2023

# Oncology Nurses' Experiences Dealing With and Managing Compassion Fatigue While Caring for Terminally Ill Patients

Stacey-Ann Mary Whyte
*Walden University*

# Walden University

College of Health Sciences and Public Policy

This is to certify that the doctoral dissertation by

Stacey-Ann Mary Whyte

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Compreca Martin, Committee Chairperson, Health Services Faculty
Dr. Cheryl Cullen, Committee Member, Health Services Faculty
Dr. Nicole Dhanraj, University Reviewer, Health Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

# Oncology Nurses' Experiences Dealing With and Managing Compassion Fatigue While Caring for Terminally Ill Patients

by

Stacey-Ann Mary Whyte

MHA, Florida Atlantic University, 2016

BS, Palm Beach State College, 2013

BSN, Florida Atlantic University 2021

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Services

Walden University

May 2023

# Abstract

Compassion fatigue (CF) is a significant cause of nurse burnout (BO). Oncology nurses are particularly susceptible to CF because of the continual contact with terminally ill patients and recurrent experiences with patients' death. A search of existing literature found no published studies that explicitly focused on interviewing oncology nurses to gain their expression of their lived experiences with CF while caring for terminally ill patients. This phenomenological qualitative study explored oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. Figley's compassion fatigue theory grounded this study. The research questions focused on the lived experiences of providing care to terminally ill patients and the impact CF has on the quality of care the oncology nurses deliver. 10 English-speaking RNs who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida, were interviewed. Data were inductively coded and categorized into themes. 5 themes emerged: (a) emotionally and physically exhausted; (b) patients' young age; (c) patients' death; (d) impact on care; and (e) personal time. Recommendations for future research are conducting phenomenological qualitative studies with oncology nurses from other parts of Florida or other states and oncology nurses with 1-3 years of experience. Implications for positive social change include teaching CF management skills as a means of burnout prevention and creating interventions that help oncology nurses combat the effects of CF.

# Oncology Nurses’ Experiences Dealing With and Managing Compassion Fatigue While Caring for Terminally Ill Patients

by

Stacey-Ann Mary Whyte

MHA, Florida Atlantic University, 2016

BS, Palm Beach State College, 2013

BSN, Florida Atlantic University 2021

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Services

Walden University
May 2023

# Acknowledgements

I want to thank God for keeping me focused and at peace throughout this PhD journey. Thank God for always providing for me spiritually and financially to complete this PhD.

To my husband, Clive, thank you for being patient and supportive as your wife was “still in school.”

To my brother Wade, thank you for inspiring me in many ways and being my biggest motivation for completing this PhD.

To Dr. Compreca Martin, my dissertation chair, thank you for being kind and patient. You were always calm and always be grateful to you.

To Cheryl Cullen, my committee member, who expressed much excitement at my topic even when I was unsure it was good enough for a dissertation. Thank you for encouraging me to finish.

To Dr. Nicole Dhanraj, my URR, who helped me align my proposal so it would make sense and for doing it in such a kind manner. Thank you.

And finally, to Jennifer, Lilian, and Walaa, who I met in 2018 at Residency 1 in Atlanta, Georgia. We instantly connected and formed a support group named “future PhD holders” thank you ladies; I am so happy we met. We did it!

## Table of Contents

# List of Tables

# List of Figures

# Chapter 1: Introduction to the Study

Compassion fatigue (CF) is the emotional, physical, and mental fatigue that comes from encounters with compassion stress (Al-Majid et al., 2018). CF involves an obsession with patients' physical and emotional sufferings (Wentzel et al., 2019). Figley (1995) used the more user-friendly expression CF to soften the term "secondary traumatic stress disorder" and correlated it with CF among clinical healthcare practitioners who usually are first to witness patients' pain, distress, and suffering. Figley also described the nine components of the CF process, as follows: (a) exposure to suffering, (b) concern, (c) empathetic ability, (d) empathetic response, (e) compassion stress, (f) prolonged exposure, (g) traumatic memories, (h) demands of life, (i) compassion fatigue. These nine components demonstrate how caregivers' concern and empathy for their patients emotionally expose them to the adverse side effects of witnessing their patients' prolonged suffering resulting in the caregivers experiencing CF.

This phenomenological study explored oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. Nurses with CF may experience emotional, physical, and mental exhaustion leading to a decreased ability to provide compassionate care (Al-Majid et al., 2018). Oncology nurses report an elevated risk of CF after 3 years of working with terminally ill patients (Cross, 2019; Kohli & Padmakumari, 2020). Oncology nurses are exposed to terminally ill patients and must express empathy when caring for these patients. Empathizing with these terminally ill patients while providing care can become challenging, causing nurses to experience CF. Wentzel et al. (2019) further stated that prolonged and continual contact with frequent deaths, grief, and hopelessness experienced by patients places oncology nurses at a higher risk of developing CF. Figley's (1995) compassion fatigue theory was used to ground this study. At the heart of the theory are the concepts of empathy for patients' sufferings and exposure to patients' sufferings.

Burnout (BO) is a consistent problem across the oncology nursing sector. Two contributing factors of BO are staff shortages and increased workloads. These factors, coupled with the stressors of caring for terminally ill patients, can cause CF (Nwanya & Rowberry, 2021). CF can cause nurses to change units, leave their profession, and negatively affect staff satisfaction and the quality of patient care (Arimon-Pagès et al., 2019). Wells-English et al. (2019) found that both BO and CF significantly predicted turnover intention.

This chapter consists of the background and problem statement with a description of the gap in the literature. The study's purpose, significance, and nature; the research questions; and the conceptual framework for the study follow. The chapter also contains the operational definitions used throughout the study and states the assumptions, scope, delimitations, and study limitations.

## Background of the Problem

This study explored oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. In this study, I sought to understand how CF in nurses contributes to the nursing shortage in the healthcare industry. The healthcare sector is experiencing a shortage of qualified nurses to care for the population. Colosi (2019) reported the Bureau of Labor Statistics (BLS) projected by 2024, the registered nurse (RN) labor shortage could reach 1.13 million RNs. Rising turnovers and retirement make the nursing shortage a challenge in most markets. The nurse turnover rate is 17.2% compared to 19.1% of all hospital staff combined (Colosi, 2019). The high risk of CF affects nurses' performance and job satisfaction, resulting in high turnover rates for many healthcare facilities.

## Problem Statement

Oncology nurses may experience CF from caring for terminally ill patients and interacting with patients' families. Lack of support, work schedule, high patient acuity, and staffing insufficiencies further heighten CF's effects on oncology nurses (Reiser & Gonzalez, 2020). The CF oncology nurses experience may result in them leaving the oncology nursing profession (Al-Majid et al., 2018), further increasing the shortage of nurses the healthcare industry is experiencing. Patient safety and outcomes could be negatively impacted by the emotional, physical, and mental exhaustion and disengagement caused by CF (Al-Majid et al., 2018). Adverse patient outcomes could result in low Health Grades score for healthcare facilities.

Future studies must explore the personal and environmental oncology nursing variables (Jarrad & Hammad, 2020) that contribute to CF in oncology nurses. There need to be interviews with the oncology nurses to hear their expression of the CF they experience when caring for terminally ill patients. Jarrad and Hammad (2020) recommended a qualitative inquiry to explore the oncology nurses' lived experiences of the CF phenomena. The conversation should also include what effect CF has on quality patient care and the types of interventions the oncology nurses use to cope with the CF they experience.

## Purpose of the Study

This phenomenological qualitative study explored oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. The target population was 10 English-speaking RNs who worked or are working with terminally ill patients in an oncology unit for three years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida. The implications of this study for positive social change include informing nursing schools of the value of teaching CF management skills as a preventative method in the curricula. Additionally, this study may inform healthcare nursing leaders to include more intervention activities, such as individual counseling sessions with a therapist. These interventions could help oncology nurses manage their CF and help reduce the high turnover rate associated with the oncology nursing profession.

## Research Questions

The research questions for this study were the following:

- RQ1: What are the oncology nurses' experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients?
- RQ2: How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurses' ability to deliver quality patient care?

- RQ3: What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients?

## Conceptual Framework

Figley’s (1995) compassion fatigue theory was used to ground this study. At the heart of the theory are the concepts of exposure to patients’ sufferings and empathy for patients’ sufferings. Figley described CF as stress from exposure to traumatized individuals rather than from exposure to the trauma. Figley further described CF as a state of biological, psychological, and social exhaustion and dysfunction from prolonged exposure to compassion stress. Figley reported that nurses favored the term “compassion fatigue” when discussing the compassion stress they experience. Feeling CF in the line of duty as a nurse better described the causes and manifestations of their duty-related experiences.

Katz (2019), who also studied CF, mentioned that it is the result of prolonged exposure to the sufferings of others. Watching patients endure pain and discomfort stimulates an empathetic response from the nurses. Nurses who work with terminally ill patients absorb the suffering of their patients while providing care. Having a preoccupation with the sufferings of their patients could inevitably lead to CF. Chapter 2 details Figley’s (1995) compassion fatigue theory and the nine components of the compassion fatigue process.

## Nature of the Study

A phenomenological qualitative inquiry aligned with the research purpose to explore oncology nurses’ experiences dealing with and managing CF when caring for terminally ill patients. The aim was to explore the CF oncology nurses’ experience when caring for terminally ill patients and how it impacts quality patient care. The objective was to understand how oncology nurses deal with and manage the CF they experience when caring for terminally ill patients. The study includes interviews of 10 English-speaking RNs who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida.

I recruited through my own professional network, the Oncology Nursing Society (ONS). I emailed my contact person at ONS asking her to post the study invitation. I also called the oncology nursing departments in Miami-Dade, Broward, and Palm Beach County and asked to speak with the directors to see if they were interested in participating in the study to achieve a sample size of 10 participants. During interviews, I collected nursing demographics (e.g., age, gender, education, and nursing experience in oncology) and work practice settings. Field notes from the participants determined saturation.

## Operational Definitions

The operational definitions used in this study are as follows:

- *Burnout*: The state of emotional, mental, and physical exhaustion which results in increased distance mentally and low satisfaction in work responsibilities (Nwanya & Rowberry, 2021).
- *Compassion fatigue*: A state of biological, psychological, and social exhaustion and dysfunction from prolonged exposure to those suffering and all it invokes (Figley, 1995).
- *Coping strategies*: How individuals manage their actions and thoughts and action to meet specific demands (Varadarajan & Rani, 2021).
- *Intervention*: To interfere with the outcome of a condition or process (to prevent harm or improve function) (Merriam-Webster, n.d.).
- *Oncology nurses*: Registered professional nurses who are employed or worked in an oncology unit (Wentzel et al., 2019).
- *Prevention*: The act of preventing or hindering (Merriam-Webster, n.d.).
- *Secondary traumatic stress disorder*: Stress of helping a traumatized or suffering individual (Wells-English et al., 2019).

## Assumptions

There were three primary assumptions for this study:

- The participants would answer the interview questions truthfully and provide rich information.
- My affinity towards nurses and inexperience as an interviewer would not affect the delivery of the interview questions or cause the interviewees to give answers I wanted to hear.

- I would have access oncology nurses to conduct the interviews necessary to complete the study.

These assumptions served as the study's basis. The oncology nurses' lived experiences were the basis for this study's phenomenological approach. I assumed the oncology nurses had experienced CF and were willing to talk about their experiences with CF while caring for terminally ill patients. I also assumed the oncology nurses would answer truthfully about how CF affects the quality of patient care they provide. CF is important to the study as Figley (1995) described CF as the fatigue that comes from encounters with compassion stress. I also assumed the ONS would agree to post my flyer, and that the oncology nurse directors would participate in this study.

## Scope and Delimitations

The study's scope comprised of the experiences of oncology nurses. The study included oncology nurses' experiences involved in the everyday care of terminally ill patients and the CF that comes from providing care. For this study, delimitations included interviews with 10 English-speaking oncology nurses who have cared for terminally ill patients in an oncology unit at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida.

## Limitations

The limitations that could have hindered this study included not having the anticipated access to the 10 English-speaking oncology nurses with experiences caring for terminally ill patients for the interview portion of the study. The time constraints due to the researcher's work and oncology nurses' schedules could have slowed the study's progress. The interviews occurred outside the work environment, which required working around the nurses' schedules to find dates and times that would work for them. Also, the nature of the study entailed interviewing the oncology nurses, which could have evoked unpleasant memories or emotions they experienced while caring for their terminally ill patients. The oncology nurses could also have experienced non-work-related stressors in their personal lives, such as relationships or financial issues, that could have caused me to assume it was related to CF. The research findings were shared with participants to address these limitations.

## Significance of the Study

There is a shortage of qualified nurses primarily due to premature retirement, and CF could be a contributing factor. Understanding how CF affects nurses may assist healthcare organization leaders in developing and implementing programs to help nurses manage their CF. Moreover, nurses who can balance their work and quality of life provide better patient care (Holland et al., 2019). Improving nurses' working conditions may help reduce the high turnover rate associated with their profession. Taylor-Clark et al. (2022) reported a balanced, healthy, and supportive psychosocial work environment could prevent CF and increase patient satisfaction.

Healthcare facilities ensure the delivery of quality patient care by having safe staffing influenced by the workload and acuity of the patients (Juvé et al., 2020). Administrators of healthcare facilities must be conscious that the nursing department is the largest and, arguably, the essential department in a hospital. Therefore, it is incumbent upon administrators and nurse leaders to cultivate a conducive work environment for nurses providing quality care to patients, as having an insufficient number of nurses will negatively affect patient outcomes (Moisoglou et al., 2020). Healthcare leaders must understand how crucial it is to support and retain their nurses to help them love what they do without becoming emotionally bankrupt by the effects of CF.

## Summary

Oncology nurses must provide care while practicing compassion, the act of being sensitive to the sufferings and pain of others (Ortega-Galán et al., 2021). The study focused on oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. The aim was that the results of this study would be published in peer-reviewed journals to add to the body of literature on CF in oncology nurses.

