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Research report

Difficulties felt by nurses engaged in terminal cancer care at designated cancer hospitals, with a focus on length of experience and nursing identity

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Key words

designated cancer hospitals, terminal cancer care, nurses, sense of difficulty, length of experience

Abstract

Cancer care in recent years has seen the end of life become more complex, increasing the difficulties and conflicts felt by nurses. In this study, we carried out a self-administered questionnaire survey of 149 nurses working at a Japanese provincial designated cancer hospital, and investigated the association between how the types of difficulties felt by nurses engaged in terminal cancer care changed as a result of their length of experience and looked at the association between these difficulties and their nursing identity. To measure feelings of difficulty, a 23-item questionnaire was produced and classified into five factors on the basis of the results of exploratory factorial analysis. Difficulties were classified into five factors : 【Engaging with patients facing "death" and their families】, 【Frustration at the inability to be sufficiently involved】, 【Differences between the images of the end of life held by patients and their families】, 【Difficulties with integrated care by different medical professionals】, and 【System-induced difficulties】. Analysis was also carried out for items selected by reszpondents as particularly difficult.

Overall, novices focused on their sense of difficulty in providing direct care by 【Engaging with patients facing "death" and their families】; mid-career nurses focused on 【Frustration at the inability to be sufficiently involved】; and veterans on relationship-related difficulties, such as 【Differences between the images of the end of life held by patients and their families】 and 【Difficulties with integrated care by different medical professionals】. The item that scored highest for feelings of difficulty was <Being asked by a patient to "do something" about their physical or mental suffering>, which was selected by a high proportion of nurses from novices to veterans. The item <When someone exhibits little emotion, and I don't know what they are thinking> also scored highly among novices and mid-career nurses, but less highly among veterans. These difficulties were correlated with the total score for professional identity, establishment of a nursing viewpoint, and confidence in the choice of nursing as an occupation. The results suggested that given the increasing complexity of terminal cancer care, training support is needed with more practical and technical content tailored to years of experience.

Designated cancer hospitals, Terminal cancer care, Nursing identity, Difficulty,
Length of experience

Introduction

One in 3.5 people in the Japanese population dies of cancer, and 87% of these spend their final days in a medical institution[1]. On the other hand, cancer is now becoming a treatable condition and designated cancer hospitals and others are offering highly advanced treatment and are now able to provide not only initial treatment but also extended cancer treatment for patients with multiple metastases by means of chemotherapy, including molecularly targeted drugs, palliative radiotherapy, and symptomatic treatment. As patients repeatedly go in and out of hospital, the timing of the gear change from active treatment to end of life care becomes uncertain as the terminal stage becomes more difficult to discern, complicating the difficulties felt by nurses[2].

The difficulties felt by nurses engaged in end-of-life care have been studied together with concepts such as burnout and fluctuation[3][4]. Burnout of professional vocation while engaged in the complex combination of bereavement grief and supporting patients through death was identified[5][6]. Specifically, in addition to the difficulties entailed in informing patients of their prognoses and explaining their conditions, difficulties in end-of-life care and in communicating with patients and their families were particularly felt acutely. Length of experience, type of ward, and professional identity are other factors that have also been shown to be associated with feelings of difficulty[7][8]. In terms of dealing with and adapting to difficulties, there was a significant correlation between dealing with difficulties and age. Older nurses were capable of dealing with difficulties, which helped them adapt more easily[9].

These findings were obtained in a study that examined the difficulties faced by nurses in general hospitals, hospices, and providing at-home care. In this study, the focus was on designated cancer hospitals. This is because rapid advances in cancer treatment are now making the terminal stage harder to discern. This study therefore explored afresh the question of what sort of difficulties are faced by nurses under these circumstances. We identified the issue of what sort of difficulties are felt by nurses at hospitals where the "terminal stage" is now more difficult to discern, as described above, and how these difficulties change with length of experience.

The objective of this study was to investigate the association between how the types of difficulties felt by nurses engaged in terminal cancer care at designated cancer hospitals changed as a result of their length of experience and the association between these difficulties and their nursing identity.

Methods

1. Research design

A cross-sectional study design was conducted using a self-administered questionnaire survey.

2. Study subjects

Questionnaire were distributed to 237 nurses working on 7 wards with large numbers of mid-life or elderly terminal cancer patients at a single designated cancer hospital. One hundred and forty-nine nurses (response rate 62.9%) participated in the questionnaire. The effective response was 149 (effective response rate 100%).

