Fostering Psychosocial Wellness in Oncology Nurses: Addressing Burnout and Social Support in the Workplace

Jacqueline Medland, RN, MS, Josie Howard-Ruben, RN, MS, CHPN, and Elizabeth Whitaker, RN, BSN

Purpose/Objectives: To identify psychosocial wellness and the avoidance of burnout as key priorities for the retention of oncology nurses and to describe a program designed for a specific setting to enhance the psychosocial wellness and coping skills of oncology nurses.

Data Sources: Published research, books, and journal articles; theory; practice; and personal experience.

Data Synthesis: Oncology nurses benefit from programs designed to bolster the development of coping skills to reduce stress, foster supportive relationships in the workplace, facilitate work-related grief and bereavement, and reduce burnout.

Conclusions: Fostering psychosocial wellness in the workplace potentially can increase oncology nurse retention.

Implications for Nursing: A renewed recognition of the stressful nature of oncology nursing should give rise to programs that address the psychological well-being of oncology nurses. Oncology nursing leadership, recognizing the potential for stress and burnout inherent in this profession, should research and develop programs to enhance staff coping skills and mutual support.

Key Points . . .

➤ Burnout is an occupational hazard of oncology nursing, but strategies to ameliorate its occurrence have not been well researched.

➤ Enhancing the ability of staff nurses to support each other can result in a more supportive work environment and may improve nurse retention.

➤ Normalizing the experience of work-related grief and bereavement in the workplace facilitates coping in oncology nurses.

➤ Designing strategies to empower oncology nurses to cope with the stresses of oncology nursing should be tailored to each specific work environment.

As the pace of nursing care accelerates, staffing levels reflect the diminishing RN workforce, and the United States' nursing shortage looms on the horizon, helping oncology nurses to cope effectively with their challenging work environment emerges as an organizational imperative. Oncology nursing offers not only personal fulfillment and intellectual stimulation, but it also is intensely demanding, both physically and emotionally. Recognizing the challenges inherent in oncology nursing, particularly in the inpatient environment, and guiding nurses to meet them efficiently and effectively while caring for themselves are essential to any successful oncology program.

The diversity of career options, more lucrative compensation, and flexible work schedules have contributed to a much smaller pool of potential nursing students. The lure of nursing opportunities outside the hospital setting, in turn, has spread the available nursing workforce across a multitude of work settings. As fewer RNs are educated, the number of nurses who choose to enter oncology nursing also may decrease. In one survey, oncology nurses, oncologists, and nurse executives overwhelmingly perceived that that far too few RNs with an oncology specialty are available for practice and predicted to practice in the future (Buerhaus, Donelan, DesRoches, Lamkin, & Mallory, 2001). This situation is likely to be exacerbated as fewer students enter the profession. A sense of urgency about the retention of RNs becomes even more crucial as a cadre of seasoned nurses approaches retirement age. The need to value and treasure oncology nurses has never been greater than it is today.

Valuing Oncology Nurses

Appreciating oncology nurses as a cherished resource in the healthcare setting mandates a comprehensive approach to

Jacqueline Medland, RN, MS, is the director of Oncology Services at Northwestern Memorial Hospital in Chicago, IL. At the time this article was written, Josie Howard-Ruben, RN, MS, CHPN, was an oncology clinical nurse specialist in Oncology Services and Elizabeth Whitaker, RN, BSN, was a staff nurse in the inpatient hematology-oncology unit, both at Northwestern Memorial Hospital. (Submitted October 2002. Accepted for publication February 13, 2003.)

their retention, not only by providing for their technical competence and educational needs, but also by including programs that allow them to creatively manage the emotional components of their role and to learn and cultivate life- and practice-enhancing skills. Novice nurses, in particular, require clinical and psychological mentorship as they work toward becoming oncology nurses and find themselves highly vulnerable to the profession's many intrinsic stresses. Such enrichment of the workplace could lengthen nurses' tenure as care providers and broaden their ability to mentor the next generation of nurses. Cohen, Brown-Saltzman, and Shirk (2001) challenged nurses, "professionals ethically committed to promoting the well-being of others" (p. 25), to strive for the moral maturity of honoring their own need to be regarded compassionately. Buerhaus et al. (2001) noted that as the American population ages, the number of patients at risk for developing cancer will increase; in addition, the complexity of the provision of high-quality care for patients with cancer is served best by nurses specializing in oncology.