In this chapter, I introduced the lived experience of oncology nurses with CF. I provided the background and problem statement with a description of the existing gap in the literature. I described the study's purpose statement and the three primary research questions. I then explained the conceptual framework and the nature of the study. Key terms were defined, and the study's assumptions, scope, delimitations, and limitations were discussed. The chapter concluded with the significance of the study. The literature review strategies used to describe the conceptual framework and literature review are presented in Chapter 2.

# Chapter 2: Literature Review

Compassion fatigue (CF) is a significant cause of nurses' burnout (BO). Figley (1995) stated that CF involves an obsession with patients' physical and emotional sufferings, which results in compassion stress. Prolonged and continual contact with frequent deaths, grief, and hopelessness experienced by patients places oncology nurses at a higher risk of developing CF (Wentzel et al., 2019). The emotional exhaustion caused by CF could lead nurses to engage in detachment behavior as a coping strategy. Al-Majid et al. (2018) also reported that the emotional, physical, and mental exhaustion and disengagement caused by CF could negatively impact patient safety and outcomes.

The literature review in this chapter included information on the effects of BO and CF on oncology nurses and the coping strategies oncology nurses used to combat the effects of BO and CF. This chapter reviewed the literature on existing resources for interventions and prevention for BO and CF in oncology nurses. The databases, key search terms, and search engines used in the literature search strategy were also the focus of this chapter. The chapter also included detailed information about the study's conceptual foundation and the scope of the literature review, an exhaustive review of the literature related to key variables and concepts, and a summary and conclusions. Oncology nurses may experience CF from caring for terminally ill patients and interacting with patients' families. Lack of support, work schedule, high patient acuity, and staffing insufficiencies further heighten CF's effects on oncology nurses (Reiser & Gonzalez, 2020). The CF oncology nurses experience may result in a decision to leave the oncology nursing profession (Al-Majid et al., 2018). Al-Majid et al. (2018) further stated that patient safety and outcomes could be negatively impacted by the emotional, physical, and mental exhaustion and disengagement caused by CF.

## Literature Search Strategy

This literature review consisted of searching multiple nursing, nursing science, and nursing education databases. Databases searched included ProQuest Nursing, Ovid Nursing Journals, EBSCO, MEDLINE, CINAHL, and Google Scholar. Keywords used included: *compassion fatigue*, *oncology nurses, burnout, coping strategies*, *intervention*, and *prevention*. The keywords were used independently and in combination. The most common combinations of search terms were *compassion fatigue and oncology nurses*; *oncology nurses and burnout*; *compassion fatigue, oncology nurse, and coping strategies, coping strategies or coping skills*; *compassion fatigue, oncology nurse, and intervention*; and *compassion fatigue and prevention*. The search included 2018 through 2022. The purpose of searching between 2018 and 2022 was to locate pertinent work related to the selected theory. The results yielded 591 articles that required filtering to focus on the key concepts.

## Oncology Nurses

This study explored the CF oncology nurses' experience when caring for terminally ill patients and how it impacts quality patient care. The objective was to understand how oncology nurses deal with and manage the CF they experience when caring for terminally ill patients. Before exploring the CF oncology nurses' experience when caring for terminally ill patients, it was essential to describe what oncology is and what is an oncology nurse, and the oncology nurse's role on the oncology team. A search of the literature provided insight into the world of oncology, a description of oncology nurses, and the oncology nurse's role on the oncology team.

*Oncology* refers to cancer diagnosis, treatment, and prevention (National Cancer Institute, n.d.). *Oncology nurses* are registered professional nurses employed or who worked in an oncology unit (Wentzel et al., 2019). Oncology nurses are essential to the cancer care team to provide expertise and support to individuals diagnosed with cancer (Challinor et al., 2020). Oncology nurses reduce the burden of cancer by helping to improve how patients manage their cancer symptoms and the side effects by coordinating care requirements (Young et al., 2020). Lubejko and Wilson (2019) described oncology nurses as coordinators of care delivery who provide safe delivery of cancer treatments and optimize patients’ quality of life by assessing the patients for therapy complications.

Oncology nurses’ primary function is to treat people with cancer daily (Algamdi, 2022; Arimon-Pagès et al., 2019). They often have to support the patient’s caregivers and family members. Oncology nurses provide education to their patients and healthcare professionals on cancer treatments. Oncology nurses are leaders in providing quality cancer care with new radiation, medical, and surgical options that have transformed the cancer care landscape (Lubejko & Wilson, 2019). Oncology nursing is a rewarding and worthwhile profession, but repeated exposure to stressful incidents could affect oncology nurses’ psychological well-being (Wentzel et al., 2019). Nwanya and Rowberry (2021) reported CF affects oncology nurses more than nurses in other specialties because of the emotional burden of oncology nursing.

The current state of healthcare, coupled with political and institutional constraints, such as increased workloads, lack of management support, staffing shortages, and limited resources, makes it harder for oncology nurses to continuously provide compassionate care (Challinor et al., 2020; Gribben & Semple, 2021). Providing care for terminally ill patients with multiple chronic health problems could increase oncology nurses' levels of CF (Arimon-Pagès et al., 2019; Boyle & Bush, 2018; Zhang et al., 2022). The pressure to provide their dying clients quality care and the constant exposure to human suffering makes oncology nurses prime candidates for developing CF (Ortega-Campos et al., 2019; Salmond et al., 2019; Zhang et al., 2022).

## Conceptual Foundation

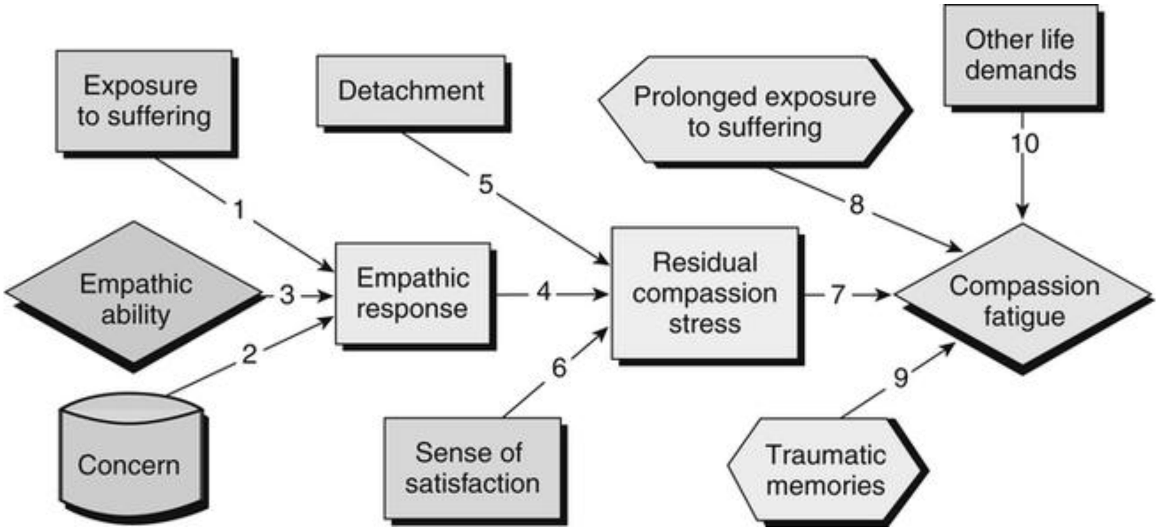
Oncology nurses are particularly susceptible to CF because of the continual contact with terminally ill patients and recurrent experiences with patients' deaths (Wentzel et al., 2019). CF is a state of emotional, physical, and mental exhaustion caused by a person's depleted ability to cope with their everyday environment (Algamdi, 2022). CF is one of oncology nurses' most commonly reported work-related consequences (Xie et al., 2021). BO and secondary traumatic stress are the two components of CF. Gustafsson and Hemberg (2022) reported that CF arises from an innate response to relieve patients' pain and suffering, resulting in long-term consequences that are not easily reversible.

In Figley's (1995) conceptual model, the four determinants of CF are the ability to empathize, the caregiver's response to the patient, difficulty detaching oneself from work, and satisfaction from providing care. The CF model is based on the caregiver's responses to stress, whether they are adaptive or maladaptive. Figley differentiated CF from BO by linking CF with secondary traumatic stress to describe the psychological, physiological, and social symptoms resulting from responding empathetically to the suffering experienced by others. The stress caused by CF manifests as sadness, a lack of enthusiasm, exhaustion, and irritability.

Figure 1, illustrating Figley's (1995) compassion fatigue process, demonstrated the formation process of how nurses providing prolonged care could experience CF. The nine components of the CF process explained how caregivers' concern and empathy for their patients emotionally expose them to the adverse side effects of witnessing their patients' prolonged suffering resulting in the caregivers experiencing CF. Pehlivan and Güner (2018) described CF as a gradual process that progresses from empathy to compassion stress and CF. The oncology nurse's concern and empathic ability to respond to patients' sufferings initiate the CF process. The oncology nurse's empathetic response to patients' suffering, coupled with an absence of satisfaction and an inability to detach from the patients' suffering, causes the nurse to develop CF.

**Figure 1**

*The Compassion Fatigue Process (Figley, 1995)*



The nine components of Figley's (1995) compassion fatigue process are as follows:

1. Exposure to suffering involves the nurses consistently providing care for terminally ill patients during 12-hour shifts several days each week. Nurses serve as the primary care provider for their terminally ill patients and have to be present in the patient's environment and witness first-hand the patients' suffering.
2. Concern involves the nurses' motivation to respond to their patient's pain and suffering.
3. Empathetic Ability refers to the nurses' skill for recognizing the pain and suffering of their patients.

4. Empathetic Response is the nurses’ concern for their patient’s pain and suffering, which stimulates nurses to try to reduce the suffering of their patients.
5. Compassion Stress arises from the nurses’ compulsion to relieve the suffering of their patients.
6. Prolonged Exposure results from the nurses’ persistent sense of responsibility for their patient care even after their shift has ended.
7. Traumatic Memories refer to memories of traumatic events such as witnessing a patient dying while receiving care.
8. Demands of Life involves the nurses trying to balance or manage their responsibilities and unexpected changes in their routine while working in a demanding and stressful environment.
9. Compassion Fatigue ultimately results from biological, psychological and social exhaustion and dysfunction from prolonged exposure to caring for terminally ill patients.

## Literature Review Related to Key Concepts

The literature review first focused on oncology nurses’ experiences with BO and CF when providing daily care to their terminally ill patients. Second, the literature review revealed the studies on oncology nurses’ coping strategies to combat the effects of BO and CF. Third, the literature review documented the interventions and preventions against BO and CF that could help oncology nurses. I concluded the literature review by discussing the gap in the literature that I explored in the present study.

## Burnout and Compassion Fatigue

BO and CF have similar symptoms; however, BO has a gradual onset, whereas CF could manifest suddenly (Pehlivan & Güner, 2018). BO and CF have professional and personal consequences, which could cause patient safety issues (Al-Majid et al., 2018; Wells-English et al., 2019). Oncology nurses' BO is associated with job stressors, intense workloads, staffing shortages, long work hours, time pressures, and conflicts with other healthcare professionals (Jarrad & Hammad, 2020; Nwanya & Rowberry, 2021; Reiser & Gonzalez, 2020). BO produces low personal job satisfaction, hopelessness, and difficulties functioning in the work environment or effectively performing your job responsibilities (Al-Majid et al., 2018; Nwanya & Rowberry, 2021; Reiser & Gonzalez, 2020). The effects of BO on oncology nurses could be a problem for healthcare providers who want to improve patient care.

Conversely, CF among oncology nurses emanates from the compassion stress they experience when caring for terminally ill patients and their families (Al-Majid et al., 2018; Wells-English et al., 2019; Wentzel et al., 2019). Experiences with patients' death could often leave nurses with overwhelming grief and loss, resulting in CF (Al-Majid et al., 2018; Arimon-Pagès et al., 2019; Jarrad & Hammad, 2020). Oncology nurses who repeatedly experience CF from the grief and loss of patients' death may use the negative coping strategy of detachment to cope with their patients' death. Over time, using detachment to cope with CF from the grief and loss of patients' death could cause oncology nurses to become less compassionate in their care, resulting in poor quality of nursing care (Wentzel et al., 2019; Xie et al., 2021). Poor quality nursing care could reflect negatively on a healthcare organization. Nurse-rated quality of care is an essential indicator of patients' perception of the overall quality of care they receive from a healthcare organization.

## Coping Strategies

Stress results when stressors exceed an individual's resources and ability to cope (Crane et al., 2019; Lorente et al., 2021; Maajida Aafreen et al., 2018; Zhang et al., 2022). The CF oncology nurses experience arises from their stressful working environment (Arimon-Pagès et al., 2019; Jarrad & Hammad, 2020). Work stress could affect oncology nurses' mental health and adversely affect the quality of care their patients receive. Adverse consequences of oncology nurses' experiencing work-related stress include medication errors, documentation errors, and increased hospital-acquired infections (Mazzella Ebstein et al., 2019; Molavynejad et al., 2019; Partlak Günüşen et al., 2019). Work stress is associated with low morale, high rates of absenteeism, higher job turnover, reduced work performance, decreased job satisfaction, and reduced quality of nursing care for patients (Boamah et al., 2022; Janatolmakan & Khatony, 2022; Rajamohan et al., 2019; Salehi et al., 2020). Work-related stressors specific to oncology nurses could arise from administering aggressive cancer treatments, dealing with the deaths of patients, interactions with demanding patients and families, and workload (Grech et al., 2018; Soheili et al., 2021; Wazqar, 2019). How CF-related work stressors affect oncology nurses could depend on their coping strategies.

Oncology nurses employ coping strategies to deal with the emotional consequences of CF. In this study, I explored oncology nurses' specific interventions to cope with the effects of the CF they experience while caring for terminally ill patients. Positive coping styles such as meditation and listening to music could reduce BO and help the oncology nurses repel CF (Ryan et al., 2022; Zhang et al., 2022). Negative coping strategies, which included consuming alcohol or drugs and efforts to detach from the situation, resulted in avoidance tendencies and emotional denial that led to depersonalization from thoughts, feelings, and behaviors (Geuens et al., 2020; Varadarajan & Rani, 2021; Voitenko et al., 2021; Zhang et al., 2022). Furthermore, negative coping strategies required avoiding an empathetic commitment and suppressing emotions (Arimon-Pagès et al., 2019; Varadarajan & Rani, 2021). Negative coping strategies should not be associated with a profession where empathetic commitment is essential for patient care.

