LEARNING TO TRANSITION: 
NURSES’ ENTRY INTO CANCER NURSING PRACTICE

by

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Abstract
In the 21st century, the delivery of cancer care is facing unprecedented challenges, including an increasing number of cancer patients, a shortage of nursing personnel, a shift in care from in-patient to outpatient facilities, and new technologies requiring additional resources and education. The purpose of this critical qualitative study was to explore how nurses learn to transition into cancer nursing practice (CNP) in the workplace. The inquiry examined the contextual and learning factors that enhanced or impeded the nurses’ transition into diverse cancer settings. A comprehensive literature review was conducted in three areas: workplace identity and transitions; social learning theories and informal learning in nursing practice; and the context of cancerland, namely, cancer system, cancer patients’ experience, and cancer nursing as a specialty. Participants completed a preinterview questionnaire that determined whether they met the criteria and were representative of the phenomenon being studied. Telephone interviews were conducted with 15 nurses with more than 3 months and less than 2 years working in 1 of 4 cancer facilities in Ontario. An interpretive, phenomenological approach was used to formulate a description of the newly hired nurses’ lived experience. Three overarching themes emerged unique to CNP: (a) Getting In - nurses perceptions of their recruitment and selection into CNP; (b) Surviving In - nurses’ struggles learning CNP and the emotional strain of “being with” critically ill and dying patients; and (c) Staying In - factors that impacted the nurses’ decision to stay or leave, such as effective nursing
leadership, quality of work life, and accessibility of supports (preceptors and mentors) and professional education. The findings will assist nursing leaders, educators, and preceptors when developing strategies to enhance the recruitment, orientation, and education of nurses into CNP. The review included a description of the ways in which the nurses perceived their new role, as well as the rewards and difficulties they encountered as they coped during their first few months of practice. Also included were descriptions of the ways in which the nurses learned to transition into the different cancer nursing subspecialties of in-patient; outpatient; chemotherapy; radiation therapy; and urban, rural, and remote settings.
ACKNOWLEDGEMENTS

First and foremost, this work is a tribute to the 15 nurses who shared a rare glimpse into their day-to-day struggles in cancerland. The pseudonyms of the nurses are dedicated to the strong and creative women in my family: Ethel, Irva, Doris, Fran, Cathy, Sharon, Lorraine, Gayle, Shirley, Norma, Courtney, Rebecca, Kelly, Robin, and Jennifer. The pseudonyms of Linda, a cancer patient, and Carol, a cancer nurse, are in honour of all the wonderful patients and nurses who have enriched my life.

I am deeply grateful to my supervisor, Dr. Nina Bascia, who gently nurtured my work from start to finish. I want to thank Dr. Jim Ryan for his scholarly guidance and advocacy in bringing the doctoral program to the Thunder Bay Cohort ~The Lucky 13! I am very indebted to Dr. Margaret Fitch, my oncology nursing mentor, for being a vital part of my cancer education and this dissertation. I am also very honoured to have received funding from the Canadian Cancer Society, Ontario Division.

My desire to become a nurse began when I was 4 years of age and hospitalized in the Nipigon District Memorial Hospital. Those experiences profoundly shaped my nursing soul! The late Margaret Page, Professor Emerita Nursing and Fellow of Lakehead University, inspired me to have courage and explore all the possibilities in the world of nursing. This dissertation would not have been possible without the loving support of my husband, Lynne, and my daughters, Kelly and Robin. Colleagues Sally, Michelle, and Jan were always there to encourage me along the way. In the final days, I learned to no longer pursue the answers, but to respect the process and let the work unfold. Every day, I had to remind myself of the words from the album by Blues singer Kenny Neil, 2009:

Let Life Flow ... Yah! ... Yah! ... You’ve got to let life flow...
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DEDICATION

In memory of my mother, Doris (Haywood, Lake, Bedore)

Daring, dedicated, destined to be in our hearts forever more!
CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

In a small cancer facility in a northern community, Linda, a 43-year-old wife and mother, arrives for her chemotherapy treatment. She was diagnosed with breast cancer a few months ago, has undergone surgery, and is now midway through six cycles of high-dose chemotherapy. The full weight of her body collapses into the chemo chair as if it can no longer hold her up. She smiles at me and says, “I am tired and bald,” and she points to the scarf tied around her head and laughs. I begin to start her intravenous (IV), and the needle shakes in my hand. I aim and miss the vein … my brain freezes… I look at Linda and see the pain and disappointment in her eyes. She says, “My veins are really bad, and all the nurses have trouble getting me.”

I feel worse than ever because I know I am still learning and there are nurses who can get it on the first try. I turn to Carol, a nurse with 20 years of chemo experience who is starting an IV on a patient in the next cubicle, and I say, “Carol, can you help me with this?” I feel ashamed; I have asked her twice today to help me, but she responds immediately and says, “I will be there in a minute.” She starts the IV and shows me some pointers for the next time while looking at the patient and joking with her about the cute ducks on her scarf keeping the rain off her head today.

Later, I am heading down the highway in the rain, going home after a very trying day. Suddenly, I cannot see the windshield, not because of the rain, but because I am crying so hard that my vision is blurry. I pull over to the side of the road and sob with my hands draped over the steering wheel. The next day in the staff lounge over coffee I ask Carol, “How do you do it?” (I pause because I feel a tear coming.) … “start all those IVs
and deal with the pain and death that comes with working with cancer patients?” She puts her arm around my shoulder and says:

I don’t - I just take it one day at a time, we all have good days and bad days, we help each other, we cry on each other’s shoulders and we are thankful that we are not the one in the chemo chair today.

This experience, which has lived in my memory for the past 20 years, was triggered while I was writing this thesis. As I wrote it down, I could hear the rain hitting the office windowpane where I was working, and I began to realize that my memory of this event embodied most of what I wanted to say about learning. Powerful learning occurs when it is the least expected and often when people are distressed, feeling lost, and about to give up. The instinct to survive to care for patients as if they were “loved ones” drives nurses to reach out and ask for help.

This incident was submerged but reemerged as I struggled to express my thoughts on learning, causing me to pause and reflect, which resulted in an awareness that true, honest, open, and transformative learning occurs through critical self-reflection and meaningful interaction with others in a safe, trusting, and supportive environment. The result is the gift of learning about how others experience life, thereby enriching one’s own life and in turn others. It was this critical incident at the beginning of my career as a cancer nurse that inspired me to want to know more about how nurses learn to care for patients when they enter cancerland.

As a result of my own experiences as a cancer nurse, and as part of my doctoral studies, I conducted a small pilot study exploring newly hired nurses’ intention to enter oncology and their experiences during recruitment and orientation. I presented the findings at the 2002 12th biennial international conference on cancer nursing in England.
(Sevean, 2003). As a result, I became more acutely aware of the impending worldwide shortage of nurses and its potentially devastating impact on the future cancer nursing workforce (Aiken et al., 2001). Following the conference, I proceeded to develop a study that would examine how nurses newly hired to cancer settings make sense of their cancer nursing practice (CNP).

**Problem Statement**

Currently, the probability of developing or dying from cancer, based upon 2009 incidence rates, is 45% for Canadian men and 40% for Canadian women. An estimated one of four Canadians is expected to die from cancer, and the risk increases with age, with 60% of cancer deaths occurring among people who are at least 70 years of age or older (Canadian Cancer Society [CCS], 2009). Early in the 21st century, the CCS predicted that by 2010, cancer would become the leading cause of death. As early as 2004, cancer was reported by the World Health Organization (WHO) as the leading cause of death globally, with 7.4 million, or approximately 13%, of all deaths (CCS, 2000, 2009; WHO, 2009).

The delivery of cancer care is facing unprecedented challenges, including an increasing number of cancer patients, a shortage of personnel, and new technologies requiring additional resources and education. Nurses play a major role in the delivery of quality cancer care and function as guides to patients and their families as they make sense of their cancer experiences. Cancer nurses work with individuals and their families in a variety of settings, including hospitals, emergency units, chemotherapy clinics, cancer centers, communities, and palliative/hospice units. Oncology (cancer) nursing is a specialty and additional knowledge, cognitive and clinical skills are required to support
the practice (Canadian Association of Nurses in Oncology [CANO], 2002). In 2010, there was still no accurate accounting of all the health care professionals who work in cancer care and the services they provide. The Canadian Cancer Workforce Scoping Study (Canadian Association for Provincial Cancer Agencies/Canadian Partnerships Against Cancer [CAPCA/CPAC], 2010) described the cancer workforce system as facing an “era of uncertainty” and posed a variety of questions:

1. Who will replace the large cohort of aging Baby Boomers who will retire in the next few years?
2. Where will the new hires come from without increases in student enrolments?
3. Will there be financial resources to support programs?
4. How much longer can they keep up with the increasing flow of patients and survivors?

In early studies conducted in the United States by the Oncology Nursing Society (ONS), researchers indicated that the shortage of nurses was particularly acute in outpatient and in-patient cancer care settings (as cited in Lamkin, Rosiak, Buerhaus, Mallory, & Williams, 2001, 2002). Since 1981, there has been a corresponding decline in the enrollment in nursing schools by almost 8% (Buerhaus, Staiger, & Auerbach, 2000). These predictions also have been realized in Canada, where there are shortages in virtually all provinces across the country and in every specialty area of nursing practice (Canadian Nurses Association [CNA], 2006; Canadian Institute of Health Information [CIHI], 2007, 2008). The CNA (2009) has been urging governments, educational organizations, and professional associations to collaborate at a Pan-Canadian level to increase enrolment in registered nursing programs and consider policy options to improve
the recruitment and retention of students entering nursing.

In Canada, cancer caseloads are rising inexorably because of the increasing incidence, new treatments, and the growing prevalence of cancer survivors, all of which contribute to additional demands on the cancer workforce (CPAC, 2008). There also is a serious shortage of personnel in the cancer workforce, limiting service quality, education and research (CAPCA/CPAC, 2010). A recently released report on the future health care workforce emphasized that “any investment that we make in cancer care without comprehensively addressing the cancer workforce will fail” (Canadian Breast Cancer Foundation, 2009, p. 1). Reported shortages in nursing (Villeneuve & MacDonald, 2006), combined with rising cancer rates, have created a concern among nursing leaders that the supply of nurses will be insufficient to meet the future needs of cancer patients and their families. Because of the projected increase in retirements of senior nursing leaders, succession planning will become a priority for health care organizations in order to develop and maintain strong nursing leadership in the future (Green & Downes, 2005).

Over the past 2 decades, cancer nurses have been challenged by increasing caseloads to expand their practice role to include new technologies, complex treatment protocols, telephone triage, and management; however, all of these additional competencies require greater expertise and autonomy. Cancer nurses need increased opportunities to advance their competencies, but there has been a lack of available educational programs or incentives to encourage nurses to complete specialized cancer education. CANO (2006) stated that “the evolving health care system and new technologies require new approaches to oncology nursing education” (n.p.). It is timely for nurse researchers to speak with nurses about the factors enhancing or impeding their
transition into CNP. The lessons learned from this study may be useful in assisting nurse managers, nurse educators, and cancer nurses to develop strategies to enhance the recruitment, orientation, and education of nurses into the specialty of CNP.

Study Purpose

Foley (1999) asserted that the most interesting and significant learning occurs incidentally in people’s everyday lives and, more importantly, as people struggle to make sense of what is happening and work out ways of doing something about it. With this thought in mind, I decided that I would talk to nurses as they made the transition into their new roles as cancer nurses. I also wanted to examine how the experience of being cancer nurses was different from other areas of nursing in regard to emotional demands on self. According to M. Z. Cohen, Haberman, Steeves, and Deatrick (1994), “When asked about what parts of the job were rewarding, cancer nurses also described all the sources of rewards as sources of difficulties” (p. 10). I was the most interested in exploring the uniqueness of the specialty so that I could identify those aspects germane to the discipline of nursing rather than specific to the role of cancer nurse. I asked the nurses to share their most stressful experiences and the strategies they used to cope with those “trying moments” during the transition into their new role as cancer nurses.

The purpose of the study was to describe the lived experience of newly hired cancer nurses and their socialization into CNP. The phenomenon studied was how newly hired nurses made sense of their nursing practice in cancerland. The aim of the study was to address one overarching research question: How do nurses learn to manage the transition into CNP? The inquiry was an exploration of the contextual and learning factors that enhanced or impeded their transition into CNP. The study also was guided by
the following research subquestions:

1. What individual, organizational, and societal factors influence nurses’ decisions to enter CNP?

2. How do nurses learn interpersonal, technical, and professional skills when making the transition into CNP?

3. How do the learning needs and expectations of newly hired cancer nurses compare to the reality of CNP?

4. How do nurses learn to cope with the impact of role strain that accompanies transition into CNP?

5. What are some of the individual, organizational, or interpersonal factors that impact nurses learning to manage the transition into CNP?

Study Significance

Only a few studies have explored nurses’ transition from one specialty area to another (Brown & Olshansky, 1997; Linder, 2009; Rosser & King, 2003). Even fewer have focused specifically on how newly hired nurses perceive their transition into CNP. This study provides an understanding of the transition experiences in cancer nursing and builds on previous studies on role socialization and informal learning during transition experiences. Prior to 1990, the majority of studies related to nursing socialization, role development, and role strain ignored individual differences and considered experience deductively by attempting to create an explanatory model. Researchers have failed to consider nursing practice holistically within the context of the practice setting. Benner, Tanner, and Chesla (2009) stated, “Students [new learners] need experience working side by side with an experienced nurse who can point out saliencies, nuances and qualitative
In this study, I employed a qualitative approach to explore the phenomenon of becoming a cancer, or an oncology, nurse and illuminate presuppositions about the everyday lives of newly hired nurses and their struggles adapting to CNP. For the purposes of this study, I used the terms cancer and oncology synonymously. This perspective can assist others to better understand their experiences and the changes needed in the workplace to enhance the transition into the role of a cancer nurse. The constructions of experience and meaning can be helpful in planning and developing education and supports for nurses choosing CNP as a specialty. The study extends, refines, and corroborates previous knowledge generated on transitions from one practice setting in nursing to another.

Although I focused specifically on newly hired cancer nurses’ experience, the themes that emerged may apply to other nurses’ transition experiences. At the same time, experiences clearly unique to the specialty of cancer nursing emerged from the data analysis:

1. The emotional difficulties inherent within a specialty that deals with death and dying.
2. The effect that newly hired nurses have on staff, organization and resources.
3. Knowledge and skills that are transferable from other areas of nursing.
4. Knowledge and skills considered unique to the specialty of CNP.
5. Organizational supports that can promote the newly hired cancer nurses’ transition.
6. The role and contribution of mentors and preceptors to the nurses’ transition.
Each of the 15 newly hired cancer nurses interviewed for the study was embedded in her own unique cancer context. Their narratives reflected the complexities inherent when socializing to a new workplace, as well as the importance of informal learning in the process of making sense of how to meet the diverse needs of patients during their cancer experience. In a recent review of the current literature pertaining to what it means to be a cancer (oncology) nurse, M. Z. Cohen, Ferrell, Vrabel, Visovsky, and Schaefer (2010) reported a deficit of studies related to recruitment and retention, environment, setting, workplace issues and career trajectory (life cycle). Therefore, it was timely to explore how newly hired nurses were recruited and orientated; the challenges they faced during their first few months; and the factors that influenced their decision to get in, survive in, and stay in CNP.

**Study Outline**

Chapter 2 undertakes a comprehensive review of the literature relevant to how people cope with changes in their workplace identity; make transitions into new job roles; and, more importantly, learn what is necessary to survive in their new workplace. Social learning theories provided the theoretical underpinnings of this study. A historical overview of significant learning theories was conducted: adult learning; self-directed learning; transformational learning; narrative learning (i.e., the power of emotions, feelings, and imagination); context-based adult learning; and informal/incidental learning. The process of how nurses learn in practice and make sense of living in a new social context was explored, followed by an overview of the context of cancerland, including the cancer system, cancer patients’ experiences, demographics of the cancer nursing workforce, working conditions of cancer nurses, and cancer nursing as a specialty.
The conceptual framework was based upon what is known about how people learn to adapt to new social contexts. In practice-based professions, learning is situational and embedded in a unique social context that shapes the learning experience. The conceptual framework provided a lens to examine how 15 newly hired nurses made sense of their practice in cancerland and identify the factors affecting their transition into CNP.

Chapter 3 outlines my approach to developing and analyzing the research findings, including my perspective as a researcher; study recruitment procedure; data collection process; data analysis process; ethical considerations; study limitations; and study forms; letters of introduction, letter of informed consent, questionnaire, interview script and trigger questions. The nurses’ demographic characteristics also were examined, including age and sex, educational background, previous nursing experience, location of cancer facilities, types of positions held by participants, and theoretical and clinical orientation programs (see Appendix A). The breadth of the sample was reflective of the diversity of CNP and representative of geographical locations, types of practice, nursing experience, and education programs.

Chapter 4 presents a detailed accounting of the nurses’ experiences during the recruitment and selection phase prior to beginning their new cancer nursing positions. The nurses’ experiences illuminated how they learned about CNP, what influenced their decision to apply, and what factors impacted their eventual acceptance of cancer nursing positions. The contextual factors related to being recruited and hired into in-patient; outpatient; and urban, rural, and remote cancer settings were explored. Through the nurses’ eyes, I took a closer look at the challenges they faced gaining access to cancerland, such as the significance of labour market issues, social networking, career
planning, personal and professional experiences with cancer, recruitment strategies, and hiring practices in diverse practice settings.

Chapter 5 describes how the nurses made sense of their practice and learned what they needed to know in order to problem solve situations unique to cancer care. The nurses’ practices were similar in that they occurred in cancer settings in Ontario and each nurse was new to her setting and was struggling to make sense of her role as a cancer nurse. Early challenges included finding out how cancer nursing knowledge was shared informally and the factors that influenced the nurses’ eventual adoption of the skills required for safe and competent CNP. The nurses’ stories began to unfold with their initial orientation to CNP as they discussed the factors influencing their orientation. The significance of learning with patients, families, and nurse preceptors and mentors was highlighted. The nurses described the emotional work of caring for ill and dying patients and the strategies that they used to cope effectively with the strain of witnessing immense suffering.

Chapter 6 explores the contextual factors that enhanced or impeded the nurses’ decisions to remain in CNP, including quality of work-life (QOWL) issues; job satisfaction, rewards, and incentives; access to continuing education; and commitment to CNP. The nurses explained what it was like to work in various cancer subspecialties that had their own distinct bodies of knowledge and related subcultures. For example, nurses who worked in in-patient areas rather than outpatient areas described their experiences and share coping strategies unique to those settings. Nurses who practiced in rural and remote communities told their stories from different perspectives than their counterparts from urban areas, where supports and resources were more readily available to them.
In chapter 7, the positive and negative contextual factors that affected informal learning as the nurses made sense of CNP in diverse workplace settings are examined. Factors influencing recruitment to CNP, what is being learned, how it is being learned, and the contextual factors affecting learning are discussed. The nurses’ experiences, relevant literature, and my stance as the researcher contributed to the analysis of the study findings and the strategies that can support the development of a learning culture.

Chapter 8 outlines the development of the study; significant findings; and relevant implications for practice, education and research. The strategies to enhance recruitment, orientation, education, leadership, and policy are identified. The study limitations and future research directions are explored.
CHAPTER 2: LITERATURE REVIEW

Introduction

“Nothing endures but change.” (Heraclitus, 540-480 BC)

The world is constantly changing, and human lives are in transition until death. Not all transitions are equal, and some stand out as significant changes in the trajectory of a person’s life. I would agree with McAdams, Josselson, and Lieblich’s (2001) observation:

The stories we make and tell about the major transitions in our own lives contribute to our identities, help us cope with challenges and stress, shape how we see the future, and help to determine the nature of interpersonal relationships and our unique positioning in the social and cultural world. (p. xv)

Chapter 1 began with my own narrative about making a change from surgical nursing to CNP. The story began even further back, when I went for surgery for a suspicious breast lump that fortunately turned out to be negative for cancer. Following that surgery, I began to think about my career path and the fact that I had always wanted to be involved in cancer care. These thoughts prompted me to apply for a position. I then began the hard work of making that transition into CNP. In the first month, I was given self-directed learning modules to review, asked to attend a 3-day workshop, and then assigned to work with nurses to learn the “ropes” in the outpatient clinics and chemotherapy unit. Of course, that is where I met patients like Linda and nurses like Carol, both of whom helped me learn what having cancer is like and how to care for patients with cancer.

I liken those early days to climbing Mount Everest without any guides, but a written manual; no idea how to use the equipment; no map to follow; and a few travellers to talk to on the way up. I remember that for several months, informal learning
opportunities arose as part of the normal day-to-day learning challenges, and I was grateful to my colleagues for getting me through. At times, I felt a loss of my previous sense of identity as a surgical nurse and a longing to return to more comfortable ground. I also remember that it took almost 2 years before that hill turned into a brisk walk on a hilly pathway and was not nearly so intimidating! Several years later, when I returned to school, I wondered whether my story was different from or similar to others, and if so, how. I was curious about what people needed to learn to survive, who helped them to learn, and what were the enablers and barriers that affected their learning. These experiences allowed me to focus on this area of inquiry and eventually develop the proposal for this study.

Educational philosopher Maxine Greene (1978) stated, “None of us can think of our own lives, can remember events and people and situations without some consideration of context, without some mention of social milieu, cultural forces, institutional life, historic moment” (n.d.). The nurses in this study had distinctly unique perspectives as they told their stories about entering cancerland. Without an in-depth understanding of the context (i.e., cancer, cancerland, CNP), there was little value in exploring how nurses make sense of CNP. According to Buckman (2006), “Cancer Is a Word, Not a Sentence, and there are so many overtones and associations attached; it is probably the most dreaded word in the English language” (p. 9).

Cancer is a process, not a disease, shared by more than 200 very different diseases. Most cancers have very little in common with each other, apart from sharing the fundamental cancer process. This explanation is not well understood by the general public and results in cancer being perceived “as a mythical and mysterious disease often
resulting in death; rather than a highly treatable disease that over half of patients survive and will not be troubled by it for the rest of their lives” (Buckman, 2006, p. 10).

In a society that values youth, wealth, and health, to be old, poor, or sick is to be marginalized and pushed aside. Society has stigmatized the word cancer so that it has become associated with negative emotions and attitudes, so much so that those who get cancer feel downgraded. Therein lies the heart of the matter, and as Pausch (2007) stated, “When there is an elephant [a person with cancer] in the room, introduce them” (n.d.).

Generally, people are uncomfortable talking about the subject of cancer and will say nothing to the cancer patients, subsequently abandoning them emotionally.

When nurses enter cancerland, they are frequently branded with the same stigmatization as cancer patients. I remember that when I left my teaching position and went into CNP, my nursing colleagues and friends stopped asking me about my job. At a party, a nursing colleague asked me what was new, and I said, “I am working with cancer patients,” and she responded, “That must be very, very sad,” and made a quick escape to the bar. Nurses bring with them personal and professional experiences that influence their perceptions of what it might be like to live and work in cancerland.

This study presents the narratives of 15 nurses as they made their transition into CNP. They revealed their struggles and the learning opportunities that helped them to make sense of their new roles as a cancer nurses. The literature review encompasses three major thematic areas: (a) workplace identity and transitions; (b) social learning theories, informal learning, and learning to transition in nursing practice; and (c) the context of cancerland: cancer system, cancer patients’ experiences, and CNP as a specialty.

Cancerland has its own cultural norms and practices, and it is essential that the reader
have an in-depth understanding of the meaning of cancer and what it is like to live and work in cancerland. The chapter culminates with a description of the conceptual framework for the study.

Workplace Identity and Transitions

“All the world is a stage upon which the actors play out their respective roles in accordance to the context and setting…the ruler rules, the minister ministers, the father fathers, and the son sons” (Confucius).

People learn new identities when they undertake workplace transitions and adopt new roles. Studies on workplace identity have described organizations as systems comprised of multiple roles and psychosocial processes by which organizational roles are defined and role behaviour is enacted (Dubin, 1976; Katz & Kahn, 1966). If this is so, then how contextually based are behaviours in relationship to workplace identity? Biddle (1979) and Turner (1978) stated that roles are behaviours and involve overt actions performed by persons and are limited by a contextual specification. If this is true, then behaviours exhibited by persons within a discrete contextual boundary can change from context to context and are consistent within the behaviours of persons within specific contexts (Biddle, 1979).

During the transition to a new workplace, adapting to the role takes time because the old role is not always easily discarded. The ease with which individuals can let go of previous roles usually depends on how closely aligned the roles are to their personal identities. Turner (1978) remarked, “Some roles are put on and taken off, like clothing without a lasting effect… other roles are difficult to put aside when a situation is changed and continue to colour the way in which many individual’s roles are performed” (p. 1).
Discrepancies between role prescription and actual role behaviour can be explained by the inability to let go of previous roles and merge into new roles (Turner, 1978). This phenomenon can be attributed to the most intense feelings occurring early on when individuals are preoccupied with mastering the new roles, followed by a more flexible commitment to the roles once they have developed an interdependent relationship with other roles within the context of the organizational culture (Turner, 1978).

Mastery of a role involves learning new skills, and the magnitude of the gap between what is known and what is yet to be learned can impact significantly the challenges faced by the newcomers during the transition. Professional nursing practice is comprised of specialties and subspecialties within practice areas. Making the transition either as a new graduate or from one specialty to another can result in a substantive change in identity and nursing practice, and may necessitate transitional supports during the first year of employment (Cowin & Hengstberger, 2006; Ellerton & Gregor, 2003; Hayes et al., 2005).

**Workplace Identity in Nursing**

“Nurses provide services within a formal structure or system…their role is defined by the context and by the formalized role prescription designed by the organization” (Creasia & Parker, 2001, p. 77). Workplace identity and role behaviours in nursing are complex and diverse; contextual, professional, and personal factors all play roles in influencing behaviour. A model of role formation in nursing includes such individual factors as attitudes, role expectations, values, education, and previous experiences and their impact on role development; as well as the influence of such organizational and interpersonal factors as mission, goals, structure, and policies (
Creasia & Parker, 2001).

There are two main nursing roles: caregivers attending to patients’ needs and integrators coordinating specialized services to meet patients’ needs. Subsumed within the caregiver role are a number of subroles: teacher, counselor, and advocate (McClure, 1989). Role challenges that have occurred in nursing in part because of rapid changes within health care organizations can be categorized in terms of role stress, role ambiguity, role conflict, role incongruity, role overload, role incompetence, role overqualification, and role satisfaction versus role dissatisfaction (Hardy & Conway, 1988).

Wilkinson (1994) identified the nursing role as one of the most stressful in health care because of the intensity of providing direct patient care around the clock, often accompanied by staff shortages and poor support from health care organizations. High levels of stress also have been identified in cancer nursing, but they are usually counteracted by equally high levels of reported job satisfaction and a commitment to the subspecialty (Wilkinson, 1994). Several interventions have been identified as contributing to job satisfaction, including continuity of nurse-patient relationships, authority to initiate independent nursing actions, individual accountability, and feedback on performance (Tonges, Rothstein, & Carter, 1998; Traynor & Wade, 1993). The following themes of role ambiguity, role confusion, role development, and role expectations impact the adoption of new nursing roles (Jamieson, Ross, Hornberger, & Morse, 1999; Neal, Brown, & Rojjanasrirat, 1999). During the initial phase of learning new roles, nurses have described experiencing the effect and struggling to make sense (Smith-Blair, Smith, Bradley, & Gaskamp, 1999).
Workplace Transitions

The life of an individual in any society is a series of passages from one age to another and from one occupation to another. Progression from one group to the next is accompanied by special acts, like those which make up apprenticeship in our trades. (Gennep, 1904/1960, pp. 2-3)

Career changes have been the source of considerable research; so what has been learned about career transitions? First, role transitions are clearly a time of struggle and considerable tension that requires individuals to reach outside of their personal boundaries and engage with others in cocreating solutions to the dynamics explicit in role strain as a result of sociopolitical changes within organizational contexts. Second, role transitions occur in stages that focus on gaining access to the new positions and initial entry into the positions, gaining knowledge about the workplace, making sense of the new positions, and deciding to remain or leave the new positions. The term transition can be characterized as the movement or passage from one position, state, stage, subject, concept, to another (Golan, 1981). Adults continuously experience transitions, and the reactions to transitions depend on the type, context, and impact of the transitions; transitions are a process and include assimilation and continuous appraisal (Schlossberg, 1984). The question to ask is this: How do these concepts on making career changes relate to nurses making transitions from one nursing context to another?

To understand career transitions in nursing, it is helpful to examine the early work of Gennep (1904/1960). He proposed three transitional rites of passage: (a) preliminal rites, or the rites of separation from the previous world; (b) luminal, or threshold, rites that are executed during the transitional stage; and (c) postliminal rites, or the ceremonies of incorporation into the new world. Several theories and frameworks have been proposed to explain career-related role transition.
The study of employees’ entry and socialization into organizations has increasingly received attention within organizations because of their economic significance and potential impact on the QOWL for new employees and the organization as a whole (Wanous, 1992). Organizational entry for newcomers can result in two possible outcomes, namely, turnover due to unmet or unrealistic expectations, or successful role-related and cultural learning experiences that result in adaptation to the new role (Louis, 1980). Several models of newcomer experience have been proposed and include stages of organizational entry: recruitment and selection; orientation and initial adjustment; and socialization and sense making, attributing meaning based upon past experiences and current resources (Allen & van de Vliert, 1984; Louis, 1980; Nicholson, 1984; Wanous, 1992). Allen and van de Vliert proposed a useful model to examine the processes encountered when someone experiences a transition from one role to another that includes three stages: (a) antecedent conditions, the determinants that may trigger a shift in behavior; (b) role transition, the cognitive, affective, and behavioral responses to the strain posed by role transitions; and (c) reactions and consequences, the factors that enhance or impede the adoption of the role change.

_Nurses in Transition_

“Role transition, the process of assuming and developing a new role, is a form of role incongruity that is familiar to nurses” (Creasia & Parker, 2001, p. 80). The phenomenon of making transitions from one nursing role to another has become the subject of many investigations, so what is known about how nurses make transitions into new roles? A review of studies identified three main assumptions regarding nurses’ transitions: (a) The transition is potentially unsettling and may be enhanced or impeded
by a number of factors; (b) mentorship enhances the transition experience and mentors require preparation and continued support in their role; and (c) nurses bring a number of expectations with them as they enter new specialties (Benner et al., 2009; Brown & Olshansky, 1997; Delaney, 2003; Ellerton & Gregor, 2003; Klaich, 1990; Murray, 1998; Rosser & King, 2003).

The first role transition from student to new graduate nurse has been studied extensively, beginning with the phases of reality shock (honeymoon phase, shock-and-rejection phase, recovery phase) as experienced by students entering the nursing workforce (Kramer, 1974). Because several of the study participants were new graduates, the phases of reality shock were relevant to their ability to cope with their first nursing position while learning about CNP at the same time. Recent studies examining the transition experiences of students to staff nurse positions have highlighted the importance of the availability of structured support (i.e., orientation programs, mentors, and preceptors) to assist new graduates with the reality shock of entering the work world (Deirdre, 2001; Delaney, 2003; Godinez, Schweiger, Gruver, & Ryan, 1999; Pearson & Care, 2002; Whitehead, 2001).

Senior nurses often experience several role transitions during their careers as they move from one unit or specialty to another. Schumacher and Meleis (1994) noted, “Conditions that may influence the quality of the [role] transition experience and the consequences of transitions are meanings, expectations, level of knowledge and skill, environment, level of planning, and emotional and physical well-being” (p. 119). Senior nurses entering clinical settings where they lack experience in those areas may be limited to the novice level of performance if the patient population and related skills to care for
the patients are unfamiliar to them (Benner, 1984). Development of clinical expertise for novice nurses is dependent on the social ecology of the group, and performance will improve if teams have shared visions and focus on the importance of morale and social climate (Benner et al., 2009). Price (2008) suggested that nurses’ transitions are greatly influenced by experiences with role models and recruitment and retention strategies, and that they should actively engage practice mentors in the process.

Whether nurses are new graduates or experienced nurses, the transition experience to a specialty area can be disconcerting depending on context and environmental factors. Primary care nurse practitioners during their initial transitional year into practice have described a stage from limbo to legitimacy comprised of four main categories: laying the foundation, launching, meeting the challenge, and broadening the perspective (Brown & Olshansky, 1997). In a similar study, nurse practitioners in their first year of employment identified the following themes: loss of personal time and privacy, changes and losses in relationships, feelings of isolation, uncertainty in establishing their role, and a special bonding with patients (Kelly & Mathews, 2001). Nurses who changed from hospital-based practice to home care described similar feelings of anxiety, incompetence, and a lack of skills to provide care in the home (Murray, 1998).

*Cancer Nurses in Transition*

How are transitions into CNP similar to or different from transition experiences into other nursing specialties? What do we know about nurses’ transitions into cancer care and palliative care? These specialty areas of practice have the following characteristics in common: (a) unique practice regarding type of patient, knowledge base, and nursing practice; (b) personal development to cope with the role strain of working
with death and dying; and (c) the importance of access to effective role models and mentors that have expertise in cancer and palliative care (Caton & Klemm, 2006; Fitch, Matgas, & Robinette, 2006; Linder, 2009; Rosser & King, 2003; Sevean, 2003). What is known is that cancer nursing has a substantive knowledge base; what is not known are the contextual factors that enhance or impede the successful integration of nurses into CNP.

To date, only a few studies have explored the experiences of cancer nurses and newly hired nurses making the transition into a cancer subspecialty. In a small-scale pilot study, I explored nurses’ intention to enter the cancer workplace and their perspectives during recruitment and orientation. In this study, I asked newly hired nurses to describe their experiences during their first few months as cancer nurses. I asked questions about certain milestones during their transition, such as initial orientation, education and training programs, mentorship and preceptorship experiences, and critical incidents or informal learning during real-life experiences that marked their progression toward becoming socialized into their new role as cancer nurses.

I also asked these newly hired nurses to identify the learning strategies and supports that enhanced their socialization as well as the barriers that impeded their learning and adaptation to their new workplace. Several factors impacted their experience: (a) access to formal education opportunities to learn their cancer subspecialty (knowledge/skills); (b) stress of coping with cancer patients and their families; (c) access to effective role models, mentors, and preceptors within the cancer community of practice (CoP); (d) ongoing development of their career vision (suitability of career choice; Sevean, 2003).
Recently, an innovative program designed to assist new cancer nurses learn about coping with stress in their practice was evaluated (Fitch et al., 2006), and the results indicated that it is important to provide opportunities for cancer nurses to develop effective interpersonal coping skills. More recently, a study was conducted to examine the experiences of pediatric cancer nurses during their first year of hire; the practice implications included supporting nurses beyond the acquisition of skills and knowledge (Linder, 2009). The nurses’ experiences were themed into three categories of role development, unique practice, and personal development. “Successful role development is essential to ensure the retention of new pediatric [cancer] nurses as well as their future achievements within the subspecialty” (Linder, 2009, p. 29). Linder’s study was the first study devoted to looking at newly hired pediatric cancer nurses and highlighted the importance of understanding nurses’ perceptions of their new role and how they could contribute to the development of the subspecialty.

Social Learning

“Experience is the best teacher of all things” (Julius Caesar, DeBello Civili, 52 BC). The concepts underpinning how adults learn in their day-to-day practice has been the subject of many studies. Practice-based professionals often refer to their work as part science and part art. Dewey (1934) defined art as being about human community, meaning, lived experience, and how persons relate with “sensitivity to the quality of things” (p. 49). Artful practice is about human understanding and how people experience life, reflect on themselves, make sense of their own situations, and change their actions accordingly (Greene, as cited in Ayers & Miller, 1998; Novitz, 1996). Florence Nightingale, the founder of modern nursing and the first nurse researcher, decided to call
nursing *the finest art*, which conveyed her deep respect for the actual work of nursing (as cited in Donahue, 1996).

Many nurse theorists have asserted that the real work of artful nursing practice is to build experience, wholeness, and connections with humans and the universe (Parse, 1987; Peplau, 1988; Rogers, 1989; Watson, 1994). The terms *art* and *science* are significant in the development of nursing practice education, and “there is a delicately balanced movement between art and science as portrayed by experienced nurses that transcends as it uses the differences between these two forms” (Peplau, 1988, p. 28).

The nurses who participated in this study were living and learning in practice contexts, so it is critical to understand what is known about how adults learn. The discourse on adult learning began in the 20th century when Knowles (1980) coined the term *andragogy* to distinguish it from preadult schooling. The recognition of learning as a distinct professional field of practice has impacted the development of teaching and learning in professional schools such as nursing, medicine, law, social work and other like practice disciplines. Over the past few decades, the advances in nursing education have paralleled the developments in adult education, and new ways of teaching nursing practice that reflect the principles of adult learning have emerged.

*Principles of Andragogy*

The principles of andragogy posit that adult learners are self-directed, bring with them prior life experiences, have needs closely aligned with social role changes, and frequently focus on the immediate need for the acquisition of knowledge and skills (Knowles, 1980). There has been considerable debate on whether or not these assumptions constitute a theory of adult learning (Hartree, 1984) and to what extent the
assumptions apply to only adult learners. Some researchers have argued that adults are motivated to learn in order to keep their job and that life experiences for adults can sometimes act as barriers to their learning (Merriam, 2001). Eventually, educational theorists moved to a continuum of teacher-directed to student-directed learning, mirroring Houle (1996). Even though andragogy has contributed to the understanding of adults as learners, it does not take into account knowledge about the processes by which adults learn or the context in which the learning takes place (Merriam, 2001).

Self-Directed Learning

The model of self-directed learning (SDL) emerged at the same time as andragogy, building on the work of Houle (1996), who provided the first description of SDL. The approaches to SDL vary; some models focus on the learners’ capacity to be self-directed (Knowles, 1975; Tough, 1971), whereas others incorporate critical reflection as central to the process of transformational learning (Brookfield, 1986; Mezirow & Associates, 2000). Instructional models of SDL focus on process. The best known of these is the staged self-directed learning (SSDL) model (Grow, 1991, 1994). In this model, learners can locate themselves on a matrix in terms of their readiness and comfort level being self-directed, both of which can be matched with appropriate learning strategies. Other models are associated with measuring such learner characteristics as educational level, creativity, learning style, readiness, and self-directedness (Merriam, 2001).

Adult learners continue to be an important area of investigation, but in recent years, there has been a shift toward examining the sociopolitical context of adult education (Brockett, 2000). Future areas for investigation that could illuminate further
understandings of adult learning through SDL may seek to answer the following questions:

1. Why do some adults remain self-directed in their learning over long periods of time, but others do not;
2. Do issues of power and control create barriers to using SDL in formal education settings;
3. Does being a self-directed learner have an impact on how the teacher plans instructional activities; what impact does public policy have on the adoption of SDL programs;
4. What does the critical practice of SDL look like in different practices;

Since the early 1990s, SDL and reflective practice have been teaching strategies commonly employed in nursing education programs. For example, Ontario nurses conduct an annual self-assessment of their learning needs and develop learning goals related to maintaining their provincial nursing licenses (College of Nurses of Ontario [CNO], 2010).

*Transformational Learning*

“The transformational learning process is intuitive, holistic, and contextually based” (Merriam, 2001, p. 17). While andragogy and SDL grew from 1950 to the early 1990s, transformational learning gained prominence in the 1990s and continues to expand. Two key perspectives emerged, namely, Freire’s social-justice focus through consciousness raising and Mezirow’s approach using rational thought and reflection in
the transformative learning process (Merriam, 2001). The meaning-making process in “the real world in complex institutional, interpersonal, and historical settings must be understood in the context of cultural orientations embodied in our frames of reference” (Mezirow & Associates, 2000, p. 24). An important aspect of the transformational learning model is that it occurs in situations of cognitive dissonance, that is, when people are struggling with learning. Transformational learning also is part of collaborative learning experiences, and an open and trusting environment is essential for participation and critical reflection (Merriam, 2001; Mezirow & Associates, 2000). Recent studies have taken a narrative approach to transformative learning, allowing people to share stories of their day-to-day struggles, how they coped with transitions, and how they were mentored through developmental transformations (Daloz, 1999). These concepts have been reflected in the development of nursing curricula during the past 2 decades.

An alternative approach focuses on the extrarational process and speaks to the role of imagination in facilitating soul-based learning that emphasizes feelings and images (Dirkx, 1998; Healy, 2000), and because it involves emotions, it can create ethical challenges for researchers (Merriam, 2001). Transformational learning theory emphasizes how adults make sense of their world, shifting away from “what we know to how we know” (Merriam, 2001, p. 22). This type of learning is particularly evident in clinical settings, where nurses are learning in the moment and moral and ethical issues are part of the decision-making process (Benner et al., 2009; Newman, 2008).
**Narrative Learning (Power of Feelings, Emotions, and Imagination)**

“Personal stories are not merely a way of telling someone (or oneself) about one’s life; they are the means by which identities may be fashioned” (Rosenwald & Ochberg, 1992, p. 1).

“To understand who a person is, it is necessary to understand emotion” (Denzin, 1984, p. 1).

Emotions are inextricably linked to everyday experiences and are part of the adult learning context. For example, the simple act of an adult returning to school or starting a new job can cause intense emotions to surface (Amey & Dirkx, 1999). Emotions are associated with images and voices that emerge from the conscious and unconscious brain (Chodorow, 1997). Neo- and post-Jungians have suggested that images expressed as emotions can help people to make deeper connections with their inner selves. Educators have traditionally based theory and practice on rationality in favour of emotionality, which has been perceived as “baggage” that learners bring to the classroom (Merriam, 2001). A steadily growing body of research has supported the notion that emotions and feelings in contexts and interactions are essential to adult learning and that the concept of emotional intelligence enhances the perceiving, processing, storing, and retrieval of information from the external environment. The role of emotions, feelings, and imagination in learning and connecting the inner self to the day-to-day experiences in the external world is powerful and holds deep meanings for the learner (Goleman, 1995; Merriam & Caffarella, 1999; Taylor, 1996).

People instinctively are storytellers and it is the way in which they make sense of their day-to-day lives. Hermans (1997) pointed out that the personal narrative is dynamic
and has a social dimension and that people’s personal stories are constantly shaped by culture and context. The narrative is an unfolding of those stories, and the central task of the personal narrative is the creation of coherence (Rossiter, 1999). Narratives have the power to evoke great personal change; in an Alcoholics Anonymous meeting, for example, members exchange stories that allow others to see the destructive pattern of an alcoholic life and imagine how their lives can be changed (Merriam, 2001).

Narratives, learning journals, and life history biographies can be used by learners to examine the process and content of their learning, and reflect on the effectiveness of their teaching (Merriam, 2001). Narratives shared between novice nurses and seasoned nurses have been studied extensively and have been identified as powerful learning tools to help nurses to cope with the intense feelings experienced when caring for critically ill and dying patients (Benner et al., 2009; J. S. Cohen & Erickson, 2006). Nursing students are encouraged to document and critically examine their practice through reflective practice journals, and they also are encouraged to share their experiences with others to promote further critical reflection.

**Context-Based Adult Learning**

“Adult learning does not occur in a vacuum” (Merriam & Caffarella, 1999, p. 22).

“Learning is a complex and diverse sphere of human activity, as central to human life as work or politics… adult learning and education are also contextual and contested activities” (Foley, 1999, p. 7).

Traditional learning methods have been criticized for focusing on the transmission of explicit knowledge, but lately, educators have shifted to exploring the impact of environmental context on individual learners (Hara, 2009). Sociocultural models have
proposed that learning is not an individual and intellectually isolated experience, but is shaped by the context and culture embedded in the learning experience. Situated learning is a reoccurring process that allows adults to act and interact in social situations. In a situated learning process, adults learn within a community of other learners and gain knowledge from engaging with more experienced members (Lave, 1988).

Cognitive apprenticeships are often the conduit through which learners are socialized to certain learning communities; role models provide guidance (coaching, scaffolding); self-directed learning takes over once confidence with skills is achieved; and learners discuss with others what they have learned in subsequent practice situations (Merriam, 2001). Internships, apprenticeships, and mentoring programs provide the learners with real-world, context-based learning, and they have become common practice when orientating nurses to new positions.

CoPs are self-organized and selected groups of people who have a common purpose and want to learn from each other (Lave & Wenger, 1991; Wenger, 1998). CoPs provide individuals with a lens to focus our understanding of informal collaborative learning that occurs outside formal classrooms and in training environments (Lave & Wenger, 1991). There is an ongoing debate among scholars that CoPs cannot be intentionally created; rather, they must emerge and can be nurtured or cultivated over time (Boud & Middleton, 2003; Hara, 2009; Wenger, 1998). Recently, interprofessional teams have been used in health care to plan patient-centred care, but further research is needed to assess their effectiveness and the enablers and barriers to their effective implementation (CAPCA/CPAC, 2010).
**Practice-Based Learning**

Researchers have suggested that there is a sociopolitical context around individuals naming themselves as learners. In a practice environment, having themselves recognized as learners could legitimize the learners as competent workers; on the other hand, in other organizational cultures, being the learners could create tensions or be associated with being novices who are not yet functioning as competent workers (Boud & Solomon, 2003). In nursing, increasingly, “we have to manage and deploy new and existing knowledge,” and CoPs are being encouraged as “an innovative strategy for educators and practitioners to collaborate to manage new knowledge and emerging practice” (Andrew, Tolson, & Ferguson, 2008, p. 246).

**Informal and Incidental Learning in the Workplace**

“The person who really thinks learns quite as much from his failures as from his successes” (Dewey, 1938, p. 4). Informal and incidental learning are learner focused and intentional, but not highly structured. These modes of learning include self-directed learning (Candy, 1991; Knowles, 1950); experiential learning (Boud, Cohen, & Walker, 1993; Kolb, 1984); critical reflection and transformative learning (Mezirow, 1991); reflection in action (Schon, 1983); tacit knowing (Nonaka & Takeuchi, 1995; Polanyi, 1967); situated cognition (Lave & Wenger, 1991); and CoPs (Boud & Middleton, 2003; Wenger, 1998). Results of studies conducted over the past 2 decades have indicated that in the workplace, 60% to 80% of adult learning is unintended and occurs informally (Garrick, 1998; Koopmans, Doornbos, & van Eekelen, 2006; Marsick & Watkins, 1990). Koopmans et al. noted that “informal learning is the result of natural opportunities to
learn, and thus interactions occurring during the individual’s everyday working life are important sources of informal learning” (p. 136).

Informal learning is characterized as follows: integrated with daily routines, triggered by an internal or external jolt, not highly conscious, haphazard and influenced by chance, an inductive process of reflection and action, and linked to the learning of others (Marsick & Volpe, 1999). Marsick and Watkins (1990) developed a dynamic model of informal and incidental learning that depicts a progression of meaning making in a learning cycle that includes the following steps: initiate the triggers, interpret the experience, examine alternative solutions and learning strategies, produce the proposed solutions, assess intended and unintended consequences, learn lessons, and reframe the context. Marsick and Watkins identified three conditions to enhance informal and incidental learning: (a) critical reflection to surface tacit knowledge and beliefs, (b) stimulation of the learner to identify options and learn new skills to implement solutions, and (c) creativity to encourage a wider range of options.

Further studies have concluded that informal and incidental learning often are the result of unexpected events; for example, Menard’s (1993) study of nurses in Vietnam demonstrated that during times of crisis, nurses through their own ingenuity invented tools and techniques to accommodate the lack of resources in MASH units. Individuals still need to learn more about the interface between learning at the individual, team, and organizational levels and the nuances and differences among and between these levels (Merriam, 2001).

