

Oncology Nurses' Perceptions About Palliative Care

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This article has been chosen as particularly suitable for reading and discussion in a Journal Club format. The following questions are posed to stimulate thoughtful critique and exchange of opinions, possibly leading to changes on your unit. Formulate your answers as you read the article. Photocopying of this article for group discussion purposes is permitted.

1. What do you think of when you consider palliative care?
2. In what ways are your perceptions consistent or divergent with the perceptions expressed by the nurses who participated in the focus groups?
3. Discuss the mix of patients on your unit. What proportion of them could be considered to need palliative care services?
4. If you identify a patient or family in need of palliative care, what would be your first step?
5. What facility resources are available to offer patients and families who need palliative care services?
6. Discuss one or two strategies that could be attempted to improve provision of palliative care services in your unit.

At the end of the session, take time to recap the discussion and make plans to follow through with suggested strategies.

Purpose/Objectives: To explore oncology nurses' perceptions about palliative care.

Research Approach: Descriptive study with narrative data analysis.

Setting: Oncology units in three midwestern hospitals.

Participants: 33 actively practicing oncology nurses.

Methodologic Approach: Oncology nurses participated in focus groups that elicited concrete experiences and reflections about palliative care. Researchers identified subtexts by which to sort data, worked inductively in each subtext to identify categories, resorted the text according to the categories, carefully examined the category narratives, and established narrative descriptors that captured the essence of each category. Data matrices were constructed to examine the emerging categories more closely.

Main Research Variable: Oncology nurses' perceptions about palliative care.

Findings: Narratives revealed 14 descriptors about palliative care. Considerable agreement occurred in nurses' descriptions about the nature of palliative care. Divergent viewpoints were evident as nurses described how palliative care intersects with other practice areas. Three descriptors of the healthcare context in which palliative care occurs were identified: limited time for addressing complex palliative care issues, health care's emphasis on prolonging life, and the challenge of coordinating care across disciplines.

Conclusions: Participants clearly comprehend palliative care goals. However, divergent perspectives about the intersections of palliative care with oncology nursing may limit timely consultation with specialty palliative care teams. The current acute care context poses challenges to implementing palliative care.

Interpretation: Palliative care teams and oncology nurses need to develop partnership models that clearly illustrate how both partners contribute to palliative care across the continuum of oncology care. Furthermore, the partnership models must address barriers that the acute care context poses to quality palliative care.

Key Points . . .

- ▶ Patients and their families often suffer during life-threatening illnesses as they grapple with quality of life and multiple treatment choices.
- ▶ Nurses are in a pivotal position to affect the quality of palliative care offered to patients and their families.
- ▶ Oncology nurses describe key aspects of palliative care as a core part of their professional practice.
- ▶ Confusion and divergent perspectives about the place of palliative care in the trajectory of cancer care exist among oncology nurses.

Managing symptoms, providing information about treatment options, and supporting families as well as patients are core aspects of palliative care. Yet data from decedents' family members indicate that clinical

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outcomes such as symptom relief and patient and family satisfaction with emotional support at the end of life fall far short of the ideal (Lynn et al., 1997; Teno et al., 2004). Furthermore, the Institute of Medicine (2001) asserted that inadequate training of healthcare professionals and lack of research posed two barriers to effective palliative care for patients and their families. The aim of the current study was to explore oncology nurses' perceptions of palliative care through narrative analysis of the nurses' descriptions of real life experiences. Narratives of experience comprise descriptions of human perceptions, and perceptions represent the meaning that humans attach to their realities (Gadamer, 1963/1987; Ricoeur, 1991). The manner in which healthcare professionals perceive clinical situations partially determines the clinical care practices they choose to implement (Ferris, von Gunten, & Emanuel, 2001). Therefore, studying perceptions offers an opportunity to explore and improve clinical practice. Because evidence exists that patients and their families suffer unnecessary hardships during life-threatening disease and end of life, research needs to yield deeper insights about why that suffering continues. Nurses are in a pivotal position to provide insight and offer important suggestions for advancing the quality of palliative care in hospital settings.

