple behaviours and symptoms that extend from frazzled tiredness and anxiety to psychological and physical illness” (p. 24).

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## Prevention and treatment of compassion fatigue

Strategies for preventing and reversing CF are also abundant in the literature and include balancing work and play, talking to others, finding an emotional outlet such as crying or physical activity, and the use of support groups (Figley, 1995). In an article by Espeland (2006) on career revitalization and burn-out prevention, she suggested that CF might be prevented and reversed by attitude adjustment. Specifically, to “revitalize a career... individuals need to change their thought processes and viewpoints about the people and things that may be contributing” (p. 178).

## Compassion fatigue and oncology nursing

It seems reasonable that RNs who work with cancer patients are potentially at risk for CF. Oncology nursing involves caring for people who may require complex physical, emotional, and spiritual interventions. Many authors including Barrett (2004) and Yates (2004) have acknowledged that cancer nursing is as a particularly stressful occupation. de Carvalho, Muller, de Carvalho, and de Souza Melo (2005) attempted to quantify the level of stress faced by cancer nurses. The 35 oncology nurses in their study rated 38 out of the 50 work situations as stressful (de Carvalho, et al.). According to Vachon (2001), compassion fatigue can result from oncology nurses’ constant need to give and support others. Hayes, Ponte, Coakley, and Stanghellini (2005) in their discussion related to retaining oncology nurses identify “compassion fatigue is a factor that can cause nurses to leave oncology” (p. 1090). It is crucial that professionals in this specialization are attentive to the possibility that they are at risk for CF. This study provides readers with an exploration of how one group of oncology caregivers, exemplary RNs, seems to avoid CF.

## Research process

A descriptive phenomenological research approach (van Manen, 1997) was used, as the goal of the project was to explore if there was something within the lived experiences of this group of nurses that facilitates the avoidance of CF.

The research processes were in accordance with the **Tri-Council Policy Statement on Ethical Conditions for Research Involving Humans** (National Council on Ethics in Human Research, 2005). All study participants consented after they were fully informed as to the purpose and processes related to the study. Potential participants were provided the opportunity to choose not to participate or to withdraw at anytime without penalty. The participants were also given the opportunity to review the transcripts of their conversations and to change or delete comments. Nurses who participated were informed that their real names and location of work, and the names of patients they described during the conversations would be changed in all reports to protect identities.

A purposive sample of seven registered nurses (RNs) who worked in settings where they cared primarily for people who had cancer was recruited. The settings where participants worked included an acute palliative care unit, a hospice, and an adult oncology unit. The first four of the seven participants were recruited on the acute palliative care unit. Participants were all considered “exemplary nurses”, as they were acknowledged by their colleagues as those nurses they would want to care for them or their family members if they were ill with cancer (Perry, 1998). These exemplary nurses did their work in a remarkable way and achieved outstanding outcomes for their patients and, subsequently, were positively affected themselves (Perry, 1998).

This definition of exemplary nurse used in the study is supported in the literature. Beyond Perry’s definition, other authors have defined exemplary nursing or “good nursing” in similar ways.

For example, Olthuis, Dekkers, Leget and Vogelaar (2006) note that a good nurse has more than a specific set of skills. In their words, “good nursing involves the personal identity of the nurse” (Olthuis et al., 2006, p. 29). Likewise, Schoessler and Farish (2007) in a study of the development of nursing expertise concluded that nursing excellence is “driven from the inner being rather than imposed from without, and it is focused on improving patient care for the sake of the patient” (p. 172). Parish (2007) echoed the importance of the connection between the patient and nurse, pointing out that good nursing has “relationships at the heart of it” (p. 23).