Positive and negative coping strategies allow nurses to project a facade of strength to maintain control of their situation and carry out their nursing duties. Using an avoiding strategy could require the nurse to oscillate between avoiding and experiencing emotions so they could find meaning and transcend loss (Phillips & Volker, 2020). Oncology nurses use detachment as another coping strategy to protect their emotional health (Wentzel et al., 2019). With detachment, the oncology nurse created an emotional separation from CF's effects by erecting a protective curtain to cope with the anxiety and stress produced by the work environment. By adopting a coping strategy, the nurse had an emotional separation from the patient's suffering and the nurse's duty to care (Wentzel et al., 2019). Arimon-Pagès et al. (2019) noted a need for formal training and support mechanisms to improve coping strategies.

## Intervention and Prevention

There is a correlation between BO and CF in oncology nurses, and the correlation mandated customized staff-oriented interventions by oncology nursing policymakers to protect oncology nurses (Jarrad & Hammad, 2020). Furthermore, oncology nurses could benefit from interventions such as staff psychiatric and professional counseling, positive coping strategies training, and relaxation techniques such as yoga (Jarrad & Hammad, 2020). Hospital administrators should develop interventions to train oncology nurses in emotional management, psychological stress relief, and social support (Xie et al., 2021). Wells-English et al. (2019) also noted debriefing interventions fostered group healing and resilience after poor patient outcomes.

Early interventions that included self-care behavior methods such as sufficient hours of rest and sleep, exercise, and a nutritious diet could help prevent the risk of CF (Kohli & Padmakumari, 2020). The concept of self-care has increased in popularity among healthcare professionals, and oncology nurses should participate in self-care activities such as meditation or simply walking outside (Kohli & Padmakumari, 2020). All oncology nurses should be offered workshops on CF and training programs with counseling sessions as prevention methods (Kohli & Padmakumari, 2020). Algamdi (2022) reported proper assessment and implementation of prevention plans could offset the rise in cases of CF among oncology nurses.

## Summary and Conclusions

Across the nursing profession, nurses frequently use CF to explain the manifestation of the compassion stress and fatigue of their duty-related experiences when demonstrating compassion in the duty line. Oncology nurses are at a higher risk of experiencing CF because of the continual contact with terminally ill patients and recurrent experiences with patients’ deaths (Wentzel et al., 2019). The majority of the existing literature highlighted the uptick of CF in the oncology nursing profession. Recent studies focused on the prevalence, causes, coping strategies, and intervention and prevention programs. Few studies involved directly interviewing oncology nurses to explore their experiences with CF while providing care to terminally ill patients and gain their perspectives on their coping strategies.

In Chapter 2, the literature review revealed a gap in interviewing oncology nurses to explore their experiences dealing with and managing CF when caring for terminally ill patients. The study explored oncology nurses’ experiences dealing with and managing CF when caring for terminally ill patients using a phenomenological qualitative inquiry. I found one study that conducted interviews but utilized a mixed-methods approach to develop interventions for managing CF. Another study used interviews to explore the emotional evolution of being an oncology nurse. The study of oncology nurses’ experiences dealing with and managing CF when caring for terminally ill patients was significant for adding to the existing knowledge by revealing previously unexpressed emotions and responses of oncology nurses.

Chapter 3 includes the research plan and design, the participants’ selection process, interview process, interview questions, data collection, data analysis plan, and further explanations of the research methods used for the study. The gap in the knowledge regarding the existence of interviews with oncology nurses to explore their experiences dealing with and managing CF when caring for terminally ill patients was evident in the literature. The chosen research design aligned with similar studies that examined oncology nurses’ stressors from their line of duty.

# Chapter 3: Research Method

This phenomenological qualitative study aimed to add to the existing literature on phenomenological studies regarding the lived experiences of oncology nurses and the CF they experience when providing patient care to terminally ill patients. In this chapter, I discussed the research design and rationale; my role as the researcher; the instrumentation, recruitment, participation, data collection and analysis plan; and issues of trustworthiness and ethical procedures.

## Research Design and Rationale

A phenomenological qualitative inquiry aligned with the problem statement and purpose and directed a study of oncology nurses' experiences dealing with and managing CF while caring for terminally ill patients. The following research questions were central to this study:

- RQ1: What are the oncology nurse's experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients?
- RQ2: How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse's ability to deliver quality patient care?
- RQ3: What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients?

The interview questions, guided by the phenomenological qualitative approach, resulted in words or phrases the oncology nurses used to express their experiences with CF.

Using the phenomenological method, I explored what CF meant to nurses who experienced daily emotional, physical, and mental exhaustion while caring for terminally ill patients. The phenomenological approach expressed the researcher's interest in individuals' lived experiences of a phenomenon (Sundler et al., 2019). This approach aligned with my research purpose: to understand oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients.

## Role of the Researcher

My role as the researcher was to collect data by engaging the participants by asking open-ended questions that produced words and phrases to answer the research questions. Engagement was critical to have an excellent qualitative interview (Dennis, 2018). The data collection process involved direct contact with the participants as they shared their personal experiences with CF. I identified and addressed any potential personal biases to avoid ethical dilemmas during this process. Personal biases that could have influenced the analysis and affected the study results included my love and admiration for nurses, how unbalanced I believed the nurse-to-patient ratio is, and my perception of the lack of supportive counseling or mental health counseling for nurses.

I worked as a healthcare quality coordinator in charge of proving educational activities for nursing staff based on new policies and procedures, the needs of the team, and other quality improvement requirements to improve patient care. I recognize the intent of hospital administrators to reduce medical errors and improve patient care. I have not seen measures to assess nurses’ level of BO or their mental health assessment after an adverse event. I have friends who have been nurses for years who have expressed the lack of resources to help with the effects of CF.

I avoided ethical issues by excluding my friends from the research participants. I did not share with participants any information about my work as a quality management coordinator. I informed the study participants that a master’s prepared healthcare administrator was conducting the research and was in the doctoral dissertation process. My rationale for not sharing my quality management experience was to avoid inducing participants’ reluctance to share information regarding how CF affected the quality of patient care they provide.

A second ethical issue that was considered was the participants re-visiting the emotional, physical, and mental exhaustion they experienced when caring for terminally ill patients. I received approval from the Walden University Institutional Review Board (IRB) to ensure the ethical treatment of all participants before conducting the interviews. I informed the participants I would be recording the interviews on my cell phone with an application called NoNotes. I also informed the participants they could end the interview at any time without fear of negatively affecting the study.

## Methodology

The various qualitative approaches aim to observe, describe, and understand the nature of human experiences. Choosing an appropriate research design could mitigate threats to both internal and external validity (Siedlecki, 2020). Regardless of the method selected, qualitative researchers rely primarily on words and images to describe the phenomenon or event from the participants' perspective (Cypress, 2018). The qualitative study allows researchers to describe everyday social behaviors (Mohajan, 2018) in ways that upset the positivist paradigm that suggests it is possible to apply static universal beliefs and laws to all social phenomena and life events (Cuthbertson et al., 2020).

I used a phenomenological qualitative inquiry to explore oncology nurses' lived experiences while caring for terminally ill patients. The phenomenological approach enabled me to explore the phenomenon's effect on the nurses' daily lives. I collected and analyzed the oncology nurses' perceptions of a specific, definable phenomenon or the human factors involved in their experiences. I sought to answer the research question of how nurses perceive a phenomenon by placing it within a context (Larkin et al., 2019).

## Participant Selection Process

The participants for this study were 10 English-speaking RNs who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida. The hospitals had no direct involvement with nor received any immediate benefits from the study. The reason for seeking nurses with 3 years or more experience working with terminally ill patients in an oncology unit was that oncology nurses reported an elevated risk of CF after 3 years of working with terminally ill patients (Cross, 2019; Kohli & Padmakumari, 2020). Also, participants with 3 years or more experience working in an oncology unit could provide quality information based on their experiences in oncology. The nurses each possessed expertise in caring for terminally ill patients, hence the small number of participants needed for the study (Hennink et al., 2019). Exclusion criteria included nurses who have never worked in an oncology unit with terminally ill patients and nurses who had fewer than 3 years of experience working with terminally ill patients in oncology. Participants were not limited based on age.

I used purposive sampling to choose the participants for the study. I emailed my contact person at ONS and asked her to post the study invitation. I also called the oncology nursing departments in Miami-Dade, Broward, and Palm Beach County. I asked to speak with the directors to see if they were interested in participating in the study to achieve a sample size of 10 participants. I used an interview guide to collect information about nursing demographics (e.g., age, gender, education, and oncology nursing experience) and work practice settings. Of all the potential participants, only 10 participated in the telephone interviews. I conducted the participants' semi-structured interviews until I achieved thematic saturation. The interviews were conducted outside the work environment, as the organizations were not directly involved in this study.

## Informed Consent and Confidentiality

Walden University has appropriate measures to perform ethical and accurate research and protect research subjects. The participants received informed consent forms before the interviews began. I also used pseudonyms to identify participants. I took precautions not to disclose any data linkable to a participant's identity. Participants' names, addresses, and telephone numbers were de-identified after the interview to minimize the risk of inappropriate disclosure of personal information. The collected data will be stored for 5 years on a portable backup drive in a locked cabinet after the completion of the research. After 5 years, I will have the data destroyed permanently. No payments, compensation, reimbursement, free services, or other gifts will be given to the participants, as their participation is entirely voluntary.

## Instrumentation

The study's instrument included semi-structured interviews in which the participants were asked questions designed to elicit information I could use to answer the following research questions:

1. What are the oncology nurse's experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients?
2. How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse's ability to deliver quality patient care?
3. What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients?

I had to have a conversation with the participants to document their experiences with CF while caring for terminally ill patients, I had conversations with nurses who have had actual experiences with the phenomenon I was exploring. I used my cell phone to conduct the interviews with the study participants. The interviews were recorded on my cell phone with an application called NoNotes, which also provided a verbatim written transcript of the interviews with the participants.

I used a semi-structured interview format so that I had a basic framework of questions to guide the interview. I also asked follow-up questions as needed which encouraged the participants to elaborate on a response during the interview. I asked open-ended questions so the participants could provide their most genuine responses. The primary research questions guided the interview questions without directly asking the primary research question. The interview questions explored how the nurses expressed compassion to their terminally ill patients and if expressing empathy came naturally to them. I developed these interview questions specifically for this study.

Nurses' compassion, competence, confidence, conscience, commitment, and comportment come under scrutiny during stressful times. Asking the nurses what "compassion fatigue" meant to them elicited the answer of empathy and concern for patients' suffering. Compassion and empathy are values that often attract people to nursing (Traynor, 2022). It may help to understand why they experience CF because they extend compassion daily. Oncology nurses usually possess higher levels of skill and knowledge to operate advanced equipment and run tests, but technology can only meet the physical and physiological needs of the patient. The hands-on approach is still needed, however, as there is no substitute for the humanistic aspect of caring for meeting emotional and spiritual needs (Vaeza et al., 2020). Asking questions that allowed the nurses to explain how they expressed compassion to terminally ill patients gave me a view of the human aspect of care.

## Pilot Study

I conducted a pilot study to test the research instrument for data collection before conducting the main study. The pilot study's purpose was to ensure clarity in the interview guide's questions so the participants could comprehend and respond accordingly. I also wanted to ensure each interview would not exceed the 1 hour I was approximating. IRB approval for this study was obtained from the IRB at Walden University (Approval No. 11-15-22-0674230) to ensure I followed all ethical procedures. I recruited three nursing colleagues who met the pilot study's inclusion criteria. I used telephone calls and emails to recruit the three participants and emailed them the informed consent form. I also asked for the three participants' permission to record the interviews. The same format was followed as for the main study by conducting semi-structured audio interviews. The three participants were informed that I would record the interviews on my cell phone with an application called NoNotes. The three participants were also informed that they had the right to end the interview without fearing they would negatively affect the study.

## Procedure for Recruitment, Participation, and Data Collection

The study's participants were recruited through my own professional network the ONS. I emailed my contact person at ONS and asked her to post the study invitation. I also called the oncology nursing departments in Miami-Dade, Broward, and Palm Beach County. I asked to speak with the directors to see if they were interested in participating in the study to achieve a sample size of 10 participants. I also asked the oncology nurses who responded to my request to refer other participants to the study. When I received the oncology nurses' response agreeing to participate in the study, I emailed the consent forms to the participant and arranged an interview date and time. I informed the participants the interviews would last for an hour, but that the time might vary slightly, depending on how detailed their answers were and if there were any follow-up questions. I informed the participant that I would be recording the interviews. I also let the participants know they could stop the interview at any time for any reason they see fit.

I conducted 10 semi-structured interviews with oncology nurses to gain their perspectives on the CF they experience when caring for terminally ill patients. I thanked the participants for their time and positive contribution to my research at the end of the interview. I informed them that they would receive a transcribed copy of the interview so they could correct any errors made in what they said during the transcription process. I also reminded the participants that their answers were confidential and that the final published study would not reveal their identities. I also informed them how to get a copy of the final published study.

## Data Analysis Plan

I conducted the first semi-structured audio interview with one oncology nurse. I analyzed the content of the interview to determine the validity and reliability of the data collection instrument. I reviewed the participant's answer to each question to determine if the arrangement of the questions allowed for a complete interview that explored the participant's lived experiences. I assessed for strategic follow-up questions I could ask to elicit more information. I also analyzed the interview duration to ensure that I did not exceed the 1 hour I stated on the consent form and was able to ask all the questions I intended to ask to answer my research questions.