Burnout and Oncology Nursing

The intense and ongoing losses experienced in oncology care make oncology nurses particularly vulnerable to the "burnout" syndrome (Lewis, 1999). Burnout has been described as the end result of stress that combines emotional exhaustion, depersonalization, and low personal accomplishment in the professional life of a caregiver (Penson, Dignan, Canellos, Picard, & Lynch, 2000). Burnout results from prolonged high levels of stress at work and, if left untended, can contribute to the exodus of healthcare workers from these emotionally intense situations. Burnout is costly, not only in terms of turnover, but also because it affects patient care: Staff members who remain in areas where burnout is endemic exhibit increased rates of absenteeism and reduced productivity. Leiter, Harvie, and Frizzell (1998) described a correlation between nurse burnout and patient evaluations of the quality of care: Patients who were housed on units where nurses felt exhausted or frequently expressed a desire to quit were less satisfied with the care they received.

Too often, oncology nurses have ignored their own grief (Boyle, 2000) and neglected their own emotional experiences when caring for patients. Yet the very nature of cancer care mandates addressing the needs of caregivers as well as patients, and oncology nurses benefit from a workplace where the intense emotionally laden experience that surrounds them is managed well. Saunders and Valente (1994) noted that nurses require several skills to constructively cope with work-related bereavement, including understanding the process and theory of bereavement, completing their own bereavement tasks, and cultivating the ability to use social support. The psychological impact of caring for patients with cancer and their families can prove overwhelming if the appropriate support system is not in place. A common scenario finds new nurses exiting inpatient settings just as they are acclimating, taking their experience and the institution's investment in them out the hospital door.

Administrators in oncology recognize the stress involved in oncology nursing; unfortunately, they have not been able to identify the specific determinants of the stress or support measures that are most effective to remedy this situation (Hinds, Quargnenti, Hickey, & Mangum, 1994). This sug-

gests that steps should be taken to identify the stress-response sequence in nurses. In one study, researchers suggested that varying occupations may require differing coping skills (Redinbaugh, Schuerger, Weiss, Brufsky, & Arnold, 2001). An awareness of the complex interplay between personal (coping style and personality) and interpersonal (social support and work environment) resources (Kash & Breitbart, 1993) provides the basis for interventions designed to thwart stress and burnout.

In their study of pediatric oncology nurses, Hinds et al. (1994) explored the variability of stressors, reactions, and consequences between novice nurses who left their positions prior to the twelfth month of employment and those who stayed on and between new nurses and veteran nurses. Although the sample size was small and limited to pediatric oncology nurses, some of the findings may have relevance in adult oncology nursing. At three and six months, the new nurses reacted to stressors by trying to provide quality nursing care; crying; attempting to divert their attention from work-related stress by shopping, cleaning, or exercise; trying to avoid thinking about work-related situations; or discussing their feelings with supportive people (e.g., coworkers, family, friends). However, their responses were infused with self-doubt, and they tended to be very aware of their inadequacies as novice professionals. By one year, six of the nine nurses in the "new nurse" group had resigned from their positions, and the authors noted that the nurses seemed lonely and did not feel supported or trusted by their peers. The new nurses described feeling nervous and scrutinized and perceived that the more seasoned nurses were insensitive. The nurses reported that they sometimes lacked an understanding of patient treatment protocols.

In contrast, the three nurses who remained described a sense of support from their coworkers and had more varied coping skills. They felt that they were not alone and were able to make a difference in patient care (Hinds et al., 1994). Experienced nurses drew on a wider range of coping reactions, were more active in the coping techniques they used, and focused more intently on increasing competence and control over the work situation; they focused less on themselves and more on ways to enhance patient care situations (Hinds et al.). Strategies to enhance new nurses' coping skills and foster a supportive workplace could prove to be key in their retention.

