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Taking action: An exploration of the actions of exemplary oncology nurses when there is a sense of hopelessness and futility perceived by registered nurses at diagnosis, during treatment, and in palliative situations

by Katherine J. Janzen and Beth Perry

ABSTRACT

"There is nothing more that can be done" is a phrase that may occasionally cross the minds of oncology nurses. This paper reports on the actions of exemplary oncology nurses who were faced with such situations where their colleagues gave up or turned away. The research question, "What actions do exemplary clinical oncology nurses (RNs) undertake in patient-care situations where further nursing interventions seem futile?" prefaced data collection via a secure website where 14 Canadian clinical oncology registered nurses (RNs) provided narratives documenting their actions. Thematic analysis utilized QRS NVivo 10 software and hand coding. Four themes were generated from data analysis: advocacy, not giving up, genuine presence, and moral courage. Implications for practice and future research are provided.

"There is nothing more that can be done." Besides hearing that patients have cancer, hearing (or sensing) that 'there is nothing more' is perhaps the most devastating experience for patients (Doell, 2008). Perry (2006) indicates that exemplary oncology nurses always seek to do something more for patients when usual nursing interventions have been ineffective or when others fail to act. More research is needed to better understand specific nursing interventions that may further assist all oncology nurses in taking action (Perry, 2006). The purpose of this research is to describe the actions of exemplary clinical oncology RNs who, when faced with other nursing colleagues who gave up or turned away, take action.

BACKGROUND LITERATURE

A search of CINAHL, Pub Med, Google Scholar, ProQuest, Sage, MEDline, and Health Source Nursing Archives Edition

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databases using the search terms "exemplary nurses," "exemplary oncology nurses," "expert oncology nurses," "futility," and "when nothing more can be done" revealed themes such as compassion fatigue, advocacy in nursing, mentoring in nursing, nursing vigilance, 'good' nurse, good work, moral dilemma, and stress. There were no direct references to actions of oncology nurses in responding to seemingly hopeless or futile situations where it seemed there were no further nursing interventions that could improve the patient's well-being.

The exception is a study by Perry (2005a) who noted that cancer patients' "fear of being abandoned, of being given up on, of being left alone to face pain, technical procedures, or even death is immense" and that exemplary oncology nurses know this and take action (p. 20). Dias, Chabner, Lynch and Penson (2003) agree that upon hearing (or sensing) that nothing more can be done to improve their situations, patients often feel abandoned. While the literature is emphatic that no patient should ever be told that "there is nothing more to offer," nursing interventions described in the literature in such situations relate primarily to further attempts at symptom management and emotional support repeating previously tried interventions (Baille, 2007; Dias et al., 2003; Doell, 2008; Goodrich & Cornwell, 2008; Beckstrand, Callister & Kirchhoff, 2006; Pavlish, Brown-Saltzman, Hersh, Shirk & Rounkie, 2011).

De Carvalho, Muller, de Carvalho and de Souza Melo's (2005) study found that unresolved patient suffering was one of the chief sources of stress for oncology nurses. Twenty-six percent of nurses experienced significant stress when they felt that there was nothing more that could be "done to provide comfort to a patient" (p. 191) and 22% experienced extreme stress when they watched "a patient suffer and [were] not able to do anything about it" (p. 192). In response to stressful situations such as these, nurses felt a "profound sense of guilt" (Boyle, 2000, p. 916) for not being able to alter patient outcomes and a "sense of personal failure" (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013, p. 172).

Reflective nurses asked themselves, "Could I have done anything differently?" and they almost always felt the answer was "yes" (Boyle, 2000, p. 916). Feelings of regret often surface (Pavlish et al., 2011; Beng et al., 2013; Pavlish et al., 2012). Nurses, as they search for alternate actions and improved outcomes for patients, experience significant tests of their strength and courage (Kerfoot, 2012). While physical

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distancing and/or emotional withdrawal from patients has been found to decrease nurse stress in situations where it is deemed that no more can be done (de Carvalho et al., 2005; Dias et al., 2003; Miller 2006), exemplary nurses “stay with patients through pain, suffering and grief keeping the promise to never abandon” through diagnosis, treatment, and palliation (Perry, 2005a, p. 20).