Many researchers have claimed that there is no separation between workplace activities and learning, and that observing, listening to, and participating in work
activities are ways in which workers can learn about their new role responsibilities (Billett, 2001; Lave & Wenger, 1991). The workplace also can be a source of contestation between newcomers or old timers, full-time or part-time workers, teams with different roles and standing in the workplace, individuals’ personal and vocational goals, or among supervisors and management representing workers (Billett, 2001). Workers often are active participants, and “there is relational interdependency between the individual and work that can act to sustain or transform both self and their work” (Billett & Somerville, 2004, p. 309).

More recent studies involving informal learning have been organized according to two frameworks for understanding and investigating informal learning in the workplace. The first group of frameworks deconstructs the key concepts of formal learning (learning from experience, tacit knowledge, transfer of learning and intuitive practices) and “the second group comprises frameworks for addressing three central questions: what is being learned, how is it being learned and what are the factors that influence the level and direction of the learning effort” (Eraut, 2004, p. 247). Eraut (2004) developed a typology of descriptors for “what is being learned” that includes task performance, role performance, awareness and understanding, academic knowledge and skills, personal development, decision making and problem solving, teamwork, and judgment. “How is it being learned” is categorized according to four main types of work activity: participation in group activities, working alongside others, tackling challenging tasks, and working directly with patients. “What are the factors that influence the learning effort” are categorized into two main foci; learning factors and contextual factors that are mediated
by the confidence and the commitment of the learner situated in the learning environment (Eraut, 2004).

In a recent qualitative study on contextual factors that impact informal learning, the following themes emerged as positive organizational factors: learning-committed leadership and management, an internal culture committed to learning, work tools and resources; and people who form webs of relationship for learning (Ellinger, 2005). Conversely, negative organizational factors included leadership and management not committed to learning; an internal culture of entitlement that is slowly changing; lack of work tools and resources; people who disrupt webs of relationships for learning; structural inhibitors (physical architectural barriers, silo mentality); lack of time because of job pressures and responsibilities; too much change too fast; and not learning from learning (Ellinger, 2005). Finally, it is important to note that because of the tacit nature of informal learning and the fact that it is embedded in the daily activities within the workplace, it makes it a challenging topic to study within organizational cultures (Berg & Chyung, 2008; Eraut, 2000).

Summary

In summary, what is already known about how people learn informally in the workplace?

- Informal learning encompasses all types of learning that occur outside of the classroom or formalized curriculum activities (Boud & Middleton, 2003; Eraut, 2000; Garrick, 1998; Marsick & Volpe, 1999; Solomon, Boud, & Rooney, 2006).
Informal and formal learning are not dichotomies, but rather workplace learning experiences shaped by structural practices associated with work practices (Jubas & Butterwick, 2008; Sawchuk, 2008).

It is not an individual activity, but embedded into social contexts, workplace organizational structures, and subcultures (Billett, 2001; Boud & Middleton, 2003; Koopmans et al., 2006; Lave & Wegner, 1991).

It involves interactions with others within the workplace context: managers, peers, other professionals, patients, and families (Berg & Chyung, 2008; Boud & Middleton; 2003; Lave & Wegner, 1991).

Informal learning is tacit and implicit; triggered by learning events from the past and present; and can influence future behaviours (Eraut, 2000, 2004);

It is intuitive and analytical in nature, and it involves reflective deliberation; planning, evaluation, problem solving, and reflecting; and making sense of one’s own experience (Benner, 1984; Dewey, 1933; Dreyfus & Dreyfus, 1980; Eraut, 2000; Schon, 1983).

It involves looking at situations from different angles, searching for ways to frame problems, and developing new approaches for future application in similar workplace situations (Benner, 1884; Eraut, 2000; Hunter, Spence, McKenna, & Iedema, 2008; Tanner, 2006).
How Nurses Learn in Clinical Practice

Professional Knowledge

“Nursing, medicine, law, social work and other like practice disciplines involve a curious mix of science, technology, praxis and include the working out of knowledge, inquiry, and relationships in practice” (Benner, Hooper-Kyriakidas, & Stannard, 1999, p. 19). Given what is known about how people learn informally, what can be applied to how nurses make sense of their everyday workplace? Historically, professional roles such as nursing developed according to how those professions were connected to the larger society. During the early 20th century, large-scale organizations favored specialization, and specialized occupations were created based upon the emergence of new scientific knowledge (Carr-Saunders, 1928).

Professional knowledge is hierarchical in nature and involves problem solving, general principles, and the application of specialized knowledge to real-life complex situations (Moore, 1970). Professions have been defined as roles that are grounded in systematic, fundamental knowledge, specialized, firmly bounded, scientific, and standardized (Glazer, 1974). Three basic elements of professional knowledge include a common science core, followed by the applied science elements and a practicum or clinical work commonly referred to as the attitudinal and skill components. The acquisition of the skills traditionally occurs simultaneously or later in professional education and depends on the availability of patient situations. Both basic and applied sciences are convergent, whereas practice is divergent, and practice problems have unique and unpredictable elements (Schein, 1973).
The exploration of how people obtain professional knowledge stems from researchers who have examined working lives from diverse perspectives. How people learn from practice is different from the traditional academic viewpoint, and there is a mystique associated with the acquisition of practical competence (Argyris & Schon, 1974; Schon, 1983). Practitioners usually are unable to describe their knowing, and people commonly use terms such as art and intuition to try to explain the phenomenon (Benner, 1984; Schon, 1983). It is well recognized that there is an element of art in professional practice and that the complexity of day-to-day professional practice challenges professionals to solve problems on the spot based upon past experiences (Argyris & Schon, 1974).

Reflective Learning in Practice

In recent years, professionals have begun to recognize that when they are confronted with complex situations, their ability to observe and reflect on past experiences to develop new solutions is the art of good practice. Schon (1983) commented, “When someone reflects-in-action, he (she) becomes a researcher in the practice context” (p. 65). Professionals rely on technical expertise gained through knowledge and practice, so “reflection-in-action is not generally accepted as a legitimate form of professional knowing” (Schon, 1983, pp. 68-69). Therefore, professionals become comfortable with technical expertise that addresses the norm in most circumstances, but they fail to recognize when their efforts fall short in unique situations.

The opportunity to apply reflection in action may be inhibited by the constraints of the professionals’ work setting. For example, teachers are required to adhere to standardized curriculum tasks and lack the freedom to reflect on their practice; they also
work in isolated classrooms and are unable to communicate with peers to test their views (Schon, 1983). “Nursing has been perceived as oppressed by virtue of among other things gender, occupation and class…historically, nursing education perpetuated the rituals of tradition and was oppressive in terms of what was taught and how it was taught” (Mooney & Nolan, 2005, p. 240). More recent developments in nursing education have resulted in nurse educators promoting transformative learning strategies that address the complexities of nursing practice and aim to emancipate nurses (Mooney & Nolan, 2005; Newman, 2008).

Development of Nursing Expertise

Traditionally, nursing has been studied from a sociological perspective that examines role relationships and socialization, but very little actually has been learned about how nurses learn from their clinical practice and share their expertise with other nurses (Benner, 1984). The early work of Benner et al. (1996, 1999) changed the way in which nurses perceive new nurses entering the field and placed real value on expert nurses as mentors and guides to new nurses. Learning challenges faced by beginners as they assume their practice roles include the following:

1. Minimal capacity to attend to the person as a whole and see patients as complex and perplexing.

2. Inability to recognize concrete manifestations of clinical signs and symptoms that they may have only studied theoretically.

3. Reliance on theory and principles learned in basic education and trust that clinical situations will unfold in a discernible order that can be solved with sufficient knowledge of the body and procedures of care.
4. Perception of clinical situations as a test of their personal knowledge and skills that creates anxieties in the beginner about personal insufficiencies in the face of the demands of complex clinical practice situations (Benner et al., 1996).

Different levels of agency or influence vary with expertise and “experiential learning is required before practitioner’s actions are guided by recognizing patterns to respond to the actual situation” (Benner et al., 1996, p. 14). For example, novice nurses’ agency is limited to their clinical understanding and expertise in specific clinical situations where they lack experience; on the other hand, competent nurses’ agency is enacted by achieving goals, developing plans, and making choices (Benner et al., 1999).

In a study of critical care nursing practice, Benner et al. (1999) conveyed that proficient nurses told stories of how they were able to read clinical situations as they unfolded before their eyes and engaged in reasoning that responded to the demands of the clinical situations based upon their past experiential knowledge and embodied knowledge. Other researchers have noted that clinical and ethical reasoning are inextricably linked to clinical practice and that learning to make safe and competent clinical judgments requires ongoing experiential learning, reflection, and discourse (Benner et al., 1999; Lowe, Rappolt, Jaglal, & MacDonald, 2007; Tanner, 2006). Clinical learning is experienced as a story, so experiential learning must be constructed as narratives to capture the agency, temporality, and practical understanding of the situation (Benner et al. 1999). Educators have widely advocated the use of critical reflection to facilitate learning, which is used primarily in complicated or uncertain situations.
(narratives) to enhance learning and practice changes (Eraut, 2004; L. Perry, 1997; Tanner, 2006).

**Nursing Preceptorship**

A strategy that has been considered valuable when preparing new nurses for entry to practice is preceptorship. Preceptors help to guide the transition and integration of nurses and student nurses into the workforce (Dracup & Bryan-Brown, 2004). Preceptoring promotes critical thinking and ethical decision making, and it provides many benefits to the learner, such as (a) bridging the gap between theory and nursing practice; (b) fostering critical thinking and career development, increasing self-esteem, enhancing managerial skills, promoting a sense of professionalism; and (c) acting as a recruitment and retention strategy for health care organizations (CNA, 2004; Myrick, 2002; Registered Nurses Association of Ontario [RNAO], 2006; Ryan-Nicholls, 2004).

**Learning Needs of Nurses in Specialty Practice**

In the nursing workplace, there exist formal learning (seminars, lectures); informal learning (mentoring); and preceptorship (partially structured) learning strategies. All of these strategies are used in the orientation of new nurses to clinical units. Hunter et al. (2008) asserted that the orientation of staff is a multilayered and complex process that requires managers to ensure that expert staff are available and that time is allocated in the busy workday for learning and reflection. Personal support and reflection are essential during the first year that nurses are hired, and researchers have recommended that safe practice environments should provide ongoing opportunities for learning well beyond the often too short formal orientation (Hunter et al., 2008; Linder, 2009).
What is known about the learning needs of nurses entering new specialty areas of practice is that (a) their learning needs are high and remain high throughout their first year; (b) the transition of new nurses affects all staff, and expert staff must provide considerable mentorship to assist new nurses in learning their new role; and (c) role transition is unsettling for new nurses and often results in stress, and because nurses bring expectations with them as they enter a specialty (new context), they may be unsettled by the clash between their expectations and the reality of the workplace, and may need supports to learn strategies to cope more effectively with their transition into a new context (Hunter et al., 2008; Rosser & King, 2003).

Cancer Context

Considering the treatment for cancer literally stood still for more than 3,000 years, the pace of change fostered by national and international clinical trials and oncology nursing research in the last century has been nothing less than stunning, and it is this warp speed era of discovery in which cancer nurses today find themselves working. (Wiernikowski, 2009, p. 79)

Canada’s ability to meet the growing demand for cancer care is facing unprecedented challenges. The number of newly diagnosed patients requiring treatment is increasing annually. The number of new cancers reported has more than tripled over the past 4 decades to an estimated 166,400 in 2008 from 49,600 in 1969. The number of new cases and deaths continues to rise, perhaps because of overall population growth and aging. New cases are not the only factor increasing the provision of cancer services; advances in treatment resulting in lower mortality rates and patients living longer also have contributed to the growing demand. As of 2004, an estimated 835,000 Canadians had lived up to 15 years following their cancer diagnosis, a figure double that of the estimated 413,600 living at least 10 years in 1990 (CCS, 2009).
Cancer Patients’ Experience

“The surgeon—a more genial and forthcoming one this time—can fit me in; the oncologist will see me. Welcome to cancerland!” (Ehrenreich, 2001, p. 45). During a (2009) CTV interview, actress Lisa Ray stated, “When I found out I had cancer, I didn’t cry, it was like ‘fading to black,’ an isolating experience” (n.d.). Psychological distress resulting in shock is an expected response to a cancer diagnosis and is experienced by all cancer patients to some degree, even those who normally cope well with emotional turmoil (Fitch, Porter, & Page, 2008). From the onset of symptoms to treatment, each person’s experience with cancer is shaped by a multitude of factors. The individual may enter the cancer care continuum at different points and move through the experience within variable time frames. The cancer care continuum is comprised of the following phases: prevention, screening, diagnosis, treatment, and rehabilitation or palliative care (Cancer Care Ontario [CCO], 2008).

The health care professionals encountered along the continuum include family physicians, public health professionals, oncologists, nurses, pharmacists, therapists, spiritual care providers, and community volunteers. As cancer patients encounter the health care system, they also typically require a number of diagnostic, treatment, and supportive care services, often at different facilities.

From the moment an individual thinks there might be something wrong with their body, throughout the course of the diagnostic investigation, treatment and follow-up care, the experience of living with cancer is a continuous one for that person and family. (Howell, Fitch, & Deane, 2003)

As soon as individuals are diagnosed, cancer-related events are embedded in their daily lives. The illness-related demands become part of everyday living and decision making” (Fitch et al., 2008, p. 14). The cancer experience is physical and psychosocial,
and individuals’ needs vary throughout the experience and change in intensity over the course of the illness, and unmet needs add to the burden of suffering and emotional turmoil that cancer patients experience (Charmaz, 1991; David, 1999; Gray, 2003; McLean, 1993; Phillips, 1998; Rosenbaum, 1982; Weisman, 1979).

Cancer patients will encounter many diverse settings and cancer care experts throughout the course of their journey. For example, Linda, whom we met in chapter 1, most likely would have had all her screening and diagnostic tests completed as an outpatient at a breast screening centre. Once her tumour had been detected, a biopsy would have been taken by a surgeon, who would have been working very closely with nurses; an anesthesiologist; and a pathologist, who would have been backed up by medical laboratory technologists to determine the presence or absence of cancer. A radiologist would have been involved in isolating her tumour site through innovative imaging techniques. During the process to establish her diagnosis, Linda would have been referred to an oncologist and a supportive care team that would have included a social worker and a spiritual counselor. Her surgeon would have consulted with a radiation and medical oncologist to jointly plan the most effective approach for her therapy. Surgery would most likely have been the first treatment selected and might have been performed as an in-patient or as a day surgery procedure.

Following in-patient surgery, and while recovering on the hospital ward, Linda would have been cared for by an ever-changing team of registered nurses, specialized nurses, and unregulated care aides/health providers, and she might have found it disorienting to deal with all of these care providers, along with a social worker, a physiotherapist, an occupational therapist, the surgical specialist, and a team of residents
in a teaching hospital. Thus, she might have been assigned a patient navigator to help guide her through the various procedures and decision points.

The protocols for treating her cancer could have involved radiation therapy, systemic therapy, or a combination of both, and she would have been seen by the radiation oncologist as well as the medical oncologist for treatment planning. These treatments would have been provided on an outpatient basis and would have involved repeated visits to the treatment centre over weeks, and months. In the radiation therapy suite, her treatment would have been planned by a medical physicist, who would have been working with a dosimetrist; delivered by the radiation therapist; and supported by cancer nurses. Though her treatment would primarily have been as an outpatient, she might have stayed in a cancer lodge, miles away from her family and supports. Systemic therapy would have been provided on an outpatient basis, unless there had been complications, and overseen by a cancer nurse, with the drugs prepared by a pharmacist or pharmacy technician. Linda’s treatment could have extended up to a year or more, and supportive care would have been made available to Linda throughout her treatment.

After a year, Linda would have been referred to a community-based program for ongoing treatment and rehabilitative care. If the treatment were successful, she would have been referred back to her family physician in the community for follow-up care. She would have been told that her cancer could reoccur, possibly resulting in further treatment cycles.

If pain and symptoms had reappeared, she would then have been referred for further treatment; if she had not responded to treatment, she would have been referred to the palliative care team. This community-based team would have included specialist
palliative care physicians and nurses, a wide range of supportive care professionals, and a bereavement coordinator for her family. Throughout all the phases of Linda’s cancer experience, she and her family would have been supported by a team of cancer professionals who would have provided specialized cancer services at certain points along the cancer care continuum. Of course, in an ideal world, all patients would have Linda’s experience, which followed neatly along the continuum of care. Of course, circumstances vary, and unfortunately, patients do not always find the necessary supports because of a multitude of factors within the cancer care system, one of them being the lack of qualified nurses to care for cancer patients.

*Delivery of Cancer Care*

Cancer patients and cancer survivors require ongoing care, including systemic therapy, supportive and rehabilitative care, follow-up care, or palliative care. Treatments are becoming more complex and require more resources and personnel working in other phases of the cancer control continuum, factors that create additional stresses on an already overburdened cancer workforce. Patient and family expectations are increasing, placing additional demands on cancer workers to manage these expectations. Rising health care costs also have created a competitive environment and have placed a strain on the limited health care dollars and health care professionals. Health care reform has been ongoing for nearly 2 decades, involving the increased regionalization of health care delivery, new approaches to primary health and patient-centred care, the development of electronic health records, an emerging focus on interprofessional education, an emphasis on performance measurement, and reductions in wait times in key areas (Hayter, 1998).
Delivery of cancer care has historically been marginalized from mainstream health care, and it has become more integrated with acute care health delivery and initiatives for chronic disease prevention and management only recently. Canada’s publicly funded cancer control system originated in the 1920s when several provinces purchased the expensive radium needed for treatment. Centralized cancer care organizations were established in Saskatchewan and Manitoba in 1930 and in British Columbia in 1935. In the 1940s, Alberta and Ontario also implemented cancer foundations (Hayter, 1998). During the 1970s and 1980s, the principles of primary, secondary, and tertiary disease control were developed, and the cancer control continuum expanded to include prevention, screening, early detection, curative treatment, supportive and rehabilitative care, and palliative care. Adjuvant chemotherapy and systemic therapy protocols became more common in the late 1970s, eventually resulting in more treatment being delivered as an outpatient, or community, service (Kennedy, 1999).

In 1996, collaborative efforts led by the Canadian Strategy for Cancer Control (CSCC), which brought the CAPCA, the National Cancer Institute of Canada, the CCS, and Health Canada together with a broad spectrum of cancer stakeholders, including patient advocates. The CSCC (2002) had five main priorities, three of which were human resources, rebalancing of the focus to include prevention as well as supportive and palliative care, and standards. In 2001, the Canadian Strategy for Palliative and End-of-Life Care considered care needs for all terminal conditions, including cancer.

More recently, in 2006, the CPAC was established. The cancer control strategy goals of CPAC are to (a) reduce the expected number of new cases of cancer among Canadians, (b) enhance the QOWL of people living with cancer, (c) lessen the likelihood
of Canadians dying from cancer, and (d) increase the effectiveness and efficiency of the cancer control domain (CPAC, 2008; CAPCA/CPAC, 2010). It will be interesting to note over the next few years how Canadians respond to whether the cancer system is meeting their needs and whether outcomes show an improvement in the overall quality of cancer care services.

*Cancer Nursing Workforce*

Projections indicate that there will be a shortage of 113,000 nurses by 2016 (CNA, 2006). Canada’s nursing workforce is in transition, and the paucity of information about cancer nurses, plus the lack of information about the services that they actually provide to cancer patients, is a serious obstacle to effective planning (CIHI, 2007; CNA, 2006). Very little information regarding the actual number of nurses providing cancer services, where they are located, and the types of care they are providing to patients across the cancer continuum is available. However, even though considerable information is available from the CIHI about the regulated nursing workforce, information on oncology is limited.

Overall, the number of RNs employed in nursing in Canada increased steadily from 1980 to 1992 by about 50%; over the next years to 2002, the numbers employed declined slightly and then leveled off. In more recent years, the number of RNs employed in nursing rose by 4.8% from 241,342 in 2003 to 252,948 in 2006. Most RNs are female (94.4%). The average age of the RN workforce increased from 44.5 years in 2003 to 45.0 years in 2006, with 20.8% of RNs ages 55 years and over (CIHI, 2007). A profile of the average nurse working in oncology can be created using existing data on the average RN in Canada in 2006. The profile of this group of RNs showed that the average age was
43.6 years, with 95.4% female, and 16.2% ages 55 years and over (CNA, 2006). Most
Canadian RNs were educated in Canada (92.1%), with international graduates accounting
for 7.9%.

Trends in the nursing workforce have included the introduction of programs for
certification of nursing specialties in oncology and palliative care. In 2006, the number of
RNs with valid oncology certification rose to 1,332 (< 1% of the nursing population),
whereas another 916 of nursing population nurses possessed a valid palliative care
certificate (CIHI, 2007). Minimal changes in the employment status of RNs have
occurred since 2003; in 2006, 55.8% were employed in full-time positions, 32.5% in part-
time positions, and 10.8% in casual positions, with 1.0% having unknown status.
Relatively few nurses have worked in oncology: In 2006, 2,975 RNs (1.2%) were report
working in oncology direct care, more than double the 1,332 RNs with an oncology
certificate (CIHI, 2007). Nurses working in oncology were more likely to be employed in
hospital settings (78.5%; CNA, 2006). Although many nurses provide care to cancer
patients in medical or surgical wards, or in home and community care settings, the
contribution of these nurses to overall cancer control has not been explicitly defined.
Nurses employed in public health and health promotion, as well as in family practice,
may also provide cancer control services ranging from prevention through palliative care.

Most published data for RNs seldom have provided detailed information for
nurses working in oncology or possessing valid oncology certification. However, for
nurses working in oncology, profiles published on the CNA (2006) website have
provided information on age, sex, education, employment status, and place of
employment. In addition, as future nurses obtain this qualification, the numbers available for reporting and analysis will increase.

Projections in the supply of RNs have been fairly well documented in Canada. According to the Organization for Economic Cooperation and Development (OECD, 2008), there were 8.8 qualified nurses per 1,000 population in Canada in 2006, a figure less than the average of 9.7 in OECD countries. Recommendations are to increase enrollments in nursing education programs to attain 12,000 new nurses each year and to embark on efforts to increase the percentage of new graduates remaining working in Canada from 85% to 95% (CNA, 2002).

Demand factors contributing to the nursing shortage are population aging, changing disease patterns due to aging, and demand by hospital function; supply factors include nursing school enrollment, attrition rates, in- and outmigration, retirement and death rates, working conditions, job satisfaction, retention, and working hours. All of these variables contribute to the recruitment and retention of nurses into the cancer workforce, but the workplace conditions most often determine whether nurses remain in the cancer system or leave it.

Working Conditions of Cancer Nurses

Health care providers in general are the most stressed of all employed Canadians, with 45% reporting that most days on the job were quite or extremely stressful as compared to 31% of other workers (Canadian Community Health Survey, as cited in Wilkins, 2007). The National Survey on the Work and Health of Nurses (NSWHN, 2005, as cited in Shields & Wilkins, 2006) compiled information on working conditions for all regulated nurses, many of whom provide care to cancer patients. Survey results showed
that female nurses were more likely to work paid overtime (30.0%) than all employed females (13.3%), for an average of 5.3 hours per week. Unpaid overtime also was more common among female RNs than other female workers (49.7% vs. 26.1%), for an average of 4.0 hours per week. Overall, close to 3 in 10 RNs reported a high role overload score, which considered such factors as often arriving early or staying late to get work done (54%), often working through breaks to complete work (62%), having too much to do, and having to do everything well (57%; Shields & Wilkins, 2006). Close to half of all nurses in hospital settings reported working mixed shifts, and 41.1% reported working shifts of 12 or more hours in hospitals. Shift work also was common in long-term care facilities, but in community health and other settings, few nurses worked 12-hour shifts, and over 70% worked days. More nurses (27.0%) felt that the quality of care they delivered had deteriorated, as compared to 15.8% reporting improvement (Shields & Wilkins, 2006).

Several Canadian studies have explored stress and burnout among the cancer workforce. A study of systemic therapy teams in Ontario highlighted the negative consequences of burnout for individuals and organizations, which often translates into absenteeism, high turnover rates, and reduced productivity, and may possibly have an effect on quality of care (Grunfeld et al., 2000). Several studies have confirmed the high stress rates for nurses and have reported higher absence rates for full-time RNs (10%) than for all full-time workers (7%); in the NSWHN (2005), 31% of nurses reported high job strain, 45% low coworker support, 25% low supervisor support, 62% high physical demands, and 12% job dissatisfaction, as compared to just over 8% of the total employed population (as cited in Shields & Wilkins, 2006).
Greenslade and Paddock (2007) noted that nurses experience significant workplace health and safety risks, including on-the-job injuries (8.9%); needlestick or sharps injuries (11.4% in past 12 months); physical assaults from patients (28.8%); and emotional abuse from patients (43.6%); in addition, 47.8% were concerned about their own risk in contracting a serious disease in the workplace. Back injuries were more common among female nurses (25%) than all employed females (19%), and higher proportions of nurses reported depression, arthritis, high blood pressure, among other conditions. More than one third of the nurses reported pain in the last 12 months that affected normal activities; the pain was severe enough in the past 6 months that it affected the ability of nearly one quarter of the nurses to do their jobs.

Overall, Greenslade and Paddock (2007) reported that just over 3 in 10 nurses commented that their physical and mental health made it difficult for them to handle their workload in the past 4 weeks. Not surprisingly, work absences due to any health problem were reported by 61% of the nurses; the average days missed was 23.9% per annum. The CNA (2006) reported that the total work time loss due to absenteeism represented 9,754 positions and contributed to overtaxing an already stressed health care system.

Although data in the CNA report (2006) related to all nurses working in Canada, cancer nurses are likely to experience similar working conditions. Research has shown that cancer nurses who deliver chemotherapy are at considerable risk because of their lack of education about the risks of administering chemotherapeutic agents, and the CANO (2006) embarked on developing national standards that include education about safe handling of chemotherapy agents. In a study on the QOWL of oncology nurses, the results indicated
That factors that place oncology nurses at greater risk for poor QOL, particularly in the psychological and social domains, include being 40 years of age or older, having a lower education, being divorced or widowed, working longer than 40 hours per week, and working in unsafe conditions. Additionally, nurses working in oncology who do so by mandate, and not by choice, are at a greater risk for poor QOL. (Ergun, Oran, & Bender, 2005, p. 198)

CNP as a Specialty

Nursing is concerned with the experience of health and illness, the promotion of independent functioning, and the provision of physical and emotional support for individuals and families. Nurses work with patients and their families throughout the cancer experience, providing care, coordination of the plan of care, education and counseling, and referral to community and other resources to meet the person’s on-going needs. (CANO, 2006, Standard of Care section)

To obtain the true picture of nurses working in cancer care, one must know about the types of services and the amount of time nurses spend providing care to cancer patients. Although some knowledge exists about how many specialty cancer nurses currently work in Canada, little is known about what contributions other nurses make toward the care of cancer patients. Information on the services that cancer nurses and other nurses provide is needed in order to understand how best to deploy the cancer nursing workforce.

Before nurses can practice in the cancer care setting, they must become RNs. Most provinces in Canada now require a baccalaureate in nursing (BN or BScN) to become an RN, which is typically a 4-year program (CNA, 2006; Canadian Association of Schools of Nursing [CASN], 2008). A number of colleges in Quebec offer diploma programs with the option of continuing after completion to a degree program. In Alberta and Manitoba, most students enter a diploma program and can then progress seamlessly into a baccalaureate program because of articulation agreements set up for this purpose. Most nursing diploma programs have merged with baccalaureate programs following the
announcement by the CNA (2006) that entry to practice requires a minimum of a 4-year baccalaureate degree.

Fast-track programs also are offered in an effort to train more nurses and permit students to complete their education in less time than traditional programs. Such programs include accelerated/compressed, second-degree entry, advanced entry, and bridging programs. In the 2006-2007 academic year, 38 fast-track nursing programs were available in Canada, an increase of 19% from 2005-2006 (CNA, 2006; CASN, 2008).

Cancer nursing, which has been available only for the past 25 years, is a relatively new specialty in the field of nursing. Nursing leaders in the field are just beginning to identify a distinct knowledge base. National professional organizations in both Canada and the United States are dedicated to oncology nursing. The International Society of Nurses in Cancer Care also represents cancer nurses around the world. The CNA offers certification in 17 specialties, one of which is CNP. RNs working in oncology for at least 2 years can attain the distinction of Certified in Oncology Nursing (Canada; CON[C]) once they successfully complete the certification exam offered by the CNA. Nurses are being encouraged to seek certification, though it is not yet a mandatory requirement to take the exams as a condition of employment (Hughes et al., 2001).

During the past decade, the number of jobs in oncology, as well as the number of specialized units dedicated to caring for cancer patients and their families, have been increasing. These positions require a minimum of 2 years of nursing experience, but most nurses have 5 to 10 years of experience prior to assuming a position in oncology. Nurses enter the specialty at an older age; historically, they tend to stay in the specialty longer than in other comparable specialties. Nurses have a high level of commitment to the
specialty and participate in many informal and formal continuing education opportunities (CANO, 2002). More recently, the trend has shifted to hiring new graduate nurses because the workplace is experiencing a severe shortage of nurses in all areas of nursing practice. This trend creates a new dynamic and impacts existing orientation programs because these new graduates are not only adjusting to the role of a new graduate but also are simultaneously learning a new specialty area of practice.

CNP Education and Certification

In 1987, Tiffany proposed three categories of cancer nurses. Generalist nurses may care for cancer patients within an assigned caseload and are prepared at the basic educational level. Generalist nurses graduate from a diploma or a baccalaureate program and will often work in settings where cancer patients receive care along with other patient populations (e.g., emergency unit, surgical unit, or community). Nurse are designated as generalist nurses upon first entering into a setting where the primary care is cancer care, and they may move to the next level once they have acquired additional knowledge, through in-service education, continuing education, skill development and practice, and clinical experience in a setting where individuals with cancer and their families are the prime focus of care.

Specialized cancer nurses care for patients in specialist centres or work with cancer patients as a specialized population in hospitals or communities. Oncology nurses have taken a formal training program and may hold a nationally recognized qualification. Specialized cancer nurses have a combination of expanded education and experience focused on cancer care, such as 2 years in a setting delivering primarily cancer care. Specialty education may be acquired by specialized cancer nurses through enrolment in
an undergraduate nursing program, completion of an oncology certificate program, distance specialty education, or registration in and attainment of the Canadian oncology nursing certification.

Advanced practice cancer nurses are experts in one aspect of oncology nursing and are supported by advanced preparation (Tiffany, 1987). Advanced practice cancer nurses are prepared at the master’s level (MScN or equivalent), where ideally, the graduate program focuses on oncology nursing, with a particular emphasis on a subpopulation or area within cancer control, or a subspecialty within cancer care such as psychosocial care and counseling (CANO, 2006). In this study, newly hired cancer nurses were considered either generalist nurses or new graduate nurses in the process of making a transition to the specialized cancer nurse role.

Quality of Work-Life Issues in CNP

QOWL is another important dimension of cancer care, and “much of the satisfaction cancer nurses’ experience in their practice emerges from matters related to attending to quality of care issues” (Fitch, 1998, p. 24). Larson (1992) suggested that cancer nurses could be more susceptible to burnout because of such common situational stressors as not enough time, lack of support, and unrealistic expectations of themselves. The stress of adapting to cancer nursing and all of its many challenges can result in burnout resulting from unrelieved stress; therefore, it is critical to provide resources at stressful times to support nurses personally and professionally (M. Z. Cohen, Haberman, & Steeves, 1994).

Researchers have maintained that the reasons nurses specialize in cancer nursing are similar to professional and personal rewards derived from their daily practice. Studies
examining the personality profiles of cancer nurses have concluded that they tend to be warm, friendly, and interested in people; they also are empathetic and insightful, and have relatively high scores in primary factors of emotional sensitivity and imagination (Bean & Holcombe, 1993; Gambles, Wilkinson, & Dissanayake, 2003). Haberman, Germino, Maliski, Stafford-Fox, and Rice (1994) identified the factors that shape the career life cycle trajectory of cancer nurses: critical incidents or life-changing events, patient and family outcomes, orientation, the nature of daily work, role balancing, influential role models, the environmental culture of cancer care, role diversity, and specialization.

Conceptual Framework

Researchers in professional domains such as education, nursing, medicine, law, psychiatry, counselling and psychology increasingly are becoming aware of the importance of interpretive models that place human situatedness central and are based on the belief that we best understand human beings from the experiential reality of their lifeworlds. (van Manen, 1997, p. xi)

In this study, the 15 cancer nurses struggled to make sense of their everyday lives and the critical incidents that triggered informal learning opportunities. At the heart of the study were the newly hired nurses (the learners) in cancerland, working side by side with patients, families, peers, managers, and other health professionals, and experiencing the turbulence inherent in daily practice life.

For the most part, their learning was informal and driven by real-time practice needs that cannot always be anticipated in a dynamic health care environment. This dilemma is commonly referred to as the theory-to-practice gap, the “Grand Canyon” between formal and informal learning. The ways in which learners bridge the gap in between, that is, the hybrid spaces” (i.e., at the bedside, coffee breaks, staff lounges, car
rides to work, in the elevator) remains a relatively unexplored phenomenon (Solomon et al., 2006).

For example, even though I had extensive experience working with patients, when I first cared for Linda, I lacked the cancer-specific knowledge and skills required to competently administer her treatments. I had difficulty providing supportive care to my patients because I did not know what to say about possible treatment-related side effects and complications. During orientation, my identity was challenged, and I felt despondent, lost, and useless. I had lost my legitimacy as an experienced nurse and had reverted to being a novice nurse, dependent on others to regain competency in this new workplace setting.

Formal learning (i.e., cancer courses) had given me basic information on types of cancer and skills, but it was not until I worked alongside Carol in the chemo unit that theory came to life and my confidence grew. My conversations with Carol over coffee in the staff room provided the (hybrid) space to reflect on the emotional, intellectual, and practical challenges that confronted me on a day-to-day basis. A few months later, after a tough day in the chemo unit, I said to Carol, “I think I am getting the hang of this cancer stuff,” and Carol said to me, (laughing), “Oh- now you are becoming one of us – [looking up] heaven help us!” My reflective, interactive process of learning on the job supported the position that “individual learning is socially embedded, but social learning is also shaped by how individuals understand and articulate their realities” (Church, Bascia, & Shragge, 2008, p. 15).

Reflecting on that pivotal moment, I realized that informal learning that occurs as the result of necessity shaped by the organizational context can assist novice nurses in
making sense of their practice. Informal learning is implicit, intuitive, and automatic, and it occurs in a social context that is shaped by cultural norms and expectations. Eraut (2000) stated, “The knowledge gained is constructed in a social context whose influence on what is learned, as well as how it is learned cannot be denied” (p. 131). “Context permeates every phase of the learning process—from how the learner will understand the situation, to what is being learned, what solutions are available, and how existing resources will be used” (Cseh, Watkins, & Marsick, 1999, p. 352). In practice settings, formal and informal learning go hand in hand, and informality and formality in learning are expressed as a relational continuum rather than dichotomous categories/binaries (Billett, 2006; Colley, Hodkinson, & Malcolm, 2003; Jubas & Butterwick, 2008).

Because the study involved interviewing nurses in transition between new and old contexts and at different points in transition, working in diverse contexts, and coping with individual and structural factors, it was essential that the framework for the study be dynamic. The study was guided by one universal concept regarding transitions, namely, that having an awareness of the meaning of the transition for the individuals is essential to understanding their experiences and the consequences. Primarily, I was focused on exploring one question: What is the lived experience of nurses learning to transition into CNP? I knew that I was going to be interviewing nurses from a variety of cancer settings and that each nurse would be at a different phase of transition and coping with distinct individual, organizational, and interpersonal factors. The conceptual framework had to be flexible so that I could capture the meaning of the transition experience for each nurse.

The framework for the study was based upon the stages of transition identified by Allen and van de Vliert (1984): antecedent conditions, role transition and role strain, and
reactions and consequences. The antecedent conditions contributing to the nurses’ entry into their positions in CNP included prior experiences, intention, and recruitment and selection processes. Role transition represents a separation from the old role and the adoption of the new role expectations and standards for behaviour. The change in role, regardless of being perceived as a positive or a negative experience, produces role strain. Role strain is the subjective counterpart of the actual role stressors that are inherent in a role change that requires individuals to assume a new set of values, attitudes, and behaviours.

The level of intensity of strain produced by role transition varies from one individual to another, and is dependent on the presence or absence of such moderating factors as individual factors (knowledge, skills); organizational factors (context); and interpersonal factors (social support systems). The questions that guided the study were reflective of the phenomenon of making sense of everyday life experiences and were organized according to the stages of transition experienced by the newly hired nurses working in the cancer care setting.

I developed an interview protocol based upon the conceptual framework. The questions were designed to act as triggers to illuminate the nurses’ reflections on critical incidents that occurred during their transition into the cancer workplace. The nurses were asked to reflect on their experiences related to the following states of transition:

Antecedent Conditions

1. What are the factors (personal, professional) that influence the nurse’s intent to assume a position in oncology nursing?

2. What are the prior work experiences that are congruent with the knowledge
and skills required to function as an oncology nurse?

Role Transition and Role Strain

1. What are the experiences of oncology nurses during their initial orientation?

2. What are the supports (formal, informal) that impact the oncology nurses’ transition into their role?

3. What skills/competencies are unique to the oncology nurse’s role?

4. How do oncology nurses cope with role strain during their transition into their role?

5. How do the oncology nurse’s experiences compare with their prior work experiences in regard to emotional demands on self?

Reactions and Consequences

1. How do nurses’ expectations of oncology nursing compare to their experiences as oncology nurses?

2. How do newly hired oncology nurses compare their QOWL to their other nursing experiences?

3. What are the circumstances that contribute to the nurses’ adoption of their identity as oncology nurses?

Prior to beginning the study, I was aware that the conceptual framework would evolve throughout the course of the study and be shaped by the unique perspectives of the nurses during their transition into cancerland. The questions were reflective of the phenomenon of role transition, but they were not prescriptive and only acted as a guide. During my interactions with the nurses, I realized that they wanted to tell the whole story of what it was like to become cancer nurses, so I needed to let those stories unfold
uninhibited. Their narratives reflected the challenges inherent in the learning process. The nature of their learning was informal; triggered by events; guided by supports; and, most importantly, embedded in the context (cancerland).

Later, following the interviews, and during the analysis of the transcripts, I realized that contextual factors influenced the way the nurses made sense of their transition into a new practice setting. It was at this point that I developed the framework of making sense of CNP based upon the stages of transition (Allen & van de Vliert, 1984); the three central issues involved in informal learning (Eraut, 2004); and the contextual factors affecting learning (Cseh et al., 1999; Ellinger, 2005). This framework provided a lens to examine how the nurses made sense of their transition into CNP (see Table 1).

Table 1

*Conceptual Framework*

<table>
<thead>
<tr>
<th>Newly hired nurses</th>
<th>Making sense of CNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverse contexts: in-patient; outpatient; urban, rural, &amp; remote</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Stages of transition</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antecedent……role transition &amp; role strain……reactions &amp; consequences</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What is being learned?</th>
<th>Learning needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer knowledge, role development, personal coping mechanisms, problem-solving and decision-making skills, teamwork</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>How it is being learned?</th>
<th>Ways of learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interacting with patients and families, on-the-job learning with nurses and others, participation in team activities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What factors are affecting learning?</th>
<th>Facilitators and barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning culture, structural supports, open and accessible people, leadership commitment to learning</td>
<td></td>
</tr>
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</table>
CHAPTER 3: METHODS AND DATA ANALYSIS

Introduction

Experience itself is just one thing after another, and you try to pattern it by organizing and to make sense of it by reflecting, by turning back on yourself and reflecting on your own stream of experience. You ask yourself, “How does this world present itself to me? Against my own background, my own biography?” (Greene, as cited in Ayers & Miller, 1998, p. 2)

I agree that life is a series of events that can result in inertia and lack of action if left unconnected; however, if people can look back, remember, and make sense of their connections to people, places, and events, they can make sense of their lives. My inquiry into how nurses new to cancer care made sense of cancerland began as the result of my own orientation to the specialty of cancer nursing. As part of my master’s degree, I undertook an oncology clinical placement at a large urban cancer facility. I become aware of how the field had expanded over the previous 20 years and now included a distinct body of oncology nursing knowledge that spanned several oncology subspecialties.

Following graduation, I obtained a position in a smaller cancer facility as a clinical nurse specialist. I struggled during my orientation with intense emotional reactions to the plight of patients and their families, and at one point, I thought that I was not cut out to be a cancer nurse. At the time, I was fortunate to be working in an environment of seasoned practitioners who understood the struggles of those just entering cancerland. I connected with them, and they helped me to learn how to pace myself through the first few months, which turned into years of gratifying work that shaped my future profoundly.
It was because of my own struggles that I developed an orientation program based upon my experiences and guided by the core concepts more recently outlined by the CANO (2002, 2006). During the program, I had nurses discuss their personal and professional experiences with cancer to help them to cope with the culture shock of being in cancerland. Even though most of them had gained extensive experience working with patients in other specialty areas as well as cancer patients occasionally on their respective units, they had never worked in an environment of 100% cancer patients. They often expressed feelings of being unprepared to talk to the patients and families about cancer and would admit that they did not know what to say to these patients about their disease and treatment protocols.

The nurses also lacked cancer-specific knowledge and skills that would enable them to competently administer treatments and provide supportive care for patients with treatment-related side effects and complications. Their poignant stories of facing the stresses of living with or working with cancer patients and their families paralleled my own struggles when I first entered cancerland and cared for patients such as Linda. The nurses’ emotional, intellectual, and practical challenges resonated with me as they learned to transition into CNP.

A number of questions arose in my mind while reflecting on these experiences: How can one become better prepared to deal with the emotional teeter-totter of working with cancer patients? What do nurses need to learn to survive the first few months? What supports can be provided to guide their learning? My search for an understanding of how to guide the learning process resulted in a pilot study to explore why nurses chose cancer
nursing, followed by this study, which was designed to examine nurses’ experiences while learning to transition into CNP.

Throughout the process of developing, conducting, analyzing, and writing this dissertation, I asked myself two questions: (a) “What is my philosophical stance on learning?” and (b) “What are my philosophical underpinnings as a researcher?” I experienced my work as continually evolving and expanding as new questions emerged from the text, literature, reflective activity, and writing. At times, I felt overwhelmed, intimidated, and in awe of the power of the text to speak to me. During this long and arduous process, the only “constants” were my gaze sharpening, the ground (data) continually shifting beneath, cracks opening, and light shedding in (insights) to illuminate the phenomenon. It was not until I spoke (personal diary, 2010) with a colleague, who shared a passage from Gadamer (1989), that I understood this experience was not unique: “To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one’s own point of view, but being transformed into a communion in which we do not remain what we were” (p. 371).

What Is My Philosophical Stance on Learning?

Educational philosopher, Dewey (1938) asserted that pedagogy arises from praxis and that praxis informs pedagogy. It is interesting to note that 69 years later, van Manen (2007) stated, “In some sense all phenomenology is orientated to practice-the practice of living” (p. 13). The idea that lifelong learning is the dynamic ability of being and a necessary response to postmodern education was inspired by Dewey. I believe that having knowledge is irrelevant unless “learners in the being mode try to enrich and widen
their thoughts and theories concerning the contexts they encounter and make them flexible” (Su, 2011, p. 59).

The conceptual underpinnings of the study related to “learning to transition,” and the participants were nurses entering into CNP. I have spent half of my 40-year career as a nurse teaching nursing students and the other half in practice in a variety of roles (e.g., staff RN, clinical educator, clinical nurse specialist, and nursing administrator). My thoughts on learning are essentially grounded in a postmodernist viewpoint. Learning is about making connections between the individual and the social world, whereas knowledge is tentative and multifaceted, not necessarily rational. During the process of developing the proposal for this study, I conducted an extensive review of social learning theories and the ways in which nurses learn in clinical practice. I concluded that practice-based learning is a fusion of theory and practice, that is, praxis. Therefore, nurses primarily learn in the workplace through informal learning triggered by everyday events. Informal learning is summarized in the literature review as integrated in daily routines; triggered by an internal or external jolt; is not highly conscious; and can be a “by chance,” inductive process of reflection and action, linked to others and learning from experience.

Upon reflection (personal diary, 2005), I remembered a critical incident from my career that jolted me into the realization that powerful learning occurs in the heat of the moment, that is, when it is the least expected. This revelation inspired me to want to know more about how nurses entering CNP learn to care for their patients. I determined that relatively few studies had explored nurses’ transitions into CNP. I also knew that exploring learning in practice would require a naturalistic method of inquiry that would
emphasize understanding the human experience as it is lived. Next, I determined that I
needed to examine more closely my thoughts on being a researcher in the naturalistic
paradigm, which included the following assumptions: multiple truths exist, truth emerges
from the data to illuminate meanings, there is interactivity between the participant and the
researcher, processes must be inductive, design must be flexible, descriptions must be
thick, emerging interpretations must be grounded in the participants’ experiences,
differences rather than similarities characterize different contexts, context is critical, and
the reader does the generalization (Gadamer, 1989; Heidegger, 1962; van Manen, 1997).
This realization caused me to pause and reflect upon my past experience as a researcher,
the phenomenon that I was about to study, and what my phenomenological approach
would be.

What Are My Philosophical Underpinnings as a Researcher?

At the outset, the task at hand was to situate my ontological (i.e., being, that
which is) and epistemological (i.e., what is known, knowledge) position as a researcher.
When I began my doctoral work a decade ago, I considered myself a novice researcher,
so making a decision to embrace an interpretive phenomenological approach was a
lengthy one. During the process of writing my proposal, I reflected on (personal diary,
2005) how I had conducted my master’s thesis, which was an exploration of patients’
perceptions of caring. I used a descriptive phenomenological approach, and my
assumptions were based upon Husserl’s (1970) philosophical ideas of the universal
essences common to all persons who have lived experience. When conducting my own
analysis, my supervisor provided me with guidance on how to navigate Colaizzi’s (1978)
steps of analysis. In 1990, it was uncommon for nurse researchers to use qualitative
approaches, but today, many studies follow a qualitative design because the philosophical underpinnings are consistent with the core nursing values of the uniqueness of the person; the importance of personal discovery; and the need for an exploration of meaning, personal growth, and therapeutic use of self (Loiselle, Profetto-McGrath, Polit, & Beck, 2004).

Because I had previous experience with the descriptive paradigm of phenomenology, it would have been a comfortable space in which I could remain fixed, but I soon realized this would have required bracketing my previous experiences as a cancer nurse, something that would have been in conflict with my desire to fuse data generated from the interviews with my experience, as described by Koch (1996). I also realized when presenting my findings that I would not be able to consider the cancer context.

Next, I turned to grounded theory, a method used to generate new theory (Loiselle et al., 2004), but again, the main problem was I would have had to bracket out my personal experiences and assumptions. Similarly, ethnographic approaches that focus on learning about other cultures other than our own and gathering information through firsthand observations (field work) and questions of the participants (Loiselle et al., 2004) would not fit with conducting telephones interviews with nurses across the province learning to transition into the different cancer nursing settings. The nurses whom I interviewed lived between 100 and 1,000 miles away, and the interviews were conducted by telephone. The purposeful sample representative of the phenomenon was obtained through nurse administrative contacts in diverse cancer contexts. They distributed
research packages to nurses who met study criteria and were interested in sharing their experience transitioning into CNP.

As the researcher, my approach included conducting in-depth interviews with nurses experiencing the phenomenon of learning to transition into CNP within a framework of interpretive phenomenology; which involved reflecting on the nature of reality (Gadamer, 1989; Habermas, 1979; Heidegger, 1962; van Manen, 1997).

