Factors influencing nurses' attitudes towards caring for dying patients in oncology settings in the Western Cape Metropole

by

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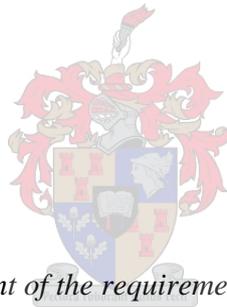
Thesis presented in partial fulfilment of the requirements for the degree Master of Nursing at the University of Stellenbosch

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March 2011

DECLARATION

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Date: March 2011

ABSTRACT

The National Cancer Association of South Africa estimates that over 80,000 of South Africans currently die from cancer each year, whilst statistics show an increase in newly diagnosed cancer cases. Despite an improvement in cure rates, cancer, because of its association with pain, suffering and death, still affects human beings in their totality. It has been demonstrated that effective psychosocial care, as provided by oncology nurses, improve the outcomes for cancer patients. Therefore, nurses' attitudes towards caring for patients that are dying are of vital importance to the quality of care provided to these patients. Attitudes towards caring for patients that are dying may be influenced by the demographic factors of oncology nurses, such as age, workplace and years of experience in oncology. It may also depend on the degree of work satisfaction and by the nature of the work environment, particularly regarding the level of support being offered to the nurse. The purpose of this study hence was to explore the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole. The objectives of this study were to determine oncology nurses' attitudes towards caring for patients that are dying, to determine the degree of work satisfaction experienced by these nurses, to determine the perceived supportive nature of their work environments, and to establish and examine any relationships between oncology nurses' attitudes towards caring for patients that are dying and demographic factors, work satisfaction and a supportive work environment. This study was theoretically underpinned by Paterson and Zderad's (quoted in Praeger, 2002) humanistic nursing theory and Peplau's (quoted in Belcher & Brittian Fish, 2002) interpersonal relations in nursing theory, because of their relevance to palliative care. A quantitative research approach, with a descriptive design, was selected to conduct the study. The target population was all the oncology nurses, caring for patients that are dying in palliative and oncology settings in the Western Cape Metropole. A convenience sample of 127 oncology nurses was selected in three different, but typical oncology settings, namely a state hospital, a

private hospital and three hospices. Data was collected by means of a self-reporting questionnaire. A pilot study was done, in order to assure the validity and reliability of the data collection instrument. Ethical approval was obtained in advance from the Ethical Research Committee of the Faculty of Health Sciences of the University of Stellenbosch. Written consent was obtained beforehand from the managers of the three oncology settings where the research was conducted, as well as from the participants.

The main findings of this study were that the majority of the respondents displayed positive attitudes towards caring for patients that are dying. In addition, most of the respondents experienced a high degree of work satisfaction and also regarded their work environments as supportive. Significant relationships were found between positive attitudes towards caring for patients that are dying and:

- hospice settings;

- higher age and;

- rank of the professional nurse.

The overall recommendation that was made was that continuing education in all aspects of palliative care be regarded as an essential strategy in maintaining and further enhancing positive attitudes amongst oncology nurses towards caring for patients that are dying. In addition, coping strategies needed to be widely implemented to help oncology nurses cope with their emotions and anxieties.

OPSOMMING

Die Nasionale Kankervereniging van Suid-Afrika beraam dat meer as 80,000 Suid-Afrikaners huidig jaarliks aan kanker sterf, terwyl statistieke 'n toename in die aantal nuwe gevalle van kanker toon. Ten spyte van 'n toename in die sukses van behandeling, beïnvloed kanker, weens sy assosiasie met pyn, lyding en die dood, steeds die mens in sy totaliteit. Dit is bewys dat effektiewe psigososiale versorging deur onkologiese verpleegkundiges die uitkomstes van pasiënte met kanker verbeter. Daarom is die ingesteldhede van verpleegkundiges, jeens die versorging van pasiënte wat sterwend is, van kardinale belang in die kwaliteit van versorging wat aan hierdie pasiënte gebied word. Sodanige ingesteldhede mag deur demografiese faktore, soos ouderdom, werkplek, en jare ondervinding in onkologie, beïnvloed word. Dit mag ook van die mate van werksbevrediging en van die aard van die werksomgewing, spesifiek met betrekking tot die mate van ondersteuning wat aan die verpleegkundige gebied word, afhang. Die doel van hierdie studie was dus om die invloed van demografiese en werksomgewingsfaktore op die ingesteldhede van onkologiese verpleegkundiges, jeens die versorging van pasiënte wat sterwend is in onkologiese afdelings in die Wes-Kaapse Metropool, te ondersoek. Die doelwitte van hierdie studie was om die ingesteldhede van verpleegkundiges jeens die versorging van pasiënte wat sterwend is te bepaal, om hulle mate van werksbevrediging te bepaal, om hul persepsie van die ondersteunende aard van hul werksomgewing te bepaal, en om enige verband tussen onkologiese verpleegkundiges se ingesteldhede jeens die versorging van pasiënte wat sterwend is en demografiese faktore, werksbevrediging en die aard van 'n ondersteunende werksomgewing te bepaal en te ondersoek. Hierdie studie is teoreties, vanweë hul relevansie tot palliatiewe sorg, deur Paterson en Zderad (aangehaal in Praeger, 2002) se humanistiese teorie en Peplau (aangehaal in Belcher & Brittian Fish, 2002) se interpersoonlike verhouding in verplegingsteorie, onderskraag. 'n Kwantitatiewe navorsingsbenadering, met 'n beskrywende ontwerp, is gekies om die studie mee uit te voer. Die populasie het al die onkologiese verpleegkundiges, wat

sterwende en palliatiewe pasiënte in kankerafdelings in die Wes-Kaapse Metropool versorg, ingesluit. 'n Gerieflikheidsteekproef van 127 onkologiese verpleegkundiges, in drie verskillende, maar tipiese kankerinstellings, is gekies, naamlik 'n staatshospitaal, 'n privaathospitaal en drie hospitiums. Data-insameling is deur middel van 'n self-gerapporteerde vraelys gedoen. 'n Loodsstudie is uitgevoer om die geldigheid en betroubaarheid van die vraelys te verseker. Etiese goedkeuring is vooraf vanaf die Etiese Navorsingskomitee van die Fakulteit Gesondheidswetenskappe van die Universiteit van Stellenbosch verkry. Skriftelike toestemming is ook vooraf vanaf die bestuur van die instellings, waar die navorsing gedoen is, sowel as van die deelnemers verkry.

Die hoofbevindings van hierdie studie was dat die meerderheid van die respondente positiewe ingesteldhede jeens die versorging van pasiënte wat sterwend is openbaar het. Boonop het die meeste respondente 'n hoë mate van werksbevrediging ervaar en hul werksomgewing as ondersteunend beskou. Beduidende verbande is getrek tussen positiewe ingesteldhede jeens die versorging van pasiënte wat sterwend is, en:

- versorging in hospitiums;

- hoër ouderdom en;

- rang van professionele verpleegkundige.

Die algemene aanbeveling wat gemaak kon word was dat deurlopende opleiding in alle aspekte van palliatiewe sorg, as 'n grondliggende strategie beskou moet, ten einde positiewe ingesteldhede ten opsigte van die versorging van pasiënte wat sterwend is onder onkologiese verpleegundiges te behou en verder aan te moedig. Voorts behoort strategieë geïmplementeer te word om onkologiese verpleegkundiges te help met die hantering van hul emosionale behoeftes en vrese.

ACKNOWLEDGEMENTS

I would like to acknowledge and wish to express my gratitude towards:

- My heavenly Father, for His love and abundant blessings;

- My supervisor, Ms. L.A. Paterson, for her continuous support, guidance and encouragement;

- Prof. M. Kidd, for the analysis of the data;

- Ms. J. Handford, for the language editing;

- All the oncology nurses, who participated in this research; and

- My two special friends, Deirdre Hewett and Cecile Theart, for their constant support and encouragement.

TABLE OF CONTENTS

LIST OF TABLES

Table number	Title	Page number
4.1	Age distribution	48
4.2	Marital status	49
4.3	Respondents having children	49
4.4	Workplace	50
4.5	Professional ranking	51
4.6	Years of experience in oncology nursing	52

LIST OF FIGURES

LIST OF ADDENDA

CHAPTER 1

SCIENTIFIC FOUNDATION OF THE STUDY

1.1   Introduction

Cancer, of which there are more than 200 different kinds, is a life threatening disease that affects everyone; men and women, young and old, rich and poor (CANSA, 2008a). Some kinds are relatively easy to detect and treat, while others spread quickly and cannot be cured (CANSA, 2008a). The statistics of the Cancer Association of South Africa (CANSA) show that there is an increase in newly diagnosed cancer cases and that it currently is one of the leading causes of patient deaths in South Africa. CANSA estimates that over 80,000 South Africans die each year from cancer (CANSA, 2008b).

Despite improvements in cure rates, there are still many uncertainties about cancer management. Cancer has a profound effect on the physical, psychological, social and spiritual aspects of life, because it is often associated with suffering and death (Maree, 2007:887). The period leading to death is characterised by an increasing prevalence of a multitude of physical, psychological, existential and social problems for the patient. Successful management and caring during this phase are thus critical for the patient, and for relatives, friends and care providers (Cherny, Coyle & Foley, 1996:261). Significantly, Botti, Endacott, Watts, Cairns, Lewis and Kenny (2006:309) have found that the provision of effective psychosocial care improves the outcomes of patients having cancer. Effective psychosocial care by oncology nurses is therefore essential to reduce the psychological distress that affects patients with cancer in all aspects of their lives. Such care has been linked to reductions in anxiety and cancer related symptoms (Kenny, Endacott, Botti & Watts, 2007:664). It is reasonable to deduce that the ability to provide effective psychosocial care is closely linked to nurses' attitudes towards caring for patients that are dying. The emotional burden of working in a palliative care

setting, may have a negative impact on oncology nurses' attitudes towards caring for such patients. Nurses' attitudes towards caring for patients that are dying may be influenced by demographic factors, such as their age, workplace and years of experience in oncology and palliative care, as well as the degree of work satisfaction experienced, and the degree of support in their work environment.

Caring, which is defined as showing care and compassion for a fellow human being (Wengström & Ekedahl, 2006:20), is particularly stressful for oncology nurses, due to the complexity of the care required by patients with cancer (Kendall, 2007:119). The impact of caring for patients having cancer, and their families, may prove to be overwhelming if support systems, particularly in the work environment, are not in place (Medland, Howard-Ruben & Whitaker, 2004:48). Nurses are of the opinion that nurse managers play an important role in ensuring care of and facilitation of healing in patients, by creating a healthy and caring management environment (Minnaar, 2003:37). Molzahn (1997, quoted in Minnaar, 2003:37) argues that the key to quality care is a humane culture in health care organisations, in which the human dignity of both patients and staff is preserved.

Work satisfaction relates to one's emotional evaluation of experiences during work and it plays a major role in an oncology nurse's decision to remain in the profession (Biton & Tabak, 2002:140). Adams and Bond (2000:537) indicate that work satisfaction is positively associated with greater professional autonomy, greater control over the practice environment and the use of nursing systems that promote accountability and continuity of care. In addition, other factors that contribute to job satisfaction amongst oncology nurses include patient care, organisation of service, support from managers, good communication and teamwork (Leung, Spurgeon & Cheung, 2007:46).

1.2   Rationale for the study

The literature provides evidence of the significant role that oncology nurses play in patients with cancer' ability to cope with their illness and in supporting their families. It is therefore obvious that nurses' attitudes towards these patients are of vital importance. However, it is evident that cancer takes its toll, not only on patients and their families, but also on the oncology nursing staff, caring for these patients.

The researcher could not find any studies investigating the relationship between nurses' attitudes towards caring for patients that are dying and their demographic characteristics, their experiences of work satisfaction and the perceived supportive nature of their work environment. It was therefore apparent that there was a need for contextually relevant research regarding this topic. Furthermore, in the year 2000, the National Institute for Nursing Research, a major research- funding agency in the USA, identified end-of-life and palliative care as priority areas for nursing research in their five-year research plan (Burns & Grove, 2007:109). It was envisioned that the data being collected and the conclusions drawn from this study would contribute to the body of knowledge, impacting on quality care for patients with cancer. The findings of the study could for example, prompt changes in policy such as the introduction of compulsory palliative care education for nurses working in palliative care settings. Furthermore, possible managerial changes based on the outcomes of the study, could have a positive influence on the quality of care delivered to the patient that is dying.

1.3   Research problem

The fact that cancer is a disease that is on the increase, and that 80,000 South Africans die each year from cancer, place a significant burden on nursing staff, working in an oncology setting. The researcher's personal experience has borne witness to the perception that caring for patients with cancer has an emotional impact on nursing staff working in an oncology environment. In

addition, nursing staff in oncology settings in the Western Cape Metropole are exposed to added work stressors, such as limited resources and staff shortages that may impact on their attitudes towards patients that are terminally ill and dying. These stressors also affect their degree of work satisfaction and their perceptions about the supportive nature of the work environment.

Nurses' attitudes towards caring for patients that are terminally ill and dying are influenced by working with these patients on a daily basis. Nurses' attitudes may be positively or negatively influenced by demographic factors (for example age and years of experience in oncology), work satisfaction and the degree of support in the working environment. If one considers that the role of caring and compassionate nursing staff has consistently been recognised as contributing to improvements in functional adjustment and quality of life of the patient with cancer (Kenny *et al.,* 2007:664), the need for research in this field is clear.

1.4   Research question

The primary research question was:

What are the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole?

1.5   Aim of the study

The aim of this study was to explore and describe the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole.

1.6   Objectives

The objectives of this study were to:

- Determine the attitudes of nursing staff towards caring for patients that are dying;

- Determine the level of work satisfaction of nursing staff;

- Determine the perceived supportive nature of the work environment;

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and their demographic factors;

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and their level of work satisfaction; and

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and the perceived supportive nature of the work environment.

1.7   Research methodology

1.7.1   Research design

According to Brink (2006:92), the research design is a "set of logical steps taken by the researcher in order to answer the research question".

A quantitative research design, using a descriptive, explorative survey, was conducted in selected oncology settings in order to obtain information about nurses' attitudes towards caring for patients that are dying and to determine any possible relationships between their attitudes, demographic factors, work satisfaction and the perceived supportive nature of the work environment.

The researcher decided on a descriptive, quantitative research design in order to generate credible data. The anonymity provided by the completion of a questionnaire was expected to elicit honest responses from the respondents. A quantitative design was used to obtain numerical data, which was then presented as frequency counts and percentages. Relationships between variables were also determined.

1.7.2   Population and Sampling

The target population is defined as the complete group of persons that meets the criteria of interest to the researcher for inclusion in the sample (Burns & Grove, 2007:234).

The target population for this study included all the oncology nurses, caring for patients that are dying in palliative and oncology settings in the Western Cape Metropole. Due to time and money constraints, the researcher, using a convenience sampling approach, focused the study on three different, but typical oncology settings, namely within a state hospital, a private hospital and three hospices. All current nursing staff that had worked for at least one year in these selected oncology settings comprised the convenience sample.

The estimated study population (N=127) constituted the following:

- Tertiary public hospital: Registered nurses (n=21), enrolled nurses (n=15), auxiliary nurses (n=26);

- Private oncology unit: Registered nurses (n=5), enrolled nurses (n=3), auxiliary nurses (n=2); and

- Hospices: Registered nurses (n=41), enrolled nurses (n=4), auxiliary nurses (n=10).

1.7.3   Inclusion and exclusion criteria

Nurses, who had worked for at least one year in the above oncology settings in the Western Cape Metropole, and who had been directly involved with the caring of patients that are dying, were included in this study.

Agency staff was excluded from the study, because they did not work on a permanent basis in palliative and oncology settings.

1.7.4　Data collection instruments

Questionnaires are often used in descriptive studies to gather information, such as the demographic data of the participants, their attitudes or opinions, and their knowledge regarding a certain situation (Burns & Grove, 2007:382).

A Likert scale questionnaire, consisting of four sections, was developed. Section A collected the demographic information of the subjects. The Frommelt Attitude Towards Care of the Dying Scale (FATCOD) was used to explore respondents' attitudes towards caring for patients that are dying in section B. A work satisfaction questionnaire, as employed by Biton and Tabak (2003:147), was adjusted for use in section C. The questions included in section D, regarding the level of support in the working environment, were compiled from an analysis of previous studies done by Traynor and Wade (1993:131), and Cashavelly, Donelan, Binda, Mailhot, Clair-Hayes and Maramaldi (2008:534).

1.7.5　Pilot study

A pilot study is a small-scale study, done on a limited number of participants, prior to the main study (Brink, 2006:166).

A pilot study was conducted to pre-test the questionnaire for any ambiguities and inaccuracies (Burns & Grove, 2007:38). The pilot study was done under similar conditions as the actual study and included 10% of the population (n=12), constituting professional nurses (n=6), enrolled nurses (n=2) and auxiliary nurses (n=4). A quota sampling technique was used to select the participants for the pilot study, whilst the participants used in this preliminary study were excluded from the main study.

1.7.6　Reliability and validity of the study

Reliability in quantitative research refers to the consistency of the measurement technique (Burns & Grove, 2009:377). Validity in quantitative research refers to

the degree to which an instrument measures what it is supposed to measure (Burns & Grove, 2009:380).

The reliability of the FATCOD scale has been established and used numerous times and in many previous studies to assess nurses' attitudes towards caring for patients that are dying (Lange, Thom & Kline, 2008:956). According to Biton and Tabak (2003:145), the questionnaire on work satisfaction had been validated and a high reliability indicated in studies done by Johnson, Hammel and Heiner (1977, cited in Biton & Tabak, 2003:145).

In this study, the reliability and validity of the questions with regards to the level of support in the working environment were established during the pilot study. The reliability of the questionnaire was also analysed by a statistician.

1.7.7 Data collection

Data collection is the precise and systematic gathering of information relevant to the research purpose (Burns & Grove, 2007:41).

The purpose of this study was explained to oncology nursing staff during scheduled meetings. The information leaflet, consent form and a questionnaire were handed out to each participant, whilst a time-frame of one week was given in which participants had to complete the questionnaire.

After completion, each participant placed the questionnaire into a sealed envelope and posted it into a sealed box, provided by the researcher. After one week the researcher collected the questionnaires and kept them in a safe place under lock and key.

1.7.8   Data analysis and interpretation

Data analysis is conducted to reduce, organise, and give meaning to the data, whilst descriptive statistics are used to analyse the numerical data of the study (Burns & Grove, 2007:41,413).

Microsoft Excel was used to capture the raw data and STATISTICA version 9 was used to analyse the data. Applicable parametric and / or non-parametric statistical tests were applied to analyse the data (Maltby, Day & Williams, 2007:117). Summary statistics were used to describe the variables. Distributions of variables were presented in histograms and / or frequency tables. Data analyses were done on the following variables, i.e. demographic data, nurses' attitudes towards caring for patients that are dying, work satisfaction and a supportive working environment.

1.8   Ethical considerations

This research was guided by the fundamental ethical principles of the right to self-determination, the right to privacy, the right to anonymity and confidentiality, justice and the right to protection from discomfort and harm (Burns & Grove, 2007:204-215).

The right to self-determination, based on the ethical principle of respect for persons, implies that individuals have the capability to determine their own destiny (Burns & Grove, 2007:204). In view of this, participants were treated as autonomous agents, who were allowed to make their own decisions regarding their participation in the study.

According to Babbie (2007:64), informed consent in research is based on participants' voluntary participation, provided they fully understand all possible risks involved. Participants were therefore informed about the purpose and procedures of the study and were allowed to ask questions to clarify any uncertainties, before they were requested to give written consent. The risks

involved in the study were also explained in the information leaflet that accompanied the consent form. Emotional discomfort during completion of the questionnaire was the only potential risk foreseen by the researcher. Furthermore, the participants were informed that participation was voluntary and that they could withdraw from the study at any time, without any penalisation (Burns & Grove, 2007:204).

The right to privacy implies that a person has the freedom to decide the circumstances under which he / she would share private information with others (Burns & Grove, 2007:209). Such freedom was respected through informed consent and voluntary participation. The researcher ensured that data would not be disclosed to anyone, in order to respect the privacy of the participants.

Anonymity refers to the process of ensuring that the participants' identities are kept secret (Brink, 2006:34), whereas confidentiality is assured when the researcher ensures participants that their private information would not be made public, or shared with anyone (Babbie, 2007:65). The rights to anonymity and confidentiality were protected by ensuring that no participant could be linked to any individual questionnaire and by keeping the collected data confidential. Anonymity was guaranteed through the anonymous completion of the questionnaire. The participants were further asked to post the completed questionnaires into a sealed box (de Vos, Strydom, Fouché & Delport, 2005:61). This ensured that nobody, including the researcher, was able to identify any subject. The researcher guaranteed participants that confidentiality would be maintained and undertook to keep the data private. Completed questionnaires were kept under lock and key.

The right to fair treatment is based on the ethical principle of justice. Participants were treated fairly and were selected only for reasons related to the study, and not because of race, culture, or friendship with the researcher (Burns & Grove, 2007:214). The researcher used a convenience sample of participants working in three typical oncology settings in the Western Cape Metropole, namely a tertiary public hospital, a private hospital and three hospices.

The participants were further protected from any discomfort and harm. The right to protection from discomfort and harm is based on the ethical principle of beneficence, which entails that one should do good and above all, cause no harm (Burns & Grove, 2007:214). The fact that there were no risks involved in the study, with the possible exception of one, were explained in the information leaflet and consent forms given to the participants, prior to completion of the questionnaire. Participants were made aware of the fact that they may experience temporary discomfort while completing the questionnaire, due to potential emotional distress they may experience with some questions in the questionnaire.

The Ethical Research Committee of the Faculty of Health Sciences, University of Stellenbosch, granted approval to proceed with the study. Written consent was also obtained from the management of the tertiary hospital, the head office of the private oncology unit, and the management of the hospices.

1.9   Functional definitions

The following are functional definitions of terms frequently used during this study, but not commonly known to the average reader:

- *CANSA:* **Cancer Association of South Africa**

The Cancer Association of South Africa is a national organisation, whose objective is to fight cancer and its consequences, by providing support to patients with cancer and their families, and to play an important role in cancer research (CANSA, 2008c).

- *EOL:* **End of Life**

The care provided to persons in their final stages of life, also called supportive care, hospice care or palliative care (Kanabus, 1990).

- *FATCOD:* **Frommelt Attitudes Towards Care of the Dying Scale**

The FATCOD Scale is a 30-item tool, using a Likert scale, to indicate respondents' attitudes towards caring for patients that are dying (Lange *et al.,* 2008:956).

- **Death anxiety**

Death anxiety is an everyday life experience and not only anxiety where there are immediate threats to life. It includes various components, such as anticipating one's own death, fear of the dying process and fear of the death of significant others (Payne, Dean & Kalus, 1998:701).

- **Oncology nursing**

Oncology refers to the study of malignant tumours. Oncology nursing specialises in treating and caring for people with malignant tumours (National Cancer Institute, 2010:1).

- **Oncology nurses**

All nurse categories caring for patients that are dying in oncology settings.

1.10 Organisation of the chapters

The research was conducted and presented as follows:

<u>Chapter 1</u>

This chapter described the rationale for the research in the field of oncology nursing, and the aim and objectives of the research. Concepts were clarified and the research design and methodology, including sampling methods and data management, were introduced. The ethical considerations were fully discussed.

Chapter 2

In this chapter, the literature review and theoretical framework for the study and their relevance to the research problem, are discussed.

Chapter 3

This chapter focuses on the methodology and research design of this study. It describes the selection of the sample of the participants, the data collection methods and the plan to organise and analyse the data.

Chapter 4

This chapter presents the analysis, interpretation and discussion of the findings.

Chapter 5

The last chapter of this research report focuses on the conclusions and ensuing recommendations.

1.11 Conclusion

Oncology nurses care for acutely ill patients and experience more deaths and family grief, than any other nursing discipline, leading to high stress levels. The existing nursing shortage has increased the nurse-patient ratio, leaving the oncology nurse, specifically, feeling physically and emotionally drained (Bush, 2009:24).

The caring relationship between oncology nursing staff and the patient plays an important role in the effective care of the patient, suffering from cancer. It is therefore important to establish a support system within the oncology unit. The most important coping strategy for oncology nurses, who experience suffering and death on a daily basis, is to talk about it (Buyssen, 1996:103). Generally, oncology nurses must take care of themselves, in order to take effective care of their patients.

In chapter two, contributions from recent research, as well as insights gained from other relevant literature, are discussed. These discussions focus on the oncology work environment, caring as it is expressed in the nurse-patient relationship, and the role of the oncology nurse in palliative care. A tentative theoretical framework, reflecting an attempt to locate the topic of caring for the dying within recognised nursing theory, is presented.

CHAPTER 2

LITERATURE REVIEW

2.1   Introduction

Cancer is a chronic condition, with 50 - 60% of patients with cancer eventually surrendering to their disease. It is a complex illness, with currently, more than 200 different kinds of cancers in both adults and children. Examples of some of the most common cancers in adults are soft tissue cancers (lung, bladder, colon, testicular, prostate, breast and ovaries), osteogenic cancers, skin cancers, cancer of the central nervous system and cancers of the bone marrow and lymphnodes. Examples of general childhood cancers are leukemias, lymphomas, Willem's tumor, retinoblastoma, neuroblastoma and hepatoma (Cancer Statistics, 2008).

Cancer statistics in South Africa show that cancer is on the increase and that it is becoming one of the leading causes of patient deaths. The Cancer Association of South Africa (CANSA) estimates that over 80,000 of South Africans die each year from cancer (Cancer Statistics, 2008). According to the South African Medical Research Council (SAMRC, 2008), the five leading cancers causing death are lung cancer (17%), oesophageal cancer (13%), cervical cancer (8%), breast cancer (8%) and liver cancer (6%). As the number of cancer cases continues to grow, more nurses will be delivering care to patients that are terminally ill and dying.

Baylor and McDaniel (1996:103) hence state that nurses who work in oncology settings, such as cancer centres in hospitals or hospices (known as institutions who are caring for patients having a life expectancy of less than a year to six months), care for patients that are dying on a daily basis and their attitudes towards these patients could have significant health care consequences for these patients. Understanding nurses' attitudes in a specific situation can

therefore help predict the quality of care that patients may receive (Baylor & McDaniel, 1996:100-103).

2.2 Caring in the nurse-patient relationship

According to Berg and Danielson (2007:500), caring in the nursing profession means attending to the wholeness of patients, whilst in oncology nursing it specifically focuses on patients with long-term and life threatening illnesses. Berg and Danielson (2007:502) found that within these parameters of the nurse-patient caring relationship, patients felt that it was crucially important to maintain their own dignity.

The art of caring is based on a professional friendship between the nurse and the patient and includes elements of hope and love (Wengström & Ekedahl, 2006:21). In her theory of transpersonal caring, Watson (1996, quoted in Kelley & Johnson, 2002:409), emphasises the transpersonal caring relationship, where nurse and patient are touched by the human centre of each other. Watson further points out that the moral commitment of the carer is to protect, enhance and promote human dignity. Since cancer is a disease that almost always threatens human dignity, the protection and promotion of human dignity is of specific importance in oncology nursing.

When referring to wholeness, Amenta (1986, quoted in Amenta & Bohnet, 1986a:4), states that the emphasis in holistic care is on the whole person, which is considered to be greater than the sum of the individual parts. Amenta further emphasises that the caring relationship between the nurse and the patient "involves body, mind, emotion, family, relatedness, culture and spirit", resulting in interaction that causes change and growth for both the patient and the nurse. Holistic care therefore demonstrates collaboration and communication rich behaviour between the patient and the professional that enhances the development of professional relationships among members of the interdisciplinary team, of whom the nurse obviously is a vital component (Amenta & Bohnet, 1986a:4).