Theoretically, similarities exist between aspects of oncology care and palliative care. However, based on the authors' experiences, healthcare practitioners in oncology tend to seek consultation from formal palliative care services less often than practitioners in critical care and medical-surgical settings. Many palliative care teams across the country express concern about the reluctance of oncology healthcare professionals to initiate referrals for palliative care specialty services. Bradley et al. (2001) reported that palliative care referrals from all services tend to be delayed. The National Comprehensive Cancer Network (2006) asserted that far too many patients are never referred to palliative care specialists or are referred too late for comprehensive palliative care to extend its full benefits. Reasons for insufficient palliative care referrals from oncology specialists and delayed referrals from all services are poorly understood. Oncology nurses can provide insights on barriers that exist regarding referrals for palliative care specialty services.

Literature Review

The concept of palliative care has evolved over time. Initially, palliative care referred only to the care of dying individuals—primarily patients with cancer (Magno, 1990; Meghani, 2004). However, demographic shifts toward an aging population and technologic advances that alter illness trajectories toward prolonged survival have challenged the early view of palliative care. Currently, the concept of palliative care in the United States has expanded to include “patient populations who may not be termed ‘dying’ but for whom alleviation of suffering and improvement of quality of life may be relevant goals” (Meghani, p. 152). For example, the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, the Center to Advance Palliative Care, and the World Health Organization have broadened their definitions of palliative care to escape cure versus palliation perspective (Meghani). Recently, Bruce (2006) urged oncology nurses to improve the quality of life

for patients with cancer by integrating palliative care services across the entire cancer care continuum.

Avoiding the dichotomous view of cure versus palliation is prevalent among palliative care organizations; however, perceptions among healthcare professionals might not reflect the conceptual shift. In fact, some authors contend that consensus on the concept of palliative care does not exist (Meghani, 2004; Ronaldson & Devery, 2001). The multiple and disparate definitions of palliative care often result in ambiguous interpretations by the general public as well as healthcare professionals (Lipman, 2002). In addition, the lack of clarity about palliative care restricts its usefulness in guiding clinical practice (Meghani). The resulting gap between the theory and practice of palliative care must be narrowed to address the unnecessary suffering that many patients and their families experience as a result of life-threatening illnesses.

The conceptual confusion that surrounds palliative care might contribute to the inadequate services offered to patients and their families for whom the goals of palliative care are appropriate. An Institute of Medicine (2001) report suggested that at least half of patients dying from cancer experience a spectrum of untreated or undertreated symptoms that negatively influence quality of life. More recently, Teno et al. (2004) surveyed family members and others who witnessed the circumstances surrounding a patient's end-of-life experience. The findings revealed that most people (69%) still died in a hospital or nursing home despite a preference for dying at home. Regardless of the setting, respondents reported that staff members inadequately addressed pain (24%), dyspnea (22%), and emotional needs (50%). Improving the quality of patients' daily experiences while living through or dying from a serious illness continues to challenge healthcare professionals. Given the evidence that unnecessary suffering continues, more information about nurses' perceptions of palliative care is imperative. Studying healthcare professionals' perceptions of palliative care offers insight into current practice situations that, in turn, yield information on ways to improve practice and decrease unnecessary suffering (Bradley et al., 2001; Gross, 2006; Hanratty et al., 2002; Ronaldson & Devery, 2001).

Methods

The current descriptive research study used focus groups to collect data about oncology nurses' perceptions of palliative care and implemented narrative data analysis to carefully examine how oncology nurses describe their perceptions of palliative care. Two institutional review boards (IRBs) approved the procedures for the study.

Research Participants

Researchers conducted nine focus groups with 33 oncology nurses who were working in three different hospitals in a large midwestern healthcare service organization. Formal palliative care services were available in each of the hospitals. Flyers introducing the study and inviting participation were posted in each hospital's oncology unit. One year of RN oncology experience was the inclusion criterion. A thorough explanation of the research preceded each focus group session, and the voluntary nature of participation was emphasized. Nurses who chose to participate were asked to review and sign an IRB-approved informed consent form.