The Affective Dimension of Oncology Nursing

An important part of appreciating oncology nurses is the recognition of what Boyle (2000) labeled as the affective dimension of oncology nursing—the psychological and emotional aspects of being an oncology nurse. Boyle advocated for raising the "bar of awareness" about the importance of this aspect of oncology nursing practice, even as more sophisticated technical competence is required. As such, caregivers require nurturing and emotional support to treat patients effectively. For example, Post-White (1998) noted that the optimal care of others begins by ensuring that the needs of the caregiver are met. Radziewicz (2001) emphasized the priority of self-care relative to being healthy and providing quality care to patients and families. The dual approach of helping nurses to develop personal coping strategies and cultivate collaborative relationships at work allows nurses to be effective caregivers who are able to contribute to high-quality patient care (Vachon, 1998).

Workplace Stress Associated With Oncology Care

Although all areas of oncology nursing are stressful, inpatient oncology RNs may have workplace issues that place them at particular risk for burnout when compared with RNs working in hospital-based outpatient and freestanding ambulatory settings. Buerhaus et al. (2001) found that inpatient RNs reported slightly higher perceptions than outpatient and freestanding ambulatory nurses that staffing had decreased, that retaining experienced RNs was becoming more difficult, and that they worked more double shifts and overtime hours. RNs working on well-staffed inpatient units, however, felt these problems less acutely. At Northwestern Memorial Hospital (NMH) in Chicago, IL, staffing levels were quite favorable, yet nurses reported high levels of stress, pointing to the essential complexity of caring for extremely ill patients in an urban academic medical center.

Stressors specific to oncology include the nature of cancer as a disease, complex treatments, caring for high-acuity patients, dealing with death, communication issues, intense involvement with patients and families, interdisciplinary conflicts, ethical issues, terminal or palliative care issues, surrogate decision making, workload, isolation outside the workplace, role overload, role conflict, lack of control, role strain, and work environment issues (Kash & Breitbart, 1993; Vachon, 1987, 2001). Recent changes in reimbursement have added to this list. In a survey of 961 oncology workers, including physicians, allied healthcare professionals, and support staff, Grunfeld et al. (2000) revealed that medical oncology personnel reported high levels of stress; in fact, many were considering leaving the field or reducing the number of hours they worked. A study of stress and coping among oncology nurses identified nine work-related stress clusters: physician-related stress, organizational factors, observing suffering, ethical concerns, death and dying, carryover stress, negative self-thoughts, inadequate resources, and coworker stress. Physician-related stress, organizational factors, and observing suffering were rated as the most frequent and intense clusters (Florio, Donnelly, & Zevon, 1998). Among palliative care professionals, Radziewicz (2001) highlighted several risk factors for psychiatric morbidity, including young age or fewer years in palliative care, high levels of job stress, low levels of job satisfaction, inadequate training in communication and management skills, stress in personal life, and previous history of psychological difficulties or family history of psychiatric difficulties.

The Role of Workplace Culture and Social Support in Burnout

Maslach (1976) described the concept of burnout as "a syndrome of physical and emotional exhaustion involving the development of negative job attitudes and perceptions, a poor professional self-concept, and a loss of empathic concern for the client being serviced" (p. 16). More recently, Maslach and Leiter (1998) elaborated on the concept of burnout, asserting that it "represents an erosion in values, dignity, spirit, and will—an erosion of the human soul" (p. 17) that occurs in a setting where job demands exceed the support and resources available for employees. Three dimensions of burnout exist: chronic exhaustion, cynicism or depersonalization, and ineffectiveness (Maslach, Schaufeli, & Leiter, 2001). In a review of 300 documents on nursing burnout, 36 applicable studies were cited and 15 key variables were identified for analysis (Duquette, Kerouac, Sandhu, & Beaudet, 1994). These authors asserted that the factors most often correlated with nursing burnout are role ambiguity, workload, age, hardiness, active coping, and social support. In another study, coworker support, positive reappraisal, and developing a growth perspective were the three most frequently used coping clusters described by oncology nurses (Florio et al., 1998).