2.3   Role of the oncology nurse in palliative care

Oncology nurses (all categories of nurses caring for patients that are dying in oncology settings), play a vital role in the provision of a supportive and safe environment to the patient and the family, as part of the health care team (Haisfield-Wolfe, quoted in Dunn, Otten & Stephens, 2005:97). According to Hottensen (2010:106), patients experience anticipatory grief when they are diagnosed with cancer, particularly if the disease is already advanced, or in a terminal phase. This is in response to multiple losses being anticipated / experienced regarding body functioning, independence, personal identity, role function in the family, cognitive and psychological functioning, dignity, and ability to complete future plans. The patient's family also experiences anticipatory grief, as they have to deal with the reality of loss over time, which often leads to conflict and dysfunction in the family. Furthermore, the family has to adapt to the life changing event of living without the loved one and must plan their future accordingly (Hottensen, 2010:107).

Hottensen (2010:107) points out that oncology nurses can assist patients and their families to develop coping strategies and to redefine their roles within the family. A particularly important task of the oncology nurse is to reframe patients' "hopes" realistically, so that they have the opportunity for personal growth and reconciliation of relationships. When patients verbalise their underlying feelings and uncertainties, the oncology nurse can listen and acknowledge their feelings (Hottensen, 2010:107). Kübler-Ross (1969:269) claims that effective verbal and non-verbal communication is of the utmost importance in the interpersonal relationship between the nurse and the patient. According to Kübler-Ross (1969:269), the most important part of communication is the fact that nurses should inform the patient that they are ready and willing to share some of his / her concerns. This meaningful relationship that develops between the oncology nurse, the patient and the family, is a characteristic of palliative care.

Palliative care, also known as end-of-life (EOL) care, aims to enhance the quality of life of patients that are dying and their families. It focuses on increasing the comfort of the patient through prevention and treatment of

suffering. Palliative care approaches the patient as a whole (physical, emotional and spiritual) and as part of a family (Palliative Care Overview, 2009). Hospice care, a specialised form of palliative care, focuses on patients with terminal illnesses and a life expectancy of six months or less. Care takes place in hospices and in patients' homes and the emphasis is placed on the comfort and quality of life, rather than on curing the patient (Morrow, 2009:1). The fact that oncology nurses in hospice settings are solely involved with persons that are dying and their families, facilitates the exercising of holistic nursing (Vassallo, 2001:17). In this way hospice nurses are thus in a position to express the wholeness of the caring aspect of nursing practice.

The actual complexity of palliative or EOL care and the associated stress to the caregiver, becomes evident when the goals of EOL care are considered. EOL care refers to comprehensive care that is given in the advanced or final stages of a terminal illness (Allen, 2009:18). According to Allen (2009:19) the goals of EOL care are:

- The avoidance of prolonged dying;

- Strengthening of family relationships;

- Relieving the burden on the patient's loved ones;

- Adequate symptom and pain control; and

- Achievement of a sense of control by the patient.

The psychological dimension of EOL care targets cognitive function and emotional health, and the nurse must be open and sensitive towards the feelings and emotional needs of the patient that is dying and the family on a continuous basis (Field & Cassel, 1997:74). The practical dimensions of EOL care entail, amongst others, aspects like arranging for home health services, getting the community involved in helping the patient and family, and making

arrangements for a will (Field & Cassel, 1997:81). Clearly, even in the best of circumstances, the achievement of these goals is not easy. The rigour of EOL care demands, combined with work related stressors, such as a lack of support, could certainly affect oncology nurses' attitudes towards the care of patients that are dying.

2.4   The oncology work environment

Oncology nursing is a dynamic field and offers intellectual stimulation and personal satisfaction, but it can also be intensely demanding physically, spiritually and emotionally (Medland *et al.,* 2004:47). Nurses in oncology settings characterise their relationships with patients as more intense than in other health care settings, because of their involvement with life and death issues and the demands of caring for certain patients over long periods of time. They therefore become more emotionally involved with the patient and the family (Peteet, Murray-Ross, Medeiros, Walsh-Burke, Rieker & Finkelstein, 1989:979).

Although the nursing profession has many benefits, such as satisfaction from involvement in patient care and positive relations with people, there is a high cost to caring, particularly in the oncology environment. Nurses who deal with the fear, suffering and pain associated with death on a daily basis, may feel similar fear, suffering and pain (Sinclair & Hamill, 2007:350). Similarly, nurses' attitudes towards caring for patients that are dying have been shown to be positively influenced by variables, such as more experience in palliative care (Ablett & Jones, 2007:736), increased contact with patients that are terminally ill (Dunn *et al.,* 2005:98), older, more mature nurses (Dunn *et al.,* 2005:101) and education in palliative care (Baylor & McDaniel, 1996:103; Mallory, 2003:310; Mok, Lee & Wong*,* 2002:327).

Ablett and Jones (2007:736) report that nurses working in hospices, and therefore more experienced in palliative care than nurses in other care settings, have a more positive attitude towards caring for patients that are dying. They

believe that only their best is good enough for the patients and their families, and their best is expressed in making a difference in the last days of the patient's life (Ablett & Jones, 2007:736).

Dunn *et al.* (2005:101) similarly found that increased contact with patients that are terminally ill had made nurses more positive towards caring for patients that are dying than those who had not often had contact with patients that are dying.

Mallory (2003:310) also found a significant positive increase in oncology nurses' attitudes towards caring for patients that are dying, after they had received palliative care education. She indicates that education and experience in palliative care definitely has a positive effect on oncology nurses' attitudes towards caring for patients that are dying, resulting in less death anxiety and better coping skills in a terminal care environment. Baylor and McDaniel (1996:103) agree that education plays an important role in helping nurses to deal with their fears and concerns, while caring for patients that are dying. This has a positive influence on their attitudes and has important implications for the quality of care the patients receive.

Suffice to say that some of the nurses working in oncology settings, find it difficult and uncomfortable to talk about death with patients that are dying (Demmer, 1999:434). For these nurses, talking to patients about death and dying, interacting with patients that are dying, and touching patients that are dying, are all associated with negative attitudes towards caring for patients that are dying (Demmer, 1999:434). According to Amenta (1986, quoted in Amenta and Bohnet, 1986b:43), health care professionals are trained to cure and rehabilitate and therefore regard death as failure and tend to avoid it. In an attempt to cope with fear of death, or death anxiety, some oncology nurses may use avoidance, which makes it difficult for them to provide effective care to patients that are dying (Braun, Gordon & Uziely, 2010:47). It is therefore essential that nurses working in oncology settings are in touch with their personal reactions to death and understand that these may affect the care given to patients that are dying (Amenta & Bohnet, 1986b:43).

Costello (2006:597) argues that good death experiences have positive outcomes for oncology nurses, whereas a bad death experience has a traumatising effect on them. The ideology of good death originated from the early hospice movement and has became part of contemporary palliative care. Good death is characterised by open communication with the patient that is dying and family, symptom relief, dignity of the individual patient and respect and acceptance of death (Costello, 2006:594). Costello (2006:595) further states that when caring for patients that are dying, nurses rely on supportive structures, such as work experiences and opportunities for reflection on individual situations, in order to facilitate the experience of a 'good death'.

The researcher therefore decided to not only concentrate on the oncology nurses' attitudes towards caring, but also on their experiences of job satisfaction, as well as the support they receive within their work environments.

2.4.1   Job satisfaction

According to Biton and Tabak (2002:141), the degree of job satisfaction that individuals experience has an influence on their level of functioning, devotion at work and long-term continuance in the specific field of work. Job satisfaction is also related to one's emotional interpretation of work experiences (Biton & Tabak, 2002:140). This in turn affects the attitude and quality of care delivered by the individual (Biton & Tabak, 2002:141). According to Lu, While and Barriball (2005:211), job satisfaction depends on the nature of the job, as well as on the expectations that individuals have of what their job should offer.

Lu *et al.* (2005:213) argue that the most important contributor to job satisfaction in the nursing environment is the degree of cohesion that exists among nurses. The ability to deliver good patient care, effective communication, teamwork and good collegiate relationships also play an important role in job satisfaction (Lu *et al.,* 2005:213). Adam and Bond (2000:541) point out that oncology nurses experience social and professional relationships with colleagues and emphasise multidisciplinary teamwork as most significant in job satisfaction. They further

suggest that in order to break the negative cycle of job dissatisfaction, nurse managers should focus their attention on creating favourable conditions for intra-professional teamwork amongst nurses and inter-professional teamwork with other health care workers in oncology settings (Adam & Bond, 2000:541).

Peteet *et al.* (1989:979) found that the emotional distress related to caring for patients that are dying, as well as the ethical issues associated with death and dying, were major sources of job dissatisfaction in oncology settings. A high workload was also experienced as another key source of stress amongst oncology nurses and was often viewed as a reason for job dissatisfaction (Cummings, Olson, Hayduk, Bakker, Fitch, Green, Butler & Conlon*,* 2008:509). Kendall (2007:118) also identified several stressors among nurses caring for patients with cancer, which included personal relationships with patients and their families and the complexity of the care required by these patients.

According to Cummings *et al.* (2008:510), changes in the organisation of health and professional nursing care services, coupled with increasing patient acuity, generate new tensions in the workplace of the oncology nurse and contribute to a higher workload. These changes increase the complexity of care to sicker patients, despite the fact that quite often fewer nurses are available. Hence, nurses' responsibilities increase, whilst no additional support is provided in order to manage the increased workload, or complexity. The above changes require nurses to find ways to balance out their daily work stressors (Cummings *et al.,* 2008:510). Oncology nurses indicated that work pressures, resulting in a lack of time for effective communication with patients, had contributed towards job dissatisfaction, implying that limited time had prevented nurses from becoming involved with the patient and family at an emotional level, which eventually had contributed to job dissatisfaction (Kenny *et al.,* 2007:668).

Pierce, Dougherty, Panzarelli, Le, Rokin and Zimmerman (2007:34) point out that stress may also have a significant influence on job satisfaction. They found that oncology nurse's had experienced higher stress levels when caring for younger patients, patients who died alone, patients in spiritual distress and those who had young children (Pierce *et al.,* 2007:34). Morgan (2009:88) states

that other contributors to job dissatisfaction among oncology nurses included moral and ethical distress, personal pain when a patient dies, and lack of support. The sense of failure that accompanies the death of a patient increases grief reactions in oncology nurses, and intensifies feelings of helplessness, guilt, failure and anger, which lead to stress and job dissatisfaction (Morgan, 2009:87).

Lu *et al.* (2005:222) also found a relationship between work related stress and reduced job satisfaction, causing a high turnover rate amongst oncology nursing staff, due to nurses leaving the field of oncology. According to Barnard, Street and Love (2006:338), oncology nurses are a valuable resource that needs to be retained. They hence emphasise the importance of identifying the stressors within oncology nursing in order to support and retain these nurses. They also point out that if one's work demands overwhelm one's coping resources, stress and burnout will occur with consequential absenteeism and low retention rates (Barnard *et al.,* 2006:339).

Larrabee, Janney and Ostrow (2003:279) similarly indicate the relationship between job dissatisfaction and intent to leave and underline the important role of nurse managers in monitoring satisfaction and in implementing support strategies that address the dimensions of job satisfaction. In order to retain oncology nurses, it is therefore important to reduce the stressors in oncology nursing and to provide a supportive working environment for them (Larrabee *et al.,* 2003:279).

2.4.2   Support in the oncology work environment

Ablett and Jones (2007:733) state that working in an oncology environment is considered to be inherently stressful, since oncology nurses are frequently exposed to the pain and suffering of patients whose diseases are incurable and who are dying. In order to maintain effective care for their patients, it is essential that nurses in oncology settings should be able to cope with the emotional impact of caring for patients that are dying (Ablett & Jones, 2007:733). Minnaar

(2003:39) found that the majority of oncology nurses did not feel valued by management, and did not feel that their concerns were addressed by nurse managers. He further points out that management should ensure adaptations in the work environment, such as more staff, better equipment and facilities, two-way communication and more effective training (Minnaar, 2003:39). Minnaar (2001:22-23) also suggests that oncology nurses should be supported in terms of different needs, such as the environment, interpersonal relationships, problem solving, development and growth, physiological and social needs, and the need for self actualisation.

Pierce *et al.* (2007:36) claim that the most stressful aspect of working in oncology settings is not the caring for patients that are dying, but rather the organisational aspects of palliative care and the lack of emotional support. According to Feldstein and Gemma (1995:230), the stress levels of oncology nurses are estimated to be twice as high as those of nurses working in other areas. This may be the reason why nurses frequently leave the oncology setting, or transfer to other areas of practice. Many nurses working in an oncology setting feel that leaving the field is the only way of coping with their chronic grief and related work stress (Feldstein & Gemma, 1995:230).

Oncology nurses identified the need for access to professional assistance and support to help them deal with their emotions and anxieties (Feldstein & Gemma, 1995:234). Hopkinson, Hallett and Luker (2004:131) further concluded that diverse supporting interventions were needed to help nurses cope with caring for patients that are dying, because of the differences between individual nurses. Demmer (1999, quoted in Hopkinson *et al.*, 2004:131) agrees that the availability of more coping resources would contribute to more positive attitudes towards caring for patients that are dying. It is therefore vitally important that management and the larger organisation have insight in oncology nurses' perceptions of death and palliative care (Costello, 2006:595).

The researcher continued the theoretical framework by focusing on Peplau's (quoted in Belcher & Brittian Fish, 2002:62) *theory of interpersonal relations in nursing* and Paterson and Zderad's (quoted in Praeger, 2002:386) *humanistic*

nursing theory, as being particularly relevant to oncology nursing and palliative care.

2.5   Theoretical framework

The nurse-patient relationship forms an integral part of the nursing practice and encompasses much more than physical care only (Mok & Chiu, 2004:475). In caring for patients that are dying, the caring is intended to promote the physical and psychosocial well-being of the patient, making a good nurse-patient relationship one of the core elements of effective palliative care that goes beyond listening and talking. Care for patients that are dying is very demanding, due to the important role the nurse plays in the interpersonal relationships with the patient that is dying and the family, as the nurse must help them to come to terms with the imminence of death (Mok & Chiu, 2004:476).

Peplau (quoted in Belcher & Brittian Fish, 2002:62), in her 'interpersonal relations in nursing theory', views nursing as therapeutic, because it involves a process of healing and assisting a person who is in need of health care. She argues that nursing is an interpersonal process, due to the interaction between the nurse and the patient. Peplau describes four phases of the nurse-patient relationship in her theory, namely the orientation, identification, exploitation and resolution phases.

In discussing these four phases, she emphasises that when the nurse and patient meet each other for the first time (orientation phase), the nurse and patient must work together to identify the need for the relationship, whilst the nurse needs to help the patient and his / her family by working collaboratively so that they can recognise, clarify and define problems (Peplau, quoted in Belcher & Brittian Fish, 2002:64).

Peplau (quoted in Belcher & Brittian Fish, 2002:66) continues that during the identification and exploitation (also called the working phase) phases, the patient responds to the interaction of the nurse during the interpersonal relationship between them. Patients may be interdependent, independent or

dependent on the nurse, and as the exploitation phase progresses, patients take advantage of the services of the nurse as professional healer and carer, being extended to them.

Within the last phase (the resolution / termination phase), Peplau contends that the patient's needs should by now have been met, and the nurse can now terminate the therapeutic relationship (Peplau, quoted in Belcher & Brittian Fish, 2002:68).

Peplau's (quoted in Belcher & Brittian Fish, 2002:76) theory emphasises the importance of including the family in the care plan of the patient, which is of the utmost importance in caring for patients that are dying. In addition, the theory accentuates communication skills, which remain fundamental in caring for patients that are dying and their families. Although Peplau's rather narrow interpretation of the termination phase is not applicable to the care of patients that are dying, the core of her theory focuses on the interpersonal process, which forms an integral part of nursing today (Belcher & Brittian Fish, 2002:78).

In their profession, and especially in palliative care, nurses have the opportunity to make a difference in peoples' health and dying experiences through their capacity to be "in-a-caring-relation". Therefore Peplau's interpersonal relations in nursing theory has major relevance to the care of the patient that is dying, because in this relationship persons meet and there is a sense of togetherness and an opportunity for self fulfilment and growth (Belcher & Brittian Fish, 2002:79).

The appropriateness of Peplau's theory was confirmed by Mok and Chiu (2004:482), as well as by Hartrick (1997:524), in their investigations into nurse-patient relationships. Mok and Chiu (2004:482) found that the caring actions, attitudes and credibility of nurses were responsible for connected and trusting interpersonal relationships in a palliative care environment. These relationships led to improvements in patients' physical and emotional states, facilitated their adjustment to the illness, decreased pain and ultimately led to a good death experience (Mok & Chiu, 2004:482).

Mok and Chiu (2004:479) described four main processes of the nurse-patient relationship, namely "encountering in the care process", "forming trusting and connected relationships", "refuelling" and "being enriched by the experience". Nurses feel a connectedness with patients that are dying, while patients feel refuelled with energy, find meaning in life and a reduction in their suffering (Mok & Chiu, 2004:479). Understanding the patient's needs, manifestation of caring actions and attitudes towards patients that are dying, holistic care and acting as the patient's advocate, were considered important for nurses in order to develop a relationship with patients (Mok & Chiu, 2004:479).

Hartrick (1997:524) states that nurses often place emphasis and reliance on productive and functional elements of human action. These constrain nurses' ability to value and experience the true elements of human relating. In caring for patients that are dying, the nurse needs to engage with the patient and family in a human-to-human relational process. To be able to achieve such a relationship, the nurse needs to put trust in herself as a caring person, and her capacity to be "in-a-caring-relation". This "in-caring-relation" encourages connectedness with the family and patient, and increases the level of care that forms the essence of relational caring (Hartrick, 1997:527). In a palliative environment, where the emphasis can no longer be placed on mechanistic models that involve curing and healing, nurses have the opportunity to make a profound difference in patients' caring experiences, and shift the emphasis to human relating that embraces caring values and the relationship in caring nursing practice (Hartrick, 1997:527).

In their theory of humanistic nursing, Paterson and Zderad (quoted in Praeger, 2002:386) also view nursing within the context of relationships. Their theory is rooted in existentialism, a philosophical approach to understanding life and making choices in order to give meaning to life. Existentialism also implies an individual's capacity for self awareness, responsibility for oneself in a relationship with others, experiencing anxiety, and being aware of the reality of death in order to experience the meaning of life. In humanistic nursing theory, the emphasis is on a human relationship in which inter-human relating is

directed towards nurturing the well-being and more-being of the person, in that nurses focus on the whole of the person (Paterson and Zderad, quoted in Praeger, 2002:387). For effective palliative care, it is important for the nurse to care for the patient that is dying holistically, in other words, as a physical, spiritual and emotional being.

Humanistic nursing occurs in a community where human beings are nurtured and comforted. It is in community that persons relate to each other in living and in dying and find meaning in their existence (Paterson and Zderad, quoted in Praeger, 2002:390). The person that is dying and the family as human beings are part of the community and are in a process of becoming more through the choices that they make (Paterson and Zderad, quoted in Vassallo, 2001:28). Paterson and Zderad's theory also embraces the concept of phenomenologic nursology, which includes the preparation of the nurse in order to be open to caring. It involves taking risks and being open to experiences, and getting into rhythm with the other's experiences. The nurse must not only be prepared in the art of nursing science, but also in the art of communication (Paterson and Zderad, quoted in Praeger, 2002:391-392).

One of the strengths of Paterson and Zderad's humanistic nursing theory is its focus on nursing and the experiences of nurses. In addition, the emphasis it places on relating, dialogue, communication and the presence of the nurse in a caring situation is important for effective palliative care practice (Paterson and Zderad, quoted in Praeger, 2002:402). Nurses who care for patients that are dying can help shape and form the dynamic process of dying, by using humanistic nursing practice in their day-to-day clinical practices. These nurses use caring behaviours, rather than curing behaviours, and the nurse, patient and family share in the nursing situation through a lived dialogue (Paterson and Zderad, quoted in Vassallo, 2001:20).

In humanistic nursing, nursing practice is a lived dialogue between the nurse and the patient, a relationship in which they meet, relate, experience each other's presence and respond to each other (Paterson and Zderad, quoted in Praeger, 2002:389). Paterson and Zderad view such meeting as a special and

purposeful coming together between the nurse and the patient and family. The nurse relates to the patient via effective verbal and non-verbal communication skills, of which listening to what the patient is saying and not saying, is the most important (Paterson and Zderad, quoted in Vassallo, 2001:24).

According to Paterson and Zderad (quoted in Vassallo, 2001:27), presence is being physically close to the patient and being with the patient. Human presence is seen as a priceless source of comfort for the person that is dying, where talking is not always needed. Simply being present can express deep feelings of "I care" and disperse the loneliness often associated with dying.

The attitudes of nurses towards patients that are dying come alive through the lived dialogue of the nursing act, where the needs of the patients are paramount. However, this nurse-patient relationship is influenced by the external world, and may be affected by the nurse's working conditions, such as a non-supportive working environment and job dissatisfaction (McCamant, 2006:335). Personal distractions, such as problems with the patient's family, may also have an influence on the relationship. The patient's ability to receive care is therefore as important as the nurse's ability to render care (McCamant, 2006:335).

Peplau's, and Paterson and Zderad's, theories of nursing provide similar conceptual frameworks to describe and attempt to understand the unique relationships that develop around the nurse and the social collective that is the patient that is dying and his / her family. These "ideal" relationships are affected by the attitudes the nurse brings to the encounter, as well as the dynamics of the work environment in which it takes place.

2.6. Conclusion

This chapter reflected on insights from the literature regarding nurses' attitudes towards caring for patients that are dying. Positive and negative influences on these attitudes were identified and discussed. In addition, the challenges posed by the oncology work environment were presented, as well as the important

contributions of job satisfaction and a supportive working environment in reducing the stress and emotional distress in nurses who work in palliative care settings.

In view of the ever increasing workload of nurses in oncology settings, the need to value and treasure oncology nurses has never been greater than it is today (Medland *et al.,* 2004:47). Oncology nurses will continue to care for patients with cancer in all phases of the disease, and will increasingly have to deal with death and the caring of patients that are dying (Lange *et al.,* 2008:959).

Nurses dealing with patients that are dying find themselves in a unique relationship, characterised by dialogue with the patient and family that forms the basis of Paterson and Zderad's (quoted in Praeger, 2002:389) humanistic nursing theory. In palliative care, particularly, nursing is directed towards nurturing the well-being and more-being of the person, and nurses focus on the whole of the person (Paterson and Zderad ,quoted in Praeger, 2002:387).

A good nurse-patient relationship is essential in caring for patients that are dying, as the aim of effective palliative care is to promote physical and psychological well-being (Mok & Chiu, 2004:475).

Caring for patients that are dying, however, generates a significant amount of emotional stress for nurses working in oncology care settings. If oncology nurses do not get the opportunity to deal with their emotions and stress, it will eventually lead to job dissatisfaction and result in nurses leaving the field (Feldstein & Gemma, 1995:234).

Chapter 3 will address the methodological process that was followed in order to reach the research objectives.

CHAPTER 3

RESEARCH METHODOLOGY

3.1   Introduction

Nurses' attitudes towards caring for patients that are dying and terminally ill may be positively or negatively influenced by demographic factors, such as age, years of experience and educational level, as well as by work related factors, such as work satisfaction and the degree of support provided by the work environment.   The purpose of this study was to explore and describe the influences of demographic and work environmental factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole.

The objectives of this study were to:

- Determine the attitudes of oncology nurses towards caring for patients that are dying ;

- Determine the level of work satisfaction of oncology nurses;

- Determine the perceived supportive nature of the work environment;

- Determine any relationships between nurses' attitudes towards caring for patients that are dying and their demographic factors;

- Determine any relationships between nurses' attitudes towards caring for patients that are dying and their level of work satisfaction; and

- Determine any relationships between nurses' attitudes towards caring for patients that are dying and the perceived supportive nature of the work environment.

The research question was:

What are the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole?

In this chapter, methodological aspects of this study are discussed, namely the research design, population and sampling, instrumentation, contents of the questionnaire, reliability and validity of the study, pilot study and the data collection.

3.2   Research design

According to Mouton (2001:55), a research design is a "blueprint or plan of how to conduct a research study". The purpose of the research design is to guide the researcher to plan and implement the study in such a way that the intended goal of the study can be achieved. It also helps the researcher to have control over the study and therefore increases the possibility that the results will provide accurate reflections of reality (Burns & Grove, 2009:218).

A quantitative research design, using a descriptive, explorative survey, was conducted at Tygerberg Academic Hospital, Panorama Medi Clinic oncology unit, Tygerberg- and Itemba Laboratories-, and St. Lukes Hospices, all in the Western Cape Metropolitan area. The aim was to explore and describe the factors, such as demographic and work environmental factors, that may influence nurses' attitudes towards caring for patients that are dying.

According to Burns and Grove (2001:537), descriptive research is conducted to discover new meaning, describe what exists, determine the frequency with which something occurs and to categorise information. According to Polit and Hungler (1999:712), quantitative research is the study being conducted by using a controlled design to obtain quantified data. This study attempted to quantify factors that influence nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole.

Quantitative research has the following characteristics, as described by Burns and Grove (2001:39):

- It uses a deductive form of reasoning;

- The meaning is given by the researcher, who interprets the quantitative research results and thus uses ethical perspectives;

- Quantitative research answers the research question that has been stated at the beginning of the research process;

- The phenomenon under study is controlled in order for the research findings to be an accurate reflection of reality, thus reducing errors and enhancing the reliability and validity of the research results;

- Data is presented in figures, which are easy to quantify;

- Data analysis follows a standardised procedure; and

- The sample is usually representative of the population.

The researcher used a quantitative research design, analysing the responses numerically, and presenting the data in frequency counts and percentages.

Descriptive and explorative survey studies are also used to determine differences between variables (Lobiondo-Wood & Haber, 2002:198). In descriptive and explorative surveys, the investigator attempts only to relate one variable to another and not to determine causation (Burns & Grove, 2007:240).

3.3   Population and Sampling

The target population consists of all the people that meet the criteria of interest to the researcher for inclusion in the research study (Burns & Grove, 2009:344). In this study, the target population included all the oncology nurses caring for patients that are dying in palliative and oncology settings in the Western Cape Metropole. However, due to a lack of accessibility, the total population could not be studied and therefore a representative sample had to be selected. According

to Babbie (2007:189), a sample is representative, if the characteristics of the sample are the same as the characteristics of the population.

The fact that no list was available of all the oncology nurses working in the Western Cape Metropole, meant that no sampling frame, or a list of all the participants in the population (Burns & Grove, 2009:348), could be compiled. In many institutions, oncology patients are treated in general wards with non-oncology patients. However, it was possible to identify institutions where oncology patients were treated in dedicated oncology or palliative care units. Due to time and money constraints, therefore, the researcher, using a convenience sampling approach, decided to focus this study on three kinds of oncology settings. According to Machin, Campbell and Walters (2007:223), convenience sampling is known as grab or "make-do" sampling, in that only participants who are available to the interviewer can be questioned. To ensure representativeness over the entire health spectrum in the Western Cape Metropole, the researcher conducted the study in a tertiary public hospital, an oncology unit in a private hospital and hospices.

For the purpose of this study, samples were drawn from a tertiary public hospital, i.e. the Tygerberg Academic Hospital, from the oncology unit of a private hospital, i.e. Panorama Medi Clinic, as well as from three hospices, i.e. Tygerberg- and Itemba Laboratories- and St. Lukes Hospices. Three hospices were selected, because of the relatively small number of staff in each.

In the tertiary public hospital, both the adult and paediatric oncology units were included, while the focus was on adult patients in the private hospital and hospices, as there were no paediatric oncology units in these institutions. All oncology nurses working in these selected settings and who met the inclusion criteria were included in the study. The estimated study population (N=127) was constituted as follows: tertiary public hospital (n=62), private oncology unit (n=10) and hospices (n=55).

3.3.1   Inclusion and exclusion criteria

The inclusion criteria were:

- Participants should have worked in an oncology setting for at least one year;

- Participants should have worked in institutions in the Western Cape Metropolitan area; and

- Participants should have cared directly for patients that are dying.

The exclusion criterion was:

- Agency staff was excluded from the sample, as they did not work on a permanent basis in oncology settings.