What sets exemplary nurses apart from their colleagues? Empathy seems to be a grounding factor expressed as being moral, emotive, cognitive, and behavioural in nature (Kendall, 1999). Haylock (2008) attributes the difference between average and exceptional nurses to a measure of “nurse traits, experiences and knowledge... which inform and motivate the nurse to advocate” resulting in a “constant state of feedback through the nurse-patient relationship” (p. 103). Pavlish and Ceronsky (2009) echo this in describing exemplary nurses as “providing physical, emotional and spiritual care” (p. 406), having clinical expertise, possessing perceptive attentiveness, demonstrating presence, exhibiting honesty, having a patient-family orientation, working collaboratively, and being deliberate in their actions. For Graber (2004) the patient-exemplary nurse relationship is expressed in terms of intimacy rather than detachment, and Haylock (2008) found that in patient-exemplary nurse relationships nurses adopt a “moral covenant to take risks and exceed usual care” (p. 137). Graber (2004) explains that exemplary nurses “integrate heart and mind in their work” and are altruistic in nature (p. 87).

Exemplary nurses distinguish between ‘required’ nursing care and care that is ‘doing more’ as they seek to develop caring relationships with patients (Olthuis, Dekkers, Leget & Vogelaar, 2006). This finding is supported by Miller (2006) who relates that a “good nurse will always strive to be better by going beyond mere expectations to achieve a higher end or good” (p. 473). Exemplary nurses empower themselves and their patients as they confront difficult situations (Oudshoorn et al., 2007). Exemplary nurses believe that there is ‘always something more that can be done’ (Pavlish & Ceronsky, 2009; Perry, 2009) and that there is no situation where the outcome is fixed (Miller, 2006).

De Araujo Sartorio and Zoboli (2010) found that exemplary nurses make a deliberate choice to maintain “humanness” in such situations. Kookan (2008) identifies listening ‘to’ and watching ‘with’ patients as further actions. Olthuis, Leget and Dekkers (2007) cite reciprocity in terms of giving, and caring conversations as important additional actions taken by outstanding nurses at times where no clear interventions are evident. Perry (2009) characterized such actions as “simple gestures” including prayer, music, touch, humour, and silence.

While futility to date has only been described in the literature as a medical construct (Ferrell, 2006, Griffiths, 2013), Attia, Abd-Elaziz and Kanded (2012) are emphatic that nurses are in fundamental positions to both research and employ interventions aimed at futility. For the purposes of this paper, futility is defined as nursing situations where it is deemed that no more can be done for patient wellbeing (de Carvalho et al., 2005; Diaz et al., 2003; Miller, 2006). Turning away or giving up is defined as physical distancing and/or emotional

withdrawal from patients (de Carvalho et al., 2005; Dias et al., 2003; Miller 2006). While the literature described above notes that there are documented actions that can be implemented under futile situations, this knowledge (save Perry’s (2009) study) is “not specific to oncology nursing... as the context is different” (M. Fitch, personal communication, July 21, 2014).

PURPOSE

The impetus of this research arose from Perry’s (2009) study where exemplary nurses “did more.” The purpose of this descriptive study was to explore specific actions of exemplary clinical oncology RNs who “did more” for patients when faced with seemingly hopeless/futile patient-care situations. Such situations can occur at any phase of cancer care and can involve unresolved physical, emotional or spiritual needs of patients. In this study, exemplary nurses are defined as those oncology nurses who “do more” when their colleagues give up or turn away when faced with futility (Perry, 2009). This study adds to the existing literature as exemplary oncology nurses work in a unique context/discipline and may have insights/interventions that other disciplines may not employ given the nature of oncology.

RESEARCH QUESTION

What actions do exemplary clinical oncology nurses (RNs) undertake in patient-care situations where further nursing interventions seem futile?

METHODS

This qualitative, descriptive study was designed to explore the actions of exemplary clinical oncology nurses who “did more” in patient-care situations where further nursing interventions were deemed futile by their colleagues. The goal of a descriptive study is the accurate portrayal and interpretation of what is being investigated from the participants’ viewpoint (Macnee & McCabe, 2008). Benner and Wrubel (1989) maintain that this approach is appropriate when studying human experience in complex, elusive, and/or still largely unexplored areas. Narrative research will be employed which explores and captures stories or experiences, and the context of these experiences, in detail (Cresswell, 2012). Narrative research is advantageous as it allows “the researcher to present experience holistically in all its complexity and richness” and “provide[s] a window into people’s beliefs and experiences” (Duff & Bell, 2002, p. 209).