Conventional wisdom about burnout often has alluded to the personal characteristics of the employee in question, citing character flaws or work process issues as the main contributors; however, Maslach and Leiter (1998) indicated that the social environment and organizational structure in the workplace are more relevant. They wrote,

> Statistical analysis of the surveys led us to conclude that burnout is not a problem of people but mostly of the places in which they work. When the workplace does not recognize the human side of work or demands superhuman efforts, people feel overloaded, frustrated and well, burned out. Self-improvement alone will not beat it (Maslach & Leiter, 1999).

Vachon (1995), referring to the hospice and palliative care settings, noted that, although stress and burnout are not universal, stress levels are increased when organizational and social issues, such as social support, involvement in decision making, and a manageable workload, are absent. Further, Gifford, Zammuto, and Goodman (2002) investigated the role of organizational culture in labor and delivery nurses and found that a human relations model of cultural values was associated positively with organizational commitment, job involvement, empowerment, and job satisfaction, and negatively related to the desire to leave a position, leading the researchers to infer that improvements in the quality of the work environment can be a powerful long-term nurse retention strategy.

Community Building in the Work Setting

Particularly in times of uncertainty and during change, social networks in the workplace play a key role in protecting employees against burnout (Garrett & McDaniel, 2001). Community building in the workplace is touted as a defense against the constantly changing healthcare environment according to Parker and Gadbois (2000), who suggested encouraging "community in the workplace" as a value to creating a meaningful and rewarding work environment. Failure of management to address this "human side of work" and the need for support and a supportive work environment intensifies stressors and puts employees at risk for developing the burnout syndrome.

Addressing the Human Spirit of the Oncology Team

Despite a newly constructed state-of-the-art hospital, turnover on the oncology units at NMH had reached more than 40% compared to a hospital average of 14.2%. Patient and family satisfaction scores left the once highly regarded hematology-oncology unit languishing in the lower quartile. A thriving and comprehensive cancer program was plagued by intense nursing workforce issues, exacerbated by a congested

urban location and a demanding academic environment. Staff identified an array of challenges similar to those reported in the literature (see Figure 1).

An assessment conducted during a period of three months by the oncology leadership team examined the relevant variables contributing to the discontent and dissatisfaction expressed by the oncology team. An array of tactics and strategies was designed to interrupt the 18–24 month cycle of turnover, with the development of social support through enhanced collaboration and the cultivation of stress management strategies high on the list.

Given the high census of oncology units, the administrative focus on bed turnover unfortunately supplanted any concerns about the emotional well-being of the care providers. Recognizing this shortcoming, the overarching mission for the hematology-oncology units became developing and maintaining a team of passionate, motivated, intelligent, and skilled professionals who are engaged in using their talents to ensure the highest quality of care for patients and families living with cancer. Understanding that the organizational aspects of work disengagement and burnout—variables related to the work setting and team atmosphere—point to the primacy of the corporate culture as a determinant of stress on the job (Maslach & Leiter, 1998), the leadership team felt compelled to implement creative methods designed to attend to these issues and, in turn, increase patient and family satisfaction.

To deal with the issue of turnover, the nursing workplace requires structuring to address compensation, benefits, flexible scheduling, supportive management, and staffing that is in line with the demands of patient acuity. At NMH, issues surrounding work intensity exerted the most powerful impact on turnover. The affective stress of being an oncology care provider loomed large, casting a shadow over the work environment that threatened to overwhelm the staff and undermine both unit stability and quality of the patient care experience. Very young novice nurses were caring for extremely sick and dying patients, and the nurses were unprepared to cope with their patients' complex psychological, social, and spiritual needs.