3.4   Instrumentation

A data collection instrument is the device used to collect data in an objective and systematic manner for the purpose of the research. Data collection instruments can be questionnaires, interview schedules, tests and available records (LoBiondo-Wood & Haber, 2002:294-296).

A survey is a technique used to collect data by making use of self report questionnaires or interviews and can be used within many different research designs, including a descriptive design (Burns & Grove, 2009:245). Babbie (2007:244) claims that a survey as a data collection technique, is the best method to collect data from large populations, where direct observation is too difficult. This is also an excellent data collection method for measuring attitudes in a population (Babbie, 2007:244). In this study, a survey was used to gather information through the distribution of self reporting questionnaires directly to the target population. The researcher found the use of self reporting questionnaires appropriate for this study, as the target population was too large to observe directly, but could be reached relatively easily through a survey.

According to Gillham (2000:8), the following are characteristics of a questionnaire:

- They are less expensive and many respondents can be reached within a short period of time;

- They provide an easy way to obtain much information within a limited period of time;

- Respondents can complete the questionnaire in their own time, without the pressure of immediate responses;

- Anonymity can be guaranteed, as no one will know any specific respondent's answer; and

- Questions are standardised so that every respondent receives the same questions.

3.5   Contents of the questionnaire

Questionnaires are often used in descriptive studies to gather information, such as demographic data of the respondents, their attitudes or opinions and knowledge of these respondents in a certain situation (Burns & Grove, 2009:239). In this study, only closed ended questions were included, where the respondents had to select an answer from a list of responses provided by the researcher. Closed ended questions ensure standardisation of responses that are then more easily processed (Babbie, 2007:246).

The researcher compiled a self reporting questionnaire, consisting of four sections. In self reporting questionnaires respondents are requested to complete the questionnaires themselves (Babbie, 2007:257).

Section A of the questionnaire collected data for measurement on the nominal scale level. This refers to data being categorised according to a defined property, where each item only fits into one specific category (Burns & Grove, 2009:375). On this level of measurement, the categories cannot be ordered into different ranks and the numbers used for coding the data cannot be used in

mathematical calculations (Burns & Grove, 2009:375). The categories of data included in Section A were the demographic information of the respondents, such as age, marital status, whether the respondents had children, the level of education, the work setting and years of experience in caring for patients that are dying.

In sections B, C and D the variables were measured on the ordinal scale level, where the variables were ranked into exclusive and exhaustive categories, with the intervals between the ranked categories being unequal (Burns & Grove, 2009:375). A Likert type scale was used to measure the attitudes and opinions of the respondents on a specific topic, for example, the degree of satisfaction experienced by working as an oncology nurse. Likert scales are used to determine the opinion or attitude of a respondent and it includes declarative statements, with a scale next to each statement. Values of each statement can range from, for example, strongly agree to strongly disagree (Burns & Grove, 2009:410).

In section B of the questionnaire, an existing scale, namely the Frommelt Attitude Towards Care of the Dying (FATCOD) scale, was applied to measure the oncology nurse's attitudes towards caring for the patient that is dying. The FATCOD scale is a thirty-item Likert scale instrument, having five response categories, ranging from strongly disagree to strongly agree (Lange *et al.,* 2008:956). Two thirds of the items referred directly to the respondent's attitudes towards the patient that is dying, whilst one third referred directly to the attitudes towards the family of the patient that is dying (Mallory, 2001:38).

The scale further consisted of an equal number of positively and negatively worded statements. Scoring was reversed for the negative statements. The researcher changed the original five response categories to six, by replacing the "uncertain" category with two other categories, namely "slightly disagree" and slightly agree". The motivation for this adjustment was to prevent respondents from selecting the neutral, uncertain category and to force them to agree or disagree with a statement. The scores of the FATCOD scale ranged between 30 – 180, with the higher scores representing more positive attitudes towards

caring for patients that are dying. Permission to use the FATCOD scale was granted by the author, prof. Katherine Frommelt.

In section C, a seven-item Likert scale questionnaire, as developed by Biton and Tabak (2002:147), was used to measure work satisfaction. The Likert scale in this instrument included six response categories, ranging from never to always. All seven items of the work satisfaction instrument were included in the questionnaire, but the term, "nurse" was replaced with the words, "oncology nurse". Permission to use the work satisfaction questionnaire was granted by the author, Tabak.

Section D of the questionnaire measured the level of support in the working environment. An eight-item Likert scale with six response categories, ranging from never to always, was compiled from an analysis of previous studies being done by Traynor and Wade (1993:131), and Cashavelly *et al.* (2008:534).

3.6   Reliability and validity of the study

In quantitative research, reliability is concerned with how consistently the measurement technique measures a variable or concept. In addition, it specifies the extent of random error in the method of measurement (Burns & Grove, 2009:377). Random error is a measurement error that refers to the difference between the measured value and the true value of a measurement (Burns & Grove, 2009:372). According to Delport (2005:163), a data collection instrument is reliable if it produces identical, or nearly identical measurements, if the same variables are measured under the same conditions.

Since the FATCOD scale was employed in various previous research studies to assess the attitudes of nurses towards caring for patients that are dying, the reliability of this instrument had been established numerous times (Lange *et al.,* 2008:956). Frommelt (1991, quoted in Dunn *et al.,* 2005:99) used a test-retest procedure to assess the reliability of the original FATCOD scale. A sample of eighteen oncology nurses was tested at two different occasions, resulting in the computed Pearson product-moment correlation coefficient in the first test being

r = 0.94, and in the second test, *r* = 0.90 (Dunn *et al.,* 2005:99). The researcher also requested a statistician to test the reliability of the adapted FATCOD scale being used in this study, resulting in the computed Cronbach's alpha coefficient value being 0.75.

According to Biton and Tabak (2003:145), the questionnaire on work satisfaction had been validated and a high reliability was indicated in studies done by Johnson, Hammel and Heiner (1977, quoted in Biton & Tabak 2003:145).

The reliability and validity of the items regarding the level of support in the working environment were established during the pilot study. The computed Cronbach's alpha coefficient done by the statistician was 0.75.

According to Babbie (2007:146), the number of research workers involved can have a negative influence on the reliability of a study. Therefore, in order to minimise unreliability from using several research workers, the researcher was solely responsible for distributing and collecting the questionnaires.

Validity in quantitative research is the extent to which the instrument actually reflects or measures what it is supposed to measure (Burns & Grove 2009:380). Contents validity is concerned with the contents of the instrument and whether it covers the full range of meanings of the variable(s) being measured (Delport, 2005:161). The instruments in this study were used to measure nurses' attitudes towards caring for patients that are dying, their work satisfaction, and the nature of the working environment. The FATCOD scale's contents validity index, as tested in 1988, was 1.00, with a computed inter-rater agreement of 0.98. In 1998 the contents validity index was repeated, producing an inter-rater agreement of 1.00 (Lange *et al.,* 2008:957). The use of the FATCOD scale, job satisfaction scale and nature of supportive work environment scale in this study was also validated through their extensive use in related studies, as revealed in the literature review.

Face validity is concerned with the face value of an instrument (Delport, 2005:161) and refers to what an instrument appears to measure and not to what an instrument actually measures. Face validity is also an important aspect of the usefulness of an instrument and may influence the willingness of respondents to complete the questionnaire (Delport, 2005:161). A pilot study was conducted to determine the face validity of the questionnaire and whether there were any uncertainties and misleading questions (Burns & Grove 2009:44). The respondents in the pilot study did not have any difficulty in completing the questionnaire. They reported that the questions were clear and easily understandable.

3.7   Pilot study

A pilot study is a smaller version of the major study and is used to develop and refine the data collecting instruments, methodology, or data collection process (Burns & Grove, 2009:44). By performing a pilot study, the researcher was able to recognise any unforeseen problems and make adjustments, before the main study was conducted (Brink, 2006:54). Mouton (2008:103) claims that disregarding a pilot study, is a common source of error in the construction of a questionnaire. According to Burns and Grove (2009:38), some of the reasons for doing a pilot study are to identify potential problems with the research design, to determine the representativeness of the sample, to refine data collection instruments and to examine the reliability and validity of data collection instruments.

The pilot study for this research was done in the tertiary hospital setting. Ten percent (10%) of the total sample (n=12) was selected for inclusion in the pilot study, which was constituted as follows: professional nurses (n=6), enrolled nurses (n=2), and auxiliary nurses (n=4). According to the Nursing Act, Act 50 of 1978 (South Africa, 1978), professional nurses are persons registered as nurses, after submitting the qualification that entitles them to registration. In addition, enrolled nurses and auxiliary nurses are persons that are enrolled as an enrolled nurse, or nursing auxiliary, after submission of such qualifications.

The quota sampling technique was used to select respondents for the pilot study. According to Burns and Grove (2009:354), quota sampling, a non-random convenience sampling technique, is used to ensure that the known characteristics of the target population are represented in the sample. The target population was known to include these categories of nurses and the actual quotas were selected on the basis of the numbers of these categories in the selected study institutions. Participants in the pilot study were excluded from the main study.

3.8   Data collection

Data collection is the "precise, systematic gathering of information, relevant to the research purpose" (Burns & Grove, 2009:43). Brink (2006:141) claims that it is vitally important for high quality data collection techniques to ensure accurate research conclusions.

Prior to commencing with data collection, written permission was obtained from the management of the different oncology settings that participated in the study. Meetings were scheduled with the oncology nurses in the different settings, during which the researcher personally explained the purpose and the procedure of the study. The researcher allowed time for questions from the respondents in order to eliminate any uncertainties. During these meetings, the information leaflet and consent form were handed out, and written consent was obtained from the respondents. These consent forms were collected separately from the questionnaires, in order to ensure anonymity.

Consistency of data collection is critical in order to ensure the validity of the study (Burns & Grove, 2009:441). It is therefore important to administer the questionnaires likewise to all the respondents. Accordingly, the researcher administered all the questionnaires in this study in person to all the respondents in the different oncology settings. The data collection instruments were handed out to each participant and a time frame of one week was given in which participants had to complete the questionnaire.

The researcher collected data over a period of two months, from the beginning of March 2010 until the end of April 2010. After completion, respondents placed their questionnaires in a sealed envelope each and posted them into a sealed box, provided by the researcher. The unit managers of the different settings kept the questionnaires in a safe, locked place after completion, until one week later when the researcher collected the questionnaires and kept them under lock and key.

3.9   Data analysis

The researcher captured the raw data by entering it onto an excel spreadsheet. Thereafter, descriptive statistics were used to describe and summarise the data (Brink, 2006:171). Frequency distributions were compiled and measures of central tendency were determined. Analysis of variance was used to examine relationships between variables, for example the relationship between nurses' attitudes towards caring for patients that are dying and work satisfaction, or the level of support in the oncology-working environment. Furthermore, inferential statistics was used to make inferences about the population and significance of the study (Brink, 2006:171).

3.10   Limitations of the study

Several limitations should be considered in this study. The convenience sample used in the study, may not have been representative of all oncology nurses at large, and may diminish the applicability of the findings in general. The relatively small sample size of 127 respondents may have affected the ability to actualise statistical significance. Furthermore, the self report method of data collection being used in this study could also have limited this study. The self report method may have resulted in falsely positive responses. Therefore, it is important to take into account the differences between how nurses actually behave in real life (true attitudes) and what nurses reflected in the questionnaire (stated attitudes).

3.11 Ethical considerations

This research was guided by fundamental ethical principles, such as the rights to self-determination, to privacy, to anonymity and confidentiality, justice and the right to protection from discomfort and harm (Burns & Grove, 2007:204-215).

Ethical approval was obtained from the Committee for Ethical Research at Stellenbosch University. This study was conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice and the Medical Research Council's Ethical Guidelines for Research. Written consent was obtained from the management of the tertiary public hospital, the private hospital and the three hospices, before the study commenced.

After information sessions with the participants, during which the purpose and procedures of the study were explained by the researcher, written consent was obtained for participation in the study. It was brought under the participants' attention that participation in this study was voluntary, and that they could withdraw at any time during the study, without any penalty. Confidentiality and anonymity were guaranteed by anonymous completion of the questionnaire and the placement of completed questionnaires in a sealed envelope and box. This ensured that nobody, including the researcher, was able to identify any participant afterwards. In addition, only the researcher, the statitician and supervisor had access to the collected data.

3.12 Conclusion

In this chapter, the research methodology that was followed during this study was discussed.

The research design, population and sampling, validity and reliability, pilot study, data collection, instrumentation, limitations of this study, and ethical considerations that were adhered to, were described.

In chapter four the analysis and discussion of the research results are presented.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 Introduction

In this chapter, the analysis of the quantitative data, obtained during this study, is discussed. This study investigated the influence of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole. The researcher conducted the study in three oncology settings in the Western Cape Metropole, namely in the oncology units of a tertiary public hospital, a private hospital and three hospices. A convenience sample of 127 participants was included in the study, comprising participants from the tertiary public hospital (n=62), the private hospital (n=10) and the hospices (n=55).

Data collection took place by utilising a self-report questionnaire, consisting of four sections. Section A collected the demographic data of the respondents. Section B consisted of the FATCOD scale and measured the oncology nurses' attitudes towards caring for the patient that is dying. Section C measured work satisfaction, while section D measured the level of support provided by the working environment.

A total of 85 respondents completed and returned their questionnaires, whilst no responses were obtained form the remaining 42 potential participants. The response rate was thus a satisfactory 66.9%.

4.2 Data analysis method

Data analysis is the organisation of the raw data in order to present them in such a way that will provide answers to the research question(s) (Brink, 2006:170). Analysis of quantitative data is done by using statistical strategies.

Descriptive statistics summarise the data, whilst inferential statistics allow inferences to be made about the population of the study (Brink, 2006:171). Probability values (*p* values), with a significance level of 0.05, were used to determine the significance of the findings. Probability refers to the chance that an event can be accurately predicted, or that a particular outcome will result for a certain action (Burns & Grove, 2007:406). The raw data was captured on computer, using MS Excel. Thereafter, STATISTICA Version 9 (StatSoft Inc. (2009) STATISTICA (data analysis software system), www.statsoft.com.) was used to analyse the data. Missing data was statistically replaced by using the software program, IMPUTATION.

The descriptive statistics used to describe the variables included frequency distributions in the form of histograms and frequency tables, measures of central tendency and standard deviations. Relationships between two continuous response variables were analysed with correlation analysis, whereas the strength of the relationship was measured with the Spearman correlation. The relationships between continuous response variables and nominal input variables were analysed, using appropriate analysis of variance (ANOVA). A *p*-value of $p < 0.05$ represented statistical significance.

Analysis of variance (ANOVA) is used to compare variances and assess the significance of differences between means in different groups. It is associated with the symbol F (Brink, 2006:183).

The standard deviation (SD) is the "average difference or deviation value", and "provides a measure of the average deviation of a value from the mean in a sample" (Burns & Grove, 2007:418).

The mean is "the sum of all the scores, divided by the number of scores" (Burns & Grove, 2007:417), whilst the "score at the exact centre of an ungrouped frequency distribution" is called the median (Burns & Grove, 2007:415).

4.3 Description of statistical analysis

The data being generated was analysed and presented in the form of frequency distribution tables and histograms. Analysis included the calculation of the mean, median and standard deviation. The mean value is the average value for the variable, while the median refers to the middle value when the values are arranged from the smallest to the largest. If the median is larger than the mean value, then most of the values will lie above the mean value. The standard deviation is an indication of how closely values are clustered around the mean (Burns & Grove, 2002:418).

The *p*-value was the measure being reported for all tests of statistical significance. It is defined as the probability that an effect, at least as extreme as that observed in a particular study, could have occurred by chance alone. If the *p*-value is greater than 0.05 by convention, the chance cannot be excluded as a likely explanation and the findings are stated as statistically insignificant at that level (Machin *et al.,* 2007:100-116). If the *p*-value is less than 0.05 it is considered significant. Therefore the 95% confidence interval was applied to determine whether there would be an association between variables. As per TerreBlanche and Durrheim (2002), a 95% confidence interval (CL) could be explained as "…a 95% probability that the actual mean of the larger population from which the sample was drawn lies within the range indicated by this value - either above or below the sample mean". The Spearman rank correlation coefficient was used to determine the degree of the relationship between two ordinal variables and is expressed with the symbol *r* (Brink, 2006:180).

4.4 Study outcomes

4.4.1 Section A: Demographic data

Question 1: Age (n=81)

Table 4.1 indicates that most respondents were in the age group between 41 - 45 (n=20) (25%), whilst only one was in the age group between 31 - 35 (n=1)

(1%). The average age of respondents was 47.7, which indicated that a significant number of respondents, taking part in this study, were middle aged and settled in their profession. According to Dunn *et al.* (2005:101), age influences nurses' attitudes towards caring for patients that are dying, with older nurses displaying more positive attitudes in this regard.

Table 4.1: Age distribution

Category	Frequency (*f*)	Percentage (%)
20 - 25	3	4
26 - 30	2	2
31 - 35	1	1
36 - 40	9	11
41 - 45	20	25
46 - 50	16	20
51 - 55	14	17
56 - 60	10	12
61 - 65	3	4
66 - 70	3	4
Total	**n=81**	**100**

Question 2:   Marital status (n=85)

Table 4.2 indicates that the majority of the respondents (n=48) (56%) were married, 22 (n=22) (26%) were single, 11 (n=11) (13%) were divorced and 4 (n=4) (5%) were widowed. This information helped the researcher determine the percentage of respondents who had family responsibilities. In addition, married respondents may have their partners as providers of emotional support.

Table 4.2:   Marital status

Category	Frequency (*f*)	Percentage (%)
Married	48	56
Single	22	26
Divorced	11	13
Widowed	4	5
Total	**n=85**	**100**

Question 3:   Children (n=85)

Table 4.3 indicates that the majority of the respondents (n=68) (80%) had children, with the remainder (n=17) (20%) being without. This information also helped the researcher to determine the percentage of respondents with family responsibilities, and in some cases, those who were single parents. It was the researcher's assumption that the bond between the oncology nurse and her family could provide an emotional support system.

Table 4.3:   Respondents having children

Category	Frequency (*f*)	Percentage (%)
Have children	68	80
Do not have children	17	20
Total	**n=85**	**100**

Question 4:   Workplace (n=85)

According to Table 4.4, the majority of the respondents (n=45) (53%) worked in a tertiary state hospital, 14 (n=14) (16%) in a private oncology unit and 26

(n=26) (31%) in hospices. Ablett and Jones (2007:736) point out that the workplace may have an influence on nurses' attitudes towards caring for patients that are dying. They report that hospice nurses tend to have more positive attitudes towards caring for patients that are dying, than nurses in other health care settings.

Table 4.4:   Workplace

Category	Frequency (*f*)	Percentage (%)
Tertiary state hospital	45	53
Private oncology unit	14	16
Hospice	26	31
Total	**n=85**	**100**

Question 5:   Professional ranking (n=82)

Table 4.5 indicates that 19 (n=19) (23%) of the respondents were auxiliary nurses, whilst 16 (n=16) (20%) were enrolled nurses. The professional nurses formed the largest group (n=24) (29%). 23 (n=23) (28%) of the respondents were professional nurses with training in oncology or palliative care. Mallory (2003:310) points out that nurses' attitudes towards caring for patients that are dying are positively influenced by education in palliative care.

Table 4.5: Professional ranking

Category	Frequency (*f*)	Percentage (%)
Auxiliary nurse	19	23
Enrolled nurse	16	20
Professional nurse	24	29
Professional nurse (specialist)	23	28
Total	**n=82**	**100**

Question 6: Years of experience in oncology nursing/setting (n=81)

Table 4.6 indicates that the majority of respondents had either 16 - 20 years (n=23) (28%), 11 - 15 years (n=21) (26%), or 0 - 5 years (n=19) (25%) of experience in oncology nursing and caring for patients that are dying. Of the remainder, 6 (n=6) (7%) had 6 - 10 years, 10 (n=10) (12%) had 21 - 25 years and 2 (n=2) (2%) had 26 - 30 years of experience in oncology nursing. The average number of years experience in oncology nursing was 13.5. Ablett and Jones (2007:736) emphasise the positive influence of years of experience in palliative care on nurses' attitudes towards caring for patients that are dying. Peteet *et al.* (1989:980) also found that time and experience in oncology settings contribute to a positive change in nurses' attitudes towards caring for patients that are dying.

Table 4.6: Years of experience in oncology nursing

Category	Frequency (*f*)	Percentage (%)
0 - 5 years	19	25
6 - 10 years	6	7
11 - 15 years	21	26
16 - 20 years	23	28
21 - 25 years	10	12
26 - 30 years	2	2
Total	**n=81**	**100**

4.4.2 Section B: Nurses' attitudes towards caring for the dying

The reliability of the FATCOD scale was considered acceptable, with a Chronbach's alpha of 0.81. On average, the majority of the respondents reported a strongly positive attitude towards caring for patients that are dying. On a scale of 1 (not positive) to 6 (very positive), the median = 4.9; mean = 4.8; and the SD = 0.4.

Question 7: Giving nursing care to the person that is dying is a worthwhile learning experience
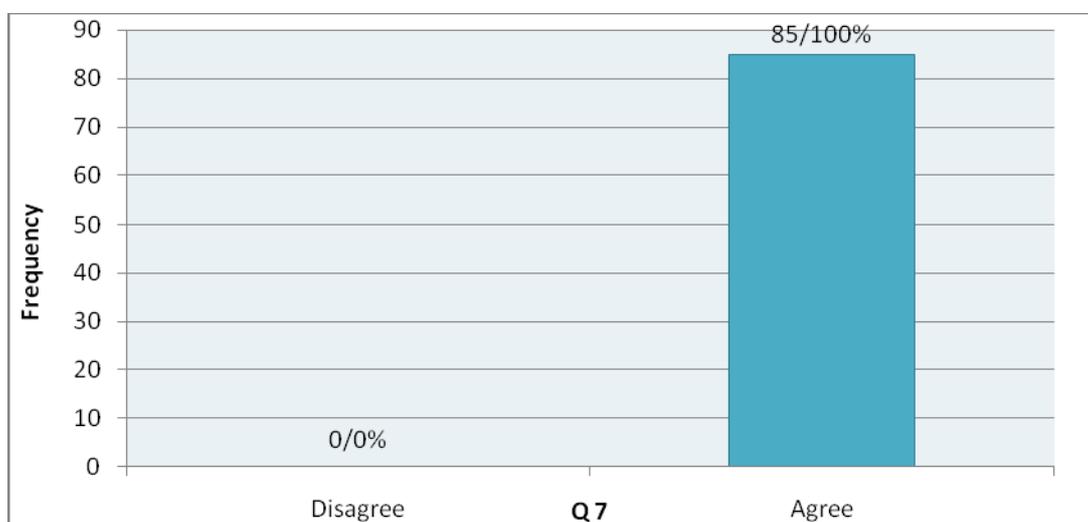

Figure 4.1: Oncology nurses' experiences of nursing care to patients that are dying.

Figure 4.1 shows that 85 (n=85) (100%) of the respondents agreed that giving nursing care to the person that is dying was a worthwhile learning experience. Amenta (1986, quoted in Amenta & Bohnet, 1986a:4) is of the opinion that the caring relationship between nurse and patient results in growth for both the patient and the nurse.

Question 8: Death is not the worst thing that can happen to a person

Figure 4.2 reveals that after reducing the response categories to agree and disagree, respondents were fairly divided regarding this statement, with 45 (n=45) (53%) agreeing and 40 (n=40) (47%) disagreeing. Costello's (2006:597) finding that good and bad death experiences can influence oncology nurses positively or negatively, may explain this divided result.
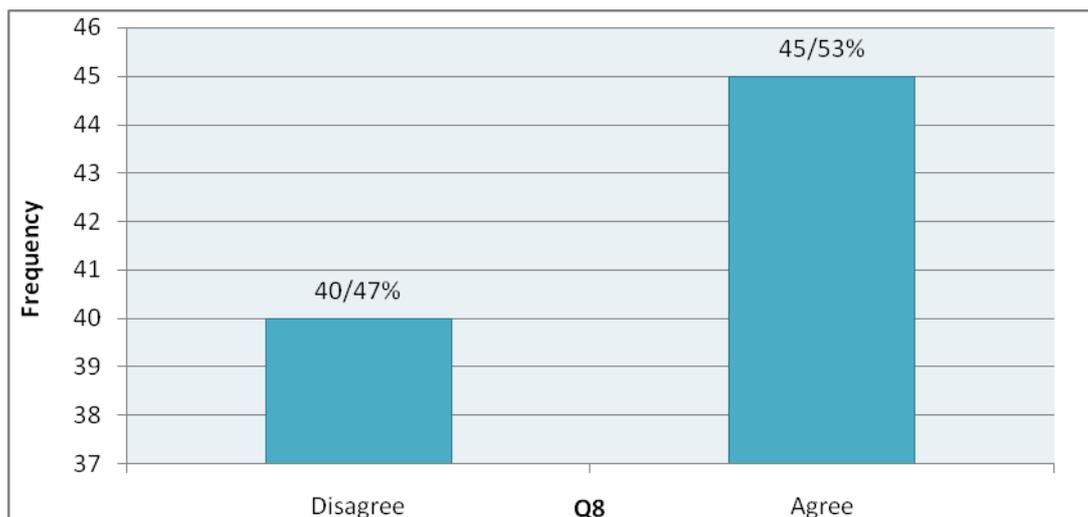
Figure 4.2: Oncology nurses' experiences of death as the worst thing that can happen to a person.

Question 9:   I would be uncomfortable talking about impending death with the person that is dying

Figure 4.3 reveals that after reducing the response categories to agree and disagree, 61 (n=61) (71%) of the respondents disagreed, whilst 24 (n=24) (29%) agreed that they would be uncomfortable talking about impending death with the person that is dying. According to Demmer (1999:434), some oncology nurses find it difficult to talk about death with patients that are dying, as this is associated with negative attitudes towards caring for patients that are dying (see paragraph 2.4). The fact that the majority of the respondents did not feel uncomfortable about it, therefore reflected the overall positive attitudes towards caring for patients that are dying, as was found during this study (see paragraph 4.4.2). Ho, Barbero, Hidalgo and Camps (2010:6) found that nurses had generally felt that they required training in communication skills in order to talk about death with patients that are dying.
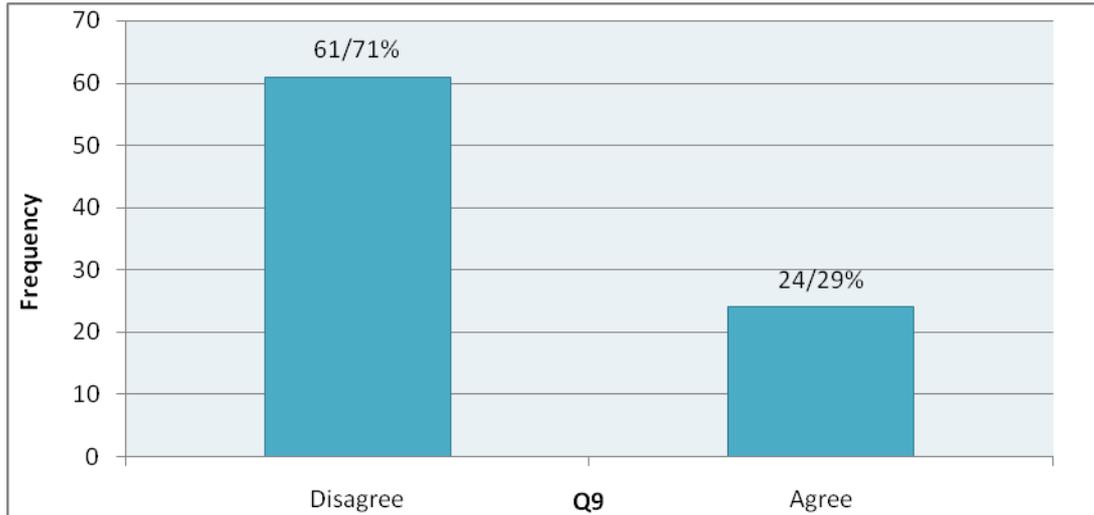
Figure 4.3: Oncology nurses' experiences of talking about impending death with the patient that is dying.