“Phenomenological reflection is not introspective but retrospective…reflection on lived experience is always re-collective; it is reflection on experience that is already passed or lived through” (van Manen, 1997, p. 10). The method of interpretation proceeds through a dialectical movement between the whole and the parts of the text and between understanding and explanation. This methodology requires that researchers be “open” so that the text can talk to them (naïve understanding) and includes structural analysis, which involves identifying essential meaning units that are condensed into subthemes and main themes. All themes are then summarized and reflected upon in relation to the research question, context of the study, and relevant literature to help researchers deepen their understanding of the text. The results are presented in everyday language as close to the lived experience as possible.

Why are interpretive approaches suited to studying the lives of nurses making the transition into cancer care? In the past 2 decades, nurse researchers have embraced the interpretive approach, which has resulted in a more in-depth understanding of patients, families, health care professionals, and the health care system, all of which shape clinical judgements in everyday practice (Benner et al., 1996; Koch, 1999; Tanner, 2006). The interpretive, phenomenological approach was chosen for this study because of the
abstract and complex nature of the concept of making sense of a new social context. The phenomenological approach gave voice to the nurses who were transitioning into CNP. They disclosed their narratives to me, precipitating the process of making meaning of the phenomenon through interpretive approaches.

Throughout the process of inquiry, I became more reflective and aware that I needed to understand my own position about the nature of reality as objective truth or subjective meaning. I came to recognize that in my position as inquirer, I could not totally understand the minds of the participants, nor could I truly recover past experience because as an individual, I was grounded in my own historical context. My interpretation was different from that of others, but through a shared reality of language and tradition, common understandings were arrived at through discourse that facilitated the emergence of meaning as I engaged with the text (Heidegger, 1962; Koch, 1999; van Manen, 1997). Current events as well as stories from my past experiences became part of the reflective process. I also asked myself several questions: What am I to make of the text? What is it getting at? When the participants told me their stories, I believed them and accepted them as their reality. I did not bracket my understanding; instead, I incorporated it into the interpretation of the story (Gadamer, 1989; Heidegger, 1962; van Manen, 1997) and looked beyond or between the lines, searching the text for hidden meanings (Habermas, 1979).

Van Manen (1997) contended that the methodological structure of interpretive phenomenological research may be seen as a dynamic interconnectedness among six research activities:
1. turning to a phenomenon which seriously interests us and commits us to the world [developing the research question with my committee in response to a pilot study I conducted in 2003]
2. investigating experience as we live it rather than as we conceptualize it [interviewing a purposeful sample of nurses from diverse cancer contexts]
3. reflecting on the essential themes which characterize the phenomenon [naïve reading of the texts, reading relevant literature and creating a diary of thoughts and insights throughout the process and being ‘open to’ what the text was saying to me]
4. describing the phenomenon through the art of writing and rewriting [writing and re-writing the findings chapters through dialogue with my thesis committee members]
5. maintaining a strong and oriented pedagogical relation to the phenomenon [personal diary of questions about the phenomenon, seeking further wisdom from the relevant literature, the text and asking questions of my thesis committee and others]
6. balancing the research context by considering parts and whole [stepping back and examining the text, re-reading parts to see how they become whole and expand the understanding of the phenomenon]. (pp. 30-31)

I found this process to be one of scholarship, and even though there are no definitive procedures for conducting phenomenological research, this type of research can best described as “interpretive sensitivity, inventive thoughtfulness, scholarly tact, and writing talent of the human science researcher” (van Manen, 1997, p. 34). While conducting the research and analyzing the findings, I came to understand that “rigorous human science is prepared to be soft, soulful, subtle, and sensitive in its effort to bring the range of meaning of life’s phenomena to our reflective awareness” (van Manen, 1997, p. 18).

In preparation to defend my dissertation, I reflected yet again (personal diary, 2012) on my approach to studying the lives of nurses learning to transition into CNP, and I read again the literature related to the use of phenomenology to explore the lived experiences of nurses in practice. From 2008 to 2011, several articles were published regarding the use of phenomenological approaches in nursing research in journals. A
controversial editorial was published by Porter (2008), who suggested that it is possible that nurse researchers could “jettison the baroque intricacies of high phenomenology and just use the basic assumptions, without any significant compromise to the integrity of research” (p. 268). He prefaced his article with a quote from William of Ockham (circa 1285-1349), stating, “Pluralitis non est ponenda sine necessitate” (loosely translated as, “Keep it simple unless there is a very good reason not to”). This editorial generated a lively discourse in the nursing community about phenomenology and its use in research.

When I first had to decide which qualitative approach best suited my research question, I realized that the discipline of nursing was struggling with the term phenomenology and that it held different meanings based upon the context, be it theoretical or practice (Earle, 2010). Nurse researchers have written about the lack of attention in published studies to explicating the phenomenological approach and the blurring of boundaries between various schools of thought from Husserl to van Manen (Dowling, 2005; Flood, 2010). A tension exists between nurse researchers who perceive phenomenology as a methodology and those who think of it as a theory about human life and how we should come to understand human life. After sombre reflection, I realized that I am in the latter group of researchers who perceives phenomenology as a way of being in the world and the lived experience “as the foundational level for producing meanings through the active involvement of human agency in inquiry” (Su, 2011, p. 62). Several landmark nursing studies exploring the lived experience of patients, families, and nurses have been deeply rooted in interpretive phenomenological tenets (Benner, 1984; Benner et al., 1996, 1999; Diekelmann et al., 1989; Watson, 1994).
Although nurse researchers have recognized the value of phenomenology as a way of investigating experiences in health care research, they also have discussed the difficulties inherent in the approach (Dowling, 2005; Koch, 1999; Pringle, Hendry, & McLafferty, 2011). They have asked whether phenomenology is description, interpretation, or both; Pringle et al. (2011) wanted to know “whether it is possible to describe something without interpreting it?” (p. 10).

Could descriptive and interpretive phenomenology be both sides of the same coin? This phenomenological perspective challenges the usefulness of bracketing or cutting off the real world, and it illuminates reflexivity throughout the research process, which allows new insights to emerge and brings together opposing phenomenological concepts. This perspective on phenomenology brings into question the overall value of member checking and whether it is incongruent with phenomenology. Several nurse researchers have put forth compelling reasons for single interviews and avoiding expert member checking; they have suggested that “re-entering the field to acquire more data does not necessarily equate to obtaining richer data” and “the true experts are those who co-constructed the findings: the participants and the interviewer” (McConnell-Henry, Chapman, & Francis, 2011, pp. 31-32).

This perspective on phenomenology also questions the inductive reasoning processes used to uncover meaning from the data. Researchers have suggested an analysis process that can be summarized as follows: (a) Read transcript through several times, making notes and comments; (b) identify and label emerging themes and meanings within the text; (c) relate back and link themes to quotes in text, using a cyclical process; (d) look for potential links between themes that may lead to master themes/superordinate
themes; (e) repeat the process with subsequent transcripts; (f) connect/cluster the themes from the texts into super-ordinate themes, with related subthemes; (g) examine texts more closely for greater depth of meaning and interpretation; (h) produce a summary table of themes for the group and a detailed, interpretive, reflexive written account (McConnell-Henry et al., 2001). In retrospect, this process most accurately reflects the inductive reasoning processes I used throughout the analysis of my work: not linear, cyclical, context bound, and never ending. As researcher, I found this process to be exhausting and exhilarating at the same time. I was at a loss to express this phenomenon to anyone until I encountered a passage by van Manen (2007) that resonated with my sentiments on the privilege of being in the moment of inquiry:

The reward phenomenology offers are moments of seeing-meaning or “in-seeing into the heart of things” as Rilke so felicitously put it. Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations-and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect. (p. 11)

Reading this passage shed light on my compelling urge to extend the analysis of the text to further explicate the phenomenon of learning to transition into CNP. I decided to conclude my dissertation with a-three stanza poetic narrative of the nurses’ lived experience of “learning to be” in transition.

Gaining Access

People doing research engage in a process called gaining access. For me, gaining access conjures up a vision of breaking down a gate or coming in with a search warrant. I prefer to think of the start of research in which I participate as beginning a relationship. (Haig-Brown, 1992, p. 97)

I concur with the sentiment of this quote because it fits well with my thoughts on the purpose of research. My research activities to date have been focused on topics
related to my everyday work. From the moment that I started to work in cancer care, I realized that this type of nursing practice was unique partially because of the distinct knowledge requirement but more importantly, because of the special needs of the patient population. I became part of a provincial team of cancer care providers who had access to the expertise of senior administrators, educators, and researchers in cancer care.

My cohort group included like managers who administered clinical programs in cancer centres and were responsible for staffing outpatient clinics and chemotherapy units across the province. We met regularly to discuss ongoing cancer nursing education programs and related research projects. It was through these discussions that I formulated the idea to focus my attention on the orientation of nurses to CNP. The nursing administrators agreed with the need to investigate this topic and volunteered to be a contact for recruiting newly hired nurses to the study. My relationship with this cohort group was critical to accessing a purposeful sample of participants who had experience with the central phenomenon or key concepts being explored (Creswell & Plano Clark, 2007).

**Sampling Procedures**

“In qualitative research, the inquirer purposefully selects individuals and sites that can provide the necessary information… individuals are chosen who hold different perspectives on the central phenomenon” (Creswell & Plano Clark, 2007, p. 112). I recruited participants from four regional cancer programs in Ontario; the participants had worked for a range of more than 3 months but less than 2 years in their positions. I conducted purposeful sampling to ensure that the data gathering addressed the essence of the study, namely, the lived experiences of newly hired nurses making sense of their
transition into CNP. I established criterion-based purposeful sampling and selected the sample according to the criteria identified (Holloway & Wheeler, 2002). I asked administrative contacts to select participants who met the established criteria for inclusion in the study.

The sampling parameters that guided the administrative contacts’ selection of participants included the following: type of participant (newly hired nurses); clinical settings (in-patient, outpatient, and community cancer clinics); basic nursing education (diploma, degree); employment status (full-time, part-time, casual work); type and length of orientation (cancer topics, chemotherapy certification, availability of a preceptor); and length of time employed (> 3 months and < 24 months).

I developed a preinterview questionnaire to assist in gathering information about the participants’ stages of transition, previous experience, formal learning opportunities, available supports, and context within which they practiced. The administrative contacts were asked to distribute the preinterview questionnaire to eligible participants as part of the research package. I utilized the preinterview questionnaire as a screening tool to ensure sufficient representation of nurses entering CNP in respect to geographical settings in Ontario; stages of transition; and types of cancer subspecialties (pediatric, adult, in-patient, outpatient, urban, rural/remote). The sample of 15 participants was heterogeneous in regard to previous nursing experience (new graduates, senior nurses > 2 to < 25 years); work assignment (chemotherapy, radiation therapy, site-specific outpatient clinics); variations in role autonomy (degree of supervision dependent on type of service or location); education (differences in breadth and length of programs); and variability in the supports available (preceptors and mentors) and the geographical settings where the
individuals practiced (urban, rural, and remote).

In qualitative research, people are central in all kinds of inquiry, but “they enter qualitative studies by virtue of having direct and personal knowledge of some event that they are willing to communicate to others and only secondarily by virtue of demographic characteristics” (Sandelowski, 1995, p. 180). According to Sandelowski,

An adequate sample size in qualitative research is one that permits-by virtue of not being too large- the deep, case-oriented analysis that is hallmark of all qualitative inquiry, and that results in - by virtue of not being too small- a new and richly textured understanding of experience. (p. 183)

The study sample size was reflective of similar qualitative studies on the phenomenon of role transition in nursing whose sample sizes ranged from 10 to 35 participants. Sample size in qualitative studies is generally small and nonrandom, and largely a function of the purpose of the inquiry, the quality of the participants, and the type of sampling strategy used (Loiselle et al., 2004).

According to Morse (1992), sampling is considered completed when the researcher is no longer identifying any new concepts or themes when interviewing additional participants. Therefore, according to the principles of sampling for qualitative research, I established a flexible range of participants and was open to the premise that as the study evolved, the number of participants interviewed and the number of interviews could vary dependent on the emergence of new themes throughout the data collection and analytical process (Streubert-Speziale & Carpenter, 2003). I interviewed participants from four regional cancer programs over 1 year, and at points, I went back to the administrative contacts to secure further participants. Each program contributed anywhere from 3 to 5 participants from in-patient and outpatient units for a total of 15 participants.
Administrative Contacts

My affiliation with CANO and Cancer Care Ontario (2000, 2008) gave me the opportunity to meet administrative contacts from regionally diverse cancer programs in the province of Ontario. The programs geographically span the province of Ontario (northwestern, northeastern, southwestern, southeastern). I assigned each program a number to maintain anonymity, but at the same time, I also linked them to their cohort of participants. As part of the study, I wanted to review each cancer program’s orientation for newly hired nurses. The administrative contacts at the regional cancer programs provided me with documents related to their in-house orientation and chemotherapy certification programs. The administrative contacts were asked to recruit 4 to 5 participants using the study sampling criteria to ensure representation of cancer programs within their respective regions. I asked the administrative contacts in the four cancer programs to distribute the research packages to participants who met the study criteria (i.e. newly hired nurses with > 3 months and < 24 months of experience in their current position as a cancer nurse). I interviewed 3 to 5 participants from each regional program to ensure that the nurses were representative of the phenomenon and included participants from the four regions of Ontario.

My rationale for the inclusion of nurses practicing in rural settings was the result of data collected during the pilot study indicating that nurses who practice in urban sites generally have access to more formal and informal supports, and that considerable variation exists in the educational preparation and role responsibilities from one setting to another (e.g., nurses in rural areas have broader scopes of practice and less availability to onsite educational opportunities and expertise; Scharff, 2006; Sevean, 2003; Sevean,
Dampier, Spadoni, Strickland, & Pilatzke, 2008). Therefore, I determined that the group sample size needed to be sufficient and flexible enough to account for these group differences.

**Accessing the Participants**

Gaining access to the research sites caused me some anxiety, but once I had secured the administrative contacts, I became more relaxed and confident about the process. I sent a letter of introduction to administrative contacts in four regional cancer facilities in Ontario (see Appendix B). The administrative contact (i.e., chief nursing officer or designate) at each of the centres distributed the research packages to newly hired nurses who met the criteria to participate in the study. I also asked the administrative contacts at that time to share documents with me in regard to their orientation and continuing education programs for newly employed cancer nurses.

I had prepared a research package for each participant who volunteered to be in the study. In the package were (a) a letter of introduction that included the purpose and significance of the study, how confidentiality would be maintained, and the ethical considerations during data collection and analysis (see Appendix C); (b) a consent to audiotape the interviews (see Appendix D); and (c) a preinterview questionnaire with a self-addressed return envelope (see Appendix E). I asked the participants to complete and mail back the consent form, preinterview questionnaire, and contact information in the postage paid envelope. This method of recruitment ensured voluntary participation and minimized the possibility of coercion during the recruitment process.

I reviewed the returned preinterview questionnaires to determine which volunteer participants met the criteria and were representative of the phenomenon being studied.
Those nurses were contacted to schedule telephone interviews. Two participants not selected were sent a letter of recognition for their participation and commended for their volunteerism and commitment to professional nursing practice.

Preinterview Questionnaire

Demographic data were collected from the nurses via a mailed-in preinterview questionnaire that was given to potential participants being recruited into the study. The orientation programs provided by the 4 administrative contacts and the current literature on core curriculum standards provided from the CANO guided the development of the preinterview questionnaire. The three-page questionnaire was constructed to capture from the nurses demographic data related to general information (age, gender); level of nursing education; nursing experience (years); employment information (status, type of employment in cancer care [in-patient, outpatient]); percentage of time spent in cancer care; and orientation (length, availability of a preceptor, in-house certification courses for chemotherapy; other topics included in the orientation program).

The preinterview questionnaire provided a demographic profile of each participant’s background and contributed significantly to my getting to know the participants during the informal preinterview contact to schedule an appointment for the taped interview. The analysis of the questionnaires gave me critical insight into the similarities and differences of the participants’ orientation experiences within their first few months of employment. Prior to interviewing the participants, I reviewed their profiles and the field notes from my initial telephone contact, and gleaned what I had learned about them. This process allowed me to anticipate areas that I would need to focus on during the interview.
A total of 40 study packages were distributed by the 4 administrative contacts to the cancer nurses who met the study criteria. Eighteen (45%) nurses returned and completed the questionnaire and informed consent; 16 (40%) of the 18 nurses were eligible to participate in the study, and 15 (37.5%) participants went on to complete the questionnaire and participate in the interview process. Two participants were not enrolled in the study because of conflicts related to recruitment criteria (i.e., length of time in their position either less than 3 months or greater than 2 years). One participant was eligible, but after several unsuccessful attempts to be interviewed, was not interviewed.

Preinterview Results

The preinterview results (see Appendix F) are discussed further in this section of the study. This overview of the participants highlights the diversity of the sample and the complexity of the contextual factors influencing the nurses’ transition into CNP.

Regional Programs

The 15 participants were distributed throughout Ontario as follows: northwestern (5 participants), northeastern (3 participants), southeastern/central (4 participants), and southwestern (3 participants). At the time of the study, there were 14 cancer centres in Ontario. The cancer centres were representative of the four major geographical regions of Ontario. The two programs in northern Ontario included 3 participants from rural outpatient units linked to the larger urban cancer centres. The urban centres provided clinical and educational support via telemedicine for the rural outpatient units. The two urban programs from southern Ontario included participants from in-patient and outpatient units affiliated with large teaching hospitals.
Age and Sex of Participants

All the participants were female; one participant who was recruited to the study was male, but he did not meet the criteria to participate in the study. The male participant had completed the orientation but was then transferred to another unit, and the administrative contacts had no other males to recruit to the study. The national percentage of males graduating from nursing programs is approximately 5% and has remained relatively unchanged for the past 20 years (CIHI, 2007). Assuming there was only 1 male among the 40 potential participants, this would place the recruitment of males to cancer nursing at 2.5% well below the national average.

The age range and number of nurses who participated in the study were as follows: 20 to 24 (2 participants), 25 to 29 (4 participants), 30 to 34 (1 participant), 35 to 39 (4 participants), 40 to 44 (2 participants), 45 to 49 (1 participant), and 50 to 54 (1 participant). The age range of the participants was atypical for the nursing population, with 53% of the sample under the age of 35 and 86% under the age of 45 years. The average age of a nurse in Canada is 47 years and has been steadily rising for the past decade as the Baby Boomers enter retirement over the next 10 years (CIHI, 2007). The average age of this sample was reflective of the older nurses in cancer care retiring and being replaced by the younger graduate nurses. The sample had 6 new graduates, 4 of whom were under the age of 24.

Nursing Education

The nursing education preparation of the participants was almost equally divided between those with a diploma in nursing (8 participants) and those with a bachelor’s degree in nursing (7 participants). The sample did not include nurses with advanced
degrees in nursing. The sample had a higher number of nurses with degree preparation (46%) than the average Canadian sample of (18%) nurses (CIHI, 2007). The reason for this anomaly was that approximately 40% (6 participants) were not only novice to cancer nursing but also new to the nursing profession. Their educational preparation was a degree, not a diploma, because of the entry-to-practice requirements established in 2005 that newly graduated nurses had to have a bachelor’s degree in nursing to be eligible for registration by the CNO. The difference between the 4-year degree and the 3-year diploma is the additional year of community nursing practice, which is a required set of competencies for RNs practicing in Ontario. These skills are applicable specifically to roles in the outpatient/community settings.

*Previous Nursing Experience*

The number of years of prior nursing experience was represented as follows: < 2 years (7 participants); > 2 but < 5 years (2 participants); > 5 but < 10 years (2 participants); > 10 but < 15 years (0 participants); > 15 but < 20 years (1 participant); and > 20 but < 25 years (3 participants). The sample could be divided into two categories, namely, 7 participants (46%) were new graduate nurses with < 2 years nursing experience and 8 participants (54%) were senior nurses with > 2 but < 25 years of nursing experience. The amount and type of clinical experience often will determine applicants’ ability to secure positions in cancer care and certain subspecialties in cancer care such as outpatient cancer care.

*Senior Nurses*

Four of the 7 senior nurses had more than 15 years of nursing experience prior to entering CNP. Three of these nurses transferred from in-patient to outpatient nursing, and
1 nurse made an internal transfer from another specialty area (i.e., cardiovascular nursing). In job advertisements, preferred criteria for CNP, especially in outpatient settings, include experience with central venous lines, pain management, palliative care, community nursing, and advanced physical and psychosocial/communication skills. The senior nurses listed their experience in terms of position, specialty area, facility, and length of time spent in each position.

Though 2 of the nurses had experience working in palliative care and 3 of the nurses had worked in emergency and critical care areas, none of the nurses had worked in cancer care. Six senior nurses were in outpatient positions exclusively; in-patient positions were held primarily by nurses with less than 5 years of nursing experience or new graduates. This finding was suggestive of an outmigration of senior nurses to outpatient nursing positions and a back filling of vacated in-patient positions by new graduate nurses (Wilkinson, 1994).

New Graduates

Nine nurses were hired for in-patient positions, and the majority (7 participants) had less than 2 years of previous nursing experience. Four nurses of the 7 had just graduated, so these were their first nursing positions. The majority of the newly hired nurses (70%) had only been in their respective positions for < 6 months. Of the new graduates in the study, 3 of 7 (45%) had completed clinical placements on cancer units as part of their 4th-year student placements, which is a growing trend, given the shortage of senior nurses in specialty areas. Traditionally, hiring criteria have been a minimum of 2 years of nursing experience prior to applying for specialty areas.
The in-patient nurses in this sample experienced shorter formal orientations, and their chemotherapy certifications were delayed until they had completed the general orientation. The new graduates comprised the majority of the sample (5 nurses, 70%) who had only been in their respective positions for > 3 and < 6 months. Only 2 new graduates had been in their positions for > 6 months, and they indicated that they had just recently completed their chemotherapy certification courses. This pattern suggested a two-tiered orientation for new graduates, and the narratives reflected different expectations for new graduates as opposed to senior nurses during their first year of employment.

**Employment Status**

The preinterview questionnaire asked the participants whether they were employed on a full-time or a part-time basis, place of employment, and percentage of time spent with cancer patients. At the time of the study, the status of employment for the participants included 8 in regular full-time work, 1 in casual full-time work, 4 in regular part-time work, and 2 in casual part-time work. Nine of the participants (60%) worked in in-patient cancer programs, and 6 (40%) worked in acute outpatient cancer programs. The majority of in-patient nurses (n = 5) were hired on a part-time rather than a full-time basis, which delayed their full orientation to cancer care. In addition, 13 participants stated that the percentage of time spent working with cancer patients was 100%, and 2 nurses said it comprised approximately 80% of their time. It is significant to note that nurses who spend the majority of their practice with cancer patients are considered specialized cancer nurses, work in dedicated cancer facilities, and obtain specialty education and certification (CANO, 2006; Tiffany, 1987).
Orientation Programs

Cancer topics commonly covered during the participants’ orientation program included carcinogenesis (80%); prevention of cancer (80%); screening and early detection of cancers (80%); nursing implications of surgical treatment (86%); nursing implications of radiation therapy (80%); nursing implications of antineoplastic therapy (53%); nursing implications of biotherapy (53%); nursing implications of bone marrow and stem cell transplantation (60%); preparation, administration, and disposal of antineoplastic agents (60%); oncologic emergencies (80%); supportive care (pain, nausea, fatigue; 60%); and common cancers (breast, lung, prostate, colorectal, lymphomas; 68%). For the most part, all of the nurses received a significant portion of their orientation on these topics and reflected in their interviews that this information was critical to caring for their patients.

Topics that received considerably less attention in orientation programs included palliative care (40%); role of the oncology nurse (46%); and strategies for coping with the stressors in CNP (40%). It is interesting to note that the areas that received less attention during orientation were considered very important by the nurses, especially the strategies for coping with the emotional impact of CNP. The participants were given the option of listing other topics included in their orientation: role of the health team in cancer care (3 participants), radiation safety (1 participant), pain management (1 participant), telephone practice (1 participant), and confidentiality and ethics (1 participant). Eleven (73%) of the 15 participants had completed an in-house chemotherapy certification course as part of their orientation, and 4 (27%) participants were scheduled to complete the course at a later date. The 4 participants scheduled to
complete their chemotherapy course at later date were new graduates.

Length of Orientation

The data gathered from the preinterview survey provided information about the orientation experience of the participants. When the participants were asked about their orientation to cancer care, the number of days (weeks) varied from as little as 5 days (1 week) to as many as 40 days (8 weeks), with the average orientation period being 12.5 days (2.5 weeks). There are some possible explanations for the variations in length of orientation. For example, 3 participants indicated they had 5 to 10 days of orientation, they were all employed on in-patient units, and the overall average for in-patient orientation was 10 to 15 days (8 participants). The in-patient nurses were new graduates and, in most cases, had not yet completed their chemotherapy certification program, which averages 5 to 10 days. Three participants had orientations that spanned 20 to 40 days in outpatient specialized cancer programs that required a high level of independence and accountability. The length and type of an orientation program are dependent on the nature of the position and the variability in each setting.

Data Collection

“There are no facts, only interpretations.” (from Nietzsche’s A. Danto translation)

Originally, “datum” means something “given or “granted.” And there is indeed a sense in which our experience is “given” to us in our everyday life. And yet, we need to realize, of course, that experiential accounts or lived-experience descriptions whether caught in oral or written discourse are never identical to lived experience itself. All recollections of experiences, reflections on experiences, or transcribed conversations about experiences are already transformations of those experiences. (van Manen, 1997, p. 54)

To make sense of a phenomenon, researchers must observe and collect information, be it documents, recorded conversations, relevant literature, or personal
reflections. In this study, I asked newly hired cancer nurses to reflect on their experiences in regard to their initial entry into their role (i.e., recruitment and orientation); their experiences in adapting to a typical day; formal and informal supports that eased their transition; and perceived barriers to achieving role competence (e.g., educational needs, professional commitment, organizational commitment, workplace climate, and position satisfaction).

Throughout the course of the study, I took notes in my journal when interacting with administrative contacts and following the interviews with the nurses. Prior to starting the study, I met with the administrative contacts several times in their offices or at conferences and spoke to them about my idea for conducting this study. Everyone verbally expressed an interest in participating and stated that the topic area was understudied and deserved more attention. They shared their own experiences as managers responsible for recruiting and orientating nurses to CNP, and as much as possible, I wrote down what they said. At that time, they also generously shared their curriculum and policy documents, and I took notes regarding their comments on what they considered critical content for cancer nurses to know.

When I called the prospective study participants, I jotted down notes afterwards in regard to what I had learned about them informally that could assist me in establishing rapport on the next contact (e.g., city; where they went to school; personal characteristics such as marital status or number of children). I also recorded contextual information about the participants and paid particular attention to their tone of voice and how that linked with what they were saying at the time. Following each telephone interview, I made handwritten notes on the interview, including reflective comments and reminders to
myself (e.g., connections to the literature or new questions to add to subsequent contacts).

I also made notations about unusual occurrences, such as when someone was emotional and crying or had an angry or quiet tone in her voice and I tried to probe those feelings to better understand their experience. I made notes to myself to return to these parts of the recording to attempt to link the context with the underlying tone. I also asked the participants whether they had any questions or wanted to share or say something that I had not asked them. This probing resulted in the nurses sharing more personal stories and documents that they felt were significant and resulted in a follow-up phone call or e-mail. Documenting the nuances during the interviews with related reflections assisted in jogging my memory when I was transcribing the interviews, and I transferred some of these comments into the transcribed interviews to provide contextual understanding.

An example of the notations in my handwritten diaries spanned 7 years and included times when I presented preliminary finding at a conference regarding the stress of caring for ill and dying patients, and members of the audience spoke with me afterwards. In this particular instance, 2 nurses approached me and were quite tearful when they shared the fact that they had similar experiences when they started their positions in cancer care, and they told me their stories which I entered into my field notes.

Each time I reviewed transcripts of the taped interviews, I wrote copious notes in the side margins, including reflections of my own experiences when I entered cancerland and the years following when I became an administrator of a cancer centre and was responsible for the recruitment and orientation of nurses. Many of these reflections were suppressed memories triggered by the participants during the interviews; following the
interviews, I would write them down immediately so that I would not forget them again. Parts of these reflections have been incorporated into the dissertation and transcribed as written from my study journal.

The administrative contacts had distributed the study packages to the eligible nurses, and each participant completed the preinterview questionnaire and consent and mailed it back to me. I had also included in the package a short profile of myself with a picture because I would be conducting telephone interviews exclusively and would not be meeting the participants in face-to-face interviews.

I utilized telephone interviews because this was a less costly way to conduct interviews. I was aware that the respondents may have been uncooperative on the telephone, especially when they did not know me personally (Loiselle et al., 2007). I also was concerned that the nurses might have been uncomfortable with a phone interview and might have been less likely to engage in conversation. I wanted the nurses to know something about me prior to my initial phone contact. I decided that I would make personal contact with each participant to set up the interview time and to give them an opportunity to get to know me. Once I had reviewed the prequestionnaire and familiarized myself with the participants’ profiles, I had a preinterview via telephone with each participant. In this short 15-minute phone call, I had the opportunity to share my profile, establish rapport, review the interview protocol, answer any questions, and schedule a time for the telephone interview. I kept journal notes of those initial calls, and this assisted me when I prepared for the interviews. I conducted the telephone interviews using an interview protocol (see Appendix G) with guided questions that I shared with the participants during the preinterview.
I interviewed 15 newly hired cancer nurses working in four regional cancer programs in Ontario. The participants were female cancer nurses who had worked in cancer settings for > 3 months and < 24 months. The audiotaped interviews were approximately 1 to 2 hours in length. The participants’ consent was reaffirmed on tape at the beginning of the interview, and the participants also were informed that they could terminate the interview at any time. One interview was scheduled per day, and the following environmental factors were taken into consideration: convenient time, privacy, and quietness.

The interviews began with open-ended questions. I eventually narrowed the focus and asked clarifying questions as themes emerged. I took the first few minutes of the interview to establish rapport with the participants and stimulate mutual sharing using the following strategies: (a) listening for and interpreting meaning in an effort to respond appropriately; (b) sharing a personal story from my own experience to assist an inarticulate participant; (c) freely exchanging ideas, impressions, and opinions; and (d) paying careful attention to the tentative interview schedule and paying attention to maintaining a proper balance of structure and flexibility (Sorrell & Redmond, 1995). I used the “hourglass” approach, which begins with general questions, works toward more focused questioning, and concludes with general questions; I also listened with an interpretive intent, not rushing the interview by respecting silence, thereby allowing the participants to gather their thoughts (McConnell-Henry et al., 2011).

The interviews took place over approximately 1 year until all of the nurses from the four regional programs had been interviewed. My concerns regarding conducting phone interviews were unfounded and provided a “hybrid space” that facilitated sharing
stories. In the preinterview, I had advised the nurses to arrange for adequate time, ensure they were comfortable, and choose a location where they would have privacy. Interestingly enough, several of the participants requested to be called at their home, and some of those interviews were quite extensive, detailed, and emotional at times. One participant in particular was quite emotional, commenting that she did not have anyone to talk to because her family did not want her to hear about her job and colleague nurses were too busy. Near the end of the interview, we spent considerable time talking about possible supports she could seek out to assist her in coping more effectively. I requested a second interview with 2 participants due to interruptions that caused the interview to end early. Two other participants called me back with information that they thought I would be interested in after their interview was completed.

Although I had assistance transcribing the interviews, I reviewed all of the draft transcriptions with the original tape recordings and made corrections, as well as added contextual information from my journal notes in the side margins of the transcripts. I numbered each line of each transcript and assigned a pseudonym to each participant. This assisted me in keeping the transcripts whole but being able to take them apart and collate the data under themes as part of the cross-case analysis. Through this somewhat tedious process, I became very familiar with the raw data, which then facilitated the data analysis. The transcripts contained thick descriptions of the nurses’ everyday lives, and the aspects they chose to share were the parts that they were the most interested in telling. “The interviewer does not just collect data, as if picking daisies; he or she colludes with the interviewee to create, to construct, stories. In this context, all stories are authentic rather than true” (Nunkoosing, 2005, p. 701).
Data Analysis

Qualitative researchers are interested in telling, and are often consumed by the need to present their stories of research as an ongoing journey. Their writing must, therefore reflect the process of research - the character and foundational beliefs of the original conceptual framework as well as the evolving one, considerations on the stumblings, in-progress victories, insights and puzzlements of the researcher as the research unfolds, disclosure of the researcher’s stance and limitations as well as descriptions of the successes and failures of the ongoing stories of multiple meaning making. So the process is the product. (Ely, Vinz, Downing, & Anzul, 1997, p. 52)

“(Interpretation) illuminates, throws light on the experience. It brings out, and refines, as when butter is clarified, the meanings that can be sifted from a text, an object, or slice of experience” (Denzin & Lincoln, 1994, p. 504). In this passage, Denzin and Lincoln described how the researcher sorts through the data and attempts to make sense of what he or she has learned about the phenomena. The aim of the study approach was to foster a greater connection between research and everyday social issues. I used a qualitative approach to explore the lived experiences of newly hired cancer nurses. The phenomenological research method is an inductive, holistic, descriptive, interactive process of inquiry (van Manen, 1997). Merriam (2001) stated, “Qualitative researchers are interested in understanding the meaning people have constructed, which is how they make sense of their world and the experiences they have in the world” (p. 6). I encouraged the participants to tell their stories so that I could gain insight into their individual experiences during their transition into CNP.

As the interviews progressed, I struggled to maintain a proper balance of structure and flexibility. In the first few interviews, structure prevailed, but as recurring themes became more visible from transcript to transcript, I became more flexible and engaged, and I began to share a unique intimacy with the respondents (Sorrell & Redmond, 1995).
The focus shifted from exploring the steps involved in adapting to a new role and became more about the how the participants were making sense of their CNP in a unique context.

By the end of a year, I had completed all of the interviews. The interviews had been transcribed one at a time along the way and had been read and reread several times each. I was overwhelmed by the amount of data and the detailed descriptions of the participants. I was aware that data analysis is an interactive process and that insights cannot be illuminated unless the researcher is completely familiar with the data (Loiselle et al., 2004). With this in mind, I applied the following four intellectual processes that play a role in qualitative analysis (Morse & Field, 1995):

1. Comprehending: Early in the analytical process, the researcher strives to make sense of the data and create a rich description of the phenomenon, and comprehension is complete when data saturation occurs.
2. Synthesizing: Involves “sifting” the data and putting pieces together at the end of this process so that the researcher can make generalized statements about the phenomenon and the participants.
3. Theorizing: Involves a systematic sorting of the data to develop alternate explanations of the phenomenon and determine their fit with the data.
4. Recontextualizing: Involves the further development of theory such that its applicability to other settings and groups is explored.

My first attempt to make sense of the data was to organize them by transition phase and questions within each phase rather than by participant. This allowed me to focus on specific topics within narratives, and patterns across the responses became clearer and categories and themes emerged. Coding was undertaken by developing conceptual files (Loiselle et al., 2004) and categorizing the data into Word documents by transition phase and related activities, and then examining more closely in each phase what the participants learned, how they learned it, and the factors influencing learning.

Following a period of more reading and rereading, I decided to write up each participant’s experience as a narrative. For many months, I pondered these individual
stories, each so unique, and compared them to my experiences, others experiences, and what the literature had to say. I grew to love those 15 strong and courageous women, and bestowed upon them the highest honour of giving them pseudonyms belonging to the 15 most influential and respected women in my life. Each of them represented a part of me from my past career as a cancer nurse, with all the beauty and flaws that occur in one’s life.

I struggled with how to assemble the parts into the whole by coding themes and subthemes within the phases of transition to see clearly why, how, and where the participants learned what they needed to know to survive in their unique part of cancerland. The 15 voices became a more powerful and convincing voice when it resonated with my experiences and the evidence that existed in the literature. The process was long and arduous, but the act of writing and rewriting revealed the pure, clear essence of the lived experience of nurses working alongside patients and learning specialized knowledge through engagement with expert peers in diverse practice settings. The interpretation of the phenomenon went through three distinct reiterations: (a) sorting data into the phases of transition; (b) writing individual narratives of the nurses’ transition; and (c) examining in and among narratives, and colour coding themes and subthemes within each transition phase. The conceptual framework lens expanded to capture a holistic picture of the phenomenon, highlighting the details inherent in day-to-day practice; the mundane, the critical incidents, the tender moments, the highs and the lows of an ever-changing practice life.

Throughout the study, I utilized strategies to establish the trustworthiness of the research process. Lincoln and Guba (1985) discussed four criteria relating to tests of rigor
that are useful for understanding qualitative approaches: credibility, fittingness, audibility, and confirmability. Sandelowski (1986) stated, “A qualitative study meets the criterion of credibility when it presents such faithful descriptions and interpretations of human experience that the people having the experience would recognize it” (p. 30). A study meets the criterion of fittingness when “its findings ‘fit’ into contexts outside the study situation and when the audience views its findings as meaningful and applicable in terms of their own experiences” (Sandelowski, 1986, p. 32). Sandelowski suggested, “A study meets the criterion of auditability when another researcher can clearly follow the decision trail used by the investigator” (p. 33). Sandelowski also suggested that “confirmability as a criterion of neutrality in qualitative research refers to the findings themselves, not to the subjective or objective stance of the researcher” (p. 34).

When analyzing the data, I adhered to the following strategies to achieve these four criteria: (a) ensuring logical, clear, and concise reporting of the findings; (b) checking for representativeness of the data as a whole; (c) having independent analysis by another researcher (i.e., thesis committee); (d) triangulating data sources to determine congruency of the findings; (e) checking descriptions, explanations, or theories about data; (f) deliberately trying to discount conclusions drawn about data; and (g) obtaining validation from the participants about data (i.e. summarizing the interview with broad questions). I maintained a personal record throughout the data collection and analysis process. The record was to provide documentation of my train of thought throughout the study and to identify potential biases that might impact the course of the study. This documentation included perceptions and reactions to the responses gained from my interactions with the participants during the study.
Ethical Considerations

The research was guided by the *Tri-Council Policy Statement (TCPS): Ethical Conduct for Research Involving Humans* (Health Canada, 1998). The TCPS articulates eight guiding principles on which standards of ethical conduct in research are based: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect of justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit (Loiselle et al., 2004). Ethics approval for the study was obtained from the University of Toronto’s Ethics Committee. The ethical review process followed the procedures outlined by the University of Toronto that is inclusive of the theory and policy studies guidelines of the Ontario Institute for Studies in Education. Ethical approval was obtained from each of the four regional sites ethical review boards.

The participants were volunteers who were asked to sign letters of informed consent. I informed them of their right to discontinue their involvement in the study at any time. I assured the participants of their rights throughout the course of the study. All data files were assigned codes and pseudonyms to protect participant anonymity. Confidentiality was maintained, but because of the telephone interviews, complete anonymity could not be maintained, although confidentiality was ensured for all participants. I gave each participant a letter stating that such confidentiality would be maintained. When transcribing the transcripts, I gave the participants pseudonyms and strategically deleted identifying information, which transformed the information into usable examples or illustrations of generalizing theoretical categories (Nespor, 2000).

I obtained written consent and permission to audiotape the interviews prior to
conducting the interviews; at the time of each interview, the consent was affirmed on the audiotape. I informed the nurses that they did not have to complete the interview and that the tape recorder could be shut off at any point during the interview. I did not enter any names on demographic forms or refer to any names in the written report, and I coded all data. Tapes and transcriptions were kept under lock and key in my office.

I disclosed the costs and benefits to the participants at the outset of the study. The research imposed only minimal costs: potential psychological or emotion distress resulting from self-disclosure, introspection, fear of the unknown or interacting with strangers, fear of eventual repercussions, anger or embarrassment at the type of question being asked; loss of time; and loss of privacy. Benefits were minimal and included gratification in being able to discuss their situation or problem with a nonjudgmental and friendly person, escape from routine, satisfaction of being part of a study and contributing to a body of knowledge, and satisfaction that the information provided may help others with similar problems or conditions (Loiselle et al., 2004).

In qualitative research, there are concerns as to who “owns” the story being told; therefore, throughout the study, I reflected on potential ethical issues that could arise and developed plans for dealing with those concerns. Oberle (2002) suggested that researchers ask themselves the following questions:

How would I feel if my story were dealt with this way? Will I feel comfortable facing participants after the report is released? What can I do to ensure that consent is informed? What are my obligations if participants disagree with my interpretations? (p. 566)

Some of the actions that I took to address these concerns included establishing a trusting relationship with the participant prior to the taped interview, reviewing the consent form at the time of the interview (on tape), and allowing time for discussion of
any concerns. During the interview, my actions included validating with the participants any confusing or potentially risky statements, informing the participants what was going to happen to the data from their interview, allowing time for questions, and informing the participants that reports would be made available to them.

Limitations

The limitations of this study included the fact that the qualitative research methodology lends itself to certain problems related to the generalizability of findings, interpretation, and researcher influence. In terms of generalizability, the degree to which findings derived from one context under one set of conditions can be applied in other settings is problematic (Merriam, 2001). The phenomenon of role transition is unique to each individual, and the generalizability of the results was restricted to the lived experiences of the nurses as they adapt to their role as oncology nurses. In regard to interpretation, Merriam (2001) contended that the study sample must be representative of the perceptions of those participants studied and that when they are asked to reflect retrospectively on their experiences, the data generated are dependent on their memories of the lived experiences. The participants’ recollection of their experiences was highly subjective and was bound within the context of their unique circumstances, and dependent not on objective measures but the interpretation of personal interaction and perception.

The study also was limited by my expertise, sensitivity, and integrity. The researcher in qualitative research is the primary instrument of data collection and analysis, and can generate insightful data illuminating the phenomenon under study or can purposefully or inadvertently produce distorted results because of the lack of research
rigor and attention to ethical processes. Researchers must be aware of their own beliefs about what is real or important, as well as their presuppositions about the phenomenon; they must remain open to the data as they are revealed (Streubert-Speziale & Carpenter, 2003).

Summary

The nurses were representative of the diverse settings where nurses provide cancer services in Ontario (in-patient, outpatient, urban, rural, and remote). They are at different points on the transition continuum and have been involved in cancer care for at least 3 months, but not more than 2 years. The sample comprised an equal mix of nurses who had been working less than 2 years as well as those with at least 2 to 25 years of prior experience. For the most part, the formal orientations were relatively standardized and based upon core curriculum concepts for specialized CNP (CANO, 2006).

The specialized knowledge is integrated at the bedside or chemo chair side through informal learning events occurring in real-life practice with patients and families coping with cancer. The informal learning opportunities that occur during the stages of transition are examined according to learning needs, ways of learning, and factors affecting learning. The study findings are presented in the next three chapters: Chapter 4 describes the antecedent conditions that influenced the nurses’ decisions to practice in cancer settings, chapter 5 describes the role transition and role strain experienced once the nurses had entered CNP, and chapter 6 describes the reactions and consequences that affected the nurses’ learning and influenced their commitment to CNP.
CHAPTER 4: GETTING IN

Introduction

In this chapter, the nurses’ perceptions of their recruitment and selection are explored: their attraction to cancer nursing positions; how they learned about CNP; what influenced their decisions to apply; the hiring opportunities in diverse cancer settings; supports available during the interview process, and the factors that influenced the nurses’ decisions to accept cancer nursing position. The Getting In phase is divided into two thematic areas: (a) being recruited, including labor market issues that influenced access to positions (availability of employment, socialization and networking, peer influences); career path (vision, goals); previous experiences (brushes) with cancer patients; and personal and professional strengths; and (b) being hired, including nurses’ experiences being interviewed (formal, informal) and hiring practices in diverse settings (in-patient, outpatient, urban, rural, subspecialties).

Being Recruited

The 15 nurses in this study were obtaining their positions when the nursing shortage was approaching a crisis point in Ontario, and at the time of the study, they were representative of the current employment trends in the Canadian nursing workforce. The sample was split approximately in half between nurses with less than 2 years of experience ($n = 7$) and nurses with 2 to 25 years of experience ($n = 8$). Nurses’ reasons for choosing cancer care and how they became aware of nursing positions were multifactorial and complex. However, the findings indicated that some of the factors influencing the nurses’ decision to apply for positions included labour market changes;
social networking; career aspirations (vision, goals); experiences with cancer (personal, professional); and previous nursing experience.

**Labour Market Issues**

For the most part, the nurses wanted to be employed in cancer care and were able to secure appropriate positions. Of particular note is how they learned about respective positions and the factors that influenced their decisions to apply for cancer nursing. A few nurses indicated that they were unable to secure employment in the areas they wanted and that cancer positions were more readily available than other specialty areas. The majority of the nurses experiencing difficulty obtaining preferred positions were new graduates (Ethel, Kelly, Robin, Irva), and cancer nursing was not necessarily a natural choice for their initial nursing positions.

Ethel was reluctant to accept the cancer unit as her first appointment, but she had been turned down for other positions on medical and surgical floors, so she eventually accepted the position. Ethel had always wanted to be a nurse and had returned to school in her early 50s to pursue a degree in nursing. At the time of her interview, she had been working in an urban hospital on a casual basis for less than 1 year on a variety of units. Six months ago, she finally obtained a permanent part-time position on an in-patient oncology unit. She shared the challenges of her new position, expressing that even though it was not her first choice, she was satisfied with cancer nursing. When asked whether or not cancer was her choice, she commented:

I thought no not oncology (cancer care), I don’t want to work with cancer…I applied all over the hospital, I couldn’t get medical but I did get oncology (cancer care)…I could have turned it down but I thought maybe oncology (cancer care) is a good place to work because of the incidence of cancer across the lifespan…I was excited to go to work on the oncology (cancer) unit.
Kelly, also a new graduate, selected cancer care as her second choice based upon her student placement experience. In her interview, she stated:

I had lots of goals when I started nursing...oncology was not a choice at all. I am really happy with oncology that is what I want to do now it is really strange I love it here...but it certainly wasn’t what I thought I would be doing when I started nursing school.

Robin, a younger nurse with less than 2 years of experience, readily admitted that she did not choose cancer nursing, but was forced into the position because no other positions were available to her and she needed a job. Robin stated:

I really didn’t have a choice, I was new to the floor they did a lot of wrong things...they seemed to force people to work on the oncology side, but I wasn’t afraid I was OK! [emotion in her voice, she raises her tone slightly]. You should be able to choose. It is not good to force anyone to go somewhere if you don’t want to be there, if nurses are not satisfied with their placement that affects patient care and it is professionally demoralizing for the nurse.

Robin also commented that she felt management was responsible for creating pressure on the new graduates to take certain placements:

I like going into new things...it was just the way they went about it was all wrong.... [Administration] put people on the cancer floor without prior consultation, and she adds I have been offered another position and will be leaving oncology.

Irva graduated 2 years ago and has worked in a casual part-time capacity in general surgery. Six months ago, she was hired to work on an in-patient surgical oncology unit. It was not her first choice, and although she has found the position challenging, she struggled to overcome the stresses and learn what she needed to survive as a cancer nurse. Irva readily admitted that the deciding factor for accepting the position was based upon the fact that it was a surgical oncology floor and surgery is one of her areas of interest.
She noted:

I was having a hard time finding a job in surgery, so I took this job a friend of my mother’s got me an interview … it wasn’t so much cancer I really like surgery … I wasn’t really looking for cancer. I’m not saying I am using this floor for experience and then moving on … I don’t know what I will be doing in 2-3 years time. However, I never thought I would work oncology.

In contrast to the younger nurses, 2 senior nurses (Cathy and Norma) decided to transfer from another in-patient specialty area to a cancer floor. For example, Norma had worked previously as a staff nurse in an urban hospital on several units (medical/surgical, hospice, respiratory), and for the past several months, she had been working on a part-time basis as a nurse on an in-patient cancer unit. She spoke very candidly about her decision:

I was interested in doing the chemo and palliation, the other types of nursing are too fast, too many orders, not seeing or getting to know the patients, I always wanted to come back to this type of nursing, I was waiting for a position to come up … not full-time but part-time.