After I conducted all the interviews, I used a spreadsheet to document the words and phrases to form codes. Codes define the interviewees' expression of their experiences (Lindgren et al., 2020). I also used a systemic order or category to sort the codes that were similar in context, and themes resulted from analyzing the codes and categorization (Lindgren et al., 2020). The codes from the interviews defined the interviewees' personal experiences with CF from caring for terminally ill patients. I had originally planned to use NVivo qualitative data analysis software, but the spreadsheet was sufficient to complete the data analysis.

## Issues of Trustworthiness

The extent to which there is confidence in the oncology nurses in the study and the methods used demonstrate trustworthiness (Stahl & King, 2020). Credibility, transferability, dependability, and conformability measure the quality of qualitative research. Ensuring credibility is one of the essential factors in establishing trustworthiness (Stahl & King, 2020). The study focused on the phenomenon of CF and was in no way based on the researcher's biases or the limitations of the study design (Johnson et al., 2020). When there is evidence of consistency in data collection, analysis, and reporting, and the data answers the research questions, there is dependability in the study (Soroush et al., 2018). In a qualitative research inquiry, the researcher must go through the process with as much rigor as possible so that other members of the discipline can rely on the study's results and advance positive social change.

## Credibility

Credibility is the extent to which a study’s findings are believable, given the data presented. There are several strategies researchers can use to establish credibility. These strategies include persistent observation, prolonged engagement, negative case analysis, peer debriefing, progressive subjectivity, member checking, triangulation, and reflexivity to establish credibility (Hayashi et al., 2021). Credibility relates to all aspects of research design, including the purpose, context, participants’ recruitment, data collection, and the quantity of collected data.

For this study, I utilized member checking to allow the participants to check the accuracy of their statements. Each participant received a transcribed copy of their interview. Member checking allowed the participants to check if what they expressed about their experiences was accurately transcribed by NoNotes. I also used triangulation to examine the consistency of different data sources within the same method (Noble & Heale, 2019). Triangulation was completed when there were enough participants to achieve thematic saturation.

## Dependability

When there is evidence of consistency in data collection, analysis, and reporting, and the data answers the research question, the researchers have shown there is dependability in their study. Dependability also means there is publicly accessible documentation and explanation of any adjustments or shifts in the methodology used in the study. Inquiry audits and triangulation are the most common methods to establish dependability (Johnson et al., 2020). I gave detailed accounts of my entire research process to ensure dependability. After each interview, I used reflective journaling to achieve triangulation.

## Transferability

Transferability is a form of external validity that refers to whether the findings from one study are applicable in another situation (Maxwell, 2021). The phenomenological research I conducted with the oncology nurses who worked in an oncology unit for 3 years or more in hospitals in Miami-Dade, Broward, and Palm Beach County is likely to be transferable if conducted at other hospitals with oncology units. Strategies to establish transferability include reflexivity, thick description, and maximum variation (Hays & McKibben, 2021). I used thick description by including the participants' location, and capturing the participants' emotions.

## Confirmability

Qualitative research often reflects the researcher's subjectivity or bias. Confirmability ensures the researcher's subjectivity does not influence the study's outcome to the extent that other competent researchers would not arrive at the same conclusion after examining the same data. A confirmability audit is the primary means of establishing confirmability (Carcary, 2020), but other methods may include triangulation strategies and researcher reflexivity processes (Hays & McKibben, 2021). I conducted confirmability audits as the study progressed to check for any and remove any biases to facilitate confirmability.

## Ethical Procedures

Compliance with all ethical requirements is integral in any research process. IRB approval for this study was obtained from the IRB at Walden University to ensure I followed all ethical procedures. I also completed a course called “Human Subjects Protection” through the Collaborative Institutional Training Initiative (CITI) and received certificate number 51805778.

My research required the IRB consent form to be given to each participant to inform them how I would protect their privacy and share their responses. The IRB consent form included whether the interview would be audio or video recorded and how long the interview would last. The participants were also made aware of the voluntary nature of the study and the risks and benefits involved. The participants were all above 18 years of age and worked or are working as oncology nurses for 3 years or more.

My primary focus was not to cause harm to my study participants. I fully disclosed the topic’s sensitive nature to prepare the participants for the possibility of evoking memories that may cause them to get emotional. I also reminded the participants they could stop the interview anytime (Gray et al., 2020). I consciously tried to avoid reacting to the participants’ answers in any manner that may have seemed judgmental or caused the participant to feel uncomfortable.

I protected the participants’ data throughout the research process and did not identify the participants by name. For each participant, I used pseudonyms, for example, N1, N2, and N3, and coded the transcripts with these pseudonyms. I redacted and password-protected the participants’ information. The NoNotes application passwordword protected the call recordings and written transcripts for safe keeping. The collected data will be stored for five years on a portable backup drive in a locked cabinet after the completion of the research. After five years, I will have the data destroyed permanently.

Full disclosure was another important ethical consideration for the participants to make the right decision, manage their behavior, and be independent (Akpa-Inyang et al., 2022). I provided the potential participants with all the relevant information about the study during the recruitment phase. I ensured the recruitment materials contained all the information about the entire doctoral study process, including the research implications. I provided informed consent forms to each participant and told them they could exit at any time. I aimed to make the research participants comfortable about their participation in this study by providing them with what to expect during the process.

## Summary

In this chapter, I gave a detailed description of the research methodology. I included the research design and rationale; my role as the researcher; the instrumentation, recruitment, participation, data collection and data analysis plan; and issues of trustworthiness and ethical procedures. I expounded upon the significance of asking the oncology nurses open-ended questions and allowing them to provide answers to give me a view of the human aspect of care. In Chapter 4, I will present the information I discovered from the interviews. I will also present the data analysis, a discussion of data analysis, emerging common themes, and results of the analyzed data.

# Chapter 4: Results

This phenomenological qualitative study explored oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. To understand the phenomenon's effect on the nurses' daily lives, it was necessary to explore the lived experiences of oncology nurses who have cared for terminally ill patients for 3 years or more. The study's design was a phenomenological qualitative approach, which involved open-ended questions to elicit answers from the participants about their experiences with CF while caring for terminally ill patients. In this chapter, after reporting the results of the pilot study, I will describe the study setting, participants' demographic information, and the data collection and analysis procedures. Evidence of trustworthiness and the results that answer the research questions will also be provided. The research questions I sought to answer in the study were as follows:

1. What are the oncology nurse's experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients?
2. How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse's ability to deliver quality patient care?
3. What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients?

## Pilot Study

A pilot study with three of my colleagues was completed to test the research instrument for the data collection before I conducted the main study. The pilot study confirmed the clarity of the interview guide's questions, and the participants understood and responded accordingly. The interviews were completed within the 1-hour timeframe I had approximated. The same format was used for the main study by conducting semi-structured audio-recorded interviews. The interviews were recorded with the NoNotes application on my cell phone. This application provides call recording and audio transcription services. The pilot study did not impact the main study, and no changes were necessary to the instrumentation or the data analysis strategy.

## Setting

Recruitment for the study occurred between November 30, 2022, and January 30, 2023. I contacted one nurse director via phone on December 1, 2022, and she agreed to participate in the study. The ONS posted a flyer on their website on January 4, 2023. Interested participants contacted me via text messages, and I arranged a date and time with them and sent them the consent form before conducting the interviews. Ten audio interviews were conducted in the evenings and on weekends between December 2, 2022, and January 26, 2023, when the nurses were available. Eight nurses were still residing in Florida, one in California, and another in Ohio on travel assignments. The 10 interviews were recorded with the application NoNotes. The application also provided verbatim written transcripts of the interviews.

## Demographics

The 10 participants were oncology nurses who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida. The participants' experiences working on an oncology unit ranged from 4 years to 37 years. There were nine female participants and one male participant. Table 1 includes demographic information for the participants.

**Table 1**

*Demographic Information of Participants*

| Demographic information | No. of participants (*N* = 10) |
|---|---|
| Gender | |
| Female | 9 |
| Male | 1 |
| Time working in oncology | |
| 4 years | 1 |
| 5 years | 3 |
| 7 years | 1 |
| 8 years | 1 |
| 9 years | 1 |
| 10 years | 1 |
| 24 years | 1 |
| 37 years | 1 |

# Data Collection

## Participants

During the recruitment phase of the study, 12 nurses responded via text messages. I responded to all 12 participants via phone calls or text messages. Ten participants proceeded to complete the interview. One nurse had yet to attain the 3 years of experience working in an oncology unit required for the study. One nurse did not return the consent form, so I could not conduct the interview.

## Location, Frequency, and Duration of Data Collection

IRB approval was received from Walden University to gather data from human subjects before starting the recruitment. Approval for the study was granted on November 15, 2022. I recruited nurses who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida.

I interviewed all 10 nurses who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida, between December 2, 2022, and January 26, 2023. Interviews ranged from 10 minutes to 25 minutes. I used open-ended questions to elicit organic and authentic responses. The following interview questions were asked:

1. How many years have you worked as an oncology nurse in an oncology unit?
2. What does compassion fatigue mean to you?
3. How do you express compassion to your terminally ill patients while providing care?

4. When you are about to enter a terminally ill patient’s room, what are some of the things you do to mentally prepare yourself to provide care for the patient?
5. How does the mental preparation you do help you to provide quality care for your patient?
6. Think of and describe a particularly stressful or difficult experience you have had as an oncology nurse: What effect, if any, did it have on your personal life, sleep, health, diet?
7. What effect did this stressful or difficult experience have on the way you provide nursing care?
8. What is your experience with witnessing your terminally ill patients dying?
9. What effect, if any, did witnessing your patient dying have on your personal life, sleep, relationships, health, diet?
10. What did you do to cope with the effects of witnessing a patient dying?
11. How could having debriefing sessions help you express your feelings after witnessing a patient dying?
12. What else would you like to tell me about your experiences with terminally ill patients?

I also asked follow-up questions to have the participants clarify or elaborate on their answers. See Appendix A for the interview questions and script.

All 10 interviews took place over the phone and were audio recorded after I obtained written consent and verbal permission to begin the interview. Recordings were completed through an application on my cell phone called NoNotes Call Recording (see

Appendix B). NoNotes is a company that provides call recording and audio transcription services. After each interview, the NoNotes application produced a verbatim written transcript of the call. I reviewed each transcript while listening to the audio recording of the interview to ensure the information was correct and to fill in words and phrases the NoNotes application did not transcribe accurately. I then made field notes about each call and journaled my thoughts and feelings about the responses and the interview. After accurately completing the transcription, I sent the corrected individual call transcripts to each of the 10 participants, asking them if the essence of what they said was captured correctly. I received responses from all 10 participants confirming the transcription was correct.

The call recordings and written transcripts were kept secure inside the password-protected application NoNotes. I sent each participant their written transcripts through password-protected e-mail. I also kept my journal notes in a separate file on my password-protected laptop.

## Data Analysis

### Coding Process

I conducted the first semi-structured audio interview with one oncology nurse. I reviewed the participant’s answers by reading and re-reading the interview transcripts and my journal notes. I wanted to ensure the participant’s responses to the questions allowed for a complete interview that explored the participant’s lived experiences. I assessed for strategic follow-up questions I could ask to elicit more information. I also analyzed the interview duration to ensure I did not exceed the 1 hour I stated on the consent form and was able to ask all the questions I intended to ask to answer the research questions.

I used an Excel spreadsheet that contained the participants' number, participants' comments, categories, and themes after I had conducted all the interviews. I then highlighted in red all the essential words and phrases that answered the interview question and linked to the research question. The initial hand-coding step analyzed the verbatim transcripts that explored oncology nurses' experiences with CF while caring for terminally ill patients. I then formed categories by analyzing the patterns and similarities among the words and phrases and the notes from my journal to create the first categories.

I listened to the audio interviews and read the transcripts several times to ensure no relevant data was missed in the initial coding. After I was confident that no critical data was excluded, I grouped similar data from the various categories and then generated smaller categories. The data similarities among the categories were noted. I then made generalizations about the oncology nurses' experiences with CF when caring for terminally ill patients. The abstractions exposed the expressions of the participants' experiences, and the themes of their experiences with CF were documented and named.

## Codes, Categories, and Themes

Data saturation was achieved with 10 interviews, as the participants began to express the same sentiments, and I obtained the needed responses to answer the research questions. Any additional participants would not lead to further information or perspectives. Five themes emerged from the data:

- Theme 1: Emotionally and Physically Exhausted

- Theme 2: Patients’ Young Age
- Theme 3: Patients’ Death
- Theme 4: Impact on Care
- Theme 5: Personal Time

The participants each led me through their experiences with CF while caring for terminally ill patients. The open-ended interview questions allowed each participant to describe their experiences with CF while caring for terminally ill patients.

The participants all expressed their understanding of and experience with CF. The common understanding of CF was feeling overwhelmed or tired. For example, one participant stated, “you get overwhelmed with caring, having to give so much compassion, having to give so much of yourself.” Another participant stated, “to be empathetic to all your patients, it can get overwhelming.” Yet another stated, “It’s wanting to go to that next level with that patient, taking that extra step, but you just don’t have it in you anymore.” Another participant stated, “you’re just finished with it; you’re just so tired.” These statements led to the categories “feeling overwhelmed” and “feeling emotionally and physically tired,” which translated into the predominant theme of being emotionally and physically exhausted.

The second most common theme that emerged was patients’ young age. The participants were asked to describe a difficult or stressful event they had as an oncology nurse. Seven participants responded to the question by giving examples of when their terminally ill patient died. Three participants specifically mentioned how the young age of the patient affected them. For example, one participant shared,

> I had a young girl in her early 20s who recently married. I would come in and take care of this young lady every day and see her dwindle down to nothing. I think the younger the patient, the harder it is.

Another participant stated,

> One patient that we had, she was a 20-year-old black female of Caribbean descent. She was pregnant, and she found out that she had lymphoma. It was her youth that struck me, and that has stayed with me for years.

Another participant stated,

> I still remember her name to this day, and this was like almost 7 years ago. She was a 32-year-old patient. She passed away, that was the worst one for me, knowing that she won't ever see her kids graduate, not even middle school. I think that ate me up so much out of all the death that I had.