Question 10: Emotional care of the patient's family should continue throughout the period of grief and bereavement
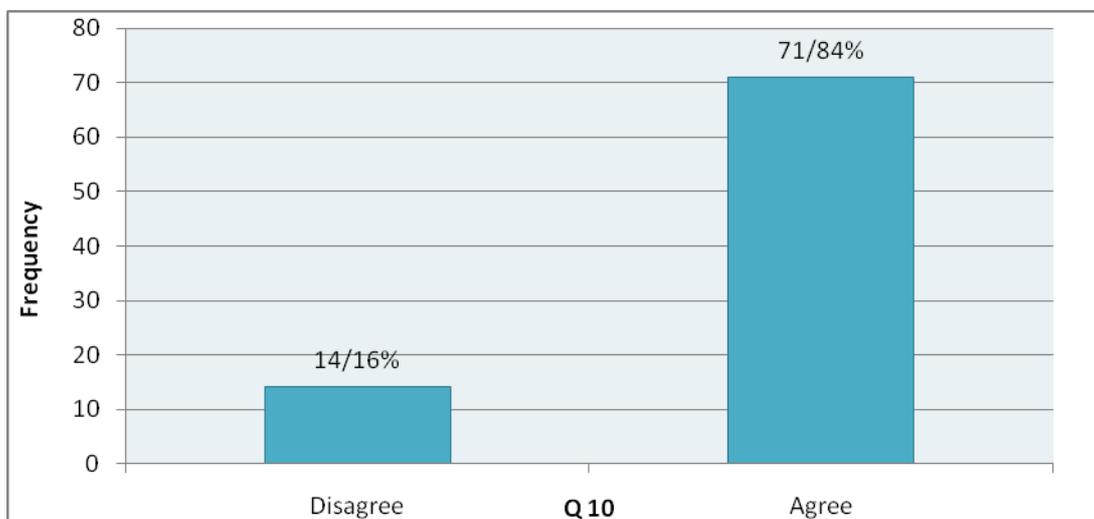

Figure 4.4: Oncology nurses' experiences of emotional care towards the patient's family.

Figure 4.4 shows that after reducing the response categories to agree and disagree, 14 (n=14) (16%) of the respondents disagreed, whereas 71 (n=71) (84%) agreed that emotional care of the patient's family should continue throughout the period of grief and bereavement. This finding was in support of

Field and Cassel's (1997:74) view that nurses who care for patients that are dying should be sensitive to the emotional needs of the patients' family during the end of life (EOL) phase, and also after the patient passed away.

Question 11: I would not want to be assigned to the care of a person that is dying

Figure 4.5 reveals that after reducing the response categories to agree and disagree, 74 (n=74) (87%) of the respondents disagreed, whilst 11 (n=11) (13%) agreed that they would not want to be assigned to the care of a person that is dying. Although Sinclair and Hamill (2007:350) and Medland *et al.* (2004:47) point out that nurses experience the care of the patient that is dying as physically and emotionally demanding, the majority of the respondents in these studies did not have a problem with being assigned to the care of a person that is dying.
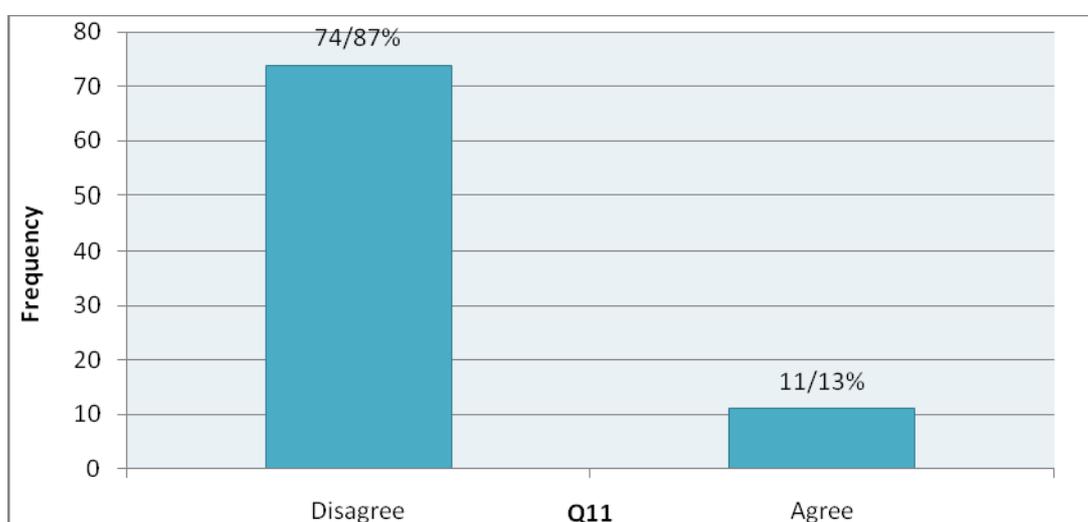

Figure 4.5: Oncology nurses' experiences of being assigned to the care of a patient that is dying.

***Question 12:   The nurse should not be the one to talk about death with the
person that is dying***

Figure 4.6 shows that after reducing the response categories to agree and
disagree that 66 (n=66) (78%) of the respondents disagreed, whereas 19
(n=19) (22%) agreed that the nurse should not be the one to talk about death
with the person that is dying. Rittman, Paige, Rivera, Sutphin and Godown's
(1997:117) are of the opinion that the nurse often knows patients that are dying
well enough to facilitate their acceptance of their deteriorating condition. They
further state that nurses experience the quality of physical care of the patient as
valuable, and they use it as an entrée to provide emotional care.
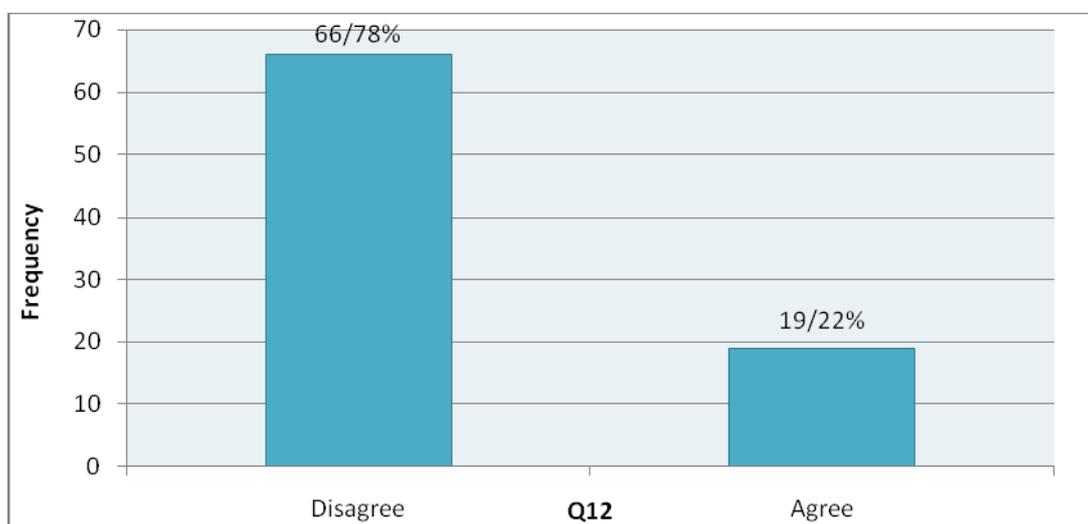
Figure 4.6:   Oncology nurses' experiences of talking about death with the
person that is dying.

Question 13: The length of time required to give nursing care to a person
*that is dying would frustrate me*
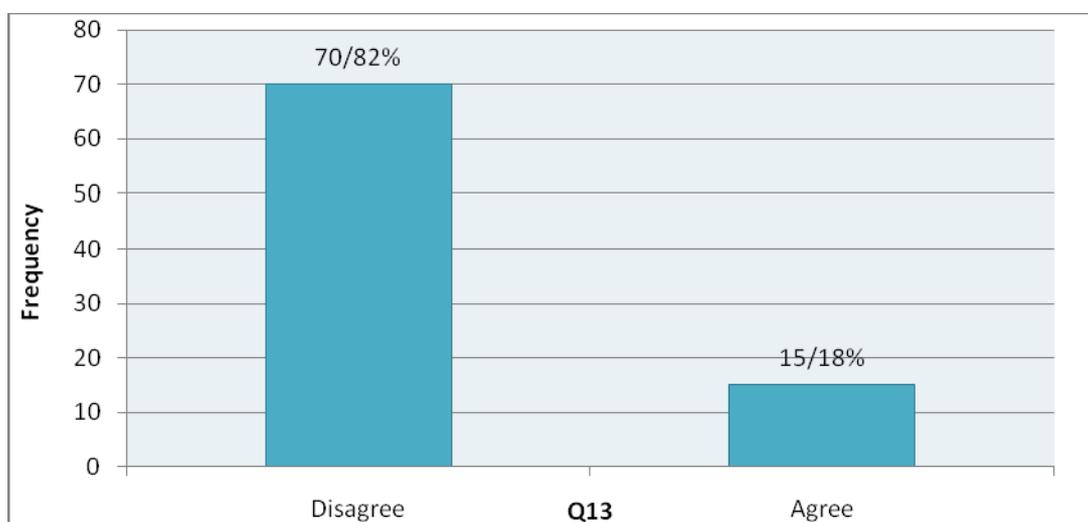
Figure 4.7:   Oncology nurses' experiences of frustration regarding the length
of time required to give nursing care to a patient that is dying.

Figure 4.7 shows that after reducing the response categories to agree and
disagree, 70 (n=70) (82%) of the respondents disagreed and 15 (n=15) (18%)
agreed that the length of time required to give nursing care to a person that is
dying would frustrate them. Peteet *et al.* (1989:979) point out that oncology
nurses characterise their relationship with patients that are dying as more
intense, because of the demands of caring over a long period of time.

Question 14: I would be upset if the person that is dying I was caring for
should give up hope of getting better

Figure 4.8 reveals that after reducing the response categories to agree and
disagree, 65 (n=65) (76%) of the respondents disagreed, with 20 (n=20) (24%)
agreeing that they would be upset if the person that is dying they were caring
for should give up hope of getting better. Hottensen (2010:107) points out that a
particularly important task of the oncology nurse is to reframe the patient's hope
in a realistic way. The fact that the majority of respondents would not be upset if
the person that is dying gave up hope of getting better, is congruent with
Kübler-Ross's (1969:269) opinion that an important characteristic of a

meaningful relationship between nurse and patient is that the nurse is ready and willing to share some of the patient's concerns.
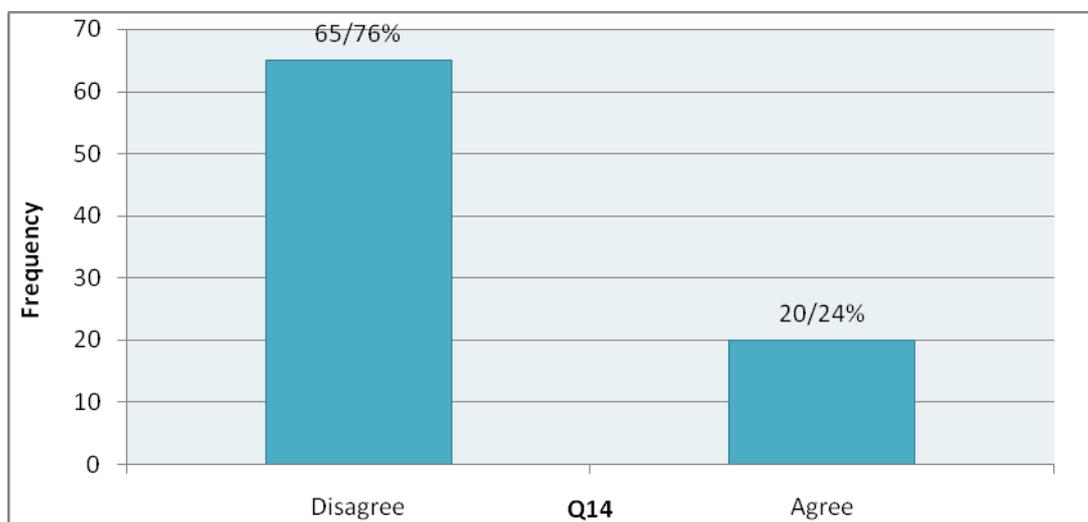
Figure 4.8:   Oncology nurses' experiences of caring for patients who give up hope of getting better.

Question 15:   It is difficult to form a close relationship with the family of a person that is dying

Figure 4.9 reveals that after reducing the response categories to agree and disagree, 60 (n=60) (71%) of the respondents disagreed, whilst 25 (n=25) (29%) agreed that they would find it difficult to form a close relationship with the family of a person that is dying. Peteet *et al.* (1989:979) found that oncology nurses had become more emotionally involved with patients that are dying and their family, because of their involvement with life and death issues.
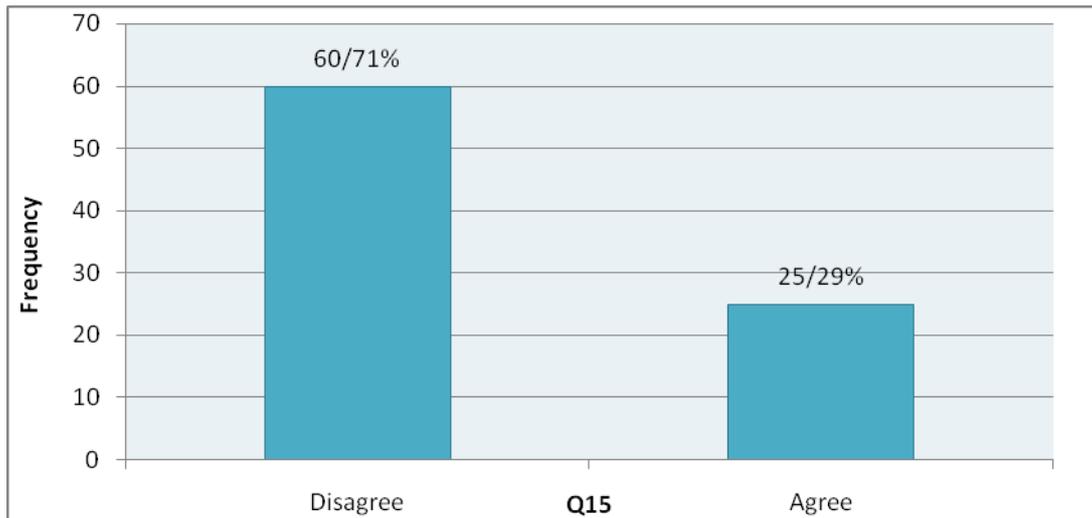
Figure 4.9: Oncology nurses' experiences of forming close relationships with the family of a person that is dying.

Question 16: There are times when death is welcomed by the person that is dying

Figure 4.10 shows that after reducing the response categories to agree and disagree, 4 (n=4) (4%) of the respondents disagreed and 81 (n=81) (96%) agreed that there were times that the person that is dying would welcome death. Costello (2006:598) points out that death is sometimes desired by the patient, family and nurses, as it brings an end to the patient's pain and suffering.
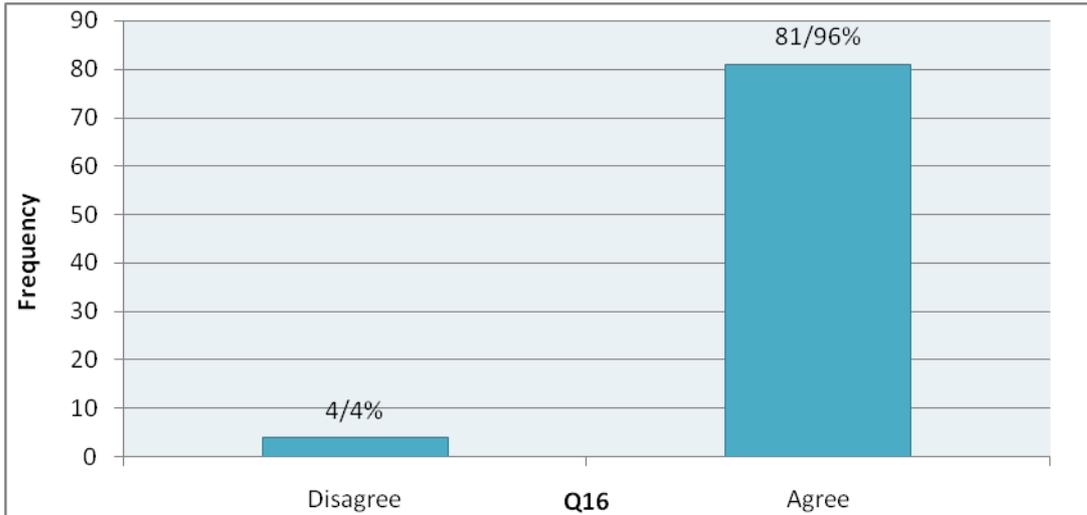
Figure 4.10: Oncology nurses' experiences of times that the person that is dying welcomed death.

Question 17:   When a patient asks, 'Nurse am I dying?', I think it is best to change the subject to something cheerful
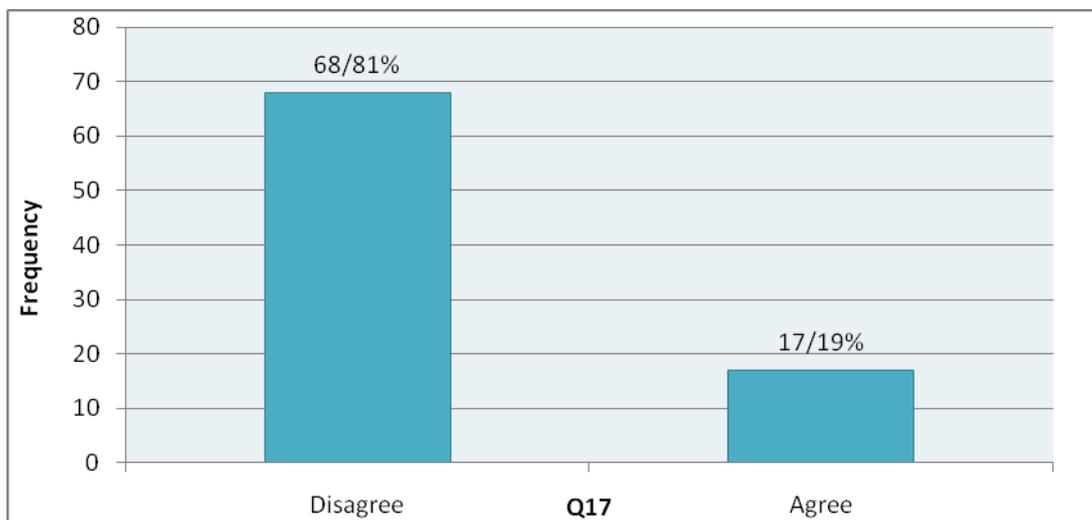
Figure 4.11: Oncology nurses' experiences of changing the subject to something cheerful when a patient asks if he / she is dying.

Figure 4.11 shows that after reducing the response categories to agree and disagree, 68 (n=68) (81%) of the respondents disagreed, with 17 (n=17) (19%) agreeing that it would be best to change the subject to something cheerful.

Hope (2005:226) emphasises the fact that patients should be answered honestly, when asking the nurse if they are dying.

Question 18: I would feel like running away, should the person actually die

Figure 4.12 shows that after reducing the response categories to agree and disagree that 79 (n=79) (94%) of the respondents disagreed and 6 (n=6) (6%) agreed that they would feel like running away, should the person actually die. As Ablett and Jones (2006:736) point out, nurses in palliative care want to spend time at the bedside of the patient that is dying and want to be present when the patient dies.
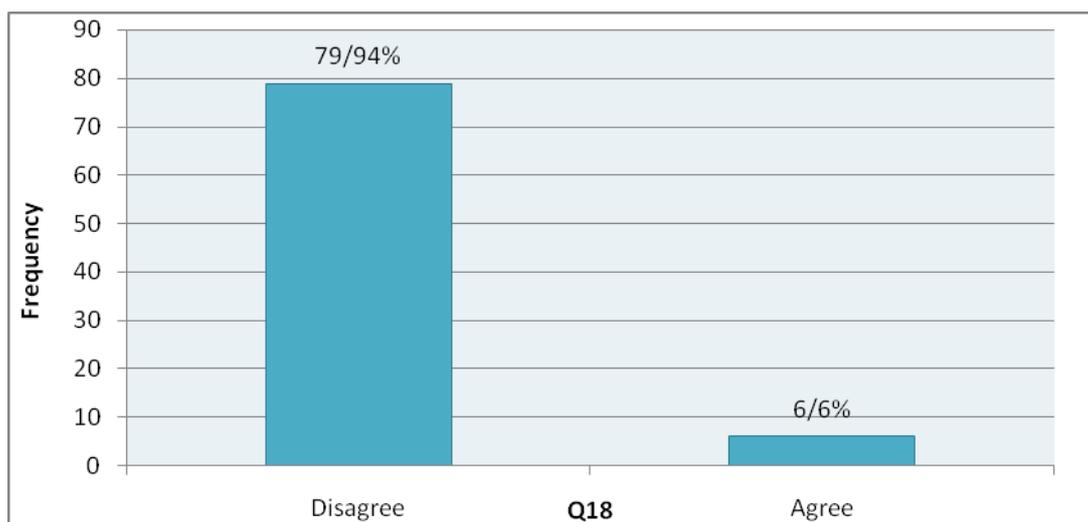
Figure 4.12:   Oncology nurses' experiences of feeling like running away, should the person actually die.

Question 19: Families need emotional support to accept the changes in behaviour of the person that is dying

Figure 4.13 shows that after reducing the response categories to agree and disagree that only 3 (n=3) (3%) of the respondents disagreed and 82 (n=82) (97%) agreed that families need emotional support to accept the changes in the behaviour of the person that is dying. This result was in support of Hottensen's

(2010:106) view of the supportive role the oncology nurse plays in helping the patient that is dying's family adapt to the life changing event, associated with the terminal illness and death of a loved one. In this regard, Field and Cassel (1997:74) emphasise the continuous nature of the support and sensitive handling needed by the patient that is dying and his family.
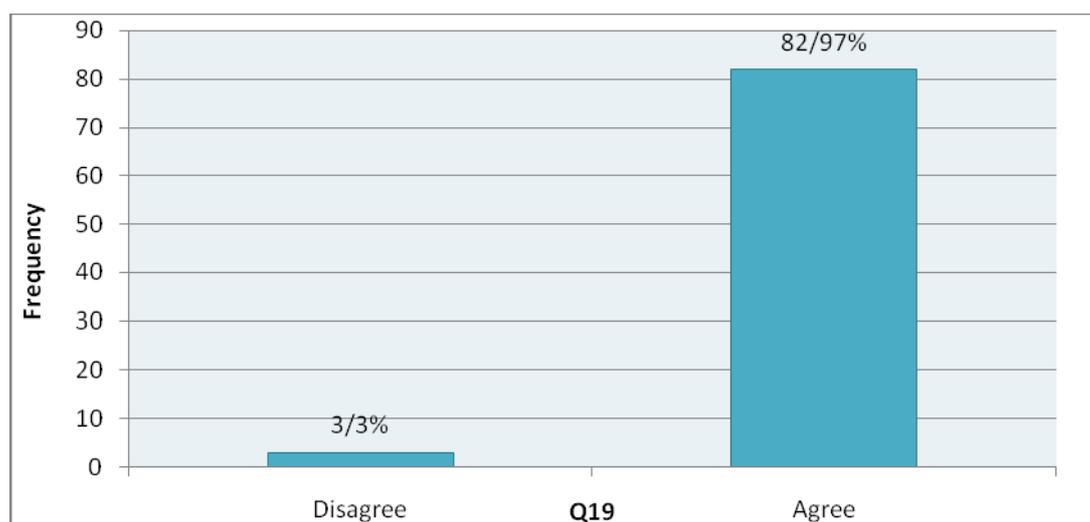
Figure 4.13: Oncology nurses' experiences of the family's need for emotional support to accept the changes in behaviour of the person that is dying.

Question 20: As a patient nears death, the nurse should withdraw from his / her involvement with the patient

Figure 4.14 shows that after reducing the response categories to agree and disagree, 79 (n=79) (94%) of the respondents disagreed, whilst only 6 (n=6) (6%) agreed that nurses should withdraw from their involvement with the patient as he / she nears death. Although Braun *et al.* (2010:47) acknowledge that some oncology nurses use avoidance to cope with their own discomfort regarding the death of patients, these results indicated that the majority of the respondents were probably in touch with their own personal reactions to death and felt that they could make a difference in the last days of the patient's life (Amenta & Bohnet, 1986b:43; Ablett & Jones, 2007:736).
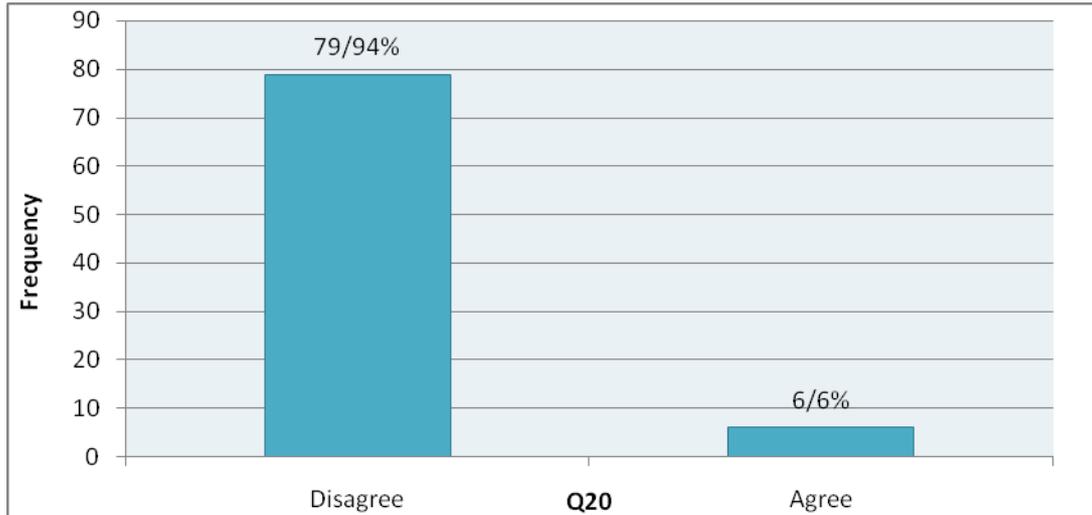
Figure 4.14: Oncology nurses' experiences of withdrawing from the patient as the patient nears death.

Question 21: Families should be concerned about helping their dying member make the best of his / her remaining life
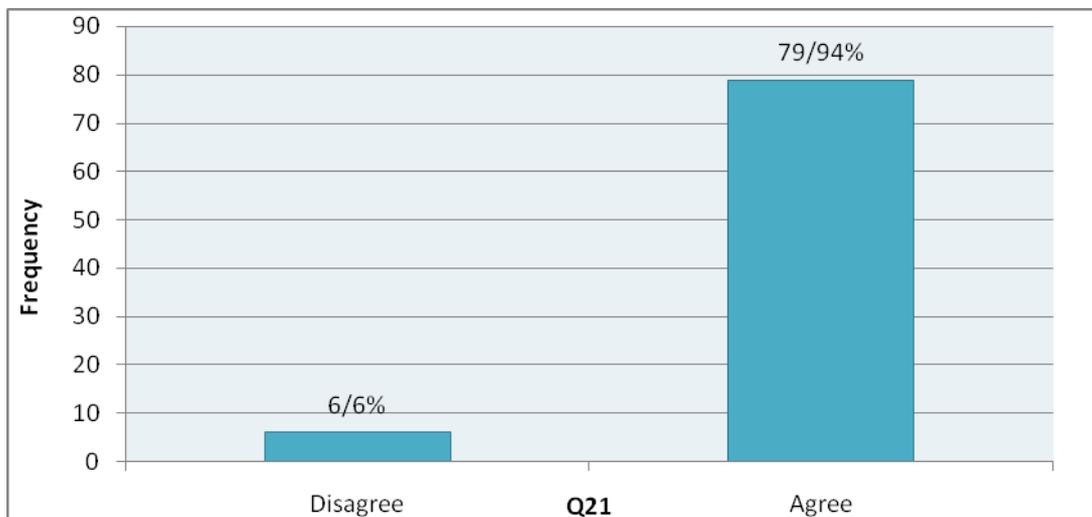
Figure 4.15: Oncology nurses' experiences of families' concern about helping their dying member make the best of his / her remaining life.