Data Collection

Focus groups have become a standard of human science research in healthcare settings (Morgan, 2002; Morse & Field, 1995). Krueger and Casey (2000) suggested using an interview template to systematically and consistently collect data across focus groups. The authors developed the interview template for the present study (see Figure 1). Commencing with concrete experiences to encourage dialogue on palliative care and proceeding toward more abstract conceptualization to procure reflections, the researchers used the same interview template in all sessions. Responding to the questions, nurses readily recalled, described, and reflected on experiences in palliative care.

The authors conducted each of the nine focus group sessions over 60–90 minutes. The audio for each session was recorded and transcribed verbatim. One researcher listened to the recordings and verified all transcriptions prior to data analysis. The transcribed recordings served as the research text.

Data Analysis

The research text focused on real world experiences in a specific context—the practice of oncology nursing. Because participants often described clinical examples to explain palliative care, narrative analysis of the research text seemed appropriate. Lieblich, Tuval-Mashiach, and Zilber (1998) defined narrative research as any investigation that analyzes human experience materials and makes them meaningful. In an attempt to remain as descriptive as possible during data analysis, the researchers in the present study first wrote reflectively about their own palliative care experiences and shared those reflections with each other. Uncovering assumptions and bracketing their experiences facilitated the researchers' abilities to enter the research text with descriptive intent. In addition, researchers maintained an audit trail during data analysis that carefully detailed how data were categorized and organized at each step.

Implementing the categorical-content method of narrative data analysis (Lieblich et al., 1998) and bracketing the

researchers' experiences, the present study's researchers read through the research text multiple times and identified four subtexts. By cross-checking the transcripts, the researchers accounted for all meaningful dialogue in the focus groups. Only two subtexts pertained to nurses' perceptions about the nature of palliative care and were analyzed for this article.

Separately, the researchers entered the two selected subtext narratives and inductively examined the data for words, sentences, or groups of sentences that described oncology nurses' perceptions of palliative care. A circular procedure was implemented that included reading carefully, suggesting categories, sorting subtexts into categories, generating ideas for additional categories, refining existing ones, and reading further (Lieblich et al., 1998). During independent analysis and collaborative dialogue, the researchers identified two major categories. Once major categories are identified, the research text should be used to completely develop and depict the meaning of each category (Lieblich et al.). Therefore, the current study's researchers recontextualized the data according to the identified categories.

Once data were recontextualized, each category was further analyzed separately by the researchers and the descriptive analysis was compared during dialogue with each other and with the text. The researchers established descriptors in each category by noting participant words. In addition, during data analysis, the researchers constructed data matrices that further examined the categories (Averill, 2002; Miles & Huberman, 1994).

Results

Nurses who participated in the focus groups reported 1–29 years of oncology nursing experience, with an average of 12.03 years. Researchers separately analyzed the two subtexts for categories of palliative care descriptions and then examined each category for specific descriptors (see Table 1).

Perceptions About the Nature of Palliative Care

Researchers identified 14 descriptors that participants used to depict their perceptions about the nature of palliative care. In an effort to examine descriptors more carefully within and across focus groups, researchers constructed a data matrix to display specific quotes that exemplified each descriptor and then analyzed differences and similarities of perceptions. By visually displaying and analyzing the data, the study's researchers could comprehend the level of convergence or divergence (Patton, 2002). For example, if many participants used common words and phrases to describe an aspect of palliative care, the researchers noted convergence as areas of agreement in the descriptor. If few participants mentioned a descriptor or if descriptors varied widely, the researchers noted divergence (as lack of agreement) in the descriptor (see Figure 2). The data matrices facilitated deeper analysis and allowed new insights to evolve.

Areas of convergence: The descriptor demonstrating the highest convergence among participants within and across focus groups was the perception that palliative care is family focused. Every narrated story included a family component, and the study participants always commented on communicating and working with families as part of patient care (see Table 2).

Introductory Questions

- How many years have you practiced as a nurse? As an oncology nurse?
- What are common nursing care priorities for oncology patients on your unit?