The third most common theme was patients' death. Some participants expressed feelings of sadness and feeling loss. For example, one participant stated, "It's a sad moment because sometimes you get so attached to your patient. Sometimes it really takes a toll on you as a nurse." Another participant stated, "it has been emotional for me to see patients go." Yet another participant stated, "It's a very sad experience. That's all I can say." Other participants expressed positive experiences. One participant stated,

> I find that when someone has made their peace and have spoken with all of their family members, and they have done all the things that they wanted to do, death can be very peaceful, and death can be very humbling.

Another participant stated, “My experience is that death is a normal process.” Other participants expressed that witnessing their terminally ill patients had made them detached. One participant stated, “It made me a little hard. I’m not as soft as I used to be.” The other participant stated, “I had to learn to disconnect from these patients because that low that emotional low is not good.”

The fourth most common theme was impact on care. Some participants expressed their level of care not being negatively impacted by CF. For example, one participant stated, “I feel like I give out more. I was drawn more to this specialty into these types of patients. I don’t think it affected my care in a negative way.” Another participant stated, “It’s grown me as a person, not even just as a nurse as a person.” Yet another participant stated, “It makes me more aware of the difficulty that family goes through. Tells you how to improve.” Another participant stated, “I made it more important for me to be able to let the patients know that they had somebody that cared about them.” Other participants mentioned how their quality of care has been negatively affected. One participant stated, “I became a little bit more indifferent. I try to not create a rapport more than nurse-client.” Another participant stated, “I have to kind of separate my feelings from what they’re going through.”

The final theme that emerged was personal time as the participants expressed their coping mechanisms. One participant stated, “I’ve been going to the gym for the past 10 years, so I’m a gym freak.” Another participant stated, “Went out with friends and had a good time after work.” Other participants mentioned using their spirituality to cope. For example, one participant stated, “Pray, that’s the coping mechanism. Praying.” Another participant stated, “praying about it, having my personal time from a religious basis.”

## Discrepant Cases

Some participants expressed not being affected emotionally by their terminally ill patients dying. One participant stated,

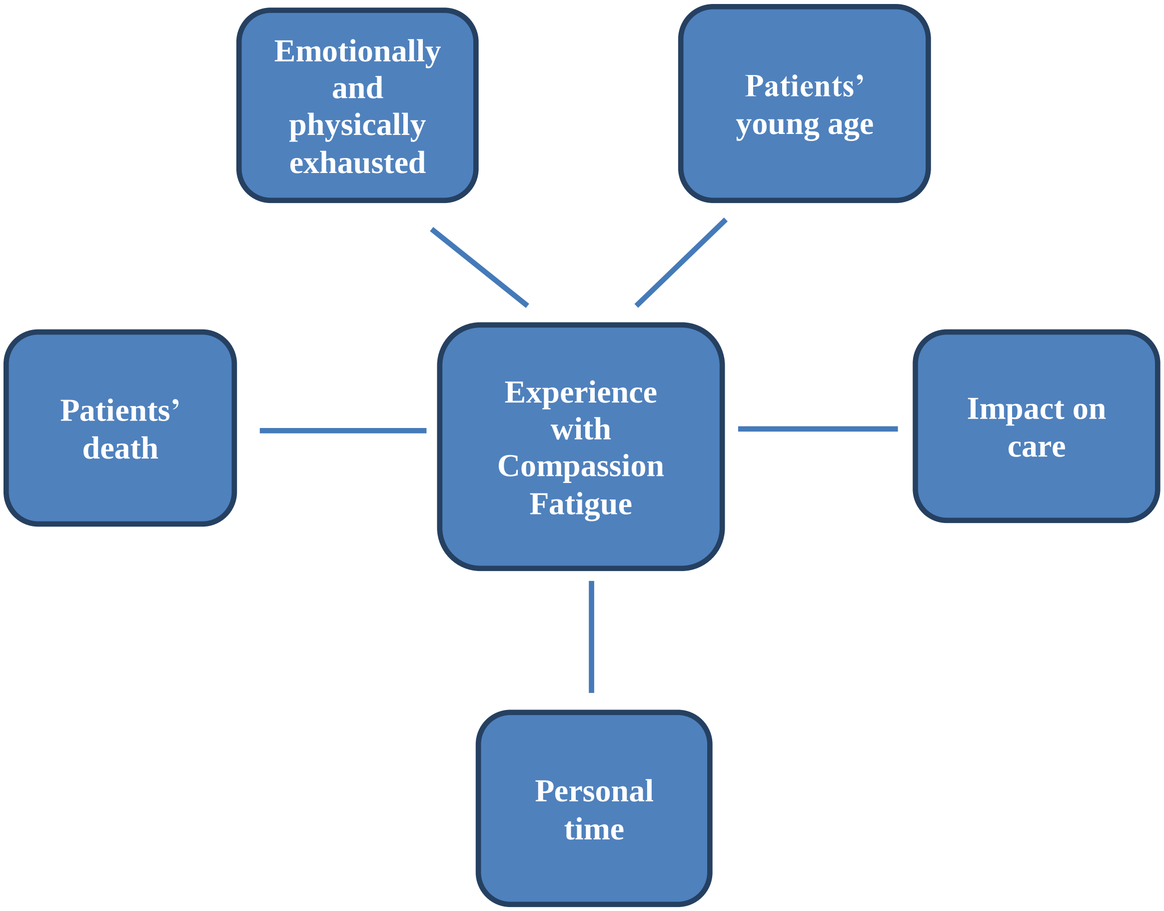
> I don’t know that it had any effect. Maybe it did. I look at it as part of the process that these things are going to happen, and you have to be able to compartmentalize and not allow it to affect you because then you have to go on to the next patient.

Another participant stated, “No, it didn’t have any effect on me.” One participant had never witnessed a patient dying but stated, “I tend to show up or come in, and it’s already happened, and it could have happened, and it was a little peaceful, so I may not have even realized initially that they were gone.” Discrepant cases were factored into the analysis through confirming and disconfirming statements regarding not being affected emotionally by their patients’ death in the categories and themes and then in the study results.

A systemic order or category was used to sort the codes that were similar in context which resulted in the five themes from analyzing the codes and categorization. See Figure 1 for an illustration of the five common themes that emerged from the interviewees’ expression of their experiences.

**Figure 2**

*Five Common Themes*



The five main themes also had several subthemes that emerged when coding the transcripts. For example, the theme of emotionally and physically exhausted had the sub-themes of overwhelmed with caring, emotionally stressful, feeling tired, and loss in feeling compassion for patients. The five main themes and their related sub-themes are listed in Table 2. The five main themes will be discussed in the Results section of this chapter.

**Table 2**

*Main Themes and Subthemes*

| Main themes | Subthemes |
|---|---|
| Emotionally and physically exhausted | • Overwhelmed with caring<br>• Emotionally stressful.<br>• Feeling tired<br>• Loss in feeling compassion for patients |
| Patients' young age | • Young girl<br>• Under 35 years old |
| Patients' death | • Sad moment<br>• Felt the lost<br>• A part of life |
| Impact on care | • Lack of Consistent care<br>• Ways to improve<br>• Negative impact |
| Personal time | • Self-care<br>• Rely on faith<br>• Peer support<br>• Detachment |

## Evidence of Trustworthiness

### Credibility

A research study's credibility is the extent to which a study's findings are believable, given the data presented. There are several strategies researchers can use to establish credibility. These strategies include persistent observation, prolonged engagement, negative case analysis, peer debriefing, progressive subjectivity, member checking, triangulation, and reflexivity to establish credibility (Hayashi et al., 2021). Credibility relates to all aspects of research design, including the purpose, context, participants' recruitment, data collection, and the quantity of collected data.

For this study, I utilized member checking to allow the participants to check the accuracy of their statements. Each participant received a transcribed copy of their interview. Member checking allowed the participants to check if what they expressed about their experiences was accurately transcribed by NoNotes. I also used triangulation to examine the consistency of different data sources within the same method (Noble & Heale, 2019). I had a total of 10 participants. Triangulation was achieved by having enough participants to achieve thematic saturation.

### Dependability

When there is consistency in data collection, analysis, and reporting, and the data answers the research question, the researchers have shown dependability in their study. Dependability also means there is publicly accessible documentation and explanation of any adjustments or shifts in the methodology used in the study. Inquiry audits and triangulation are the most common methods to establish dependability (Johnson et al., 2020). I gave detailed accounts of the entire research process to ensure dependability. My dissertation chair was used to complete an inquiry audit by reviewing the collected data and analyzing the data and results to confirm the finding’s accuracy and ensure the collected data supported the findings. After each interview, I used reflective journaling to achieve triangulation.

### Transferability

Transferability is a form of external validity that refers to whether the findings from one study are applicable in another situation (Maxwell, 2021). The phenomenological research I conducted with the oncology nurses who worked in an oncology unit for 3 years or more in hospitals in Miami-Dade, Broward, and Palm Beach County is likely to be transferable if conducted at other hospitals with oncology units. Strategies to establish transferability include reflexivity, thick description, and maximum variation (Hays & McKibben, 2021). I used thick description by including the participants' location, participants' number of years working as an oncology nurse, and capturing the participants' emotions.

### Confirmability

Qualitative research often reflects the researcher's subjectivity or bias. Confirmability ensures the researcher's subjectivity does not influence the study's outcome to the extent that other competent researchers would not arrive at the same conclusion after examining the same data. A confirmability audit is the primary means of establishing confirmability (Carcary, 2020), but other methods may include triangulation strategies and researcher reflexivity processes (Hays & McKibben, 2021). I conducted confirmability audits as the study progressed to check for any and remove any biases to facilitate confirmability. I also searched for and described disconfirming evidence elements that may have contradicted prior results (Leko et al., 2021).

## Results

The research questions were: 1) What are the oncology nurse's experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients? 2) How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse's ability to deliver quality patient care? 3)What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients? Each participant reviewed their written transcript for accuracy. My dissertation chair also reviewed the transcripts and codes. The five themes that emerged were: Emotionally and Physically Exhausted; Patients' Age; Patients' Death; Impact on Care; and Personal Time.

### Theme 1: Emotionally and Physically Exhausted

Theme one emerged from the data analysis of the participants' understanding and experiences with CF. When asked "what does compassion fatigue mean to you?" all 10 participants expressed their understanding of and experience with CF. The theme of emotionally and physically exhausted was described as being tired or overwhelmed with having to give out so much empathy to patients. For example, Participant N1 state,

> It means like when you're overly giving yourself, you get overwhelmed with caring. Well, I won't say with caring, but having to give so much compassion, having to give so much of yourself for a certain amount of time you get overwhelmed.

Participant N2 expressed the meaning of CF as "a loss in feeling compassion for those patients." N2 further stated, "I think there is fatigue. It's that wanting to go to that next level with that patient, taking that extra step but you just don't have it in you anymore." Participant N3 summed up CF in one word "Tired." N3 then stated "You are emotionally and physically exhausted; it's like you're burnt out." Participant N4 echoed N3's expression of CF by stating,

> You basically are compassionate to the patient, but at the same time, you become a little numb to the experiences because it's something that you see on a daily basis, so it's not anything that is now surprising to you and that there can also be on the edge of burn out.

Participant N5 stated, "When you're working with these patients, it's emotionally stressful seeing them deteriorate a lot of times day by day, sometimes you question yourself, the meaning of life, and it creates a big toll on you." Participant N6 explained CF by stating,

> You have to be empathetic to all of your patients, and sometimes it stretches you as a person to be able to feel that amount of compassion. I mean, just to express that with all your patients it can get overwhelming.

Participant N7 expressed her experience with CF when she stated, "You are just finished with it. You are just so tired." Participant N8 explained the effects of expressing empathy for the patients and their family members by stating, "Well-being empathetic for your patients, putting yourself in your patients and your families' shoes, and internalizing those feelings, holding on to those feelings to the point that you feel overwhelmed." Participant N9 also explained CF as "working with cancer patients and seeing what they go through from starting treatment to end of treatment, you have to find some way to have some empathy or compassion for them, but it can be a tiring job." Participant N10 stated "when caring for terminally ill patients it's like the care is never enough for the patient. There is nothing you can do to make the comfortable."

### Theme 2: Patients' Young Age

When asked interview question: "Think of and describe a particularly stressful or difficult experience you have had as an oncology nurse: What effect, if any, did it have on your personal life, sleep, health, diet?" Seven participants responded by giving examples of when their terminally ill patients died. Three participants expressed how they were affected because of the young age of the terminally ill patient. Participant N1 stated,

> Oh, there's one particular one, and I still remember her name to this day and this was like almost seven years ago. She was a 32-year-old patient. She got diagnosed with breast cancer, and I think it went to the lungs. So, with her, I knew she had two kids. She really wanted to see her youngest child graduate from kindergarten, and the fact that I knew that she wasn't going to see her child graduate from kindergarten just eats me up. That was the worst one for me, knowing she won't ever see her kids graduate, not even middle school.

Participant N2 spoke of how she was affected by the death of her young patient when she stated, "I've had a few in my career that really have sat with me and I've come home and it's taken me some time to get over that." N2 further stated,

> I think the younger the patient, the harder it is. … I had a young girl in her early 20s who recently married; she had breast cancer. That really affected me because I would come in and take care of this young lady every day and see her dwindle down to nothing. I also felt that loss. it's very hard as a nurse.

Participant N4 expressed how she was unable to let go of her young patient's death. She stated,

> One patient we had was a 20-year-old black female of Caribbean descent. She was pregnant, and she found out that she had lymphoma at that point in time, and I think she was about four to six months in, and they gave her a choice as to what it was that she wanted to do with regards to the pregnancy. I was in awe that she chose to forego treatment until she delivered her baby because her response was that she did not want to impact the health of her baby by receiving chemotherapy while she was pregnant, so she delayed the treatment at that point in time. After coming back from the delivery of her child, she sought treatment but because of the delay in care, it was more palliative because it was a very aggressive type of cancer and tumors that she had. It was her youth that struck me, and that has stayed with me for years.