Figure 4.15 shows that after reducing the response categories to agree and disagree, 6 (n=6) (6%) of the respondents disagreed, whereas 79 (n=79) (94%) agreed that families should be concerned about helping their dying member make the best of his / her remaining life. Supporting family involvement is

particularly important, when one considers that anticipatory grief may often lead to conflict and dysfunction among family members (Hottenson, 2010:107).

Question 22: The person that is dying should not be allowed to make decisions about his / her physical care

Figure 4.16 shows that after reducing the response categories to agree and disagree, 71 (n=71) (84%) of the respondents disagreed, with 14 (n=14) (16%) agreeing that the person that is dying should not be allowed to make decisions about his / her physical care. Allen (2009:19) is of the opinion that the achievement of a sense of control by the patient should characterise EOL care.
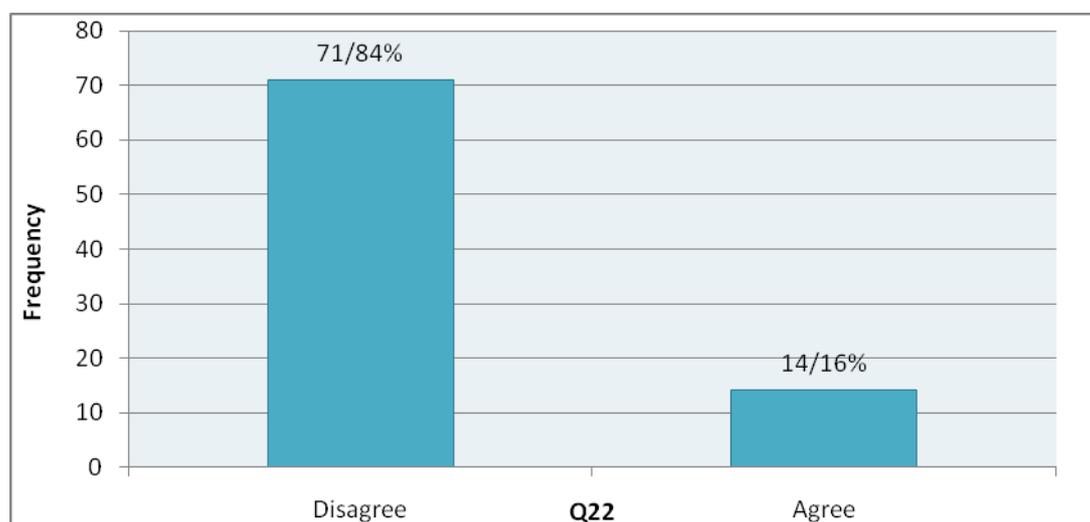
Figure 4.16: Oncology nurses' experiences of not allowing the person that is dying to make decisions about his / her physical care.

Question 23: Families should maintain as normal an environment as possible for their dying member

Figure 4.17 shows that after reducing the response categories to agree and disagree, a mere 4 (n=4) (4%) of the respondents disagreed, while 81 (n=81) (96%) agreed that families should maintain as normal an environment as possible for their dying member. The Palliative Care Overview (2009) recommend that the patient be approached as part of a family, thereby

acknowledging the importance of maintaining as normal an environment as possible.
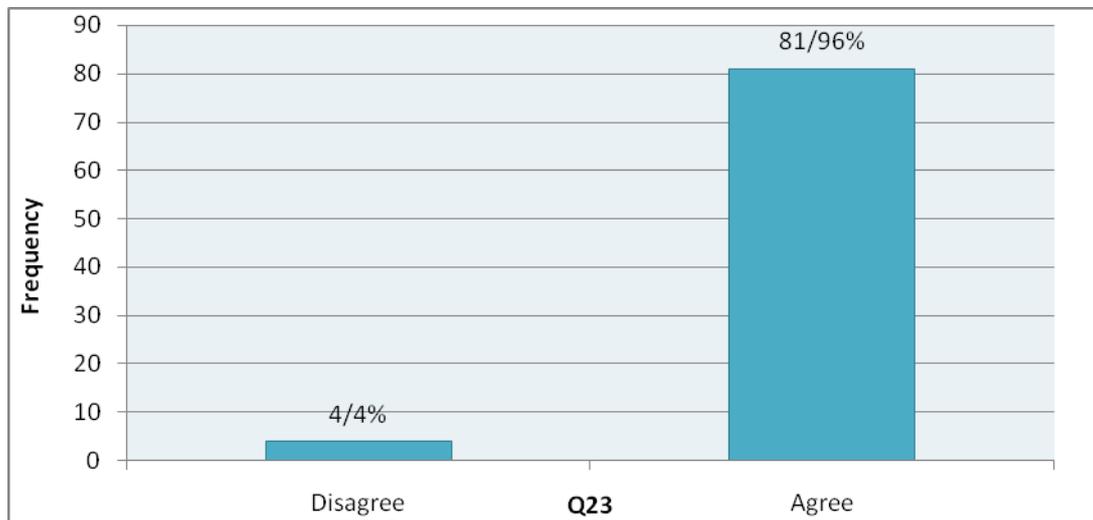
Figure 4.17: Oncology nurses' experiences of the family maintaining a normal environment for the dying member.

Question 24: It is beneficial for the person that is dying to verbalise his / her feelings
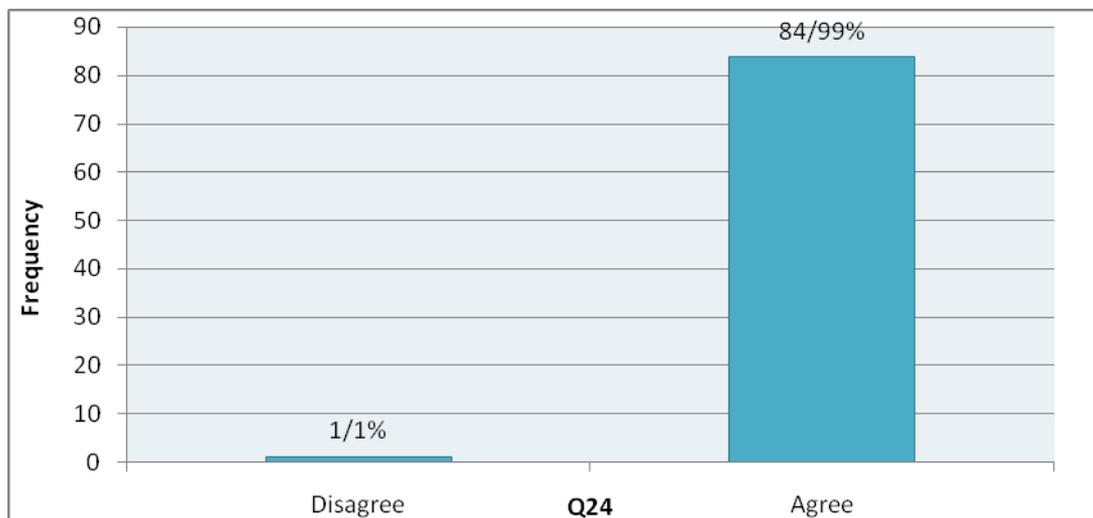
Figure 4.18: Oncology nurses' experiences of the benefit of patients that are dying being allowed to verbalise their feelings.

Figure 4.18 shows that after reducing the response categories to agree and disagree, only 1 (n=1) (1%) of the respondents disagreed, with the majority of 84 (n=84) (99%) of the respondents agreeing that it would be beneficial for the person that is dying to verbalise his / her feelings. Recognising the beneficial nature of patients that are dying verbalising their feelings, was synonymous with Costello's (2006:595) perception of a good death being characterised by open and honest communication.

Question 25: Nursing care should be extended to the family of the person that is dying

Figure 4.19 shows that after reducing the response categories to agree and disagree, 10 (n=10) (12%) of the respondents disagreed and 75 (n=75) (88%) agreed that nursing care should be extended to the family of the person that is dying. Field and Cassel (1997:74) suggest that the nurse must be open and sensitive towards the emotional needs of the patient that is dying and the family, on a continuous basis. Rittman *et al.* (1997:116) also point out that the accompaniment of the patient on the journey of death should include the family.
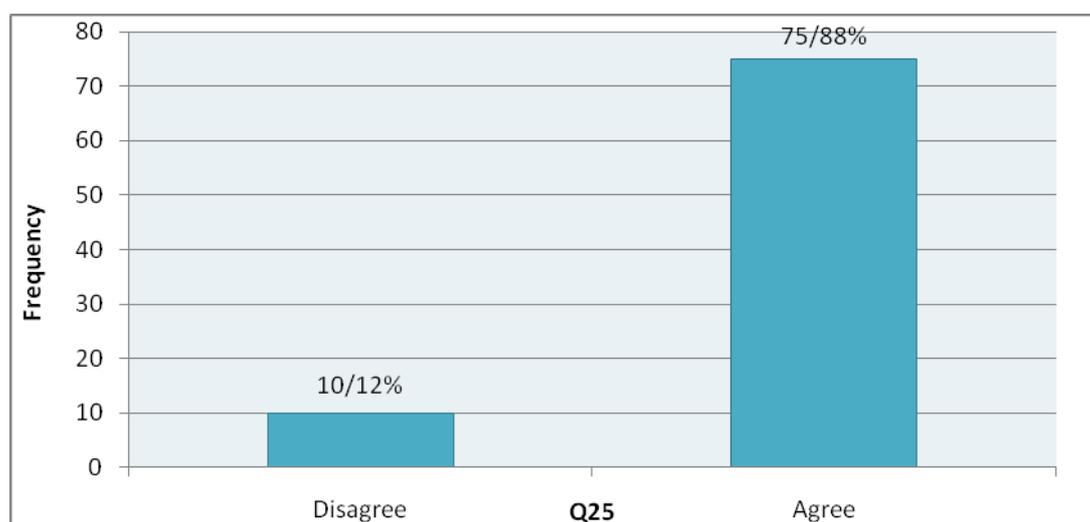
Figure 4.19: Oncology nurses' experiences that nursing care should be extended to the patient's family.

Question 26:   Nurses should permit flexible visiting schedules for patients that are dying

Figure 4.20 shows that after reducing the response categories to agree and disagree, 4 (n=4) (4%) of the respondents disagreed, whereas 81 (n=81) (96%) agreed that nurses should permit flexible visiting schedules for patients that are dying. Rittman *et al.* (1997:116) state that nurses want the family and significant others present in the caring of the patient that is dying.
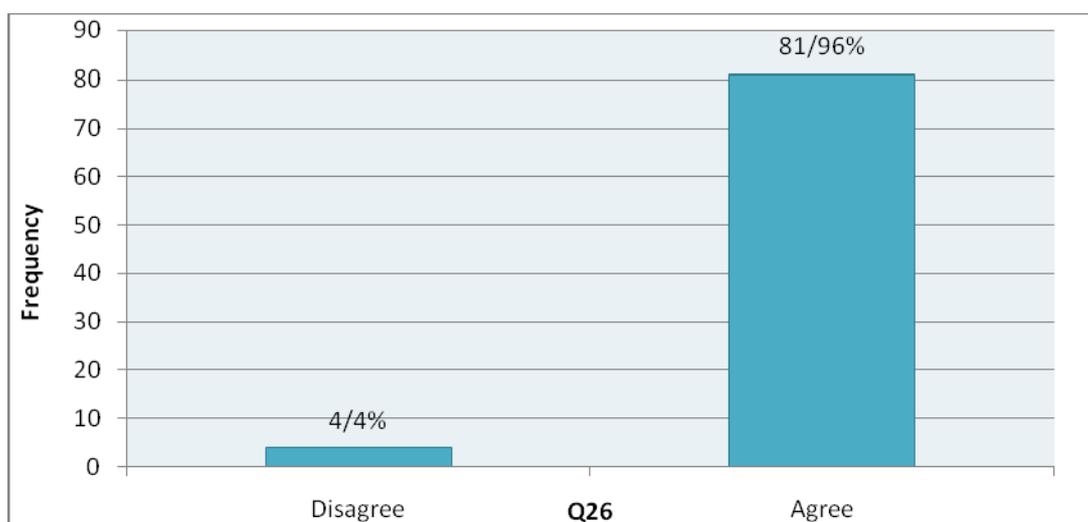
Figure 4.20:   Oncology nurses' experiences that they should permit flexible visiting schedules for patients that are dying.

Question 27: The person that is dying and his / her family should be the main decision makers

Figure 4.21 shows that after reducing the response categories to agree and disagree, 6 (n=6) (6%) of the respondents disagreed, whilst 79 (n=79) (94%) agreed that the person that is dying and his / her family should be the main decision makers. Allen (2009:19) indicates that one of the goals of EOL care is the achievement of a sense of control by the patient, as well as the involvement of the family (Field and Cassel 1997:74).
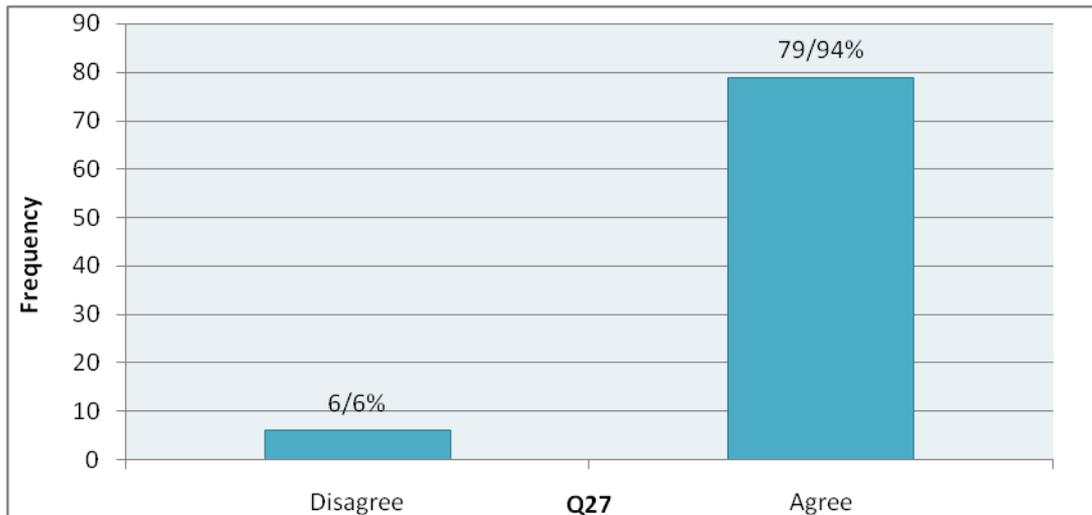
Figure 4.21: Oncology nurses' experiences that the person that is dying and his / her family should be the main decision makers.

Question 28: The family should be involved in the physical care of the person that is dying
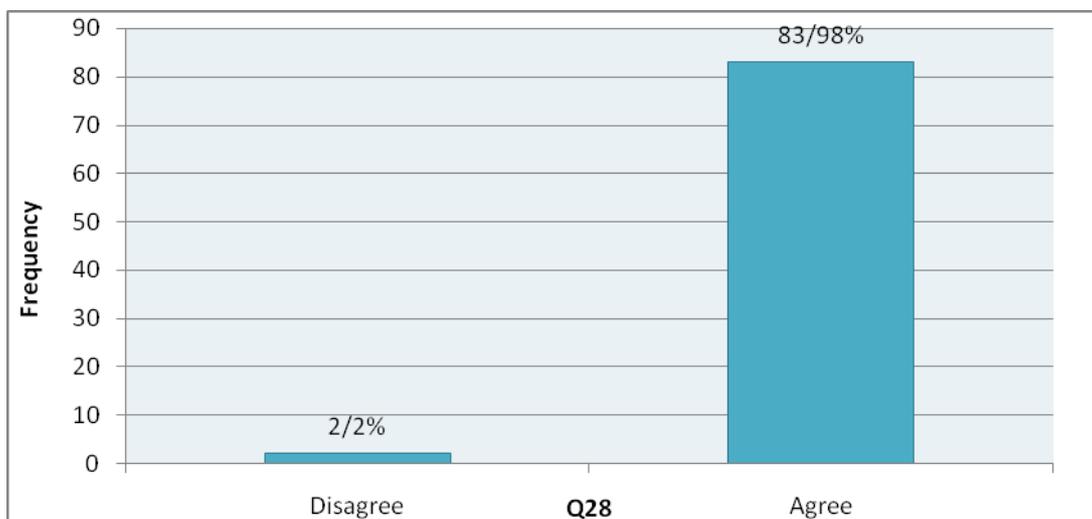
Figure 4.22: Oncology nurses' experiences of the involvement of the family in the physical care of the person that is dying.

Figure 4.22 shows that after reducing the response categories to agree and disagree, 2 (n=2) (2%) of the respondents disagreed, with a majority of 83 (n=83) (98%) agreeing that the family should be involved in the physical care of the person that is dying. Field and Cassel's (1997:81) viewpoint is that EOL

care entails aspects of home based care of the patient that is dying and getting the community involved in helping the patient and family. Hopkinson *et al.* (2005:128) agree that relatives could be helpful in the physical care of the patient.

Question 29: I would hope the person I am caring for dies when I am not present

Figure 4.23 shows that after reducing the response categories to agree and disagree, 63 (n=63) (74%) of the respondents disagreed, whereas 22 (n=22) (26%) agreed that they would hope the person they were caring for died when they were not present. Ablett and Jones (2007:736) found that nurses had viewed the nursing of people at the end of their lives as a privilege. They affirm that nurses feel that they can make a real difference by spending time with a patient at the closing time of their life.
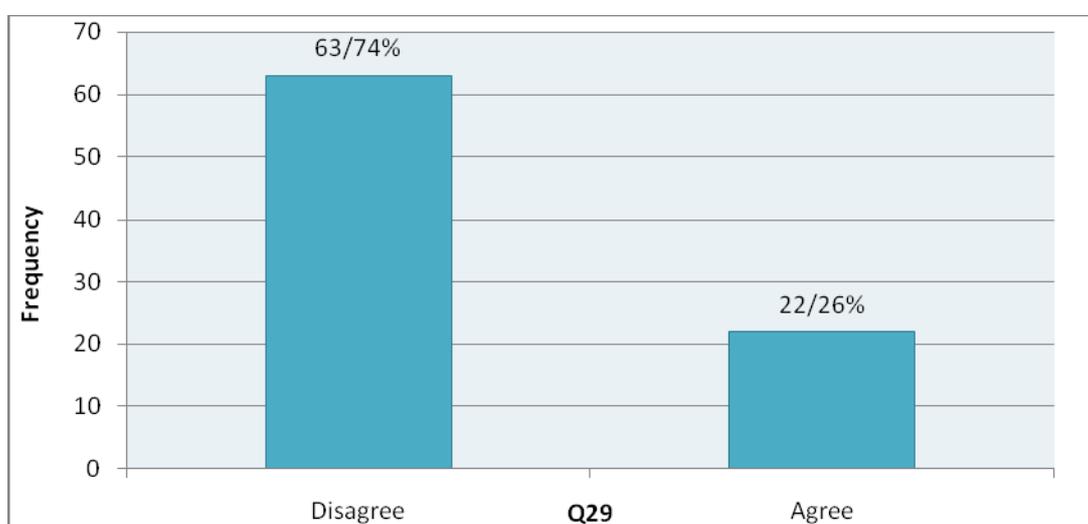
Figure 4.23:   Oncology nurses' experiences of hope that the patients they were caring for would die when they are not present.

Question 30: I am afraid to befriend a person that is dying

Figure 4.24 shows that after reducing the response categories to agree and disagree, 76 (n=76) (89%) of the respondents disagreed and 9 (n=9) (11%)

agreed that they would be afraid to become friends with a person that is dying. Rittman's *et al.* (1997:116) found that nurses had identified the development of a special bond with the patient as important in caring for patients that are dying.
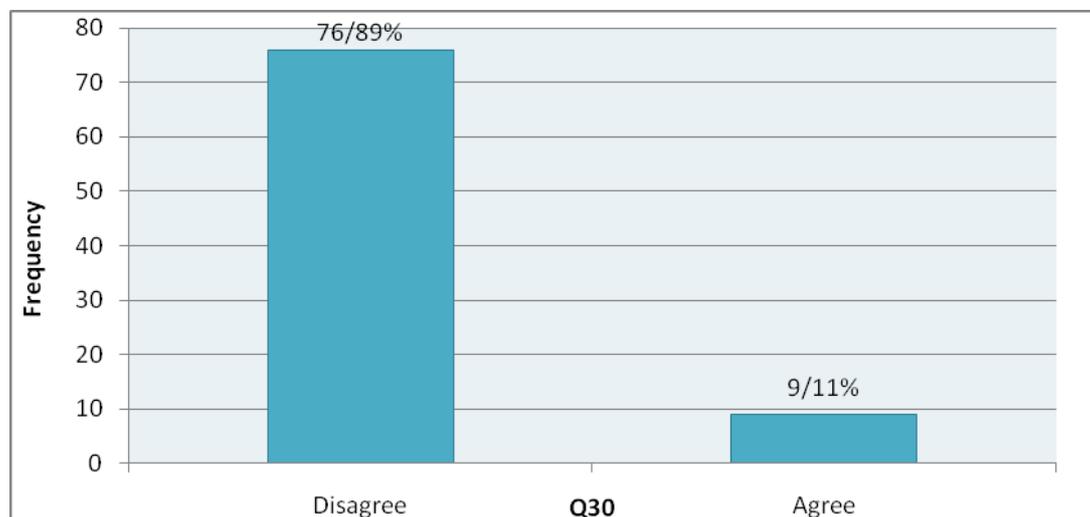
Figure 4.24: Oncology nurses' experiences of fear to befriend a person that is dying.

Question 31: Addiction to pain relieving medication should not be a nursing concern when dealing with a person that is dying

Figure 4.25 shows that after reducing the response categories to agree and disagree, 30 (n=30) (35%) of the respondents disagreed, with 55 (n=55) (65%) agreeing that addiction to pain relieving medication should not be a nursing concern when dealing with a person that is dying. One of the stated goals of quality EOL care is adequate pain control and the management of symptoms in caring for the patient that is dying (Allen, 2009:18). Costello (2006:599) also found that bad deaths had been characterised by patients who died in pain, leaving nurses feeling guilty and unable to relieve suffering.
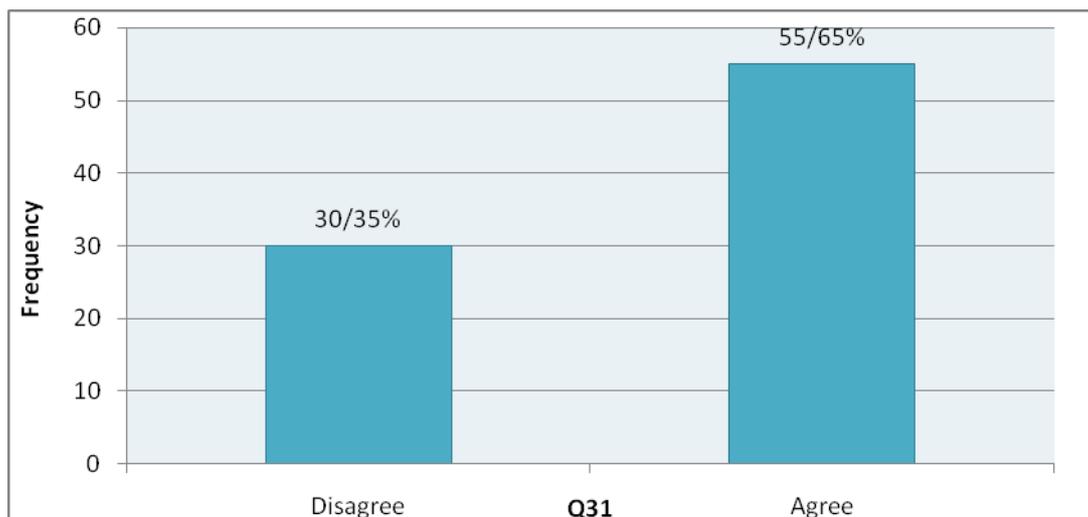
Figure 4.25: Oncology nurses' experienced concern about pain relieving medication when dealing with a person that is dying.

Question 32: I would be uncomfortable if I entered the room of a person that is terminally ill and found him / her crying
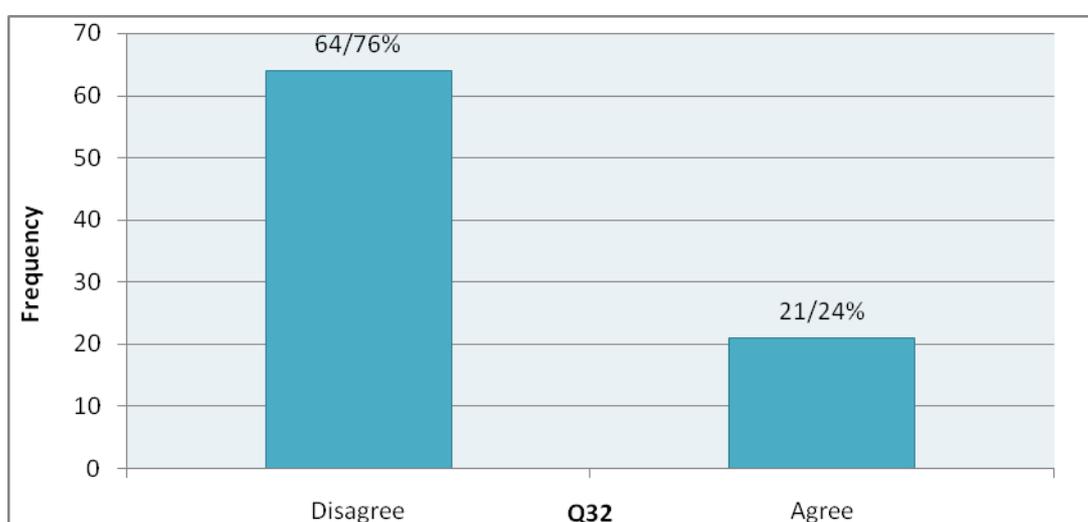
Figure 4.26: Oncology nurses' experiences of discomfort while entering the room of a person that is terminally ill and finding him / her crying.

Figure 4.26 shows that after reducing the response categories to agree and disagree, 64 (n=64) (76%) of the respondents disagreed and 21 (n=21) (24%) agreed that they would be uncomfortable if they entered the room of a person that is terminally ill and found him / her crying. This finding was congruent with

that in question 25, and with Field and Cassel (1997:74) being of the opinion that the nurse must be open and sensitive towards the emotional needs of the patient that is dying.