The mean length of clinical experience was 9.0±8.4 years, with 28 nurses (18%) having 1–2 years of experience, 38 (25.5%) 3–5 years, 42 (28.2%) 6–10 years, and 41 (27.5%) ≥11 years.

3. Survey period

September–November 2015

4. Survey method

The survey was carried out as an anonymous self-administered questionnaire. Permission was obtained from the directors of nursing departments and head ward nurses before questionnaires were distributed in the wards. After they had been left for two weeks, they were collected in a collection box.

5. Survey content

(a) Basic attributes : Length of clinical experience, type of ward

(b) Questionnaire items : Difficulties felt by nurses in terminal cancer care

Based on a study by Onodera et al.[10] covering the level of difficulty of nursing in terminal cancer nursing, a questionnaire was produced consisting 27-items independently. The difficulty scale for oncology nurses comprised 49 items grouped into 6 subscales, and items envisioned to concern communication in the terminal stage were adopted selectively from this scale. Raw descriptions by nurses in previous studies were also taken as reference material[11) 12)] when items were gathered; they were then integrated to eliminate duplicate content and the language was tightened to produce the 27 questionnaire items. We asked the respondents "Do you have difficulty with end-of-life care?", and the responses were scored on a four-point scale comprising "Not at all," "Not much," "Some," and "Very much," with "No experience" as an additional option.

In addition to scale measurements, to understand the reality of the difficulties faced by nurses, the respondents were also asked to choose 3 items out of the 27 that they felt posed the greatest difficulties, and the rates at which they were chosen were examined.

(c) Questionnaire items : Nurses' professional identity

The Professional Identity Scale for Nurses was used[13]. This scale consisted 50 items grouped into 4 subscales, and its reliability and validity has been demonstrated. The subscales comprised confidence in the selection of nurses, establishment of one's own view of nursing, pride in being regarded as necessary as a nurse, and intention to benefit society. The responses were scored on a five-point scale from "Not at all applicable" to "Extremely applicable." The number of points on each subscale and the total score for all five subscales were used. The total professional identity score was obtained by adding together the scores for each subscale.

6. Analytical methods

Because the form used to survey difficulties was a questionnaire produced by the investigators for this study, exploratory factorial analysis was carried out to confirm this structure. Multiple answers were also performed to calculate the rates at which the three items selected as the most difficult were chosen. Descriptive statistics were also produced for each item, and the values for the skewness and kurtosis of normally distributed variables were compared. Length of nursing experience was categorized according to Benner's classification[14] of nursing expertise. Those with 1–2 years of experience were classed as novices, those with 3–10 years as mid-career (in addition, it was divided into groups of 3 to 5 years and 7 to 10 years), and those with 11 years or longer as veterans.

The association between difficulties and length of experience was investigated by means of one-way analysis of variance (ANOVA) and multiple comparison ($p<0.05$ regarded as significant). Means were also calculated with difficulties as the target variable and professional identity as each explanatory variable, after which the subjects were divided into two groups depending on whether their score was above or below the mean (high and low groups) ; these groups were compared using a t-test. The statistical software used for analysis was SPSS Statistics 22.

7. Ethical considerations

We explained the purpose and meaning of this study to individual participants both orally and in writing. We also explained that participation in this study was voluntary, and other ethical consideration such as personal information protection and the limitation of use of said personal information within this study. Return of the questionnaire responses was considered consent for participation in this study. This study was approved by the Ethics Committee of the Medical School of the authors' university. (No.HS27-5-1)

Results

1. Factor structure of difficulties felt by nurses in terminal cancer care.

The results of factorial analysis of the 27-items in the questionnaire, five factors with an eigenvalue of 1 or more were extracted. Factors with

a factor loading of ≤0.35 were removed, leaving 23 items. Cronbach's alpha coefficient was 0.883, indicating good internal consistency.

Cronbach's alpha coefficient for each subscale was about 0.50 to 0.87. Although the 1st question Item had a loading of 0.344, it was regarded as an important item by the investigators and was therefore retained. Analysis of the types of items belonging to each factor identified the following factors: factor I,【Engaging with patients facing "death" and their families】, factor II,【Frustration at the inability to be sufficiently involved】; factor III,【Differences between the images of the end of life held by patients and their families】; factor IV,【Difficulties with integrated care by different medical professionals】; and factor V,【System-induced difficulties】.