The landscape of suffering, physical and psychological crises, noise, work overload, and fatigue on the unit were described by one physician team member as a "spiritual dearth." Nurses often commented that the work was "so heavy" that

- Acuity of patients
- Boundary issues
- Communication issues
- Constant change and new challenges
- Crisis scenarios
- Death and loss
- Delayed gratification in seeing improvement and responses in patients
- Ethical dilemmas
- Multiple demands on time
- Need to recharge and have time for reflection
- Organizational issues
- Overwhelming sense of responsibility
- Patient and family suffering
- Physical demands
- System issues

Figure 1. Challenges Identified by Oncology Services Team Members

they felt it intruding on their personal time and could not separate their personal lives from that of work. Worse yet, they did not feel ready to address the complex needs of patients and families. One staff nurse explained her feelings at the time.

> People say to me, "I don't know how you do it" when I tell them that I am an oncology nurse. . . . I used to explain that I wouldn't be able to if it wasn't for the courage and strength in my patient's hearts and the support and altruism of my coworkers. The Circle of Care Retreat could not have come at a better time as I was finding myself becoming overwhelmed at work and unable to express those sentiments. Instead, I held back my tears [when this subject came up] and would simply say "sometimes I don't think I can continue to be an oncology nurse."

Creating a Healthier Workplace

Faced with the reality of a staff feeling intense burden, stress, and helplessness in a workplace filled with frustration, the leadership team set out to create a healthier work environment. The goal was to create an environment where care providers would be infused with an intense sense of gratification and fulfillment and where a passion for service and excellence would prevail.

Literature-supported initiatives for stress management included staff training in counseling skills, tracking staff conflict, using stress inoculation training, promoting positive staff relations through support or discussion groups, and observing at-risk staff members (Payne, 2001). Ongoing bereavement programs were a mechanism that could be employed to support staff and facilitate their bereavement (Lewis, 1999). Groups aimed at improving patient care through fostering coping skills, problem solving, expression of feelings, and enhancement of group cohesiveness have been described as beneficial (Saunders & Valente, 1994). Other strategies identified in the literature included staff retreats, a four-day workweek, and an increase in staff size (Keidel, 2002). Individual psychiatric consultations with psychiatric liaison personnel to help individuals cope with grief also have been suggested (Saunders & Valente).

Developing a Workplace Solution: The Circle of Care Retreat

To focus a strategy on the stressors relevant to NMH, an interdisciplinary group designed the Circle of Care Retreat, a one-day workshop, to address specific concerns pertinent to improving the psychosocial wellness and skills of staff members. This retreat program (see Figure 2) is intended to acknowledge the human side of caring for patients with cancer by nurturing the spirit of the interdisciplinary oncology care team members. The retreat is the first phase of a comprehensive ongoing psychosocial support program for staff, tailored to address the intense psychosocial demands of oncology nursing. Designed specifically for the oncology patient care team, the Circle of Care Retreat serves to complement existing organizational training efforts. Support groups as needed, stress management sessions, self-care behavior coaching, skill building in the affective domain of oncology nursing so essential to compassionate patient care, and, in selected cases, individual counseling for those at high risk for burnout comprise the overall plan. If proven

- Convene an interdisciplinary group of care providers to discuss shared issues.
- Provide a unique opportunity for staff from all shifts and disciplines to interact in a nonclinical situation. Participants included staff from nursing, medicine, pharmacy, social services, psychology, physical therapy, and occupational therapy, as well as chaplains, grief counselors, unit secretaries, patient liaisons, and environmental and dietary service staff.
- Examine the impact of stress on group support, cohesiveness, and effectiveness.
- Create staff awareness of positive coping strategies for use in situations of loss and during intense periods of stress.
- Facilitate and give permission to have fun at work.

Figure 2. Major Objectives of the Circle of Care Retreat

beneficial to staff members and, in turn, to patient care, this program could serve as a model for the development of programs in other clinical areas to manage the stresses associated with the delivery of patient care.