Initial sampling involved the researcher asking a group of nurses on a palliative care unit to identify their exemplary colleagues by anonymously submitting the names of the nurses they would want to have care for them or a family member who had cancer. From this group of potential participants, nurses were randomly invited to participate. Random selection from the larger pool of nominees was recommended by unit administrators so that no nurses who worked on the unit where recruitment began would know for sure if they had or had not been nominated as exemplary. The administrators believed that a random process would help to avoid any feelings of being left out of the ranking of exemplary. Only those nurses who eventually were invited to participate would know that they had been nominated by their peers. The investigator invited the randomly selected, nominated nurses in the study using e-mail, telephone, or regular mail. Four nurses agreed to participate. Further recruitment of participants from the other settings listed above took place through snowball sampling as participants recommend colleagues from other facilities as “exemplary nurses” I should talk to. All participants were female and all had more than 10 years of oncology or palliative care experience. Data collection and participant recruitment took place in a spiral until data saturation was achieved with a sample of seven participants.

Data were collected through conversations between the researcher and the participants. Each conversation was held at a time and place chosen by the participant and lasted from one to 1.5 hours. During each of the conversations, the participant and researcher engaged in a discussion around the theme of CF. The researcher opened the conversation by repeating the definition of CF from LaRowe (2005). At this point, the researcher also told each of the participants about her earlier research related to exemplary nurses and her observation that these nurses did not seem to exhibit signs of CF. This opening was followed by a general question such as, “Have you ever felt you were experiencing compassion fatigue?” Individualized follow-up questions appropriate to the comments of each participant were used by the researcher to attempt to explore each person’s experience fully. Conversations were tape-recorded and transcribed.

Data analysis followed a process outlined by Owen (1984). Specifically, transcripts were analyzed for recurring themes using three points of reference (Owen). These points are: recurrence of ideas, repetition of ideas, and forcefulness with which ideas are expressed (Owen).

Findings include three themes: moments of connection, making moments matter, and energizing moments. These findings have practical implications for clinical nurses, nurse educators, and health care administrators. The findings section begins with a discussion of moments of connection.

## Findings

### Moments of connection

Simply put, the exemplary nurses connected with their patients and their families enabling them to put themselves in the role of the other. The nurses expressed repeatedly that their motivation and energy to continue to care at exceptional levels came, in part,

by their realization that the patients they were caring for could be their mothers, their brothers, their sisters, or their neighbours. Respondents were moved into action when they placed themselves in the position of the person with cancer. Wendy said, *“There isn’t a day that goes by when I don’t think, ‘but for the grace of God’ it could be me in that bed. That moment of realization changes how I care. It fuels my caring somehow.”* Michelle made a similar comment saying, *“It especially affects me when the person I am caring for is close to my age. At first when this happened, it made it harder but, now, when the person shares something similar to me, like my age or the fact that we both have young children, I am more able to be a good nurse for that individual.”*

Further, the data suggest that when the nurses recognize similarities between themselves and the care recipients, it assists them in knowing how their patients would like to be treated. Being able to provide care that is in keeping with a particular patient’s wants and desires potentially elevates the patient’s trust in that nurse. A patient who feels well cared for is more likely to respond positively to the nurse who provided the appropriate care and the positive cycle begins. Somewhere in this cycle it seems that the exemplary nurses come to know that they are doing their job well and achieving positive outcomes. This realization propels the nurses to continue to do their work in an exemplary way. Perhaps the catalyst for this positive experience is that moment of connection when the nurse realizes that the patient is a fellow human being who just happens to be the one in the relationship who needs care.

Consider this incident shared by a nurse named Justine. It seems to capture the cycle of connection and excellent care. Here is part of what Justine said:

*My patient had a serious GI cancer and was struggling mightily with the rounds of chemo. His name was Jocquim and he had a young family. The clincher for me was the day I saw him in that bed with two little munchkins at his elbows. I couldn’t help but think of my own two kids at home. I really did my best for Jocquim. Whenever he rang his bell, it was answered right away. I happily went out of my way to do the little extras for him. I just made a point of paying attention and remembering what he liked. Although he was in pretty bad shape his mind was still sharp so, whenever I could, I would give him choices. Little things like do you want your bath now or in an hour, or do you want your curtains open or closed. The chance to voice his preferences really seemed to calm him down and I was able to eventually help him in more profound ways to deal with the losses he was experiencing, but it all started the day I saw a reflection of myself in that bed.*

