Oncology nurses' lived experience of caring for patients with advanced cancer in healthcare systems without palliative care services

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Abstract

Background: Caring for patients with advanced cancer is complex and challenging, requiring varied expertise, including symptom management, communication skills, care coordination and emotional resilience. Within existing literature, the lived experiences of oncology nurses are poorly articulated in countries with a lower income where formal palliative care (PC) is absent. **Aim:** To explore the lived experiences of Gazan oncology nurses who provide care to patients with advanced cancer in healthcare systems, without formal palliative care infrastructure. **Methods:** A phenomenological approach was adopted. Semi-structured interviews were conducted between January and April 2022, in the Turkish Palestinian Friendship Hospital. Thematic analysis used the themes (corporeality, relationality, spatiality and temporality) to facilitate reflection on the meaning of participants' lived experiences. **Results:** Interviews were undertaken with 16 oncology nurses. The experience of the 'erosion of nurses' work when coping with anxious attachments to patients and families' was the overarching theme in nurses' views, characterised by five sub-themes: (1) inadequacy of PC training and resources, (2) serving humanity, (3) pride in their profession, (4) existential distress and the coping strategies used by nurses, and (5) reported stress and anxiety when caring for seriously ill patients and their families. **Conclusions:** The study sheds light on the challenges and powerful emotions experienced by oncology nurses who care for patients with advanced cancer, yet lack the necessary PC training and institutional resources. The findings indicate an urgent need for PC training for nurses within the Gazan healthcare system and other lower-income settings. Assessing nurses' emotions and relationships with patients and family caregivers is imperative to enable optimum care for patients with cancer and to foster resilience among their nurses.

Key words: ● advanced cancer patients ● experiences ● oncology nurses ● palliative care ● phenomenological

Cancer is a disease with a high morbidity and mortality rate (World Health Organization, 2022). In 2020, cancer accounted for nearly 10 million deaths, of which more than 70% occurred in low- and middle-income countries (World Health Organization, 2022). People living with advanced stages of cancer experience a high level of distress and fear, which have a significant impact on their physical, functional, emotional, social and spiritual wellbeing (Abu-Odah et al, 2022). Although treatments for advanced cancer are therapeutic, they may cause numerous treatment-related side effects that can persist for an extended period and increase distress and pressure to adapt to the demands of illness and treatment (Winstead, 2019).

Professionals delivering care for people living with advanced cancer require the skills and confidence to improve and maintain health-related quality of life (Verhoef et al, 2020). Nurses are the backbone of healthcare delivery who must be prepared, knowledgeable and aware of methods, skills and approaches that can be used to assist people living with cancer, alleviate their suffering and pain, and ensure quality, person-centred care is delivered. Supporting and caring for people with cancer has an impact on the physical, psychological, social, mental and

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familial wellbeing of nurses (Sinclair et al, 2007), potentially extending across both their work and personal lives (Ekedahl et al, 2007).

Oncology professionals caring for people with advanced cancer may themselves also experience vicarious traumatisation (Sinclair et al, 2007) where trauma affecting a person with advanced cancer may also affect those with whom they discuss the experience. Oncology nurses often spend extended periods of time with patients and witness their suffering and death (Sinclair et al, 2007). Caring for people with cancer may have an impact on the physical, psychological and social wellbeing of nurses (Sinclair et al, 2007). Oncology nurses who lack training in palliative care (PC) and work where PC is not available may feel powerless to relieve their patients' suffering (Silva et al, 2011). Therefore, oncology nurses should be familiar with cancer care and the tenets of palliative and end-of-life care to be able to apply them as part of the management of a patient when required.

While data exist on the experiences of cancer patients and nurses in PC settings (Broom et al, 2019; Pini et al, 2021), there is little data on nurses' experiences in settings where PC education and services are not integrated into the healthcare system, such as Palestine. This creates a gap and raises concerns about how nurses in such settings can be supported in their roles. Thus, the aim of this phenomenological study was to address the literature gap by exploring the lived experiences of oncology nurses in the Gaza Strip, Palestine, who provide care to patients with advanced cancer in healthcare systems, without formal PC infrastructure.

In Palestine's densely populated Gaza Strip, there have been recent efforts to develop PC training within undergraduate and postgraduate medical curricula in Gaza (Abu-Odah et al, 2022; Abu-Odah et al, 2022). However, most practising oncology nurses and doctors lack PC training and few hospitals provide PC. In addition, the procurement of medical supplies is often disrupted, and the capacity for cancer diagnosis and treatment is limited. Thus, the relief of cancer-related suffering is both medically and morally imperative.

Methods

Research design

A phenomenological approach was adopted (Van Manen, 1997; 2023). As a form of phenomenology, this methodology has been used successfully to capture the essence of phenomena through an in-depth understanding of nurses' lived experiences (Errasti-Ibarrondo et al, 2019). This work forms part of a wider programme of work, that includes an exploration of the experience of patients living with advanced cancer (Abu-Odah et al, 2022). The COREQ guidelines were followed for reporting the findings (Supporting Information File S1).

Participants and setting

This study identified and recruited participants from the Turkish Palestinian Friendship Hospital, the only hospital in the Gaza Strip that provided cancer care prior to the 2023 war. The data were collected in January and April 2022. Participants, all of whom were oncology nurses, were purposively sampled by two research team members (HAO and MKH) following initial identification by a senior nurse. The inclusion criteria for the study were having worked in the hospital for at least 3 years, and a willingness to discuss their experience of caring for patients with advanced cancer. Two researchers (HAO and MKH) approached eligible nurses and informed them of the purpose and procedures of the study. Online interviews were arranged to be conducted in a location chosen by the participant. Only the participant and the researcher were present during data collection.