Below, categories are indicated by square brackets and questionnaire items in angle brackets. (Table 1)

2. Comparison of the levels of difficulty of the five factors and association with length of experience was conducted. (Table 2)

The difficulty was calculated for each question

Table 1 Factorial analysis of questionnaire on difficulties felt of nurses

Item	Factor				
	Ⅰ	Ⅱ	Ⅲ	Ⅳ	Ⅴ
【Engaging with patients facing "death" and their families】(α =.870)					
Item7 Asking a patient about their "thoughts and ideas about death and prognosis."	.746	.067	-.104	.057	-.094
Item17 When a patient was in a depressed, and I don't know what I talk them.	.720	.058	-.010	-.052	.013
Item16 Responding when faced with profound questions about death or outpourings of grief from patients.	.635	.262	-.118	.074	-.027
Item8 Dealing in a straightforward manner with familiar patients as they reach the end of life.	.611	-.181	-.035	.098	.199
Item26 Responding when faced with serious questions about death or outpourings of grief from family members.	.565	.146	.220	.029	-.070
Item9 Talking to family members after giving them "bad news" about the metastasis or prognosis.	.561	.361	-.150	-.100	-.137
Item12 Being asked by a patient to "do something" about their physical or mental suffering.	.553	-.159	.300	-.109	.091
Item11 Responding when patients' express vague worries or anxiety.	.517	-.022	-.040	-.026	.214
【Frustration at the inability to be sufficiently involved】(α =.667)					
Item22 Not having time or opportunity to discuss current thoughts or the prognosis with family members.	-.208	.594	.210	.113	.057
Item24 When a patient exhibits little emotion, and I don't know what they are thinking	.104	.556	-.091	-.029	.095
Item21 When I am unable to meet a patient's desire or request	.189	.441	.100	-.039	.123
Item20 When I am faced with a patient who is irritated, resistant, or angry	.225	.402	.085	-.116	.096
【Differences between the images of the end of life held by patients and their families】(α =.783)					
Item23 Coming across a scene of conflict between a patient and family members, who do not have a good relationship with each.	-.250	.177	.687	.074	-.101
Item4 Dealing with family members who are unable to accept that patients are at the end of life.	.039	.027	.672	-.056	.255
Item18 Deciding whether patients' hopes and opinions or those of their family members should be respected when these are at variance.	.250	-.086	.486	-.053	-.046
Item19 Dealing with the situation if family members become violently agitated during the period from near-death to death.	.417	-.072	.466	.022	-.095
Item14 Being unable to respond to questions or requests for advice from family members about the prognosis.	.312	.064	.424	.102	-.146
【Difficulties with integrated care by different medical professionals】(α =.679)					
Item15 Having little to talk about in team medicine.	.097	-.33	.010	.661	.033
Item5 Providing integrated care when other nurses view patients differently or have different values.	-.037	.241	.065	.627	-.051
Item27 Not having enough time to talk about problematic situations with other nurses.	.057	.073	-.009	.520	.084
Item10 Collaborating with doctors who have different policies on end-of-life care.	.025	.115	-.018	.376	.147
【System-induced difficulties】(α =.496)					
Item3 Having patients admitted for tests and treatment in the ward at the same time as terminal patients.	.031	.147	-.094	.150	.843
Item1 Being too rushed by tests and medical treatment to have time to engage with patients.	.004	.314	.119	-.087	.344
Factor correlation coefficient	Ⅰ	Ⅱ	Ⅲ	Ⅳ	Ⅴ
Ⅰ	−	.381	.531	.235	.256
Ⅱ		−	.409	.366	-.020
Ⅲ			−	.374	.315
Ⅳ				−	.254
Ⅴ					−

Major factor method、Promax Cumulative contribution 45%

Table 2　Shows the items that were most frequently chosen and length of experience

