

The Troubled Nurse: A Qualitative Study of Psychoemotional Effects of Cancer Care on Nurses in A Nigerian Cancer Care Setting

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ABSTRACT

Objective: Nurses who care for cancer patients are exposed to varying degrees of psychological pressure. These psychological issues among nurses are thought to have some consequences relating to professional satisfaction, quality of care, and patient outcome. This study aimed to explore the psychological and emotional impact of caring for persons among cancer care nurses. **Methods:** A qualitative, descriptive approach was employed, and a purposive sampling technique was used to select seven nurses who were interviewed one-on-one. Interview data were coded and analyzed using NVivo 12 to generate the final themes and patterns. The EQUATOR's COREQ guideline for qualitative studies was adhered to. **Results:** Data analysis yielded two major themes and four sub-themes. Participants expressed concerns about their frequent encounter with dying patients on the ward which affects their own mental well-being as persons. Sometimes, the

health-care professionals used emotional distance to mitigate the emotional and psychological effects of the frequent deaths encountered on the ward. Professional dissatisfaction was also brought about by the increased amount of patients who died on the ward, the gloomy nature of the care environment, and the feeling of incapacitation to help. **Conclusions:** The findings indicate that nurses who care for cancer patients need to be supported to enhance their psychological and emotional well-being. The findings of this study could help nurse managers to understand the level of psychological pressure cancer care impose on nurses and the importance of improving the mental health of nurses in cancer care.

Key words: Cancer, mental health, nursing, oncology nursing, psychological distress

Introduction

Cancer constitutes a major health concern in Nigeria despite the efforts to find a lasting solution to this menace at the international level.^[1] Unfortunately, the rate of

cancer survival in Nigeria remains lower than what is observed in developed nations, principally because of

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late presentation,^[2] inadequate number of cancer care specialists, lack of functional equipment and other resources,^[2] and high level of poverty.^[3] Surprisingly, there are evidence that cancer patients present to the hospitals very late only when all traditional treatments have failed to cure their illnesses.^[4] This mounts more pressure on the already deficient resources in this setting.

Cancer is not just a disease as the name implies, but a group of diseases with unique etiologies^[5] and specifically, the scientific explanations of the onset of cancer can only offer limited information about its precise causes. Prompt diagnosis generally boosts the chances of successful treatment by concentrating on the prevention and detection of asymptomatic and symptomatic patients as early as possible.^[6] Due to the complexity of cancer, treatments are programmed according to the patients' individual physical and psychological health status.^[6]

Unfortunately, the high prevalence of late-stage cancers in Africa has been widely documented.^[7,8] Livingstone^[8] in her ethnographic study in a cancer hospital ward in Botswana describes that cancer in Africa is situated at the outskirts of oncological imagination. Mulemi^[7] described the terrible and arduous process patients and their loved ones in Kenya go through in an attempt to seek the diagnosis and treatment due to the lack of specialists and poor access to treatment centers. Unfortunately, there are no adequate screening centers in Africa, corroborating what Mulemi^[7] and Livingstone^[8] found in their ethnographies that 'early cancers' do not exist both in Kenya and Botswana, respectively. This can be a similar representation of the Nigerian situation.

Once a diagnosis of advanced cancer is made in Nigeria, quality of life and long-term survival are not likely. For example, In 2017, Okwor *et al.*^[9] reported that the median age for cancer survival in Nigeria was 1.9 years. Subsequently, in 2018, Aliyu *et al.*^[10] reported in their study that the median survival time for cancer patients was 22 months. More so, cancer patients in Nigeria are subjected to treatment ambiguity and daily life struggle and the nurses tend to bear the weight of the patients' suffering on themselves resulting in compassion fatigue (CF), anxiety, and other psychological issues as well as lack of professional fulfilment.