Cathy had worked as a staff nurse in cardiology for the past 4 years. She stated:

I ended up in cancer care due to a merge of in-patient units and nurses had to indicate their top three choices … we all wanted to work on the same unit so we all picked the cancer floor as our first choice we all ended up going there … but there are only 6 out of 18 of us left one year later. I had enough seniority and probably could have stayed there (on cardiology) but it really didn’t matter to me … I just wanted to go with the girls I was familiar with.

Lorraine, Fran, Gayle, Courtney, Doris and Rebecca were senior nurses working in outpatient cancer clinics, and they had either applied for their current positions or had been actively recruited by managers of cancer programs. Generally, they were not the only nurses who applied, so they had to compete for their respective positions in outpatient clinics. Their stories reflected the factors influencing senior nurses’ applications for positions in outpatient cancer nursing.
For example, Lorraine was an experienced staff nurse who had worked for nearly 20 years in general and cardiovascular surgery. During the past few years, because of an injury that restricted her from heavy lifting, she began to seek alternative nursing positions, including nurse educator, supervisor infection control, occupational health nurse, and telehealth nurse. More recently, she had obtained a position as a full-time nurse in an outpatient cancer centre in a large urban hospital. Lorraine stated that she applied for the position in an outpatient setting due to her physical limitations:

I injured myself a couple of years ago and was moving around in different temporary positions…I realized that outpatient cancer nursing, there’s very little lifting involved…from the physical point of view it was going to be within my restrictions. I didn’t get the first position I applied for, then they called me a couple of weeks later and offered me the full-time float nurse position.

Fran had almost 25 years experience as an in-patient nurse in an urban hospital. She held a variety of positions, including general surgery, orthopedics, critical care, radiology, and medical research. For the past year, Fran has been working in a cancer clinic adjacent to the hospital where she has worked for her entire nursing career. Fran was ambivalent about her decision to change to outpatient nursing. She commented:

I felt I was getting stale and I wanted to push myself a little bit and try something new…try something for a change of pace. Personally, for me, it has been a big change… I was looking forward to that because I have moved to a lot of different floors throughout my career… I knew it was going to be a challenge, but it was a lot more than I expected.

Gayle, on the other hand, was hired to fill a temporary full-time position in an outpatient clinic in an urban hospital. She admitted that her position was uncertain, and she shared her thoughts about her commitment to cancer nursing and her chances of staying in her current position:

So, I knew the job was probably good for two years…but I find myself in this position where I don’t know if I am staying because the job is temporary, I do
love (emotional tone in her voice) the job and wish I could stay in it. I don’t think I will be able to stay because there are other nurses who have given chemo for over 20 years and they want to transfer here and work days Monday to Friday rather than shift work …because I have less than 2 years seniority [in cancer nursing], I am not sure what my future holds.

Courtney, Doris, and Rebecca were senior nurses who had been actively recruited to outpatient chemotherapy clinics in rural and remote communities in northern Ontario. Doris was an experienced nurse (> 20 to < 25 years) working in a small town (< 10,000 population) as an emergency room nurse, doing everything from delivering babies to handling accident victims. At the time of the study, she was working in a part-time position (50%) in the outpatient chemotherapy clinic and another part-time position (50%) in the emergency department. Doris explained how she was hired for her current position, noting that “I was approached and I said yes…they needed an experienced nurse for the program…we are a small community and we wear a lot of hats.”

Courtney worked as a staff nurse in a small hospital for 8 years, and for the past 14 months, she has been working a cancer nurse in a regional outpatient cancer program. When she returned from a maternity leave, she was recruited into her position, noting that “there were a few positions but they really wanted me to take this one…and after my maternity leave, I was looking for a challenge so I took the position.”

Rebecca had 3 years experience as a pediatric in-patient nurse and was the only nurse in the study working with children with cancer. Rebecca had been exposed to pediatric oncology nursing during a student placement 4 years ago. When she heard about a position for a pediatric outpatient cancer nurse, she was excited to apply for the position. She stated, “I had to go for it pediatric oncology [because] it is a pretty specialized area and this is a rare opportunity for me.”
Social Networking

Rebecca, Gayle, Irva, Kelly, and Cathy indicated that they had learned about their cancer positions from colleagues who had described cancer care as a rewarding professional choice. This was a significant factor that influenced their decision to apply. For example, a colleague of Rebecca’s had called her about an opening in pediatric outpatient oncology. When asked about how she became interested in the position Rebecca stated, “I did my preceptorship in the 4th year of my degree nursing program in the pediatric oncology (cancer) program, and when I heard about a position opening up through a colleague of mine I decided to apply.” Networking with her colleagues made her aware of a job opening for a special position that she had been hoping would become available someday.

Another participant also obtained notification of her position through a former colleague. Gayle mentioned that a friend working at the cancer centre had spoken to her several times about applying for different cancer nursing positions, but she was unsure whether she wanted to work with cancer patients. Recently, her friend called her about a 2-year position to replace someone on an extended leave. Gayle decided to give it a try because her friend was so enthusiastic about cancer nursing.

Irva, a new graduate who was having a difficult time finding a job, was encouraged by a nursing classmate’s mother, who also was a nurse, to apply for a cancer nursing position at the hospital where she was working. Irva stated, “My friend’s mother [a cancer nurse] was so positive and encouraging about oncology nursing, I thought I would give it a try.” Another new graduate, Kelly, was encouraged by some senior nurses
who spoke to her about cancer nursing. She stated, “They made oncology sound so great, so I put it down as my second choice, and I got it, I am really happy I did.”

Cathy’s story was different from the other participants in the study. She stated that “her and her colleagues all wanted to work on the same unit so they picked oncology as their first choice.” She emphasized that it was not so much about wanting a cancer floor but the fact that they wanted to remain working together; because of a merger of units in their hospital, they were going to be forced to separate unless they were strategic about their choice of units.

Career Path

During the course of their careers, some nurses change their positions many times, but others do not. New graduates have expectations of a lifelong career and begin planning their career path during their final clinical placements as students. For example, Sharon, Shirley, and Kelly were new graduates who had student clinical placements on cancer units in their 4th year. Their student consolidation experiences exposed them to cancer nursing and resulted in their making cancer care part of their career path. For example, Sharon stated:

I really wanted to do something where my nursing care would be building a long term relationship with people. Shirley states I found when going through school, I really liked the personal aspect and making a difference…even though the patient might not get any better.

Shirley described the impact of her student experience on her decision to consider cancer nursing as her first career choice:

We started our orientation June of this year…a lot of us were students on consolidation here so we had some orientation…so I have been on the job for 2 months…it’s actually been really good…floor is supportive of newer nurses…teaching hospitals tend to be more supportive…I’ve had some issues in previous hospital experience where some nurses have not been very
supportive…they are all great here…so I don’t have any complaints…that’s how I became interested.

Seven of the nurses in the study had worked for more than 5 years, and of those 7 nurses, 4 of them (Courtney, Gayle, Fran, and Lorraine) indicated that their decision to enter cancer nursing could be partially attributed to the fact that they had been looking for a career change. For example, Courtney, who was returning from a maternity leave, saw a posting for a cancer nurse and thought that “it was a new position and I thought it would be a good time to make a change in my career.”

Gayle, who had worked for more than 20 years on a variety of in-patient units, decided to apply for a 2-year temporary appointment in an outpatient oncology nursing unit. She stated that “it was a good choice to make the move and start full-time in a new direction.” Fran also had more than 20 years of nursing experience and decided to leave an in-patient position and tackle outpatient cancer nursing. She stated, “It is wonderful to work in a profession where you can move around and get variety…it keeps you sparked…I think people stay in areas where they shouldn’t…and they are miserable and make everyone miserable.” Lorraine had more than 15 years of nursing experience in a variety of in-patient and community nursing positions, and after 6 months in an outpatient oncology setting, she stated that “it has been a positive change for me for sure I like the challenge…learning how to take my former training and apply it to this setting.”

Experiences With Cancer

The nurses often cited either personal or professional experiences that influenced their decisions to become cancer nurses. Four of the study participants recounted with some emotion the experiences that they had with close family members or friends who had faced cancer. Doris stated that her reasons for becoming a cancer nurse were
primarily personal, noting that “my father passed away from cancer, so I visited him on numerous occasions, and I became really interested in this type of nursing.” Fran mentioned a recent friend who had been battling cancer and died. She commented, “I have dealt with a lot of cancer over the past several years and so that became part of my decision to get involved.” Lorraine stated:

I [recently] had two family members with cancer and I spent a lot of time advocating for them in the in-patient as well as the outpatient areas… at their appointments…I was with them in chemo clinic during treatment and supporting them when they were in hospital.

Shirley, a new young graduate nurse, spoke of the death of her grandfather as being a very influential factor in her decision to pursue oncology nursing as a career. She recalled, “My grandfather died of cancer…so I really saw how the nurses worked…that’s how I became interested.” All of the nurses at some point in their interviews talked about the prevalence of cancer and the fact that people cannot remain unaffected by the disease. They thought about this when considering their decision to become professionally committed to caring for patients with cancer.

It is significant to note that 5 nurses (33%) of the study participants had previous exposure to cancer nursing through student clinical placements. It is also noteworthy that 3 of the 7 new graduates had recently completed clinical placements on a cancer in-patient unit prior to assuming their positions. Rebecca, a nurse with 4 years of nursing experience, completed a cancer placement in her 4th year that involved shadowing a pediatric outpatient cancer nurse. She subsequently went on to obtain employment on a pediatric unit. She admitted having been so inspired by the experience that when she heard about an available position for a pediatric outpatient cancer nurse, she did not hesitate to apply.
Norma, who had 10 years of experience in medical and surgical nursing as well as hospice care, stated that the main reason she became a cancer nurse was directly related to the fact that she did a placement on a cancer unit before graduating. She stated, “I really enjoyed the type of patient and was interested in doing chemotherapy and palliative care.” Since graduating, she changed from a medical unit and obtained a position in hospice/palliative care, but as soon as the opportunity arose, she applied for a position so that she could combine her palliative care knowledge while caring for cancer patients and their families. She described attaining her position as a cancer nurse as the fulfillment of her career goals, “as feeling as if I had finally arrived.”

Sharon, Shirley, and Jennifer completed student placements on cancer units immediately prior to graduation and were hoping to have opportunities for employment in cancer care following graduation. Sharon described her interview as a formality because the manager indicated that she would be hired because of her prior experience during her clinical placement. She stated, “The patient care manager and advanced practice nurse told me …I would be hired because I had done my final student placement here and they had got to see how I work…they said we really want you here.”

Shirley stated that her decision to pursue a position in cancer care was predetermined by her student experience. She commented, “I really saw how the nurses worked…that’s how I became interested.” She explained how important her clinical experience in a teaching hospital was in determining where she worked after graduation:

We started our orientation June of this year…a lot of us were students on consolidation here so we had some orientation…so I have been on the job for 2 months…it’s actually been really good…floor is supportive of newer nurses…teaching hospitals tend to be more supportive…I’ve had some issues in previous hospital experiences where some nurses have not been very supportive…they are all great here…so I don’t have any complaints.
Jennifer also credited her student placement as a critical factor in her success in obtaining employment in cancer nursing:

I was drawn to oncology…I did a rotation as a student and really liked it…I found when working on oncology I had more time with the patients…on the medical units the pace was crazy…in oncology the pace is quick but a bit slower and you can absorb more… “I really liked the nurses…they spend time with you and explain things…they were wonderful…they kind of brought me to oncology.

Professional Strengths

The nurses were asked about the professional strengths that they brought to their new positions. As new graduates, Irva, Ethel, Shirley and Jennifer focused on their knowledge and interpersonal skills. Irva emphasized her strength is finding the information she required. She remarked, “I use my resources, colleagues, and textbooks.” She emphasizes, “I never stops learning; my pursuit of education is ongoing.” Ethel was focused on the patients and credited her nursing program for teaching her about patient-centred care. She said, “I think my education did teach me to listen to the patient, to see what their story is, then go from there.”

Shirley and Jennifer mentioned excellent interpersonal skills as being their strength. Shirley stated:

I think communication is one of my strengths…I find patient advocacy too…in terms of cancer that can be tricky…whether or not you should treat people if the outcome is poor and the chance of survival is less than 5%…communication, assertiveness and speaking out for patients…those are my strengths.

Jennifer emphasized:

My strength is I am patient…I think that is very important…especially with oncology (cancer) nursing you can’t rush your patients…you have to take your time, spend quality time…you have to pace the activities of the day as well with the emotional aspect of the care…with oncology there is no routine…everything is personal to the patient and family situation.
The senior nurses (Rebecca, Fran, Gayle, Courtney, and Lorraine) identified technical, interpersonal, and decision-making skills as strengths that they acquired through previous positions. Rebecca stated, “I have experience in pediatrics, and oncology as well, community based programs, and I am bilingual which is useful considering a lot of patients have French as their first language they are more comfortable speaking French than English.”

Lorraine spoke about the personal and professional strengths that she could draw upon when working with cancer patients:

Personally I’ve had two family members who’ve had cancer…I have been in and out supporting and advocating for them…in the in-patient as well as the outpatient…because of my experience it helped me understand what the patients and families go through…issues that would come up on the phone…another strength is I have had a lot of independent practice…I worked as a supervisor…I worked out of country where I was forced to be independent…learn a new environment, new language…I’ve moved around…so I am flexible…able to learn new skills quickly.

Fran mentioned her work in many different clinical areas over the past 20 years. She stated, “I have expertise in technical skills, monitoring sicker patients, cardiac monitoring, starting IVs, dealing with emergency situations.” Gayle spoke of her areas of expertise, including “starting IVs, central venous line care, previous experience working with palliative patients, families.”

Courtney emphasized that she brought a variety coping skills with her into CNP (“community nursing skills”), working for the VON (Victorian Order of Nurses), and more autonomy; she further explained, “I have had to be more resourceful…go out and research a question…not be afraid of being on my own. I do a lot of reading.”

Cathy highlighted the importance of skills related to administering chemotherapy to patients:
I have a lot of practice doing central line care, cancer related or unrelated chest pains, cardiac care, blood pressure medications…starting IVs, running heparin drips. Cancer patients don’t usually have nice veins though, but that was okay, because the more you do it, the better you get at it.

Doris, who has worked for 24 years, brought advanced skills combined with recent personal experience related to her position. She stated, “I think years of experience…past experience with family members who had cancer…I am well suited for these patients…very capable with accessing IVs, central lines.”

Being Hired

The nurses’ experiences during the hiring process were varied, ranging from no interview to an extensive formal panel interview. The 9 nurses who received an interview, with the exception of 1 nurse, were positive regarding their interview experience and pleased to obtain their positions. Six of the study nurses (40%) were never formally interviewed for their cancer nursing positions because of prior student placements or the result of a direct transfer into a cancer unit. It is significant to note that in-patient positions were filled primarily by nurses with less than 5 years of experience and new graduates who had had recent student placements on in-patient cancer units. As students, they had preliminary interviews and informal evaluations with nurse preceptors and managers, and they had to complete initial orientation programs. As for the outpatient positions, they were taken by only senior nurses who had never worked in an outpatient cancer setting prior to their interview. These nurses had formal panel interviews followed by lengthy and extensive orientation programs.

The findings are categorized according to the formal and informal interview experiences of nurses in in-patient and outpatient settings. It is important to pay particular attention to the type of interview (formal, informal); structure of the interview (single
interviewer, or panel); content (type of questions); and factors affecting the interview process.

*In-Patient Interviews*

The majority of nurses who applied for urban in-patient cancer units had less experience (7 of the 9 were new graduates), and compared to their outpatient cancer clinic counterparts, competition for their positions seemed almost nonexistent. Irva, Sharon, Jennifer, and Norma applied for positions on in-patient units in urban cancer programs and were positive about their interviews. They all experienced a fairly similar interview process that was in keeping with common hiring practices, including an interview with the unit manager and clinical educator.

Irva, a new graduate hired to work on a surgical cancer floor, described her interview experience:

> It wasn’t cancer focused…the manager knew I had little experience…there was only one question specifically about cancer Your patient is going home and they’ll be returning to the cancer centre to have chemotherapy. How would you discharge that patient? I think that’s the only thing we talked about, oncology-wise in the interview.

Irva also stated, “During the interview process, I was impressed with the manager. She not only supported my practice but life outside work but also supported me going back to school to take courses related to my work…she was wonderful.”

Sharon, a new graduate, described the questions that she was asked during her interview:

> Initially, I wrote a test…like basic things what would you do if you came across an unconscious patient that kind of thing, interview was more psychosocial, what would you do in this situation, a lot to do with peer relationships…how would you work out that problem…your leadership, team work, being able to make a decision independently, they asked some oncology specific questions…what is the most common place to get colorectal cancer…care of the person with
esophageal cancer.

Sharon explained that the interview was not as stressful as it could have been because she had completed her final student rotation on the same unit:

The patient care manager & advanced practice nurse told me it was a formality…I would be hired because I had done our final student placement here and they had got to see how I work…they said we really want you here and don’t worry if you are not answering the questions there is no right or wrong and we are going to fill in the educational gaps once you start…it wasn’t as stressful if you just came in off the street.

Jennifer, a graduate with less than 2 years of experience, described the interview for her cancer nursing position as a positive experience:

I had an interview with the old manager who was moving to the clinic and a new manager for the floor…I interviewed with both of them…They asked me how do you like working here, what brought you to oncology, they were really good…so the interview went fine and I got hired.

Norma, a senior nurse, explained that her interview was fairly casual, noting that “yes, I interviewed for the job, the manager was there…also the clinical teacher…they pretty much ask you why you are interested in the floor…why do you want to do this type of nursing, no technical questions.”

Shirley and Kelly were new graduates, but unlike the other new graduates, they did not experience a formal interview for their positions. Shirley stated

I didn’t really have an interview…I started off as a consolidation experience…through the school…after seeing us for 3 months the coordinator really knew us and kind of offered us temporary positions through the summer…when full-time position became available I applied for that…I was the only person that applied…I got the position…there was no interview.

Shirley also commented that “being a student on the unit and having staff members as preceptors was the key to the success in obtaining my position on oncology.”
Kelly had a similar experience:

I talked to the coordinator a number of times throughout my consolidation…she asked what my plans were…and then there were a series of questions that were emailed and I went through them with my preceptor…on the last day of my consolidation I was coming off of night shift…the coordinator asked me to her office…she said we are going to hire you…so there wasn’t really an interview process per say…but we did talk about what I could expect and what she expected.

Cathy, a senior nurse who was working as an in-patient oncology nurse in an urban centre, also was not formally interviewed for her position. As the result of a merger of nursing units, she attained her position (per union contract) by transferring into the cancer program. She stated, “We had three choices, first, second, and third choices, and then by seniority…that’s how I ended up in oncology.”

Ethel and Robin, relatively new graduates with less than 1 year of nursing experience, did not participate in formal interviews for their cancer positions. Initially, they had been hired to fill part-time casual positions within the hospital. For the past 6 months, Ethel had been floating between medical floors, and Robin had just completed a maternity replacement for a pediatric unit. Ethel said, “I didn’t have an interview I went down to work an extra when they were short and the acting manager chatted with me about the shifts I would work…from there it was history.” Robin remarked that she was forced to work in oncology because no other positions were available and she needed the work. She stated, “I never had an interview I was told by the scheduling department that I had been assigned to the cancer floor because there were no other positions available.”

Outpatient Interviews

Gayle, Lorraine, and Fran were senior nurses hired into outpatient programs in urban cancer centres. These nurses faced competition for their positions and had similar
styles of panel interviews, but their personal stories were different. For example, Gayle described her interview process with the panel (manager, educator, and oncology nurse) as “very scary because I had never been interviewed for a specialized job prior to this interview.”

Lorraine described her interview as follows:

Comfortable…the manager was present, a supervisor as well as two nurses in the position…there were questions about independent practice, telephone practice, College of Nurses requirements, your ability to work on your own as well as with a team with physicians…questions about understanding cancer, what my understanding of cancer is and legal issues.

Lorraine also emphasized that one of the strengths of her interview included a tour of the facility. She stated, “They gave me a tour prior to the interview I found it relaxed me …my manager met me and we walked around…it helped me get a better understanding of the environment I would be working in.” She elaborated by explaining that because of differences between in-patient and outpatient units, the tour assisted her with the interview because “there were a lot of questions in the interview that had to do with understanding how the outpatient department operates in order to respond appropriately to the questions.”

Fran described her interview as follows:

Fluffy…I was very nervous and not sure how to prepare for it…I got into the room and instead of the usual 5-6 people which is the norm these days there were two (manager, nurse educator) …they asked fluffy questions not technical questions…it was very different.

Fran also emphasized that even though she asked questions, “I didn’t get any information about the position they told me I would be floating, which I wasn’t sure what that entailed…I mean I didn’t exactly know what to expect, it was like going in blind.”
Courtney and Rebecca were hired as cancer nurses in rural and remote satellite cancer programs in northern Ontario. Courtney described her initial entry into the regional cancer program as follows:

I was on maternity leave and noticed a posting for an oncology (cancer) nurse. Courtney says the panel who interviewed her was not familiar with cancer care and was very vague when they asked specific questions about the nature of the work, the interview wasn’t very good…I don’t think they are familiar with oncology (cancer care) at all, or the program a whole lot.

She also stated that her current boss

Is wonderful but has no idea about oncology [cancer] and if I have questions I phone the urban centre where I took my training or one of the part-time experienced emergency room nurses [who also work part-time in chemotherapy unit] if I can get them.

Rebecca did a preceptorship in the 4th year of her baccalaureate nursing course with the pediatric oncology outpatient coordinator, commenting that “when I heard the position was open, I applied.” She had a panel interview with a variety of people because her program was part of a provincial outpatient pediatric oncology program. She described the interview process as follows:

I had a panel interview with someone from pediatrics, someone from supportive care as well as someone from the provincial pediatric oncology program…the position is a little different in that I report to the local regional cancer program but also have a boss at the provincial level.

She explained that her position is different because she “reports to the local program but also has a boss at the provincial level.”

Doris is an experienced nurse (20-25 years) working in a small community hospital (> 10,000) who was sought out for her position by virtue of her extensive nursing expertise in northern communities. She explained that she was approached to take a part-time position in the regional satellite chemotherapy program. She explained,
“There was no real job interview...we are a small community hospital and wear a lot of hats...nurses work in emergency part-time and for a second position work in the operating room or oncology.”

She also explained their program:

We give chemotherapy here no radiation...radiation and experimental chemo therapy is done in the larger outpatient cancer centre...we have two chemo chairs, monitors, pumps...we service quite a few people...we have a lot of full days...it is convenient for the patients who would have to drive to the larger centre which is two hours from here.

Summary

The nurses learned about their respective positions through social networking, personal experiences, and student clinical placements. They completed formal or informal interviews, and were they hired for in-patient and outpatient cancer settings in either urban or rural cancer programs. The nurses’ previous experiences, their career vision and goals, and the availability of positions predetermined their entry into CNP.

More positions were available in in-patient cancer nursing than in other nursing specialties. On the other hand, in the outpatient settings, the jobs were more competitive and sought after by senior nurses. Whether or not it was an in-patient or an outpatient setting, each nurse entered the new position with preconceptions of what it would be like to become a cancer nurse, and each of them was faced with unique contextual factors that impacted her learning about CNP.
CHAPTER 5: SURVIVING IN

Introduction

In this chapter, the nurses’ experiences while being orientated and learning to cope during their transition into their new role are examined. Specific topics of interest include learning needs specific to CNP, supports available during the first few months, greatest learning challenges, emotional impact of witnessing suffering and death, and facilitators and barriers to learning.

The phase of surviving in encompasses two main thematic areas related to the role strain experienced by newly hired cancer nurses: (a) shock of - being orientated to (in-patient and outpatient settings) and the emotional impact of “being with” cancer patients, and (b) struggling with - learning as you go from patients and colleagues, and suffering (feeling suffering, personalizing suffering, surviving suffering, and accepting suffering).

Shock of Being Oriented

The orientation experience for the in-patient and outpatient cancer nurses was similar in some aspects and different in other ways. There was a general consensus among the participants that the amount of cancer-specific knowledge that the nurses needed to learn was significant. They also acknowledged the emotional strain of working with cancer patients and agreed that the guidance of preceptors was critical during their orientation. The didactic (i.e., formal learning) programs and the strategies for delivery (i.e. lectures, videos, learning modules) were similar in content. The clinical hands-on learning experiences (i.e., informal learning) were unique to the cancer settings, namely, in-patient, outpatient, urban, and rural, and the specific context of the individual nurse.
**In-Patient CNP Orientation**

The 9 nurses (Irva, Sharon, Shirley, Kelly, Ethel, Robin, Jennifer, Cathy, and Norma) who had been hired to work on in-patient cancer units acknowledged the significance of having support from managers, educators, advanced practice nurses, preceptors, and experienced staff. They indicated that a distinct body of knowledge is required to care for acutely ill cancer patients. This information includes knowing types of cancer and how to administer treatments, handle treatment-related side effects, and care for palliative patients. They stressed the importance of learning from experienced nurses as key to a successful orientation.

The nurses had recently completed their formal orientation to their new role, including the opportunity to work alongside an experienced nurse preceptor. Several of the nurses \((n = 7)\) had the following characteristics in common: < 2 years of nursing experience; working in in-patient settings either general oncology \((n = 3)\), or surgical oncology \((n = 4)\); and having worked at least 3 months, but not more than 18 months, in their current positions. Their orientation ranged from 1 week to 3 weeks, the average being 2 weeks \((10\) days). For the most part, the 3 nurses who had completed final student placements on their respective units had a shorter orientation than those who had not previously been placed on the unit. The orientation included a 1-week introduction to basic oncology skills, followed by 1 week of clinical practice with a preceptor.

The new graduates spoke highly of the value of having expert nurses to guide their practice not only during orientation but also during the weeks and months that followed orientation. Because their orientations were still fresh in their minds, they were able to describe in detail their informal learning experiences and the supports that
enhanced or impeded their ability to learn about cancer care and adapt to in-patient
cancer settings. They also were able to share the supports that they would need over the
next several months to continue their growth as cancer nurse and feel competent in their
new role.

*Formal orientation program.* Irva, a new graduate, described her formal
orientation (classes, resources) in great detail, stating that she received a huge binder of
information and “did a lot of reading and reading.” Irva explained that her orientation
was very intense at times:

The educator and I spent a week together and went over everything…I was given
a binder full of information about particular types of surgery, policies, dressings,
post-operative care, discharging patients…I was very overwhelmed [she repeated
three times with an increasing emotional intensity in her voice] …the week after I
went through it I thought I needed a break…I was saying to myself, “What have I
gotten myself into?” Eventually, we have to be certified to do all these things, that
terrifies me…later on the following week, I got more comfortable.

Sharon’s orientation was similar to Irva’s: She had binders of material to read and
spent dedicated time with the educator, followed by a few weeks working alongside staff
nurse preceptors. She mentioned that “there was a few days of corporate
orientation…general like running blood transfusions…PCAs [patient-controlled analgesic
pumps]…pain management course…we haven’t done chemo yet…the different surgeries,
managing central lines, IV pushes, chest tubes.”

Shirley described the specific topics covered during her orientation:

About a week, we sat with the clinical educator and went over different types of
cancers…was very helpful…met all the allied health members…OT and PT,
dieticians…found that helpful to learn about ‘their service and how to get hold of
them…a lot of focus on different cancers, treatments…and the expectations for
becoming certified in chemotherapy…we had a tour of the outpatient cancer
centre…spent some time there in stretcher bay…found it helpful got to see the
transition that patients go through…even got to sit in on clinic visits nice to see
how they go through their care…it was great to see the clinic side of it.
Shirley also commented on the weaknesses and strengths of her orientation:

I found orientation good…sometimes a little dry…and maybe if we could have had the information ahead of time…because we were kind of thrown into it…I think that is the only complaint I had…at times it was overwhelming (emotional tone) and hard…you want to go home and review all the material, but you have to get up the next day and do it again…so sometimes it was hard.

Shirley also mentioned having the unique experience of being able to discuss with other nurses what it is like to be an oncology nurse. Shirley stated that they started their orientation by watching a video about what it is like to work on oncology and that “this really helped us get to know the staff.” She talked about this very positive learning experience with great excitement in her tone of voice:

What was really nice was we had a video of the staff on our floor talking about what it is like to work on an oncology floor…and we started our orientation by reflecting upon what oncology is for them…that was a great aspect of our orientation…meeting the other members of the health care team…you felt right at home, and you knew they had been new like you and had made it.

Norma, on the other hand, described her formal orientation as much more self-directed and paced with practical experience:

I had worked with chest tubes, central lines…listening to patients…dealing with young people dying… first (3) 12-hour shifts, you follow someone…she kind of showed me the ropes…then you have the theory…class go through chemo…then CDs on chemo, life-threatening things like…spinal cord compression…5 CDs took 14-16 hours to do on your own…I got paid for the 8-hour class and the 4 shifts did the CDs on my own time… they were useful…then we did a certification…a test…you had to have 80%…questions were asking…pretty much if you understood what you read or saw on the CDs…had a preceptor (2), one for the 2 day shifts and another for the 2 night shifts.

Norma had expertise dealing with critically ill and dying patients, but chemotherapy was new to her, and she stated she needed more information and support in that area of her orientation:
I think I needed more on the chemo part…or at least working with someone with seniority and she could guide me through…like the protocols don’t follow in order…that’s why if you don’t know the protocol, it’s easy to make a mistake…when you are giving a new protocol, you really need to have someone there with experience.

Accessible supports. When the nurses were asked about the accessible supports that assisted them during their orientation, they stressed the importance of both the educator and nurse preceptor(s). Irva said she spent 1 week with the educator reviewing new topics, an activity that helped her to apply the new knowledge to her previous learning experiences. Irva explained her orientation:

She (educator) would start off discussing a topic; then she would ask me to tell her about the procedure…then she would add a few things…through that I felt engaged a bit more…she made me pull on my previous experiences in school…I was by myself…I found out the new hires spent 1 week with the educator…that was nice. I also had a variety of preceptors…I would be assigned to someone for 2 weeks (Monday to Friday)…depending on who I was partnered with I felt as though I had to prove myself…to a certain degree I understand…I felt some people treated me like a child…the resource nurse who doesn’t take a patient load was great. She would say, “Come here,” and she would show me things…she was really supportive.

Sharon stated that a lot of support was available to her, commenting that “there is an ostomy advance practice nurse, wound advance practice nurse, an oncology advance practice nurse and an educator… everyone works as a team with the patient.” When Sharon was asked whether she needed any further supports following her orientation, she admitted that “I didn’t feel ready after my orientation, and when Sharon spoke to the educator she said, nursing is dealing with the unexpected…don’t struggle ask for help…she also said don’t worry it will get better.”
Shirley also emphasized the importance of the nurse educator and clinical preceptors:

We had a preceptor…clinical educator put us with a full-time nurse who has been on the floor for several years, so we could see different cancers and treatments…work with different staff members and different shifts…get used to what it is going to be like.

Shirley stated that by far, her clinical preceptor was the greatest help to her during her orientation to the unit:

I had the same preceptor as I had as a student that was definitely an advantage…she was great…that’s why I wanted to stay there and work after graduation…she would introduce me to all the allied health members…she taught me a lot about the particulars of the floor…and how to do specific orders…things you don’t learn in school…we could have requested more hours if you think you needed more time…I think the greatest strength was the staff members themselves and picking the right people to pair you up with people who had been preceptors before…and had some experience working with students and new people…which was really helpful.

Shirley also described a session conducted by the clinical educator, noting that “she had us all sit down and talk about what caring and oncology nursing means to us.”

She described the atmosphere on the unit and warm and caring, and she stressed that everyone works as a team and supports one another. To her, the coordinator, educator, nurses, and physicians, “they are always there for you.”

Kelly, who orientated to the same unit as Shirley, described the same process for her orientation. She praised the educator and the preceptors for their support:

We had a week of classes…going over procedures…which was really good…our orientation was awesome…then we had equivalent of a full 2 weeks on the floor with somebody else…it went really well, and the staff were amazing supporting us…and they were very open…I don’t know some places in the hospital it is not like that…it is like they forget that they were all there at one time and needed help…I am not afraid to ask any questions…it was such an easy transition that way…the educator has been awesome…she encourages us…we can go and talk to her about anything…the staff have been incredible…constantly there for us…answering our questions…telling us what questions to ask…extremely
supportive…it went really well and the staff were amazing supporting us…they were very open…I don’t know in some places it is not like that…I was not afraid to ask any questions it was an easy transition.

Ethel was positive about her orientation, but she stressed that staff were not always accessible:

I actually got really good education and support…a chemo course, introduction to oncology…interesting, evidence-based…a huge binder with a lot of information I use it all the time. I was given a couple of days with a preceptor…3 or 4 days with an oncology nurse…it has been about learning yourself…we are short staffed, and quite often, you are booked for orientation, and you get pulled to work on the floor because they are so short staffed.

Ethel stated that she was learning new skills through observation and supervised opportunities to learn:

I have hung chemo twice on my unit not a lot…the more experienced nurses hang the chemo…and am learning from what she is doing…the RNs on that floor I consider to be phenomenal and very bright young minds…the physician writes his orders and discusses them, he has been good for teaching…it is a very good unit for learning.

Robin noted that “we were paired up with someone and that was good…the course was good and the manager and educator were helpful…the staff were always around.” Robin asked for more orientation and was given an additional 2 weeks of orientation.

Jennifer described the theory classes as frustrating, but she was very positive about the hands-on experience with a preceptor:

We had a couple of weeks orientation…it wasn’t a good start…fair start…we had some learning packages they gave us to read over to get the “gist” of how things worked…codes, splash kits, seizure kits stuff like that…most of it you learned on your own…talking with the nurses…wonderful staff who help you…explain things to you…which is why I like working on this floor…we were paired up with different nurses for each week…it was a good experience because you got idea how nurses work…you quickly learn that everyone does it a bit different, you do it differently and that’s OK doesn’t mean it’s wrong.
Jennifer experienced only one difficulty:

From the time I was hired until I became chemo certified, there was a 6-month gap…I had to ask other nurses to give chemo to my patients…apparently if you are hired as an experienced nurse, you could start learning how to give chemo right away…as new grads, we had to wait and get experience before we can progress to chemo…I think the nurses understood, but they still felt frustrated they had a higher workload that was a burden for them, but it was out of my hands.

Cathy recalled some of the stressors during her orientation, stating that “I needed someone to explain things …you can read books until your eyes fall out but until you can actually see things and get the experience you don’t have a grasp on it.” Cathy was clearly frustrated with the lack of experienced nurses on her unit to assist her with her initial and ongoing learning needs:

We were short staffed…it was pretty bad…it wasn’t a nice place to work and I kind of feel the only reason I am still here is because I am part-time and I don’t have to deal with it…day in and day out.

*Outpatient CNP Orientation*

Outpatient nursing is similar to community nursing in that it carries with it a higher level of isolation, autonomy, and responsibility. Primarily, experienced nurses are hired for outpatient nursing positions because they have advanced assessment and communication skills. The 6 outpatient nurses (Fran, Gayle, Lorraine, Courtney, Rebecca, and Doris) were experienced nurses, but they spoke about their significant knowledge gap in regard to cancer knowledge and skills, and they emphasized the importance of having experienced nurses to guide their learning. The nurses’ learning needs were similar, but their workplace settings were different. Three nurses were working in large urban outpatient centres with ready access to supports, and the other 3 nurses were working in rural and remote outpatient settings.
Urban outpatient CNP. Fran, Gayle, and Lorraine were experienced nurses who had been employed for 15 to 25 years on a variety of in-patient units in large urban hospitals. All three nurses described their orientation experiences to outpatient CNP as stressful and very different from their previous in-patient positions. Similar to the nurses orientating to in-patient CNP, the nurses orientating to outpatient CNP agreed that access to outpatient CNP knowledge, educators, and experienced nurses when orientating to outpatient CNP was essential.

One nurse in particular, Fran, did not have any defined nurse preceptors during her experience, and she felt that this was the reason she had difficulty adapting to her role in the outpatient setting. Fran described her orientation to outpatient oncology as very stressful, noting that “you get so bombarded at the beginning of the orientation [because] there is so much information to take in.” Fran explained that although the orientation had a lot of good information in it, she was frustrated because she did not have the opportunity to learn with a preceptor:

> I feel to a certain extent we sort of got dumped on…you are doing a lot of self learning when you get the opportunity…I’m from the old school, maybe I am task-oriented, but I like to read…and then I want to see it. There was a lot of good information…my problem…I think was I think we should of been buddied with one or two nurses…you work with them…and then at one point they step back and say now you are running this clinic.

Gayle described her orientation as “very stressful since everything was new…and overwhelming.” She also stated that the orientation was disjointed, but the orientation binder “was the most valuable and her bible.” She commented that the best part of the orientation was working with the preceptor:

> Observing and learning as you go…invaluable to observe the expert nurse handling a drug reaction…staying calm and reassuring the patient…it is as
important as knowing how to give the drug knowing what to do for the patient who is frightened.

Lorraine stated that the greatest challenge she faced was the orientation to the outpatient setting. She spoke specifically about the differences between caring for patients in the outpatient as opposed to the in-patient setting:

I was on my own. I was the only one in the orientation…you go home, and your family doesn’t understand…so it was just me…the unique thing was the orientation was designed by the educator to specifically meet my needs…that made a big difference…the only thing is I wish I had someone to go to lunch with…kind of felt isolated…the first 3 weeks was very intense…the educator was like a mentor…she prepared the week’s schedule for me and matched me up with primary nurses in different clinics…new things like interviewing patients…when you’re in the in-patient setting you focus …on the physical stuff…in the outpatient setting your main tool is your eyes and ears and your communication skills…that was the biggest challenge-what to ask the patient and where to take the information once you received it…it’s all about process in the outpatient setting…in the in-patient, there is so much paperwork …here, you have to use the computer so much, and that is different.

Lorraine, with the help of the educator, identified her own learning plan:

The educator encouraged me to put together a binder based on the different disease sites…and that was helpful…she also showed me how to search in the library, as well as on the computer system… and that was very, very helpful.

*Rural/Remote outpatient CNP.* Courtney, Rebecca, and Doris were practicing in outpatient oncology settings in rural and remote communities in northeastern and northwestern Ontario. Their oncology orientation programs were taken primarily at the urban centre that their satellite program was affiliated with, which meant travelling to and living in the urban centre while they attended classes for 2 weeks at a time, followed up with learning modules, videos, and CDs that they were able to take home to augment their learning. They had preceptors at the urban centre for 1 to 2 weeks of hands-on training administering chemotherapy, which they indicated was the most significant part of their orientation program.
Once they returned home, they could contact the preceptors by telephone, e-mail and video conferencing to obtain further support and training. One interesting aspect of their role was that they had to learn how to prepare the chemotherapy medications with a pharmacy technician, so they would spend a couple of days with the pharmacist in the urban centre to learn this aspect of their role.

Courtney, Rebecca, and Doris had to travel to receive their orientation to their new role as a cancer nurse. Courtney stated:

My orientation included a 4-day course at the urban centre, followed by a few practical hands-on training with a preceptor preparing chemotherapy. She says I was well prepared for some aspects of the role because of my community nursing background but in other areas, I needed additional training in IVs, assessments, and how to conduct telephone follow-ups.

Courtney had to travel by car for 6 hours to reach the urban centre, and she would stay for several days. The orientation included a 4-day course, followed by a couple of days of practical training with a preceptor. She described the experience as “an isolating one…she felt completely alone and she says they gave me the information on the drugs and what to look for…but didn’t prepare me for the emotional part.” She stated that because of her community nursing background, she was well prepared for some aspects, but when she went home, she needed to spend extra time in the operating room and emergency to get her technique starting intravenous lines:

I took this new comprehensive orientation program… then just 2 days starting IVs …we didn’t have to start IVs where I worked before (maternity) that was a big skill I had to learn. I went to the outpatient clinic…watched one of the nurses…then started IVs… I had trouble starting IVs (intravenous lines), so I took two extra days in the OR, got my IVs done. IV skills…assessment skills are pretty crucial including telephone practice …do a lot of telephone follow-ups…that’s difficult for me.
Rebecca recalled her orientation to pediatric outpatient cancer nursing as being very intense and lasting for a total of 8 weeks:

I had 4 weeks [of] orientation…3 in the centre [tertiary urban centre] and 1 here (regional program) with another pediatric nurse…basic orientation to the cancer centre. The pediatric team is throughout Ontario, three or four senior nurses were involved with my orientation…as well as the manager…from the cancer centre, a manager with supportive care assisted me…one of the challenges with the position was I never had contact with my predecessor…so there was no one to say this is how we do things.

Rebecca recalled the strengths and weaknesses of her orientation:

When I went to the centre, it was helpful to see how things worked at the tertiary centre and learn the role…I guess one of the weaknesses would be that it was almost too long without practical application to it…it was a lot of how things are done in (urban centre)…but that’s not the same as dealing in a small community…the biggest difference between larger centres…is if something comes up they have more people to refer the family to…I have twice as much work per patient because I have no one to refer to.

One of the weaknesses of her program was that “it was too long without any practical application…and it focused on how things are done in urban centre and that is not the same as dealing with similar issues in a small community.” Because Rebecca was the only one in her region, all of her preceptors were at a distance. She said that it helped when they had weekly teleconference calls to discuss cases, but she also stated she is still very alone because “things are different here from the city.”

Doris stated that her orientation program was primarily an SDL experience:

My orientation was a lot on my own time…I would say for 3 weeks I would review these disks [CDs] … the next day ask my preceptor questions…it was kind of hands-on…there was a post-test…then I went to the larger centre and spent a couple of days with one of the nurses…and one day with the pharmacist…to help me prepare medications…it certainly meet my needs…but really there is a lot of routine to what goes on…we have regular communication with the larger centre and we are linked electronically and we have access to their charts in the larger centre…the nurses call us re-our patients…we have teleconferences monthly…there are 20 satellites like us and we have a meeting once a month to
discuss problems…very informative…it is very educational…keeps you up-to-date on things.

Shock of “Being With” Cancer Patients

The nurses in this study had never worked in a setting where 100% of the patients have a diagnosis of cancer and are receiving either treatment or palliative care. With the exception of 3 new graduates who had completed final student placements on cancer floors, the other participants were completely naïve to CNP. They were asked during their interviews to describe their initial thoughts on what it was like to become a cancer nurse, and the stresses and challenges of those early days.

During the first few weeks of practice, both the new graduates and the senior nurses identified the emotional strain of caring for cancer patients as a significant personal and professional challenge. Though the context of their work was different, in-patient and outpatient nurses commented equally on the stress of working with critically ill and dying cancer patients. The in-patient nurses were newer graduates and had more supports available to them, whereas the outpatient nurses were more experienced and used to functioning in a highly autonomous role with fewer supports. The nurses were asked to comment on what it was like to become a cancer nurse, connect with their patients and share stressful experiences.

Becoming a Cancer Nurse

When Shirley, a new graduate of 3 three months, was asked what it is like to become a cancer nurse, she stated,

It’s definitely a huge change…the focus is more on the personal relationships with the patient everyone tells me it is amazing that I can work oncology. Even though cancer care is more stressful the supports help you get through. One of the main stressors of the role is that patients die…it happens more frequently than on other
floors...so if the patient does pass away, it affects everyone on the floor...there is an outpouring of support, and there is always somebody there.

Robin has less than 2 years of experience and has been working for the past 8 months on an in-patient unit. She described her first few weeks learning about CNP as very overwhelming:

To become an oncology nurse...it is intimidating at first because everything is new...I didn’t know a lot about cancers and treatments...I think a lot of the same nursing skills you use on other floors you use here as well...I just kind of got thrown into it not a lot of training at the beginning which made it even more intimidating...everything was new...a different avenue of nursing...a lot of different medications...different cancers...just a ton to learn.

Jennifer obtained her position as a new graduate on an in-patient unit 18 months ago. She shared her first impressions of working on the cancer floor:

We get patients from all walks of life...blue collar workers...those from highly educated...rich, poor middle class...they also come from different places Owen Sounds, Chatham, Windsor, London...you have farmers and doctors...It’s hard because it is devastating news to learn you have cancer...and there are only so many treatments we can give you...then we have exhausted our arsenal of medications or treatments...it’s fascinating, but it is also overwhelming how people deal with it and what kind of hurtles they go through...some people are very organized about the care...they have a healthy outlook on things...and other people who you’d think would have a great way of dealing with it fall apart...and you really need to spend time with them.

Lorraine, an experienced nurse working for the past 5 months in an outpatient setting, described her first few weeks:

I think there is more responsibility...the patients expect more of you...it’s difficult for them coping with their disease...it’s stressful for them...you have 8 hours to assist them with their issues...in the in-patient...you can pass on what you were not able to get done...the patient’s needs are greater...and your role as an advocate is greater.

Kelly, another new graduate of 3 months, remarked, “The very thing that makes oncology nursing so hard also makes it special.” Her first impressions of cancer nursing had an emotional impact on her:
The first young death I had in oncology…that had a big impact on me…I will never forget that…because it was a young girl around my age, you know you can relate to that…then you have to re-evaluate everything you thought you were going to do…another incident was a patient who had a sudden psychosis wouldn’t sleep was trying to hurt herself…we had to tie her down…that was hard for me…extremely hard for me…I agree they had to do it so she wouldn’t hurt herself…that was one of the hardest things I’ve ever done.

Kelly also stated, with a great deal of emotion in her voice, that “with cancer you lose so many young ones…when people die in nursing homes they have already had a good life and a lot of them are ready to go.” Kelly also expressed her surprise at how difficult CNP is:

I had no idea the care would be so complex…we deal with everything…when I thought about it, it was just chemo and they would go home…you don’t think of how complex the treatments are and that people are dying…we are constantly thinking of fluid and electrolyte imbalances…there are PICC lines all over the place…wounds…just literally everything on this floor.

She also stated that in retrospect, the transition from in-patient to outpatient nursing practice was a learning challenge:

When I first started, I realized how much support you needed during your orientation process and I actually at the end did a presentation on the challenges in that transition. It’s been a positive change, for sure…I like the challenge…learning all the disease processes…learning how to take my former training…and how I can apply it to this new setting…quite a challenge…an excellent learning opportunity.

Rebecca, a senior nurse working for the past 7 months in a highly independent role as an outpatient pediatric cancer nurse, stated, There has been a fairly steep learning curve just to learn a specialty rather than to be a generalist.” She gave more details:

It is stressful because in the general pediatric unit…patients are in and out and feel better…now I have patients I follow for three to five years…so there is certainly more involvement with families and children than as an in-patient nurse…I keep a pen and pad at my bedside because sometimes, I wake up and remember I need to follow up on something with a patient…it is difficult to learn this type of nursing…there is no one to back you up- you are it! [a raised tone to her voice]
Fran, with 25 years of experience on in-patient units, has spent the last 11 months as an outpatient cancer nurse. She described the first few weeks as far more of a learning challenge than she had anticipated, as well as emotionally unsettling. She stated [her voice choking with emotion]:

I saw a baby 1 week old in chemo…the baby’s mother …got diagnosed with breast cancer while she was pregnant…now she is starting chemo…but there is hope, you know what I mean. Personally, for me, it has been a big change…I knew it was going to be a challenge…I was looking forward to that because I have moved to a lot of different places throughout my career…I knew it was going to be a challenge, but it was a lot more than I expected.

She was surprised and stated that she had no idea how much I would need to learn and how hard it was going to be”:

My friends [nurse colleagues from previous in-patient position] didn’t realize how different this job was going to be…they kept asking me what is it like…and they see the struggles I have been going through this past year…they are saying, holy cow, I didn’t realize it was like that, well either did I.