### Theme 3: Patients' Death

Witnessing patients' death can cause traumatic memories for oncology nurses. When asked the interview question: "What is your experience with witnessing your terminally ill patients dying?" Nine participants expressed their experiences with witnessing their patients dying. Seven participants expressed sadness over witnessing their patients' death. One participant, however, explained that witnessing her patients' death can be a "humbling and joyful experience" when the patient has made peace with the situation. Another participant described patients' deaths as "a normal process."

Participant N1 stated,

> She was deteriorating, and I always had to call code on her or rapid, and so I knew the time was near and when the doctor finally said there was no more treatment for you. She passed away, and I put her in a body bag. I think that ate me up so much out of all the deaths that I had.

Participant N2 explained how having to witness her patients' death affected her as a person. She stated,

> I think it's probably not the greatest. I think I have become more understanding of life and cherish these good days. But I think it also has made me a little hard. I'm not as soft as I used to be. I'm like, well that happened, and I don't want to come across as insensitive to friends and family or my own husband or my own kids, but I become a little hard.

Participant N3 stated recounted her experience with witnessing her patient dying and said,

> It's a sad moment because sometimes you get so attached to your patient, and death is never an easy thing to deal with, whether it is with your own family or your patient. So, it is very sad; it is emotional because sometimes you have patients; as I said, you become attached. You share stories, and just seeing and knowing that someone is no longer with their family member sometimes it really takes a toll on you as a nurse, and as a caregiver, because you always want to see your patient beating the cancer and when that doesn't happen, it's very hard.

Participant N4 explained her perspective on witnessing her terminally ill patients dying as a humbling and joyful experience when she stated, "I find that when someone has made their peace and has spoken with all of their family members and they have done all the things that they wanted to do, that can be very peaceful, and death can be very humbling. People have passed on and it was a very humbling experience and it was a very joyful experience."

Participant N5 expressed an emotionally painful experience with witnessing a specific patient's death and, through tears, explained the impact by stating,

> I remember I had this patient, he was Brazilian, maybe 10 years back, and he was such a smart guy. But I saw how he deteriorated. He had to come for his chemotherapy, and he loved me, so he always wanted me to be his nurse. So, I got so involved with this guy emotionally. I almost saw him as a father figure. Oh, and he passed away when he died, I had a rough time for a month. It was basically like losing a family member.

Participant N6 kept her description of witnessing her patients' death to one short sentence. She stated, "It has been emotional for me to see patients go." Participant N7 explained her helplessness from watching one patient's death. She said, "I watched her, and there was nothing we could do. I literally watched her die right in front of me. That one bothered me the most. There was nothing I could do." Participant N8, however, did not express being emotionally affected by witnessing her patients' death. She explained her perspective of death by stating,

> My experience is that death is a normal process. But when you have the opportunity to participate in someone's end-of-life care, my focus is to make the patient comfortable. Kind of be supportive, and you know if there's family

> involved, be encouraging, be available emotionally for them, but not to take it with you, and focus on the patient at hand.

Participant N10 when asked about her experience witnessing her terminally ill patients dying, stated, “It’s a very sad experience. That’s all I can say.”

## Theme 4: Impact on Care

The participants expressed the impact CF had on their ability to deliver quality care to their terminally ill patients. When asked the interview question: “What effect did this stressful or difficult experience have on the way you provide nursing care? Six participants stated their quality of care was not negatively impacted. Three participants expressed how their quality of care had been affected negatively. One participant declined to answer. Participant N1 stated, “I feel like I give out more; I was drawn more to this specialty, into these types of patients. I don’t think it affected my care in a negative way.” Participant N2 stated, “It’s grown me as a person, not even just as a nurse as a person. I’m definitely more humble being a nurse.” Participant N3 explained that her quality of care was not affected when she stated,

> No, it didn’t affect it because I’ve always been consistent in my nursing care. It makes me more aware of the difficulty that family goes through. It tells you how to improve. It shows you ways in which you could improve to help like the loved ones who are left behind.

Participant N4 expressed her quality of care being negatively impacted by the effects of CF. She stated, “Yes, there is some negativity because you’ve been doing it for a while you become a little numb.” Participant N5 expressed how his quality of care was significantly been impacted by CF. He said,

> I became a little bit more indifferent. I try to not create a rapport more than nurse-client. It was very superficial enough that they had good care, but I wasn’t involved. I gave them what they needed. I gave them words of positivity and all that, but without that deep emotional care. I really didn’t want to be that long in those rooms chatting with them, or I’ll burn out. So, to avoid the burning, I created a distance.

Participant N7 expressed how she would put extra effort into the quality of care she provided her patients. She stated, “I made it more important for me to be able to let the patients know that they had somebody that cared about them regardless of whatever else was going on in their life.” Participant N8 explained how her experience with CF made her focus on educating her patients and their family members. She stated,

> It allowed me to in advance do the education and allow family members and patients and that decision maker to do research and then kind of provide them with information that supports what the education I’ve given. Also make sure when I’m speaking to the doctor before I have to have that conversation or that meeting with the family and the doctor to make sure that we’re on the same page.

Participant N9 described how she separated her feelings from her patients’ condition:

> I have to kind of separate my feelings from what they’re going through, and sometimes patients will try to take care of you, and that’s not what I want to

> happen. I want to still be able to take care of them and do my job, so if it’s just me taking a moment to step away and regain my composure, that’s what I do.

Participant N10 expressed no negative effect on the quality of care she provides her patients. She stated,

> As an oncology nurse, I provide 100% care to all my patients. I go by what they want and what their needs are. I go above and beyond to make them comfortable and provide them all the care they need.

## Theme 5: Personal Time

The 10 participants explained the coping interventions they use to combat the effects of CF while caring for their terminally ill patients. When asked the question: “What did you do to cope with the effects of witnessing a patient dying?” Six participants expressed positive coping strategies such as self-care, praying, and listening to music. Two participants expressed negative coping strategies such as detachment or compartmentalization. One participant was unsure if she used any copying strategies. Participant N1 explained,

> I’ve been going to the gym for the past 10 years, so I’m a gym freak. I’ve been taking months at a time off. Every year I take a couple of months off. At first, I thought I was doing it just because I could do it, but I realize I’m doing it because I feel so overwhelmed that I need to take a break.

Participant N2 also mentioned self-care activities. She stated,

> When I go home, I really try to have a few minutes to myself in my bedroom and watch TV. I like Netflix and things like that. I read a lot of books. I try to do that a

> few times a week to be by myself; I need that. I drive an hour one way to my hospital. I try not to get on the phone, and I really just listen to music, or I do nothing, just drive.

Participant N3 also mentioned listening to music as one of her coping strategies. She said, “Pray; that’s the coping mechanism. Praying, sometimes listening to music, talking to co-workers, and sharing experiences. Taking walks on campus during break time because when you walk, it helps.” Participant N4 stated she also used praying as one of her coping strategies when she said,

> Praying about it and having my personal time from a religious basis. Going to the beach, just kind of doing my own thing. Sometimes in memoriam of the patient, I’ve also actually gone to funerals, you know, just to get that closure.

Participant N5 expressed his negative coping strategy. He stated, “I never connect. I never created a real connection. I had to learn to disconnect from these patients because that low that emotional low is not good.” Participant N6 explained how she use compartmentalization as her coping strategy. She stated,

> You have to be able to compartmentalize and not allow it to affect you because then you have to go on to the next. It is also necessary for you to survive a caring profession. If you take on every single thing you’re dealing with, illnesses from every area, and if you take that on personally, then that is definitely going to break you down and affect your performance.

Participant N7 stated, “We talked about it amongst each other. My coping was to hope that we learn from whatever experience we had and did better with the next one.”

Participant N8 explained she never thought she used coping strategies. She stated, “I don’t know that I do. I feel like telling myself that it’s natural and this providing comfort being like the focus. I guess I just acknowledged that death is a part of life. It’s not a bad thing.” Participant N10 stated, “I’ll remember all the good times. All the good experiences, all the fun times we used to have, and all that.”

### Discrepant Cases

Participant N6 declined to answer the question: What effect did this stressful or difficult experience have on the way you provide nursing care? She responded, “Can we move on to the next question.” Participant N8 was unsure if she used coping strategies. She explained, “I don’t know that I do.” Some participants expressed not being affected emotionally by their terminally-ill patients dying. Participant N8 stated, “I don’t know that it had any effect.” Participant N9 had never witnessed a patient dying. She stated, “I tend to show up or come in, and it’s already happened.” Participant N10 stated, “No, it didn’t have any effect on me.”

## Summary

The research questions that guided this study were: 1) What are the oncology nurse’s experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients? 2) How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse’s ability to deliver quality patient care? 3)What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients? Interviews with 10 participants helped to answer these questions as they candidly shared their experiences. The 10 participants’ responses resulted in five themes. CF is the emotional, physical, and mental exhaustion that comes from encounters with compassion stress. The participants expressed feeling overwhelmed and emotionally and physically tired; this emerged as the theme of being emotionally and physically exhausted. Three participants mentioned the impact the young age of their patients had on them, which led to the theme of patients’ young age. The theme of patients’ death emerged as the participants expressed feelings of sadness and loss at their patients’ death because of their bond with the patient. Other participants spoke positively about witnessing their patients’ death as a peaceful and humbling experience. Some participants spoke of learning ways to improve their level of care and being humbled by their experiences. Other participants mentioned becoming numb or indifferent because of their experiences which emerged as the theme of impact on care. The theme of personal time emerged as the participants spoke of going to the gym, praying, and listening to music as self-care coping strategies. Other participants expressed using detachment and compartmentalization as their coping strategies.

In this chapter, I detailed the study’s setting, the participants’ demographics, and the data collection and analysis process for this study. I provided evidence of trustworthiness by documenting credibility, dependability, transferability, and confirmability. I then provided the research questions and the results of the findings with direct quotes from the participants, including discrepant cases. Chapter 5 will present the interpretation of the findings, detail the limitations of the study, and provide a discussion on the recommendations and implications for future research and nursing practice and how these findings can facilitate positive social change.

# Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this phenomenological qualitative study was to expand upon the existing literature on phenomenological studies regarding the lived experiences of oncology nurses' experiences with dealing with and managing CF while caring for terminally ill patients. I conducted a phenomenological qualitative study using semi-structured, individual interviews to address the lack of interviews with the oncology nurses to hear their expression of the CF they experience when caring for terminally ill patients. A phenomenological qualitative inquiry aligned well with the research purpose to explore oncology nurses' experiences dealing with and managing CF when caring for terminally ill patients. A phenomenological qualitative inquiry allowed the oncology nurses to express their lived experiences with CF and how CF impacted their quality of patient care. This approach also allowed the oncology nurses to provide information on their coping strategies to combat the effects of CF.

Findings from this study may lead to positive social change as nursing schools can use it to inform them of the value of teaching CF management skills as a preventative method in the curricula. Additionally, this study may inform healthcare nursing leaders to include more intervention activities, such as individual counseling sessions with a therapist, to help oncology nurses manage their CF and help reduce the high turnover rate associated with the oncology nursing profession.

I conducted semi-structured interviews with 10 English-speaking RNs who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida. Key findings from this study included five major themes that described the oncology nurses' experiences dealing with and managing CF while caring for terminally ill patients. The five themes that emerged were:

- Theme 1: Emotionally and Physically Exhausted
- Theme 2: Patients' Young Age
- Theme 3: Patients' Death
- Theme 4: Impact on Care
- Theme 5: Personal Time

Chapter 5 begins with the interpretation of the findings in light of the conceptual framework, followed by the findings related to the literature review from Chapter 2. I will then discuss the limitations of the study and make future research recommendations. The chapter concludes with the implications of the findings for positive social change.

## Interpretation of the Findings

The findings of this phenomenological qualitative study, in which I explored oncology nurses' experiences dealing with and managing CF while caring for terminally ill patients, aligned with the conceptual framework of Figley's (1995) compassion fatigue theory. Additionally, my interpretation of the study's findings confirms and extends the results of previous research. In this section, I interpret the study's findings as related to the conceptual framework and literature review.

### Findings Interpreted in Light of the Conceptual Framework

The conceptual framework for this study was Figley's (1995) compassion fatigue theory. Figley described CF as stress from exposure to traumatized individuals rather than from exposure to the trauma and as a state of biological, psychological, and social exhaustion and dysfunction from prolonged exposure to compassion stress. The nine components of Figley's compassion fatigue process are (a) exposure to suffering, (b) concern, (c) empathetic ability, (d) empathetic response, (e) compassion stress, (f) prolonged exposure, (g) traumatic memories, (h) demands of life, (i) compassion fatigue.

The first three themes, physically and emotionally exhausted, patients' young age, and patients' death, confirmed how exposure to their terminally ill patients personally affected the oncology nurses. Regarding Theme 1, all 10 participants expressed feeling tired or overwhelmed by constant exposure to their terminally ill patients. Xie et al. (2021) reported that CF is one of the oncology nurses' most commonly reported work-related consequences. The subthemes for Theme 1, overwhelmed with caring, emotionally stressful, feeling tired, and loss of feeling compassion for patients, further confirmed that prolonged exposure to terminally ill patients resulted in a state of biological, psychological, and social exhaustion and dysfunction. Algamdi's (2022) findings showed that CF is a state of emotional, physical, and mental exhaustion caused by a person's depleted ability to cope with their everyday environment. The prolonged exposure to terminally ill patients caused compassion stress for the participants. Several participants expressed feeling amplified compassion stress because of the young age of the terminally ill patient, as identified in Theme 2.

One of the components of Figley's (1995) compassion fatigue theory is traumatic memories, which refer to memories of traumatic events such as witnessing a patient dying while receiving care. Theme 3, patients' death, contained the participants' expression of the effect their patients’ death had on their emotional, physical, and mental state. Some participants expressed feeling “emotional stress” and having traumatic memories from the death of their patients. The finding is consistent with the research that showed experiences with patients’ death can often leave nurses with overwhelming grief and loss, resulting in CF (Al-Majid et al., 2018; Arimon-Pagès et al., 2019; Jarrad & Hammad, 2020). The overwhelming grief and loss were evident for one participant who started crying during the interview because of traumatic memories. The participant stated,

> I remember I had this patient. He was Brazilian, maybe 10 years back. And he was such a smart guy, and I saw him deteriorating. Oh, and he passed away when he died [participant crying]. I had a rough time for a month.