Transition Questions (concrete experience and reflective observation)

- Can you describe a patient situation when you focused on palliative care?
- What aspects of palliative care are most difficult for you?

Key Questions (abstract conceptualization and planning for change)

- What are ideal services for patients who require palliative care?
- What factors affect your ability to provide palliative care?
- What aspects of palliative care require more attention?

Summary Questions

- What "matters most" in palliative care?
- Have we missed anything about palliative care? Is there something we should have talked about and did not?

Figure 1. Framework for Focus Group Interviews With Sample Questions

Table 1. Palliative Care Categories and Related Descriptors

Category	Descriptors
Perceptions about the nature of palliative care	<p>It is the same as oncology care.</p> <p>It is part of oncology care.</p> <p>It spans the spectrum of chronic illness such as cancer.</p> <p>It is a step between aggressive treatment and end-of-life care.</p> <p>It is end-of-life care.</p> <p>It includes aggressive treatment.</p> <p>It is dichotomous to curative care.</p> <p>It extends beyond oncology care.</p> <p>It is a process.</p> <p>It focuses on managing symptoms.</p> <p>It focuses on comfort.</p> <p>It focuses on quality of life.</p> <p>It is family centered.</p> <p>It shifts attention to patient and family preferences.</p>
Perceptions about the context of palliative care	<p>Limited time is available to address the complexity of palliative care issues.</p> <p>Advanced technologies that prolong life are emphasized in the current healthcare system.</p> <p>Extensive effort is required to coordinate care across disciplines and settings.</p>

Narratives also indicated convergence in the description that palliative care is a process. Some participants offered the metaphor of a journey to describe their perceptions about palliative care. Other participants suggested that transitioning to palliative care offered an opportunity to reevaluate treatment goals and care plans. Another area of strong convergence was that palliative care shifts the focus toward managing symptoms and working toward holistic comfort and quality of life. Most nurses described comfort as physical, psychosocial, and spiritual well-being and claimed that comfort was their primary palliative care goal. In addition, alleviating suffering by managing symptoms was a prominent descriptor of palliative care. A final area of strong convergence among and within focus groups was that palliative care sharpens the focus on patient and family preferences.

Areas of divergence: Descriptions of how palliative care intersects with other practice areas varied extensively and were sporadically depicted on the data matrix. The researchers acknowledged that aspect of palliative care as divergent perspectives (see Table 3). For example, some participants described palliative care and oncology care as “one and the same.” Other nurses described palliative care as part of oncology care and identified the focus of helping patients manage symptoms and attain comfort as the primary areas of overlap. One participant simply declared, “I feel we oncology nurses try to incorporate [palliative care] on our own,” and another nurse asserted, “[Oncology nurses] are well suited to maximize palliative care.”

The various and disparate perceptions continued as some nurses described their views about palliative care as end-of-life care, a step between aggressive treatment and end-of-life care, or opposite to curative treatment. Several nurses described

palliative care as beyond the scope of oncology nursing at least in some situations. Nurses who expressed that viewpoint alluded to the need for additional expertise in palliative care when situations became complicated or too time consuming. A few nurses noted that palliative care pertained to other patient populations living with life-limiting diseases—not just patients with cancer. However, very few descriptors indicated that palliative care services are pertinent across the spectrum of living with life-threatening or life-limiting illness.

Lack of clarity about the boundaries of palliative care was evident in the convergent descriptors. Some participants readily admitted to lack of clarity about distinguishing characteristics of palliative care. During several focus group sessions, nurses requested a definition of palliative care. Refraining from offering perspectives, the researchers turned the question back to participants who often admitted to being confused by the phrase. Sharing her consternation, a participant questioned, “Who’s told [the patient] what ‘palliative’ means? I still hear the view that we can’t treat your cancer anymore so we’ll have to do some palliative stuff. I mean where does palliative care fit and who’s to define palliative?” Finally, one nurse declared, “A nurse needs to be comfortable operating in a gray zone because palliative care is a gray zone. It’s so individual, and that’s so gray.”

