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# Oncology Nurses' Personal Understandings About Palliative Care

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**A**lthough palliative care is becoming increasingly available, many factors limit who receives palliative care and the timeliness of its receipt. Among the most important barriers are inadequate numbers of trained providers and inaccurate understanding of palliative care (Foley & Gelband, 2001). Too often, palliative care is understood as limiting options available to the patient and family, rather than as the utilization of optimal clinical knowledge and tools to improve patient care (Ferrell & Virani, 2008). Palliative care frequently is perceived as care for people who have “failed” medical treatments (Sesterhenn, Folz, Bieker, Teymoortash, & Werner, 2008) and often is equated with end-of-life care (Paice, Ferrell, Coyle, Coyne, & Callaway, 2008; Reinke et al., 2008). Of greater concern, palliative care interventions are sometimes understood as hastening death, albeit inadvertently (de Veer, Francke, & Poortvliet, 2008). These perceptions of palliative care limit opportunities for optimal care of patients and families.

Nurses spend a great deal of time with patients and are well situated to affect patients' care and outcomes (Coyne et al., 2007; Kirchhoff, Beckstrand, & Anumandla, 2003). Oncology nurses, in particular, have a major role in the essential care of patients across the course of their disease (Willard & Luker, 2005). Patients with cancer often have a great symptom burden because of the nature of the disease and the consequences of treatments, despite the substantial potential for managing those symptoms (Foley & Gelband, 2001). The purpose of this study was to explore the personal understandings that oncology nurses hold about palliative care in general, including its dimensions of symptom management, decision making, and end-of-life care, and, more specifically, nurses' beliefs about when, how, and for whom palliative care should be provided.

Knowledge about palliative care has evolved rapidly over the past few decades, during which it has become a distinct specialty. “Palliative care refers to patient- and

**Purpose/Objectives:** To examine how oncology nurses define palliative care, views about who should and should not receive palliative care, and beliefs about palliative care decision making, including who should be involved and how decisions should be managed.

**Design:** Qualitative interviews and analysis.

**Setting:** Preferred location of each respondent.

**Sample:** 12 nurses representing different aspects of oncology nursing.

**Methods:** An interview guide was employed to ensure that specific topics were covered. Interviews were transcribed verbatim. Qualitative analysis consisted of independent, multiple reviews of the transcripts to share initial findings and identify, refine, and reach consensus on major themes and subthemes.

**Main Research Variables:** Nurses' definitions of palliative care, views about who should and should not receive palliative care, and beliefs about palliative care decision making.

**Findings:** Nurses' perceptions of palliative care focused on symptom management. Most did not distinguish between palliative care and hospice and believed that only patients who were near the end of life should receive palliative care. They viewed their role in decisions regarding palliative care to be limited and indirect.

**Conclusions:** Although oncology nurses should be at the cutting edge with regard to palliative care, these nurses' personal understandings could serve to limit care for many patients with cancer who could benefit from it.

**Implications for Nursing:** Education and clinical experience embedded in a continuous quality-improvement model are needed to ensure sustained change that will overcome the multiple, interwoven barriers to providing appropriate palliative care.

family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access