Question 33: *The dying should be given honest answers about their condition*

Figure 4.27 shows that after reducing the response categories to agree and disagree, 7 (n=7) (8%) of the respondents disagreed, whilst 78 (n=78) (92%) agreed that the dying should be given honest answers about their condition. Hope (2005:226) is of the opinion that patients should be answered honestly, if they ask whether they are dying.
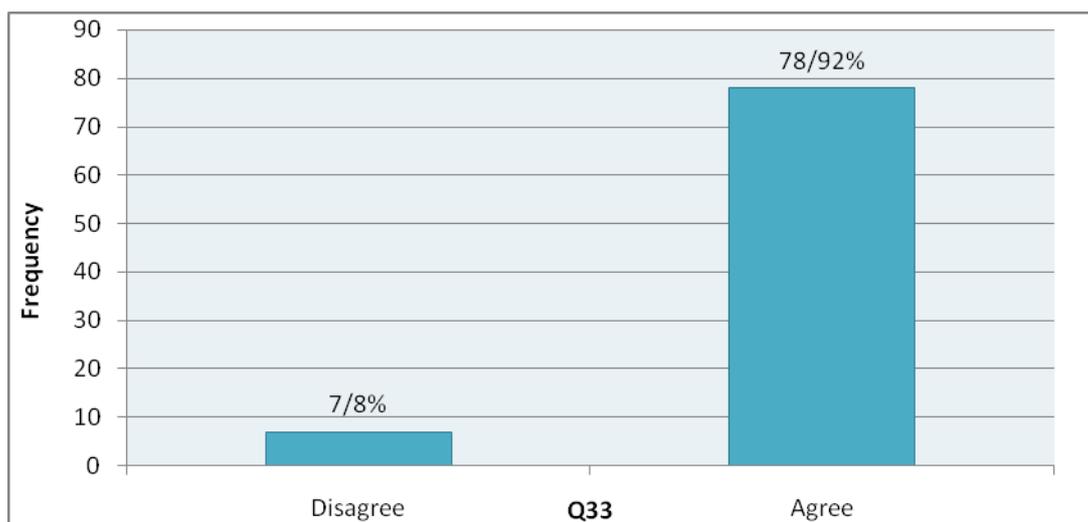
Figure 4.27: Oncology nurses' experiences of giving honest answers to the person that is dying about his / her condition.

Question 34: *Educating families about death and dying is not a nursing responsibility*

Figure 4.28 shows that after reducing the response categories to agree and disagree, 69 (n=69) (81%) of the respondents disagreed and 16 (n=16) (19%) agreed that educating families about death and dying should not be a nursing responsibility. This result reflects Costello's (2006:598) finding that nurses

should prepare patients and families for death by alleviating concerns about EOL issues.
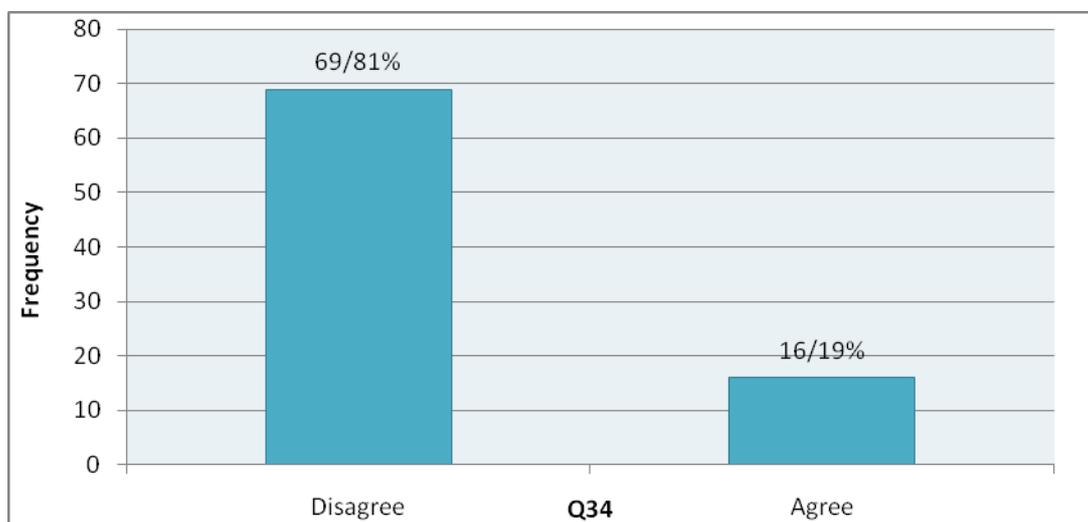
Figure 4.28: Oncology nurses' experiences regarding educating families about death and dying not being a nursing responsibility.

Question 35: *Family members who stay close to a person that is dying often interfere with the professionals' care of the patient*

Figure 4.29 shows that after reducing the response categories to agree and disagree, 18 (n=18) (21%) of the respondents disagreed, whereas 67 (n=67) (79%) agreed that family members who stay close to a person that is dying often interfere with the professionals' care of the patient. Contradictory to the majority finding during this study, Rittman *et al.* (1997:118) found that nurses had encouraged the family to be with the patient while he / she was dying. They further found that the presence of loved ones had contributed to the peacefulness of dying.
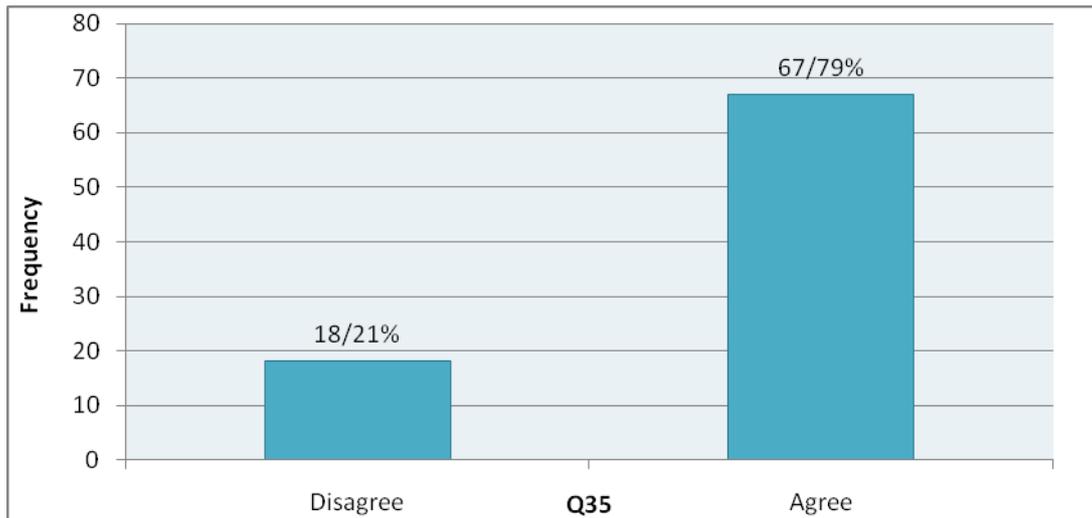
Figure 4.29: Oncology nurses' experiences regarding family members interfering with professionals' care of the patient.

Question 36: It is possible for nurses to help patients prepare for death
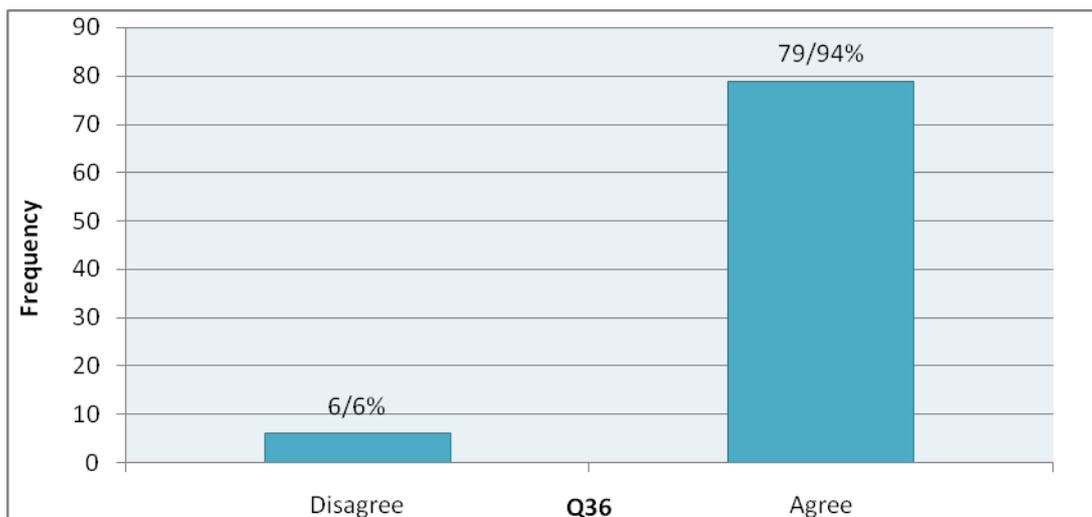
Figure 4.30: Oncology nurses' experiences that it should be possible for nurses to help patients prepare for death.

Figure 4.30 shows that after reducing the response categories to agree and disagree, 6 (n=6) (6%) of the respondents disagreed, with 79 (n=79) (94%) agreeing that it should be possible for nurses to help patients prepare for death. Costello (2006:598) found that nurses had helped patients prepare for death by providing in their religious needs and making them physically and psychologically as comfortable as possible.

4.4.3   Section C: Work satisfaction

The reliability of the work satisfaction scale was considered acceptable, with a Chronbach's alpha of 0,83. On a scale of 1 (not positive) to 6 (very positive), the mean = 4.8; median = 5.1; and SD = 0.8.

Question 37: To what degree are you satisfied with working as an oncology nurse?

Figure 4.31 shows that after reducing the response categories to frequently and infrequently, 81 (n=81) (96%) of respondents frequently experienced work satisfaction, with only 4 (n=4) (4%) of the respondents infrequently experiencing work satisfaction. Pierce *et al.* (2007:35) found a high level of work satisfaction among oncology nurses. Ablett and Jones (2007:786) also found that nurses had viewed it as a privilege to nurse people at the end of their lives.
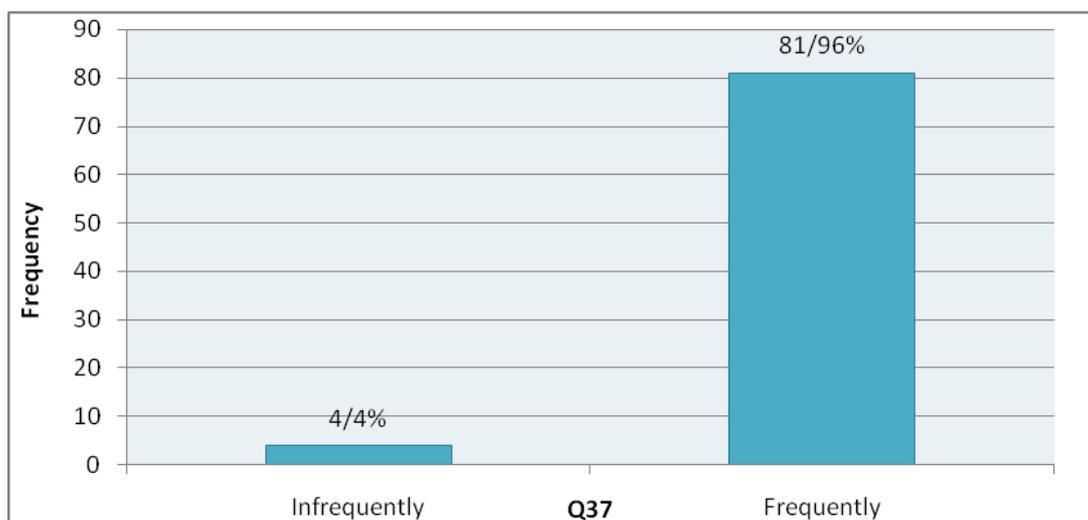
Figure 4.31:   Respondents experiencing work satisfaction with working as oncology nurses.

Question 38: If you could choose again, would you still choose oncology nursing as your occupation?

Figure 4.32 shows that after reducing the response categories to frequently and infrequently, 80 (n=80) (95%) of respondents would frequently choose oncology

nursing as their occupation, whilst 5 (n=5) (5%) would infrequently choose it. Pierce *et al.* (2007:35) found that oncology nurses had experienced high levels of work satisfaction, and therefore stayed in the field of oncology nursing for a long period of time.
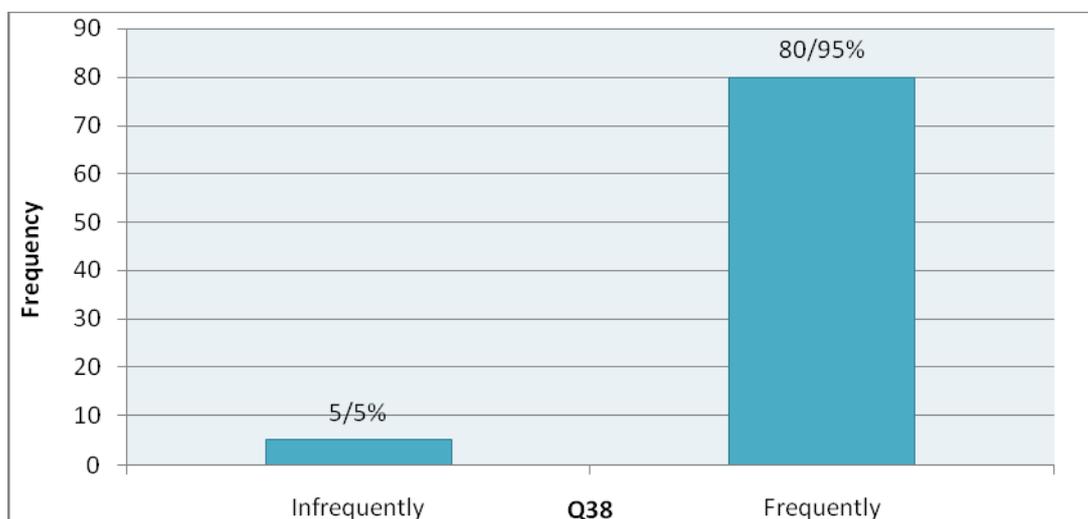
Figure 4.32: Respondents who would again choose oncology nursing as an occupation.

Question 39: Would you recommend oncology nursing as an occupation to any of your children?

Figure 4.33 shows that after reducing the response categories to frequently and infrequently, 39 (n=39) (46%) of respondents would infrequently recommend oncology nursing as an occupation to their children, whereas 46 (n=46) (54%) would frequently recommend it. Ablett and Jones (2007:733) found that cancer care had been considered emotionally stressful. This could be the reason why almost half of the respondents would not recommend oncology nursing as an occupation to their children. The 54% of respondents, who would recommend it, could fall in the category, as explained by Medland *et al.* (2004:47), that oncology nursing is a dynamic field that offers intellectual stimulation.
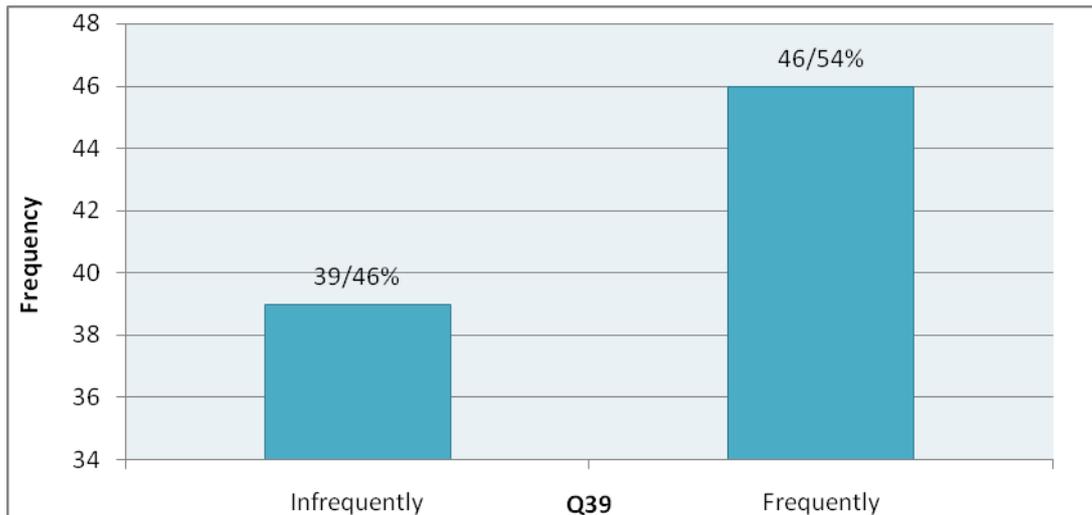
Figure 4.33: Respondents who would recommend oncology nursing as an occupation to their children.

Question 40: Would you recommend working in an oncology setting to a good friend?
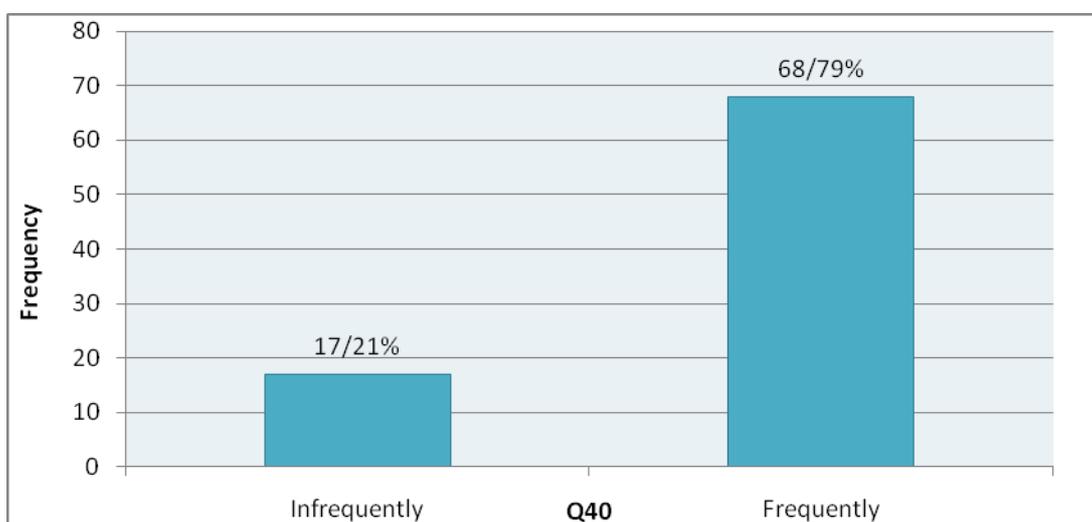
Figure 4.34: Respondents who would recommend oncology nursing as an occupation to a good friend.

Figure 4.34 shows that after reducing the response categories to frequently and infrequently, 68 (n=68) (79%) of respondents would frequently recommend working in an oncology setting to a good friend, whilst 17 (n=17) (21%) would

infrequently recommend it. Ablett and Jones (2007:786) found that nurses had viewed it as a privilege to nurse people at the end of their lives.

Question 41:   To what degree do you sense that your work is meaningful and important?

Figure 4.35 shows that all 85 (n=85) (100%) of the respondents indicated that they had frequently sensed that their work was meaningful and important. Peteet *et al.* (1989:978) found that nurses had experienced a sense of accomplishment in caring for oncology patients, and the gratitude that they had received from their patients also led to work satisfaction.
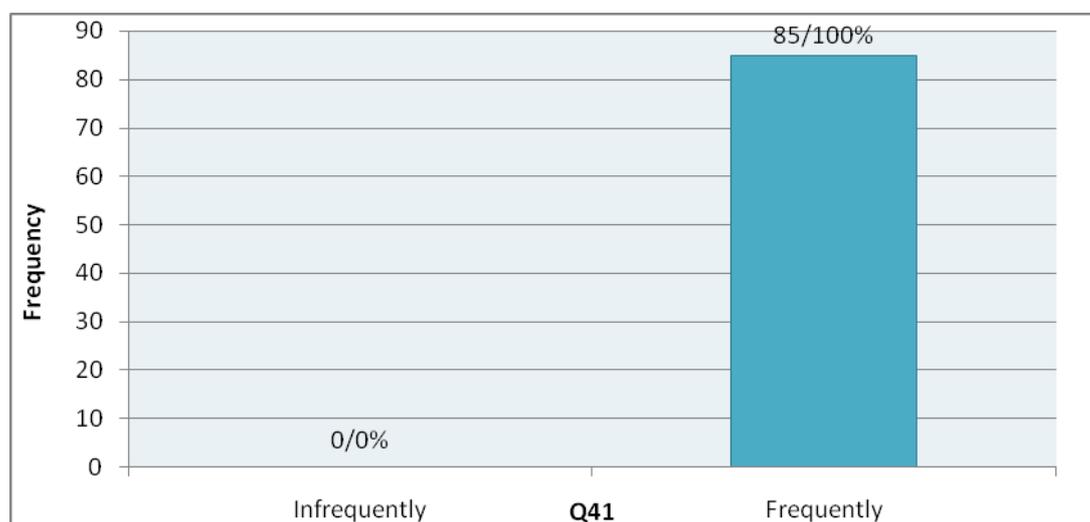
Figure 4.35:   Respondents who sensed their work as meaningful and important.

Question 42:   To what degree would you have chosen your current role as oncology nurse?

Figure 4.36 shows that after reducing the response categories to frequently and infrequently, 80 (n=80) (95%) of respondents would frequently choose their current role as oncology nurse, whilst 5 (n=5) (5%) of respondents would infrequently choose it. Ablett and Jones (2007:786) found that nurses had

viewed it as a privilege to nurse patients that are dying and as a result had experienced satisfaction working as oncology nurses.
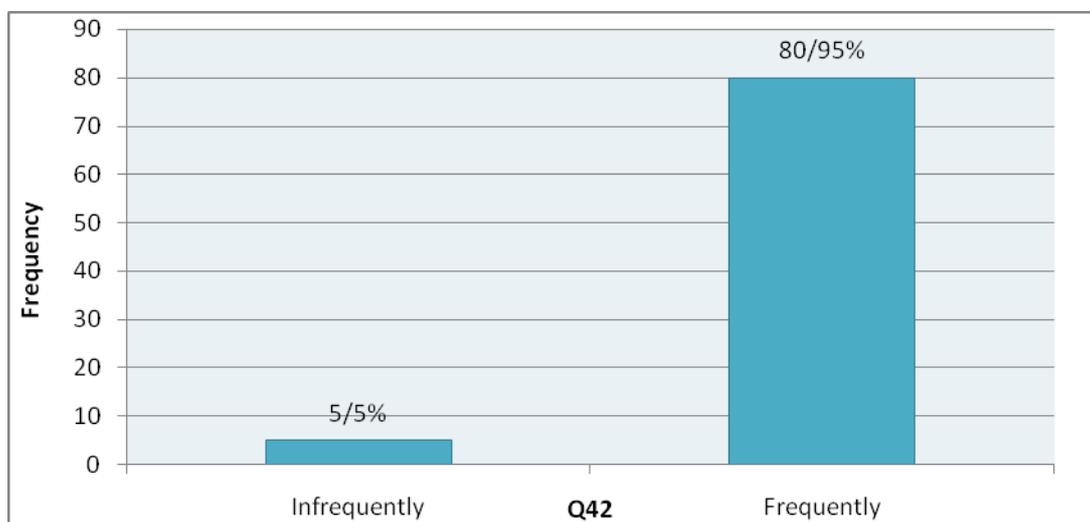
Figure 4.36: Respondents who would again choose their current role as oncology nurse.

Question 43: What are the chances that you would continue in the field of oncology nursing for the next two years?
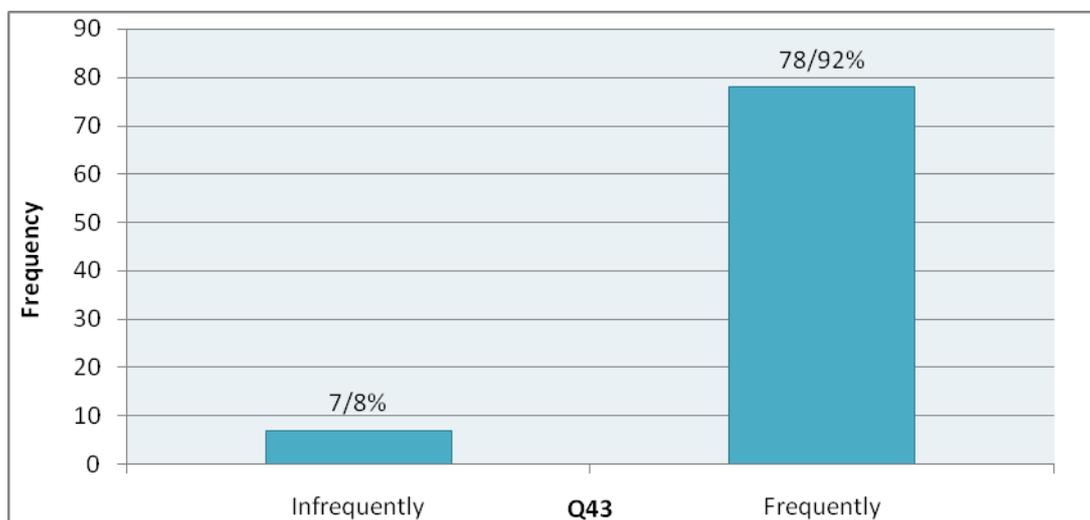
Figure 4.37: Respondents who would continue in the field of oncology for the next two years.

Figure 4.37 shows that after reducing the response categories to frequently and infrequently, 78 (n=78) (92%) of respondents would frequently continue in the

field of oncology nursing for the next two years, with only 7 (n=7) (8%), who would infrequently continue in the field of oncology nursing.

4.4.4 Section D: Nature of supportive work environment

The reliability of the nature of the supportive work environment scale was considered acceptable, with a Chronbach's alpha of 0,74. On a scale of 1 (not positive) to 6 (very positive), the mean = 4.6; median = 4.7; and SD = 0.6.

Question 44: To what degree do you receive good support and guidance from your supervisor?

Figure 4.38 shows that after reducing the response categories to frequently and infrequently, 70 (n=70) (83%) of respondents frequently received good support and guidance from their supervisor, with only 15 (n=15) (17%) infrequently receiving support and guidance. Minnaar (2001:23) emphasise the importance of emotional support and guidance from the supervisor, in order for nurses to cope in palliative care settings.
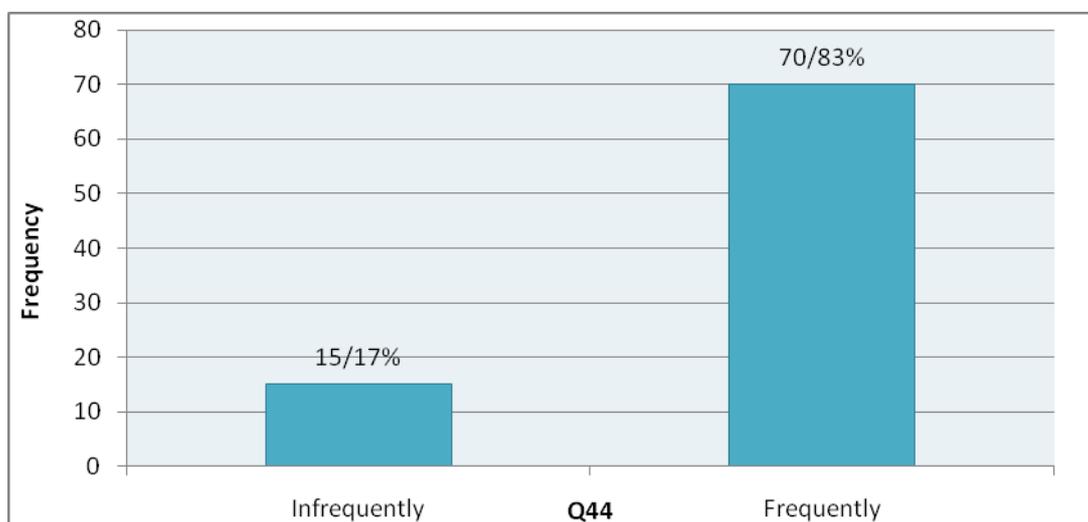
Figure 4.38: Respondents experiencing support and guidance from their supervisors.

Question 45: To what degree do you feel valued and respected in your job?