These same sentiments were echoed in Courtney’s words about her first few weeks in cancer care. When asked what surprised her about being an outpatient cancer nurse, she responded:

The emotional, it’s more emotionally challenging, and I am isolated more. I feel guilty when they are having all those side effects…I find that very frustrating…in the hospital…you see them 24 hours, you can assess better how they are doing…with outpatients, you don’t have that same ability.

Doris, a senior nurse, has 18 months of experience as an outpatient chemo nurse. She talked about her first few weeks working with cancer patients from rural communities:

You are not only dealing with that client, but you are dealing with end of life issues, you are dealing with families, you are dealing with finances…because patients ask a lot of questions…so that was very stressful in the beginning…because you didn’t really know what was available.
Connecting With Cancer Patients

Irva has worked for 3 months and is struggling to learn what she needs to know to survive as a cancer nurse. When asked about her first few weeks, she commented, “I didn’t realize the patients were going to be so acute.” Irva talked about her first hurdle on the job, which was to learn how to get comfortable talking to cancer patients:

I think that this job, it’s been really touching actually…had the opportunity to connect with my patients very quickly on an emotional level…very different from where I last worked…general surgical floor…not sure if it was because I was a new grad and shied away from it, because you never know what to say and you want to say the right thing to help, but your just not 100% sure what that is…I’m finding that I still have no idea what to say, but I’m not saying a lot. And it seems that it doesn’t take a lot, then all of a sudden we’re talking for half an hour and we’re connecting on that other level…I find that to be one thing that stands out in my mind.

She stressed that “the psychosocial, emotional part is the most difficult. Absolutely! I think skills can be taught to anyone. It’s that other area [communication] that is not so black & white and is so scary.” When Irva was asked to describe a particular incident with a patient that stood out in her mind, she described one case she would never forget

She was 29 with uterine cancer…Holy smoke she is only 29!…I kind of felt connected with her…I don’t remember what I said, “How are you feeling?” …and she started to tell me everything, and I get emotional thinking about it…[pauses for 20 seconds] it was so wonderful I could connect with someone so soon…I didn’t really say anything…I never connected so quickly with people like this before at my job…and I am terrified I am going to say the wrong thing, but it is so nice I just can’t get over that…

Irva reflected further on this experience and what it meant to her personally and professionally:

People always ask why did you become a nurse? I think one of the reasons is because we see people at their most vulnerable time…it is humbling…we are privileged to be able to help them through that time in their life…listen to their stories…
Sharon described one incident that happened during her orientation, and she learned how important it is to really listen to the patient’s story, even if it may be difficult to hear.

It is so important to talk to the patient and find out where they are coming from…for example, I had this man who didn’t want an enema as a prep for his surgery…the staff was a little upset with this patient and family…I asked him why he didn’t want it… turned out he had an enema many years ago before by-pass surgery and he had a perforated bowel and his surgery was cancelled… so I thought no wonder he is flipping out about this enema…that same day, he got his diagnosis of cancer…he was upset, so I spent time talking to him…I could have just walked away…that day, I went home and cried.

Even though Courtney has been working in cancer care for the past 14 months, she said that she was struck by the fact that

When I talk to them it makes me think I am very fortunate, and I better watch out look after myself too…they say life changes… once you are diagnosed, life as it was is different. Some want to cry. I have trouble with that, but most patients are really upbeat to be honest. They want to talk about what’s going on.

Sharing Stressful Experiences With Cancer Patients

Sharon, a new graduate who has been working for 3 months, pointed out that “initially, it is hard to handle your emotions,” but she found that sharing with others was helpful:

I felt so drained…but I also felt happy that I was able to help the patient who was palliative…when they say you have helped me through my day…there is a high feeling from that, but when you deal with all those emotions you have to go somewhere and dump afterwards…my classmates we phone each other, and I talk to the advanced practice nurse because you want to reflect back and fine tune what you are doing the next time.

Ethel has less than 2 years of nursing experience and has worked on the cancer unit for 5 months. She shared her thoughts about the initial stresses she encountered and the importance of supportive staff:
I think people with cancer are looking at life’s end…I think the big difference is…the impact of death and the ability to have hope…I find them to be remarkable people because they are generally pretty cheery and full of hope. As a new RN it has been stressful…I say to myself-I am not alone, somebody will help me if I don’t understand, or if I see something I haven’t seen before…everybody tells me after two years it is not as stressful anymore…I am looking forward to getting the first year down…I always know that if I need help I can call another RN and she would teach me…I haven’t met one that doesn’t teach.

Cathy, a senior nurse has been working on an in-patient unit for the past 14 months, remembered how the death of her first patient caught her by surprise:

I don’t think I expected to be affected so much emotionally…it is difficult to let go…I took care of a patient he was 18 years old…I had a really hard time…it really bothered me…he was too young, and they didn’t have the answers.

Norma, a nurse with 7 years of past experience who was now working on a cancer unit, recalled one of the first patients she met and what she learned from the staff on how to handle a very stressful situation:

For example, we had one young child 19 wasn’t doing well…his mother was taking it hard…it was hard on the nurse…she [pastoral care] just took her aside…asked if there was anything she could do…got her a cup of tea…it just gave her a break…time to collect her thoughts and then she could go back and be strong again for the patient and mother.

Norma also described some stressful experiences with cancer patients, how they responded to their illness, and what she learned from them that impacted her practice:

It’s nice when you can tell the patients they are in remission…in their face, you can see they are comfortable not worried anymore…you see a kind of relief…life can become normal again, but when it is not so good that is different… I was looking after this man he was watching this horrific thing happening in New Orleans…he is crying for them, and he is dying of cancer…and he is not worried about himself anymore…he is worried about these people dying and not getting any water…what a big heart…makes you think.

Gayle, an experienced in-patient medical surgical nurse, transferred to an outpatient cancer program 12 months ago. She noted that during those first few weeks, “I was surprised how stressed I felt.” She explained:
This is more stressful than any other area of nursing, more patients die, more suffering, patients sicker and need to be treated and re-treated, watching people suffer and die very emotionally draining, the uncertainty of outcome for the patient could be cured or die, The strain of sustaining people’s hope for a cure.

Courtney, Rebecca, and Doris talked about the stress they experienced as cancer nurses in small communities, where they were known to most people as the cancer nurses. Courtney explained how the job extends into her personal and community lives:

It’s a really small town, so it’s not that you don’t run into these people all the time, or someone that knows them. It certainly is always there…it’s not crying or anything like that, but when you go home, I just feel for them it is constant.

Rebecca stated, “I am on the road everyday visiting patients, and I try hard not to take the stuff home with me.” Doris described how being one of few experts in oncology in a small community places her in an ethical position to provide services to patients in need:

I think coming from a small community…you get phone calls at home from people you don’t really know, so-and-so told them that maybe you could help…we do give our patients our home phone numbers…they have those PICC lines and central lines and we are the only nurses who know how to access them.

Struggling With Learning

Nurses who work in cancer care require a certain skill set that directly relates to the nature of the work. Their patients often receive complex treatments that can include surgery, chemotherapy, radiation therapy, immunotherapy, and supportive/palliative care. Traditionally, the hiring practices for oncology nursing support the following criteria: excellent communications skills, good assessment skills, intravenous access skills, critical care skills, telephone/telemedicine practice, and emergency and palliative/hospice care, all of which are a definite asset.
The nurses in the study identified these skills as essential knowledge for their practice as cancer nurses. Once oncology nurses complete their respective orientations of 1 to 3 months, they are expected to assume full responsibility for their patients and seek assistance when unfamiliar situations arise. Therefore, the nurses are constantly assessing their own learning needs and searching out information and supports to assist them in providing care for their patients. The months immediately following orientation are a time of intense struggle and continuous learning-on-the-go, that is, trying to make sense of their new practice setting.

*Learning on the Go*

The nurses shared how they adapted their previous knowledge and skills to the cancer setting, as well as how they acquired information and support once they started working with their own patients on a day-to-day basis. For example, Rebecca, who works in a community outpatient setting, said “there are many new skills to learn,” and conveyed that she copes by approaching her peers:

> Always a lot of problems they didn’t teach you in nursing school of a community nature…usually I direct my questions my questions to the other nurses…things like how to do medical letters of support advocating for parents getting disability while their children are on treatment, funding, insurance, drug cards…my clinical skills are fine more supportive care nursing skills that takes awhile to learn.

Norma remarked that because the patients are sicker, she needs to know the boundaries of her role and how to advocate for patients:

> Patients are very sick…there is a greater need for you to be empathetic with them…need to promote their autonomy…encouraging them at the same time…also putting the responsibility back on them at times…being able to stress the limitations of your role…nurses get phone calls because the nurse is where the buck stops…they expect you to have the knowledge…they expect you to advocate for them…I have never been afraid to approach the doctor and disagree if I need to…but follow the channels…get things resolved on behalf of or in the best interests of the patient…for that reason, it’s really rewarding.
Courtney stated that although she was well prepared for some aspects of her role because of her community nursing background, she needed more training in other areas such as assessments, starting IVs, and ways to conduct telephone follow-ups with patients. Courtney stated, “In my previous positions, I had not started a lot of IVs, so I spent extra time in the operating room and in the emergency room starting IVs.”

Fran explained that the patients are more complex, so the nurses have to know more about the types of cancers and the related drugs to treat each cancer. She commented, “For example, if the patient is nauseated and vomiting …it’s more complex…what type of treatment they are on…is it one of the drugs they are on…have you switched drugs…the drugs are not common place they are different.”

Fran also commented on how unpredictable each patient situation can be. She said, “I had an incident with a patient developing spinal cord compression…all of a sudden, you are talking to people on the phone and flying by the seat of your pants.”

Lorraine focused on the importance of having strong assessment and communication skills, noting that “your main tools are your eyes and ears and your greatest strength is your communications skills.” Lorraine said, “You need good telephone practice skills,” and even though she had a lot of experience in telehealth/telemedicine in a previous position, she revealed that “my weakness was chemotherapy related skills [starting IVs, protocols].”

Cathy explained that she was able to benefit from her past experience and skills on a cardiac unit that included “central line care, cardiac care, starting IVs, running heparin drips, and administering blood pressure medications.” In terms of the skill level required to start IVs on cancer patients as compared to other patients she said that the
difference with cancer patients is that “they don’t exactly have nice veins…but that’s okay the more you do it, the better you get.” Ethel described the skills required for cancer nursing as being different and more challenging, for example, “increased number of central venous lines and vascular devices…there is a lot of care with those lines…people are getting a lot of chemotherapy drug…lots of colostomies.”

Shirley stated that the knowledge that is important to the role of the cancer nurse includes communications skills that focus on being an advocate for patients and families, symptom control and pain management skills, and palliative/hospice care.

Kelly stated that she had

No idea the care would be so complex…fluid and electrolyte imbalances…there are PICC lines [peripherally inserted central line] everywhere…lots of complex wounds. Robin states the knowledge she needs in order to grow as a cancer nurse includes more courses on different types of cancers…the common one as well as the common drugs…there are so many different cancer drugs to learn.

Jennifer remarked that she still has so much more to learn and would like more information on “how to interpret lab values, procedures, treatments and outcomes…just putting the whole thing together.”

Courtney, Doris, and Rebecca, all of whom practice in small rural communities, talk about their role as being expanded to include other duties not normally performed by nurses in urban centres, such as administrative duties, preparation of chemotherapy medications and provision of counseling and supportive care. Courtney stated that she is virtually a one-person program. She explained, “I do clerical things…administrative type duties…budgeting, you do a little of everything like for a department…yet I don’t feel like a department basically it’s just me and the patients.” She also said that “one of the
extra challenges in her role is that she has to prepare the chemotherapy medications herself,” which is an added responsibility not experienced by nurses in the urban centre.

Doris described her extra orientation for preparing chemotherapy medications:

We actually prepare our own medications it’s not the pharmacy…it is a matter of going through an orientation process with a pharmacist… I went to the larger centre and spent a couple of days with the pharmacist preparing the medication under a hood…we have pharmacy technicians who double check with us…so it was challenging…you know how important toxic spills are.

Rebecca explained her role as community-based oncology skills, such as

Medical letters of support advocating for parents getting disability insurance while their children are on treatment and drug card applications…more supportive care nursing skills that take a while to learn. Rebecca also states I have twice as much work per patient because I have no one to refer to…I do it all.

Learning With Patients

Some of nurses described their patients as being different from other patients and that they were able to connect with them on a deeper more personal level. They described how they learned from their patients about their experience with cancer, a process that assisted them in understanding the meaning of having cancer. Courtney stated that during the “one-on-one time” she has “while administering chemotherapy,” she is able to talk to her patients. She recalled patients who brought her jokes and talked about their passions, such as “the gentleman who loves fishing.” She summed it up by saying, “They are all so kind and appreciable.”

Norma stated that “cancer nurses get more respect from their patients,” and she went on to explain that “there is more of a bond because they come back for treatments…it’s the same face, you know that they kind of understand more the role of the nurse and doctor.” She also explained that because of this special understanding with the patients, they know the pressures and demands the nurses’ experience. She mentioned
that the patients are accepting “when we are short-staffed they may have to wait for a few minutes because someone else takes priority at that moment.”

Ethel explored her thoughts on why cancer patients are different, noting that “I think people with cancer are looking at life’s end…I find them to be remarkable people because they are generally pretty cheery and full of hope.” Shirley attributed the difference to the close relationships that nurses develop with cancer patients and their families, stating that “the focus is more on the relationships with the patients…even the families stay connected afterwards…they send thank-you cards.”

Jennifer stated, “You get thank you on other floors…but on oncology the severity of the situation is greater…the patient understands how much it means to get help…they are sick and emotionally drained from all the treatments.” Jennifer was quite emphatic in asserting that “I think they are more appreciative.” Robin summed it up by saying that nurses get to make a difference by making them feel better. She commented, “They are pretty sick and just watching them get better…I feel good about that.”

*Learning With Colleagues*

Some of the nurses talked about the positive culture and teamwork that is evident in cancer nursing and how these factors facilitated their learning. However, they also provided examples of negative interactions that left nurses feeling belittled and which interfered with their making the connections that they needed for learning. For the most part, their interactions with nurses and other health professionals were positive and, in some cases, were described as more positive than in other specialty areas.
Gayle commented:

We support each other a lot…the staff is fabulous …we discuss things even with the doctors…we put our heads together and discuss what we can do to make the patient’s course of treatment better…it’s a real team that works here.

Ethel said, “I consider them (staff) to be phenomenal…the nurses and physicians have been good at teaching.” Shirley stressed that the staff were very supportive, noting that “that made all the difference…the coordinator, the educators, all the nurses and physicians…they are always there for you.” Norma remarked that compared to other nursing units, “the support is better in oncology …team work is much better.” She added, “I don’t know if it is because of the type of care you provide.” Kelly emphasized that staff in cancer care are better to work with, stating that “other areas are not as great and the staff are not as happy.”

Lorraine described her working relationships as positive. “I was pleasantly surprised how compassionate and caring the physicians are…I was impressed by the female physicians and how they are with the female patients…some are just amazing.” On the other hand, she says other physicians are not as compassionate:

I find it difficult when physicians are abrupt with patients…there are those that go in and say what they need to say and walk out…and the nurse is left trying to compensate…it takes a lot of inner strength to look away from these attitudes and be sure to get the advocacy for your patients.

Irva, a young new graduate, described how both the educator and manager were very supportive during her orientation, but not all of the nurses were as understanding. She stated, “I feel some people treated me like a child…the resource nurse, who doesn’t take a patient load, was great. She would say come here and she would show me things…she was really supportive.” Another young graduate nurse also stated that some of her coworkers were not very supportive. She explained, “She was telling me I had to
Jennifer described her experiences as a new graduate, especially her relationships with the nurses. She pointed out that a “generation gap” exists:

Half the nurses I work with are very young and half are fairly old nurses…the newer ones are wonderful they remember how it was to be a student…the older nurses…think well I have done it so you will do it too that’s not everyone I know some older nurses that are nice to work with and they are caring…you can ask them for help…but others are quite snippy, you did this wrong and forgot that.

Struggling With Witnessing Suffering

All the nurses spoke of the emotional strain of caring for ill and dying cancer patients (feeling suffering). They also described the impact that it had on their personal and professional lives (personalizing suffering). They shared some strategies for coping with the suffering of patients and families (surviving suffering). Some nurses were able to come to terms with suffering as part of what makes cancer nursing a special place to work (accepting suffering). “Suffering with” was a dominant theme throughout the interviews, almost like a rite of passage upon entering cancerland that left no one unscathed. The nurses spoke about their patients’ suffering with a great sense of awe in their voices as they retold the stories of the phenomenon of caring for very fragile, ill, and dying patients. The nurses seemed surprised by the enormity and intensity of suffering they were witness to, and one nurse said, “It was like a wave and it knocked me over…and after each wave it took awhile to get up on my feet…only to be caught by the next wave.”
Feeling Suffering

All of the nurses talked about taking an emotional journey with their patients and feeling their anxiety and suffering. The nurses spoke about their experiences with patients in a highly personalized context, almost as if they felt responsible and were extremely remorseful about their patients’ struggles with cancer. For example, Courtney stated, “They didn’t prepare me for the emotional part…I feel so guilty when they [patients] are having those side effects…I find that frustrating.” Gayle remarked, “I didn’t expect it to be so emotional…didn’t expect to see the patients coming back again.” Sharon said, “It is emotionally stressful working with cancer patients they are anxious…they have just had a biopsy and are waiting.” Karen stated, “One of the main stressors in oncology …is that patients die…it happens more frequently here.” When Kelly was asked to identify her biggest challenge in cancer nursing, she said that it was “not getting attached because the patients get really close to your heart…a lot of young people die and bad things happen and it is hard to watch these things.”

The nurses also stressed that they face many emotional difficulties as they watch people suffer and die. Gayle commented, “Watching patients suffer is emotionally draining” and there is additional stress involved in “the uncertainty of the outcome…whether they will die or be cured…and the strain of sustaining people’s hope for the cure.” Gayle also stated, “It is difficult to support them when they see other patients that are being treated with them (in the next chemo chair) die.”

Doris described the key stressor of working with pediatric oncology patients as “you are not only dealing with the client, but you are dealing with end-of-life issues…so that is very stressful….it is not a matter of starting their line and giving them their
chemo…you talk about end-of-life issues.” She explained the difficulty is not only caring for the child but “when the child passes on…the parents aren’t OK…they can’t move on,” and she pointed out that even though “the child’s death may be for the best…but the parents who are left behind can’t move on and need further support from the health care team.”

Fran commented on the difficulties working with families, noting that “it is very overwhelming dealing with families. They don’t understand why their family members [patients] are the way they are.” Gayle summed it up by saying, “This is more stressful than any other area of nursing. More patients die, more suffering, and patients are sicker and need to be treated and re-treated.”

**Personalizing Suffering**

Many of the nurses identified with their patients, so the experience of watching their patients succumb to cancer gave them the opportunity to reflect on their own immortality. Courtney said, When I talk to them, it makes me think I am fortunate and better watch out and look after myself, too.” Gayle stated, “This job is a real emotional roller-coaster…you take it home with you, it affects your home life you have a sense of gratefulness for your life and family when you see such sadness every day.” Gayle also said, “Getting attached to the younger patients that you can relate to and it is really hard when they die.”

Lorraine stated:

Sometimes you are caught up in a busy clinic and you don’t realize the impact of a patient who has been told their disease has progressed…then you move on to the next patient and the next patient after that…you don’t feel the effects until you are driving home, or at home later that night.
Cathy explained:

I don’t think I expected to be affected so much emotionally…it is difficult to let go…I took care of a patient he was 18 years old…I had a really hard time it bothered me he was so young and it was so easy to personalize…that’s the hardest part with cancer that could be me, my mom, dad, grandparents…it is good in one sense because you think this could be my family member so how would I want my family member treated.

Kelly recounts her first experience with the death of a younger patient, revealing that “it had a big impact on me…I will never forget a young girl around my age, you know you can relate to that…then you have to reevaluate everything you thought you were going to do with your life.” Kelly, like Cathy, also related this experience to her own family life, commenting that “you are looking at these people saying this could be my dad or my brother…it is really close to home so much more difficult.”

Irva described a particular case she would never forget, noting that “she was 29 had uterine cancer…I kind of felt connected with her…I get emotional just thinking about it…it was wonderful I could connect with her…at the same time I was terrified I was going to say the wrong thing.”

**Surviving Suffering**

Some of the nurses also spoke of the need to be aware of the impact of patients’ deaths on their lives, put them into perspective, and learn how to develop strategies to deal with death and loss. Norma explained:

You kind of have to put your foot down (pauses) you can’t get to attached…like some nurses get attached…they get hurt when patients pass away…they are sad and some take time off…you need to talk about it (pauses)…if you don’t talk about it and keep it to yourself, it gets to you.

Norma also talked about the debriefing sessions on her unit with staff and other patients after a patient dies. She stated, “It is very important that oncology and palliative
Cathy and Gayle described their personal experiences with death and how they learned from their experiences. Cathy was very tearful when she described a difficult death of a young patient:

The social worker said, “If you want to talk to someone,” I remember thinking I’ll be fine…but I couldn’t sleep… …and when I got home, I almost phoned the social worker and I probably should have because off and on for days, I couldn’t sleep and things were going through my head. I never had an experience with death like that before.

Ethel described how she copes with so much loss:

I give them hugs (patients and families)….and for myself, I go to the supply room and I cry…I thought a lot about this…I probably should be able to handle all that - be stoic…then I thought well no I did love that person and cared for them so I think that person deserves those tears when passing.

Shirley described how she perceived experienced nurses dealing with death and dying, noting that “they cut out obituaries from the newspaper and they paste them up…they put pictures on the wall of previous patients.” Shirley pointed out, “There are a lot of supports in oncology the staff communicate about their patients…and although patients die, we can say we made the experience a peaceful one.” Gayle also talked about the importance of a supportive staff culture:

We support each other…discuss things even with the doctors we put our heads together and discuss what we can do to make the patient’s course of treatment better….even if we know the outcome is going to be poor…it’s a real team that works here…definitely the most emotional place I have ever worked.

Accepting Suffering

Some of the nurses were able to accept the suffering as part of the patients’ experience. When asked them to describe their worst and best experiences caring for
cancer patients, the worst experiences often also became their best experience as they followed the patients in their journey of suffering. Lorraine stated, “I think you grow to know the patients over time and you see their disease recur…the challenge is to continue to provide for the patient and family…and just deal with whatever the prognosis means.”

Rebecca, who is on the road everyday visiting her patients, said, “I do try very hard not to take the stuff home with me,” but she readily admitted that this is not always easy. “Sometimes, I wake up at night and think I forgot this or that…I have a pen by my bedside, and I write it down.”

On the other hand, Gayle talked about what she learns from her patients’ struggles, and how phenomenal they are with each other when they bond during treatment. She said, “They are connected because of the chemo.” Gayle also spoke about how the whole team works to support the patient and this is very satisfying because “it is real team work and we are here for each other.”

Norma considered the time that she spends with cancer patients to be special:

He was watching on television this horrific thing that was going on …he was crying for them he is dying of cancer…he not worried about himself…he is worried about those people dying and not getting any water…we see people at their most vulnerable…it is a privilege to help them through that time in their life.

The nurses described the hardest moments with patients as some of their best experiences and one of the reasons they wanted to remain in their positions as cancer nurses.

Summary

The nurses described their encounters of “being with” cancer patients as overwhelming, intense, unforgettable, inspiring, hopeful, and life changing. The nurses began their orientation in shock regarding the knowledge and clinical skills required to
care for cancer patients. They spent most of their first year on a huge learning curve, adjusting to the expectations for CNP within their unique setting (in-patient, outpatient, urban, rural). Their most challenging adjustment was learning to cope with witnessing the immense suffering of critically ill and dying patients. The nurses’ struggles were facilitated or impeded by factors that impacted their learning, such as leadership commitment to learning; availability of structural supports; and accessible people (preceptors, mentors).
CHAPTER 6: STAYING IN

Introduction

In this chapter, the nurses discussed learning to make sense of CNP as they assessed the gaps in their knowledge and sought further information and expert guidance. The “staying in” phase includes two main thematic areas related to the experiences of newly hired cancer nurses as they settled into their practice: (a) maintaining balance - the role of nursing leadership in creating quality work environments, coping with the stress of caring for critically ill and dying patients, and (b) making a commitment - comparing cancer nursing to other specialties, job satisfaction, achieving competency, and professional development.

Maintaining Balance

The nurses who had the most to contribute to this phase were those who had been in their respective positions for at least several months. They were more able to critically compare cancer nursing to other areas of nursing practice in regard to distinct body of knowledge, unique patient population, factors that supported or impeded learning, and future continuing learning needs. These nurses also were able to reflect back on their past practice; summarize their progress in terms of satisfaction with their choice; and decide whether they felt competent in their new practice and that if they did not feel competent, why and what would the impact be on their future career path. The nurses also shared the challenges of working in various different practice settings that had distinct bodies of knowledge and related subcultures. It was unanimous among these participants that the emotional challenges of CNP are considerably more intense than in other specialty areas.
and that the nurses who work in cancer care are generally more supportive of each other than in other areas.

**Impact of Nursing Leadership on Nurses’ QOWL**

Each nurse’s path was unique, and the presence or absence of strong nursing leadership had a significant impact on them as they were adapting to their new role. The nurses whose learning experiences were well supported by their nursing leadership during their orientation indicated that they also continued to receive support following orientation. For example, Shirley stated that she always has someone to call when she needs assistance:

> The nurses, coordinator and clinical educator are supportive…I think it’s a family atmosphere…and the physicians are supportive as well…so if a patient does pass away it affects everyone on the floor…there is an outpouring of support and there’s always someone there.

Kelly, a new graduate, commented on how accessible the nurses are when she needs to learn a new procedure:

> The nurses, coordinator, and educator…but mostly the nurses they are just incredible…always encouraging you to try new things…encouraging you to learn and try new things…the other day I had three people helping me to learn how to insert an NG tube.

Norma, a senior nurse, indicated that the cancer team is available. For example, “when you have a dilemma we have a lot of people that help us…like social work, pastoral care…the doctors are excellent…they help us a lot…so you are never alone…co-workers are excellent, if you have any problems.”

Several of the nurses indicated that their workplace is continually short staffed and lacks effective leadership, and that some of their colleagues do not treat them in a professional manner. For example, Irva, a new graduate, remarked:
I felt as though I had to prove myself; to a certain degree I understand…I felt like some people treated me like a child…the resource nurse (who doesn’t take a patient load) she was really great she would say, “Hey come here,” and she would show me things…she was really supportive.

Sharon shared a similar incident that left her with a poor impression of her nurse preceptor:

She was telling me I had to finish my work on time…we were in the nursing station she was yelling at me [pause voice tone louder]…I felt drained she wasn’t focusing on what I did do only what I didn’t do.

Fran, a senior nurse, also commented on the nurse educator who was responsible for coordinating her orientation and continuing professional education:

She negated any type of experience we had…talked to us like we were 5 years old…just because you have a master’s doesn’t mean you can teach…we all needed more information…needed to meet as a group and talk about different topics on a weekly basis.

Lorraine, a senior nurse, also had a similar experience with the nurse educator who supervised her orientation:

She felt that my hair should be pinned up…she kind of gave me the once over…I had seen other nurses whose hair was down, some senior nurses, so why put that kind of stress on me… it would always be that way at the beginning of the day that once-over kind of thing.

Rebecca, a senior nurse working in an outpatient program, expressed her concerned about a lack of effective leadership and ongoing educational support:

There is no nursing support person, I have no manager or position of authority with a nursing background…so no one to ask practice questions of…we need a leadership position …I am so new I don’t have a lot of experience.

Fran has a different concern related to inconsistency in support and how it impacted her learning the role of an outpatient cancer nurse:

The floating is very difficult because they try to put you in areas where some of our expertise can be used, but sometimes they put you somewhere else and you have no clue what’s going on. I thought I’d be a little more settled by now…I
think it has a lot to do with...I am somebody today and somebody else tomorrow...so you bounce around a lot when you are floating.

At the time of the study, Cathy and Jennifer were working on in-patient units that were short staffed and had no support available. As a result, their learning was compromised. Cathy stated:

We are short staffed...it is pretty bad...it isn’t a nice place to work and I kind of feel the only reason I am still here is because I am part-time and I don’t have to deal with it...day in and day out. There is a lot of new staff on our unit...often times I am the only senior staff member...it worries me.

Jennifer commented on how difficult it can be to attend professional education sessions when units are short staffed and there is no support:

I try to go to in-services but sometimes that is problematic...because you have to organize your care...you have to rush through your lunch...right now there are staffing problems on our floor...couple of nurses on sick leave...we don’t have a lot of trained staff...sometimes we’re not staffed and there are problems getting staff...so things just go by the way.

*Coping With the Stress of Caring for Critically Ill and Dying Patients*

The nurses in the first few weeks were shocked by the emotional stress they experienced caring for cancer patients. They indicated that through day-to-day practice, they learned from others how to better cope with stressful situations. The nurses shared critical incidents from their practice, how they worked through them, and the personal and professional supports that they found helpful.

*Working through stressful events.* Sharon described how she learned to cope with an anxious patient:

They have just had a biopsy and they are waiting...I’m good at helping these sorts of patients...helping them talk things through...just being able to talk to them, how do you feel about that?, what are you worried about... the educator talked to me about this and she said you have to be willing to go there with the patient.
Shirley described a stressful day with a critically ill patient:

I had a patient …he wasn’t doing too well…so I put a call out to the family, and they came in…the next day, he passed away…the nurse told me the family was really happy with what I did…and they thought he had a peaceful death…that was a good experience for a couple of reasons…it was good to know the family thought he had a peaceful death and that I could also advocate on behalf for the patient.

Kelly talked about the challenge of coping with death and dying:

The biggest challenge…probably is not getting to attached…because the patients get really close to your heart…a lot of young people die and bad things happen and it’s hard to watch these things…I have taken a number of palliative courses…you do what you can do for them…these people don’t walk in dying it is a slow process…and they are in so much pain, you want to see them go…anybody wants them to go who cares about them…it is difficult but it is nice to be there for the family during that time.

Lorraine talked about the cumulative effect of stress that comes from coping with treating and retreating patients:

Sometimes you don’t realize the impact the patient’s disease has on you…because you keep moving to the next patient…sometimes you don’t think of the effect until you’re driving home, or at home in the night…I think the patients grow on you over time…the challenge is to keep a strong face…the disease is always there, very much in their minds…the disease is always there…they’re always concerned about their symptoms…I started noticing this impact about a week ago …I have been here five months now…I am just starting to see patients coming back again and getting to know them better.

Rebecca described the satisfaction she derived from working with a critically ill patient:

A teenager with a spinal cord tumour living out in a rural area…nobody at the tertiary centre seemed to get through to her the severity of her condition…I visited five or six times…and discussed her medications and treatments…over the last few months the family has really made a turnaround…managing quite well on their own now…we are quite shocked that they made the progress they have.

Gayle described what she learned from a colleague on how to handle a critical incident:
My patient had an allergic reaction to her chemo…the nurse talked calmly to the patient while she stopped the IV, put some oxygen on the patient…in a couple minutes, the patient was feeling better…she said to me, “now you will know what to do the next time.”

_Creating a supportive workplace culture._ Shirley commented that after stressful days, she copes with her emotions by talking to a close nursing colleague or a family member:

I have a best friend from nursing…we talk a lot and debrief…I talk to her about my bad day…she talks to me about her day, too…I find talking to other nurses really helps…I am fortunate in that I have a great support system of family and friends…they are proud of what I am doing…my dad tells me he is amazed there are nurses that can work in oncology and doesn’t know how they do it…it’s nice to hear that from someone I have respected all my life…I think that kind of support really helps.

Norma described a supportive workplace culture that helps staff, patients, and families when a patient dies:

Young people dying…when it is the first time you experience it, some people can’t deal with it and they’ll close off…we have what’s called a debriefing…every time we have a patient who has been on the floor for a very long time…pastoral care comes up…it’s for the nurses and the patients…because everyone gets to know each other…and when one of them doesn’t see another they know they have died…they come and see every patient on the floor…and also talk to us on our breaks…it’s very valuable…it’s a very big key.

Robin also commented on the importance of having support from colleagues when there is a crisis situation. She said, “The worst experience is when my patient’s condition deteriorated quickly…I found I got support for that everyone is there helping you out…getting them into a private room and dealing with the family…so you make the best of it.”

Jennifer shared her thoughts on the importance of having colleagues to talk to after a stressful day:

I think it’s because my husband always says couldn’t you have picked a happier
place to work…because when you come home you kind of have to tell what happened…I really feel I have a supportive environment…when somebody is very sick and you can sit at lunch and talk about it…say I feel really bad for the family or I can’t believe this happened…you have a chance to vent and say how you feel and how things are affecting you…and it is not just you talking about it, it’s everyone else kind of reliving or venting their feelings. It’s a supportive environment.

Making a Commitment to CNP

The decision to remain in a position is determined by many factors, one of them being overall satisfaction with the position. This is difficult to determine until someone has been in the position for a few months and can compare it to previous nursing positions. The nurses’ responses were clustered into two categories, namely, unique patient population and distinct type of nursing. Three of the 15 nurses had completed student placements on a cancer unit prior to accepting their position, and based upon their experiences, they had received a positive impression of cancer care. The other 12 nurses came from a variety of nursing specialty practices. In the interviews, each participant described CNP as unique. The features of this practice include a distinct patient population and complex treatments protocols that require specialized knowledge to administer. The result is a highly charged clinical environment with an extreme level of unpredictability that creates unique emotional and relational issues for newcomers.

Unique Patient Population

The nurses identified cancer patients as different from other patient populations. These distinctions included physiological, psychological and relational aspects of cancer care. For example, Kelly stated:

With cancer, you lose so many young ones… you are looking at these people and saying that could be my dad or that could be my brother…it is really close to home and that is what makes it more difficult…and at the same time that is what makes it so appealing for me…because if that.
Ethel described the intensity of “dealing with dying patients and families…I refer them to services…I give them hugs…and for myself, I go into the supply room and I cry.” She also paused and reflected:

I thought about this a lot…I should probably be able to handle all that and be stoic…then I thought well no, I really did love that person to care for them…so I think that person deserves those tears when passing.

Norma described her special relationship with cancer patients as a privilege:

As cancer nurses we get more respect from patients…maybe it was from where I was working before…we were working so short-staffed…that we were not treated well…you know like my mom not getting well taken care of …neglected…you never get appreciated…this floor you do…get thank you cards…more of a bond…because of course they come back for treatments…it’s the same face, you know…they kind of understand more…the role of the nurse…the doctor…understand when you are short staffed that they may have to wait a few minutes because someone else takes priority.

Fran discussed the emotional intensity:

it is just overwhelming…there is no way you can do it unless you are in the practice every day, dealing with families and they can’t understand why patients are the way they are. Gayle also expresses similar feelings you take it home with you, affects your home life. She pauses to reflect and then she says although it gives you a sense of gratefulness for your life and family when you see such sadness…an emotional roller-coaster, most fulfilling, gratifying job.

Jennifer described how the patients are different and the rewards she experiences when providing care:

I think every time a patient says, thank you, I think this is the kind of satisfaction I get from my work, because you have patients that are very sick, you get thank you on other floors but with oncology (cancer care) the severity of the situation is greater and the thank you is really important, the patient understands how much it means to get the help, they are sick and emotionally drained from all the treatments, having cancer and the strain on the family, it’s really gratifying to have that thank you. I think they are more appreciative, rather than that person you put a band aid on or that gets a cast you know they will get well, but these patients you not sure, and they go through such a struggle with no guarantee of the outcome.
Specialized CNP Knowledge

The nurses working in CNP acquire a specialized body of knowledge in a unique learning culture that exists across diverse settings. This distinct body of knowledge, advanced skills, and interpersonal skills required for CNP was evident in the nurses’ descriptions. For example, Ethel stated, “Huge difference…increased number of central venous lines, PICC lines, chemo therapy protocols, a lot of patients have colostomies.” Courtney emphasized the skills required for outpatient chemotherapy practice, including “IV skills…assessment skills are pretty crucial, including telephone ones, do a lot of telephone follow-ups, that’s difficult for me.”

Rebecca described the skills that are important to her role as a pediatric cancer nurse:

It requires a fairly specialized body of knowledge, but the principles of pediatrics still apply…you have to what a well kid looks like before you can know what to do with a sick kid…understanding the protocols, diseases…explaining that to parents is pretty important…you are dealing more with the family than you are with the patient… the patient is important but there is a lot of involvement with the family… it’s a long term illness in most cases, and something that parents are dealing with for several years, and then a lifetime of follow-up care.

Rebecca explained that her role in outpatient pediatric oncology is different from her in-patient pediatric role because “this role requires a fairly specialized body of knowledge related to oncology and community nursing, dealing more with families… and the commitment to the patient and family is longstanding…sometimes several years or over a lifetime of follow-up care.”

Supportive Learning Culture

The nurses also related that they have an awareness of a supportive learning culture and better staffing patterns on cancer units.
Kelly noted:

It’s different here, other clinical areas are not as great…I have not been happy with staff…I have been in experiences where they say what do you mean you haven’t done this before…so that’s what is so great about this floor they are not like that…if it was my Mom I would want someone there like myself to support her…I would want good staff to support me if I was there as well.

Robin stated, “I usually have less patients…better nurse to patient ratio…four to one, I don’t mind that I find it good I get time to talk to patients and families which is important.”

Jennifer also described the cancer learning culture as supportive and unique from other areas of nursing practice:

You are not as focused on tasks here…other floors it is so rushed…here you have more time to stop and reflect…it’s a little slower paced…sometimes you get 15-20 minutes to talk…in low periods you can talk, reflect, update the nurses you are working with…you know my patient just found out that the cancer came back…and they are like really that’s horrible, or that was kind of expected because it’s his third time, or this type of cancer has a high chance of metastasizing… you get feedback from the nurses even if it is only 2 or 3 sentences…but it is supportive.

Lorraine talked about quality-of-work life issues in outpatient cancer nursing that set it apart from in-patient nursing:

Shift work is not good for anyone…at least the outpatient clinic is Monday to Friday, so you have your weekends with your family…vacation days off…you are not required to work overtime…physically it is less demanding…the physical stress is a lot less…I would say there is better satisfaction (outpatient), because there’s a better relationship and more respect, I think between nurses and physicians…they have a greater respect for your role…also your patients depend on you…you get a lot of personal satisfaction…a lot of support and education…a very positive work environment…much more positive than other work settings, friendly, positive environment, where there are no “big Is” and “little yous”…you can ask any question and not feel dumb…that’s important…in other experiences I have had, there’s a lot of being hard on one another…you know, a lot of stress on your colleagues.
Fran, a senior nurse, compared outpatient to in-patient cancer nursing and identified significant differences in patient population, specialized knowledge, and structural issues:

Everything is different here (outpatient) then the main part of the hospital…totally different world…different computer systems, forms, protocols, 30% of the difference is the administrative things and 70% in the cancer aspects of the job, for example if a patient is nauseated and vomiting it’s more complex. So, why are they having it? What type of treatment are they having? Is it one of the drugs they’re on? Have you switched drugs? What drugs are we ordering? The drugs are not commonplace; they are different.

Rebecca’s comments related to the increased accountability and stress involved in the role of a cancer outpatient nurse:

When I was working on the floor, you would have your two to five patients and you would work your shift and go home and pass it off to someone else… my workload is pretty flexible…I was on the road everyday from N…> 100 km to T…> 200 km to S…> 300 km, doing school visits, home visits…I do try very hard not to take the stuff home with me. But sometimes I wake up in the middle of the night and think, “oh crap, I forgot to that”…I have a pen at my bedside and write it down…when you go home normally you pass it off to the next shift, there is more to this…if you don’t do it nobody does.

Courtney emphasized the uniqueness of outpatient cancer nursing:

It’s outpatient, that in itself is very different…they are facing a life threatening disease. You see the stress (pause)...it’s constant, on their families too. I’m finding it more challenging. I do get a really good feeling when someone is finished all their cycles and they’ve done well. I feel a little helpful.

Courtney also described the great sense of responsibility she feels for her patients’ care because she is the only one responsible for making arrangements for her patients:

It can be difficult to organize the patients’ care in the hospital you see them 24 hours, you can better assess how they are doing with their treatments…and when they are outpatients you don’t have the same ability to watch over them.
Doris, a senior nurse with 25 years of experience, has been working in an outpatient chemotherapy program for the past 22 months. She compared her work in emergency with the outpatient clinic:

Coming from emergency…with such a lack of physicians…it is never ending…I mean it is so busy there…that you don’t go for a break and you are run off your feet from the moment you walk in the door…I leave emergency and come here I know I am here for a certain amount of time and I am giving these people all of me for that time…I am not run off my feet…it is more organized…and it is not just a matter of starting their line and giving them their chemo…you talk about end of life issues…I don’t feel rushed…I can take the time I need…maybe it is because we are a smaller clinic…but sometimes you go home from a shift in emergency and you think …I ran all day, did I really help anybody?...did I do anything good today? You can spend more time with your patients and the physician comes and actually sees them in clinic…a lot of things are organized through the clinic…there is a closeness here…it’s like you hug everyone when they are leaving, and say see you next time…they bring us gifts.

Doris said one of the main differences between outpatient and in-patient nursing is that care in other areas is more routine, but in outpatient oncology, “it is different because the treatment is patient-focused and individualized.” She was surprised at how much nurses need to know in this type nursing, commenting that “you can never stagnate …you constantly have to re-fresh your knowledge with new protocols all the time.”

Courtney and Rebecca were outpatient cancer nurses at the time of the study, and they recounted some of the challenges of being cancer nurses in rural and remote communities. Though there may be differences from one community to another, they agreed that they experience a feeling of isolation in their role by virtue of the fact that there are practicing without supports. Courtney remarked, “It’s emotionally challenging, and I am more isolated…you are practicing alone without any supports close at hand.” She explained that the supports are lacking:
Even though I have two back-up nurses who work in emergency and can cover for me when I get sick or go on holidays…it’s not the same as working with other nurses on a day-to-day basis to share problems and support one another.

Rebecca also stated, “You are alone in the role…normally you can pass it off to the next shift/person…there is so much more to this…if you don’t do it, nobody does.”

*Job Satisfaction*

The nurses were asked at the end of their interviews whether they were satisfied with their positions and that if they had it to do over again, would they choose CNP? Twelve of the 15 participants said that they were satisfied with their positions; 3 were not. Shirley, Kelly, Irva, and Ethel had been in their positions for only 3 months at the time of the study, but they were satisfied with their choices so far. Kelly, who never thought that she would be working in cancer care, stated:

> I think oncology is a good place for me. I am really happy with it…that’s what I want to do now, it is really strange I love it here, but it certainly isn’t what I thought I would be doing when I started nursing school.

Irva, stated:

> Yes, absolutely I really like the unit they are encouraging people to build their knowledge…this is a place I could grow; and she goes on to say, I’m not saying I am using this floor for experience and then moving on…I don’t know what I will be doing in 2-3 years…however I never thought I would work oncology.

Jennifer, a new graduate working on an in-patient cancer unit for the past 18 months, is very committed to the specialty. She commented:

> Yes! Definitely, definitely choose oncology again…I remember people saying oh oncology is the most depressing floor in the hospital…I think it is the floor with the most hope…and the people on this floor even though they might not be hoping for a cure…they’re still hoping for a quality of life…spending time with their family or appreciating things they have experienced and being thankful for it. I think it is quite amazing and you don’t get that on any other floor.
Senior nurses Sharon, Lorraine, Norma, Gayle, Courtney, and Doris stated emphatically they would definitely choose oncology nursing again. Their reasons were based upon the unique challenges and advanced knowledge related to cancer nursing. Gayle asserted with emotion in her voice, “Yes, I am very satisfied with the role want to stay forever.” Doris, who has been in her position for 22 months, said, “I have a lot of satisfaction with this. I think it was the right decision for me.”

Cathy, Robin, and Fran were not as satisfied with their positions in cancer care. Cathy revealed that she would take a position, but under different conditions. She said, “I would choose oncology (cancer care) again, if I could do it (orientation) on an organized unit it would be fine with senior people to work with.”

Robin stated, “I didn’t really have a choice…they seemed to force people to work on the cancer floor.” After working in cancer care for 8 months, she said, “I am returning to pediatrics. I got a full-time position, I started out there and prefer PEDS.”

Fran, a senior nurse with more than 20 years of experience, was very candid about her past year working in an outpatient cancer program:

No, I would not take another job in cancer (pauses and says in a low tone) to tell you the truth, I still look on the job board because I am not sure if this is for me. I would like it to be for me…I think I may be too hard on myself because I don’t feel like I am at the point where I would like to be after being here one year. I was so comfortable and confident in my nursing abilities that I thought I could take on a change like this. But maybe at this age I should have taken the easy road and stayed where I was, dealing with people bleeding, dying and going crazy and swinging at you. Sometimes I feel like a glorified secretary…I want to feel like a nurse…I’ve worked all these years and I am good at what I do. I may not be an expert in this area, but I am a good nurse.

The 3 rural nurses were satisfied with their choice to become oncology nurses and indicated that they would be remaining in their positions. They indicated that even though their work was very lonely at times and emotionally intense, they felt that they had more
quality time to spend with their patients and that their role was really making a
difference. Courtney stated, “You have one-on-one time when you are administering
chemotherapy.” She also talks about getting to know the patients, noting that “one
[patient] brings me jokes every week…another gentleman who loves fishing brings me
fish.” She concluded by stated, “I want to continue learning the availability of nurses
from the urban centre by phone and the educational sessions that are offered by
videoconferencing are invaluable.”

Doris remarked:

You can spend more time with your patients and the physicians comes here to see
them…it’s like you hug everyone before they leave. We are linked electronically
with the larger centre and have monthly teleconferences…very informative and
keeps us up to date.

Rebecca also stressed the importance of having contact with her peers in the
urban centre. She asserted that “teleconferencing with the pediatric team… is very
important you can discuss things with senior nurses and you are not so alone.”

Achieving Competency

The nurses were asked to comment on their level of competency as cancer nurses.
They were requested to rank their performance as beginner, advanced beginner,
competent, advanced, or expert. The 6 nurses with less than 6 months of experience (Irva,
Sharon, Shirley, Kelly, Ethel, Lorraine) rated themselves as beginners or advanced
beginners. Kelly, a new graduate who has worked for 3 months, commented:

I am a beginner, I know a lot more than I did, there is so much more to learn, I
don’t think I could call myself anything but a beginner, I am fairly good at it,
haven’t been there long…someday I will be very good at it, I am definitely
getting better at it.
Sharon also has worked 3 months and rates herself as an advanced beginner:

I feel like an advanced beginner because I feel with the things I know I am very confident, it is just the things I haven’t done yet, there is so much to learn, I think in maybe a year I will feel more confident.

Shirley, another new graduate who has worked for 3 months, stated:

I would probably say an advanced beginner right now…it is kind of hard right now working under a temporary license, just got my results back I can now call myself a registered nurse that has given me extra confidence, after being on the floor for about six months I will probably feel more confident.

Ethel has worked for 5 months. She described in detail how she felt that she has progressed:

I would be a 3 out of ten, working on becoming competent, some of the oncological emergencies I haven’t seen yet. I am working on it and I have a good support system, would give myself a 3 in cancer care skills, and a 5 in general nursing skills. I have all the regular nursing things down, but cancer care is a huge learning curve, huge! [voice raised]

Lorraine, who also has 5 months of experience, and rated her overall performance as advanced beginner:

I feel like an expert when it comes to telephone practice…but that is due to my previous experience in telehealth…but when it comes to chemotherapy, that’s definitely an area of weakness for me…so I would say it varies depending on the situation…but I am a lot further ahead than when I started but still a lot more to learn….I don’t think I will feel like an oncology nurse until I finish the chemotherapy program…which I will do later once I am comfortable in the clinics.