By examining the data matrix, the researchers concluded that oncology nurses’ perceptions about the nature of palliative care yielded areas of agreement and disagreement. Areas of convergence were beliefs that palliative care is a process that includes managing symptoms, working toward comfort and quality of life, interacting with families, and respecting patient and family preferences in planning care. Areas of divergence pertained to perceptions about the manner in which palliative care intersects with other areas of practice such as oncology practice and end-of-life care.

Perceptions About the Context of Palliative Care

Considerable convergence was found regarding descriptors of the context in which palliative care occurs. Without

Convergence (similar words, phrases to describe perceptions)

Palliative care

- Is a process
- Is managing symptoms
- Is working toward comfort
- Attempts to enhance quality of life
- Is family centered
- Sharpens focus on patient and family preferences.

Divergence (dissimilar or infrequent words, phrases to describe perceptions)

Palliative care

- Is the same as oncology care
- Is part of oncology care
- Extends beyond oncology care
- Is a step between aggressive treatment and end-of-life care
- Is the same as end-of-life care
- Includes aggressive treatment
- Is opposite to curative care
- Spans the entire spectrum of living with chronic disease.

Figure 2. Descriptor Convergence and Divergence in Perceptions About the Nature of Palliative Care

Table 2. Convergent Views and Supporting Quotes

Areas of Convergence	Samples of Supporting Quotes
Palliative care is family focused.	<p>“You’re not only taking care of the patient, but you’re taking care of parents, [the] spouse, children. So it’s not just one person that you’re dealing with.”</p> <p>“You’re trying to be present with the family, trying to talk with them and understand what stage they’re at with the grieving process.”</p> <p>“A person with a terminal diagnosis is pretty lonely. They’re there all by themselves and without that permission to talk to family members, they keep their illness inside.”</p>
Palliative care is a process.	<p>“It’s hard to say when palliative care ends. When you’ve been walking with them on the journey and hospice starts, palliative care doesn’t seem to end. We just take on another dimension.”</p> <p>“Palliative care is helping patients along their journey of illness and into coping and dealing with the rest of their life. Nurses help them live a life with the issues [patients] encounter and provide different kinds of support along the way.”</p> <p>“The palliative care process is taking them from treat, treat, treat, to wait a second, let’s sit back and see what we can do, like comfort and the moving-on process.”</p> <p>“Palliative care is just helping the family and patient through the transition to the next level, whatever that might be.”</p>
Palliative care is managing symptoms and improving quality of life.	<p>“Palliative care is taking someone with a bad diagnosis and trying to help them figure out what they’re going to do and prepare them and maximize their days.”</p> <p>“Palliative care is managing symptoms to increase quality of life. And it’s not just symptoms, it’s their spiritual health, their mental health, it’s all of it.”</p> <p>“I kind of watch them and their symptoms, and when they’re having more problems, I offer them palliative care–type stuff because they’re getting to the point where they see we’re not going to cure this but we are going to keep fighting and we can keep fighting but we can add members to our fire-fighting team.”</p> <p>“[The family] could not give up aggressive treatment, but clearly he needed supportive care because he was deteriorating rapidly. So we had to keep a dual focus—keep them happy with what we were doing to try to cure this in their minds, but at the same time really make this kid who was suffering comfortable with palliative care.”</p>
Palliative care sharpens the focus on patient and family preferences.	<p>“She had some major goals to accomplish. She just did all this stuff that nobody thought she could. It was kind of shocking, and it kind of wakes you up a bit. You never know when to say she shouldn’t have done it because she gained some very valuable time.”</p> <p>“I listen to what they think is their top priority, and I am there to address their top priority.”</p> <p>“I say to patients, ‘We are trying to prolong your life until you decide that’s not appropriate.’”</p>

being prompted, the participants described a healthcare system that offers limited time to address complex palliative care issues, emphasizes advanced technologies to prolong life, and requires extensive effort to coordinate care. Each descriptor is explained, and supporting quotes are offered in Table 4.