More than 150 staff members participated in the retreat, which was held away from the clinical area in a relaxed setting on the hospital campus and offered on five separate occasions to accommodate all staff. Portrayed as an avenue to help staff to fulfill their commitment to one another, staff members from nursing, medicine, pharmacy, and social services, as well as psychologists, grief counselors, unit secretaries, patient liaisons, chaplains, rehabilitation therapists, and environmental (housekeeping) and dietary service employees assigned to the oncology areas, participated. The philosophy of the oncology leadership team that all hospital employees working in the clinical area play an important role in the patient experience helped to create the foundation for this multidisciplinary program.

A variety of activities and exercises designed to accentuate the uniqueness of each individual and identify individual gifts was incorporated into the day. The question, "Did you choose oncology or did oncology choose you?," was asked and answered, revealing factors that brought people to the oncology setting (see Figure 3).

Throughout the day, interactive and informal presentations about staying well, managing losses, developing stress management skills and strategies (e.g., relaxation, journaling), facilitating bereavement, cultivating team effectiveness and group support, and storytelling were conducted. An art therapy session called "All Gifts Differing" was presented and gave participants an opportunity to fashion artwork such as clay sculptures. This activity reflected the unique attributes that staff members bring to the work setting and resulted in an impressive range of creative talent and artistic renderings. A videotape introduction to the FISH!© (Lundin, Paul, & Christensen, 2000) management philosophy emphasized the power each individual has to improve the work environment (see Table 1). Team members were introduced to the CARES philosophy (see Table 2), providing a framework for incorporating the stress management and self-care skills they learned into their practices.

From Inspiration to Innovation

Circle of Care participants shared many personal patient care experiences with their peers in a safe and accepting atmosphere. Admissions of vulnerability and expressions of loss and sadness were embraced as normal responses to oncology care. An im-

portant discovery for the groups was the acknowledgment that they needed to better manage the losses experienced in the oncology setting; the groups brainstormed many potential solutions, practices, and creative rituals that could help staff to facilitate their own grieving. Some suggestions included placing a flower across the pillow of a patient who died, attending wakes or funerals, hanging a purple ribbon on the door of a patient after death, initiating palliative care sooner so as to provide greater benefit to the patient and family, establishing grief counseling on the unit, valuing and participating in culturally sensitive rituals for dying patients, initiating a candlelight memorial service, sending cards to family members to let them know their loved one is remembered, and writing their reflections about patients and sharing them with the family.

Although not all of these ideas will be implemented, several significant insights discovered during the retreats led to changes in the workplace. The realization that facilitating the opportunity for caregivers to cope with a patient's death was a shared responsibility emerged as a profound insight. As a result, mutual support is essential for caregivers when patients die. The accepted protocol on the units now allows that when a patient dies, the body is prepared with a partner, and patient care assignments are reshuffled so that the primary nurse can appropriately attend to the needs of the patient and family. As a result of their expressed needs, nurses and patient care technicians now are encouraged to go to a safe place to vent when a patient dies (they often retreat to the medication room, which was outfitted with privacy shades for this purpose), and patient care assignments are supported by a fellow nurse. When a patient's body is removed from a room, a symbol of another life passing is displayed on the door. Staff members also have been encouraged to come together when a loss occurs, take

- Availability of employment
- Caregiving opportunities
- Closeness and psychological intimacy with patients and families
- Commitment
- Fascination with the biology of the disease
- Helping to do important work
- Helping people
- Humbling experience
- Influence
- Information
- It is about living.
- Making a difference
- Mentoring opportunities allow one to grow and learn
- Opportunity to gain mastery
- Personal experience with cancer
- Personality
- Privilege
- Provides personal challenges on many levels
- Purpose of nursing
- Puts life into perspective
- Requires spirituality and compassion
- Rewarding experience
- Rewards of working with grateful patients
- Sense of family
- Takes courage
- Team work
- Value building human connections
- Value remaining optimistic in the face of adversity