The 9 nurses (Rebecca, Norma, Robin, Fran, Gayle, Courtney, Cathy, Jennifer, Doris) with more than 6 months of experience in their positions rated their performance as advanced beginner to competent. Rebecca, who has been in her position for 7 months, stated, “Yes, I feel like a pediatric oncology nurse now…I would say competent, but certainly not advanced.” Norma, who also has been in her position for 7 months, commented, “I don’t feel like an oncology nurse yet…maybe in another few months…I
feel competent…I know on the other floor it took 1 ½ years to feel 100% confident…there is so much to learn…especially in this specialty much greater.”

Robin, who has been in her position for 8 months, said:

I still feel like a new nurse I have only been nursing for a year and half and I still feel like I have tons to learn, you can’t go into it thinking you know everything, once you stop asking questions then stuff happens (pauses)…you make mistakes, so I always feel like I can learn more. I still feel like I don’t know a lot about cancer and the different types, there is tons to learn and it comes with more experience.

Gayle, who has been in her position for 1 year, remarked, “I am very satisfied I want to stay forever, I am comfortable here.” However, Fran, who also has been in her position for 1 year, felt like an advanced beginner and unsure of her practice:

I am not sure about the position… I keep hoping that all of a sudden it’s going to click in for me, that I am going to have the confidence and I’m going to feel competent, I can’t keep saying I am new here, how much longer can I say that unless things change I don’t think I will stay (low tone in her voice) I do like working with this type of patient, I just wish I could do better for them, that I had the knowledge base.

Courtney and Cathy have been in their respective positions for 14 months. Courtney said, “I don’t feel competent…a beginner…I want to know a lot more. As opposed to Cathy who states, Yes, I feel like a cancer nurse, I have learned a lot in the last year…there is still a lot to learn.”

Jennifer, a new graduate who has worked for 18 months, noted, “I feel like a beginner, I still feel I am a novice, my preceptor told me you are a novice, you stop being a new nurse 10 years after you start [she laughs]!”

Doris, a senior nurse who has worked for 22 months in her position in outpatient chemotherapy, described her experience:

To feel competent it took almost two years, I have worked in different fields, but it is just kind of routine and the doctors order the same things. This is different
because all the treatment is patient-focused and individualized, not all treatments are the same, they are similar, but not all the same.

Continuing Learning Needs

The nurses’ priority learning needs for continuing professional education included communication skills, chemotherapy, pain management, palliative care, and mentorship. Irva emphasized that “the psychosocial, the emotional part is the most difficult I think skills can be taught to anyone. It’s that other area that is not so black & white and is so scary.”

Shirley stated, “There is a lot to learn, communication skills, being assertive, pain issues, comfort issues, a lot of people don’t make it so palliative care is important.” She also talked about the chemotherapy skills she still has to learn:

The clinical educator would like us to work on the floor for awhile and then in 6 months, get our chemotherapy certification. There’s some studying involved, and then you write a test…spend a couple of days at the cancer centre in the chemotherapy suite shadowing a nurse to see what it is like. Once I get certified, I will be able to give chemotherapy up on the floor.

Kelly, who is in a similar situation, commented, “I am not chemo certified…the educator wants us to wait until we are familiar with the floor before we become chemo certified…I plan to attend some conferences.”

Ethel, who has worked for 5 five months, identified a number of learning goals over the next 2 years:

I want to become a oncology (cancer) certified nurse…I need two years clinical experience then I can challenge the exam…I would like to take some courses on pain management course…it is ethical the administration of pain medications to end-stage cancer patients, they have less liver and kidney function, I see this patient, who is very much zooded, and I wonder how much more can I administer without risking that person’s life and safety. I saw Narcan given the other day, it is not [a] nice thing to see. I wonder what is the upper limit for RNs to give to manage pain medications.
Lorraine remarked, “Chemotherapy, that’s definitely an area of weakness for me…so I would say it varies depending on the situation…but I am a lot further ahead than when I started but still a lot more to learn.”

Norma also identified chemotherapy as a learning need:

I think more on the chemo part…or at least working with someone with seniority and she could guide me through…like the protocols don’t follow in order…that’s why if you don’t know the protocol, it’s easy to make a mistake…when you giving a new protocol you really need to have someone there with experience.

Robin talks about her learning goals, noting that “I would take more courses on different types of cancers, I find I don’t know a lot, you see the common ones…the most common drugs…but there are a lot of different chemo drugs.” Gayle also stated, “I need more education on the drugs and specific cancers.”

Jennifer, still a new graduate after 18 months, confessed to feeling like a novice:

I think I would like to be more confident in what I know…I am still kind of learning, and trying to interpret things, and trying to connect things, you know, with lab values with procedures, and procedures with outcomes, and treatments and illnesses, just kind of putting the whole thing together. I think right now I am still pretty fragmented with what I know and what’s going to happen in the long run. I am still trying to put the pieces together….It’s still in my head and slowly with experience and practice and trying, all those pieces are going to move together. This is something I need to work on, putting the whole picture together.

Jennifer, Sharon, Fran, Courtney, Cathy, and Doris would like more support from their colleagues to assist them with their learning goals. Jennifer emphasized the importance of “learning the ropes from other nurses.” She also stated:

I think the support for novice nurses is good enough…it could always improve…I think it is individual…not everyone is the same…just giving a self-learning package will not do, you need support and guidance…makes the biggest difference when you have someone there to help you put it together.

Sharon stated, “Ideally you need more buddying…more pairing off with different people to help you with learning procedures.” Fran commented, “There was a lot of good
information…my problem… I should of have been buddied with one or two nurses…you work with them…and then at one point they step back and say now you are running this clinic.”

Cathy conveyed that working with experienced staff was critical to achieving her learning goals. She stated, “[Having] an opportunity to work with senior staff…someone that can explain…you can read books until your eyes fall out…until you actually see things and get the experience you don’t have a grasp on it.”

Courtney and Doris, both of whom work in rural outpatient programs, agreed that mentorship is important, even if the mentor is at a distance. Courtney explained:

Definitely a mentor…someone you could contact regularly, on a long term basis…who has experience with outpatient because that’s new for me. I would really like to see telehealth education regularly set so you look forward to it…you could ask a question of people who have the experience.

Doris said, “We have regional conferences and those keep us updated…you see the same people and exchange ideas…we have our monthly teleconferences…all these things help keep us current.”

Summary

The nurses shared the ways in which they were able to maintain balance in their practice and learn to cope with the stress of caring for critically ill and dying patients. They were able to compare CNP to other specialty areas of practice in regard to quality-of-work life issues, supports, and nursing leadership. The nurses identified CNP as a specialized body of knowledge related to a unique patient population. Making a commitment to CNP was expressed by the nurses in terms of experiencing job satisfaction, achieving competencies, and participating in continuing professional
education. The nurses discussed the strategies and best practices that enhanced learning about CNP in diverse contexts.
CHAPTER 7: MAKING SENSE OF CNP

Introduction

In this chapter, the nurses’ perceptions of the contextual and learning factors that impacted their transition into CNP are explored. The narratives reflected a trajectory of progression from recruitment through the role transition typical of newcomers to the workplace setting. For the most part, their learning has been informal and dependent on the importance the individual and the organization have placed on learning as a core competency and a lifelong process (Ellinger, 2005). Learning is inherently socially constructed and contextually embedded, and examining the contextual factors that can impact informal learning is crucial to expanding the understanding of how informal learning can “best be supported, encouraged, and developed” in the workplace (Marsick & Volpe, 1999, p. 3).

It was important to examine the positive and negative contextual factors that affected informal learning as the learners progressed through their transition into the workplace. Particular attention was paid to what was being learned, how it was being learned, the factors affecting learning, and the strategies supporting the development of a learning culture. The perspectives are inclusive of the findings in chapters 4, 5, and 6, as well as my stance and the supporting literature.

The nurses’ stories assisted me in understanding who they are, where they came from, why they wanted to become cancer nurses, what they needed to learn, what supports assisted their learning, and what factors impacted their ability to learn how to care for cancer patients. When comparing their individual portraits, common themes related to the socialization of nurses to a new nursing role, specifically that of a cancer
nurse, became evident Also noted in this chapter are some of the differences among nurses who assume roles in outpatient cancer facilities, nurses who assume roles in in-patient units, and nurses who practice in care rural and remote settings. The nurses were interviewed at different points in their transition, some immediately following their orientation, and several a year or more after employment. Listening to the stories of the 15 nurses could be likened to reading a novel from beginning to end 15 times: The plot was similar, and the outcomes were somewhat predictable, but the experience was unique for each nurse and contextually detailed.

Initially, I was focused on plotting the nurses on a time line that matched the stages of transition. However, I soon realized that time was a predictor of progression but by no means was an absolute. I also became aware that whether or not the nurses were satisfied with their positions was complex and multifactorial, related to their unique setting, and predetermined by previous experience and career aspirations. After reading and rereading the stories, it became evident that the nurses who had been in their positions for 3 to 6 months were in the initial stage of transition. They were coping with reality shock, dependent on the support of others, and struggling with the challenges of learning new clinical skills. Generally, the nurses in their positions for more than 1 year had mastered the cancer-specific clinical skills, were less reliant on supports for their learning, and were becoming contributing members within a CoP. For the purposes of examining the nurses’ informal learning experiences in each phase and related themes, I created a participant time line that included previous experience, contextual setting, and phases of transition and identified themes (see Table 2).
Table 2

*Making Sense of CNP*

<table>
<thead>
<tr>
<th>Phases of transition</th>
<th>Getting in: being recruited, being hired</th>
<th>Surviving in: shock of being orientated, 'being with' patients, struggling with, learning-as-you-go</th>
<th>Staying in: maintaining balance, making a commitment</th>
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<th>Role</th>
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Factors Influencing Recruitment to CNP

I asked the nurses why they decided to take positions in CNP, the factors influencing their decisions, and previous work experiences and professional strengths that eased their transition into CNP. Half of the 15 participants admitted that they did not choose CNP as a career option. Most of those participants were new graduates, and the only employment opportunities available to them were on in-patient cancer units. The other half of the sample included senior nurses who had taken positions in outpatient cancer clinics. Of those nurses, approximately 50% had applied and been interviewed for their positions, and the remaining 50% had been actively sought by managers to fill vacant positions in outpatient cancer clinics. Other factors that influenced the nurses to
take positions in CNP included labour market issues, social networking, career path, experiences with cancer, and professional strengths.

*Career Vision*

Historically, Canadian nurses have had very little difficulty obtaining employment in a variety of specialty areas, but unless nurses obtain graduate degrees, opportunities for promotion to management, education, and research positions are limited. Therefore, staff nurses tend to view specialty areas of nursing as a promotion and an opportunity for career development that involves continuing education and challenging work (Williamson, 2008). Of the nurses in the study, the 3 new graduates and 4 of the senior nurses indicated that their decision to accept positions in CNP could be partially attributed to the fact that they considered the change as part of their career vision.

While conducting this study, I counted the number of times that I had changed my position from one specialty area to another or had returned to school to advance my education. I was astounded to record 17 times in my reflective journal. The changes included a variety of roles: surgery, medicine, intensive care, and oncology nursing; clinical nurse educator; clinical trials manager; advanced practice nurse; manager of education; accreditation/quality assurance coordinator; director patient services; and nursing professor. Each change was part of a lifelong learning career path that began early in my education when one of my professors told me, “The world of nursing is very big – go out and explore it!” Nursing has undergone tremendous changes and has been transformed from “an occupation whose members struggled within a social context that devalued nurses’ work as unskilled, to a profession comprising autonomous, well-educated, career-oriented knowledge workers” (Donner & Wheeler, 2001, p. 79).
Employment Opportunities in CNP

CNP has not been as popular as other areas of specialty nursing practice, so it has been significantly affected by recent nursing shortages. The job preferences for new graduates do not typically include cancer care; instead, the most popular choices are obstetrics, pediatrics, community nursing, public health, and high-tech areas like the operating room (Rognstad, Aasland, & Granum, 2004). Recently, in-patient cancer nursing has become the first position for many new graduate nurses, and the participants in this study were no exception, with 7 of the 9 nurses working in in-patient cancer having less than 2 years of nursing experience.

Recruitment strategies targeted at nurses for CNP positions have not traditionally included new graduates or student nurses. The past hiring practices have usually advertised CNP positions as requiring a minimum of 2 years of nursing experience, central venous lines skills, and oncology certification as an asset. It has only been within the past 5 to 10 years that hiring practices have changed, and the trend of hiring inexperienced new graduates has coincided with the severe shortage of nurses. Three of the participants had previous clinical placements as senior-level students and applied for in-patient cancer nursing positions because of their positive experiences.

The expansion of cancer services and the opening of new cancer centres across the country have provided opportunities to recruit new graduates to cancer units through student placements in their senior year as a solution to the nursing shortage. However, clinical placements of nursing students tend to be identified from historical context, that is, decisions made between manager and teacher (Smith et al., 2007). Results from a survey completed for the Inventory of Strategies to Deliver Nursing and Inter-
professional Clinical Placements in Canada indicated that the majority of schools have tended to rely on historical use, that is, placements from previous years, together with faculty member and student requests, to find placements. Some respondents also have used telephone directories, canvassing throughout the year, sending out annual calls for placements to agencies, visiting rural communities, and seeking input from municipal governments to find placements. Finding preceptors to supervise students on a one-to-one basis in clinical settings is an issue. Lack of preceptors also was identified by the survey respondents as a barrier to finding clinical placements (Smith et al., 2007).

Four other participants did not choose CNP, but applied because cancer in-patient positions were the only ones available to them. Upon examining the narratives of the 9 in-patient nurses, it was evident that younger and less experienced nurses (< 2 years) were hired exclusively into in-patient cancer units. The nurses in this sample experienced shorter formal orientations, and their chemotherapy certifications were delayed until they had completed the general orientation. Five of the nurses working on the in-patient cancer units were hired on a part-time basis, which further delayed their full orientation to cancer care. Traditionally, new graduates with < 2 years nursing experience are not hired into cancer care, but within the past 5 years, the trend includes accepting new graduates to specialty areas, even though the job advertisements still indicate a preference for more experienced nurses.

Recruitment is challenging for many specialty, especially for cancer nursing, a specialty with high stress levels, complex care, exposure to toxic chemotherapy agents, and the day-to-day struggle to deal with death and dying (Buerhaus et al., 2000). Because favourable patient outcomes have been linked positively to adequate nurse staffing, there
has been an increased effort to strengthen recruitment strategies to fill positions that remain vacant primarily because of the lack of qualified staff (Buerhaus, Donelan, DesRoches, Lamkin, & Mallory, 2001).

There has been a shift in care from in-patient to outpatient settings, and senior nurses are seeking employment in cancer outpatient clinics for a variety of quality-of-work life issues. This shift in expertise from in-patient to outpatient settings resulting in a lack of preceptors means that in-patient units may be overwhelming for new graduates (Williamson, 2008). It is critical that new graduates be supported in practice and that health care organizations enhance their recruitment strategies to (a) develop orientation programs to meet the unique needs of new and experienced nurses’ orientation and professional development programs, (b) support the professional development of experienced oncology nurses, and (c) provide opportunities for nurses to reflect on practice and examine the emotional stresses associated with CNP (Hayes et al., 2005).

While I was examining the narratives, it became apparent that the 6 senior nurses were working in outpatient positions exclusively, as opposed to the in-patient positions, which were held primarily by the nurses with less than 5 years of nursing experience or new graduates. This finding is suggestive of an outmigration of senior nurses to outpatient nursing positions and a back filling of vacated in-patient positions by new graduate nurses. Senior nurses would choose outpatient over in-patient nursing for several reasons, all of which relate to QOWL issues, including more challenging positions with increased autonomy; better schedules, that is, more day shifts and weekends and statutory holidays off; less physical working conditions; increased educational supports; opportunities to participate in research programs; and an increasing
trend toward more outpatient care for cancer patients (Williamson, 2008). Many cancer nurses are hired in in-patient cancer hoping to eventually secure positions in outpatient programs as a career promotion.

Managers also set the criteria for outpatient positions that include a preference for applicants with higher levels of educational preparation and previous nursing experience. Because cancer is being treated more commonly on an outpatient basis, more positions are becoming available in outpatient clinics as opposed to hospital units. The skill set for nurses working in in-patient and outpatient settings are dramatically different. Employers have encouraged the outmigration of senior nurses into outpatient cancer care for two main reasons, namely, more opportunities for more challenging work for experienced nurses, and the fact that outpatient nursing requires greater autonomy, expert decision-making abilities, advanced assessment skills, and central venous line competencies. This increase in outpatient positions aligns with the increase in the number of patients receiving treatment on an outpatient basis whenever possible, unless their conditions require unplanned emergency admissions to an in-patient unit because of side effects of treatment or palliative care.

Social Networking

Social networking plays an important role in attracting nurses to specialty areas of practice. It is common knowledge that nurses network extensively with other nurses regarding the most desirable areas to work. One third of the participants learned about what it might be like to work in cancer care and the rewards and benefits associated with the specialty through social networking. Senior nurses frequently share information about their experiences in specialty areas not only with new graduate nurses (< 2 years nursing
experience) but also with nursing students in order to assist them in making career choices. Three new graduates indicated that their managers also paid attention to what their preceptors said about their performance as students. It is common practice for managers to take into consideration feedback from highly respected nurses when considering prospective hires for their units. This is particularly important because CNP often is not considered by nurses who have not been previously exposed to the specialty through student or work experiences.

**Professional Experiences**

Professional experiences are a stimulus for attracting nurses into cancer positions, and those experiences often begin when the nurses are still students. Unfortunately, cancer units traditionally did not promote student placements because they were reluctant to hire students directly into cancer care without prior nursing experience. This trend is changing, and students are obtaining clinical placements on cancer units, resulting in an increased recruitment of new graduates to CNP positions. For example, organizations are developing partnerships with schools to develop multifaceted recruitment strategies to attract and retain nurses (Reid Ponte et al., 2005). From my own experience, recruiting to cancer positions can be challenging, and changing clinical placement patterns requires collaboration between faculty and managers; however, when students have clinical placements in cancer care, they are socialized to consider positions that they may not have previously considered (Smith et al., 2007).

**Personal Experiences**

Even though social networking and professional experiences have an impact on attracting nurses to certain specialties, personal experiences also play a significant role.
Several nurses in the study recounted stories of personal experiences that contributed to their decisions to learn more about cancer care and eventually apply for positions. It is through personal experiences that nurses learn about the unique perspectives of cancer patients and their families as well as the challenges they face interacting with the healthcare system. In some cases these opportunities give them the chance to observe others in the role of cancer nurse and observe how they support patients and families. When given the opportunity to “walk a mile in the shoes” of providers, patients, and families, they get to try on the role and consider how it might fit. Studies in cancer care have confirmed that nurses make decisions regarding a career in cancer care based upon their personal and professional exposure to the specialty, and whether their experiences have been positive or negative (M. Z. Cohen & Sarter, 1992; Corner, 2002).

In the study, 4 of the nurses shared personal experiences that had significantly impacted their decision to apply for cancer nursing positions. Upon reflection, I realized that my interest in cancer nursing began with the death of my grandfather from lung cancer. Ten years later, I had a suspicious breast lump removed, and that experience was the catalyst that eventually prompted me to apply for a position in an outpatient cancer centre.

**Professional Strengths**

The nurses also identified the professional strengths that they brought to their new positions. The 7 nurses with less than 2 years of nursing experience emphasized their current knowledge and ability to search out information, as well as their interpersonal skills. The 8 senior nurses cited specific examples related to technical skills (i.e., IV
skills, central line care); telehealth practice; community nursing skills; and previous experience working with acutely ill and dying patients.

Closely aligned expertise with the positions being assumed eases the transition experience. The learners’ knowledge gap is significant when leaders are planning orientation programs for newcomers to cancer settings. One of the ways managers and nurses can begin to identify career aspirations and learning needs is during the interview process. Managers hiring nurses and nurses applying for positions should pay particular attention to the standards for CNP (CANO, 2006; ONS, 1989). The advertisement for the position and the interview process should include the related competencies required for practice in order to provide a realistic expectation for job performance. Six of the nurses described their interviews in detail, noting that they were asked questions related to cancer knowledge; advanced clinical and psychosocial competencies; and leadership, decision-making skills, and team work skills.

*Nurses’ Interview Experiences for CNP Positions*

Forty percent of the nurses in the study were not formally interviewed for their positions. A variety of informal interview processes occurred with 3 new graduates who had pregraduate placements on the units where they were hired. Also, 3 outpatient nurses were actively sought out to apply for their positions because of their extensive experience. Currently, the standard process for hiring nurses calls for an interview with a panel of at least three or four members, including the unit manager, possibly a manager from another unit or an educator/advanced practice nurse, and an experienced cancer nurse.
For the past decade, the mounting nursing shortage has created a staffing crisis in most hospitals. Given that the nursing wage is standardized because of negotiated union contracts, nurses throughout the province receive equal pay and benefits. Union contracts also dictate that certain nurses have seniority rights that allow them to transfer from unit to unit within the same organization and circumvent the application and interview process if they possess the necessary criteria for the position advertised. Although this right provides job protection for nurses, it also can create a situation where everyone is competing for the same pool of nurses, interviewing can become a meaningless process, and there are no extra incentives that managers can offer to recruit nurses into specialty areas. Because certain specialties are more attractive than cancer nursing, this situation leaves managers begging new graduates to consider positions on their cancer units.

Recent nursing studies have indicated that organizational cultures have changed over the past decade, so restructuring and staff shortages has resulted not only in eroding trust in leadership but also decreasing visible leadership (Bakker, Fitch, Green, Butler, & Olson, 2006; Porter-O’Grady & Malloch, 2003).

For several years, I had the opportunity to interview and hire nurses for in-patient and outpatient positions, and I found the interview process to be an important part of the nurses’ introduction to the organizational culture. It might sound “cliché” to say, but first impressions do count, and on a more practical note, the interview is an opportunity to assess the nurses’ learning needs and to begin planning an effective orientation process to ensure the retention of a future employee. One of the participants, who never had an interview for her position, felt forced into the job, and clearly stated that she would leave the unit at the first available opportunity. Another participant described her interview as
“fluffy”; did not know what to expect in her new position; and stated, “It was like going in blind.” Yet another nurse, who had been transferred into a unit without the benefit of an interview, felt that her orientation suffered, was unsure of her choice, and was continuing to look for other opportunities. In today’s competitive job market, the interview process is a crucial step for both the applicant and the health care organization. During this time the individual and the organizational leader learn about each other, begin to establish a trust relationship, and forge the next steps in the process of learning about the organizational culture—the orientation.

What Did the Nurses Learn About CNP?

The nurses were asked about their learning experiences in CNP, including their experiences during orientation and the formal and informal supports that assisted them. They were asked to identify the knowledge and skills unique to their new role, and how they would compare their prior work experiences in respect to emotional demands on self. The nurses were hired for different CNP settings, each of which had a distinct cultural norm. The settings were either in-patient or outpatient and located in urban, rural, and remote communities. The stresses and challenges were different in each setting, and these variations impacted their learning needs, supports for learning and the factors affecting learning.

The nurses completed in-house orientations to their respective cancer nursing settings. The orientation programs included a formal theory portion, followed by a clinical practicum supervised by a nurse preceptor. The orientation programs varied anywhere from a minimum of 10 days to a maximum of 40 days, with an average orientation of 15 to 20 days (3-4 weeks). The in-patient orientation programs tended to be
shorter, with most being 2 to 4 weeks (9 in-patient nurses), and the outpatient orientation programs averaged 4 to 8 weeks (6 outpatient nurses). The 2 nurses who had orientation programs longer than 20 days (4 weeks) were involved in highly specialized outpatient oncology nursing roles (i.e. pediatric oncology, specialized radiation therapy procedures). During their orientations, the nurses were assigned nurse preceptors. At least 3 participants reported having two or more preceptors, and 1 nurse reported not having a nurse preceptor during the orientation. Eleven of the participants completed an in-house chemotherapy certification course, an additional 5- to 10-day course; 2 never completed a chemotherapy course; and 2 were pending completion.

The orientation programs for newly hired nurses in cancer facilities are relatively similar in length, topics covered, and supports provided. I obtained copies of the orientation programs for the four cancer facilities contacted during this study. The programs were generally 2 to 4 weeks in length and included a theory component that was followed by a clinical practicum experience with a nurse preceptor. The programs were tailored according to the setting and were divided into three distinct areas: in-patient, outpatient chemotherapy clinic, and outpatient clinics. The clinical practicum was supervised by a nurse preceptor, and in order to administer chemotherapy independently, the nurses had to be certified by a nurse clinician. The orientation and chemotherapy certification programs were completed in house and followed the CANO (2006) standards. The orientation programs for the study participants varied according to whether they were new graduates or senior nurses, their previous experience, and the availability of certified preceptors.
When the participants were asked about their orientation to cancer care, the number of days (weeks) varied from 5 days (1 week) to 40 days (8 weeks), with the average orientation being 12.5 days (2.5 weeks). There are some possible explanations for the variations in length of orientation, for example, 3 participants indicated that they had 5 to 10 days orientation, all of the nurses employed on in-patient units, and the overall average for in-patient orientation was 10 to 15 days (8 participants). The in-patient nurses were new graduates and, in most cases, had not yet completed their chemotherapy certification program, which averages 5 to 10 days. Three participants had orientations that spanned 20 to 40 days in outpatient specialized cancer programs, which require a high level of independence and accountability. The length and type of orientation program was dependent on the nature of the position and the variability in each setting.

The curriculum of the oncology orientation programs in each of the settings included the following topics: (a) prevention of cancer; (b) screening and early detection of cancer; (c) carcinogenesis; (d) common cancers (breast, lung, prostate, colorectal, lymphomas); (e) nursing implications of surgical treatment, radiation therapy, and antineoplastic therapy; (f) preparation, administration, and disposal of antineoplastic agents; (g) oncological emergencies; and (h) supportive care (pain, nausea, fatigue). Some of the nurses reported other topic areas, including the role of the oncology nurse/primary nurse; strategies for coping with the stressors in CNP; palliative care; pain management; radiation safety; telephone practice; and confidentiality and ethics. The nurses reported that the didactic (formal) portion of their orientation program, approximately half of the orientation hours, or 1 to 2 weeks, included a variety of
teaching strategies: lecturers, guest speakers, CDs and videos, interactive learning modules (binders or CDs), hands-on demonstrations, case-studies, self-tests, discussions, and conferences. The clinical portion, the remaining half of the orientation, or 1 to 2 weeks, was working on the clinical unit with experienced nurse preceptors.

The outpatient and in-patient oncology nurses described the strengths and the weaknesses of the didactic and clinical portions of their orientation programs. Although the nurses indicated that it was useful to have self-learning materials, CDs, and videos to refer to, they were no substitute for the time spent learning from their preceptors and patients on a day-to-day basis. A few nurses commented on the sequencing of their learning experience, noting that the theory component often was lengthy and not linked to the practice setting. There has been a lack of evidence on which programs work effectively, and why, and there has been an assumption that increased knowledge and confidence lead to a positive impact on practice (Wyatt, 2006).

In-Patient CNP

The learning experiences of the new graduates were different from those of the experienced graduates working on in-patient oncology units. The new graduates were not allowed to administer chemotherapy for 3 to 6 months after their initial orientation, and then once after they had completed a chemotherapy course and had completed a supervised clinical practicum. This situation contrasted with that of the more experienced nurses (> 2 years of nursing experience), who were taught how to administer chemotherapy as part of their initial orientation. For the most part, the new graduates described their orientation as occurring in two phases, namely, an initial orientation to the unit and hospital, as per any new graduate hire, and a second orientation occurring 3 to 6
months later that included such cancer care skills as the administration of chemotherapy including and the management of side effects and cancer-related emergencies. This pattern of orientation created some difficulties for the new nurses because it delayed their ability to function as cancer nurses and resulted in resentment in some cases from senior staff nurses. Three of the new graduates requested an extension of their orientation program because they did not feel competent to practice unsupervised.

The nurses unanimously agreed that preceptors were essential and that ongoing support from staff, educators, and managers enhanced their growth. For the most part, their orientation was informal and included day-to-day support from nurse preceptors and opportunities to learn through dialogue with others. They indicated that communicating with patients, having opportunities to apply knowledge and skills, getting to know the team, and learning how to cope with the strain of caring for critically ill and dying patients were very important milestones in the first few months.

Although there has been a growing emphasis on cancer education programs for nurses, research into the effectiveness and impact of cancer education on practice has been scant. For new graduates orientating to general practice, there has been some evidence that preceptorship and internship programs, in addition to formal education, enable them to transition into new roles effectively (Messmer, Gracia Jones, & Taylor, 2004; Parchen, Castro, Herringa, Ness, & Bevans, 2008). Although I was unable to find any studies regarding the preparation of new graduates for specialty practice, nurse manager colleagues confirmed that it is common practice to extend the orientation of new graduates when they are working in CNP.
Outpatient CNP

The learning experiences for the nurses recruited to outpatient cancer clinics were different from those hired for in-patient cancer units. The 6 nurses (Courtney, Rebecca, Doris, Gayle, Fran, and Lorraine) who work in the outpatient settings had anywhere from 4 to 25 years of prior nursing experience in a variety of clinical areas. The outpatient clinics are attached to the in-patient hospital unit for administrative purposes as well as easy access for patients who need diagnostic and pharmacy services. The services are linked through administrative channels, yet the outpatient services have distinct staff and function generally during the daytime hours from 7:30 am to 5:30 pm. It is common for outpatient nurses to be familiar with in-patient staff, and vice versa.

A typical outpatient cancer program is divided into three main service areas: outpatient clinics, chemotherapy treatment clinic, and radiation therapy treatment clinic. The orientation of nurses varies according to their involvement in these areas, but in their orientation, they are exposed to all three areas. The outpatient nurses mentioned that their positions are different from those of in-patient nurses in the following areas: (a) increased responsibility, accountability coordinating patient care; (b) increased administrative duties (clerical duties, telephone consultation); (c) closer relationships with patients and physicians; and (d) positive quality work life factors (i.e., no shift work, and weekends and holiday off). The orientation of outpatient nurses is different from that for in-patient nurses: The programs need to be developed and delivered by outpatient experts and standardized to ensure a consistent and high-quality orientation program (Steinbauer, Houchin, Payne, Waters, & Condor, 2009).
Rural CNP

Being rural means being a long way from anywhere and pretty close to nowhere. Being rural means being independent or perhaps just being alone. Being a rural nurse means that when a nurse saves a life, everyone in town recognizes that she or he was there, and that when a nurse loses a life, everyone in town recognizes that she or he was there. Being rural means turning inwards for answers, because there may be nobody to turn to outward. Being rural means that when a nurse walks into the emergency room, it may be her or his spouse or child who needs a nurse, and at that moment, being a nurse takes priority over being anyone else. Being rural means being able to deal with what she or he has got, where she or he is, and being able to live with the consequences (Scharff, 2006, p. 181).

These words resonated with my experience of living and working in rural communities in northern Ontario. In my role as an advanced practice nurse, I developed and delivered cancer nursing education and chemotherapy certification to nurses in rural and remote communities. I also was involved in the recruitment and selection of senior nurses to rural communities within the catchment area of the regional cancer program. Although there are similarities and differences in the roles among nurses working in outpatient cancer settings, as opposed to nurses practicing on in-patient cancer units, there also are distinctions between urban and rural or remote outpatient CNP. Rural nursing is recognized by the CNA to be a nursing specialty, as is oncology nursing and hospice/palliative care (McIntyre & MacDonald, 2010). These three nursing specialties are essential to providing comprehensive cancer care, and in rural areas, the same nurses often provide all of these services to patients and families.

Eight of the nurses (in-patient & outpatient) are part of northern regional cancer programs and have worked in smaller urban-like settings surrounded by vast geographical regions isolated from cancer specialists in larger urban centres. At the time of the study, 3 of the participants were working in outreach programs linked to smaller urban cancer centres. They received their education and day-to-day support via distance
technologies. Their patients’ blood work and tests are completed in their home communities and were sent electronically to urban centres to be reviewed by oncologists. The orders for chemotherapy and other treatments are dispatched to the community cancer team, comprised of a family physician, a nurse, and a pharmacy technician. The team members have received specialized cancer education and training at the smaller urban centres prior to assuming their role in their home communities.

The learning experiences of the nurses working in these remote communities vary in regard to access (getting in), coping (managing in), and ongoing development (staying in). The nurses who are recruited to the remote cancer program are usually highly experienced nurses who have had prior experience in emergency, operating room, and general medicine/surgery. These nurses have to be expert generalists in both hospital and community settings (MacLeod, Kulig, & Stewart, 2004; Winters et al., 2006). This skill mix required for CNP is not difficult to find because small hospitals cross-train their staff to work in all areas of the hospital and community. In addition, nurses working in the regional cancer program work on a part-time basis because of the low volumes of patients, so they have more than one nursing specialty if they were working on a full-time basis.

In the late 1990s, provincial government funding was made available to set up infrastructures in small rural communities in northeastern and northwestern Ontario. The larger urban centres recruited family physicians, nurses, pharmacists and pharmacy technicians, and psychosocial personnel from communities within their regions and provided cancer education and training face to face and by telehealth (Ontario Telehealth Network). Each community also received funds to develop the infrastructure for
chemotherapy treatment units. The program is operated under the concept of care closer to home and was intended to keep patients in their own communities, where they could receive their chemotherapy treatment, rather than travel to the larger urban chemotherapy units.

Nurses working in rural and remote outpatient cancer clinics with populations of 5,000 to 10,000 face a different experience than their counterparts in urban centres. Their geographic isolation poses challenges for recruitment, orientation, and ongoing involvement in the specialty. In their particular settings, they may be one of two or three nurses involved in the administration of chemotherapy and the provision of supportive care to cancer patients and their families. The nurses’ orientation initially takes place in the urban centres and is followed up by preceptors who mentor via teleconference. Ongoing education and patient support are provided via teleconferencing through the Ontario Telehealth Network.

The nurses who participated in this study emphasized that their role is important to their communities and that without chemotherapy and cancer services, the patients would have no choice but to travel great distances (> 100 km-600 km) to the urban centres, sometimes over ice roads, and often without the support of their families. The nurses also emphasized the importance of the Ontario Telehealth Network to support not only patient care but also their CNP and continuing education needs.

Sevean et al. (2008) evaluated workshops on cancer assessment skills delivered via telehealth, and the results indicated that education via telehealth is a viable and cost-effective option that does not require the nurses to leave their rural communities. Another recent study proposed distance education as one solution to the nursing shortage in
smaller communities and advocated providing online education to address learning gaps (Talbert, 2009). “The benefits of telehealth extend not only to patients and families but are linked to benefits for providers as well as the health care system in smaller communities” (Sevean et al., 2009, p. 2578).

The rural cancer nurses in the study were very passionate about and committed to their work. They did admit to feeling an increased sense of responsibility for ensuring that the people living in their communities had access to the cancer services they needed. This heightened level of responsibility, combined with the emotional toil of caring for critically ill and dying cancer patients, has been reported in the literature:

We are responsive in our community because we see those people in our churches and in our grocery stores. And so, you know, we try to be all things to all people...maybe that is kind of bad. But in the end we are the ones who see these people outside of our work life, too. (MacLeod et al., 2004, p. 13)

Examples of this sense of responsibility were evident in 2 of the study nurses, who commented about keeping a notepad at the bedside to write things down about patients for the next day and voluntarily being on call 24 hours a day to care for patients who had problems with their central venous lines.

Chemotherapy Certification

Eleven (73%) of the 15 participants completed an in-house chemotherapy certification course as part of their orientation, and 4 (27%) participants were scheduled to complete the course at a later date. The 4 participants scheduled to complete their chemotherapy course at a later date were new graduates who indicated that they could not administer chemotherapy until they had completed their new graduate orientation and assessment. These graduates indicated that the delay in their orientation to chemotherapy was not well understood by other staff members and, in some situations, resulted in
resentment from senior nurses.

The types of chemotherapy protocols that nurses have to administer also vary according to their positions. Generally, nurses working in outpatient chemotherapy units require additional training and skills to remain current in chemotherapy protocols because the focus of their position is the administration of chemotherapy. Several of the nurses in the study identified the need for continuing education in chemotherapy, but they were unsure what extra training might exist beyond the standard in-house chemotherapy course that they took during orientation. The reason for this confusion is that there is no provincial or nationally recognized standardized chemotherapy certification course; instead, facilities have in-house courses to prepare their cancer nurses.

The membership of the CANO (2006) “has expressed concern that cancer nurses’ chemotherapy administration practice, competencies, and education vary across Canada” (“CANO National Chemotherapy Standards” section). The CANO is currently piloting the CANO/ACIO National Chemotherapy Administration Standards and Competencies in 2010. The effects of chemotherapy education and certification have been studied, and the results have indicated support for newly hired nurses in CNP to participate in programs to ensure a culture of safety by preventing chemotherapy-related errors (Coleman et al., 2009; Sheridan-Leos, 2007). Positive role models for novice practitioners have been identified by researchers as important; role models themselves require continued professional development (Verity, Wiseman, Ream, Teasdale, & Richardson, 2008).

Learning About “Being With” Cancer Patients

In the first few weeks of practice, the nurses, regardless of previous experience, education, or work setting, described how overwhelmed they felt by the emotional
intensity of being with cancer patients. When comparing CNP to other nursing experiences, they unanimously agreed that CNP is not only more complex but also more emotionally stressful. The results of several landmark studies would concur that CNP is unique in regard to emotional strain. In 1978, Newlin and Wellisch described the life of the cancer nurse as living on an emotional roller coaster. Since then, other studies have been conducted to examine the stresses inherent in caring for cancer patients. A phenomenological study was conducted asking nurses to describe a typical day:

These nurses described working with patients with cancer as being on the front lines of a war against death, disfigurement, and intense human suffering. It requires the performance, prioritization, and coordination of multiple complex tasks. It involves handling frequent, unexpected crises, both physiologic and psychological. It carries the rewards of reversing fatal illness, balanced by the ever present reality of death. Working with patients with cancer requires constant vigilance in monitoring for sudden problems and life-threatening errors. The cancer nurse’s empathy is sharpened by the awareness that this could be my loved one. Finally, working with patients with cancer means “being there” for people in their most private moments of suffering and responding to the heights and depths of their responses to this suffering. (M. Z. Cohen & Sarter, 1992, p. 1485)

In 1994, the ONS embarked on a landmark phenomenological study of oncology nurses’ perceptions of the rewards and difficulties of their work, as in prior research patients were part of the difficulties but also the rewards of cancer nursing including; being there, time spent supporting, seeing patients survive, and patients’ and families’ appreciation (as cited in M. Z. Cohen, Haberman, Steeves, & Deatrick, 1994). The intensity of working with cancer patients is further underscored by the fact that there is no typical day for oncology nurses and that managing and organizing their work is problematic and adds to the stress of providing care for critically ill patients who often are perched between life and death (Steeves, Cohen, & Wise, 1994). Nurses who are newly hired to work in cancer or palliative nursing are continuously exposed to the stress
of working with dying patients and their families, which impacts their transition experience (M. Z. Cohen, Haberman, & Steeves, 1994; Rosser & King, 2003).

All the nurses in the study commented effusively on the stress of working with critically ill and dying cancer patients and their families. For new graduates, this experience often was the first time that they had confronted suffering and death. They described how through their patients’ eyes, they learned what it is like to have cancer and be facing death. Senior nurses spoke of the increased percentage of dying patients in their CNP as compared to their previous practice settings. Their difficulties in adapting were attributed to patients being more complex and the learning curve to CNP being steeper. The orientation programs included information on ways to provide for the patients’ physical needs but very little information on the psychosocial aspect of cancer care.

The nurses also valued talking to other cancer nurses about how to cope with the emotional ups and downs of daily practice. They identified that their orientation programs were generally lacking information on psychosocial strategies to assist them in coping with the emotional strain. They often said they would not have made it without the support of more experienced staff, who would talk to them about how they coped with the emotional strain of working with cancer patients.

I can identify with the nurses in the study because when I first started in CNP, I was working with a very seasoned group of cancer practitioners, so I was able to talk to them about the emotional impact of working with cancer patients and their families. A few years later, when I was developing an orientation program for nurses, I built in time for senior staff to share with new staff their stories of coping with their most difficult cases. The literature includes examples of programs to assist nurses to cope with the
stresses involved in CNP (Fitch et al., 2006; Lewis, 1999; Medland, Howard-Ruben, & Whitaker, 2004).

These programs have been focused on dealing with the long-term stress of working with cancer patients, but few have addressed the needs of newcomers. Two nurses in this study described experiences that they had during their orientations. They watched videos of senior staff talking about their experiences with patients, followed by a discussion with other nurses and the nurse educator. They found this a very valuable experience because it normalized the work-related suffering and grief experienced in day-to-day practice. As one participant said, “No one is immune to the pain, nor should they be, but we need to be aware of it and the toll it can take on you personally.” An innovative program, “Care for the Professional Caregiver,” focuses on providing staff nurses with an opportunity to learn how to deal with stress by sharing stories and discussing coping strategies. Further research could be undertaken in other settings and possible “links between attending such a program and reduction in feelings of stress or rates of absenteeism could also be explored” (Fitch et al., 2006, p. 115).

Hinds, Quargnenti, Hickey, and Mangum (1994) suggested that stressors and reactions among pediatric cancer nurses are the most acute 6 to 12 months after being hired. Evidence has shown that stress can be linked to the number of deaths in cancer settings and the fact that newly qualified nurses are more at risk; however, there has been “insufficient evidence about how stress may fluctuate over time or the factors that exacerbate stress” (Corner, 2002, p. 196). Barnard, Street, and Love (2006) reported that the nurses in their study ranked their stress scores higher when nurse-physician communication was poor, workloads were heavier, and there was a lack of sufficient
supports. Work stress, including the number of deaths and the lack of psychosocial support at work, increases nurse burnout (Campos de Carvalho, Muller, Bachion de Carvelho, & de Souza Melo, 2005; Quattrin, Zanini, Annunziata, Calligaris, & Brusaferro, 2006). J. S. Cohen and Erickson (2006) noted, “Students and novice nurses may experience more uncertainty and distress related to ethical issues because of their limited knowledge base, lack of confidence and influence, and discrepancies between what they learned in school and what they see in practice” (p. 775).

If novice nurses do not build in the necessary skills to cope with emotional strain over time, they are susceptible to caregiver burnout. Burnout has been linked to prolonged high levels of stress, feelings of apathy, and withdrawal, with the result being workplace turnover, absenteeism, and reduced productivity (Lewis, 1999; McElroy, 1982; Medland et al., 2004; Yasko, 1983). Researchers have recommended that to reduce burnout, healthier workplaces should be created and coworker support increased, especially for less experienced nurses (Kushnir, Rabib, & Azulai, 1997; Medland et al., 2004). Evidence has shown that social support networks are important during times of change and uncertainty in the work environment; in other words, a supportive workplace can protect against burnout (Garrett & McDaniel, 2001).

Compassion fatigue describes the unique stressors that affect people in caregiving professions such as nursing. Compassion fatigue is different from burnout in that it links emotional fatigue to the prolonged exposure of nurses to the trauma of loss and grief (Bush, 2009). Individuals experiencing compassion fatigue develop symptoms similar to those experiencing posttraumatic stress disorder. Bush recommended that nurses need to learn to set boundaries and limits, and to reach out for support from
coworkers, peers, family and friends. Most of the nurses in the study self-identified that they needed increased psychosocial support from colleagues and family, although some of the nurses appeared to have fewer support networks in place and were already showing signs of being at risk for burnout and compassion fatigue.

**Learning About Caring for Ill and Dying Patients**

M. Z. Cohen, Haberman, Steeves, and Deatrick (1994) reported that the nurses in their study who were caring for cancer patients not only demonstrated self-confidence, courage, emotional strength and a desire to be empathetic but also believed that they understood their patients’ experiences, were isolated in their work, and experienced difficulty dealing with suffering. The nurses in the study attributed most of their stress to caring for patients who were suffering. Nurses who are newly hired to work in cancer or palliative nursing are continuously exposed to the stress of working with dying patients and their families, which impacts their transition experience (M. Z. Cohen, Haberman, & Steeves, 1994; Rosser & King, 2003).

One of the nurses in my study had previous experience working in hospice care, and because of her advanced knowledge and skills, she felt confident caring for palliative patients. The other 14 nurses identified the need for further support and education related to working with critically ill and dying patients. Research has shown that nurses with negative attitudes toward death (i.e., fear of death, death avoidance) are more likely to experience chronic compounded grief, which then results in despair, social isolation, and somatization (Braun, Gordon, & Uziely, 2010; Feldstein & Buschman Gemma, 1995; Saunders & Valente, 1994; Wu & Volker, 2009).
Several researchers have suggested that training and support programs for cancer nurses be developed and include the domains of quality palliative care: structure and processes of care; physical, psychological, social, spiritual, existential, and cultural aspects of care; care of the imminently dying patient; and ethical and legal issues (Ekedal & Wengstrom, 2006; Meraviglia, McGuire, & Chesley, 2003; Pavlish & Cernosky, 2009; Watts, Botti, & Hunter, 2010). In my study, the 6 new graduates and nurses with less than 2 years of nursing experience confirmed palliative care as an area of practice that they were the least prepared for, and they expressed the need for further education. What was surprising is that senior nurses remarked that they had never experienced the same extent of suffering and death in their previous positions and felt unprepared to cope with the needs of palliative care cancer patients and their families.

Ferrell, Virani, Paice, Coyle, and Coyne (2010) suggested that there is an urgent need for improved palliative care throughout the world as well as training programs for undergraduate students and nurses in all settings. Supporting cancer nurses as they work through grief and loss is essential. Positive strategies include creating time and space for staff self-care, communicating with others who understand, spending quality time with patients and families, and acknowledging the nurses’ efforts as well as the work structures and organizational processes to support nurses’ bereavement (Wenzel, Shaha, Klimmek, & Krumm, 2011).

How Did the Nurses Learn About CNP?

Some nurses who encounter difficulties learning a new practice lose self-confidence because practice-based learning can pose challenges (Kelly & Mathews, 2001; Murray, 1998). Unless nurses can be comfortable with the reality that they are
novices and need to function at a lower level of competency until they master their role in a specialty area, they may have difficulty making a successful transition (Benner, 1984; Rosser & King, 2003). CNP is a particularly challenging specialty because the knowledge is relatively new and is not generally included in the basic education of nurses. In addition, the learning occurs in daily practice and involves getting to know a unique patient population and specialized body of knowledge under the guidance of a cancer care team.

*Learning With Patients*

Nurses working in cancer care often describe having a personal connection with their patients and that by spending time with them, they learn how to provide cancer care. The nurses in this study noted that cancer care is a specialized body of knowledge that addresses the needs of a unique group of patients and their families. When nurses help patients to make sense of their disease and end-of-life issues, it also helps the nurses to make sense of their role in providing holistic cancer care. Several nurses in the study described their relationships with patients as a privilege that was special. They felt rewarded when working with patients.

These nurses also were comfortable in the “presence” of their patients and expressed a sense of satisfaction in helping patients during times of intense suffering and joy. I could relate to their stories because I remember being with patients who had lived with their disease for many years. I was in awe of their inner strength and felt privileged to care for them. Recent studies have suggested that cancer nurses form strong connections with their patients and overcome challenging situations with them (Perry, 2006); these bonds result in considerable emotional work and a struggle to maintain
balance on the intimacy continuum with patients (Dowling, 2008). They also raise concerns that nurses could be carrying guilt and distress that impact their health (Quinn, 2003). Nurses must be aware of the subtle balance on the intimacy continuum with patients and families.

The consequence of nurse-patient intimacy is like a two sided-coin for nurses. They feel a sense of satisfaction, which sustains their caring efforts. However simultaneously, they make efforts to maintain a comfortable emotional distance from patients for fear of over-involvement (Dowling, 2008).