## Findings Related to Reviewed Literature

The fourth theme, impact on care, showed how CF impacted the quality of care the nurses provide their patients. The participants spoke of feeling “numb” or “indifferent” and only providing “superficial” care. These findings confirmed similar results of prior research that found that oncology nurses who repeatedly experience CF from the grief and loss of patients’ death may use the negative coping strategy of detachment to cope with their patient’s death. Over time, using detachment to cope with CF from the grief and loss of patients’ death can cause oncology nurses to become less compassionate in their care, resulting in poor quality of nursing care (Wentzel et al., 2019; Xie et al., 2021).

Other researchers have found that work stress can affect oncology nurses’ mental health and adversely affect the quality of care their patients receive (Mazzella Ebstein et al., 2019; Molavynejad et al., 2019; Partlak Günüşen et al., 2019). This study's participants confirmed the findings as one participant stated,

> I never created after that a real connection. It was very superficial enough that they had good care, but without that deep emotional care like the one you provided, if it was your mother or your father passing away. They encourage you to do that, but you know that's awful mentally for any nurse.

Another participant stated, "If you take on every single thing you are dealing with illnesses from every area and if you take that on personally, then that is definitely going to break you down and affect your performance."

The final theme, personal time, showed the coping strategies the oncology nurses use to combat the effects of CF. The participants discussed using positive coping strategies such as "praying" and "listening to music." The participants mentioned that using these coping strategies helped them relax and stay focused on performing their duties without feeling stressed. This finding is supported by research that indicates positive coping styles such as meditation and listening to music could help oncology nurses repel CF (Ryan et al., 2022; Zhang et al., 2022).

Research conducted by Kohli and Padmakumari (2020) found the benefits of self-care activities by stating that early interventions that include self-care behavior methods can help prevent the risk of CF. Oncology nurses should participate in self-care activities such as meditation or walking outside. The participants in this study confirmed the benefits of using self-care interventions such as "taking a walk" or "going to the beach" to prevent feeling emotionally, mentally, and physically exhausted. One participant stated, “It helps you to relax. It helps you so your mind can be free.” Another participant stated, “You get to de-stress and alleviate some of that stress.”

In the specific context of dealing with and managing CF, Figley’s (1995) compassion fatigue theory suggests that CF is a state of biological, psychological, and social exhaustion and dysfunction from prolonged exposure to compassion stress. The confidence in this research is demonstrated by the number of participants who reported that they had experienced emotional and physical exhaustion from exposure to compassion stress while caring for their terminally ill patients. Based on the aggregate data in this study, compared to previously published studies, the participants experienced a negative impact of CF on their quality of care. The participants also expressed coping strategies for managing the effects of CF while caring for their terminally ill patients.

## Limitations of the Study

The main limitation of this study was including only oncology nurses who worked or are working with terminally ill patients in an oncology unit for 3 years or more at hospitals in Miami-Dade, Broward, or Palm Beach County, Florida. Although the number of participants was sufficient to give detailed answers to the research questions, the stringent inclusion criteria expose this research to limitations of experiences held by nurses within the Miami-Dade, Broward, or Palm Beach County area. The answers to the interview questions could differ if the study were conducted in other parts of Florida or other states.

One projected limitation outlined in Chapter 1 was needing the anticipated access to the 10 English-speaking oncology nurses with experiences caring for terminally ill patients for the interview portion of the study. One interested participant still needed to attain the 3 years of experience necessary for the study, so she could not participate. There were possibly more interested participants who could not participate because of this limitation. It is impossible to tell whether the responses provided to the research questions would be answered similarly by participants with fewer than 3 years of experience.

Another limitation of qualitative research is the researcher's bias. The interviews for this study were hand-coded and analyzed by this researcher. The personal and solo data analysis could have allowed personal bias stemming from my love and admiration for nurses to creep into the final data analysis. Having a dissertation committee to review the findings helped to prevent presenting biased results.

## Recommendations for Future Research

The phenomenological qualitative study aimed to add to the existing literature on phenomenological studies regarding the lived experiences of oncology nurses and the CF they experience when providing care to terminally ill patients. The study focused on interviewing oncology nurses to gain their expression of their lived experiences with CF while caring for terminally ill patients. Based on the main limitation presented above, it is evident that more generalizable data could be achieved if phenomenological qualitative studies were conducted with oncology nurses from other parts of Florida or other states.

Future researchers should consider conducting phenomenological qualitative studies with interviews of oncology nurses with fewer than 3 years of experience caring for terminally ill patients. The fact that the topic of CF piqued the interest of an oncology nurse with fewer than 3 years of experience to the point that she wanted to participate should cause future researchers to ponder the inclusion criterion of 1–3 years of experience. Oncology nurses report an elevated risk of CF after 3 years of working with terminally ill patients (Cross, 2019; Kohli & Padmakumari, 2020). However, the elevated risk of CF could be lower than the 3 years previously reported in light of the changing healthcare climate that includes a global pandemic.

Future researchers should also consider conducting phenomenological qualitative studies with nurses who cared for Covid patients during the global pandemic. The nurses should be interviewed to hear their expressions of the CF they experienced while caring for their Covid patients. Future researchers should also consider phenomenological studies to explore CF among unlicensed assistive personnel instrumental in providing direct patient care.

## Implications

This study's findings are supported by literature that oncology nurses experience CF while caring for terminally ill patients. The oncology nurses discussed their coping strategies for dealing with and managing CF while caring for their terminally ill patients. Positive social change can occur in nursing schools if they teach CF management skills as a preventative method. This study shows that oncology nurses experience CF; therefore, nursing schools should prepare students to manage the biological, psychological, and social exhaustion and dysfunction from prolonged exposure to compassion stress (Figley, 1995). A response from one of the participants that highlighted this need for social change: "I wish someone had told me not to get emotionally attached to my patients."

Teaching nursing students that CF is the emotional, physical, and mental fatigue that comes from encounters with compassion stress (Al-Majid et al., 2018) and teaching them positive coping strategies, such as mindful meditation, can help them deal with and manage CF.

The findings of this study may also inform healthcare nursing leaders to include more intervention activities. Positive social change that includes intervention activities, such as individual counseling sessions with a therapist, can help oncology nurses manage their CF and help reduce the high turnover rate associated with the oncology nursing profession. The oncology nurses in this study spoke of their coping strategies, but none mentioned any services available to them where they work to help them deal with and manage CF. Nursing leaders must advocate for the nurses and emphasize the need to protect their emotional, physical, and mental health by creating a healthy work environment where the nurses get the support they need to perform their duties.

## Conclusion

This phenomenological qualitative research study explored oncology nurses' experiences dealing with and managing CF while caring for terminally ill patients. Although other studies have identified an uptick in CF among oncology nurses and have explored the prevalence, causes, coping strategies, and intervention and prevention programs, this study identified a gap in directly interviewing oncology nurses to explore their experiences with dealing with and managing CF while providing care to terminally ill patients. This study included conversations with the oncology nurses regarding the effect CF has on the quality of care they provide and the types of interventions they use to cope with the CF they experience.

The conceptual framework for this study was Figley’s (1995) compassion fatigue theory. The participants’ responses provided insight into their understanding of and experiences with compassion fatigue. The participants’ responses sufficiently answered the three research questions:

1. What are the oncology nurse’s experiences with the emotional, physical, and mental exhaustion of compassion fatigue while caring for terminally ill patients?
2. How does the emotional, physical, and mental exhaustion of caring for terminally ill patients impact the oncology nurse’s ability to deliver quality patient care?
3. What interventions do oncology nurses use to cope with the emotional, physical, and mental exhaustion they experience while caring for terminally ill patients?

The findings in this study indicated that oncology nurses experience emotional and physical exhaustion from caring for terminally ill patients and can feel a sense of loss at the death of their patients. The findings were corroborated by research studies evaluated in the literature review. The findings also indicated that CF could negatively affect the oncology nurses’ quality of care. The findings showed that the oncology nurses use personal interventions to combat the effects of CF.

The healthcare sector is experiencing a shortage of qualified nurses to care for the population. Nursing is not just a profession or discipline but an innate desire to care for all human lives. Caring elicits compassion from nurses, which can cause fatigue in nurses’ emotional, physical, and mental health over time. Oncology nurses who provide care for terminally ill patients are more susceptible to CF because of their constant and consistent exposure to their terminally ill patients. Oncology nursing policymakers must provide additional resources to help oncology nurses deal with and manage the CF they experience. I hope this study will provoke policymakers to try to answer the question, who is caring for the caregivers?

# References

Akpa-Inyang, F., Ojewole, E., & Chima, S. C. (2022). Patients' experience on practice and applicability of informed consent in traditional medical practice in KwaZulu-Natal Province, South Africa. *Evidence-Based Complementary and Alternative Medicine, 2022*, Article 3674467. https://doi.org/10.1155/2022/3674467

Algamdi, M. (2022). Prevalence of oncology nurses' compassion satisfaction and compassion fatigue: Systematic review and meta-analysis. *Nursing Open, 9*(1), 44–56. https://doi.org/10.1002/nop2.1070

Al-Majid, S., Carlson, N., Kiyohara, M., Faith, M., & Rakovski, C. (2018). Assessing the degree of compassion satisfaction and compassion fatigue among critical care, oncology, and charge nurses. *Journal of Nursing Administration, 48*(6), 310–315. https://doi.org/10.1097/nna.0000000000000620

Arimon-Pagès, E., Torres-Puig-Gros, J., Fernández-Ortega, P., & Canela-Soler, J. (2019). Emotional impact and compassion fatigue in oncology nurses: Results of a multicentre study. *European Journal of Oncology Nursing, 43*. https://doi.org/10.1016/j.ejon.2019.09.007

Boamah, S. A., Hamadi, H. Y., Havaei, F., Smith, H., & Webb, F. (2022). Striking a balance between work and play: The effects of work–life interference and burnout on faculty turnover intentions and career satisfaction. *International Journal of Environmental Research and Public Health, 19(*2), 809. https://doi.org/10.3390/ijerph19020809

Boyle, D. A., & Bush, N. J. (2018). Reflections on the emotional hazards of pediatric oncology nursing: Four decades of perspectives and potential. *Journal of Pediatric Nursing, 40,* 63-73. https://doi.org/10.1016/j.pedn.2018.03.007

Carcary, M. (2020). The research audit trail: Methodological guidance for application in practice. *Electronic Journal of Business Research Methods, 18*(2), 166-177. https://doi.org/10.34190/jbrm.18.2.008

Challinor, J. M., Alqudimat, M. R., Teixeira, T. O., & Oldenmenger, W. H. (2020). Oncology nursing workforce: Challenges, solutions, and future strategies. *The Lancet Oncology, 21*(12), e564-e574. https://doi.org/10.1016/s1470-2045(20)30605-7

Colosi, B. (2019). *2019 National health care retention & RN staffing report*. https://pdf4pro.com/amp/cdn/2019-national-health-care-retention-amp-rn-staffing-report-5bab3b.pdf

Crane, M. F., Searle, B. J., Kangas, M., & Nwiran, Y. (2019). How resilience is strengthened by exposure to stressors: The systematic self-reflection model of resilience strengthening. *Anxiety, Stress, & Coping*, *32*(1), 1-17. https://doi.org/10.1080/10615806.2018.1506640

Cross, L. A. (2019). Compassion fatigue in palliative care nursing: A concept analysis. *Journal of Hospice & Palliative Nursing, 21*(1), 21–28. https://doi.org/10.1097/NJH.0000000000000477

Cuthbertson, L. M., Robb, Y. A., & Blair, S. (2020). Theory and application of research principles and philosophical underpinning for a study utilizing interpretative phenomenological analysis. *Radiography, 26*(2), e94-e102.

https://doi.org/10.1016/j.radi.2019.11.092

Cypress, B. (2018). Qualitative research methods: A phenomenological focus. *Dimensions of Critical Care Nursing, 37*(6), 302-309. https://doi.org/10.1097/dcc.0000000000000322

Dennis, B. (2018). Validity as research praxis: A study of self-reflection and engagement in qualitative inquiry. *Qualitative Inquiry, 24*(2), 109-118. https://doi.org/10.1177/1077800416686371

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder* (pp. 1–20). Brunner/Mazel.