The most frequently cited context descriptor about the acute care setting in all of the focus groups was limited time for offering compassionate and comprehensive palliative care. Viewing patients in palliative care as a very special population, one nurse said, “You have to take extra time with them and in a calm manner, not in and out of the room like so many others are doing.” Nurses emphasized being torn between demands and needing time to focus their care as well as juggle their emotions as they cope with losing patients for whom they have cared deeply. The minimal time that the healthcare system offers to patients in palliative care and their families was viewed as a lack of respect for the journey that accompanies a life-threatening illness and the dying process.

Participants also described health care’s emphasis on life-saving technologies, which leads to awkwardness when discussing death and lack of acceptance that death is an inevitable consequence of life. Some nurses suggested the need for a dying plan—similar to options the healthcare system has created for birthing. For example, one nurse noted, “[Nurses] need to set up a plan so people are more comfortable saying, ‘Here’s what I’d like it to look like. I would like it to be at home, or I want to be at the hospital, or I want my family there, or I want my dogs on the bed or whatever.’” Several nurses described the “mode of doing everything possible to prolong life” and the “overwhelming soup bowl of choices” that patients encounter as their disease progresses. The language of “winning the battle” and “not giving up” perpetuates the emphasis on treating to cure.

Often the healthcare system fails to fill the void that the lack of curative treatment presents, and nurses struggle to advocate for patients and their families. Nurses described logistical demands that pressured them to move patients in palliative care aside in favor of patients who require treatment. Nurses also noted insurance companies that “spend \$200 on a pill [for treatment] but won’t spend \$60 on a massage [for comfort].” As succinctly summarized by one nurse, “It’s like we are always trying to jump through hoops to do what we need to do to get the care done when patients need palliative care.”

Nurses described the difficulties of coordinating care when patients require palliative care. Inaccessible physicians, inadequate healthcare team communication, and insufficient care provider continuity pose significant challenges. Some nurses described complex situations in which patients, their families, and the healthcare team conflict over the direction of treatment. Several nurses commented that the lack of focused, interdisciplinary attention is very difficult for patients in palliative care and their families. In addition, patients might be managed at home with a set of treatments, but when they are admitted to the hospital, the established set of treatments do not follow and patients must adjust to different routines.

Without being queried, focus group participants described a complex healthcare context in which palliative care operates. Nurses commented on the challenges of limited time and competing demands. Participants also noted the primary focus

Table 3. Divergent Views and Supporting Quotes

Areas of Divergence	Samples of Supporting Quotes
Palliative care is the same as or part of oncology care.	<p>“When I think oncology, I think palliative.”</p> <p>“It’s the same thing. You’re still providing the support to help the patient get to where they want to be.”</p>
Palliative care is the same as end-of-life care, a step between aggressive treatment and end-of-life care, or opposite to curative treatment.	<p>“Palliative care seems like hospice because ‘palliate’ means to keep comfortable versus cure. I always linked hospice and palliative together.”</p> <p>“Where does one start and the other end? I think hospice is a subset of palliative care. It’s the stage when you aren’t doing any of the invasive treatment.”</p> <p>“I think on our unit they start talking about palliative care and I automatically think, ‘So we’re leading to hospice,’ unless something dramatic happens.”</p> <p>“I have a hard time trying to define [palliative care and hospice care]. They just kind of run into one another. It’s difficult to understand. Where does one start and the other end? The words are confusing and if they confuse us, think about how patients and their families feel!”</p> <p>“There’s palliative and then there’s curative and sometimes that’s not clear.”</p>
Palliative care is beyond the scope of oncology care.	<p>“A grand case scenario is where you need help [from palliative care teams] with the whole volume sometimes. We’re not very good at that.”</p> <p>“We thought we had a plan and we could manage it and something else showed up—some other event. And it might not be medical. It could be a big family situation or anything. But sometimes, I think there’s just more than we can handle.”</p> <p>“Palliative care is focused on patients’ life needs in the setting of illness whereas oncology nurses do that to some extent, but we mostly have to focus on our own specialty.” [describing a situation where a patient was treated extensively for her cancer and was left to deal with several “treatment-inflicted issues”]</p>
Palliative care pertains to all patients living with chronic diseases.	<p>“Oncology just by diagnosis is a little narrower than palliative care. Palliative care covers more diagnoses, more populations, and, therefore, more people.”</p> <p>“What we do in palliative care circs the diagnosis. It’s how we manage patients and how we help them get through each section of their disease process and the trajectory.”</p>
Lack of clarity about the nature of palliative care	<p>“That’s palliative, isn’t it?” [describing a patient situation in which surgery was performed to reduce tumor size]</p> <p>“Well, it can be palliative radiation or palliative surgery. With palliative, you’re still treating, aren’t you?”</p> <p>“I’m not always sure about what the limitations are [on] code status and [parenteral nutrition], chemo, and even radiation therapy. I definitely haven’t been understanding [palliative care] well enough.”</p> <p>“I notice that when that term [palliative care] floats on our station, I think a lot of people have got various ideas as to what it means. I really do. I think physicians do as well.”</p> <p>“I think there’s always the interpretation of what palliative care means to each individual, and I think the biggest challenge is that it gets labeled and that we make assumptions. But my assumption might not be the same as yours which might not be the same as the lady in the bed or the physician. So it becomes a real challenge.”</p>