On further conversation Justine adds, *“Somehow establishing a connection with a patient through something we have in common, an interest, a hobby, a home town, or through seeing a photo of them before they were ill helps me to provide care that is more empathetic.”*

Another important part of making this initial connection with a patient related to knowing something of the patient’s history and circumstances. The nurses commented that connecting was facilitated when they knew about the background of the patient. For example, knowing a little of the patient’s past job, hobbies, and family life helped “make the person more real”, said Justine. If the patient was very physically debilitated by the cancer or the treatment, then it became even more important that the caregiver had some idea of how the person looked and acted when healthy. Jackie explained, *“I always like to see a photo of the person so I can see how they looked before they got cancer. It helps me to remember that they are still that person and I am able to be a better nurse to them somehow.”* Sophia said something similar, *“When a family member is around to share their memories of the patient in*

*their pre-illness life, I really enjoy that. It helps me to care differently for the sick person because they become more than a body in a bed, they become Bill or Bob or Alice or Amy. It makes quite a difference to how I feel about my patients when I know that they played golf, ran a business, or liked to fish.”* As Justine succinctly said, *“I keep myself functioning effectively by remembering my patients are real people too.”*

The nurses conveyed during the conversations that they were attentive to the importance of what might seem like trivial patient needs. This attentiveness to the “little things” was important for establishing connections with their patients. Although the RNs were challenged for time during their workday, they talked about the satisfaction they got from making the time they did have with each patient meaningful time. As Justine said, *“It doesn’t take me any longer to wash someone’s face with a smile on my own.”*

In summary, establishing a connection with their patients seemed to be a precursor to excellent nursing care. Providing excellent care was appreciated by the patients and the nurses received positive feedback regarding their work. This affirmation that resulted in part by the initial connection fueled the positive cycle of caring that energized the exemplary nurses. The nurses gave examples of different ways in which they established a connection including recognizing the similarities between themselves and their patients, discovering something about the pre-illness patient, and meeting patient needs in a positive way.

### **Making moments matter**

The second common theme that emerged from the discussions with the exemplary nurses on the topic of avoiding CF could be described as appreciating fully the significant moments of the nurse-patient relationship. I called this theme “making moments matter.” The RNs portrayed being a part of the nurse-patient relationship as a privilege. They described oncology nursing, in particular, as imbedded with extraordinary professional encounters that invite two people who were previously strangers to share intimacy of person and mind. They found this opportunity to engage in meaningful human-to-human encounters a “gift.” As Jackie said, *“Often within minutes of meeting, nurses, by virtue of their role, are asking patients to expose their bodies and share their personal feelings. In this way, nurses have a huge responsibility. What other professional has such a chance to confront daily the real essence of living—relating to another person. How could I not love my job?”* In a sense, nurses are privy to this unveiling of another, to the fundamentals of human existence, to what is really meaningful in life. As Maureen said, *“I don’t have to look far every day to see my purpose in life. It is in front of me daily. My patients really need me.”*

The exemplary nurses studied made comments that suggested that they were very aware of both the responsibility and privilege that their role brings. They also spoke very positively about how they valued these moments shared with a person in need and how they relished the opportunity to make a difference that these moments provided. Sarah said, *“Even today, after more than 25 years of nursing, I still get a little tingle down my spine when I think of the level of trust my patients place in me. Just because I am a nurse, they tell me things I am sure they wouldn’t tell me if it wasn’t that my ID tag says RN. It makes me feel good—special sort of. I really value those experiences.”*

With high levels of trust comes the opportunity for meaningful relationships to develop if the trust is upheld and nurses meet needs competently. Sometimes the nurse-patient relationship is lengthy in the case of a nurse following a patient along the trajectory of diagnosis to treatment of a cancer. Other times, the relationship may be very short if the person is being seen for an outpatient procedure, for example. But in all

instances, the one commonality described by the nurses in the study was that they took each encounter seriously and did their best for the person each time they provided care. As Sarah stated, *"I have found that the little things seem to matter to many of my patients. If I can get the little things right, like the positioning of things in the room or even the pronunciation of the person's name, it opens the doors to allow me to meet deeper needs."* Another respondent, Carol, said, *"We are all really busy, but I always take enough time to acknowledge my patients by name and to smile with them. My aim is to make them feel like they are the only person on my mind in that time we have together. In the end, I find taking a little more time saves me time in the end and the time we do have together is more satisfying for both of us."*