Sample and data collection

A convenience sample of 14 Canadian clinical oncology RNs was recruited through an advertisement placed in the Canadian Oncology Nursing Journal (See Appendix A). Potential participants were directed to a research website, which presented a full description of the study. Electronic informed consent was obtained and consenting participants provided written descriptions of incidences (narratives) from their practice when they felt they had taken action in situations where other oncology nursing colleagues decided that nothing more could be done. Study approval was granted from the

University Research Ethics Board prior to beginning data collection. The researchers were the only ones who could view the responses in the drop box. Confidentiality was addressed as there were no identifiers of participants, as the responses were anonymous, other than demographic data. Data were collected over a period of one and three-quarter years. Submission was uni-directional. Study participants connected with the research team through a research website established specifically for this study. Sample size was affirmed at saturation of themes. Participants could submit several narratives as the text box adjusted to allow unlimited narratives ($n = 20$). Respondents were asked to describe the event(s), factors leading up to the situation(s), the specific actions they took, and outcomes of the intervention(s).

The internet opens up many possibilities related to data collection within the qualitative realm. Perry (2006) conducted a study of career satisfaction in oncology nurses, and in 2009 mounted studies of exemplary oncology nurses using a web-based data collection strategy. These projects allowed for the informed development and refinement of a process for collecting qualitative data using the internet. A similar data collection strategy, based on this tested approach, was used for this study. Since data collection took place through a research website, clinical oncology nurses from all parts of Canada who have internet access were able to participate in the study. This is an important consideration because nurses who may have not traditionally had opportunities to participate in research projects could become active in nursing research by participating in this study online.

Data analysis

Thematic analysis (Cresswell, 2012) was undertaken first by each of the researchers independently: the first researcher using QRS NVivo10 (QRS International, 2013) software for qualitative data analysis and the second using hand coding. Thoroughly reading and re-reading the narratives, researchers came to agreement regarding themes. Owen's (1984) three points of reference for identifying themes were considered: recurrence of ideas within the data (ideas that have the same meaning but different wording), repetition (the existence of the same ideas using the same wording) and forcefulness (cues that reinforce a concept). As data submission was uni-directional, no methods were used to validate the themes with participants.

RESULTS

Demographics

Fourteen female participants shared a total of 20 narratives. Participants had the option of sharing one or more narratives on the secure website. Two held oncology certification. Number of years as an RN ranged from eight to 30 years and number of years as an oncology nurse ranged from less than a year to 30. Educational preparation included three RNs with diplomas, seven with Bachelor of Nursing degrees, and four with Master of Nursing credentials. Ages of participants ranged from 20 to 70 years with a mean age interval of 32.9 to 33.6 years.

Themes

Four themes were identified: advocacy, not giving up, genuine presence, and moral courage. Each theme will be described below and illustrated with verbatim quotes from participants' narratives.

Theme 1: Advocacy. Advocacy can be demonstrated in several ways. In the study, sometimes advocacy was giving voice to patients and encouraging them to ask for what they needed or wanted. At other times, advocacy was being that voice for patients. One thing these nurses had in common was that they did not take 'no' for an answer. In advocating they bent rules, ignored policies, questioned authority, and passed by the chain of command to get patients what they needed.

In order to advocate for patients, the study nurses took actions that mattered. On the surface these actions may seem rather negligible such as really listening, observing, asking, and assessing what the patient really wanted. But after the 'finding out' phase, these nurses went further, standing strong and having the courage to try to make the right things happen for patients. Advocacy meant not judging patient needs once evident.

I had a fellow last week... He had head and neck cancer (of course everyone assumed he got it from drinking and smoking—we don't really know). He had slipped up and taken his narcotics incorrectly and "lost" some and now he was in huge pain. My heart just went out to him. I pushed aside all the voices in my head that were saying it was his fault for the situation he was in and we admitted him and started aggressive pain control until we got him comfortable. He thanked me and thanked me—I would do the same for anyone. There is no one who does not deserve my best care—there is no one for whom I can do no more.

Theme 2: Not Giving Up. Giving up was called the "ultimate abandonment" by participants. Study nurses refused to give up—even when they admitted they did not know what to do next. Nurses recognized that patients "all have one basic need—for their nurses and the team not to give up on them." One nurse emphasized, "I never give up. I can't. I find a way." The presence and support of the whole team was meaningful to these nurses and they felt their support. Sometimes not giving up meant stalling until a solution could be found. Many times these solutions were unorthodox and would only be appropriate in a specific situation.