Registered nurses who care for cancer patients are exposed to the varying degrees of psychological pressure. These psychological issues among nurses are thought to have some consequences relating to professional satisfaction, quality of care, and patient outcome.^[11] Working in oncology units can produce emotional exhaustion and low levels of personal accomplishments.^[11,12] Symptoms of emotional exhaustion among nurses have been observed. Burnout

affects an employee's well-being and the quality of the care, which can lead to errors, reduced patient safety, and poorer therapeutic outcomes.^[13] Nurses with emotional imbalances will be less able to stand in the patient's shoes and listen emphatically and would prefer to protect themselves by putting the patients at a distance.^[14] Besides, burnout was found to be significantly predictive of turnover intention.^[15]

This study, therefore, aimed to explore the experiences of nurses who care for cancer patients in a Nigerian cancer care setting. Specifically, this study explored the psychological and emotional demands of cancer care on nurses in this setting.

Methods

A qualitative study was adopted to collect the data from seven nurses. This study is in compliance with the EQUATOR's COREQ checklist for qualitative research.^[16] This study was conducted in the oncology unit of University College Hospital (UCH). UCH is a federal government-owned hospital in Ibadan, Oyo State, Nigeria, the largest city in West Africa where the first university in Nigeria is located. After receiving ethical approval with approval number (UI/EC/0539) from the Institute for advanced medical research and training, University of Ibadan and obtaining permission from the hospital, a purposive sampling technique was used to select seven nurses in cancer care cancer who were approached for face to face in-depth interview about their experiences.

After obtaining informed consent, participants were interviewed individually in an area and time they were most comfortable with, lasting between 40 min and 1 h depending on the comfort of the participants and the amount of information they were willing to give. The interviews were recorded using a digital recorder and notes were also taken simultaneously to summarize nonverbal observations.

The interviews were conducted once and were digitally audio-taped and then transcribed verbatim. Computer software such as NVivo 12 (QSR international, Melbourne, Australia) were used to organize and reformat the raw data. At the end of the interview, the researchers listened to the recording in full and wrote down their immediate thoughts including the overall content of the interview, gaps or ideas which they wanted to explore further, and key words or phrases that were repeated by the participants. Descriptors from the words of the participants that described the phenomenon of interest were identified to initially generate codes. Codes with similar contents were grouped into meaningful categories or descriptive labels. Data categories were reviewed and sorted to discover

recurrent patterns within the data. The researchers looked for saturation of ideas and recurrent patterns of similar and differing meanings. As analysis continued, categories were developed or reframed until major themes emerged. Illustrative quotes from the interviews were presented. The four aspects of trustworthiness (credibility, transferability, dependability, and conformability) proposed by Lincoln and Guba^[14] were adopted to ensure rigor.

Results

Although a representative sample was not necessary for this study, the sociodemographic information of the nurse participants represented the spectrum of nurses working in the oncology unit [Table 1]. All the nurses were female and Christians; educational background ranged from those who had a diploma in Nursing and Midwifery to those who possessed bachelors and graduate degrees. Majority of the nurse participants were from the Yoruba ethnic group. The majority of the nurses had worked for more than 10 years. Only Nurse 5 had worked for 8 years as a general nurse. Majority of the nurses had worked in cancer care for <7 years with only Nurse 7 working in cancer care for up to 26 years.

Data analysis yielded two themes and four subthemes related to the phenomenon of interest as presented in Table 2.

Nurses' disinclination for cancer care practice

There were nurse participants in this study who emphatically stated that they did not possess the propensity and inclination for cancer care. Only one nurse expressed an innate interest for the care of persons living with

cancer. In the themes, the two patterns that emerged were: Professional unfulfilment in cancer care and disinclination for cancer care.

Professional unfulfilment in cancer care

The presence of emotional commitment or its absence thereof determines how much professional fulfilment a nurse in cancer care enjoys. Since cancer care nursing is filled with so many complexities, and is compounded by the frequent deaths on the ward, nurses need to be emotionally committed to caring for cancer patients. Majority of the nurse-participants in this study were unfulfilled and highly dissatisfied in their current area of practice. This professional dissatisfaction was brought about by the increased amount of patients who died on the ward, the gloomy nature of the care environment, and the feeling of incapacitation to help. There were nurse participants who recounted their experiences in other hospital units and wards where they were appreciated by patients and relatives when the patients were discharged from the wards with feelings of celebration. Sometime, nurses in this study felt caring for cancer patients was an effort in futility much like "walking on a treadmill" and that they did not usually have much reasons to "celebrate" on the cancer ward. The nurses expressed their sentiments bluntly as follows:

"Working here so far has not been fulfilling to me as a nurse. The reason for this is that majority, if not all of our patients end up dying. Only very few get well but they eventually come back and die. Because of these, working here has not been really fulfilling. The joy of working is not really there. We do not get the job satisfaction of helping somebody get better and return home, and probably, you get to see them many years later and you are happy that they are alive and well, but here in this ward, it is sad, it is sad working with cancer patients" (Nurse 3).

