

Challenges Encountered by Vietnamese Nurses When Caring for Patients With Cancer

Ly Thuy Nguyen, MSN, BSN, RN, Lourdes Clemenceau Annoussamy, PhD, MBA-HHM, and Virginia T. LeBaron, PhD, ACNP-BC, AOCN®, ACHPN®, FAANP

Providing holistic care is acknowledged as central to providing quality care for patients with cancer, but providing competent nursing care consistent with these approaches remains a challenge for nurses in Vietnam. Obstacles for Vietnamese oncology nurses include their low status, the limited scope of nursing practice, work overload in a hierarchical system, and cultural beliefs that view death and dying as taboo. Additional research to support oncology nurses in Vietnam must acknowledge the merits of improving nursing education as an important strategy for enhancing nursing autonomy, quality of care, and outcomes for the increasing number of patients with cancer in low- and middle-income countries.

Nguyen is a lecturer at Hanoi Medical University and Annoussamy is the nursing director at L'hôpital Français de Hanoi, both in Vietnam; and LeBaron is an assistant professor in the School of Nursing at the University of Virginia in Charlottesville.

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Nguyen can be reached at nguyenthuyly.hmu@gmail.com, with copy to editor at ONFEditor@ons.org.

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Cancer is an increasing problem in Vietnam, with more than 125,000 people diagnosed each year, most at an incurable stage (International Agency for Research on Cancer, 2012). Despite the growing need for oncology care, Vietnam lacks adequate cancer treatment facilities, and a National Cancer Control Program is still in development (Vietnam Ministry of Health, 2015b). Because of the low awareness about cancer among the population and the absence of sufficient early diagnosis and appropriate treatment, mortality from cancer remains high (Ngoan le, Lua, & Hang, 2007). The Vietnamese healthcare system is struggling to reduce the number of new cancer cases and to provide adequate care services for existing patients with cancer. With minimal staffing and limited resources—combined with caring for extremely ill and symptomatic patients—Vietnamese nurses face a number of barriers in providing quality care for patients with cancer and their families. This article will discuss key barriers for Vietnamese oncology nurses related to nursing status and cultural factors.

Nursing Status

In Vietnam, nursing practice has been significantly influenced by many years of war, with nursing care focused mainly on basic tasks, such as administering medications or performing wound dress-

ings. This focus has generated a long legacy of ambiguity about the nursing role, which has resulted in varying standards for nursing care and societal expectations about how nurses should function professionally. Two main factors that contribute to the low status of Vietnamese nurses ascribed by the public include inadequate educational preparation and gender inequality and bias.

Educational Preparation

In Vietnam, only one nursing university exists; most nurses are trained in medical universities, colleges, or schools, which include nursing faculty. The current nursing workforce in Vietnam possesses varying levels of education, including a secondary certificate program (two years), a college program (three years), or a bachelor's degree (four years). Most nurses (about 70%) in Vietnam practice with a secondary certificate (Vietnam Ministry of Health, 2009). Regardless of educational preparation and training, all nurses assume the same role in healthcare environments (Muc, 2009). In response, the Vietnam Ministry of Health (2015a) issued a governmental decision that, from 2021 onward, the healthcare system will only recruit college program- and bachelor's degree-level nurses, and, by 2025, all existing secondary-level nurses must upgrade to higher education levels.

The majority of the first year of nursing education is committed to compulsory subjects set by the Ministry of Education and Training University Education Curriculum Framework, such as Ho Chi Minh Ideology and Principles of Marxist-Leninist Philosophy. The second year incorporates supportive subjects (e.g., general anatomy, physiology) and techniques for basic care. The third and fourth years focus on disease and biomedical treatments. The topics of nursing research and management are briefly introduced in the third or fourth year, which are only provided for college program and bachelor's degree students. The Ministry of Education and Training allows each health educational institute to vary as much as 40% in its curriculum frame (Hill & Crow, 2013). However, lack of national standards or formal evaluation for nursing education leads to the failure of nursing education in meeting national and international competency standards (Crow & Thuc le, 2011; van der Velden, Van, Quoc, Van, & Baron, 2010). Standardization regarding what nursing education should achieve varies throughout the country and from institute to institute. Diplomas from the secondary level at accredited health educational institutes are sufficient for nurses to practice as RNs across the country. To receive a lifetime nursing license, which is not compulsory, nurses are only required to continuously practice in hospitals or clinics for at least nine months. Of note, the nursing curriculum does not pay sufficient attention to practical training; clinical rotations for nursing students are limited and characterized by a large number of students with minimal clinical instructor supervision (one clinical instructor for more than 50 students) (Truong, 2015). In addition, lack of communication between healthcare sectors and nurse educators is a significant challenge