He was a challenging patient. He would not allow any care. He had been a man with significant political influence. We knew because we were told and retold. We had a patient who was nasty, lying in filth, abusive and the only thing some could do was post a sign in the room discrediting staff abuse and close the door! His wife and family visited briefly and said nothing. There I stood outside the door. What in the bloody hell was I going to do? I decided I needed a witness, so I recruited a team member and told her I was going to do some care on this man regardless of what kind of tantrum he was about to inflict on me and I needed a witness in case I ended up in court. So, in we went to be greeted with a significant amount of profanity to which I replied,

Mr. Smith would you please shut your — mouth and listen to me! He was stunned. My teammate was stunned. I was stunned. I slowly and in a controlled voice explained my plan to provide even minimal care. The only choice I gave him was when—now or in about 15 minutes. Well, that was the beginning of a tolerable friendship and the outcome was good. Over the weeks he was with us he even spoke of his fears and doubts.

Theme 3: Genuine Presence. Genuine presence is about being there for patients to meet physical, spiritual, and emotional needs. For patients who sense potential abandonment, genuine presence can be an important nursing intervention. One nurse said, “I know that many times when there seems no way to help them, I can still give them some of me.” Nurses can be physically in the room with patients and care for them, but truly being “with them” is different. Participants described going beyond merely doing tasks and actually spending time with patients. Finding extra time to spend with patients was acknowledged as challenging, yet some participants found ways to create a sense that they had time to spend by slowing their pace as they entered the room or working with an aura of calmness. Others made certain that the time with patients for physical care was infused with emotional connection. As one nurse wrote, “It doesn’t take me any longer to give a med making eye contact and smiling.” Another nurse recounted that “listening and giving voice” was so important to giving the sense of genuine presence and that it encompassed “going beyond” doing care tasks.

There was a young girl I will never forget. I met her when she was first diagnosed. I was there when her kidneys started to fail, when she had her first seizure, when she cried and when she laughed. I was also there when she gave up. Some of nurses would get busy moving from task to task, as she had many care needs. They would move in and out of the room frantically just trying to get things done. When I would care for her I would smile, laugh, and ‘play’ as I did my work. She would refuse to eat some days and then I would come on shift and she would ask me to eat with her. I could have stayed at the nursing station completing paper work, but I chose to have a meal next to her. I wanted her to know I was with her.

Theme Four: Moral Courage. The word courage comes from the Old French word *corage* with modern attributions to having “fresh courage” (Online Etymology Dictionary, 2014e, p. 1). Courage denotes “heart or innermost feelings” and is a “common metaphor for inner strength,” “bravery,” “zeal [or] strength” (p.1). When other nurses turned away and gave up, the study RNs exhibited courage despite difficult situations. One RN demonstrated her courage noting,

Sometimes I feel that I am not a very good nurse because I can’t distance myself from my patients. I have had patients refer to nurses as angels. I wish I really was an angel and I could heal the many sufferings that I come across... the other staff say there is nothing more we can do... but I can’t give up.

Moral courage was often described as the very essence of nursing including courage to do what is right, courage not to judge despite patient circumstances; courage to treat all human beings as equals.

I know the temptation is to spend available time and energy on people we feel we can help. With the homeless and addicted who live in shelters or on the streets there is a tendency to blame them for their situations. I make myself dismiss this temptation. They are humans too—equally deserving of my care and attention.

Participants wrote about moral courage overcoming the moral distress they felt when they knew what actions they should take, but had difficulty carrying out the actions. The study participants chose to exhibit moral courage, which is evident in the words of this RN who wrote, “I felt moral distress because I knew the right thing to do, but couldn’t make myself do it! After I gave myself a stern talking to I faced the situation head on.” Part of exhibiting moral courage is being open and honest in interactions with patients.

The study participants, instead of protecting or distancing themselves from patients, chose to make meaningful connections with patients and family. Some participants reported that their peers did not make connections with patients to protect themselves emotionally. Yet the RNs in the study found that making connections with patients and families brought a sense of intimacy to these relationships that enhanced the quality of patient care and inspired them to take action. These connections became the impetus for continued moral courage and the fuel required to never give up—even when faced with futility. “Hmmm, how could anyone possibly think you have to protect yourself by not making connections? I know not giving up and doing everything I can and really caring gives me energy to keep going.”