"Caring for people with cancer is extremely challenging. It is not easy to nurse patients who you know will not survive. There is a special joy in nursing a patient and the patients survives and become healthy again, but we do not have that here" (Nurse 4).

"I like it when caring for a patient and there is an improvement, the patient gets well and you still continue with that relationship but here even if the patient is discharged within a week, 2 weeks or a month the relative will come and say we have lost the patient, so it is disheartening to work here, really, that is my own view" (Nurse 2).

"When I was posted here, I asked myself: 'What am I doing in a cancer ward?' I was not happy because working on this ward takes a lot of courage; you see so many things, like cancer of the breast and cervix, and the most discouraging part of it is being aware that you are just nursing this patient to death because they will eventually die" (Nurse 6).

Table 1: Sociodemographic data of participants

Name labels	Gender	Highest qualification	Religion	Ethnicity	Years as a nurse	Years in cancer care
Nurse 1	Female	RN, RM	Christianity	Yoruba	14	5
Nurse 2	Female	RN, BNSc	Christianity	Yoruba	17	1
Nurse 3	Female	RN, RM	Christianity	Isoko	14	2
Nurse 4	Female	RN, BNSc	Christianity	Yoruba	19	1
Nurse 5	Female	RN, BNSc, MPH	Christianity	Yoruba	8	6
Nurse 6	Female	RN, RM, BNSc	Christianity	Etsako	10	2
Nurse 7	Female	RN, RM, BEd	Christianity	Yoruba	36	26

RN: Registered nurse, RM: Registered Midwife, BNSc: Bachelor of Nursing Science, MPH: Master of Public health, BEd: Bachelor of Education

Table 2: Presentation of themes and subthemes

Theme	Sub-themes
Nurses' disinclination for cancer care practice	Professional unfulfilment in cancer care Disinclination for cancer care
Death and health anxiety in cancer care	Emotional instability associated with death and dying Personal health anxiety

The narratives of the nurses mentioned above indicate that there are little or no moments for the care professionals to celebrate positive outcomes as usually seen in the labor wards, surgical wards, and other medical wards. During an interview with a nurse on the ward, her statement was as follows:

“If you know what we pass through here and what we see on a daily basis on the ward, you would [agree] with me that this ward, this unit is not a good place to work as a nurse. People die every day and it affects us as human beings” (Nurse 1).

The lack of professional fulfilment among the nurses was a significant finding. In fact, it had reached an extent that the nurses were processing their transfers or considering quitting the job completely compounding the issue of high turnover and workload in cancer care. It is important to note that the years of participants’ clinical experience as nurses range from 8 years to 36 years, implying that the participants must have experienced work situations in other units before being posted to the cancer unit. Participants mentioned that the professional unfulfillment was also caused by poor compensation and antineoplastic and occupational health risks associated with cancer care. These opinions are in relation to participants’ experiences in their previous work units. Nurse 3 and Nurse 4 said the following:

“Remuneration of nurses is very poor. These things affect us one way or the other and affect the care we give to the cancer patients” (Nurse 3).

“Even, the nurses are jeopardizing their health just to take care of others. Many of us have health issues such as back ache, knee pain, and others. In fact, I used diclofenac this morning that reduced my pain and enabled me to do my job this morning” (Nurse 4).

Disinclination for cancer care

Many participants described their feelings of disinterest in caring for cancer patients which inhibited empathy-based care. Most nurses mentioned that they were introduced to cancer care when they were inexperienced and thus expressed significant disinterest in cancer care nursing. Some nurses even reprimanded themselves for working in the oncology unit and expressed that they “don’t want to have anything to do with cancer.”

“I can’t say I enjoy working in this unit because I do not have a choice since I was deployed here. I have to do my best whether I like it or not” (Nurse 2).