on aggressive treatment that often results in a lack of respect for palliative care. Finally, nurses described the difficulties in providing focused, interdisciplinary care across the continuum of care settings for palliative care patients and their families.

Discussion and Implications for Practice

The present study reveals oncology nurses’ views of palliative care practices. Fortunately, as noted in the convergent palliative care descriptors, participants’ perceptions align closely with the goals of palliative care. However, when describing complex palliative care situations, very few nurses expressed the need for specialized palliative care services. Because the study’s participating nurses indicated that offering holistic comfort and support is within their domain of practice, the nurses tended to offer palliative care services themselves rather than seek consultation from specialized palliative care teams.

With 8 of the 14 palliative care descriptors representing divergent viewpoints on how palliative care intersects with clinical practice areas, this study provides further evidence that different definitions and perceptions regarding palliative care are common in clinical practice (Davidson et al., 2003; Meghani, 2004). Confusion about when to offer formal palliative care services in the cancer care continuum exists (Ronaldson & Devery, 2001). Given the pivotal role that oncology nurses play in providing information and guiding decision making about options for care, the confusion limits the information that nurses describe to patients (Bradley et al., 2001). Too often, rather than being a routine partner in providing services to patients with life-limiting disease, palliative care services are viewed as only necessary in extreme circumstances. Prevalence in that view of palliative care prevents appropriate and timely consultation with palliative care specialists (Lynn, 2001). Palliative care specialists and oncology nurses need to develop partnership models that clearly illustrate how both partners contribute to palliative care services offered to patients and their families across the continuum of oncology care.

Nurses in the present study described contextual aspects that strongly influenced their ability to provide palliative care. Participants expressed significant frustration with the limited time available for meaningful interactions with palliative care patients and their families. Several other studies have substantiated the importance of the nurse-patient relationship and the time that is required to establish trust and meaningfulness with palliative care patients and their families (Bertero, 2002; Contro, Larson, Scofield, Sourkes, & Cohen, 2002; Cutcliffe, Black, Hanson, & Goward, 2001; Mok & Chiu, 2004). In addition, coordinating quality care across various healthcare services consumes a significant amount of time. Nurses expressed feeling “caught between services” as they advocate for patients and attempt to coordinate care. Reorganizing care delivery to offer advanced practice palliative care nurse specialists as part of oncology programs and holding regularly scheduled palliative care rounds are two initiatives that might address frequently experienced frustrations.