DISCUSSION

Taking action

There are 1,652 words in the English language that etymologically relate to ‘taking action,’ (Online Etymology Dictionary, 2014a, p. 1). The word ‘take’ is related to the Old English word “to seize” and has attributions of being able “to touch,” “to hold,” or in Old French to “prize” (2014b, p. 1). The word action denotes “a putting in motion, a performing, a doing” which has connections to simply “being” (Online Etymology Dictionary, 2014c, p.1). Taking action, from the Latin, *reclamationer*, means a “cry of no; a shout of disapproval,” and a commitment to “protect” (2014d, p. 1). ‘Taking action,’ then, is refusal to give up or to accept the status quo of futility, a commitment to protect, and a way of being. Further, ‘taking action’ enables nurses to touch, to hold, and for both nurses and patients, to prize or value interventions. ‘Taking action’ encapsulated the themes.

The power of nursing interventions

The findings point to the power of nursing interventions in seemingly hopeless/futile patient care situations. Nursing interventions are those that are unique to nursing rather than those that are undertaken or ordered by other care providers.

As nurses spend the most time with patients, nursing interventions become the very foundation of nursing care especially in oncology. In short, nursing interventions can enhance or detract from a patient's oncology experience at any stage of the disease trajectory. Cohen, Ferrell, Vrabell, Visovsky, and Schaefer (2010) call for holistic interventions from oncology nurses, which this research supports.

Nursing interventions have the potential to change both nurses and patient's lives for the better. This finding is supported by Kisvertová, Klugar, and Kabelka (2013) who found that spiritual existential interventions such as listening actively, being present, engaging individuals with dignity and respect, and prayer were those commonly utilized by effective nurses. Prayer can assist patients who are suffering emotionally or spiritually and need not be dismissed as an intervention, especially if requested by patients/families (Kisvertová, et al., 2013). Research by Perry (2005a) also supports the "power of the simplest gesture[s]" such as prayer, music, touch, and silence as therapeutic oncology nursing interventions (p. 50). The participants went beyond usual interventions such as symptom management and emotional support. While their usual interventions always included "providing teaching, empowering [and] facilitating validated... interventions," which are supported by the literature, other interventions such as Perry's power of the simplest gesture were common in this research. These interventions included "facilitating patient control," using "prayer," "involving the family in care, [and] goal setting."

Genuine presence seems to be an especially effective nursing intervention. Presence can be understood in two ways: "hard" presence, which entails technical-skill presence and "soft" presence, which is more related to perceptions of respect and human presence (Papastavrou et al., 2012, p. 376). A nurse can be skillfully present and, yet, not be humanly present or perhaps even more significant, humanely present. Oncology patients experience considerable threats to their integrity as holistic beings throughout the disease trajectory (Osterman, Swartz-Barcott, & Asselin, 2010). This research reinforces that genuine presence/soft presence can be enacted in many ways and achieved through taking consideration of not only physical needs, but also focusing on emotional and spiritual needs of patients. Vaartio-Rajalin and Leino-Kilpi (2011) concur with a call for "more focus [on these needs at] the beginning [and throughout] the illness trajectory" (p. 526).

For the RNs in this study, giving up was never an option; the RNs "always found a way." From the smallest gesture to the most noticeable verbal interactions they reported that there was never a problem that did not have a possible solution. This is the hallmark of exemplary oncology nurses. Oncology nurses demonstrated that they have ingenuity, and with the support of colleagues, can come up with solutions to difficult situations. When faced with situations of futility nurses in the study did not turn away. Rather, they asked themselves, "What more can I do for this patient?" and then took action. This is consistent with the label of an exemplary oncology nurse (Perry, 2009).

As the findings demonstrate, action often involved advocacy. Advocacy is not a neutral activity—instead it begins with action and often results in empowerment of the nurse, patient and family. This finding is supported by research that describes nurses as conduits to achieving advocacy and supports the notion that advocacy is one of the most important roles within a nurse's practice (Kadooka, et al., 2014; Vaartio-Rajalin & Leino-Kilpi, 2011).