for clinical nurse teaching in Vietnam (Harvey, Calleja, & Thi, 2012).

In 2009, the Vietnamese Nurses Association developed general nursing competency standards through international assistance and collaborative partnerships (Chapman, Lewis, Osborne, & Gray, 2013). The Vietnamese nursing competency standards consist of three domains that reflect the breadth of nursing practice: professional, legal, and ethical responsibilities of professional practice; provision and coordination of care; and leadership and management (Ministry of Health, 2012). However, the current nursing undergraduate curriculum does not incorporate nursing activities outlined in the nursing competency standards, and, therefore, a gap exists between policy and education provision (Truong, 2015). In addition, competency standards for nurses working in oncology settings have not been developed in Vietnam. Therefore, no professional framework exists to guide nurses who work in these complex care settings.

The nursing curricula for all levels is dominantly taught by physicians, with insufficient content focusing on nursing care science (Pron, Zygmunt, Bender, & Black, 2008). Because physicians lead nursing education in Vietnam, the content tends to be disease-centered versus patient-centered. Therefore, the majority of nurses focus mainly on technical skills and, consequently, may not be sufficiently equipped with background nursing knowledge, symptom assessment and management skills, and foundational research principles. Nursing practice is allocated by tasks rather than by patients, which may prevent nurses from having a holistic approach to individual patients. For example, one nurse is assigned to administer chemotherapy and another nurse is responsible for

taking vital signs for every patient in the unit. The Ministry of Health has reported that technical nursing care is failing to provide patient- and family-centered care (Harvey et al., 2012). In addition, research is not acknowledged as a necessary part of everyday nursing practice, and nursing competencies regarding evidence-based practice are not mentioned in the governmental documents (Vietnam Ministry of Health, 2011). Little educational material is available in the Vietnamese language, and what little is available is often outdated. Almost all current evidence-based resources are published in English and are available electronically, making them inaccessible to the majority of Vietnamese nurses who do not understand the foreign language and who cannot access the Internet. Implementing evidence-based oncology practice can be further complicated in the context of knowing what to do but not being able to do it because of limited facilities or resources and administrative support. To make matters worse, specialty training or standardized education in chemotherapy administration or cancer biology is not required for oncology nurses in Vietnam. Consequently, oncology nurses in Vietnam develop their specialist nursing knowledge through informal learning strategies, such as learning with and through others, learning from experience, and attending workshops or conferences.

Gender Bias and Inequality

The other key factor contributing to the low status of nurses in Vietnam is the high percentage of female nurses. For example, a cross-sectional survey of 251 oncology nurses conducted in the three largest cancer hospitals in North Vietnam indicated that the majority of oncology nurses were female (92%) (Nguyen, Yates, & Osborne,

2014). Gender equity remains a burning issue across Vietnam, where women generally have fewer educational opportunities than men and face difficulties in asserting their right to take part in decision making. The Vietnam Ministry of Health (2009) reported that the majority of Vietnamese nurses do not have bachelor's degrees, and only a small number of nurses can access postgraduate courses in Vietnam.

Because of their low status and the expectation that they will work under the direction of doctors with little questioning, Vietnamese nurses perform limited activities on behalf of their patients. For example, patient education is mostly performed by physicians (Pron et al., 2008), and nurses generally do not recognize this as their responsibility (Nguyen et al., 2014). Opioids, such as morphine, are controlled and prescribed by doctors; nurses can administer morphine only with a doctor's order, which does not facilitate autonomous nurse practice (Crow & Thuc le, 2011). Vietnamese nurses are required to contact the physician each time pain medication is needed because an as-needed medication policy is not instituted (Pron et al., 2008). Nurses are often not well trained in morphine administration and pain management. Consequently, the majority of Vietnamese nurses working in oncology settings have a limited understanding of morphine and the actual risk of addiction, and may fear legal repercussions for providing opioid analgesia (Nguyen et al., 2014); this puts many patients with cancer at risk for great suffering (Krakauer, Ngoc, Green, Van Kham, & Khue, 2007).