Another contextual factor that affects nurses’ ability to provide palliative care is the emphasis on life-prolonging technologies. Willard and Luker (2005) found that the dominance of technology and treatment concerns in clinical practice

Table 4. Descriptors of Context and Supporting Quotes

Descriptor	Samples of Supporting Quotes
Offers limited time	<p>“You try to be present for the patient and the family, try to talk with them and understand what stage they’re at in the grieving process and their understanding of what’s going on and what the goals of care are, but at the same time, you’re thinking of your three other patients and you have to get so-and-so to surgery and chemo up on this other patient. It’s just hard to have time for it all.”</p> <p>“We just need time to be present and make patients and families feel cared about. Even if they’ve had a bad experience, knowing that someone cares about them in the system can alleviate a lot of situations.”</p> <p>“We’re doing all the mechanical things. I mean it’s all a rush, there’s no personal time. It’s the biggest frustration to me—rush, rush, rush—and it’s very disrespectful to the person and their families at this stage in their disease process.”</p>
Emphasizes advanced technologies to prolong life and marginalizes dying patients	<p>“We are so much about technology and improvement, and everyone wants to keep trying the newest and best things to keep life going. And when nothing more can be done, we think we’ve failed and then the doctors seem to pull back.”</p> <p>“The patient placement manager says that ICU [intensive care unit] needs to send this person to your floor to die [because an ICU bed is needed for an ICU patient]. What does that say to the patient and the family? How many nurses and physicians will say, ‘Well, we just have the dying patient in 23 and she isn’t a lot of work.’ Or the patient placement manager will call and ask, ‘Do you have any idea when the patient in 23 is going to die because we need a private?’ We simply need more respect for the dying process so we can make it a good process for patients.”</p>
Requires extensive efforts to coordinate care	<p>“Nursing in palliative care is a lot of troubleshooting and not only with our patients and their families but sometimes we’re the ‘in-between’ between the patients and their physicians.”</p> <p>“It’s frustrating when the patient and the nurses are ready to focus on palliative care, but the physician is dragging his heels. It’s especially frustrating when the patient is suffering.”</p> <p>“It’s awkward working with three different social workers or physicians on three different days with at least three different ideas on how to manage things.”</p>

constrains the type of supportive treatment, such as palliative care, that is offered. Davidson et al. (2003) reported that, in the absence of a clear palliative care orientation, healthcare professionals feel compelled to continue aggressive treatment. Meier, Morrison, and Cassel (1997) suggested that the

healthcare system must restore balance to its treatment goals such that a peaceful dying process is acknowledged as a legitimate goal of care. Some nurses in the current study suggested that the healthcare system lacks respect for the dying process. The unfortunate result might be the marginalization of dying patients in acute care settings. Viewing dying within the social construct of marginalization requires further research.

When palliative care is initiated only after treatment fails or disease management becomes too time consuming, serious gaps in service can occur (Lo, Snyder, & Sox, 1999). As a result, opportunities to relieve suffering and help patients achieve meaningfulness from life-limiting conditions are neglected. The complexity of care during serious illness requires a dual treatment focus (disease oriented as well as palliative care), and nurses are in a key position to advocate for additional services to help patients cope with the multiple challenges of living with and dying from serious illnesses (Gross, 2006). Emphasizing high-quality and evidence-based palliative care practices, advancing education in palliative care, developing a routine referral system for palliative care services, and operating from a partnership model are significant steps toward improving quality of life for palliative care patients and their families.

Limitations

This study yields only context-specific and nongeneralizable results. Limiting the number of participants and researching only acute care oncology nurses’ perceptions constrain the view of palliative care. Because palliative care is such a complex field of health care, perspectives from other healthcare settings and healthcare team members as well as patient and family perspectives across many cultural, ethnic, gender, and socioeconomic differences are required to enlarge the body of knowledge.

Conclusion

Convergence in perspectives about palliative care goals clearly indicates that research participants are aware of treatment goals for palliative care patients. However, divergent perspectives about the intersections of palliative care with oncology nursing practice may limit timely consultation with specialty palliative care teams. The current acute care context poses several challenges to oncology nurses as they implement palliative care. Partnering with palliative care specialty teams might break through the barriers and allow oncology nurses and palliative care specialists to collaborate in providing high-quality and well-coordinated palliative care across the entire spectrum of patients’ experiences with life-threatening conditions.

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