Figure 4.39 shows that after reducing the response categories to frequently and infrequently, 65 (n=65) (76%) of respondents frequently felt valued and respected in their job, whereas 20 (n=20) (24%) infrequently felt valued and respected. Contrary to Minnaar's (2003:39) finding that the majority of nurses had not felt valued in their job, the majority of the respondents in this study had indicated that they felt valued and respected in their job.
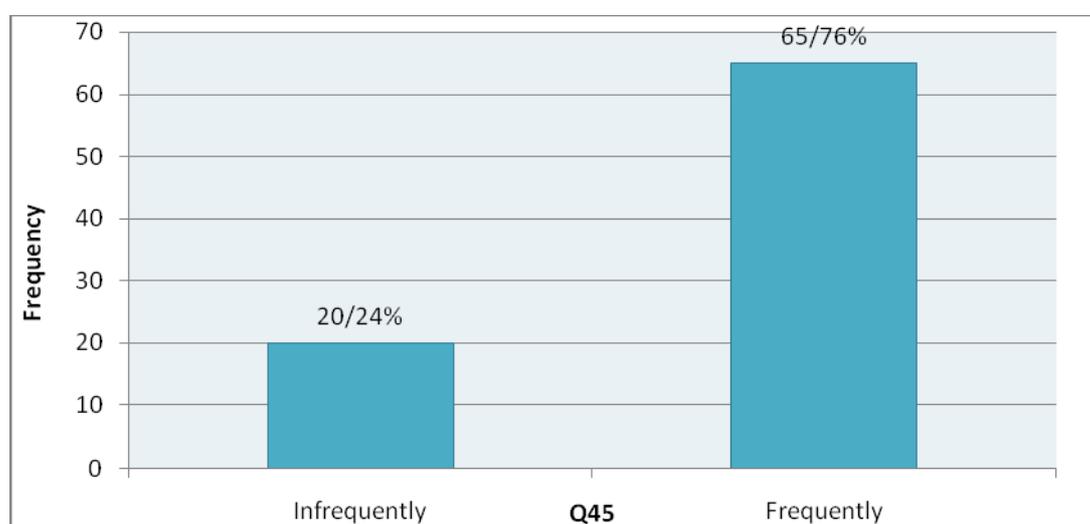
Figure 4.39: Respondents feeling valued and respected in their job.

Question 46: To what degree do you feel part of a team?

Figure 4.40 shows that after reducing the response categories to frequently and infrequently, 79 (n=79) (94%) of respondents frequently felt part of a team, with a minority of only 6 (n=6) (6%) infrequently feeling part of a team. Hopkinson *et al.* (2005:128) found that a coping technique, employed by nurses to lessen their decision making responsibilities with patients that are dying, had been to involve others in making clinical judgements. In order to employ this coping technique, it is therefore important that the oncology nurse should feel part of a team. Wengström and Ekedahl (2006:24) also describe the importance of the health team as a coping strategy.
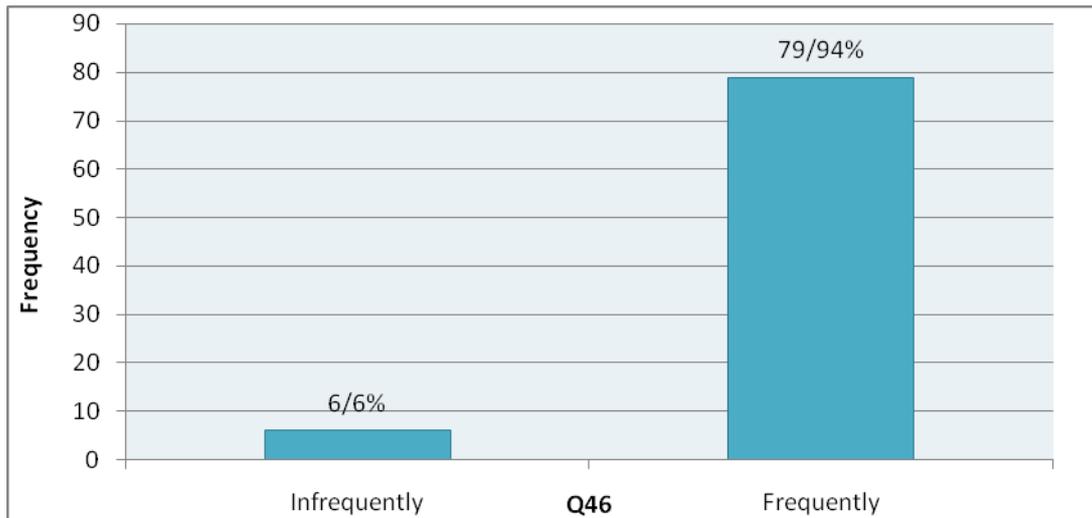
Figure 4.40: Respondents feeling part of a team.

Question 47: To what degree do you feel a good relationship with your patient would benefit a supportive work environment?

Figure 4.41 shows that after reducing the response categories to frequently and infrequently, 82 (n=82) (97%) of respondents frequently felt that a good relationship with their patients would benefit a supportive work environment and only 3 (n=3) (3%) infrequently felt that way. Wengström and Ekedahl (2006:21) point out that a good, caring relationship with the patient reduces the stress associated with EOL care. Rittman *et al.* (1997:115) also emphasise that being engaged in a good relationship with a patient that is dying helps nurses to deal with their own mortality and makes them more comfortable with an environment in which death commonly occurs.
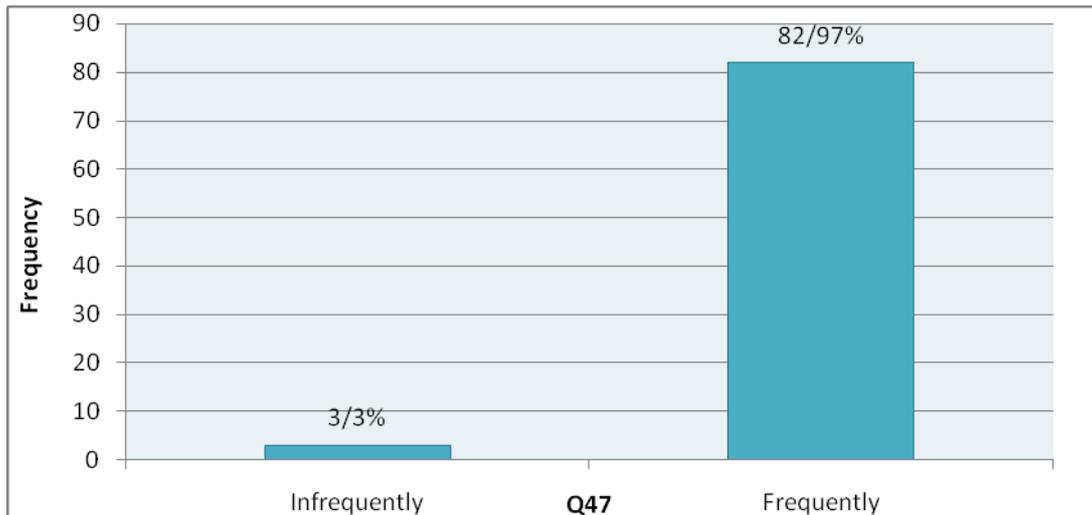
Figure 4.41: Respondents who felt that a good relationship with the patient would benefit a supportive work environment.

Question 48: To what degree do you feel open communication with co-workers will benefit a supportive work environment?
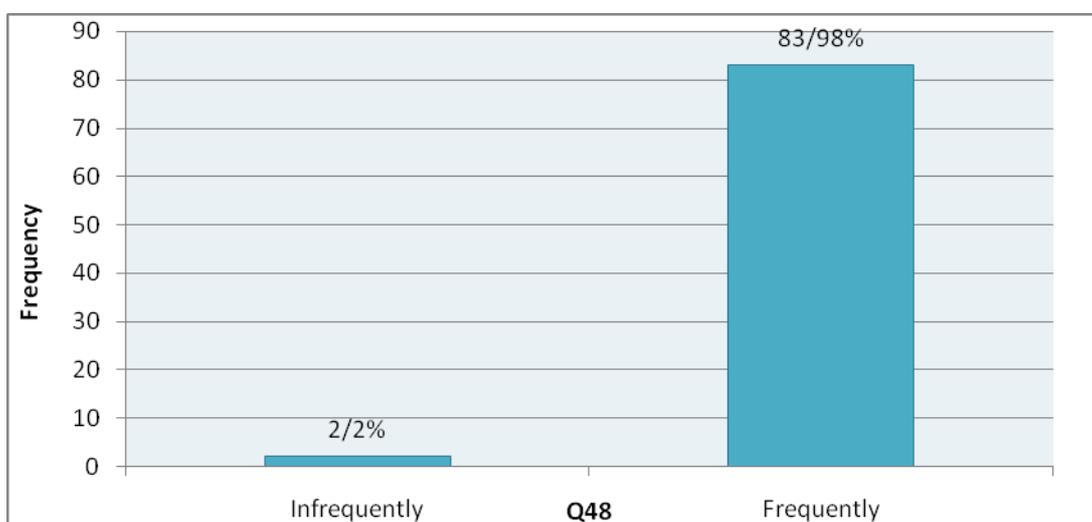
Figure 4.42: Respondents who felt that open communication with co-workers would benefit a supportive work environment.

Figure 4.42 shows that after reducing the response categories to frequently and infrequently, 83 (n=83) (98%) of respondents frequently felt that open communication with co-workers would benefit a supportive work environment, whilst only 2 (n=2) (2%) infrequently felt that way. Ablett and Jones (2007:737)

found that offloading to colleagues had been one of the coping strategies that nurses used in palliative care.

Question 49: *To what degree do you feel that regular debriefing groups would benefit a supportive work environment?*

Figure 4.43 shows that after reducing the response categories to frequently and infrequently, 81 (n=81) (96%) of respondents frequently felt that regular debriefing groups would benefit a supportive work environment, whereas a minority of 4 (n=4) (4%) infrequently felt that way. Peteet *et al.* (1989:980) found that regular support groups had helped nurses to maintain their ability to effectively care for the patient. Fieldstein and Gemma (1995:234) agree that staff support groups help palliative care nurses to deal with their grief and losses.
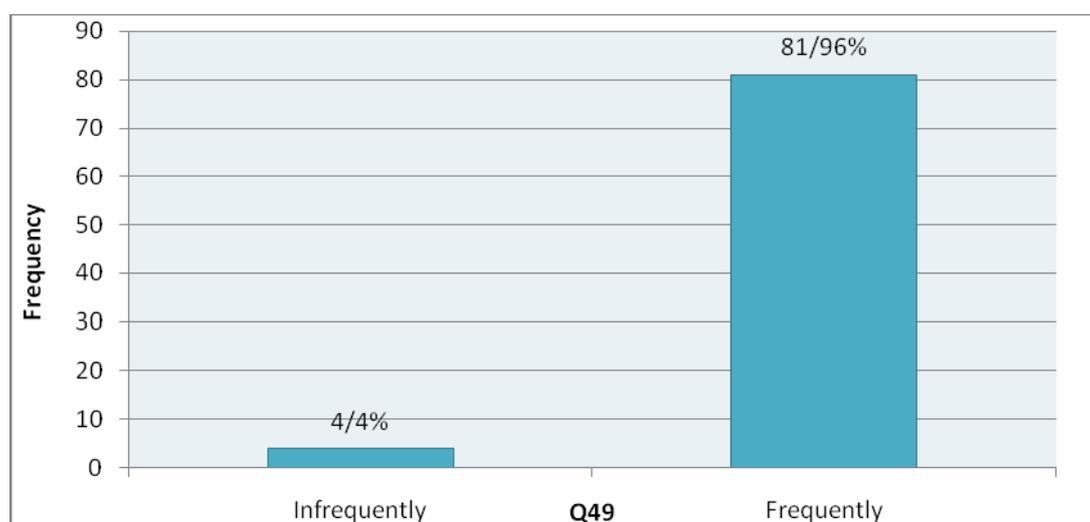
Figure 4.43: Respondents who felt that regular debriefing groups would benefit a supportive work environment.

Question 50: *To what degree do you experience your workplace as supportive?*

Figure 4.44 shows after reducing the response categories to frequently and infrequently, 70 (n=70) (82%) of respondents frequently experienced their

workplace as supportive, whereas 15 (n=15) (18%) of respondents infrequently experienced a supportive workplace. Ablett and Jones (2007:737) found that nurses who cared for patients that are dying, had experienced their workplace as supportive, provided coping strategies were in place, such as offloading to colleagues and a healthy work-life balance. They also found that adequate staffing and a pleasant working environment had promoted a supportive work environment. Kenny *et al.* (2007:667) found that nurses in palliative care had considered supportive management to be important in order for a workplace to be supportive.
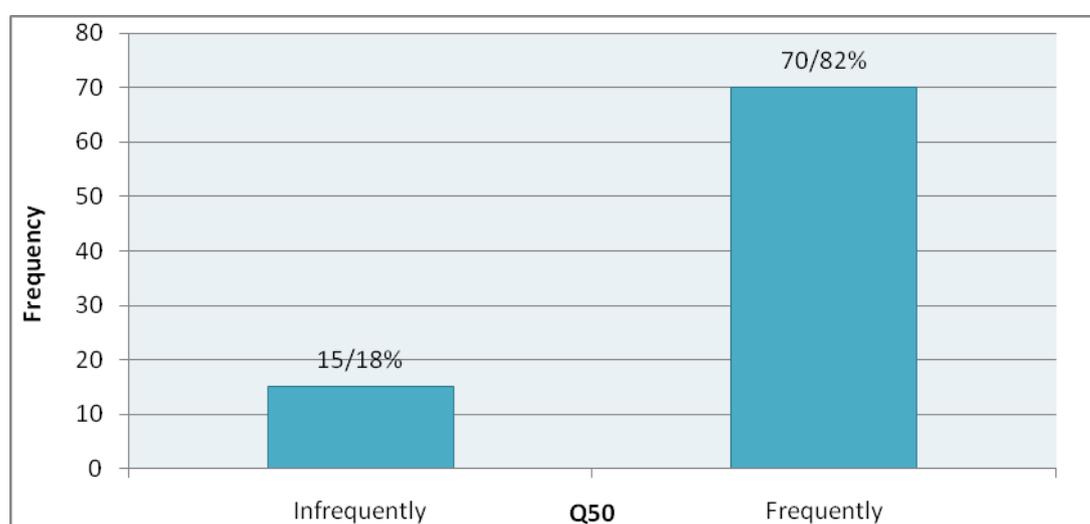
Figure 4.44: Respondents who experienced their workplace as supportive.

Question 51: To what degree do you take an emotional burden home at the end of your shift?

Figure 4.45 shows that after reducing the response categories to frequently and infrequently, 56 (n=56) (66%) of respondents frequently took an emotional burden home at the end of their shift and 29 (n=29) (34%) infrequently did. Payne *et al.* (1998:704) found that the majority of the nurses in palliative care had continued to think about work-related issues at home.
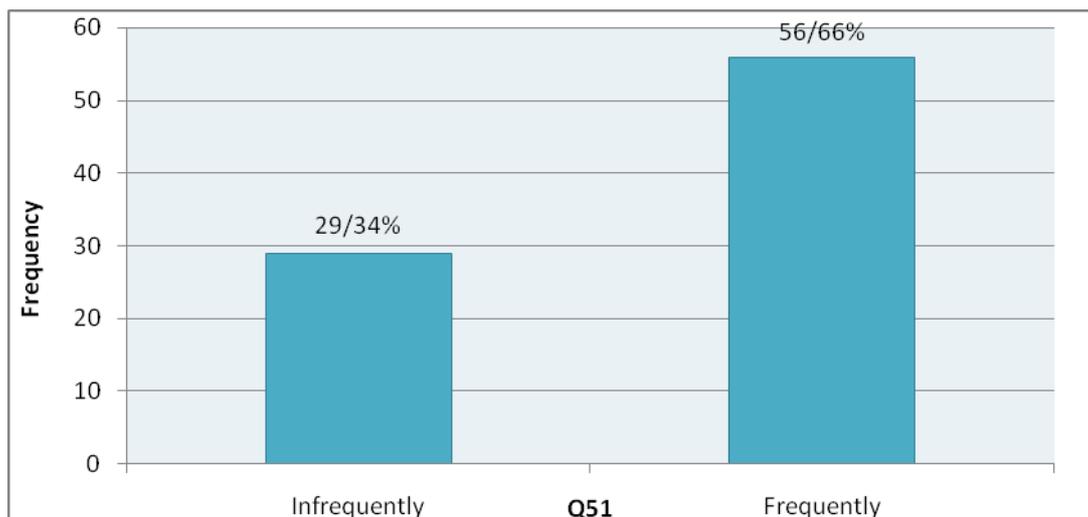
Figure 4.45: Respondents who had taken an emotional burden home at the end of their shift.

4.5   Analysis of quantitative data

In this section, the correlation statistics are presented regarding the following variables, in order to describe the relationship between them:

- The relationship between work satisfaction and FATCOD;

- The relationship between a supportive working environment and FATCOD;

- The relationship between a supportive working environment and work satisfaction;

- The relationship between age and FATCOD;

- The relationship between marital status and FATCOD;

- The relationship between whether respondents have children and FATCOD;

- The relationship between workplace and FATCOD;

- The relationship between professional rank and FATCOD;

- The relationship between years of experience and FATCOD;

- The relationship between workplace and work satisfaction; and

- The relationship between workplace and the nature of a supportive working environment.

4.5.1 Relationship between work satisfaction and FATCOD

The Spearman's correlation was used to examine the relationship between FATCOD and work satisfaction. The results showed that no statistically significant relationship was found between FATCOD and work satisfaction (r = 0.07). The probability value (p = 0.55) was more than 0.05, which meant that the relationship between FATCOD and work satisfaction was statistically insignificant.

4.5.2 Relationship between nature of supportive work environment and FATCOD

The Spearman's correlation was used to examine the relationship between FATCOD and the nature of a supportive work environment (r = 0.10). The probability value (p = 0.38) was more than 0.05, which meant that in this study, there was no significant relationship between the supportive nature of the work environment and FATCOD.

4.5.3 Relationship between nature of supportive work environment and work satisfaction

The Spearman's correlation was used to examine the relationship between the nature of a supportive work environment and work satisfaction. There existed a positive relationship between the nature of a supportive work environment and work satisfaction (r = 0.50). The probability value p = 0.00 was smaller than 0.05, which meant that the relationship was significant. A supportive work environment therefore was positively associated with an increase in work satisfaction.

4.5.4   Relationship between age and FATCOD

A Spearman's correlation was used to examine the relationship between the age of the respondents and FATCOD. The results showed a statistically significant, positive correlation between the age of the respondents and FATCOD (r = 0.34, p = 0.00), signifying that attitudes towards caring for patients that are dying was more positive with an increase in the age of oncology nurses.

4.5.5   Relationship between marital status and FATCOD

The ANOVA test was used to examine the relationship between the marital status of respondents and FATCOD. The results showed no statistical significance between the marital status of the respondents and their attitudes towards caring for patients that are dying (F(3, 81) = 0.74795, p = 0.53), signifying that marital status in this study did not show an effect on the oncology nurses' attitudes towards caring for patients that are dying (mean = 4.83; SD = 0.48).

4.5.6   Relationship between respondents having children and FATCOD

The ANOVA was used to examine statistically significant differences between respondents having children and respondents without children, and FATCOD. The results showed that there were no significant differences (F(1,83) = 1.2341, p = 0.27) between respondents with children (mean = 4.80; SD = 0.48) and respondents without (mean = 4.94; SD = 0.49) and their attitudes towards caring for patients that are dying.

4.5.7   Relationship between workplace and FATCOD

The ANOVA test was used to examine the relationship between workplace and FATCOD. The results showed a statistically significant relationship between

workplace and nurses' attitudes towards caring for patients that are dying (F(2,82) = 4.3105, p = 0.02). Hospice (mean = 5.05; SD = 0.40) oncology nurses' attitudes towards caring for patients that are dying were more positive than their colleagues in the tertiary state hospital (mean = 4.71; SD = 0.51). However, there was no statistically significant difference (p = 0.61) between FATCOD of the oncology nurses in the private oncology unit (mean = 4.78; SD = 0.41) and the oncology nurses in the tertiary state hospital.

4.5.8   Relationship between professional rank and FATCOD

The ANOVA test was used to examine the relationship between oncology nurses' professional rank and FATCOD. The results showed that there was a statistically significant relationship between oncology nurses' professional rank and their attitudes towards caring for patients that are dying (F(3,78) = 7.9223, p = <0.01). Professional nurses (mean = 4.99; SD = 0.41), and professional nurses who specialised in oncology and palliative care (mean = 5.05; SD = 0.42), showed more positive attitudes towards caring for patients that are dying, than auxiliary nurses (mean = 4.71; SD = 0.42) and enrolled nurses (mean = 4.44; SD = 0.46), who did not specialise in oncology, nor palliative care.

4.5.9   Relationship between years of experience and FATCOD

The Spearman's correlation was used to examine the relationship between years of experience and FATCOD. The results showed that in this study there was no statistically significant relationship (r = 0.13, p = 0.26) between oncology nurses' years of experience and their attitudes towards caring for patients that are dying.

4.5.10 Relationship between workplace and work satisfaction

The ANOVA test was used to examine the relationship between workplace and work satisfaction. The results showed a statistically significant relationship

(F(2,82) = 4.3861, p = 0.02) between workplace, i.e. tertiary state hospital (mean = 5.00; SD = 0.93), private oncology unit (mean = 5.16; SD = 0.78) and hospices (mean = 4,45; SD = 0.76), and work satisfaction. Oncology nurses in the tertiary state hospital and private oncology unit experienced more work satisfaction than their colleagues in hospices.

4.5.11 Relationship between workplace and nature of supportive work environment

The ANOVA test was used to examine the relationship between workplace and the nature of the supportive work environment. The results showed no statistically significant relationship (F(2,82) = 0.90046, p = 0.41) between workplace, i.e. tertiary state hospital (mean = 4.76, SD = 0.72), private oncology unit (mean = 4.62, SD = 0.47) and hospice (mean = 4.56, SD = 0.50), and the nature of the supportive work environment. Therefore, in this study, oncology nurses experienced the supportive nature of their work environment similarly, irrespective of the workplace.

4.6 Conclusion

In this chapter, the demographic data being obtained during this study was presented in the form of frequency tables.

The results of the FATCOD scale and of the factors influencing oncology nurses' attitudes towards caring for patients that are dying in oncology settings (work satisfaction and supportive nature of the work environment) in the Western Cape Metropole, were presented in the form of histograms and analysed.

Correlation statistics were performed in order to determine any statistically significant relationships between the demographic and selected research variables investigated. Based on the outcomes of this study, statistically significant positive relationships were established for the following:

- The relationship between the nature of a supportive work environment and work satisfaction;

- The relationship between the age of the respondents and FATCOD;

- The relationship between the workplace and FATCOD;

- The relationship between oncology nurses' professional rank and FATCOD; and

- The relationship between the workplace and work satisfaction.

According to the results of this study, therefore, support in the work environment positively influenced work satisfaction. The higher the age of the respondents, the more positive oncology nurses' attitudes towards caring for patients that are dying were. It was significant that oncology nurses in the tertiary state hospital and private oncology units experienced more work satisfaction, than their colleagues in hospices, Furthermore, professional nurses showed more positive attitudes towards caring for patients that are dying, than non-professional nurses.

A discussion of the findings, conclusions, recommendations and limitations of the study will follow in chapter 5.

CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1   Introduction

Nursing constitutes a caring profession and as was established from the literature study, oncology nurses spend more time with patients that are dying and their families, than any other health professional. As such, their attitudes towards caring for patients that are dying and the influence it might have on their abilities to care, is vitally important, since these may affect the quality of care that the patient receives.

The purpose of this study was to explore the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in three typical, oncology settings in the Western Cape Metropole. This study was directed by its objectives, as specified in chapter 1 (paragraph 1.7).

The objectives of this study were to:

- Determine the attitudes of nursing staff towards caring for patients that are dying;

- Determine the level of work satisfaction of nursing staff;

- Determine the perceived supportive nature of the work environment;

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and their demographic factors;

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and their level of work satisfaction; and

- Determine any relationship(s) between nurses' attitudes towards caring for patients that are dying and the perceived supportive nature of the work environment.

In this chapter, the findings from this study are discussed and conclusions are drawn from the research outcomes. Recommendations, arising from the outcomes of this study, are also presented. Finally, recommendations for further studies are made and the limitations of the current study are identified.

5.2   Discussion and Conclusions

In the next part of this chapter, the study findings, according to the above stated objectives, are discussed. The conclusions represent a synthesis of the findings, in order to create a meaningful whole from the information that was generated through the data analysis, as well as from the findings of previous studies (Burns & Grove, 2007:437).

5.2.1   Objective 1

Objective 1 was to determine the attitudes of oncology nurses towards caring for patients that are dying. According to the FATCOD scale, the majority of the oncology nurses who participated in this study, demonstrated a strongly positive attitude towards caring for patients that are dying, as evidenced by the fact that the mean score for the FATCOD scale was 4.8. Of the individual items making up the FATCOD scale, respondents were clearly divided about whether death was the worst thing that could happen to someone (question 8). The only item where the majority of the respondents demonstrated a 'negative' attitude was question 35, i.e. family members who stay close to a dying person often interfere with the professionals' care taking of the patient.

It had become clear that in many ways the respondents had conformed to / demonstrated the characteristics, as identified in the literature, as being typical

of nurses with a positive attitude towards caring for patients that are dying. These characteristics included being older and more mature (Dunn *et al.,* 2005:101), having more experience in palliative care (Ablett & Jones, 2007:736) and increased contact with patients that are terminally ill (Dunn *et al.,* 2005:98). The majority of the respondents in this study were older than 41 years. Only 19 of the respondents in this study had less than 6 years' experience in palliative care. Lange *et al.* (2008:956) point out that prolonged contact with patients that are terminally ill encourages positive attitudes towards caring for patients that are dying. Prolonged contact with patients that are dying was characteristic of the participants of this study, as they were all exposed to caring for terminally ill and patients that are dying on a daily basis. This may have explained the positive attitudes being demonstrated by the majority of the respondents in this study.

The identified positive attitudes of the respondents were congruent with the theoretical framework of this study. Paterson and Zderad's (quoted in Praeger, 2002) humanistic nursing theory, as well as Peplau's (quoted in Belcher & Brittian Fish, 2002) interpersonal relations in nursing theory, emphasise the relational dimension of nursing.

The results of the FATCOD scale regarding the role of the family in taking care of the patient that are dying, provided a somewhat mixed picture with regards to support for the conceptual framework underpinning this study (see chapter 2, paragraph 2.5). In her interpersonal relations in nursing theory, Peplau emphasises that the family should be included in caring for the patient (Belcher & Brittain Fish, 2002:78). Similarly, Paterson and Zderad describe the patient and family as sharing in the nursing situation, through a lived dialogue (Vassallo, 2001:20). During this study, in all, but one, of the questions dealing with family involvement in the care of the dying (questions 10, 15, 19, 21, 23, 25, 27, 28 and 34), respondents clearly and overwhelmingly supported the involvement of the family, thereby recognising their understanding of the family being an important role player during EOL care. Contrary, in question 35, n=67 (79%) of respondents had indicated that family members who stayed close to a

dying person often interfered with the professionals' care of the patient. However, in light of the other results of the FATCOD scale, this may have represented a statement of fact regarding the realities of a pressurised work environment, rather than a negative attitude towards family involvement.

Results of the FATCOD scale regarding communication between the nurse and the patient (questions 9, 12, 17, 24 and 33), supported the humanistic nursing theory of Paterson and Zderad, which emphasises the importance of the lived dialogue between patient and nurse (Vassallo, 2001:20). According to the FATCOD, good communication between the nurse, patient and family promotes positive attitudes towards caring for patients that are dying, which was evident from the outcomes of this study. The rest of the FATCOD scale involved the human relationship between the nurse and the patient. Paterson and Zderad also place emphasis on the human relationship in their humanistic nursing theory. To them, the inter-human relating is directed towards the more-being of the person and the whole of the person (Praeger, 2002:387). According to Praeger (2002:402), oncology nurses who demonstrate positive attitudes towards caring for patients that are dying, should be able to give holistic, palliative care for the dying, in other words, as a physical, spiritual and emotional being. The findings from this study also supported Peplau's interpersonal relations in nursing theory, which emphasises the nurse-patient relationship. According to Mok and Chiu (2004:482), the caring actions and attitudes of nurses in nurse-patient relationships are responsible for connected and trusting, interpersonal relationships in a palliative care environment.