Mean ± SD

		Engaging with patients facing "death" and their families	Frustration at the inability to be sufficiently involved	Differences between the images of the end of life held by patients and their families	Difficulties with integrated care by different medical professionals	System-induced difficulties
Whole of Nurse		3.14 ± 0.48	3.31 ± 0.47	3.24 ± 0.53	2.64 ± 0.52	2.98 ± 0.60
years of experience	1 ～ 2 （n = 26）	3.25 ± 0.51	3.24 ± 0.54	3.29 ± 0.55	2.47 ± 0.47	3.00 ± 0.53
	3 ～ 5 （n = 36）	3.08 ± 0.43	3.25 ± 0.39	3.24 ± 0.46	2.50 ± 0.48	2.88 ± 0.59
	6 ～10（n = 41）	3.14 ± 0.48	3.31 ± 0.51	3.14 ± 0.61	2.60 ± 0.48	3.04 ± 0.64
	11～　（n = 40）	3.13 ± 0.50	3.41 ± 0.43	3.32 ± 0.50	2.90 ± 0.53	3.01 ± 0.63

ANOVA　　＊ $p < 0.05$　＊＊ $p < 0.01$

Table 3　Multiple answer of item that scored highest of difficulties

（N=139）

Item	Years of experience 1 ～ 2	Years of experience 3 ～10	Years of experience 11～	Total	Selection rate
【Engaging with patients facing "death" and their families】					
Item7 Asking a patient about their "thoughts and ideas about death and prognosis."		10	5	20	14.4%
Item17 When a patient was in a depressed, and I don't know what I talk them.	8	7	3	18	12.9%
Item16 Responding when faced with profound questions about death or outpourings of grief from patients.	8	17	3	28	20.1%
Item8 Dealing in a straightforward manner with familiar patients as they reach the end of life.	3	15	11	29	4.3%
Item26 Responding when faced with serious questions about death or outpourings of grief from family members.	1	4	2	7	4.3%
Item9 Talking to family members after giving them "bad news" about the metastasis or prognosis.	5	5	1	11	7.9%
Item12 Being asked by a patient to "do something" about their physical or mental suffering.	8	21	9	38	27.3%
Item11 Responding when patients' express vague worries or anxiety.	3	3	2	8	5.8%
【Frustration at the inability to be sufficiently involved】					
Item22 Not having time or opportunity to discuss current thoughts or the prognosis with family members.	0	8	4	12	8.6%
Item24 When a patient exhibits little emotion, and I don't know what they are thinking	2	21	8	31	22.3%
Item21 When I am unable to meet a patient's desire or request	6	15	10	31	22.3%
Item20 When I am faced with a patient who is irritated, resistant, or angry	5	18	8	31	22.3%
【Differences between the images of the end of life held by patients and their families】					
Item23 Coming across a scene of conflict between a patient and family members, who do not have a good relationship with each.	0	6	5	11	7.9%
Item4 Dealing with family members who are unable to accept that patients are at the end of life.	5	12	2	19	13.7%
Item18 Deciding whether patients' hopes and opinions or those of their family members should be respected when these are at variance.	3	15	11	29	20.9%
Item19 Dealing with the situation if family members become violently agitated during the period from near-death to death.	3	7	4	14	10.1%
Item14 Being unable to respond to questions or requests for advice from family members about the prognosis.	1	7	0	8	5.8%
【Difficulties with integrated care by different medical professionals】					
Item15 Having little to talk about in team medicine.	0	0	5	5	3.6%
Item5 Providing integrated care when other nurses view patients differently or have different values.	0	3	2	5	3.6%
Item27 Not having enough time to talk about problematic situations with other nurses.	0	1	3	4	3.6%
Item10 Collaborating with doctors who have different policies on end-of-life care	3	4	7	14	10.1%
【System-induced difficulties】					
Item3 Having patients admitted for tests and treatment in the ward at the same time as terminal patients.	0	7	2	9	6.5%
Item1 Being too rushed by tests and medical treatment to have time to engage with patients.	3	16	3	24	17.3%

item with average out of 4 points per. The factor with the highest mean score was "Frustration at the inability to be sufficiently involved," with a score of 3.31, followed by "Differences between the images of the end of life held by patients and their families" at 3.24, and "Engaging with patients facing 'death' and their families" at 3.14. The mean scores for "Difficulties with integrated care by different medical professionals" and "System-induced difficulties" were both between 2 and 3. In terms of length of clinical experience, there were significant differences between the proportions of novices and veterans ($p<0.01$) and between early mid-career nurses and veterans