“I know that specialty training in oncology nursing is very important for those who want to really focus in the care of cancer patients. But for me, God forbid bad thing, I can’t specialize in oncology nursing because I don’t want anything that has to do with cancer” (Nurse 4).

Death and health anxiety in cancer care

Confronting death is a frightening human concern that is influenced by personal experiences and sociocultural orientations. Patients and nurses in cancer care suffer from existential death-related concerns and intense emotional turmoil. Participants’ existential suffering is mainly discussed in the light of death. Death is not easy to talk about since it frightens nurses, patients, and relatives. Death anxiety in this context is associated with the fact that exposure to death reminds nurses of their own mortality. Although the nursing educational curriculum in Nigeria contains some components on death and dying, these concepts are usually not emphasized in detail until when the nurses are exposed to it in practice. Majority of the participants expressed the concerns about their frequent encounter with dying patients on the ward which affects their own mental well-being as persons. Unfortunately, the sociocultural factor that analogizes cancer to dying has not helped matters to the extent that the nurses themselves exhibited intense fear and anxiety for cancer. This theme presents the different issues surrounding cancer death on the ward and will be discussed under two “emotional instability associated with death and dying” and “personal health anxiety.”

Emotional instability associated with death and dying

The findings of this study revealed that cancer care took its toll on the nurses’ emotions compounded by a perceived lack of formal support. The nurses disclosed that their burnout was an outcome of their patients’ emotional demands and the patients’ poor prognosis and care outcomes. Nurses and other health-care professionals often raised existential questions in their frequent encounter with life and death. Sometimes, a patient could be considered to be improving, and suddenly, the patient was dead. This is reflected in the comments of the participants:

“Working in this unit predisposes us to a lot of emotional instability. At one time, you will be happy to see patients getting better, after sometime, you may suddenly hear that the patient has died. One will be wondering why the patient died so soon despite evidence of improvement in His/her condition. This makes us have mood swings sometimes... I actually felt good about the care I gave to her but then the news of her death made me depressed” (Nurse 1).

“It was not my decision to work here. I was posted here. I am not happy to work here because my patients end up dying. If most of my patients eventually die, what then is the joy of nursing? See, if one is not careful, he may enter into depression. It really affects us psychologically but we try our best to cope” (Nurse 3).

Patients and health-care personnel alike drew on their religious beliefs to sustain their hope and resilience. Sometimes, the health-care professionals use emotional

distance to mitigate the emotional and psychological effects of the frequent deaths encountered on the ward. A nurse discussed how nurses used emotional distance to manage or mitigate the psychological distress they are exposed to on the ward:

“When you get attached to the patient, it affects your mind and emotional health when the patient dies. Most of the time I try not to get attached to the patients because it will affect me when the patient finally dies, so working on this ward, I’m not really happy because I am not having job satisfaction” (Nurse 6).

Sometimes, being posted or transferred to the cancer unit was perceived as a punishment for the nurses. Participants explained that most nurses in the other units thought they were being punished by the nursing administrators to work in an emotion-draining unit. In fact, some nurses said they cried heavily during their first periods on the cancer ward, all the nurses confirmed that their posting to the cancer ward was against their choice but they had to obey the “order from above.” This finding suggests that nurses have very limited control over their ward postings and are left with the option of complying with the instructions from the administrators regardless of the nurses’ preferences. The frustration the nurses pass through each day is reflected in the quotation below:

“But we see pathetic cases on this ward and we always put ourselves in their shoes. I feel very sad each time I finish my duty for the day, I know that I just have to try my best and do the little that I can for my patients to facilitate their recovery and till the day they eventually die” (Nurse 4).

The reaction to these psychological and emotional stressors was different among nurses. Although majority of the nurses were severely affected and expressed a sense of wanting to give up, few others actually adapted to the pressure and even enjoyed their duties. For example, nurse 7 described how her initial emotional pressure did not affect her compassionate caring for persons with cancer. Interestingly, findings revealed that nurse 7 had the highest years of experience both as a nurse and on the oncology unit, and was among the two nurses who possessed a Master’s degree.