Over the years, I have witnessed many experienced cancer nurses who have made strong connections with patients, have provided high-quality care, and have been very satisfied with their careers. Those very same expert nurses like Carol talked about how much they learned from each patient and how that learning contributed to their practice. Theorists have referred to this as nursing praxis, which is grounded in a unitary, transformative paradigm; a dynamic partnership between nurse and patient; a dialogue of an evolving pattern of meaning, insight, and action; transforming for both nurse and patient (Newman, 2008). This phenomenon is described in CNP as “joint transcendence” and it occurs “as exemplary oncology nurses care for their patients, patients share their humanity with them” (B. Perry, 2006, p. 40).

Learning With Nurse Preceptors

Thirteen of the participants had a preceptor supervise their orientation to various areas of cancer care, and 2 participants had more than one preceptor or mentor. The preceptors, who are an essential part of the clinical practicum, are usually senior nurses who are certified in their specialty area of practice and who are responsible for
supervising nurses learning to start central line skills and administer chemotherapy. The nurse who did not have a preceptor was a senior nurse who had transferred to a cancer in-patient unit that lacked senior staff. She was not assigned a preceptor because of the shortage of qualified preceptors.

In the narratives, the nurses mentioned the support that they received from their nurse preceptors and other mentors who assisted them in their learning. The introduction of nurses to new roles requires staff support and an emphasis on staging and orientation during the transition (Graff, Roberts, & Thorton, 1999). Nurses newly hired into cancer settings have identified the significance of having clinical preceptors to support them during orientation (Linder, 2009; Sevean, 2003). The literature has suggested that further attention should be paid to what newcomers need to learn, who can best assist them with their learning, and how organizations can support their learning to ensure the retention of nursing staff (Mayer & Nevidjon, 2009).

Nurses have a responsibility to constantly advance their abilities and knowledge, and this responsibility includes sharing their skills with new nurses or students through preceptorship and mentorship programs (RNAO, 2006). Johnson, Cohen, and Hull (1994) noted that a combination of protégée and mentoring activities enhances “the development of expert nurses who combine competent clinical practice with strong interpersonal commitment to their patients and the oncology nursing profession” (p. 27). The role of a mentor or preceptor from the students’ perspective can be divided into three subroles: (a) supporter: give advice, sort out problems or worries the mentee had, be there as an ally; (b) guide and teacher: act as a role model, move the mentee along the continuum between observing and doing, and give feedback on their performance; and (c) supervisor, more at
the beginning than the end, and allow for gradual independence (M. A. Gray & Smith, 2000).

The nurses in the study described their mentors or preceptors as providing advice, helping to problem solve complex situations, listening to their concerns, role modeling and supervising new skills, and introducing them to the cancer care team. The 2 nurses who did not have preceptors indicated that they still did not feel orientated to their respective positions and had few supports. Most of the nurses had at least one preceptor or two for their initial orientations and continued to consult with their assigned preceptors and other nurses following their orientation. Some nurses suggested that they would like a mentor to provide support and knowledge as part of their ongoing education.

The five core competencies of mentors and leaders include self-knowledge, strategic vision, risk taking and creativity, interpersonal and communication effectiveness, and inspiration (Dracup & Bryan-Brown, 2006). Several of the participants described their preceptors, educators, and managers in these terms, and they found their mentorship invaluable. The preceptorship partnership is the most effective means of ensuring that students and new nurses integrate professional theory with clinical practice, but a growing lack of nurse preceptors may threaten the process (Chisengantambu, Penman, & White, 2005; Ryan-Nicholls & Kimberly, 2004). Three of the study participants were attracted to CNP following student placement experiences guided by experienced cancer nurses, and they agreed that their preceptors eased the transition into their positions. A recent study exploring the transition experiences of new graduates indicated that “the nurses who were satisfied with their positions were those who had
accessible and competent preceptors for an extended period of time who answered their questions and modeled professional behavior” (Ellerton & Gregor, 2003, p. 106).

Two participants did not have access to preceptors because of the lack of qualified preceptors on their unit, a situation that they acknowledged hindered their progress. Most of the literature has supported mentoring as positive, although there has been little empirical evidence that having a mentor improves clinical learning. Andrews and Wallis (1999) suggested that when students and nurses are mentored, they may feel more supported and “comfortable” in their new clinical area and that learning has less to do with direct transference of knowledge and more to do with socialization and the relationship between mentor and mentee. The 13 preceptored nurses in the study talked about how helpful their preceptors were, and they also spoke at length about the support that they received from preceptors as well as other nurses and the entire cancer team. Andrews and Wallis suggested that because no one person has all the attributes of a good mentor, mentees could be best served by a mentoring team. Nursing management needs to consider “recruitment and retention on a continuum where organizational investment begins with a well-developed orientation and ongoing mentorship to ensure knowledge development” (Bakker et al., 2010, p. 205).

Learning With the Cancer Team

There was general consensus among the nurses was that CNP is challenging and that they needed to learn psychosocial as well as cancer-related knowledge and skills to survive. I remember my first days in the chemotherapy unit, my awkwardness with patients, and how overwhelmed I felt by all the things I did not yet know. I do not know
how I would have survived without Carol, my preceptor, and the rest of the team members who took the time to teach me.

There has been a long-standing tradition in cancer care that professionals work in collaborative teams to plan and implement cancer programs. The nurses working in urban in-patient programs described their work environment as team orientated, which was more evident than in other areas they had previously worked and critical to providing quality patient outcomes. The 3 nurses working in rural and remote areas spoke about the importance of working collaboratively with urban centres to deliver services. They also relied on learning about new technologies and treatments via distance education. Cancer and palliative care professionals are increasingly utilizing interdisciplinary community networks to deliver services to rural and remote communities (CAPCA/CPAC, 2010).

In Manitoba, community oncology clinics were introduced as early as 1978 (Schipper & Nemecek, 1991). During the 1990s, cancer control programs were increasingly located in community settings, whether for prevention, breast screening, systemic therapy, or palliative care. Several provinces continued to build upon the early work in Manitoba by establishing community networks of practitioners to provide cancer control programs closer to home in small regional communities. A few recent studies have indicated that telehealth/telemedicine “is an effective mechanism for delivering (cancer) nursing and other health services to rural/remote communities and can impact positively on the quality of health care” (Miller & Levesque, 2002; Savenstdet, Zingmark, & Sadman, 2004; Sevean et al., 2009, p. 2573; Young & Ireson, 2003). Home care programs also have evolved to provide supportive and palliative care. Recently, Health Canada’s cancer control programs were amalgamated within the Centre for
Chronic Disease Prevention and Control, now located within the Public Health Agency of Canada (as cited in CIHI, 2007).

The increasing regionalization of health care delivery, new approaches to primary health and patient-centred care, reduced wait times in key areas, the development of electronic health records, an emerging focus on interprofessional education, and the emphasis on performance measurement have necessitated the development of innovative programs that ensure that they have the right providers in the right places to provide the right services to the patients within an appropriate time frame (CAPCA/CPAC, 2010). This trend is gathering momentum, and health care providers and educational institutions are collaborating to promote and support interprofessional cancer education through the utilization of distance learning programs (CAPCA/CPAC, 2010; Sevean et al., 2008).

What Factors Influenced Their Learning About CNP?

It has been well established in the literature that informal learning is one of the most prevalent forms of learning in the workplace (Billett, 2002; Boud & Garrick, 1999). Despite the prevalence of informal learning, not much is known about how it occurs and the factors that influence learning in the workplace. The growing focus on learning as a core competency and a lifelong process has resulted in a shift to examining the extent to which the organization’s environment serves to enhance or inhibit such learning (Ellinger, 2005). Nurses need information to do their work, and they get it by working with expert nurses whom they respect in a supportive health care environment. The research focused on learning that is socially constructed and contextually embedded has been scant. It is essential to explore the contextual factors that shape informal learning to advance the current understanding of how it is nurtured and sustained in the workplace.
(Cseh et al., 1999; Ellinger, 2005). The nurses’ stories provided a glimpse of the quality-of-work life issues and organizational leadership practices that can enhance or impede the development of a dynamic learning culture.

Leadership Commitment to a Culture of Learning

The fast-paced workplace of the 21st century demands that contemporary leaders have a different emphasis and skill set from those who predominated in the past (Porter-O’Grady, 2003a). Nursing leaders would do well to examine carefully leadership best practices and take into consideration the current social context of workers. One might ask about the costs of throwing over past best practices in favor of newer more innovative solutions. Possibly, the result could be chaos, but if the old models continue to be applied to new situations, there is a risk of repeating the mistakes of the past. One should carefully examine the relevancy of these models in light of the current health care context.

Health care professionals are living in times of uncertainty and constant change, and leaders stand to lose if they do nothing at all (Porter-O’Grady, 2003b). Leaders need to become strategic risk takers and support others who take risks while creating a new context for workers in the health care system (Savage, 2003). Risk taking is an act of courage on the part of leaders that requires conviction by the leaders in their beliefs and values. This moral courage, coupled with ethical fitness, evolves as the result of ongoing reflection by leaders about their core values, morals, and decisions (Clancey, 2003). This capacity of courage stems from a process of deep reflection and is motivated by the concern to do “good” for the public and provide quality care that is optimal to our professional standard (Potempa, 2002). Today leadership is defined as a much broader
concept that is less hierarchical and inclusive of vision and creativity and can reside in ordinary individuals (Porter O’Grady, 2003a; Ryan, 2006).

The problem is that nursing leadership has been defined as an elite person with certain characteristics rather than a “state of mind” inherent in each nurse. The definition of leadership has to be a communal and more inclusive practice that requires power sharing among nurses and with administrators; in turn, this philosophy will extend to other health professionals, patients, and their families (Koermer, 2000; Ryan, 1998, 2003, 2006). Leadership can be envisaged as “an innate capacity inherent within each individual… this perspective sees communities, groups, and organizations as leaderful in this way, leadership is an artful exchange of leadership-followership, where all become part of something more in an exquisite dance of synergy” (Koermer, 2000, p. 14).

In the past decade, there has been a shift in health care from the hospital to the community. Nurses are not as embedded in highly structured work environments as they were in the past, and they have become more autonomous health care providers required to assess increasingly complex situations and make critical decisions. This is evident in cancer care because the treatment of patients has shifted from in-patient to outpatient cancer clinics (Williamson, 2008). This shift to the community necessitates cancer nurses to become more autonomous in their role and expand their leadership skills. Some of the new nursing leadership roles identified include decision maker, critical thinker, buffer, advocate, visionary, forecaster, teacher, communicator, evaluator, facilitator, risk taker, mentor, influencer, creative problem solver, change agent, diplomat, energizer, coach, counselor, and role model (Marquis & Huston, 2000).
I recognized many of these roles evolving in the nurses, particularly those who had been in their role for more than 1 year and expressed confidence and satisfaction with their position as cancer nurses. The nurses identified their practice as highly autonomous and recognized that they needed to develop leadership skills to provide comprehensive quality care to their patients. Some of the nurses directly mentioned managers and educators as being responsible for providing the structure to assist them with their learning (i.e., learning modules, supervised demonstrations, preceptors, and extended orientation if required).

The Canadian cancer workplace is challenged by the same quality-of-work life issues as other nursing specialties: Nurses are among the most overworked, stressed, and sick workers and 8% of the workforce is absent each day due to illness (Villeneuve & MacDonald, 2006). Cummings et al. (2008) noted that “nurses’ burnout must be monitored carefully in order to ensure that those who are currently satisfied with their job are also physically and emotionally able to remain in the workforce and continue to provide valuable services” (p. 517). It is significant to note that the nurses who participated in the study praised the cancer team for providing supportive leadership in their day-to-day practice. Although they were grateful to their nurse preceptors, they also made reference to the members of the cancer interdisciplinary team as contributing to their growth and successful transition into the cancer workforce.

Some of the nurses talked about the need to keep current and learn new treatment protocols, which showed that cancer care programs are vibrant CoPs. They also stated that compared to other areas in which they had previously worked, the cancer community is a learning culture that is well supported, patient focused, and aligned with the best
practice movement to ensure quality care. Of course, 3 nurses had opposite views to these positive viewpoints regarding relational leadership. These 3 nurses spoke of leaders who were disconnected from practice and lacking vision. They also mentioned that even though educational opportunities were available, they were unable to attend because of staff shortages. One nurse indicated that the lack of senior nurses on the unit meant that she did not have a preceptor. She also was unable to find any appropriate role models and deemed the practice environment as unsafe and the learning culture as nonexistent.

The nurses in the study concurred that CNP is more stressful compared to other areas of nursing practice. They also indicated that although it is stressful working with critically ill and dying patients, if they had a supportive work environment, they could provide quality care, which would increase their job satisfaction.

Job satisfaction is multidimensional and the most cited reason for job turnover. The greatest predictors of job satisfaction are QOWL issues, such as meaningful work, team work, collegiality, external control, and autonomy (Best & Thurston, 2004; McLennan, 2005). It is urgent to listen to nurses’ stories that are filled with the tremendous burden of guilt and over commitment that nurses bear when factors in the work environment prevent them from providing complete quality care (McGillis Hall & Kiesners, 2005). The narratives in my study reported that most of the time, the nurses had support for their work from nurses and the entire cancer team, including the oncologists, which they indicated was not their experience on other nursing units.

The pressures seemed greater on in-patient units than on outpatient units, particularly pressures related to being unable to access preceptors because of senior nurses retiring and a lack of experienced nurses in the workplace. In-patient nurses commented that
when they are short staffed, it is difficult to attend professional education sessions, unless they give up lunch or breaks. Those same nurses felt conflicted because they had also identified a steep learning curve in cancer care and knew that being able to attend the education sessions directly contributed to their ability to provide quality care to their patients. This was further compounded by staff shortages that negatively impacted their ability to learn on the job because not only did they not have the formal knowledge but they also lacked the informal opportunities to learn from role models in practice. One senior nurse in the study indicated that this phenomenon of staff shortages and lack of access to critical information on cancer treatment protocols frequently placed her in situations where she felt incompetent to provide safe care to her patients. This nurse also indicated that there was lack of organizational leadership on the unit to assist with problem-solving issues. As a result, she was seeking new employment opportunities.

Styles of leadership have been shown to have a powerful effect on the development of health workplace environments. Efforts by organizations and individuals to encourage and develop transformational and relational leadership are needed to enhance nurse satisfaction, recruitment, and retention (Cummings et al., 2010).

**Competent CNP**

Competence is a complex concept and includes an individual-centred definition based upon personal attributes as well as a social definition that refers to meeting social expectations and “whose expectations count will depend on local micropolitics” (Eraut, 2004, p. 264). Studies focused on nurses’ perceptions of their learning needs have shown that nurses request more knowledge and practice in the following areas: communicating with the patient in different states of illness, dealing with psychosocial problems of
cancer patients, and taking nursing measures to minimize or prevent treatment related side effects (Corner & Wilson-Barnett, 1992). Nurses also have rated their competence in “physical care” much higher than that of “helping the patient deal with an uncertain future” and “helping the patient come to terms with the fact that he/she has cancer” (McCaughan & Parahoo, 2000, p. 421).

The nurses in the study were asked to comment on their level of competency and rate their performance as following: beginner \((n = 1)\), advanced beginner \((n = 2)\), competent \((n = 3)\), advanced \((n = 4)\), or expert \((n = 5)\). Of the 15 nurses, only 3 nurses ranked their performance as competent, even though all of these nurses had worked for more than 1 year in their current position. The remaining 12 nurses rated their performance as beginner to advanced beginner, and 5 rated their general nursing knowledge as advanced beginner to competent but ranked their cancer nursing knowledge as beginner. Senior nurses commented that the knowledge required to care for cancer patients is more complex than other nursing specialty areas.

The nurses also identified the following priority learning needs for continuing professional education and mentorship: psychosocial and communication skills, chemotherapy administration, caring for patients with treatment-related side effects, pain management, and palliative care. The nurses felt that their progress was satisfactory and was meeting the expectations of colleagues and managers. A couple of new graduates had felt comfortable enough to ask for an extension of their orientation and had been told by their managers that they could request this if they felt that they needed more time. Two nurses indicated that they felt that their progress was not rated as satisfactory by their colleagues. One new graduate stated that some of the nurses on her floor were frustrated
that she could not give chemotherapy and her course was delayed by the manager.

Another senior nurse expressed feeling incompetent after being in her position for 1 year and felt that her orientation had not been organized well enough to meet her learning needs.

*Being a Cancer Nurse*

The nurses in the study were asked at the end of their interview whether they felt as if they were cancer nurses, and if not, what needed to happen in order for them progress in their role. I had anticipated that the nurses who had been in the position longer would have been more comfortable than those who were newer to their position. The nurses’ responses were interesting. Some of the nurses who had been in the position less than 6 months said they felt like cancer nurses or were becoming cancer nurses. Nurses who had been in the position longer than 1 year either felt like they were cancer nurses or did not feel like cancer nurses and lacked confidence in their positions.

When I went back to the individual case narratives, it became clearer to me that the antecedent conditions in many cases predetermined how comfortable the nurses were in their new roles. Nurses who had a clear career vision, a strong social network, previous personal or professional experiences with cancer, and personal and professional strengths were more comfortable in their positions and positively oriented. During orientation, if the nurses had access to cancer knowledge and adequate people supports to mentor their CNP, they experienced meaningfulness and satisfaction in their new positions. This realization resonated with my findings in the pilot study that perceived satisfaction resulted in a greater commitment to the position. This finding is consistent with other research findings that have pointed to job satisfaction as having a strong relationship with
job stress, organizational commitment, work content, and environmental rather than economic variables (Blegen, 1993; Irvine & Evans, 1995; Tonges et al., 1998; Traynor & Wade, 1993).

I also looked at the commitment of the nurses to remain in CNP. First I examined the transcripts of the 6 nurses who had been in their positions for more than 1 year and their intention to remain in their positions. Three of the 6 nurses (50%) stated that they were not planning to remain in their positions. One nurse had already accepted another position, another nurse was actively looking for a new position, and a third nurse was grateful to be working on a part-time basis because of stress and staff shortages and was unsure how much longer she would remain in her position without further supports. When I examined the cohort of 9 nurses who had worked for less than 1 year, the nurses did not express any intention to leave their positions, but at least half of the nurses indicated that their working conditions were not very supportive. I began to wonder that as those nurses progress, and if they do not receive more support, will half of them also consider leaving?

On average, turnover rates in CNP are as low as 0.3% to 6% and as high as 21% and over (Hayes et al., 2005). Turnover costs are on the average 2.5 times a nurse’s annual salary and include direct salary of the new hire and preceptor, education and development costs, marketing and recruitment costs, loss of productivity during orientation, and the intangible cost of turnover on current staff (Gullatte & Jirasakhiran, 2005). Job satisfaction is the most cited reason for staff turnover, and two key factors are related to job satisfaction: stress and nursing leadership (Gullatte & Jirasakhiran, 2005). Recruitment is a challenge, particularly for CNP, an area associated with high levels of
stress, toxic agents, complex research protocols, and death and dying; and nursing leadership need to create a culture of retention inclusive and responsive to professional growth and practice (Reid Ponte et al., 2005).

**Summary**

The factors that influenced nurses getting into CNP were individual career choice and labour market issues that predeterm ined the availability of nursing positions. Nurses were recruited to their positions through social networking and prior professional and personal experiences with cancer care. It became apparent that cancer nursing leadership have not been particularly proactive in seeking out potential cancer nurses. Cancer nursing positions were advertised primarily through word of mouth and student clinical placements. The formal orientation programs included a curriculum based upon the CANO’s (2006) standards of practice. The content and length of the programs varied according to the clinical practice environment (in-patient, outpatient, chemotherapy, radiation therapy), and the geographical setting (urban, rural, remote). The challenges involved in surviving the first few months of practice included learning how to communicate with cancer patients and their families as well as caring for critically ill and dying patients. Learning about CNP occurred informally as part of everyday situations with patients, preceptors, and the multidisciplinary cancer team. Some of the factors that influenced nurses to stay and continue learning included access to preceptors, mentors, professional education, and nursing leadership to guide and support their learning.
CHAPTER 8: IMPLICATIONS OF FINDINGS

Introduction

I took a critical approach to examine how CNP is similar but different from other areas of nursing practice, specifically in regard to contextual factors within the workplace setting. I explored the uniqueness of the cancer nursing community in order to identify aspects that are germane to the discipline of nursing practice and those that are specific to CNP. The study sample included participants purposefully selected to represent (a) subspecialties of cancer nursing (in-patient, outpatient, chemotherapy, radiation therapy, adult, pediatric); (b) age ranges from 25 to 55 years; (c) previous nursing experience ranging from new graduate to 25 years of nursing experience; (d) geographical regions of the province of Ontario; and (e) urban, rural, and remote communities. I examined the role of the cancer nurse from the point of view of the nurses upon first entering the specialty and their subsequent journey into cancerland.

I asked the newly hired nurses to (a) describe how they were recruited and hired into their positions; (b) compare this field of nursing with other specialty areas and to identify the skills and competencies specific to the role of cancer nurse; (c) describe the unique aspects of the role; (d) identify the educational needs of nurses entering the specialty; (e) identify personal, organizational, and interpersonal factors that enhanced or impeded their ability to become socialized to their new workplaces; (f) share their experiences, including critical learning incidents and useful strategies that assisted them during trying moments in their new positions in cancerland; (g) examine their feelings related to job satisfaction and competency in their new roles; and (h) explore their intention to remain in CNP.
The nurses’ descriptions of their lived experience were regarded as reality. The collective conscious awareness of the participant and researcher experiences became emphasized during the course of the study. I maintained a self-reflective record of my thoughts throughout the study in order to identify any potential source of biases. I used interpretive coding to summarize the reported experiences into case narratives. I conducted a cross-case analysis and compared specific expressions and statements to identify categories of experiences. I clustered the categories as common themes that provided an overall description of the nurses’ experiences and the factors influencing their intention to remain in CNP. The study findings were categorized into three main themes and related subthemes presented in chapter 4 (Getting In), chapter 5 (Surviving In), and chapter 6 (Staying In).

A more in-depth analysis of the study findings involved using a conceptual framework based upon the phases of transition and the essential issues involved in informal learning (Eraut, 2004): (a) knowledge that the participants needed to carry out their day-to-day work, (b) leadership and supports available to guide their learning, and (c) contextual factors that enhanced or impeded their learning (Ellinger, 2005). The conceptual framework provided a useful lens to examine the nurses’ transitions in relation to their previous experiences and current contexts. The diverse cancer contexts (in-patient, outpatient, urban, rural, or remote) made it difficult to compare and contrast their learning experiences.

The addition of informal learning theory within the conceptual framework broadened the scope of the conceptual lens, thus allowing the reader to view the entire phenomenon. As a result, it becomes apparent to the reader that the nurses’ learning
experiences were different from context to context. In the “Getting In” phase, nurses shared the ways in which they learned about their positions and what they learned during the hiring process that influenced their decision to accept their new roles as cancer nurses. They also shared who influenced them during the recruitment phase and identified facilitators and barriers they encountered during the hiring process. In the “Surviving In” phase, the nurses completed a formal orientation program and then began working with preceptors and the cancer team. They struggled with the depth of knowledge required and the emotional impact of working with critically ill and dying patients. In the “Staying In” phase, the nurses identified continuing learning needs, people and system supports required to enhance professional growth, and strategies that facilitated achieving competencies and fostered quality-of-work life.

Conceptually and methodologically, this study built upon previous qualitative studies conducted in the general nursing population on role socialization and transition. The knowledge gained from examining how these nurses learned to transition into diverse cancer contexts extended, refined, and corroborated previous knowledge generated on transitions from one practice setting in nursing to another. The study informs others of the importance of examining transition experiences from a social learning perspective and demonstrates that qualitative inquiry can be a useful approach when little is known of these experiences (Streubert-Speziale & Carpenter, 2003). The individual’s experience is not common, but the phenomenon is (Morse, 1995); therefore, patterns of adaptation by nurses new to CNP and different contexts became evident when the data were analyzed.
The study also contributes to the understanding of how nurses learn what they need to know to care for patients when they are moving from one clinical practice role to another. Some of the issues central to adapting to CNP include (a) the emotional difficulties inherent within a specialty that deals with death and dying; (b) the effect that novice nurses have on nurses, other staff, and the organization; (c) the knowledge and skills that are transferable from other areas of nursing; (d) the knowledge and skills considered essential to the specialty practice; (e) the organizational supports that can promote the nurses’ transition; and (f) the role that mentors and preceptors can contribute to the nurses’ transition. CNP is a specialized body of knowledge involving a unique population of patients in many diverse settings, and nurses require accessible supports in order to make a successful transition into CNP.

In this chapter, an overview of learning to transition into CNP is presented, along with a discussion of implications for practice, education, and research with respect to insights gained from newly hired nurses’ experiences as they adapted to their positions as cancer nurses. Ways to address the implications of learning to transition into CNP are organized according to the research subquestions and are supported not only by the findings but also by evidence-based strategies to enhance recruitment, retention, cancer education, healthy workplace environments, and nursing leadership.

Learning to Transition Into CNP

“I hear and I forget; I see and I remember; I do and I understand.” (Confucious, Philosopher, 551-479). This statement sounds simplistic and straightforward, so why are adult educators still mired in teaching strategies that rely on hearing and seeing rather than hands-on engagement and inquiry in the workplace? “Learning is not only an
individual activity but also a social event. An individual learner has to interact with his or her immediate social group or organization within certain social and cultural contexts” (Yang, 2004, p. 245). Making sense of CNP involves transformative learning experiences that occur at the bedside in the moment of care. Precious moments of social learning occur among nurses, patients, and others; as a result, sacred moments of caring interaction happen that profoundly shape practice on the ground.

The nurses in this study were practicing in diverse cancer contexts, and how they made sense of their CNP was shaped by informal learning opportunities in their everyday work environment. The nurses brought with them knowledge that they had gained from previous nursing experiences, and their learning needs were directed by the day-to-day needs of the patients and families under their care. They were aware that their patients’ lives depended on whether or not they had sufficient cancer knowledge and skills. By in large, this awareness motivated the nurses to learn what they needed to know in order to provide quality cancer care.

The newly hired nurses shared their stories about becoming cancer nurses. They were asked to reflect on the following questions: How did they obtain their positions? What were the first few weeks like? How did their orientation help them? Did they feel supported? What surprised them about this area of nursing? What were the learning challenges? If they had it to do over again, would they choose cancer nursing? They were encouraged to describe in detail events when they felt unsure of themselves and needed to find ways to learn, problem solve, and move forward.

Once again, I reflected on my encounters with Linda, a cancer patient, and Carol, a cancer nurse, during my struggle to become a cancer nurse. As a learner, I was acutely
aware of the need to acquire the specialized knowledge and skills necessary to work with cancer patients and their families. I forgot that the learning process is more than the systematic acquisition of facts; it is a holistic process that transforms learners as they make sense of their new reality (Merriam, 2001). I needed to put my patients’ experience into context, including cultural background, environment, illness experience, and relationships. In fast-paced and complex clinical environments, nurses must identify priorities and be flexible and fluid to rapidly changing situations. “This fluidity is possible through the experience of reading situations and responding to changes” (Benner, Sutphen, Leonard, & Day, 2010, p. 48). Benner at al. (2010) commented that nurses use a form of “clinical reasoning-in-transition that keeps track of a particular patient, how the illness or illnesses are unfolding and the meaning of patient responses” (p. 55). I asked the nurses in this study to describe what they needed to learn, how they learned what they needed to know, and what factors impacted their learning.

The nurses recognized that they needed to learn from their patients’ individual situations. The nurses’ narratives were rich with detailed descriptions of patients’ experiences coping with their cancer and the nurses’ feelings about becoming cancer nurses. Inner awareness of my own struggles to become a cancer nurse informed how I made sense of the nurses’ reactions to becoming cancer nurses. I realized the importance of “Heidegger’s notion of being, it is being-in-the-world rather than knowledge of the world that should be considered when determining the purpose of adult education practices in changing times” (Su, 2011, p. 67). This statement explains why the nurses emphasized the importance of being with and learning from patients, nurses, and others. They also recognized that even though they needed to acquire knowledge and skills, these
alone were insufficient without meaningful interactions with patients. They made sense of their patients’ lives within diverse contexts by connecting, imaging, intuiting, and learning informally with others (Merriam, 2001).

The nurses emphasized the importance of preceptors and strong leadership as they embarked upon their new role as cancer nurses. The nurses also described how they learned what they need to know and the factors that impacted their learning experiences, positively or negatively. They shared that learning was facilitated by gaining an understanding of the cancer patients’ experiences, access to specialized cancer nursing knowledge, and support from expert oncology preceptors. The nurses identified a positive learning culture as the most significant factor influencing their transition into their new role. The policy discourse in the workplace often denies the complexity of informal learning by oversimplifying the processes and outcomes of learning and the factors that influence learning (Ellinger, 2005; Eraut, 2004). The nurses frequently cited a lack of nursing leadership, staffing shortages, and busy workplaces as barriers to learning as reasons for considering leaving their positions. In light of the unprecedented challenges facing Canada’s cancer control system, the implications for practice, education, and research will require nursing leadership to develop new ways to recruit, orientate, educate, and retain nurses in CNP.

Getting In: Implications for CNP

In chapter 4, the findings for the “Getting In” phase were themed. The nurses’ perceptions of their recruitment and selection into CNP, how they learned about cancer nursing positions, and the factors influencing their decision to accept certain roles were explored.
In this section, the implications for CNP and education related to each theme are highlighted. Labour market forces were the most frequent predictor why nurses considered taking positions in cancer care. There were more in-patient positions available for new graduates than in other specialty areas of nursing. Outpatient positions were considered by senior nurses as a promotion, and the benefits included flexible schedules and opportunities for professional development.

Previous personal and professional experiences with cancer were strong predictors for choosing CNP positions over other like positions. The nurses who had positive experiences while caring for family members and friends also were influenced to enter CNP. Nursing students who had clinical placements on cancer units, whether by choice or default, were more open to applying for positions and often were approached by managers to consider employment. Nurses who chose CNP as a career path prepared themselves for the position by seeking out student placements or by working in similar settings such as palliative or hospice care. Experienced nurses who were approached by managers for positions in the outpatient setting were sought out because of their work in critical care or palliative care as well as their expertise related to psychosocial care, advanced assessment, and central venous line skills. Table 3 presents the strategies for practice and education that relate to the following research subquestions:

1. What individual, organizational, and societal factors influence nurses’ decisions to enter CNP?

2. How do nurses prepare to learn interpersonal, technical, and professional skills when making the transition into CNP?
### Table 3

**Getting In: Implications for CNP**

| Research subquestion 1: What individual, organizational, and societal factors influence nurses’ decisions to enter CNP? |
|---|---|---|
| **Themes** | **Practice** | **Education** |
| Career path:  
- cancer nursing placements as part of a career path  
- nursing leaders, educators promoting CNP as a distinct specialty | Nursing leadership promoting CNP:  
- promote opportunities for undergraduate students to have observational experiences  
- support professional cancer nursing association events (i.e., CANO) | Academic nursing leadership promoting CNP:  
- promotion of CNP at career fairs, nursing events  
- promote awareness of CNP by identifying students and faculty with a career interest in CNP |
| Networking:  
- senior cancer nurses promoting CNP  
- opportunities for clinical placements in CNP for undergraduate students | Nursing leadership supporting CNP:  
- support increased awareness of the specialty within their organization  
- develop cross appointments between specialty practices (i.e., Palliative/hospice care) | Academic nursing leadership supporting CNP:  
- partner with health care organizations to promote CNP (i.e., Interagency committees, professional education) |
| Labour market issues:  
- shift from in-patient to outpatient cancer services  
- shortage of nurses in specialty areas  
- senior nurses applying for outpatient positions  
- new graduates hired directly into in-patient cancer units  
- lack of preceptors for in-patient and outpatient settings, particularly rural outpatient clinics | Nursing leadership developing CNP:  
- offer extended orientation programs for new graduates  
- provide opportunities for senior nurses to develop leadership and mentorship skills  
- develop clinical placement opportunities for faculty and undergraduate students (Bakker et al., 2010)  
- provide support to rural nurses via telehealth and telemedicine (Sevean et al., 2009) | Academic nursing leadership developing CNP:  
- foster partnerships between nursing schools and health care  
- offer clinical placements for students  
- integrate cancer concepts into the nursing curriculum  
- provide cancer education to rural communities via telehealth and telemedicine  
- promote student clinical placement opportunities in rural/remote communities |

**Research subquestion 2: How do nurses prepare to learn personal, technical, and professional skills when making the transition into CNP?**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Practice</th>
<th>Education</th>
</tr>
</thead>
</table>
| Experiences with cancer:  
- personal experiences with family members  
- professional experience in related clinical areas (e.g., palliative/hospice care, critical care) | Nursing Leadership:  
- encourage nurses to share and reflect on those experiences (individual, group) to ease transition  
- identify learning goals and related skills based on prior learning experience | Academic Nursing Leadership:  
- assist students with an interest in CNP to develop individualized learning goals for clinical placements  
- develop mentorship, cross-appointments, and fellowships for academic faculty with CNP experts (Hayes et al., 2005) |
Surviving In: Implications for CNP

In chapter 5, the findings for the “Surviving In” phase were themed. Chapter 5 began with the nurses’ orientation to their new roles as cancer nurses and the shock and awe that accompanied the newcomers’ arrival into cancerland. The struggles that they encountered learning a new specialty practice and the emotional strain of “being with” critically ill and dying patients were examined.

In this section, the implications for CNP and education related to each theme are highlighted. The nurses, whether they were new graduates or experienced nurses, stated they were not prepared for the emotional impact of “being with” cancer patients and their families 100% of the time and witnessing the suffering of critically ill and dying patients. They also were unprepared for how quickly they would need to learn new knowledge and skills related to psychosocial care, chemotherapy administration, treatment-related side effects, oncological emergencies, and palliative and end-of-life care.
The nurses, when comparing CNP to other nursing specialties, were quick to point out that the knowledge and emotional stamina required when caring for cancer patients and their families exceeded expectations comparable to other areas of nursing practice.

Table 4 presents the strategies for practice and education related to the following research questions:

3. How do the learning needs and expectations of newly hired cancer nurses compare to the reality of CNP?

4. How do newly hired cancer nurses learn to cope with the impact of role strain that accompanies transition into CNP?

Table 4

**Surviving In: Implications for CNP**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Practice</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being orientated:</td>
<td>Nursing leadership:</td>
<td>Nursing leadership:</td>
</tr>
<tr>
<td>- formal in-house oncology nursing curriculum focused on CANO standards</td>
<td>- assist the newly hired nurse to identify learning goals and preferences</td>
<td>- offer competency-based oncology nursing curriculum, multiple modalities (e.g., SDL modules) with hands-on guidance from preceptors and cancer team</td>
</tr>
<tr>
<td>- factors that contributed to learning success included; access to nurse preceptors, clinical educators, cancer team experts, managers, and supportive peers; dedicated time for learning, and opportunities to extend orientation based on self-assessment and feedback</td>
<td>- provide dedicated time and resources for learning activities i.e. practice skills in a lab, knowledge validated by assessment</td>
<td>- provide new graduates with an extended orientation (up to 1 year)</td>
</tr>
<tr>
<td>'Being with':</td>
<td>Nursing leadership:</td>
<td>Nursing leadership:</td>
</tr>
<tr>
<td>- complex, critically ill and dying cancer patients</td>
<td>- develop clinical partnerships with cancer experts and faculty that can guide new nurses on how to open conversations with cancer patients and their families about critical issues related to: diagnosis, treatment related side</td>
<td>- provide narratives to help nurses reflect on and gain insight into their own practice</td>
</tr>
<tr>
<td>- talking with patients and families about diagnosis, treatment, side effects, psychosocial, socioeconomic and spiritual issues</td>
<td>Nursing leadership:</td>
<td>- provide physical space for nurses to share patient cards, pictures, obituaries, and memorials</td>
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</table>

Table 4 Cont’d
Research subquestion 4: How do newly hired cancer nurses learn to cope with the impact of role strain that accompanies transition into CNP?

<table>
<thead>
<tr>
<th>Themes</th>
<th>Practice</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggling with learning:</td>
<td>Nursing leadership supports a learning culture:</td>
<td>Nursing leadership supports a learning culture:</td>
</tr>
<tr>
<td>“learning-on-the-go”</td>
<td>- provide assigned preceptors/mentors as a resource</td>
<td>- team conferences, rounds to problem solve difficult patient situations requiring collaborative decision making and creative critical thinking to problem solve and find innovative solutions</td>
</tr>
<tr>
<td>- adapting previous knowledge and skills</td>
<td>- access to a social network to consult with for clinical decision- making and problem solving</td>
<td>-listening to patient and family narratives to gain an deeper understanding of the meaning of having cancer, and patients’ and families’ needs</td>
</tr>
<tr>
<td>-learning new knowledge and finding the expertise in the moment of care</td>
<td>-“being there” by providing comfort and support, assisting patients to survive, -helping patients’ and families’ cope with emotions and problems -provide opportunities to learn the roles of the cancer team members</td>
<td>-interprofessional cancer education to gain a greater understanding of each cancer team members’ unique contribution to holistic cancer care</td>
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<tr>
<td>“learning with patients”</td>
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<tr>
<td>-understanding the meaning of having cancer</td>
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<tr>
<td>-rewards of ‘being with’ cancer patients</td>
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<tr>
<td>“learning with colleagues”</td>
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<tr>
<td>-getting to know the roles of other cancer team members</td>
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<tr>
<td>-seeking and accepting support from others</td>
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<tr>
<td>Struggling with suffering:</td>
<td>Nursing leadership values self-care of the care giver:</td>
<td>Nursing leadership values self-care of the care giver:</td>
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<tr>
<td>“feeling the suffering”</td>
<td>- provide opportunities for staff to participate in reflective practice rounds and education for self-care</td>
<td>- conduct reflective practice rounds that provide nurses with an opportunity to support each other and gain insight into patient experiences and their own practice</td>
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<tr>
<td>-emotionally draining witnessing suffering, a sense of helplessness “personalizing suffering”</td>
<td>- build time into the agenda of regularly scheduled meetings for networking, informal chat</td>
<td>- provide education on vicarious trauma/loss, and strategies for self-care</td>
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<tr>
<td>-identifying with the patients, reflecting on one’s own immortality</td>
<td>- dedicate time and space for the cancer team to share self-care strategies and celebrate successes and losses (i.e., rounds, video-conference time for rural providers; Wenzel et al., 2011)</td>
<td>-practice skills for self-care i.e. journaling, visualization/relaxation, mind-body exercises and massage (Fitch et al., 2006)</td>
</tr>
<tr>
<td>“surviving suffering”</td>
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<tr>
<td>-seeking external support, developing a self-awareness of the impact of suffering “accepting suffering”</td>
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<tr>
<td>- developing self-care strategies</td>
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<tr>
<td>-emotional strain, moral distress, problem solving and ethical decision making</td>
<td>effects, psychosocial, socio-economic and spiritual issues -provide opportunities for nurses to reflect on practice and examine emotional stresses associated with caring for cancer patients -engage rural cancer nurses via telehealth to reduce social isolation</td>
<td>-honor and respect patients and families ceremonies of celebration/remembrance (Wenzel et al., 2011) - provide regularly scheduled telemedicine rounds to rural cancer nurses (teams) conducted by the urban team -provide annual face-to-face forums for rural teams to meet with urban teams for education and networking</td>
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<td>-outpatient/rural role expanded to include; patient advocate, educator, patient navigator inclusive of administrative duties to ensure patient services are coordinated within the community</td>
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</table>
Staying In: Implications for CNP

In chapter 6, the findings for the “Staying In” phase were themed. Chapter 6 outlined the quality-of-work life issues, job satisfaction and rewards, and continuing education needs that impacted the nurses’ choice to remain in or leave CNP. The factors that impacted the nurses’ decisions included nursing leadership, quality-of-work life, and accessibility of supports and professional education.

In this section, the implications for CNP and education related to each theme are highlighted. The nurses unanimously agreed that support within the first few months was critical for their survival as cancer nurses. They clearly stated that guidance from nurse managers, clinical educators, preceptors, mentors and the cancer team was essential to achieving competency in their work. The nurses who were the most satisfied with their new roles credited their successful transition to a supportive learning culture.

Those nurses who did not experience a supportive learning culture indicated that the lack of leadership, staff shortages, few opportunities for continuing education, and an overall dissatisfaction among their colleagues often resulted in unprofessional behavior toward newcomers. The nurses with orientations that were less than ideal often did not express feelings of competence, were more likely to be dissatisfied with their positions, and considered leaving their positions. Table 5 presents the strategies for practice and education that relate to the last research question:

5. What are some of the individual, organizational, or interpersonal factors that impact nurses learning to manage the transition into CNP?
### Table 5

**Staying In: Implications for CNP**

Research subquestion 5: What are some of the individual, organizational, or interpersonal factors that impact nurses’ learning to manage the transition into CNP?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Practice</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining balance: “the impact of nursing leadership on nurses’ [QOWL]”</td>
<td>Nursing leadership provides support for nurses dealing with real-life issues in the workplace: -listening to the stories about the challenges nurses undergo in the workplace -providing opportunities to discuss key issues that need to be addressed -provide dedicated time and resources to explore issues -developing a model that embraces retention as a strategy for recruitment</td>
<td>Nursing leadership develops a learning framework that engages individuals in improving the workplace environment: -tailoring workplace learning to real-life needs identified by learners -encourage engagement in learning activities by both the learners and those who are facilitating learning -involve learners in the selection and preparation of learning guides, resources (Billet, 2001)</td>
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<td></td>
<td>- leadership committed to learning and creating quality care environments</td>
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<td></td>
<td>-access to a network of cancer care experts</td>
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<td>-dedicated time, adequate staffing, structural supports</td>
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<td></td>
<td>-novice nurses lack knowledge and skills related to palliative care and end-of-life (EOL) care</td>
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<td></td>
<td>-nurses experience anxiety about end-of-life care</td>
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<td></td>
<td>-nurses experience the loss of patients</td>
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<td>-nurses grieve and mourn for patients and families</td>
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<td></td>
<td>-nurses express need for end-of-life competencies</td>
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<td></td>
<td>- novice nurses not adequately prepared for EOL care are at risk for or exhibit signs of compassion fatigue and burnout</td>
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<tr>
<td>“cooperating with the stress of caring for critically ill and dying patients”</td>
<td>Nursing leadership provides support and training for nurses in EOL: -assessing novice nurses prior exposure to EOL, and address learning gaps -develop an EOL program that is evidence-informed and addresses physical, psychosocial, social and spiritual needs of patients - develop clinical mentors that can assist novice nurses’ ability to cope with EOL care (Watts et al., 2010; Wenzel et al., 2011) - supporting resilience development including; self-care practices, a quiet room or serenity room (Grafton et al., 2010)</td>
<td>Nursing leadership provides a competency-based curriculum in EOL: communication, cultural diversity, respect of patient, symptom management, legal and ethical issues, grief and bereavement, use of standardized assessment tools, importance and worth of comfort care, evidence-informed care, collaboration, holistic treatment based on care plans and evaluation of interventions (Conte, 2011; Watts et al., 2010) - develop organizational and personal stress-management strategies as mainstream education i.e. self-care (Caton &amp; Klemm, 2006)</td>
</tr>
<tr>
<td>Making a commitment: “unique patient population”</td>
<td>Nursing leadership provides a workplace environment that supports professional growth and job satisfaction (Wenzel et al., 2011)</td>
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<td></td>
<td>-diverse settings; urban, rural/remote, in/outpatient</td>
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<td></td>
<td>“distinct type of nursing”</td>
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<td></td>
<td>-different sub-specialties; adult,</td>
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<td></td>
<td>-provide context specific</td>
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Table 5 Cont’d
pediatric, surgery, chemotherapy, radiation
- competencies required differ according to the cancer settings and subspecialties

“job satisfaction”
- nurses’ intent to “stay-or-go” related to leadership, supports (preceptors) and QOWL factors

“achieving competency”
- progression from novice-to expert practitioner
- nurses expressed a need for further education/practice in priority areas in order to achieve competency

“continuing learning”
- nurses identified priority areas for learning i.e. palliative/EOL care, chemotherapy, oncologic emergencies, treatment related side-effects

orientation programs to meet the needs of new and senior nurses
- access to visible leadership that collaborates with staff to solve problems
- promoting good working relationships between members of the cancer team
- establishing a clear vision and -goals for CNP
- providing mentorship to assist novice nurses during their orientation to CNP
- building on leadership capacity through mentorship programs and developing clinical experts
- offering continuing professional education in priority areas
- providing opportunities to participate in research activities i.e. journal clubs, conducting studies (Bakker et al., 2010)

-i.e. CANO/ACIO National Chemotherapy Administration Nursing Practice Strategy (NCAS) 2008-2012

(National Chemotherapy Standards, Phase 1, Interim Report, 2009)

Nursing leadership promotes further research into nursing human resources (NHR):
- explore the recruitment and orientation of nurses into oncology (cancer) nursing practice and the effect of QOWL issues on retention (M. Z. Cohen et al., 2010)
- examine the impact of oncology education programs on practice
- evaluate strategies to promote the development of CNP role (Linder, 2009)

Future Directions: CNP Education

We need to think about where new oncology (cancer) nurses come from… and develop nursing student programs to encourage interest and provide good experience in oncology. We need to harness the wisdom of more experienced oncology nurses in these efforts. We cannot afford the “brain drain” as these seasoned nurses approach retirement. We need to offer programs for preceptors and mentors to tap their expertise. We also might want to expand opportunities and create new roles in oncology for seasoned nurses such as a best-practice coach, team builder, patient safety officer and technology facilitator. (Mayer & Nevidjon, 2009, p. 367)

In recent conversations with nursing leaders, I heard their concerns about the future of CNP. I shared the findings from this study with the administrative contacts at each of the study sites, and the results echoed their day-to-day experiences and what they are hearing from nurses on the front line. There is a sense of urgency in their voices that suggests unprecedented changes in the way cancer services will be delivered in the future. One nursing leader told me, “The question one needs to ask is what kind of cancer
care system are we preparing nurses for because certainly it will not and cannot look the same as our current system.”

Several recently published studies and reports on cancer services and the cancer workforce have reflected these very same sentiments. Cancer care is being increasingly integrated into community settings as patient numbers rise and new treatment options necessitate managing cancer in local communities as a progressive chronic disease. The cancer nursing workforce is stretched to the limit, and the cancer system is close to the breaking point. Nurses who work in cancer care live in an era of uncertainty as they wonder who will replace them when they retire and how much longer they can keep up with the increasing flow of patients and survivors. They work in a period of unprecedented technological advancements that bring the need for continuous on-the-job training and the continual redesign of work processes, all the while taking into consideration patient needs, work efficiencies, and quality assurance. They work in a time of major health care system reform, with the result being ongoing demands to embrace change. They work with the knowledge that treatment successes are leading to an expanding number of cancer survivors, which means that more people are being cured of their cancer and require follow-up care in their local communities.

Because of the shortage of nurses and the high cost of orientating cancer nurses, it is imperative that nurse managers be more innovative in developing recruitment and retention strategies. The specialty area is relatively new, and nurses and nursing students often are unaware of this unique area of specialty nursing. Nursing leaders would do well to market the specialty and focus on screening and interviewing processes to ensure that the candidates who are hired are willing to commit to cancer nursing (Sevean, 2003). The
literature also has supported the fact that nurses are retained in specialties that offer professional development and continuity of care (Hayes et al. 2005; Linder, 2009; Williamson, 2008). Some innovative strategies for providing students with opportunities to observe and experience CNP include clinical oncology rotations for undergraduate nursing students; oncology nursing fellowships; and Spend a Day With an Oncology Nurse, a 1-day observational experience with an oncology nurse preceptor (Reid Ponte et al., 2005).