Table 4 Association between difficulties and professional identity

Mean ± SD

		N	Engaging with patients facing "death" and their families	Frustration at the inability to be sufficiently involved	Differences between the images of the end of life held by patients and their families	Difficulties with integrated care by different medical professionals	System-induced difficulties
Confidence in the selection of nurses	High group	93	3.10 ± 0.40	3.38 ± 0.39	3.23 ± 0.47	2.72 ± 0.50]*	2.98 ± 0.59
	Low group	49	3.23 ± 0.53	3.27 ± 0.51	3.31 ± 0.56	2.54 ± 0.50]*	3.02 ± 0.62
Establishment of a nursing viewpoint	High group	93	3.10 ± 0.42	3.34 ± 0.39	3.18 ± 0.47]*	2.71 ± 0.53	2.97 ± 0.64
	Low group	43	3.22 ± 0.50	3.32 ± 0.50	3.35 ± 0.54]*	2.57 ± 0.47	3.02 ± 0.57
Pride that nurse is required from the patient	High group	93	3.13 ± 0.42	3.33 ± 0.44	3.23 ± 0.51	2.71 ± 0.55	2.95 ± 0.66
	Low group	48	3.19 ± 0.50	3.34 ± 0.46	3.30 ± 0.52	2.59 ± 0.45	3.05 ± 0.55
Oriented to the social contribution	High group	93	3.12 ± 0.41	3.39 ± 0.38	3.22 ± 0.49	2.69 ± 0.55	3.02 ± 0.64
	Low group	49	3.20 ± 0.52	3.26 ± 0.50	3.32 ± 0.53	2.58 ± 0.45	2.97 ± 0.56
Total score of professional identity	High group	93	3.09 ± 0.42	3.36 ± 0.39	3.18 ± 0.49]*	2.71 ± 0.52	2.99 ± 0.63
	Low group	48	3.24 ± 0.50	3.31 ± 0.50	3.36 ± 0.53]*	2.57 ± 0.48	3.02 ± 0.57

t-test

* $p < 0.05$

($p<0.01$) who identified 【Difficulties with integrated care by different medical professionals】 as a difficulty, with veterans finding this a difficulty in both cases. There was no other association between the type of difficulty and length of experience.

3. Items selected by nurses as particularly difficult and length of experience. (Table 3)

In terms of difficulties felt particularly strongly by nurses, <Being asked by a patient to "do something" about their physical or mental suffering.> was selected by 27.3% of all nurses, <When I am faced with a patient who is irritated, resistant, or angry> by 22.3%, <When I am unable to meet a patient's desire or request> by 22.3%, and <When a patient exhibits little emotion, and I don't know what they are thinking> by 22.3%.

Table 3 shows the items that were most frequently chosen and length of experience. Those with 1–2 years of experience chose only items related to "Engaging with patients facing 'death' and their families," while nurses with 3–10 years of experience also chose some that concerned "Frustration at the inability to be sufficiently involved." Nurses with 11 or longer years of experience also chose items related to "Differences between the images of the end of life held by patients and their families," in addition to the preceding two factors.

4. Association between difficulties and professional identity. (Table 4)

There was a significant difference in the score for 【Difficulties with integrated care by different medical professionals】 between nurses who scored above the mean (2.72 ± 0.50) or below the mean (2.54 ± 0.50) on confidence in the selection of nurses, with those who scored higher than the mean finding this a greater difficulty ($p<0.05$). There were significant differences in the scores for 【Differences between the images of the end of life held by patients and their families】 between nurses who scored above the mean (3.18 ± 0.47) or below the mean (3.35 ± 0.54) on the establishment of a nursing viewpoint ($p<0.05$), and those whose total score was above the mean (3.18 ± 0.49) or below the mean (3.36 ± 0.53) ($p<0.05$), with nurses with lower scores finding this a greater difficulty in both cases.

Discussion

1. Association between difficulties faced by nurses at a designated cancer hospital and length of experience

The difficulties faced by nurses in terminal cancer care were classified into 5 categories. Of these, 【Engaging with patients facing "death" and their families】, 【Frustration at the inability to be sufficiently involved】, and 【Differences between the images of the end of life held by patients and their families】 entailed difficulties in caring directly for patients and their families, with the majority of nurses responding that these were "Difficult" or "Somewhat difficult," and with their mean scores exceeding 3 points.