“Getting here, I saw different kinds of patients, all kind of cancer affecting all part of the body, some disgusting look, different type of cancer even childhood cancers. I felt very bad...I believe there is nowhere I cannot work, so I started getting along. With time it became interesting to me, like I said being passionate, being empathetic, getting interested in working with them, getting close to them then I started enjoying the caring experiences. I knew I needed to know more about this special area to be able to further improve my care of the patient” (Nurse 7).

Personal health anxiety

Most of the nurses did not bother much about cancer until they were posted to the cancer unit, which was when they started becoming worried about cancer. These fears resulted in an obsessive examination of their bodies whenever they felt any slight symptom, of which the symptoms did not cause any worries in the past before their posting to the cancer ward. Although participants had cared for cancer patients and the dying in the past in other units, their experiences on this present unit seem overwhelming. This experience made participants more conscious of their own mortality with the resultant anxiety and unease. This is reflected in the narratives of Nurse 4 and Nurse 5 below:

This ward has affected my personal life because it made me to focus on my health. There are some things I used to take for granted in the past but I am now aware about them. Let me share my experience with you, I had a very terrible experience the initial time when I resumed my duty on the oncology ward. During my first 2 months of working in the oncology ward, I started experiencing some scary feelings on my two breasts and I was scared to the roof that I was developing breast cancer. Until I confided in a female doctor on this ward who laughed out loud and explained to me that it was usual for new staff to experience such, and that I was not the first person to experience it on the oncology ward, it was psychosomatic. Anyway, this experience made me to do thorough breast examination. I no longer take things for granted, even with my children and husband. Anytime they have any complaints, I always ask for signs and symptoms to rule out cancer or any other thing sinister (Nurse 4).

I don’t take things for granted again. For example, I was going home on a particular day after a hectic duty, my knees started to ache and this got me really afraid because I had recently nursed a patient with cancer that presented with knee pain, I quickly pulled over and prayed in the car for God to avert danger. Throughout that week, I was so scared (Nurse 5).

Sometimes, this health-anxiety was converted to health-consciousness and nurses often depended on their colleagues for emotional support and shared their fears with one another according to the comments of Nurse 2. Although health-consciousness could be considered as a positive outcome, this outcome is embedded in anxiety and some forms of obsession.

Personally, working here has also created in me the consciousness to cultivate healthy habits that will not jeopardize my health. Even at that, sometimes, cancer comes out of the blue without any known predisposition (Nurse 2).

Discussion

Cancer is a complex condition and caring for cancer patients can be physically and emotionally demanding. This requires a total commitment from the nurse.^[17] However, certain factors such as forced duty postings do not always guarantee that the nurses on the cancer ward are those who are committed to cancer care. Nurses' preference do not determine the units where they will be posted to, as this is solely determined by the nurse managers. There are speculations that the placement of nurses to the oncology unit was a punitive measure by the administrators, although this speculation was the nurses' impression and was not substantiated. According to Taleghani *et al.*,^[18] the most influential demographic factor on empathy and burnout was work experience of nurses. From critical analysis, the factors that resulted to nurses' disinclination were lack of professional fulfillment and absence of "moments for celebration." The few nurses that expressed some levels of satisfactions were those with innate proclivity/drive for cancer care and the care of those suffering. Davis *et al.*^[19] in their phenomenological study found that only nurses who were emotionally committed to journeying alongside patients and families were in the position to make a difference.

From their findings, Davis *et al.*^[19] reported that nurses in cancer care were witness to the suffering of patients and families and tried to connect with them in ways that they perceived as meaningful. This emotional investment and the level of engagement with patients and families required balance. This finding was supported by Castaneda and Scanlan.^[20] The professional dissatisfaction identified in this study emerged from the increased amount of patients who died on the ward, the gloomy nature of the care environment and the feeling of incapacitation to help, similar to what^[21] described as challenging moments in cancer care.