A possible reason for some of the respondents occasionally having reported negative attitudes towards the care taking of patients that are dying, may well have been due to them not being in touch with their personal reactions to death (Amenta & Bohnet, 1986:43b), or due to them being uncomfortable with interacting, touching, or communicating with patients that are dying (Demmer, 1999:434).

Many of the items on the FATCOD scale are relational in nature and a positive score, as in the case of most of the responses, reflected the high premium

being placed by the respondents on interaction and relationship between nurse, patient and family. All together, a positive attitude towards caring for the dying obviously enables meaningful relationships to develop.

It could thus be concluded that:

- The oncology nurses, who participated in the study, demonstrated predominantly positive attitudes towards caring for patients that are dying; and

- The findings confirmed the theoretical underpinning of the study, namely that the interpersonal nurse-patient relationship personifies caring, as expressed by the overall positive attitudes of the nurses.

5.2.2   Objective 2

Objective 2 was to determine the level of work satisfaction of oncology nurses in the Western Cape Metropole. Work satisfaction was generally high, with the results being as follows:

- n=81 (96%) of the respondents were satisfied with working as oncology nurses;

- n=80 (95%) of the respondents would choose oncology nursing as an occupation again, if they were to choose over;

- n=67 (79%) of the respondents would recommend oncology nursing to friends;

- n=85 (100%) of the respondents found their current work as meaningful and important;

- n=80 (95%) of the respondents would choose their current role as oncology nurses, if they could choose again; and

- n=78 (92%) of the respondents would continue working for the next two years in the field of oncology.

However, despite the fact that the majority of the respondents had experienced work satisfaction, another n=46 (54%) would not recommend oncology nursing as an occupation to their children. The reason for this may have been due to participants not wanting their children being exposed to the emotional pain and suffering that accompany caring for terminally ill and patients that are dying. The mean for the work satisfaction scale was 4.8, (see chapter 4, paragraph 4.4.3), which meant that the majority of the respondents had experienced work satisfaction. The results of this study corresponded with studies by Bruce *et al.* (2007:35) and Peteet *et al.* (1989:976), who had also found that respondents had rated their work satisfaction in the oncology settings as quite high.

Peteet *et al.* (1989:979) had found that emotional distress, related to caring for patients that are dying, had been a major source of job dissatisfaction. However, despite the fact that n=56 (66%) of respondents acknowledged having taken an emotional burden home with them (question 51), they reported a high level of job satisfaction. Other factors, e.g. the high degree of support (question 44), feeling valued (question 45) and feeling part of a team (question 46), were probably pivotal in the respondents' assessment of their levels of job satisfaction.

In conclusion, the oncology nurses who participated in this study:

- Predominantly experienced a high level of work satisfaction.

5.2.3 Objective 3

Objective 3 was to determine the perceived nature of the supportive work environment of oncology nurses in the Western Cape Metropole. The majority of oncology nurses, who participated in the study, experienced their work environments as supportive (mean = 4.6), with the results being as follows:

- n=70 (83%) of the respondents felt that they received support and guidance from their supervisors;

- n=65 (76%) of the respondents felt valued and respected in their jobs;

- n=79 (94%) of the respondents felt part of a team;

- n=82 (97%) of the respondents felt that a good relationship with their patients would benefit a supportive work environment;

- n=83 (98%) of the respondents felt that open communication with co-workers would benefit a supportive work environment;

- n=81 (96%) of the respondents felt that regular debriefing groups would benefit a supportive work environment; and

- n=70 (82%) of respondents experienced their workplaces as supportive.

Despite the fact that n=56 (66%) of respondents admitted to taking an emotional burden home at the end of their shifts, they generally regarded the nature of their working environments as supportive. They agreed that support, guidance and respect from their supervisors were important in creating a supportive working environment. They also felt that a good relationship between the nurse and the patient, and being able to communicate effectively with the patient and family, were important for enhancing a supportive working environment.

The findings from this study corresponded with studies by Minnaar (2003:39) and Pierce *et al.* (2007:36), who had found that if nurse managers valued their nurses and gave them emotional support and guidance, that it would contribute towards a supportive work environment. In addition, Feldstein and Gemma (1995:234) and Hopkinson *et al.* (2004:131) had found that professional debriefing groups and professional assistance and support to oncology nurses promoted a supportive work environment.

In conclusion, the oncology nurses who participated in this study:

- Predominantly experienced their workplaces as supportive; and

- Indicated that a supportive management team, regular debriefing sessions, teamwork, good nurse-patient relationships and effective

communication were important for the work environment to be classified as supportive.

5.2.4 Objective 4

Objective 4 was to determine any relationships between nurses' attitudes towards caring for patients that are dying and demographic factors. The demographic factors that were examined in this study were age, marital status, whether the respondents had children or not, workplace, professional rank and years of experience in oncology and palliative care.

The findings from this study indicated that there was a positive relationship between nurses' attitudes towards caring for patients that are dying and their age, suggesting that older nurses exhibited more positive attitudes towards caring for patients that are dying (see paragraph 4.5.4). This finding correlated with a previous study, indicating that older, more mature nurses displayed more positive attitudes towards caring for patients that are dying (Lange *et al.,* 2008:958). The fact that the majority of the oncology nurses n=69 (85%) in this study were between the ages of 36 – 60, could provide a possible explanation for the overall, more positive attitudes being reported towards caring for patients that are dying.

The analysis of this study's outcomes did not yield any statistically significant relationships between nurses' attitudes towards caring for patients that are dying and their marital status, or whether they had children or not. These findings corresponded with the study by Braun *et al.* (2010:46), who had also found no significant associations among marital status and nurses' attitudes towards caring for patients that are dying.

The analysis of the outcomes of this study established a statistically significant relationship between nurses' attitudes towards caring for patients that are dying and the workplace. Regarding the workplace, Ablett and Jones (2007:736) had found that hospice oncology nurses were more experienced in palliative care and working with patients that are dying, and they hence showed more positive attitudes towards caring for patients that are dying. According to Rooda (1999,

as quoted in Dunn *et al.* 2005:98), nurses who mostly cared for patients that are terminally ill, had more positive attitudes towards caring for patients that are dying. As this study was also conducted in hospices and oncology settings where nurses cared for a large percentage of patients that are terminally ill, it may have been one of the reasons why they generally reported more positive attitudes towards caring for patients that are dying.

Based on the findings, as reported in paragraph 4.5.8, there was a statistically significant relationship between oncology nurses' professional rank and their attitudes towards caring for patients that are dying. This finding corresponded with findings by Baylor and McDaniel (1996:103), Mallory (2003:310), and Mok *et al.* (2002:327), who had all found that education in palliative care promoted more positive attitudes towards caring for patients that are dying.

According to this study, no statistically significant relationship between oncology nurses' years of experience in palliative care and their attitudes towards caring for patients that are dying were established (see paragraph 4.5.9). This finding was noteworthy, since it departed from results from previous studies, as conducted by Mallory (2003:310) and Lange *et al.* (2008:958), who had found that more years of experience in palliative care had contributed to more positive attitudes towards caring for patients that are dying by oncology nurses.

In conclusion, the findings from this study suggested that:

- Older nurses displayed more positive attitudes towards caring for patients that are dying, than their younger colleagues;

- Hospice nurses displayed more positive attitudes towards caring for patients that are dying, than their colleagues in the tertiary hospital; and

- Professional nurses, as well as professional nurses with education in oncology or palliative care, showed more positive attitudes towards caring for patients that are dying, than the lower qualified enrolled and auxiliary nurses.

5.2.5   Objective 5

Objective 5 was to determine any relationships between oncology nurses' attitudes towards caring for patients that are dying and their levels of work satisfaction. Contrary to the researcher's expectations, and although the majority (see paragraph 5.2.1) of nurses, who participated in this study, demonstrated positive attitudes towards caring for patients that are dying, as measured by the FATCOD scale, and the majority of nurses' who participated in this study experienced work satisfaction, no statistically significant relationship between the two was found. The researcher also did not locate any studies in literature, where a relationship between oncology nurses' attitudes towards caring for patients that are dying and work satisfaction, was reported.

The results hence did not support the expectation that a high level of work satisfaction would be positively associated with positive attitudes towards caring for patients that are dying.

In conclusion, during this study:

- No statistically significant relationship existed between nurses' attitudes towards caring for patients that are dying and work satisfaction.

5.2.6   Objective 6

Objective 6 was to determine any relationship between nurses' attitudes towards caring for patients that are dying and the perceived supportive nature of the work environment. No significant relationship between nurses' attitudes towards caring for patients that are dying and the perceived supportive nature of the work environment was established during this study. This finding was contrary to the expectations of the researcher, who had anticipated that if nurses' had experienced their work environments as supportive that they would display more positive attitudes towards caring for patients that are dying.

The researcher also did not find any studies in literature, reporting any relationship between oncology nurses' attitudes towards caring for patients that

are dying and a supportive work environment. However, in light that previous studies (Hopkinson *et al.,* 2004:131; Feldstein & Gemma, 1995:234) had identified the need for a supportive work environment and diverse supporting interventions to help oncology nurses deal with their emotions and anxieties in caring for patients that are dying, one would expect that a supportive work environment would indeed influence nurses' attitudes towards caring for patients that are dying.

In conclusion:

- In this study, there was no statistically significant relationship between nurses' attitudes towards caring for patients that are dying and a supportive work environment.

5.3   Recommendations

The above findings revealed that the participants in this study:

- Had predominantly positive attitudes towards caring for the dying;

- Experienced job satisfaction; and

- Experienced their workplaces as supportive.

It became evident from the literature review that a positive attitude towards caring for patients that are dying is very important in ensuring that patients receive good quality care. Strategies should therefore be implemented to ensure that oncology nurses maintain a positive attitude towards caring for patients that are dying. The majority of nurses who participated in the study experienced job satisfaction, thereby reflecting favourable managerial involvement and input into the oncology work environment. However it is of the utmost importance that supervisors in an oncology environment maintain regular debriefing sessions, promote effective teamwork and offer good support and guidance, in order to sustain a supportive working environment.

The recommendations, arising from this study, were therefore firstly based on evidence of best practice as reported in the literature, aimed at creating and maintaining positive attitudes towards caring for patients that are dying. Secondly, they aimed at addressing those few areas, as revealed by this study, where participants, although perhaps predominantly 'positive' or 'satisfied', were less positive. These areas might benefit from some sort of remedial intervention.

5.3.1   Education in palliative care settings

Literature reveals that an educational program in palliative care influences nurses' attitudes towards caring for patients that are dying. Mallory (2003:310) points out that nurses' attitudes towards caring for patients that are dying have become more positive, after having been submitted to an educational program in palliative care. Lange *et al.* (2008:958) similarly found that education had positively affected nurses' communication with patients that are dying and their families, and therefore had promoted positive attitudes towards caring for patients that are dying.

In order to maintain and develop caring and positive attitudes among oncology nurses, the researcher thus recommends that:

- The concepts of end of life and palliative care be introduced in the curriculum of undergraduate nursing students, in order to improve their attitudes towards caring for patients that are dying and to prepare them in providing holistic care to the patient that are dying and his / her family;

- A relevant, palliative care, educational component be introduced into the orientation programs of all new nurses employed in oncology and palliative care settings;

- Continuous and regular in-service, educational programs in end of life and palliative care are planned, developed and implemented for nurses taking care of patients that are dying; and

- Management provides equal opportunities for end of life care education.

5.3.2   Implementation of coping strategies

It was apparent from the literature that coping strategies help oncology nurses deal with their fears of death and make them aware of their personal attitudes towards death (Hopkinson *et al.,* 2004:131). The importance of nurses being in touch with their personal attitudes towards death, and of feeling comfortable with death and dying, so that effective care can be provided to the patient that are dying, is a common theme throughout the literature (Amenta & Bohnet, 1986b:43;   Braun *et al.,* 2010:47). Although interventions, such as regular debriefing sessions, were acknowledged as being valuable by the respondents, previous researchers emphasise that the supportive role of management should be diverse and directed at various needs, such as improvement of the environment, improved communication and sufficient staff (Minnaar, 2003:39; Hopkinson *et al.,* 2004:131).

The researcher therefore recommends:

- The development of effective coping strategies for oncology nurses, such as debriefing group sessions, to complement education in palliative care;

- Managerial adaptations in the work environment regarding human resources and facilities; and

- Implementation of strategies that would improve communication between management and nursing staff on ward level.

5.4   Recommendations for further studies

5.4.1   Correlation between the attitudes of nurses working in palliative care and other health care settings

The researcher recommends that a comparative study be done to determine if there is a difference in the attitudes towards caring for patients that are dying

between nurses having higher levels of exposure to patients that are dying in palliative care settings and nurses working in other health care settings, such as medical / surgical wards.

5.4.2 Comparison between the patient's experience and nurses' attitudes

A further recommendation by the researcher is that a study be done to compare patients' experiences of nurses' attitudes towards caring for patients that are dying and nurses' evaluation of their own attitudes towards caring for patients that are dying.

5.5 Limitations of the study

According to Burns and Grove (2007:37), limitations in a study may reduce the credibility of the findings, as well as the generalisability of the findings to a larger population. Several limitations regarding this study were identified that should be considered when interpreting the results, namely:

- Since all of the respondents were female, no possible differences in male nurses' attitudes towards caring for patients that are dying were established;

- Although this study was performed in three different oncology settings, the sample size of 127 was relatively small, which may have had an effect on the recognition of statistical significance, for example, the absence of a statistically significant positive relationship between the FATCOD scale and level of work satisfaction. In addition, the small sample size may have limited the generalisability of the study findings to nurses providing care to other patient populations, such as intensive care or medical-surgical nursing;

- The use of a questionnaire as a data collection instrument had its inherent limitations, i.e. respondents may have misunderstood questions, or they may have deliberately falsified their answers;

- It was important to consider that there may have been a difference between true attitudes, in other words, what nurses really thought and felt, and stated attitudes, or what nurses said they thought and felt. Respondents may have been tempted to give socially desirable answers, particularly regarding their attitudes towards caring for patients that are dying;

- The FATCOD scale did not identify any prior death experiences by nurses that may have had an impact on nurses' attitudes towards the care of patients that are dying; and

- The work satisfaction section of the questionnaire did not contain any items dealing with remuneration. Such a question may have yielded different results regarding work satisfaction.

5.6   Summary

A quantitative, descriptive study, to explore nurses' attitudes towards patients that are dying in oncology settings in the Western Cape Metropole, was conducted. Nurses, working in oncology settings, are on the frontline of health care workers who care for terminally ill and patients that are dying. Such demanding work may influence their attitudes towards caring for patients that are dying. Several research studies have shown that the attitudes towards caring for patients that are dying affect the quality of care the patient that are dying receives. As their work needs to be performed with the utmost care, respect and compassion, it was important to undertake a study to investigate oncology nurses' attitudes and the influence of work satisfaction and a supportive work environment on their frames of mind.

The final conclusion reached from the outcomes of this study was that oncology nurses, who participated in this study, predominantly displayed positive

attitudes towards caring for patients that are dying. Most of them also experienced work satisfaction and regarded their workplaces as supportive. The results showed that some demographic factors indeed influenced nurses' attitudes towards caring for patients that are dying, such as age, workplace, years' of experience in palliative care and the professional rank of participants. These findings were congruent with the conceptual frameworks of Paterson and Zderad's humanistic theory and Peplau's interpersonal relations in nursing theory. The majority of participants acknowledged the importance of a good nurse-patient relationship and the role of the family in the holistic care of the patient that are dying.

The overall recommendation from this study is that oncology nurses should undergo training in palliative care, and receive effective emotional support to help them cope with their fears and anxieties, relating to caring for patients that are dying. This should promote positive attitudes towards caring for patients that are dying and, subsequently, effective and quality palliative and end of life care to patients that are dying and their families.

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ADDENDUM A
RESEARCH QUESTIONNAIRE

TITLE OF THE RESEARCH PROJECT

Factors influencing nurses' attitudes towards caring for dying patients in oncology settings in the Western Cape Metropole.

AIM OF THE RESEARCH

The aim of the study is to explore the influences of demographic and work environment factors on nurses' attitudes towards caring for patients that are dying in oncology settings in the Western Cape Metropole.

CONSENT

Completion of the questionnaire is voluntary and informed consent will be obtained from each subject.

Anonymity of participants is ensured and the researcher undertakes to treat all information as confidential.

The success of the study depends on the respondents' truthful completion of the questionnaire.

Thank you for agreeing to complete the research questionnaire.

Freda de Kock

SECTION A: DEMOGRAPHIC DATA

1.   What age are you? _____ years old.

Indicate your answer (2 – 5) by placing a tick (√) in the open box next to the relevant answer.

2.   What is your marital status?

Married	M	
Single	S	
Divorced	D	
Widowed	W	

3.   Do you have children?

Yes	Y	
No	N	

4.   Where do you work?

Tertiary state hospital	1	
Private oncology unit	2	
Hospice	3	

5.   What is your professional rank?

Professional nurse (speciality)	4	
Professional nurse	3	
Enrolled nurse	2	
Auxiliary nurse	1	

6.   How many years' experience do you have in oncology? _____ years.

SECTION B: FROMMELT SCALE OF ATTITUDES TOWARD CARE OF THE DYING

Mark each answer on the sheet that corresponds with your personal feelings about the attitudes or situations presented. Respond to all of the statements.

Indicate your answer by placing a tick (√) in the relevant box next to the question.

No	ATTITUDE	1 Strongly disagree	2 Disagree	3 Slightly disagree	4 Slightly agree	5 Agree	6 Strongly agree
7	Giving nursing care to the person that is dying is a worthwhile learning experience.						
8	Death is not the worst thing that can happen to a person.						
9	I would be uncomfortable talking about impending death with the person that is dying.						
10	Emotional care of the patient's family should continue throughout the period of grief and bereavement.						
11	I would not want to be assigned to the care of a person that is dying.						
12	The nurse should not be the one to talk about death with the person that is dying.						
13	The length of time required to give nursing care to a person that is dying would frustrate me.						
14	I would be upset if the person that is dying I was caring for should give up hope of getting better.						
15	It is difficult to form a close relationship with the family of a person that is dying.						
16	There are times when death is welcomed by the person that is dying.						
17	When a patient asks, 'Nurse am I dying?', I think it is best to change the subject to something cheerful.						

No	ATTITUDE	1 Strongly disagree	2 Disagree	3 Slightly disagree	4 Slightly agree	5 Agree	6 Strongly agree
18	I would feel like running away should the person actually die.						
19	Families need emotional support to accept the changes in behaviour of the person that is dying.						
20	As a patient nears death, the nurse should withdraw from his/her involvement with the patient.						
21	Families should be concerned about helping their dying member make the best of his/her remaining life.						
22	The person that is dying should not be allowed to make decisions about his/her physical care.						
23	Families should maintain as normal an environment as possible for their dying member.						
24	It is beneficial for the person that is dying to verbalise his/her feelings.						
25	Nursing care should be extended to the family of the person that is dying.						
26	Nurses should permit flexible visiting schedules for patients that are dying.						
27	The person that is dying and his/her family should be the main decision makers.						
28	The family should be involved in the physical care of the person that is dying.						
29	I would hope the person I am caring for dies when I am not present.						
30	I am afraid to befriend a person that is dying.						
31	Addiction to pain relieving medication should not be a nursing concern when dealing with a person that is dying.						

No	ATTITUDE	1 Strongly disagree	2 Disagree	3 Slightly disagree	4 Slightly agree	5 Agree	6 Strongly agree
32	I would be uncomfortable if I entered the room of a person that is terminally ill and found him/her crying.						
33	The dying should be given honest answers about his/her condition.						
34	Educating families about death and dying is not a nursing responsibility.						
35	Family members who stay close to a person that is dying often interfere in the professionals' care of the patient.						
36	It is possible for nurses to help patients prepare for death.						

SECTION C: WORK SATISFACTION

Read each question carefully and mark your degree of work satisfaction.

Indicate your answer by placing a tick (√) in the relevant box next to the question.

No	ISSUE	1 Never	2 Very rarely	3 Rarely	4 Frequently	5 Very frequently	6 Always
37	To what degree are you satisfied working as an oncology nurse?						
38	If you could choose again, would you still choose oncology nursing as your occupation?						
39	Would you recommend oncology nursing as an occupation to any of your children?						
40	Would you recommend working in an oncology setting to a good friend?						
41	To what degree do you sense that your work is meaningful and important?						

No	ISSUE	1 Never	2 Very rarely	3 Rarely	4 Frequently	5 Very frequently	6 Always
42	To what degree would you have chosen your current role as oncology nurse?						
43	What are the chances that you will continue in the field of oncology nursing for the next two years?						

SECTION D: NATURE OF SUPPORTIVE WORK ENVIRONMENT

Read each question carefully and choose <u>one</u> of the possibilities next to each question.

Indicate your answer by placing a tick (√) in the relevant box next to the question.

No	ATTITUDE	1 Never	2 Very rarely	3 Rarely	4 Frequently	5 Very frequently	6 Always
44	To what degree do you receive good support and guidance from your supervisor?						
45	To what degree do you feel valued and respected in your job?						
46	To what degree do you feel part of a team?						
47	To what degree do you feel a good relationship with your patient will benefit a supportive work environment?						
48	To what degree do you feel open communi-cation with co-workers will benefit a supportive work environment?						
49	To what degree do you feel that regular debriefing groups will benefit a supportive work environment?						
50	To what degree do you experience your workplace as supportive?						
51	To what degree do you take an emotional burden home at the end of your shift?						

ADDENDUM B

PERMISSION TO USE THE FATCOD SCALE AND PRE-USED QUESTTIONNAIRE

From: Kay Frommelt [Kay.Frommelt@clarke.edu]
Sent: 26 August 2009 04:10 AM
To: Freda de Kock
Subject: RE: FATCOD Attitude toward dying scale

Dear Freda,

I am hereby, through this e-mail giving you my official consent for you to use the FATCOD for your research. Best of luck with your studies.

Kay Frommelt
Katherine H Murray Frommelt, PhD, RN, FT

_____

From: Freda de Kock [fredadekock@vodamail.co.za]
Sent: Tuesday, August 25, 2009 1:29 PM
To: Kay Frommelt
Subject: FATCOD Attitude toward dying scale

ADDENDUM C

PERMISSION TO USE THE WORK SATISFACTION SCALE AND PRE-USED QUESTTIONNAIRE

From: PROF. Nili Tabak [ntabak@post.tau.ac.il]
Sent: 08 August 2009 05:03 PM
To: 'Freda de Kock'
Subject: RE: Questionnaire on nurse's work satisfaction

DEAR FREDA DE KOCK
YOU CAN USE THE QUESTIONNAIRE IN YOUR STUDY.
I WILL BE GLAD TO HEAR ABOUT YOUR THESIS.

PROF NILI TABAK

-----Original Message-----
From: Freda de Kock [mailto:fredadekock@vodamail.co.za]
Sent: Wednesday, August 05, 2009 10:17 PM
To: ntabak@post.tau.ac.il
Subject: Questionnaire on nurse's work satisfaction

ADDENDUM D

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

10 December 2009

MAILED

Ms F de Kock
Department of Nursing
2nd Floor, Teaching building
Stellenbosch University
Tygerberg campus
7505

Dear Ms de Kock

"Factors influencing nurses' attitudes towards caring for dying patients in Oncology settings in the Western Cape Metropole."

ETHICS REFERENCE NO: N09/11/341

RE : APPROVAL

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned case study on 9 December 2009, including the ethical aspects involved, for a period of one year from this date.

This case study is therefore now registered and you can proceed with publication. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project, but this approval will however be submitted at the next meeting of the Health Research Ethics Committee for ratification. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Approval Date: 9 December 2009   Expiry Date: 9 December 2010

10 December 2009 10:19   Page 1 of 2

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
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ADDENDUM E

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

Verwysing Reference Isalathiso	Verpleging
Navrae Enquiries Imibuzo	Mev G Joseph
Telefoon Telephone Ifowuni	(021) 938-4675

Tygerberg Akademiese Hospitaal en
Mitchellsplein & Tygerberg Mondgesondheidsentrums

Tygerberg Academic Hospital and
Mitchells Plain & Tygerberg Oral Health Centres

Isibhedlele Sase Tygerberg Kwakunye Ne
Mitchells Plain Neziko Lamazinyo Lase Tygerberg

Privaatsak X3/ Private Bag X3
Tygerberg, 7505

6 Mei 2010

Freda De Kock
Tygerberg Hospitaal
Privaatsak X3
TYGERBERG
7505

Geagte Freda De Kock

INSAKE : U NAVORSINGSPROJEK : FAKTORE WAT 'N INVLOED KAN Hê OP VERPLEEGKUNDIGES SE HOUDING TEENOOR DIE VERSORGING VAN STERWENDE PASiëNT IN ONKOLOGIE EENHEDE IN DIE WES-KAAPSE METROPOOL

Ek erken ontvangs van u navorsingsprotokol en vraelys.

Toestemming was verleen dat u kan voortgaan met die navorsingsprojek.

Dit sal waardeer word as u ons terugvoer met die uitkoms van u navorsing sal gee.

U samewerking word waardeer.

VERPLEEGHOOF
(GJ/mh/gehalteversekering – briefhoofafr/06-05-2010)

ADDENDUM F
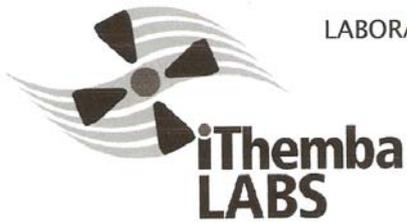
LABORATORY FOR ACCELERATOR BASED SCIENCES

iThemba LABS

P O Box 722
Somerset West
7129
South Africa

Tel : +27 21 843 1323
Fax : +27 21 843 3382
Email : amenda@tlabs.ac.za
Internet : http://www.tlabs.ac.za

Dear Ms de Kock

Permission to include the nursing staff in your study:

I hereby grant my permission that the nursing staff may participate in your study. The staff consists of 8 nurses with two per shift, therefore you may visit us over a period of two days.

Regards
Amenda Lawrence.

ADDENDUM G

PANORAMA MEDI-CLINIC
Private hospital

Medi-Clinic Limited • Reg. No. 1969/009218/06

Rothschild Boulevard, Panorama, Parow 7500 • T +27 21 938 2111 • F +27 21 938 2146
PO Box 15041, Panorama 7506 • www.panoramamc.co.za

25/02/2010

Sr F. de Kock
Oncology Department
TYGERBERG HOSPITAL

Dear Sr de Kock

RESEARCH: ONCOLOGY

I hereby grant permission for you to conduct part of your research in our hospital's oncology department.

Please let me know when you would like to interview the participants.

Kind regards

MRS ANNMARIE SIEBRITS
NURSING MANAGER

ADDENDUM H

From: Margot van der Wielen [MargotV@stlukes.co.za]
Sent: 21 January 2010 03:08 PM
To: Freda de Kock
Subject: RE: Research Proposal - Freda de Kock
Importance: High

Dear Freda

On behalf of the nursing staff at St Luke's Hospice, you have our official approval to carry out your research on our staff at our premises.

Good luck with it - we look forward to meeting you soon.

Warm regards

Margot

Margot van der Wielen
Education and Training Manager
Centre for Palliative Learning
St Luke's Hospice

92 Harfield Rd
Private bag X4
Kenilworth 7745
Tel. 021 797-5335
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margotv@stlukes.co.za

ADDENDUM I

From: Tygerberg Hospice [tygbhospice@lantic.net]
Sent: 19 January 2010 02:15 PM
To: 'Freda de Kock'
Subject: RE: Research Proposal - Freda de Kock

Dear Freda de Kock

Sorry for the delay but all personel are once again back at work. Thank you for your approved research proposal which you forwarded to us at the Nursing Department at Tygerberg Hospice, which we have read and the personel are willing to be used as research subjects.
Please accept this as written consent from the 9 Professional Nurses at Tygerberg Hospiceto conduct your research here.
Greetings
Sr. Lindsay Clift
NSM

-----Original Message-----
From: Freda de Kock [mailto:fredadekock@vodamail.co.za]
Sent: Sunday, 20 December 2009 16:04
To: tygbhospice@lantic.net
Subject: Research Proposal - Freda de Kock