Moral distress is well described in the literature (Burston & Tuckett, 2013; Ferrell, 2006; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). McLennon, Uhrich, Lasiter, Chamness and Helft (2013) state, "oncology nurses routinely experience ethical dilemmas" and moral distress (p. 293). What this study adds is that moral courage may be one solution to moral distress. RNs in this research often knew exactly what they should do in a particular situation, but moral courage was paramount to engage them to action. Helping nurses gain moral courage and valuing nurses who exhibit moral courage in providing care, may inspire nurses to take action and, as a result, reduce moral distress. It is posited that this inspiration leads to what the authors deem as 'proactive distress', which is moral distress combined with action.

LIMITATIONS

All research designs have limitations. The sample in this study was limited to RNs. Nurses with other skill sets such as Licensed Practical Nurses and Nursing Attendants may have experiences with responding to patients in these situations that would have been informative. Nurses needed to have internet skills and internet access to get detailed information about the study and to participate. Participation was limited to Canadian nurses who were currently practising in oncology. There may be a group of informants who could have provided a rich perspective who were no longer actively practising in oncology or who practised in other specialties where people with cancer are cared for. Participant self-selection represents a bias (Birnbaum, 2004). As this is a descriptive study, the findings were not meant to be generalizable.

Limitations of narrative research include subjectivity of researcher(s), "imposition of meaning on participants' lived experience", and a "time commitment", which makes narrative research incompatible for large numbers of participants (Duff & Bell, 2002, p. 209). Using the internet for data collection mediates the limitation of time commitment (Fricker & Schonlau, 2002).

IMPLICATIONS FOR PRACTICE AND FURTHER RESEARCH

RNs in all specialties may care for people with cancer at some phase of the cancer trajectory. At all phases difficult situations can arise and nurses may sense that they have done all they can. The knowledge of strategies that exemplary oncology nurses employ in these patient situations could inform nursing interventions for others. There are positive personal and system effects when RNs have the tools to be successful in patient interactions and when they know what to do when it seems there is nothing more that can be done.

Exemplary oncology nurses experience less compassion fatigue and enhanced career satisfaction (Perry, 2008). Using strategies suggested by the study findings may make nurses more effective in challenging patient situations, thus reducing nurse stress. In a cyclical fashion, professionally satisfied nurses are more likely to stay engaged fully in their careers providing care that is exemplary (Perry, 2008) and minimizing nurse attrition (Perry, Toffner, Merrick & Dalton, 2010). Additional research confirming and expanding the findings of this study would provide RNs with added strategies to enhance patient/family well-being. Findings have supported previous research and added new knowledge about actions influencing outcomes for both patients and nurses.

Since the literature indicates that abandonment is such a pivotal issue for patients in oncology, this research has the potential for being important for patient wellbeing. This new knowledge could lead to further research focused on the development of evidence-based intervention strategies for patients in especially challenging situations where a sense of hopelessness and futility prevail. Nurses are in a prime position and have considerable insight into what constitutes futility (Kadooka et al., 2012). Research participants consistently described some of their RN colleagues giving up when faced with futility. Why do exemplary oncology nurses view futility

as an opportunity to take action while other oncology RNs are paralyzed by it? The authors leave the reader with one final question, "Are nursing interventions ever futile?" Additional research is needed to explore these questions and further the findings of this study.

CONCLUSION

The "hallmark of nursing... is caring well for others" (Miller, 2006). Caring extends past usual nursing interventions especially in situations where some believe that nothing more can be done. Taking action through advocacy, never giving up, genuine presence, exhibiting moral courage are concrete ways that nurses can provide care for people in such situations. These actions have the capacity to become an essential part of clinical oncology nurses' daily practice resulting in positive outcomes for patients and for the nurses themselves. Perhaps these actions result in the ultimate "making a difference" in the lives of patients during times of diagnosis, treatment, or palliation when patients experience extreme vulnerability.

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Appendix A: Recruitment Advertisement

Exemplary Oncology Nurses Do More

Have you faced situations where others say there is nothing more that can be done?

Exemplary oncology nurses know there is **always something more they can do**. What have you done when caring for...

- terrified newly diagnosed patients
- distressed families
- people suffering physically, emotionally and spiritually, or
- patients at the very end of life

...when others turn away?

Share your stories for a study about what exemplary oncology nurses do when it seems everything has been tried.

Click on "Beyond Futility Study" at the following website <http://moments.athabasca.ca>

Stories are written online, anonymous, and should only take about 15 minutes of your time.
You may learn more about yourself and help other oncology nurses too.

For more information email Katherine Janzen at kjanzen@mtroyal.ca