Sometime, nurses in this study felt caring for cancer patients was an effort in futility much like "walking on a treadmill" and that they continuously remarked that they did not usually have much reason to "celebrate" on the cancer ward as compared to other hospital wards and units. Futile care refers to the provision of medical care with fruitless therapeutic outcomes for the patient.^[20] Futile care may also involve any type of care which neither enhances patients' survival or hospital discharge nor helps them maintain or promote their quality of life^[22,23] which clearly portrays the sentiment of a nurse who expressed that "working here so far has not been fulfilling to me as a nurse. The reason for this is that majority, if not all of our patients end up dying." Another nurse also narrated that "it is not easy to nurse patients that you know will not

survive." For these nurses, the care provided to the cancer patients didn't have any long lasting impact making the nurses feel incapacitated. Based on previous studies, there is a significant relationship between nurses' perception of futile care and moral distress.^[24,25] Generally, findings of this study suggest the presence of nurses' turnover intentions. Although there are currently no studies comparing the turnover rates in oncology units with nononcology units in Nigeria, evidence from literature has established that CF, psychological and emotional stressors are among the leading causes of nurses' turnover, and these stressors are prevalent in the oncology units.^[11]

Being nested with cancer is an excess physical and emotional load for nonspecialist nurses in cancer care.^[11] International research has shown that oncology nurses possess greater coping abilities when caring for terminally-ill cancer patients than nonspecialist nurses in cancer care.^[26,27] Nurses in this study were particularly predisposed to emotional instability because they do not have specialized training in oncology nursing. They used terms such as "feelings of depressions", "being down" "feel very sad" "not emotionally stable" and "sad moments" to describe the emotional and psychological pressure while they are exposed to caring for cancer patients in Nigeria. Similar findings were reported in a study conducted among Jordanian nurses in cancer care.^[27]

Cancer-related health anxiety or fear is another psychological implication of caring for persons with cancer on a regular basis. The nurse-participants in this study narrated their experiences with cancer-related health anxiety which was more prominent during their 1st week of duty on the cancer ward. A nurse-participant narrated that "during my first 2 months of working in the oncology ward, I started experiencing some scary feelings on my two breasts and I was scared to the roof that I was developing breast cancer." In an interview with another nurse, she explained "...my knees started to ache and this got me really afraid because I had recently nursed a patient with cancer that presented with knee pain." This negative psychological response has been found to be prevalent among nurses who care for cancer patients. For example, Cal *et al.*^[28] found that majority (71.9%) of the nurses in cancer care had experienced cancer fears during clinical practice. Similar findings had been reported over a decade ago by.^[29]

The findings from this study suggest the possibility of CF and health anxiety among the nurse-participants. According to reported evidence, the majority of published studies on CF were conducted in Western countries, which suggests the need for additional research in other settings to determine effective interventions that address CF and stress cross-culturally.^[30] Strategies to reduce these

psychological effects individually and organizationally may improve patient and employee well-being.^[15] In addition, risk factors and protective measures should be studied more comprehensively.^[31]

Limitations

The present study has some limitations. The seven nurse-participants were Christian, and five of our participants were from the Yoruba ethnic group, so nurses from other socio-cultural backgrounds were not represented. The participant's work experience was diverse; only one nurse-participant worked in oncology for more than a decade whereas six nurses had worked full time in cancer care for 6 years or less. Likewise, nurses' ages were not considered in the analysis, therefore generational gaps may remain unidentified. Male nurses were not represented in this study.

Conclusion

In accordance with previous research, the findings of the study revealed symptoms of emotional exhaustion among the participant-nurses. The attributed causes were a lack of propensity and inclination for cancer care as well as the fact that remuneration does not match the health risks involved in cancer care. For this reason, the nurses in cancer care were considering leaving the system. Another consequence of disinclination was the inhibition of empathy-based care by a disinterest in caring for cancer patients. In summary, findings suggest that nurses who care for cancer patients need to be supported which can increase their psychological, emotional well-being, retention, and enhance wellness in the workplace. Nigeria does not have standards for the scope of practice for oncology nurses, specialty education in oncology nursing should be considered in Nigeria, as specialized education has been found to help nurses cope with the psycho-emotional responses associated with cancer care.

Clinical implications

Significant attention is being paid to the effects of cancer on the mental health of patients and relatives in the literature, with little consideration for the psychological and emotional burdens of cancer care on nurses in Nigeria. Nurses in this study suffered health and death anxiety occasioned by poor prognosis and high patient mortality. This study could help oncology unit administrators to understand the level of psychological and emotional pressure cancer care impose on nurses and the importance of paying attention to and improving the mental health of nurses who care for the dying.

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Conflicts of interest

There are no conflicts of interest.

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