The participants also shared stories of times when they did something for a patient that they really considered quite routine, yet the patient had been very appreciative of the intervention. For example, Julie said, *"There was one man who was frustrated because he never knew what day it was. I couldn't figure it out because he had a calendar right by his bed. I thought maybe he was confused. When I mentioned it to him he said, 'I'd know what day it was if I could read those \*!!\* numbers!' It was then I realized that the numbers were too small for his eyesight. So, I took a black felt marker and traced overtop of each number so that it was bigger and darker. He was thrilled. It gave him back his sense of time."*

Finally, included in this theme of making moments matter, the exemplary nurses talked about being appreciative of all expressions of gratitude. Julie said, *"You want to know how I keep going? I know that rewards of this job often come at the times you least expect it and in the smallest of thanks."* She then went on to tell me about this situation in which she felt the gratitude of a family and was inspired by the experience to continue her caring ways.

*I learned very early in my career that I wasn't going to get a pat on the back every time I did something right, so I stopped looking for that on a daily basis. I stopped thinking that the head nurse, or one of the other nurses, or one of my patients was going to say something like, 'wow you are great, or you did that really well.' The funny thing is, once I stopped expecting that kind of level of appreciation I started to feel appreciated. I found out that appreciation takes many forms and that even the smallest of thanks can really make me feel I am worthwhile. I remember this one guy, an old fellow who never smiled. I don't think he said anything that didn't begin or end with a swear word. One night he just mouthed the word 'thanks' when I tucked him in. No bad language attached! There was another lady who was deemed by the staff as 'ungrateful and impossible' who actually asked me what days I would be working because she said she 'felt safe with me.' There was a father who didn't thank me in words, but I could tell by the look in his eyes that he was pleased with my attention to his son's physical comfort as I fluffed his pillow and combed his hair every time I turned him. I think if you feel the appreciation that comes in small doses almost every day, you know that you are doing your job well and you don't get compassion fatigue.*

In summary, making moments matter began by nurses valuing the opportunity to establish meaningful relationships with their patients. The respondents saw the opportunity for these relationships as part of the privilege and responsibility inherent in their role. The exemplary nurses avoided CF by coming to see these relationships with their patients as a gift. The nurses were attentive to the importance of getting the "little things" right for their patients so that trust and meaningful relationships could be established and maintained. The nurses came to realize that gratitude from their

patients could take many forms. In these ways, the exemplary nurses avoided CF, in part, by appreciating fully the significant moments of the nurse-patient relationship.

### Energizing moments

A third theme that emerged in the discussion with the nurses was that they had a zest for life attitude. In other words, they brought energy to their work that spilled over into their patient encounters. This energy took many forms including a sense of humour, a playful spirit, a positive attitude, and a sense of self-confidence and self-awareness. Enacting their nursing role with positive energy resulted in many encouraging outcomes for both the patients and for themselves. As Julie said when I asked her how she keeps from being overwhelmed by her work, *"I put on my shield of up-beatness and I never, ever let it down."* Sarah said something similar, *"I try to keep things on the light-hearted side. I know that sounds weird when you are talking life and death—when you are talking cancer but, with the right attitude, things just go better somehow."* Justine, who seemed to have a very appealing sense of humour, echoed the comments of others saying, *"When I am able to laugh with my patients it lets them know that things are still OK. It helps them relax and it makes my work, and the terrible things I see, less of a weight on me."*

The literature is supportive of what the respondents said about light-heartedness as a defence strategy against CF. Potter (1998) recommends appropriate humour and laughter in the professional setting. In her words, "Humour will save our sanity, our health, and our perspective." Espeland (2006) claims that nurses who can find humour in stressful situations can develop a new perspective on the situation and prevent CF.