【Engaging with patients facing "death" and their families】 refers to the difficulty of engaging

with patients and their families who are grieving or downcast when faced with "death" This included the item <Being asked by a patient to "do something" about their physical or mental suffering.>, which was selected as a matter of great difficulty by novices, mid-career nurses, and veterans alike. 【Frustration at the inability to be sufficiently involved】 indicated the dilemma felt when the respondents were unable to carry out nursing in the way they would prefer. This included the items <When someone exhibits little emotion, and I don't know what they are thinking>, and <When I am faced with a patient who is irritated, resistant, or angry>, which were selected as particularly difficult by mid-career nurses.

These difficulties are indicative of the problems entailed in dealing with terminal patients complaining of both physical and mental suffering and with panicked family members in a crisis situation. Previous studies have also identified communication with patients and their families as the greatest difficulty for nurses [11]. What makes communication so difficult? Sakashita [15] identified the state of being unable to become involved in terminal care and wanting to run away as "A mental wall on the part of nurses themselves," and described this as consisting of "formless anxiety," "the dilemma of discrepancy," and "feelings of oppression." In the present study, <Being asked by a patient to "do something" about their physical or mental suffering.> indicated the high level of stress involved in seeing someone suffer physically and mentally while watching them die. 【Frustration at the inability to be sufficiently involved】 is related to two factors: time, and the inability to identify needs sufficiently.

Patients are spending less time hospitalized in designated cancer hospitals, and developing an intimate relationship in a limited time is an exceptionally difficult skill. In this situation, the closer nurses want to come to patients and their families, the more strongly they feel the "dilemma of discrepancy" [15], and their feelings of difficulty increase.

【Differences between the images of the end of life held by patients and their families】 refers to the fact that family members may have different ideas about the end of life than patients themselves, and that these may be difficult to reconcile. The mean score for this category rose with increasing length of experience. This difficulty stems from the fact that support is not provided to patients and family members only as individuals, but that several people are involved simultaneously. Conciliating relationships is one aspect required of nursing interventions. From the viewpoint of nurses' practical abilities, the shift in focus from the perspective of the individual to that of the relationship between the patient and his or her family or between family members, with the dawning awareness that intervention might be called for to create relationships and engage in conciliation, can be understood as indicating development as a nurse [16]. The fact that nurses felt that this mismatch in ideas was a difficulty shows that they understood this situation in terms of systems thinking.

Table 3 illustrates changes in the categories of difficulty as a result of length of experience. For novices, it was all that they could do to face up to the situation of relating to the death of the terminal patients they were nursing. Although mid-career nurses were more experienced, they were still frustrated by their inability to deal adequately with the diverse, complex needs of terminal patients and their families. Veterans used their accumulated clinical experience to try to provide nursing that was more respectful of patients' wishes and ideas, but were unused to adopting a relationship conciliation approach or lacked the skills to do so when patients and their families had different ideas and came to experience this as a difficulty.

The mean scores for 【Difficulties with integrated care by different medical professionals】 and 【System-induced difficulties】 were both between 2 and 3. These two categories both related to indirect care. Previous studies have found that nurses' attitude to terminal care is greatly affected by the characteristics of the surrounding environment [17]. In the present study, however, indirect care was not felt to be a major

difficulty. This suggested that nurses prioritized resolving the symptoms and complaints of the patients and their families with whom they were directly engaged, rather than difficulties stemming from coordination with other medical staff or those resulting from hospital systems.

2. Association between difficulties felt by nurses and professional identity

Nurses' difficulties in【Engaging with patients facing "death" and their families】and【Frustration at the inability to be sufficiently involved】were not associated with any of the factors in professional identity. However, their difficulty in dealing with【Differences between the images of the end of life held by patients and their families】was associated with both a low total score and a low score for establishment of a nursing viewpoint. Individuals with a weak professional identity who had not established a nursing viewpoint thus had more difficulty with aspects involving relationship conciliation. Previous studies have found that honest communication between patients and their families becomes impaired at the end of life, and they are unable to express their emotions to each other[11]. It has been suggested that the experience of nursing terminal cancer patients and their families helps the growth of professional identity as nurses overcome the difficulty they feel in engaging with this situation[10]. Put another way, individuals with a weak professional identity may feel greater difficulty when faced with the problematic situation of end-of-life care.

Individuals who scored highly on confidence in the choice of nursing as an occupation in the professional identity scale felt that【Difficulties with integrated care by different medical professionals】were more problematic. These were also those with the longest experience. In the scoring of professional identity, confidence in the choice of nursing as an occupation normally increases with age, and peaks in veterans. At the same time, the more experience nurses accumulate, the more difficult they find it to indicate the distinctiveness of nursing work in the context of relationships with other medical professionals[18]. Although veteran nurses take pride in their identity as nurses, this is mingled with a sense of diffidence toward other professions. This demonstrates an aversion to coordinating the work of nurses as part of the medical system, with difficulties arising as a result of a lack of skills in accommodating others, a result suggesting that further training is required.