Cultural Factors

Cultural practices and spiritual beliefs are fundamental factors that influence the way people make

decisions and interact with others in societies. In addition to nursing knowledge and technical expertise, nurses bring cultural and spiritual beliefs about death and dying into their work (Black & Rubinstein, 2005; Tan et al., 2006; Wu & Volker, 2009). In Vietnamese culture, social taboos present barriers to talking openly about death. If people have to discuss death, they speak in restrained tones about its unfortunate nature. Vietnamese people use phrases such as "passed away" or "pass on" instead of "death" or "dying." Nurses caring for patients with cancer can face cultural stigma; such work is perceived as unlucky because a cancer diagnosis suggests a death sentence. If nurses have just cared for a dying body, it is believed that they should not have physical contact with children, who are pure and vulnerable. In Vietnamese culture, social avoidance of death issues and low nursing status can have an influence on nurses' willingness to discuss prognosis or talk about death and dying with patients with cancer and their families.

The predominant religion in Vietnam is Buddhism (more than 50%) (U.S. Department of State & Bureau of Democracy, Human Rights, and Labor, 2013), which influences the Vietnamese culture and attitudes toward life, death, and dying. According to Buddhist beliefs, death is not the end of life; it is merely the end of the body that a person inhabits in this life. The soul does not perish at death but seeks another existence in a new life, and this goes on and on. If a person dies a good death, the spirit will be gently released to another world. In contrast, if a person dies a bad death, the spirit will be hurt deeply. A good death is dying quickly and painlessly without losing any part of the body after important wishes in one's personal life have been completed. When approaching death, a dying person

should receive holistic care and be mentally encouraged and consoled by family members and the community. Therefore, in Vietnam, a dying person often wishes to die at home surrounded by beloved family members because it is believed to be a peaceful place for a natural or good death. This belief results in the discharge of the majority of dying patients from hospitals just prior to death. Consequently, nurses should be equipped with end-of-life care knowledge and skills to monitor and assess near-death signs and symptoms to help patients maintain a peaceful psychological state and ensure that their wishes about the place of death are met. Unfortunately, no national training course in palliative care for Vietnamese oncology nurses is offered, and, to date, palliative education is only available for oncologists from a few hospitals (Krakauer et al., 2007). Efforts are currently underway to develop a national palliative care curriculum for nurses in Vietnam.

Full Disclosure

In many Asian cultures, directly informing a patient of a cancer diagnosis is perceived to be unnecessarily cruel (Matsumura et al., 2002). This concern merges with Asian values of respect for aging patients who are perceived as more vulnerable to being distressed by bad news (Candib, Quill, & Stein, 2002). In addition, Buddhist beliefs that the person must have done something wrong in a present or past life to have attracted cancer are common (Migrant Information Centre [Eastern Melbourne], 2009). These perceptions may cause nurses to be reluctant to provide honest answers about patients' conditions (Nguyen et al., 2014) and may conflict with the view of full disclosure based on the Western tradition that values patient autonomy and decision making.

Vietnamese families play an important role in caring for and protecting the life of individual members. In-hospital fundamental nursing care, such as mobilizing, feeding, toileting, bathing, and comforting, are mostly provided by patients' relatives. Neither nurses nor other healthcare professionals acknowledge the role of nurses in advocating for patients because they believe this role is the responsibility of patients' families. Family members may keep information regarding diagnosis and prognosis a secret, with the goal to protect the patient from losing hope and to avoid inflicting further emotional and physical distress. A quantitative survey of 122 Vietnamese family members revealed that they did not want patients to be informed of their cancer diagnosis (61%) or treatment plans (47%) (Cam, Quach, Stalford, & Dang, 2010). This finding is supported by a number of other studies (Donovan, Williams, Stajduhar, Brazil, & Marshall, 2011; Werth, Blevins, Toussaint, & Durham, 2002), which stated that, in contrast to Western ideals, many Asian cultures prefer family-centered approaches to care and communication. This perspective has likely influenced the attitudes of Vietnamese nurses, who favor informing and involving the family more than the patient.