Figure 3. Reasons for Entering Oncology Nursing

Table 1. Adapting the FISH!© Philosophy to the Oncology Nursing Workplace

FISH!© Category	Oncology Interpretations
Play	Creating the element of fun in oncology setting is a time-honored tradition. The nursing staff suggested presenting lighthearted awards to patients such as the "Clean Plate Award," calling each other good-natured nicknames on the unit (e.g., Frances became Francois), having a word of the day that elicits a fun response, and performing the "neutropenia dance," a rain dance of sorts calling for white blood cell production rather than rain. Recruiting IV-toting patients for the one-kilometer "Gerbil Run" around the unit puts a little fun in each day. Another initiative is the Jolly Trolley, a cart operated by volunteers and the women's auxiliary that offers trinkets and frozen treats. Although the work in the clinical setting is fraught with gravity, a sense of playfulness and humor can have a place.
Make their day	Through providing exemplary service and patient care, nurses can engage patients and families in the therapeutic process. Offering a kind word or small gesture to another staff member helps to facilitate team building. Going an extra step creates positive feelings and can be contagious (to both patients and staff), and helping to cheer up patients or coworkers can make them feel appreciated. Staff identified performing anonymous small kindnesses for each other and paging each other (all staff RNs carry pagers) with words of support as possible strategies.
Be there	Being present with patients, families, and other members of the team assures them that their concerns are being addressed and thoughtfully considered. Instead of thinking about the multitude of tasks that lie ahead, staff said that they could focus intently on providing excellent care by being in the moment and actively listening to others. Caring for each other unconditionally as part of the oncology team encompasses "being there." Allowing coworkers to express their grief and engage in the mourning process as they experience the cumulative effects of grief are other ways of being there.
Choose your attitude	Staff identified that the daily mood on the unit could be influenced by choosing a positive attitude. Each individual attitude contributes to that of the larger team. Bringing staff members with a poor attitude to another place with humor can help to elevate the workplace mood. A negative attitude can lead to negative outcomes, just as choosing to think positively can lead to a more optimistic outlook on symptoms, side effects, and difficult choices.

Note. Based on information from Lundin et al., 2000.

time off the unit if necessary, and allow themselves outward expressions of grief, such as crying.

Continuing the Journey

A Circle of Care Bereavement Council group, composed of alumni of the Circle of Care Retreat sessions, was convened after the retreats to discuss implementation of the many strategies generated by participants. Spurred by comments from many participants that an outward sign acknowledging that a patient death had occurred on the unit was needed to alert the staff, the council chose to place a sign or placard on the door of the patient's room. The design of the placard is the same as the artwork depicted on the sympathy card that is sent to patients' families (see Figure 4). An electric candle, kept at the nurse's station, is illuminated after a patient dies and remains lit for 24 hours, signifying the recent loss of a patient. Staff members on the two oncology units and the palliative care unit convey the message to the other units that a patient has died so that all staff will be aware of the death.

A memory board had been designed to honor patients who have died and placed in each of the report rooms. Whenever a patient with cancer dies, whether in the hospital or another

Table 2. CARES Program

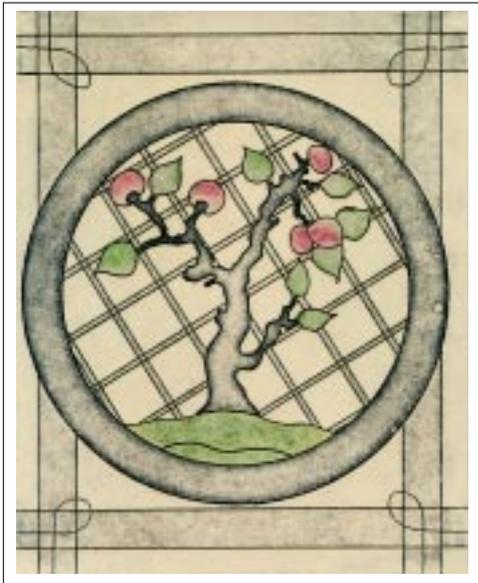| Initial	Element	Strategy
C	• **Creation** of a community of care as opposed to feeling solely responsible for meeting the needs of clients • **Caring** for each team member unconditionally • **Cognizant** that the stress of the day depends more on work group than patient care assignment	Share responsibilities to allow a team member to grieve.
A	• **Awareness** of the signs and symptoms of stress or burnout in self and others and a recognition that stress management needs to be as integral a competency as hanging chemotherapy	Incorporate a stress management station into annual competency training and certification.
R	• **Reinforcement** of the importance of relaxation and rejuvenation as a self-care skill so that the needs of others can be met effectively	Instruct stress reduction and stress management strategies such as journaling, meditation, and art therapy.
E	• **Emphasis** on regular aerobic exercise and eating healthy	Encourage staff to take time for meals and breaks off the unit, and build this into the work processes of the unit with techniques such as block scheduling and the buddy system.
S	• **Spiritual awareness** and reconnection to whatever is personally meaningful	Reconnect to faith and be playful and attentive to the "spirit" at work.