Limitations of this research and future considerations

This study was carried out at a single provincial designated cancer hospital. Although the functions of designated cancer hospitals, their nursing structure, and the attributes of nurses are all consistent, as are the elements of difficulties that relate to direct care, the relationships between different medical professionals and the systems involved may have been affected by the medical culture of this specific hospital. It is thus impossible to make generalizations about terminal cancer on the basis of findings from a single hospital. In light of this study, further studies at more hospitals are required in order to clarify the difficulties involved in indirect care, such as system-induced difficulties.

Conclusions

1. We identified five categories of difficulties felt by nurses at a designated cancer hospital:【Engaging with patients facing "death" and their families】;【Frustration at the inability to be sufficiently involved】;【Differences between the images of the end of life held by patients and their families】;【Difficulties with integrated care by different medical professionals】; and【System-induced difficulties】. The mean scores were higher for difficulties related to direct care, such as dealing directly with death, frustration, and differences in ideas about the end of life, and lower for difficulties related to differences between medical staff and system-induced difficulties.

2. The items most often chosen as particularly difficult were <Being asked by a patient to "do something" about their physical or mental suffering.>, <When I am unable to meet a patient's desire or request>, <When I am faced with a

patient who is irritated, resistant, or angry>, and <When a patient exhibits little emotion, and I don't know what they are thinking>. <Being asked to "do something"> was chosen by a high proportion of nurses et all levels of experience. <Irritated or resistant> and <Exhibiting little emotion> were chosen by fewer, veteran nurses.

3. In terms of the association between items selected as particularly difficult and length of experience, novices chose items related to【Engaging with patients facing "death" and their families】, mid-career nurses those that concerned【Frustration at the inability to be sufficiently involved】, and veterans those concerning【Differences between the images of the end of life held by patients and their families】.

4. In terms of the association between difficulties and professional identity, nurses with a low total score for professional identity and who had not yet established their own nursing viewpoint had more difficulty with【Differences between the images of the end of life held by patients and their families】, while【Difficulties with integrated care by different medical professionals】was associated with a high level of confidence in the choice of nursing as an occupation, suggesting that further training in accommodation skills may be required.

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Conflict of interest

The authors do not have a conflict of interest (COI) with any operator.

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がん診療連携拠点病院での「がん終末ケアにおける看護師の困難感 －「経験年数」と「看護アイデンティティ」を焦点化して－

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キーワード

がん診療連携拠点病院，がん終末期ケア，看護師，困難感，経験年数

要　旨

近年のがん医療の高度化の中で、人々の「終末期」のとらえが複雑化し、対峙する看護師の困難感や葛藤が増している。本研究は地方都市の、Aがん診療連携拠点病院の看護師149名を対象に、自記式質問紙調査を行い、がん終末期ケアにおける看護師の困難感の内容と、経験年数による変化、看護師のアイデンティティとの関連を明らかにした。困難感の測定のため、23項目のアンケート票を作成し、因子分析で５因子が見出された。すなわち、【「死」に直面した患者/家族への関わり】【十分に関わりきれないもどかしさ】【患者・家族間の終末期像のズレ】【医療者間での統一したケアへの困難】【システムに起因する困難】の５つである。また、特に困難感が高い項目を分析した。

全体として、新人は【「死」に直面した患者/家族への関わり】などの直接ケアに困難感が集中し、中堅は【十分に関わりきれないもどかしさ】、さらにベテランは【患者・家族間の終末期像のズレ】や【医療者間での統一したケアへの困難】など関係調整的な関わりで困難を感じていた。特に困難感が高い項目は、＜身体的/精神的苦痛で「どうにかして」と言われたとき＞で、新人からベテランまで高い選択率だった。また新人、中堅で高かった＜感情の表出が少なく、何を考えているかわからないとき＞は、ベテランでは低かった。これらの困難感には、職業的アイデンティティ総得点、看護観の確立と看護師選択への自信の有無が関連していた。これらの結果からは、経験年数に応じた内容の研修サポートの必要性が示唆された。