Geuens, N., Verheyen, H., Vlerick, P., Van Bogaert, P., & Franck, E. (2020). Exploring the influence of core-self evaluations, situational factors, and coping on nurse burnout: A cross-sectional survey study. *Plos one, 15*(4), Article e0230883. https://doi.org/10.1371/journal.pone.0230883

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, *25*(5), 1292-1301. https://doi.org/10.46743/2160-3715/2020.4212

Grech, A., Depares, J., & Scerri, J. (2018). Being on the frontline: Nurses' experiences providing end-of-life care to adults with hematologic malignancies. *Journal of Hospice & Palliative Nursing*, *20*(3), 237-244. https://doi.org/10.1097/njh.0000000000000433

Gribben, L., & Semple, C. J. (2021). Factors contributing to burnout and work-life balance in adult oncology nursing: an integrative review. *European Journal of Oncology Nursing, 50*, Article 101887. https://doi.org/10.1016/j.ejon.2020.101887

Gustafsson, T., & Hemberg, J. (2022). Compassion fatigue as bruises in the soul: A qualitative study on nurses. *Nursing Ethics, 29*(1), 157–170. https://doi.org/10.1177/09697330211003215

Hayashi, P., Jr., Abib, G., Hoppen, N., & Wolff, L. D. G. (2021). Processual validity in qualitative research in healthcare. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 58,* Article 00469580211060750. https://doi.org/10.1177/00469580211060750

Hays, D. G., & McKibben, W. B. (2021). Promoting rigorous research: Generalizability and qualitative research. *Journal of Counseling & Development, 99*(2), 178-188. https://doi.org/10.1002/jcad.12365

Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? Estimating sample sizes in focus group research. *Qualitative health research, 29(*10), 1483-1496. https://doi.org/10.1177/1049732318821692

Holland, P., Tham, T. L., Sheehan, C., & Cooper, B. (2019). The impact of perceived workload on nurse satisfaction with work-life balance and intention to leave the occupation. *Applied Nursing Research, 4*9, 70–76. https://doi.org/10.1016/j.apnr.2019.06.001

Janatolmakan, M., & Khatony, A. (2022). Explaining the consequences of missed nursing care from the perspective of nurses: A qualitative descriptive study in Iran. *BMC*

*Nursing, 21*(1), Article 59. https://doi.org/10.1186/s12912-022-00839-9

Jarrad, R. A., & Hammad, S. (2020). Oncology nurses' compassion fatigue, burn out and compassion satisfaction. *Annals of General Psychiatry, 19*(1), 1–8. https://doi.org/10.1186/s12991-020-00272-9

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education, 84*(1), Article 7120. https://doi.org/10.5688/ajpe7120

Juvé, U. M., González, S. M., López, J. M. M., Planas, C. M., Rodríguez, F. H., Batuecas Duelt, I. J., Tapia, P. M., Pons Prats, M., Jiménez, M. E., Barberà Llorca, M. À., Asensio, F. S., Berbis, M. C., Zuriguel, P. E., Delgado, H. P., Rey Luque, Ó., Zabalegui, A., Fabrellas, N., & Adamuz, J. (2020). Acuity, nurse staffing and workforce, missed care and patient outcomes: A cluster-unit-level descriptive comparison. *Journal of Nursing Management (John Wiley & Sons, Inc.), 28*(8), 2216–2229. https://doi.org/10.1111/jonm.13040

Katz, A. (2019). Compassion in practice: Difficult conversations in oncology nursing. *Canadian Oncology Nursing Journal, 29*(4), 255–257.

Kohli, D., & Padmakumari, P. (2020). Self-care, burnout, and compassion fatigue in oncology professionals. *Indian Journal of Occupational & Environmental Medicine, 24*(3), 168–171. https://doi.org/10.4103/ijoem.IJOEM_201_19

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology, 16*(2), 182-198. https://doi.org/10.1080/14780887.2018.1540655

Leko, M. M., Cook, B. G., & Cook, L. (2021). *Qualitative methods in special education research. Learning Disabilities Research & Practice, 36*(4), 278-286. https://doi.org/10.1111/ldrp.12268

Lindgren, B. M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, Article 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Lorente, L., Vera, M., & Peiró, T. (2021). Nurses stressors and psychological distress during the COVID-19 pandemic: The mediating role of coping and resilience. *Journal of Advanced Nursing*, *77*(3), 1335-1344. https://doi.org/10.1111/jan.14695

Lubejko, B. G., & Wilson, B. J. (Eds.). (2019). *Oncology nursing: Scope and standards of practice*. Oncology Nursing Society.

Maajida Aafreen, M., Vishnu Priya, V., & Gayathri, R. (2018). Effect of stress on academic performance of students in different streams. *Drug Invention Today*, *10*(9).

Maxwell, J. A. (2021). Why qualitative methods are necessary for generalization. *Qualitative Psychology, 8*(1). https://doi.org/10.1037/qup0000173

Mazzella Ebstein, A. M., Sanzero Eller, L., Tan, K. S., Cherniss, C., Ruggiero, J. S., & Cimiotti, J. P. (2019). The relationships between coping, occupational stress, and emotional intelligence in newly hired oncology nurses. *Psycho-oncology*, *28*(2), 278-283. https://doi.org/10.1002/pon.4937

Merriam-Webster. (n.d.). https://www.merriam-webster.com/dictionary

Mohajan, H. K. (2018). Qualitative research methodology in social sciences and related subjects. *Journal of Economic Development, Environment and People*, *7*(1), 23-48. https://doi.org/10.26458/jedep.v7i1.571

Moisoglou, I., Yfantis, A., Galanis, P., Pispirigou, A., Chatzimargaritis, E., Theoxari, A., & Prezerakos, P. (2020). Nurses work environment and patients' quality of care. *International Journal of Caring Sciences*, *13*(1), 108–116.

Molavynejad, S., Babazadeh, M., Bereihi, F., & Cheraghian, B. (2019). Relationship between personality traits and burnout in oncology nurses. *Journal of Family Medicine and Primary Care, 8*(9), 2898. https://doi.org/10.4103/jfmpc.jfmpc_423_19

National Cancer Institute. (n.d.). NCI Dictionary of Cancer terms. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncology

Noble, H., & Heale, R. (2019). Triangulation in research, with examples. *Evidence-Based Nursing*, *22(3*), 67-68. https://doi.org/10.1136/ebnurs-2019-103145

Nwanya, M., & Rowberry, D. (2021). The importance of understanding burnout: an oncology nurse perspective. *British Journal of Nursing, 30*(10), S8–S14. https://doi.org/10.12968/bjon.2021.30.10.s8

Ortega-Campos, E., Vargas-Román, K., Velando-Soriano, A., Suleiman-Martos, N., Cañadas-de la Fuente, G. A., Albendín-García, L., & Gómez-Urquiza, J. L. (2019). Compassion fatigue, compassion satisfaction, and burnout in oncology nurses: A systematic review and meta-analysis. *Sustainability*, *12*(1), 72.

https://doi.org/10.3390/su12010072

Ortega-Galán, Á. M., Pérez-García, E., Brito-Pons, G., Ramos-Pichardo, J. D., Carmona-Rega, M. I., & Ruiz-Fernández, M. D. (2021). Understanding the concept of compassion from the perspectives of nurses. *Nursing Ethics*, *28*(6), 996–1009. https://doi.org/10.1177/0969733020983401

Partlak Günüşen, N., Üstün, B., Serçekuş Ak, P., & Büyükkaya Besen, D. (2019). Secondary traumatic stress experiences of nurses caring for cancer patients. *International Journal of Nursing Practice*, *25*(1). https://doi.org/10.1111/ijn.12717

Pehlivan, T., & Güner, P. (2018). Compassion fatigue: The known and unknown. *Journal of Psychiatric Nursing/Psikiyatri Hemsireleri Dernegi*, *9*(2).

Phillips, C. S., & Volker, D. L. (2020). Riding the Roller Coaster: A Qualitative Study of Oncology Nurses' Emotional Experience in Caring for Patients and Their Families. *Cancer Nursing*, *43*(5), E283–E290. https://doi.org/10.1097/ncc.0000000000000734

Rajamohan, S., Porock, D., & Chang, Y. P. (2019). Understanding the relationship between staff and job satisfaction, stress, turnover, and staff outcomes in the person-centered care nursing home arena. *Journal of Nursing Scholarship*, *51*(5), 560-568. https://doi.org/10.1111/jnu.12488

Reiser, V. L., & Gonzalez, J. F. Z. (2020). Confronting compassion fatigue in oncology nurses. *Nursing*, *50*(5), 54–60. https://doi.org/10.1097/01.nurse.0000659332.20270.6c

Ryan, A., Cross, D., & Worthington, J. (2022). Emotional labour in oncology and haematology nursing: exploring effects and coping strategies. *Cancer Nursing Practice, 21*(3). https://doi.org/10.7748/cnp.2022.e1815

Salehi, T., Barzegar, M., Saeed Yekaninejad, M., & Ranjbar, H. (2020). Relationship between healthy work environment, job satisfaction and anticipated turnover among nurses in intensive care unit (ICUs). *Annals of Medical and Health Sciences Research, 10(*2).

Salmond, E., Salmond, S., Ames, M., Kamienski, M., & Holly, C. (2019). Experiences of compassion fatigue in direct care nurses: a qualitative systematic review. *JBI Evidence Synthesis, 17*(5), 682-753. https://doi.org/10.11124/jbisrir-2017-003818

Siedlecki, S. L. (2020). Understanding descriptive research designs and methods. *Clinical Nurse Specialist*, *34*(1), 8-12. https://doi.org/10.1097/nur.0000000000000493

Soheili, M., Taleghani, F., Jokar, F., Eghbali-Babadi, M., & Sharifi, M. (2021). Occupational stressors in oncology nurses: A qualitative descriptive study. *Journal of Clinical Nursing*, *30(*21-22), 3171-318. https://doi.org/10.1111/jocn.15816

Soroush, A., Abdi, A., Andayeshgar, B., Vahdat, A., & Khatony, A. (2018). Exploring the perceived factors that affect self-medication among nursing students: a qualitative study. *BMC nursing, 17*(1), 1-7. https://doi.org/10.1186/s12912-018-0302-2

Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing open, 6*(3), 733-739. https://doi.org/10.1002/nop2.275

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education, 44*(1), 26-28.

Taylor-Clark, T. M., Swiger, P. A., Anusiewicz, C. V., Loan, L. A., Olds, D. M., Breckenridge-Sproat, S. T., Raju, D., & Patrician, P. A. (2022). Identifying Potentially Preventable Reasons Nurses Intend to Leave a Job. *The Journal of Nursing Administration, 52*(2), 73–80. https://doi.org/10.1097/nna.0000000000001106

Traynor, M. (2022). Empathy, caring and compassion: Toward a Freudian critique of nursing work. *Nursing Philosophy,* e12399. https://doi.org/10.1111/nup.12399

Vaeza, N. N., Delgado, M. C. M., & La Calle, G. H. (2020). Humanizing intensive care: toward a human-centered care ICU model. *Critical Care Medicine, 48*(3), 385-390. https://doi.org/10.1097/ccm.0000000000004191

Varadarajan, A., & Rani, J. (2021). Compassion fatigue, compassion satisfaction and coping between male and female intensive care unit nurses. *Indian Journal of Positive Psychology, 12*(1), 49–52.

Voitenko, E., Myronets, S., Osodlo, V., Kushnirenko, K., & Kalenychenko, R. (2021). Influence of Emotional Burnout on Coping Behavior in Pedagogical Activity. *International journal of organizational leadership, 10*(2), 183-196. https://doi.org/10.33844/ijol.2021.60525

Wazqar, D. Y. (2019). Oncology nurses’ perceptions of work stress and its sources in a university-teaching hospital: A qualitative study. *Nursing open, 6*(1), 100-108. https://doi.org/10.1002/nop2.192

Wells-English, D., Giese, J., & Price, J. (2019). Compassion Fatigue and Satisfaction: Influence on turnover among oncology nurses at an urban cancer center. *Clinical Journal of Oncology Nursing, 23*(5), 487–193. https://doi.org/10.1188/19.cjon.487-493

Wentzel, D., Collins, A., & Brysiewicz, P. (2019). Describing compassion fatigue from the perspective of oncology nurses in Durban, South Africa. Health SA Gesondheid: *Journal of Interdisciplinary Health Sciences, 24*(0), e1–e7. https://doi.org/10.4102/hsag.v24i0.1279

Xie, W., Wang, J., Zhang, Y., Zuo, M., Kang, H., Tang, P., Zeng, L., Jin, M., Ni, W., & Ma, C. (2021). The levels, prevalence and related factors of compassion fatigue among oncology nurses: a systematic review and meta-analysis. *Journal of Clinical Nursing, 30*(5-6), 615–632. https://doi.org/10.1111/jocn.15565

Young, A. M., Charalambous, A., Owen, R. I., Njodzeka, B., Oldenmenger, W. H., Alqudimat, M. R., & So, W. K. (2020). Essential oncology nursing care along the cancer continuum. *The lancet oncology, 21*(12), e555-e563. https://doi.org/10.1016/s1470-2045(20)30612-4

Zhang, B., Li, H., Jin, X., Peng, W., Wong, C. L., & Qiu, D. (2022). Prevalence and factors associated with compassion satisfaction and compassion fatigue among Chinese oncology healthcare professionals: A cross-sectional survey. *Asia-Pacific*

*Journal of Oncology Nursing*, *9*(3), 153-160.

https://doi.org/10.1016/j.apjon.2021.12.012

## Appendix A: Interview Questions and Script

### Introduction to Interview Script

I appreciate you agreeing to participate in this study, and I look forward to learning about your experience as an oncology nurse. I will ask you several questions relating to your experiences with compassion fatigue when providing care for terminally ill patients. Please feel free to ask me to repeat or clarify any of the questions I ask, and I encourage you to elaborate on your answers when you think it is necessary. Do you have any questions before we begin?

Question 1: How many years have you worked as an oncology nurse in an oncology unit?

Question 2: What does compassion fatigue mean to you?

Question 3: How do you express compassion to your terminally ill patients while providing care?

Question 4: When you are about to enter a terminally ill patient's room, what are some of the things you do to mentally prepare yourself to provide care for the patient?

Question 5: How does the mental preparation you do help you to provide quality care for your patient?

Question 6: Think of and describe a particularly stressful or difficult experience you have had as an oncology nurse: What effect, if any, did it have on your personal life, sleep, health, diet?

Question 7: What effect did this stressful or difficult experience have on the way you provide nursing care?

Question 8: What is your experience with witnessing your terminally ill patients dying?

Question 9: What effect, if any, did witnessing your patient dying have on your personal life, sleep, relationships, health, diet?

Question 10: What did you do to cope with the effects of witnessing a patient dying?

Question 11: How could having debriefing sessions help you express your feelings after witnessing a patient dying?

Question 12: What else would you like to tell me about your experiences with terminally ill patients?

Researcher to Participants: Thank you for participating in this study. If you have any questions, please do not hesitate to contact me either by phone or email, both are on the consent form given to you prior to this interview. Have a wonderful day!

# Appendix B: Privacy Policy for NoNotes Media

NoNotes is a company that provides call recording and audio transcription services and can be found at www.nonotes.com. “All of our transcriptionists have signed confidentiality agreements as part of their employment contracts. We activate a standard Non-Disclosure Agreement (NDA), or we can sign any NDA you wish to put in place. We are also happy to sign any additional legal information you might have. We protect your privacy using 128bit Secure Sockets Layer (SSL) encryption. Our passwords are double-hashed and only internal NoNotes staff have access when transcription permission is granted. All our servers are located in a class-A facility with climate control, retinal scan access and around-the-clock security.”