Figure 4. Bereavement Card

1. I make a difference.
2. I am continually strengthened by the courage of my patients and their families.
3. The biology of the disease is fascinating.
4. It is less about dying and more about living.
5. It is an opportunity to accompany patients on their journey.
6. Every aspect of my being is challenged.
7. The patients give back to us, such as a grateful smile at the end of a long, hard day.
8. It is an environment of lifelong learning.
9. The challenges of patient care bring out the best in each and every team member.
10. It is where the purpose of nursing is made real.

Figure 5. Why Be an Oncology Nurse?

setting, a paper dove with the patient's name and date of death is pinned to the board. The dove remains on the board for one week and then is placed in a folder on the board. Sympathy cards are sent to the family and are available on the memory board for several weeks for staff members to sign. The card is placed on the unit where the patient died, but any staff member who has cared for the patient is welcome to go to that unit to sign the card before it is sent to the patient's family three to four weeks after the death. Additional strategies are being planned and include increasing the chaplaincy support on the unit, educating interns on managing loss, creating an annual memorial service, and relying more heavily on the skills of the palliative care team. The Education on Palliative and End-of-Life Care (EPEC) Project content also will be incorporated into the program. EPEC, based in the Feinberg School of Medicine at Northwestern University in Chicago, IL, strives to educate all multidisciplinary healthcare professionals about the essential clinical competencies in palliative care and complements the Circle of Care multidisciplinary model.

Implications for Nursing

The positive impact of uniting members of the multidisciplinary cancer care team around the central issue of psychosocial wellness has been felt on many levels at NMH, including increased retention of nursing staff. Oncology nurses themselves identified many positives aspects of the role (see Figure 5). To evaluate the effectiveness of the program, outcomes such as increased overall patient satisfaction, psychosocial patient satisfaction, and spiritual patient satisfaction scores will be measured. An evaluation of the rate of staff turnover and the level of staff psychosocial wellness, as evidenced by follow-up human services surveys, is planned for the future. Most importantly, staff will be monitored for changes in behavior reflecting use of positive coping strategies and constructive self-care behaviors. In the future, ongoing psychosocial staff support will be offered through Circle of Care retreats, occasional bereavement support groups, stress management sessions, self-care behavior coaching, skill building in the affective domain of oncology nursing, and, when needed, individual counseling. The team's psychosocial well-being will be assessed continually, and the staff support program will be refined accordingly.

Additional research about oncology staff nursing burnout and social support in the oncology work setting is needed to identify those at highest risk for burnout, assist in the development of interventions to ameliorate these issues, and sustain the careers of those nursing professionals who have chosen oncology care as their life's work.

Author Contact: Jacqueline Medland, RN, MS, can be reached at jmedland@nmh.org, with copy to editor at rose_mary@earthlink.net.

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For more information . . .

➤ Top 10 Signs You're Approaching Burnout
http://webpages.charter.net/stormking/topten.html

➤ Burnout Test
www.queendom.com/tests/career/burnout1_r_access.html

Links can be found at www.ons.org.