Recent changes in nursing practice call for increased attention to career development and retention of nurses in positions of direct patient care. Nursing care in the acute care setting has grown so complex that it is no longer possible to standardize or routinize the nursing role (Benner, 1984). This complexity makes the education and replacement of nurses expensive. “Educators, employers and professional organizations are being challenged to collaborate with individual nurses on career development activities that will enable nurses to provide high-quality care in an ever-changing health care system” (Donnor & Wheeler, 2001, p. 79). Donner and Wheeler contended that career planning is a continuous process of self-assessment and goal setting, not a one-time event. The five phases of the process include scanning the environment, completing a self-assessment and reality check, creating a career vision, developing a strategic plan, and marketing oneself. Nursing leaders must build in the capacity for career development and ensure that nurses can “be the best” and “do the best.”

The factors that impact the recruitment and orientation of nurses into the workforce are dependent on quality education programs that are learner centred and focus on engagement rather than traditional teacher-driven approaches that see teachers as
expert. It is essential to embrace new and more progressive frameworks for professional education, think about where the new oncology nurses are coming from, and understand how to harness the expertise of cancer nurses in mentor-mentee programs that promote and sustain CNP. Some of the following strategies have been suggested to improve the interaction between academic programs and the cancer nursing workforce: (a) appoint faculty to nursing research programs in health care organizations, (b) provide more clinical rotations for under graduate students, (c) create opportunities for faculty to develop expertise in oncology nursing, (d) offer an oncology nursing faculty fellowships, and (e) participate in professional conferences and job fairs (Reid Ponte et al., 2005).

Gullatte and Jirasakhiran (2005) suggested that creating a culture of retention is key to ensuring a healthy and strong workplace that is positioned to attract new employees to CNP. They offered a variety of strategies to enhance recruitment while also promoting retention: (a) Create a shared vision; (b) market the image of nursing; (c) conduct goal-directed interviews of new staff and existing staff; (d) develop an in-depth orientation program individualized to the learners’ needs; (e) provide challenging opportunities and professional education for senior staff; (f) foster relationships with faculty and nursing students; (g) value workplace diversity; (h) create a learning organization; (i) empower staff to be involved in decision making that directly affects their daily work and practice; (j) establish open and honest communication; and, most importantly, (k) do not make false promises or paint a false picture.

Managers need to give novice nurses and senior nursing students the opportunity to work with qualified preceptors so that they can acquire the competencies and skills necessary for safe practice (Linder, 2009; Reid Ponte et al., 2005; Sevean, 2003). New
graduates identified that having a preceptor was a significant factor during their orientation not only for “guidance in clinical skill development but also fostering a sense of hope and self-confidence in the new graduate” (Linder, 2009, p. 37). In a recent systematic review of interventions by health care organizations to increase retention of new graduate nurses, the findings indicated that a preceptor model for new graduate nurses lasting between 3 to 6 months was the most effective strategy to increase retention (Salt, Cummings, & Profetto-McGrath, 2008). It also has been found that orientation programs need to be structured to meet the unique needs of new and experienced nurses; these strategies include a new graduate development program and a faculty model that enhances the preceptor model by using students with master’s and doctoral degrees to introduce skills and concepts that apply across units, and foster the development of critical-thinking and problem-solving abilities (Hayes et al., 2005).

Linder (2009) suggested that orientation programs should be staged or stratified with specific clinical opportunities and paced to support individual nurses’ learning needs. New graduates in particular must deal with the reality shock of assuming full responsibility of their nursing role as well as the additional stress of the oncology nursing role, which necessitates orientation programs that include (a) gradual introduction to workload responsibility; (b) standardization of the orientation phase as well as provision of and standardization of mentors and preceptors; (c) restriction on work hours (e.g., no overtime); (d) restriction on patient load; (e) no specialty work area in first rotation; (f) close monitoring of the graduate in the first 8 weeks via clinical supervision sessions with the educator (transition coordinator); and (g) self-concept assessment and esteem enhancement throughout the transitional year (Cowin & Hengstberger-Sims, 2006).
One of the most successful strategies to promote recruitment and retention includes the implementation of orientation and cross-training between or among units with preceptors. A recent literature review on mentorship revealed that nurses value the opportunity to develop practice through mentorship activities (Andrews & Wallis, 1999). The implementation of structured mentoring programs creates a supportive environment for new nurses, recognizes the contributions of experienced nurses, and enhances the recruitment and retention of staff (Greene & Pueter, 2002). Other strategies for promoting the retention of senior nurses include advanced oncology classes, nursing grand rounds, and support for nurses who want to obtain specialty certification (Williamson, 2008).

Evidence has shown that current models of professional development are not designed to engage multigenerational learners. Benner et al. (1996) offered insight into the importance of experiential learning in engaging nurses to improve practice over time, recognize whole situations, and achieve higher levels of skilled performance that requires context-dependent judgments and skill. Evidence (Notarianni, Curry-Lourenco, Barham, & Palmer, 2009; Sadler, 2003) has suggested that engaging multigenerational learners with different learning styles is challenging. Today’s nursing workforce has members from three generational cohorts, including (a) Baby Boomers, whose self-identity tends to be derived from their jobs and who prefer structured learning and clear guidelines; (b) Generation Xers, who prefer a learning environment where they can demonstrate their own expertise and who see time as a precious commodity, so engaging in learning experiences need to be efficient and relevant; and (c) Millennials, who are technologically savvy, read less, value personal feedback, and view technology as playing a factor in their learning activities.
Newer professional education models have supported engaging learners in learning environments that include virtual practice, simulated practice, and standardized patient practice. One such model provides a framework to guide educators in planning learning experiences that promote the development of cognitive, affective, and psychomotor domains. The model marries the use of standardized patients and virtual and simulated practice environments with traditional clinical practice and offers the opportunity to address learning styles of a multigenerational workforce (Notarianni et al., 2009). Lowe et al. (2007) suggested that clinical processes and practice context are conducive to the use of reflection to integrate learning into practice and link to assisting learners to incorporate practice changes.

Many researchers have tried to identify cancer nurses’ learning needs, but there has been scant evidence that continuing education is making a difference in practice (Wyatt, 2006). Clearly, if cancer education is to be successful, it has to embrace new ways of learning that address the diversity of nurse learners across the cancer spectrum. There is a knowledge base that is distinct to CNP (CANO, 2006). Nurses’ perceptions of their educational needs in caring for patients with cancer include psychosocial care, communications skills, palliative care, pain management, and end-of-life care (McCaughan & Parahoo, 2000), as well as the administration of chemotherapy and ways to deal with treatment-related side effects (Sheridan-Leos, 2007).

Chemotherapy education programs that use a systems approach to identify errors and devise processes to avoid errors should include educational models that support a culture of safety and competence (Sheridan-Leos, 2007). In 2010, the Canadian Association for Oncology/Association canadienne d’infirmières d’oncologie
(CANO/ACIO) embarked on developing a national strategy for chemotherapy administration that will include the development of CANO/ACIO national chemotherapy administration standards and competencies. Recent studies exploring the work of nurses administering chemotherapy have indicated that educational programs need to offer coordinated education and training strategies focused on safe and effective practice and the prevention of errors (Sheridan-Leos, 2007; Verity et al., 2008).

Recognition of the variability and complexity of rural cancer nursing work has been lacking. Urban-centric policies, guidelines, and educational programs, and a lack of resources and opportunities for continuing education have stymied the development of rural CNP. Education for rural nurses needs to embrace methods of delivery that are inclusive. New technologies such as distance education via video conferencing will allow learners to attend classes and obtain professional upgrading closer to home (McIntyre & McDonald, 2010; Sevean et al., 2008).

Currently, workforce shortages and increasing patient loads are having an impact on the CNP environment, so it is paramount that nurse leaders reflect a more inclusive paradigm of leadership (Turley, 2002). In addition, leaders need to strengthen their emotional intelligence, use appreciative inquiry, and practice empathetic listening (Vitello-Cicciu, 2003). Nurse leaders should role model such behaviours as getting involved locally and nationally in health and nursing policy; thinking and practice collaboration; convene people for discussions and dialogue; listening; remaining flexible; and, most importantly, negotiating (Turley, 2002). They have to create the right culture to nurture this shift in paradigm from patriarchy and exclusion to inclusion and negotiation (Rippon, 2001).
Cummings et al. (2008) suggested that “visible/relational leadership and positive relationships in the workplace among nurses, managers and physicians play an important role in quality oncology nursing environments and nurses’ job satisfaction” (p. 517). Cummings et al. also asserted that it is imperative that nurses at all levels acquire leadership skills in order to practice effectively within dynamic and uncertain health care environments. The progressive leadership education model (LEM) was developed based upon the constructs of leader as visionary, leader as achiever, leader as critical thinker, leader as communicator, and leader as mentor (Cummings et al., 2008). The LEM could be applied in academic and clinical settings to develop critical-thinking and problem-solving skills.

March (2010) concluded that when it comes to the cancer control workforce, “planning is fragmented, Canadian research on health human resources is limited, no overall perspective exists for Canada’s cancer control workforce, and many key problems are highly fragmented” (p. 7). March recommended effective planning, management and coordination of health human resources, and career development opportunities as part of succession planning in consideration of the looming retirement bulge of senior level leadership and practitioners. Researchers (Cummings et al., 2008; Green & Downes, 2005) have verified the shortage of nursing leaders and have suggested that succession planning be a priority to ensure that there are not gaps in leadership. Green and Downes (2005) suggested that organizations need to ask the following questions:

1. Has a pool of talented persons who could assume leadership positions been identified?
2. Do these persons have the qualifications necessary to chart the future direction of the organization?

3. Have the CEO, vice presidents, or directors taken responsibility for mentoring succession talent?

4. Are persons being mentored satisfied with the mentoring experience?

5. Are mentors satisfied with mentees success?

6. Have contingency plans been developed if mentored persons move onto other positions or places?

7. Have the mentored persons who were hired been satisfactory?

Future Directions: CNP Research

Research that continues to explore the contextual factors that promote and impede informal learning will enable practitioners to better assess an organization as a setting for such learning, as well as develop tools to measure the extent to which this type of learning is occurring and the factors that positively and negatively influence such learning. (Ellinger, 2005, p. 412)

The viewpoint of researchers on the best approaches to study informal learning has become a topic of much debate. Knowledge elicited at the bedside is tacit and involves experts’ role-modeling knowledge and skills through performance. According to Eraut (2000), even though researchers have generally agreed that it is beneficial to observe this phenomenon, researchers still need to be inventive when exploring the knowledge that underpins performance. Because practice is transformed by individuals in response to societal change, it follows that individuals should be active participants in remaking work practices and technical innovations. Although implementation of change processes is part of work-life learning, it remains a neglected area of research because of its real-time, invisible nature (Billet & Sommerville, 2004).
In addition, there are also significant methodological challenges inherent in examining the phenomenon of informal learning. Interview-type studies are the most common, but they are not always easy to conduct because interviewees often do not recognize their informal learning. “The resultant skill/knowledge is either tacit or regarded as part of a person’s general capability rather than something that has been learned” (Eraut, 2000, p. 249). Interview methods have been used quite extensively to explore phenomena focused on SDL projects, key life events, and recent life changes, as demonstrated in the current study. Other methodologies for examining informal learning that have not been as explored extensively include survey research, situated microanalytical research, and mixed methodologies (Sawchuk, 2008).

Some researchers have argued that workers resist formalizing the informal learning that happens in the in-between spaces, such as the lunch room or when driving to and from work. These situated learning events are considered socializing, even though significant learning occurs either through active participation or reflection. This stance supports the notion that learning can be discreetly categorized as formal, informal or nonformal, although it has been argued that “research into formalizing informal learning formalizes the activity” (Boud & Rooney, 2006, p. 11). Some researchers have suggested examining workplace teams and ways in which members of work groups learn as part of their practice (Boud & Middleton, 2003; Lave & Wenger, 1991; Wenger, 1990).

A similar but alternative approach involves exploring different learning contexts to gain a better understanding of how organizations promote and impede informal learning opportunities in the workplace (Ellinger, 2005; Eraut, 2004). In regard to future research directly focused on informal learning, this is a challenging endeavor because of
the tacit nature of informal learning. Berg and Chyung (2008) suggested paying attention to this hidden phenomenon in workplace learning by using ethnographic research methodology to uncover variables that may be crucial to developing a learning organization.

Recently, nurse researchers (M. Z. Cohen et al., 2010) conducted a review of the literature from diverse countries and identified 21 concepts related to the work-life trajectory of cancer nurses. The results indicated that mostly descriptive studies and a few intervention studies have examined relationships, the witnessing of suffering, the meaning of oncology nursing, and interventions found useful to support nurses. The interventions included storytelling, clinical support of nurses, workshops to find balance in lives, dream work, and mentoring as support. The researchers recognized that although the health care system has changed significantly in the past 15 years, interventions to support nurses providing care have not. They also indicated that they found no research about recruitment and retention, environment setting, workplace issues, and career trajectory (life cycle). These findings surprised me because before I began this study, I was unable to find research in these areas. This lack of studies was my rationale for conducting the pilot study in 2003.

Therefore, given the major themes presented in my study and the lack of attention that has been paid to this neglected area of research, I feel confident in making recommendations for future research. Some of the recommendations highlight the need for cancer nurses to be surveyed and interviewed about such topics as professional commitment, organizational commitment, workplace climate, position satisfaction,
learning needs, their intent to remain in their positions as oncology nurses, and what would make a difference in assisting them to decide to stay in oncology.

Future research could investigate strategies to promote the development of CNP. Research could focus on the following issues identified by the study participants: developing and evaluating how individualized orientation programs can improve retention, measuring indicators of success within the role and how these influence role development, examining psychosocial challenges and strategies that nurses use to cope with role strain, investigating compassion fatigue and burnout, exploring best practices to care for critically ill and dying patients, and evaluating strategies to support nurses’ learning experiences. Future research directions should build on previous descriptive studies, and small-scale intervention studies should be conducted as multisite studies using mixed methodologies. Key areas identified for further research are presented in Table 6.

Table 6

Making Sense of CNP: Future Directions for Research

<table>
<thead>
<tr>
<th>Getting in</th>
<th>Areas identified for further research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being recruited</td>
<td>- multi-site studies exploring recruitment, retention, environment, workplace issues, career path (vision), and career trajectory (life cycle) (Sevean, 2003; M. Z. Cohen et al., 2010)</td>
</tr>
<tr>
<td></td>
<td>- examine (survey) undergraduate programs to identify innovative strategies to promote the integration of cancer concepts into nursing curriculum (Sevean, 2003; Price, 2008)</td>
</tr>
<tr>
<td>Being hired</td>
<td>- evaluate models of recruitment that provide realistic and contemporary portrayals of CNP role; and engage mentors, peers and role models within the process of recruiting and hiring</td>
</tr>
</tbody>
</table>

Table 6 Cont’d
Surviving In Areas identified for further research

**Shock of...**
- Being orientated
  - investgate interventions to promote role development of novice nurses i.e. tailoring orientation experiences, staff behaviours/support, and SDL (Linder, 2009; Sevean, 2003)
  - multi site large scale study to determine the efficacy of certification in oncology nursing to nurse sensitive outcomes (Coleman et al., 2009)
  - investigate how you can assist cancer nurses develop expert practices and strategies to cope with work-related stress (Corner, 2002; Sevean, 2003)

**Being with patients**
- Struggling with... learning-as-you-go
  - evaluate the effectiveness of preceptor programs for both new graduates and senior nurses that have a focus lasting between 3 and 6 months (Linder, 2009; Mayer & Nevidjon, 2009; Salt et al., 2008)
  - multisite studies that examine the effectiveness of the provision of self-care information, education, and environmental supports as intervention strategies that serve to build oncology nurses’ innate resilience; and the impact these strategies have on recruitment and retention (Grafton et al., 2010; Medland et al., 2007)

**Suffering**
- evaluate palliative care and EOL care programs provided to novice nurses for long-term benefits (e.g., job satisfaction, retention; Caton & Klemm, 2006)
- evaluate the use of telehealth/telemedicine as an effective, viable and cost effective strategy for delivering professional development to rural and remote cancer teams (Sevean et al., 2008)

**Making a commitment**
- examine mentoring as a viable strategy for promoting retention (Bakker et al., 2010; Funderburk, 2008)
- conduct studies that focus on nurses’ narratives (stories) about the challenges they undergo to assist in identifying key issues in the workplace that affect retention (Hall & Kiesner, 2005)
- conduct research studies on contextual factors that promote and impede informal practice-based learning; and develop tools to measure the extent to which this type of learning is occurring and the factors that positively and negatively influence such learning (Ellinger, 2005)

<table>
<thead>
<tr>
<th>Staying in</th>
<th>Areas identified for further research</th>
</tr>
</thead>
</table>
| **Maintaining balance** | - explore the recruitment, retention, education, and ongoing professional development strategies to best support the needs of nurses orientating to CNP in small rural and remote communities (Sevean et al., 2008; McIntyre et al., 2010)
  - evaluation of the organization of cancer nursing services and multi-professional/interprofessional collaboration models within the cancer team that promote increased efficiency and improved patient outcomes (Richardson, Miller, & Potter, 2002, CPAC/CAPCA, 2010)
  - evaluate education programs for the administration of chemotherapy focused on competencies and resources to promote and support safety (CANO, 2006, 2010; Sheridan-Leos, 2007; Verity et al., 2008)
  - evaluate palliative care and EOL care programs provided to novice nurses for long-term benefits (e.g., job satisfaction, retention; Caton & Klemm, 2006)
  - evaluate the use of telehealth/telemedicine as an effective, viable and cost effective strategy for delivering professional development to rural and remote cancer teams (Sevean et al., 2008)|
-conduct studies focused on modifiable factors that lead to work improvement, job satisfaction and retention (e.g., type of leadership, orientation, professional practice development opportunities, new nursing positions [roles] that support nurse autonomy to make patient care decisions; Bakker et al., 2010; Cummings et al., 2008, 2010)

### Conclusion

Although the topic of adult learning has been at the center stage of the adult education field since its inception, and even though many theories and models have been constructed, no single conceptual framework exists that can be used to explain the complex phenomenon of adult learning (Merriam, 2001; Yang, 2004). Throughout the course of the study, I struggled with the conceptual framework and the integration of informal learning theory with transitional concepts. Although I agree that learning is a social activity, I wanted to focus on the individual nurses’ perceptions of how they were making sense of their CNP relevant to their particular contexts. I was searching for a more holistic way of examining the phenomenon of informal learning when I chanced upon the holistic learning theory, which encompasses learning as both an individual and a social activity (Yang, 2004).

As a final reflective discourse with the text, I reread chapters 4, 5, and 6 to confirm the themes. As a result, I embarked upon an existential expression of the phenomenon of learning to transition into CNP. The newly hired nurses’ perceptions of becoming cancer nurses is presented as a poetic narrative that “explicates themes while remaining true to the universal quality or essence of the experience…transcending the experiential world in an act of reflective existence” (van Manen, 1997, p. 97) by linking the parts with the whole while using insight and understanding to illuminate learning as an individual and a social activity occurring within a social, cultural, political, and technological environment (Yang, 2004).
McCorkle (2011) contended:

The existential plight that patients and families experience remains the same and the essence of what cancer nurses do is to form relationships with patients during that raw experience of vulnerability and guide them through their cancer journey…by providing a ‘safe passage’, and each and every time, forming this relationship is a privilege to be present with another human being, to be available, and to nurse. (p. 339)

The poetic narrative paints a portrait of the nurses’ struggle learning to “be” in transition “an existential state that can be dynamic and flexible in order to meet the challenges of establishing authentic existence and knowledge for living with change” (Su, 2011, p. 69). The poetic narrative, to paraphrase Charles Dickens, “is the best of jobs, and the worst of jobs,” emphasizes that “nurses’ experiences with work are shaped by both common and very individual and personal realities” (M. Z. Cohen, Haberman, Steeves, and Deatrick, 1994, pp. 9, 16).

“It is the best of jobs, and it is the worst of jobs”

Getting In

I thought no not cancer! I don’t want to work with cancer. I was drawn to cancer nursing did a rotation as a student. I really liked it. I loved it! I had lots of goals when I started nursing cancer was not a choice at all. I thought I would give it a try, my friend’s mother [a cancer nurse] suggested cancer. I had a hard time finding a job in surgery, so I took this job. I thought it would be a good time to make a career change, it was a new position. I injured myself a couple of years ago, there is less lifting in the outpatient clinic. I felt I was getting stale, wanted to push myself a bit, try something new. I ended up in cancer care due to a merger of in-patient units. It was my second choice. I was looking for a challenge after my maternity leave, they wanted me. I was approached, they needed an experienced nurse, and I said yes. I had no choice they forced people to work on the cancer floor! I am not afraid! I am ok…Really, I am ok!

Surviving In

I found orientation good sometimes a little dry. I was the only one in orientation, you go home and your family doesn’t understand.
Not everyone is the same just giving a self-learning package will not do. The nurses are just incredible! Amazing! Always at your side while you to learn. The nurses are supportive so are the physicians I think it’s a family atmosphere. It makes a big difference when someone is there to help you put it all together. We sort of got dumped on a lot of self-learning when you get the opportunity. They gave me the information on drugs but didn’t prepare me for the emotional part! I felt so drained but also so happy to help the patient who was palliative, dying. When they say you have helped me through my day there is a high feeling from that. You have to deal with all those emotions go somewhere and dump afterwards. The first young death I had a big impact on me, I will never forget that never! I had No idea it would be so complex we deal with everything, literally everything! I don’t think I expected to be affected so much emotionally, it is difficult to let go. In a small community you get phone calls at home so-and-so said you could help. You have to put your foot down. You cannot get too attached keep your distance! We support each other discuss things put our heads together it is a real team! The most emotional place I have ever worked! Definitely, emotional…Definitely!

**Staying In**

I had to prove myself! I felt some people treated me like a child talked down to me. One of my coworkers was yelling at me, I felt drained, discouraged. She wasn’t focusing on what I did do only what I didn’t do. Not fair! We get more respect, more of a bond, they come back for treatment. We are the face! Every time a patient says thank you I think this is the satisfaction I get from my work. We are short staffed, pretty bad it is not a nice place to work. Yes! , Definitely, definitely! I would choose cancer nursing again and again. People saying Oh! Oncology is the most depressing floor in the hospital. I think it is the floor with the most hope! I would choose oncology again if I could do it on an organized unit. I am not sure keep hoping all of a sudden it’s going to click in for me. I would like to be more confident in what I know I am still kind of learning. There is so much more to learn! Trying to interpret things, trying to connect things… Trying to put the whole thing together! Then, it changes every day with every new patient!
REFERENCES


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### APPENDIX A: DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Region #</th>
<th>Age</th>
<th>Nursing education</th>
<th>Exp # yrs</th>
<th>FT/PT</th>
<th>Out/In-patient</th>
<th>Length of orientation</th>
<th>Oncology experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irva</td>
<td>#3</td>
<td>25-29</td>
<td>Diploma</td>
<td>&lt;2</td>
<td>PT</td>
<td>IP-urban medicine</td>
<td>10 days</td>
<td>3 months</td>
</tr>
<tr>
<td>Sharon</td>
<td>#3</td>
<td>35-39</td>
<td>Degree</td>
<td>&lt;2</td>
<td>FT</td>
<td>IP-urban surgery</td>
<td>10 days</td>
<td>3 months</td>
</tr>
<tr>
<td>Shirley</td>
<td>#4</td>
<td>20-24</td>
<td>Degree</td>
<td>&lt;2</td>
<td>FT</td>
<td>IP-urban medicine</td>
<td>5 days</td>
<td>3 months</td>
</tr>
<tr>
<td>Kelly</td>
<td>#4</td>
<td>20-24</td>
<td>Degree</td>
<td>&lt;2</td>
<td>PT</td>
<td>IP-urban surgery</td>
<td>15 days</td>
<td>3 months</td>
</tr>
<tr>
<td>Ethel</td>
<td>#1</td>
<td>50-54</td>
<td>Degree</td>
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<td>PT</td>
<td>IP-urban medicine</td>
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<td>5 months</td>
</tr>
<tr>
<td>Lorraine</td>
<td>#3</td>
<td>35-39</td>
<td>Diploma</td>
<td>15-20</td>
<td>FT</td>
<td>OP-urban chemo</td>
<td>20 days</td>
<td>5 months</td>
</tr>
<tr>
<td>Rebecca</td>
<td>#2</td>
<td>25-29</td>
<td>Degree</td>
<td>2-5</td>
<td>FT</td>
<td>OP-rural *pediatric</td>
<td>40 days</td>
<td>7 months</td>
</tr>
<tr>
<td>Norma</td>
<td>#2</td>
<td>30-34</td>
<td>Diploma</td>
<td>5-10</td>
<td>PT</td>
<td>IP-urban medicine</td>
<td>5 days</td>
<td>7 months</td>
</tr>
<tr>
<td>Robin</td>
<td>#1</td>
<td>20-24</td>
<td>Degree</td>
<td>&lt;2</td>
<td>FT</td>
<td>IP-urban medicine</td>
<td>10 days</td>
<td>8 months</td>
</tr>
<tr>
<td>Fran</td>
<td>#3</td>
<td>40-44</td>
<td>Degree</td>
<td>20-25</td>
<td>FT</td>
<td>OP-urban radiation</td>
<td>30 days</td>
<td>12 months</td>
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<td>Gayle</td>
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<td>40-44</td>
<td>Diploma</td>
<td>20-25</td>
<td>FT</td>
<td>OP-urban chemo</td>
<td>15 days</td>
<td>12 months</td>
</tr>
<tr>
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<td>PT</td>
<td>IP-urban medicine</td>
<td>10 days</td>
<td>14 months</td>
</tr>
<tr>
<td>Jennifer</td>
<td>#4</td>
<td>20-24</td>
<td>Degree</td>
<td>&lt;2</td>
<td>FT</td>
<td>IP-urban medicine</td>
<td>10 days</td>
<td>18 months</td>
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<tr>
<td>Doris</td>
<td>#2</td>
<td>45-49</td>
<td>Diploma</td>
<td>20-25</td>
<td>FT</td>
<td>OP-rural chemo</td>
<td>15 days</td>
<td>22 months</td>
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APPENDIX B: LETTER OF INTRODUCTION FOR CHIEF NURSING OFFICERS

Administrative Informed Consent Letter

Project Title: Novice Oncology Nurses: Socialization and Role Transition

Researcher: Patricia A. Sevean, EdD Candidate
Department of Theory and Policy Studies in Education
Ontario Institute for Studies in Education of the University of Toronto (OISE/UT)

Dear Chief Nursing Officer or/ Designate

I am a graduate student in the Theory & Policy Studies in Education Department at Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). I am currently planning a research project that will involve nurses, managers, and educators in cancer facilities in Ontario. This study is being conducted as partial fulfillment of the OISE/UT requirements for the doctoral degree in Educational Administration. In order to begin the project, I require your written consent.

This study will explore the experiences of nurses who are new to the specialty of cancer (oncology) nursing. The researcher will interview novice oncology nurses and capture their perspectives regarding their transition into the role of an oncology nurse. The purpose of this study is to extend and deepen the understanding of the experience of the novice nurse who is making a transition into the role of an oncology nurse. In order, for nursing leaders to strategically plan for the future cancer workforce it is important to understand why nurses enter the field of oncology, and how the transition affects both their personal and professional lives. This understanding of the uniqueness of oncology nursing will provide insight to nurse managers, educators and health care planners in their struggle to ensure there is an adequate supply of qualified nurses to care for cancer patients and their families in the future.

Data for this study will be collected through pre-interview demographic questionnaires and telephone interviews with novice oncology nurses who work in cancer facilities in Ontario. The novice nurses will be asked to participate in one or two audio taped interviews. The telephone interviews will last approximately one hour to one and half hours and will be pre-scheduled at a convenient time for the participant. Costs associated with the telephone call will be at the expense of the researcher, the participant’s time will be a voluntary contribution. Interviews will be semi-structured with the investigator asking some questions related to their previous experience and education in nursing, as well as a discussion of their more recent experience as a novice oncology nurse.
The researcher is also requesting that each cancer centre provide documents relevant to the orientation, education, recruitment and retention of novice nurses to cancer services (i.e. policies, programs/curricula).

The final analysis and resultant description of the novice nurse’s experience will not include any references to individual participants or the specific location of any cancer facility. In the final dissertation, pseudonyms will be used to identify all of the participants and their locations. Any references in the final report that might reveal the identity of an individual will be removed or altered. All data will be kept confidential while the study is proceeding. The only individuals who have access to the data are Patricia Sevean, the principal investigator, and Dr. Nina Bascia, her thesis supervisor. All data will be destroyed in five years following the completion of the study. All data will be kept safely stored in locked files. All names of individuals and facilities will be removed. Although I may use the data collected in this study for aims other than dissertation, the use data will be strictly limited for academic-related purposes, such as academic articles, presentations in academic conferences, and so forth.

The risk of being harmed as a result of participation in this study is minimal. Participants will be asked to describe their perceptions, thoughts, opinions and beliefs. There is the risk of possible emotional discomfort for an individual participant and they will be encouraged not to pass questions if they are unable to respond to a certain question, or if a question triggers a negative memory. Be assured that participant’s responses will be probed, but not challenged or evaluated in any way during the interview session. Participants in these interviews may decline to answer any question that they are unprepared or unwilling to respond to. At anytime during the interview (telephone or face-to-face) participants can terminate the interview or request it be re-scheduled.

Participation will not benefit participants or the cancer facility directly. However, it could contribute to the further knowledge and understanding of the novice oncology nurse’s experience, thereby assisting educators and administrators in more effectively planning for orientation, education, recruitment and retention of nurses into the specialty of oncology. This in turn could have a positive influence on orientation programs for novice oncology nurses. A copy of the final report will be available on request.

Regional cancer facilities that agree to participate in the study will be asked to distribute the research packages to eligible novice fulltime and part-time nurses employed > 3 months and < 24 months in inpatient and out-patient clinics. Please distribute study packages that contain: an information letter, researcher bio, a letter of informed consent, pre-interview demographic questionnaire. Participants who volunteer for interviews and send in their demographic questionnaire and informed consent will be contacted directly by the researcher to schedule interviews at a convenient time and location. The research study has received ethical approval from the University of Toronto and an official copy of the approval is attached for your records and your respective ethics bodies.

It is my sincere hope that your facility will agree to take part in this informative and worthwhile professional experience. Thank you in advance for your participation. If you have any questions you can contact the researcher or her supervisor.

Patricia A. Sevean
Ed.D. Candidate
Theory and Policy Studies in Education
OISE/University of Toronto

Dr. Nina Bascia
Professor, Thesis Supervisor
Theory and Policy Studies in Education
OISE/University of Toronto
By signing below, you are indicating that your centre is willing to participate in the study, you have received a copy of this letter, and you are fully aware of the conditions above. Please mail the completed informed consent back to the researcher in the self-addressed postage paid envelope provided. Please keep a copy of this letter for your files.

Administrator’s Name: ____________________  Cancer Centre: ____________________

Administrator’s Signature: ____________________  Date: ____________________

Please initial if you would like a summary of the findings of the study upon completion: __________

Please initial if you agree to provide the requested documents: __________

Contact Phone Number: ( ) ________________

Contact Address:
____________________________
____________________________
____________________________
Dear Novice Nurse:

I would like to invite you to participate in a research project about the experiences of nurses new to cancer nursing. I am a graduate student in the Theory & Policy Studies in Education Department at Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). I am currently planning a research project that will involve nurses, managers, and educators in cancer facilities in Ontario. This study is being conducted as partial fulfillment of the OISE/UT requirements for the doctorate degree in Educational Administration.

The researcher will interview novice oncology nurses and capture their perspectives regarding their transition into the role of an oncology nurse. The purpose of this study is to extend and deepen the understanding of the experience of the novice nurse who is making a transition into the role of an oncology nurse. In order, for nursing leaders to strategically plan for the future cancer workforce it is important to understand why nurses enter the field of oncology, and how the transition affects both their personal and professional lives.

Data collection for this study will be collected through telephone interviews with novice oncology nurses who work in cancer facilities in Ontario. The participants will be asked to complete a demographic questionnaire and participate in one or two audio taped interviews. The telephone interviews will last approximately one to one and half hours and will be pre-scheduled at a convenient time for the participant. All costs associated with the telephone call will be at the expense of the researcher. Interviews will be semi-structured with the investigator asking some questions related to your previous experience and education in nursing, as well as a discussion of your more recent experience as an oncology nurse. You will be assigned a number that will correspond to your interviews and transcriptions.
The final analysis and resultant description of the novice nurse’s experience will not include any references to individual participants. In the final dissertation, pseudonyms will be used to identify all of the participants and their locations. Any references in the final report that might reveal the identity of an individual, or group will be removed or altered. All data will be kept confidential during while the study is proceeding. The only individuals who have access to the data are Patricia Sevean, the principal investigator, and Dr. Nina Bascia, her thesis supervisor. All data will be kept safely stored in locked files. All names of individuals and facilities will be removed. All data will be destroyed five years following the completion of the study. Although I may use the data collected in this study for aims other than dissertation, the use data will be strictly limited for academic-related purposes, such as academic articles, presentations in academic conferences, and so forth.

The risk of being harmed as a result of participation in this study is minimal. You are asked to describe your perceptions, thoughts, opinions and beliefs. There is the risk of possible emotional discomfort if you find that you are unable to respond to a certain question, or possibly a question may trigger a negative memory. Be assured that your response will be probed, but not challenged or evaluated in any way during the interview session. As a participant in these interviews you may decline to answer any question that you are unprepared or unwilling to respond to. At anytime during the interview you can terminate the interview or request it be re-scheduled. Participation will not benefit you directly. However, it could contribute to the further knowledge and understanding of the novice oncology nurse’s experience, thereby assisting educators and administrators in more effectively planning for orientation, education, recruitment and retention of nurses into the specialty of oncology. This in turn could have a positive influence on your own ability to be a mentor for other novice oncology nurses. A copy of the final report will be available on request.

Thank you in advance for your participation. If you have any questions you can contact the researcher or her supervisor.

Patricia A. Sevean
EdD Candidate
Theory and Policy Studies in Education
OISE/University of Toronto
Telephone: (807) 343-8396
Email: psevean@lakeheadu.ca

Dr. Nina Bascia
Professor, Thesis Supervisor
Theory and Policy Studies in Education
OISE/University of Toronto
Telephone: (416) 923-6641 ext: 2511
Email: nbascia@oise.utoronto.ca

By signing below, you are indicating that you are willing to participate in the study, you have received a copy of this letter, and you are fully aware of the conditions above. Please mail your completed informed consent and demographic questionnaire back to the researcher in the self addressed postage paid envelope provided. Please keep a copy of this letter for your files.

Name: ______________________________ Cancer Centre: __________________
Signed: __________________________ Date: ___________________

Please initial if you would like a summary of the findings of the study upon completion: ______
Please initial if you agree to have your interview audiotaped: ________

Your Contact Phone Number: ( )________________
APPENDIX D: INFORMED CONSENT FOR INTERVIEWS

Project: Novice Oncology Nurses: Socialization and Role Transition
Researcher: Patricia A. Sevean, EdD Candidate
Department of Theory and Policy Studies in Education of the University of Toronto (OISE/UT)

I, _____________________________, have read the Letter of Introduction for the proposed research and agree to participate.

I understand that the data collected is to be used for research and analytical purposes and that the only individuals who will have access to these data are Patricia Sevean, the principal investigator and Dr. Nina Bascia, her thesis supervisor.

I understand that the data will be destroyed when no longer needed (two years maximum).

I understand that my name, or the name of the cancer facility will not be released or mentioned in any reports or publications; and that it will be replaced with a pseudonym in the final dissertation and or any publications/presentations.

I understand that I have the right to “pass” if there are questions that I am unable or unwilling to answer.

I understand that I am free to withdraw from the study at any time without a penalty or negative consequence.

I understand that my involvement in this study is voluntary and will not benefit me directly, but could potentially contribute to the knowledge and understanding of the novice oncology nurse’s experience; thereby assisting administrators and educators in planning for effective orientation, education, recruitment and retention programs.
I agree to permit the researcher to audiotape the interview(s).

I,__________________________________________, give informed consent to the researcher, Patricia Sevean, to use this information for the explained purposes.

Signature of Interviewee: ____________________________________________

Signature of Researcher: _____________________________________________

Date: ________________________________

Please mail in the (self-addressed postage paid envelope enclosed) your Informed Consent and completed Demographic Questionnaire to the researcher including your phone number and/or an email address. The researcher will contact you in order to schedule a telephone interview at your convenience.

Name: ________________________________
Phone Number: _ (_____) ______________
Email: ________________________________
Mailing Address: (optional) ________________________________

Where to contact the researcher:
Pat Sevean, Assistant Professor
School of Nursing, Lakehead University
955 Oliver Road, Thunder Bay, ON P7B 5E1
Phone Number: 1(807) 343-8396
Email: pat.sevean@lakeheadu.ca
Fax: 1 (807) 343-8246
APPENDIX E: PREINTERVIEW QUESTIONNAIRE

PRE-INTERVIEW DEMOGRAPHIC QUESTIONNAIRE FOR PHASE I

Project: Novice Oncology Nurses: Socialization and Role Transition
Researcher: Patricia A. Sevean, EdD Candidate
Department of Theory and Policy Studies in Education of the University of Toronto (OISE/UT)

DEMOGRAPHIC QUESTIONNAIRE:
(Please complete and return with your signed consent and contact information)

1. General Information
   Sex: M_______ F______
   Age: 18-24____ 25-34____ 35-49____ 50-59____ 60-65____

2. Education
   Your basic/initial nursing credential is/was?
   R.N. Diploma_______ R.N. Degree (Nursing) ________

   What is the highest level of education you have completed in nursing?
   Bachelor’s Degree in nursing ______
   Master’s Degree in nursing ______
   Doctorate in Nursing ______
   Other certificates and/or diplomas in nursing ________
   Other courses and/or programs in nursing __________

   What areas you have completed in non-nursing education?
   Diploma____
   Bachelor’s Degree____
   Master’s Degree____
   Doctorate______
   Other certificates/courses and/or programs______
3. **Nursing Experience**
What are your total years of nursing experience?
- Less than 2 years
- 2 to less than 5 years
- 5 to less than 10 years
- 10 to less than 15 years
- 15 to less than 20 years
- 20 to less than 25 years
- 25 years or more

List your previous employment experiences starting with the most recent according to number of years, position (i.e. staff nurse) and specialty area (i.e. surgical unit,) and type of facility (i.e. hospital, community)

<table>
<thead>
<tr>
<th>Number of Years</th>
<th>Position</th>
<th>Specialty Area</th>
<th>Type of Facility</th>
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4. **Employment Information**

What is your current employment status?
- Regular Full-time
- Casual Full-time
- Regular Part-time
- Casual Part-time

What is your place of major employment?
- Outpatient Cancer Centre
- Inpatient Oncology Unit
- Other ___________________________

Do you work in any specific area(s) of oncology? (% of time spent in each area)
- Outpatient clinic
- Site Specific
- Chemotherapy
- Radiation Oncology
- Bone Marrow Transplant
- Hematology
- Breast Screening
- Palliative & Supportive Care
- Other ___________________________

5. **Orientation/Continuing Education** Please consider the following questions regarding your orientation to Oncology?

How long (hours) was your orientation? ____________________
Did you have a preceptor or mentor? YES___________ NO____________

Were you required to complete any in-house certification courses? (i.e. Chemotherapy)
Type: ___________________________ Length: ___________________________

Content included: (mark with X if included in your orientation)
Carcinogenesis ___________
Prevention of Cancer ___________
Screening & Early Detection of Cancer ___________
Nursing Implications of Surgical Treatment ___________
Nursing Implication of Radiation Therapy ___________
Nursing Implications of Antineoplastic Therapy ___________
Nursing implications of Biotherapy ___________
Nursing Implications of Bone Marrow and Stem Cell Transplantation _______
Preparation, Administration, and Disposal of Antineoplastic Agents _______
Oncologic Emergencies _______
Supportive/Symptom Care (pain, nausea, fatigue) _______
Palliative Care _______
Common Cancers (breast, lung, prostate, colorectal, lymphomas) _______
The role of the Oncology Nurse _______
Strategies for coping with the stressors in Oncology Nursing Practice _______
Other(s):
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

COMMENTS: (relative to previous or current experience)
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY   CODE: _________
APPENDIX F: FINDINGS: PREINTERVIEW QUESTIONNAIRE

DEMOGRAPHIC QUESTIONNAIRE

Project: Novice Oncology Nurses: Socialization and Role Transition
Researcher: Patricia A. Sevean, EdD (Candidate)
Department of Theory and Policy Studies in Education of the University of Toronto (OISE/UT)

Note: results in bold font

N =15
(2 rural, 13 urban) (6 outpatient, 9 in-patient) (6 new, 9 experienced)

4 Sites:
Site #1: - 5 participants (1 rural, 4 urban) (2 outpatient, 3 in-patient)
Site #2: - 3 participants (2 rural, 1 urban) (2 outpatient, 1 in-patient)
Site #3: - 4 participants (4 urban) (2 outpatient, 2 in-patient)
Site #4: - 3 participants (3 urban) (3 in-patient)

DEMOGRAPHIC QUESTIONNAIRE:

1. General Information
   Sex: M____0____ F___15____
   Age: 20-24__4__ 25-29__3__ 30-34__1__ 35-39__3__
   40-44__2__ 45-49__1__ 50-54__1__( * no one over 55)

2. Education
   Your basic/initial nursing credential is/was?
   R.N. Diploma____8____
   Bachelor’s Degree in Nursing____7____
   Master’s Degree in Nursing____NA____
   Doctorate in Nursing____NA____

3. Nursing Experience
   What are your total years of nursing experience?
   Less than 2 years____7____ 15 to less than 20 years____1____
   2 to less than 5 years____2____ 20 to less than 25 years____3____
   5 to less than 10 years___2_____ 25 years or more____NA______
4. **Employment Information**

What is your current employment status?
- Regular Full-time ___8___
- Casual Full-time ___1___
- Regular Part-time ___4___
- Casual Part-time ___2___

What is your place of employment?
- Outpatient Cancer Centre ___6___
- In-Patient Oncology Unit ___9___

Percentage (%) of time spent in oncology?
- 100% oncology- 14, 80% oncology- 2

5. **Orientation/Continuing Education**

How long was your orientation? (*average 12.5 days)
- 1 week (5 days) ___3___ (in-patient)
- 2 weeks (10 days) ___5___ (in-patient)
- 3 weeks (15 days) ___4___ (outpatient & in-patient)
- 4 weeks (20 days) ___1___ (outpatient)
- 6 weeks (30 days) ___1___ (outpatient, HDR-high dose radiation)
- 8 weeks (40 days) ___1___ (outpatient, pediatric interlink nurse)

9 participants- orientation 10-15 days
3 participants- orientation less than 10 days *inpatient oncology
3 participants- orientation 20-40 days *outpatient specialized oncology roles

Did you have a preceptor or mentor?
- YES ___14___  NO ___1___

* 2 participants had a multiple preceptors

Did you complete an in-house certification courses? (ex- Chemotherapy)
- 11-completed chemo course, 4- have not completed (chemo course)

Content included: (mark with X if included in your orientation)
*2 did not complete this part of the survey

Carcinogenesis ______12_______
Prevention of Cancer _____12_______
Screening & Early Detection of Cancer _____12_______
Nursing Implications of Surgical Treatment _____13_____
Nursing Implication of Radiation Therapy _____12_____
Nursing Implications of Antineoplastic Therapy _____8____
Nursing implications of Biotherapy _____8_____
Nursing Implications of Bone Marrow and Stem Cell Transplantation _____9____
Preparation, Administration, and Disposal of Antineoplastic Agents _____9____
Oncologic Emergencies _____12_____
Supportive/Symptom Care (pain, nausea, fatigue) _____9____
Palliative Care _____6_____
Common Cancers (breast, lung, prostate, colorectal, lymphomas) _____10____
The role of the Oncology Nurse _____7_____
Strategies for coping with the stressors in Oncology Nursing Practice _____6_____

Other(s) (list):
Health Team in Oncology (Role of other health team members) -3
Role of Primary Nurse - 1
Radiation Safety - 1
Pain Management - 1
Telephone Practice - 1
Confidentiality & Ethics - 1
APPENDIX G: INTERVIEW PROTOCOL

TELEPHONE SCRIPT AND INTERVIEW QUESTIONS

Script for Telephone Interview:

“May I please speak with ____________. Good morning/afternoon/evening. This is Pat Sevean I am calling in regards to our pre-scheduled interview for the research study on what it is like to become an oncology nurse. The interview will be approximately one hour and I will begin now by turning on the tape recorder. I am going to review the consent form with you to clarify any questions you may have [read consent form]… do you have any questions? [answer any questions] During the interview I would request you speak directly into the phone so that your responses will be clearly recorded. I would also like to ask you at this time if you would be available for a follow-up interview to clarify or add additional information as the study proceeds. I will begin the interview now by asking you to tell me what it is like to become an oncology nurse?”

Interview Questions:
The following open-ended research question will guide the researcher:

Focus Question:
“Tell me about what it is like to become a cancer (oncology) nurse?”

The researcher will also utilize the following trigger questions to explore the participant’s perceptions of their socialization and transition into their new role as an oncology nurse. The questions are categorized according to the phases of the transition process (antecedent questions, socialization/transition questions, and reactions/consequences questions) and the moderators that influence the transition process (individual, organizational, and interpersonal):

Antecedent Questions:
1. What factors influenced your decision to become an oncology nurse? (personal, professional)
2. Were there any supports offered to you during the selection process?
3. What were the strengths and weaknesses of the recruitment and selection process?
4. What personal and professional strengths did you bring to oncology nursing?
5. What did you perceive to be your greatest challenges in contemplating the role of an oncology nurse?

**Role Socialization/Transition Questions:**
1. How did you prepare for your new role as an oncology nurse?
2. Describe your initial orientation to oncology (first two weeks).
3. What formal and informal structures were in place for new oncology nurses? (courses, workshops, conferences, mentors/preceptors, and so forth)
4. What were the most valuable learning opportunities that prepared you for your role as an oncology nurse?
5. Were you able to utilize previous work experiences/skills in your new role in oncology? If so what were those skills?
6. Describe any particular critical incident(s) you can recall from your first few weeks in oncology? How were they dealt with? Who was influential in dealing with the incident(s)?
7. What key experiences were of the greatest and least value in preparing you for your role as an oncology nurse?
8. What were some of the key stressors you encountered during your transition to the new role?
9. Did you feel supported by the organization during your orientation? Describe specific activities?
10. Who was the most influential during your orientation? Describe how they supported you?
11. What individual strengths did you bring to your orientation to oncology nursing?
12. What were the strengths and weaknesses of your orientation to oncology nursing?
13. How does oncology nursing compare with other areas of nursing in regards to emotional strain?
14. If you experienced emotional strain who assisted you in coping with the strain?
15. Describe your best and worst experience so far as an oncology nurse.

**Reactions and Consequences Questions:**
1. What further supports formal or informal do you need to assist you in this role?
2. What do you feel are your greatest areas for future improvement as an oncology nurse?
3. How are you thinking about the role of an oncology nurse now as compared to before your orientation?
4. How does oncology-nursing compare with other areas of nursing?
5. How would you describe your quality of work-life?
6. Is there anything unique about this area of nursing?
7. Is oncology nursing what you expected? Have there been any surprises?
8. Are you satisfied with your position as an oncology nurse? Why?
9. If you had it to do over again would you choose this specialty, if so, Why?
10. Do you feel like an oncology nurse? If not, why? What supports would help you to become an oncology nurse?
11. Is there any question I should have asked you that I didn’t?