What the nurses in the study may have been suggesting with their comments about light-heartedness and humour is the importance of attitude. Nurses do not always have control over all aspects of their work environment, but they do have control over how they respond to those circumstances. As the exemplary nurses seemed to have discovered, a positive response in a difficult situation often results in better outcomes all around. Consider this story shared by Michelle.

*All things were lining up to be a really bad day. I was five minutes late for report. I couldn't find a chair. I spilled my coffee on my uniform. My patient assignment was unfairly heavy and I was assigned James. James had head and neck cancer and really was in total suffering. I could have spent my entire shift just caring for him. When his bell was ringing as I stepped out of report, I wasn't surprised. When I opened the door to his room, I was shocked. There he was stark naked and totally soaked. His feeding tube had disconnected and there was spillage everywhere. For a moment I almost cried and then I just looked at the pathetic scene and started to laugh. Somewhere deep within me I saw something kind of cute about the scene as he sat there with his hand covering his unmentionables. He had tried to change his own gown, but had finally given in and rang his bell for help. With a smile I said, "Hang in there James, we will get this all cleaned up lickity-split!" And I did. Before long, the scene changed to a comfortable patient and a clean room and I was on track to a good day.*

## Discussion

In an exploratory study such as this, data analysis may never be complete; rather, it unfolds in a spiral of increasing complexity (Polit & Hungler, 2001). As I read and re-read the transcripts to seek depth of understanding, the possibilities for discussion magnified. I returned to the purpose of the study, which was to explore the phenomenon, and I concluded that exploration often occurs in stages. What is presented in this

paper represents only a beginning understanding of why exemplary oncology nurses seem to avoid CF. Additional data collection, analysis and exploration with these participants and others is needed to more fully understand these complex phenomena. The initial themes presented in this paper raise some points that may merit further discussion. To that end, a discussion of attitude, the link between attitude and values, and strategies to promote a positive attitude are presented here. Themes for further research and analysis are also described.

### Attitude

In looking for a common link between the three themes of profound moments of connection, making moments matter, and energizing moments, the concept of attitude surfaced. Attitude is similar to outlook and is defined as, "a complex mental state involving beliefs and feelings and values and dispositions to act in certain ways" (Webster's Dictionary, 1990). Perhaps it takes a certain attitude on the part of a nurse to seek moments of connection, to fully appreciate available moments, and to approach life with light-heartedness. Is it possible that the exemplary oncology nurses' avoidance of CF was rooted in the attitude or outlooks they held?

In many ways, our attitude flavours how we see life, how we experience the successes and calamities of our days, and how we view others who cross our paths. The thought processes that make up our attitude seem to have a very direct impact on how we experience our lives. Attitude is a decision (Yamshon, 2004). It appears that the nurses in the study purposely decided to put a positive spin on their work experiences. As Maslach, Schaufeli, and Leiter (2001) suggest, turning negative thinking into positive thinking can have an enormous impact on how nurses experience situations. For example, nurses with a negative outlook could see oncology as depressing, and physically and emotionally exhausting. A positive-thinking nurse might see oncology nursing as challenging and rewarding; a chance to make a significant difference in individuals' lives during very critical times.

**The link between attitude and values.** As the definition details, one root of attitude is values held. Leners, Roehrs, and Piccone (2006) claim that values are acquired; they can be taught directly or learned indirectly by observing the behaviour of others (p. 504). These same authors note that nursing values are "the nature of being a nurse" (p. 504). Aiken and Catalano (1994) say that core nursing values contribute to a nurse's sense of identity or way of being. Would not one's way of being also include one's way of thinking, one's attitude?