In Vietnam, informing patients about their condition, with full disclosure of their diagnosis and prognosis, may be not recognized as being within the scope of nursing practice but rather the domain of the doctors. The role of contemporary nurses is unclear, and this perception limits their professional scope of practice and decision-making authority. Therefore, nurses in Vietnam may not be equipped with effective communication and interpersonal skills needed to provide bad news to patients. Of even more concern than the lack of skills in communication is the possibility

that nurses may be unaware of the importance of full disclosure in promoting patients' autonomy in making decisions. In fact, only 40% of oncology nurses agreed with the following statement: "The dying person and his/her family should be the in-charge decision makers" (Nguyen et al., 2014). In contrast, a related study conducted in Vietnam reported that 66% of 160 patients with cancer would actually like disclosure of their terminal illness and 78% of patients wished to make their own treatment decisions (Cam et al., 2010). This contradiction between the preference of patients to be informed about their condition and be autonomous in decision making and actual socio-cultural practice may influence nurses' attitudes toward this issue in conflicting ways.

Talking About Death and Dying

Oncology nurses in Vietnam report less positive attitudes toward talking about death and dying with patients with cancer and their families (Nguyen et al., 2014); many reasons are likely for this. Vietnamese nurses are overworked because of nursing shortages and overcrowding in healthcare systems (World Health Organization, 2012), so they may have limited time to supportively talk with patients about death and dying. In Vietnam, physicians are acknowledged as having knowledge and power to make the best decisions, and, therefore, patients and their families defer medical care decisions to the wisdom and experience of physicians (Purnell & Paulanka, 2003). The physician's relationship with patients and their family members is primary, with the nurse having a limited therapeutic relationship. At the same time, oncology nurses may have developed distancing strategies by minimally communicating with patients and their family members to cope with the stress and anxiety of

witnessing human suffering (Bush, 2009; LeBaron, Beck, Black, & Palat, 2014; Mackereth, White, Cawthorn, & Lynch, 2005; Pendry, 2007).

Not all Vietnamese nurses are prepared to discuss death and dying or develop close relationships with patients and their family members. This is true even among a small proportion of oncology nurses who received palliative care training; they report misconceptions regarding communication and emotional support (Nguyen et al., 2014), because their education is typically focused on technical skills and the biomedical model of disease rather than holistic and therapeutic nursing interventions (Harvey et al., 2012). Vietnamese nurses are very task-focused under the command of physicians in the hierarchical structure of hospitals. In addition, patients in Vietnam may not want to directly address end-of-life care because death is interpreted as bad luck and patients may feel they are already among the dead and no longer able to enjoy their daily lives (Candib et al., 2002). These reactions may cause the discussion about end-of-life care to occur too late (Latour, Fulbrook, & Albarran, 2009). Strong patient and family cultural beliefs about death and dying, combined with lack of nurse empowerment and limited interest and training to have these conversations, may lead nurses to fail to empathize with the experiences and feelings of patients with cancer and their families at the end of life.

Conclusion

Although providing holistic care is acknowledged as central to providing quality care for patients with cancer, providing competent nursing care consistent with these approaches remains a challenge. Obstacles for Vietnamese oncology nurses include nurses' low status because of inadequate nursing education and gender inequality, the

limited scope of nursing practice, work overload in a hierarchical system, and cultural beliefs that view death and dying as taboo. Additional research to support oncology nurses in Vietnam (and similar settings) must acknowledge the merits of improving nursing education as an important strategy for enhancing nursing autonomy and quality of care and outcomes for the increasing number of patients with cancer in low- and middle-income countries (LMICs). Nursing education in LMIC settings, such as Vietnam, must account for relevant cultural and social factors related to nurse training, role socialization and expectations, and the realities of clinical practice.

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