There is much agreement in the literature about the importance of core nursing values, and debate about what those values are. I agree with Beasley (2006) who summed it up this way, the "core nursing values are quality and patient-centred caring" (p. 27) supported by the underlying value of altruism (Perry, 2005). Perhaps what the exemplary oncology nurses in this study demonstrated was an embracing and enacting of these core values, fueled by values which, in turn, fueled their positive attitude towards their work. I am reminded of Descartes who said, "I think therefore I am" (Keeling, 1968). In some interpretations, this phrase is taken to mean that thinking influences action and action influences thought. Perhaps this cycle is part of the puzzle that explains why nurses with a certain attitude seem to avoid CF.

**Strategies to encourage a positive attitude.** How do oncology nurses, nurse educators, and health care administrators encourage the values that lead to the positive attitude about life and cancer care? Studies by Schank, Weis, and Ancona (1996), and Schank and Weis (2001) demonstrated that education is important to professional values acquisition. Academic curricula and continuing education programs for nurses need to include the teaching of professional values and the molding of attitudes.

Also, as noted above, values may be acquired, in part, by observing others. Perhaps the sharing of stories is one teaching strategy through which values of exemplary nurses can be "observed" in a virtual sense and hopefully conveyed to others. Storytelling is a powerful teaching tool. As Harris (2006) explained, "Storytelling is more than ordinary conversation, it goes deeper into feelings" (p. 14). Wright (2006) goes further saying that hearing stories enables us to empathize and translate these feelings into action (p. 22). Perhaps in this way stories of exemplary care may influence values starting a cascade of attitude refinement toward the positive. Sharing of stories and establishing mentoring relationships with positive role models may be one powerful strategy for preempting CF or healing CF in nurses.

### Themes for further research and analysis

As with all research, many questions are raised and many themes cry out for further analysis, discussion, and development. One troubling theme in the literature is that caring and empathy, which are often noted as core values of nurses and other health care professionals, have been cited as causes of CF. It is disturbing that foundational values that inspire nurses to become nurses may have some part in the cause of CF. This thought opens the door to interesting research questions.

Other questions that arise from this study, but that remain unanswered include, what motivates, sustains, rewards and satisfies oncology nurses and what prevents or protects them from CF? Additionally, why does the connection with patients/families seem to sustain some nurses? Why is it that nurses seem to connect more readily with patients in whom they see a reflection of themselves? What is it about the practice of exemplary oncology nurses that facilitates nurse-patient connection? I am reminded of an article by Deborah Boyle (2000) in which she implores oncology nurses to "re-embrace the interpersonal realm of our practice" (p. 916) because to do so, she argues, "can create a culture of compassion that formally is heralded as oncology nursing's greatest asset" (p. 922). Research related to triggers and sustainers of effective interpersonal nurse-patient relationships is needed.

Another topic that arises from the analysis is that of the reciprocity in the nurse-patient relationship. Participants in this study used words such as "gift," "privilege," and "honour to care for" to describe their experience of nursing certain individuals. What reward does the nurse receive from providing exemplary care that could be considered a gift? Jean Watson (1989, p. 132) writes about "transpersonal caring," the experience in which both the nurse and patient are changed by the caring event. Likewise, Perry (1998) discussed this phenomenon where both the nurse and patient obtain something positive from their relationship and she has called this experience "joint transcendence." This positive cycle is a rich area for further study, as it seems to be a key element for an effective nurse-patient relationship where the well-being of both participants is enhanced.

### Conclusion

It seems that there is something within the lived experience of exemplary oncology nurses that facilitates the avoidance of CF. As illustrated by the three key themes of moments of connection, making moments matter, and energizing moments, it seems the outlook of this group of RNs is key to starting the positive cycle of care that helps to prevent CF. The findings of this study have implications for clinical nurses, nurse educators, and health care administrators who seek to prevent and reverse CF. Further studies are needed to understand more fully the possible links between

core nursing values acquisition, and enactment and the development of a positive outlook, which seems to assist in the prevention of CF. Many other questions arise that only surfaced in this study and need further exploration such as the cause of nurse-patient connections and the nature and role of reciprocity in the

nurse-patient relationship. If CF can be avoided, or at least dealt with effectively when it occurs, the personal and professional well-being of RNs and the care of their patients will not be compromised. ♣

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