The researcher collected data following the principle of data sufficiency and saturation, determined when no new substantive data is acquired among multiple, diverse participant experiences representative of the phenomenon, and issues begin to repeat with no further contribution to the study (Hennink et al, 2022).

Data collection

The data were collected between November 2021 and March 2022. Skype-based, semi-structured, in-depth interviews were conducted with participants. This interview method enabled nurses to provide their personal narratives (Sekse et al, 2018). The interview guide included the following questions: 'I am aware that you have been providing care to patients with advanced cancer; how do you feel when you when providing care to patients with advanced cancer?'

The subsequent questions concerned the experience in the absence of PC services. 'Can you describe the daily experience of working in an oncology centre?' is a question designed to elicit experiences of comfort and discomfort.

To gain a deeper understanding of participant experiences, follow-up questions were asked: To what extent working with patients in advanced cancer at the end-of-life affect your personal and professional life?', 'In your experience, can you please share your thoughts on whether you

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believe that training and knowledge in PC are necessary for you to cope with stressful events?'.

The interview guide was piloted with two nurses, and subsequently minor revisions were made to the phrasing and content of questions. All interviews were conducted in Arabic by the first author (HAO), a male who holds a PhD degree in nursing and has experience in conducting qualitative interviews. Interviews were digitally videotaped in the nurses' native Arabic language, and transcribed verbatim before translations of transcripts were made in English. To ensure rigour, the participants were given both Arabic and English versions of the transcripts from their interviews. This enabled participants to provide comments and feedback on the accuracy of their interview transcript. Following receipt of participant feedback on their transcript, the transcripts were included in the analysis. Analysis of transcripts was completed in Arabic, including developing themes and subthemes, and then translated from Arabic to English. The translation was confirmed by an Arabic- and English-speaking public health lecturer as a back translation. During the interview, field notes were taken and were cited in direct quotations.

Methodological orientation/ data analysis

All video recordings were transcribed into a Microsoft Word document, along with field notes taken during the interviews. All the transcripts were anonymised, exported to MAXQDA 10 software, and analysed following van Manen's analytic-reflective method (Van Manen, 1997). Using the existential lifeworld theme, the analytic-reflective method proceeded by extracting thematic categories and reflecting on their meanings. To do this, assumptions of Van Manen's phenomenology of practice were adopted: 1) theoretical knowledge is revealed/translated into practice through a reflexive relationship, 2) lived experience refers to grasping what constitutes the phenomenon, rather than how it appears; 3) researchers are required to have continuous structured reflection seeking understanding, using the hermeneutic circle (i.e., understanding parts in the discursive whole) to illuminate the meaning, and discover common and unique themes (Errasti-Ibarrondo et al, 2018).

The process of inductive and deductive thematic analysis occurred through two researchers (HAO, JB) reading each transcript multiple times to get a sense of the participants' experiences. The authors then labelled chunks of the transcripts to extract the essential and incidental meanings embedded within them.

The emergent subthemes with the same meaning were grouped into main themes. Following the formulation of main themes, the lifeworld themes (corporality, relationality, spatiality and temporality) served as guides for reflecting on providing care to people with advanced cancer in the absence of PC services (Van Manen, 1997). Lived time (also known as temporality) is subjective time, as opposed to objective time concerning the past, present and future. Subjective time refers to how individuals personally experience and perceive time, which may not always align with the standard measurement of time on a clock. It is a way to understand how people relate to and understand the passage of time in their lives (Van Manen, 1997). The relationship with others in a shared interpersonal space is known as a lived relationship (or relationality) (Van Manen, 1997). The ambience of the surroundings, as well as its textural and spiritual aspects, are what we sense as lived space (spatiality) (Van Manen, 1997). Lived time and lived space are two aspects of the lived world that are intimately connected experientially. The bodily or physical existence in the world is known as the lived body (corporeality) (Van Manen, 1997).

Trustworthiness/rigour

The study's rigour was upheld by using Lincoln and Guba's four key concepts: credibility, confirmability, auditability and transferability (Ray et al, 2023). Credibility was evaluated by maintaining a long engagement with the data (more than 9 months) and employing member and peer-checking techniques. After data analysis, the researcher contacted the participants and gave them a full Arabic version of the transcript with coded interviews and a summary of emergent themes to approve the researchers' interpretations. To maintain auditability, the process of the study was checked by the four qualitative expert researchers (HAO, JB, JJS, MA), and all evidence and documents were saved securely. The study context was adequately described so that readers could determine whether or not it was transferable.

Ethical considerations

Ethical approvals were obtained from the Helsinki Committee-the Palestinian Health Research Council (ID No: PHRC/HC/1003/21) and the Palestinian Ministry of Health to conduct the study at Turkish Palestinian Friendship Hospital (ID No: 806943).

Informed written consent was obtained from all participants included in the study, after providing each participant with a thorough explanation of the study's background and aim.

Participants were assured that their identities would be protected using pseudonyms, and that their personal information would be securely stored and accessible only to the research team. In addition, they were given the autonomy to decide whether they wanted to participate in the study, and were informed of their right to withdraw at any time without consequence. Furthermore, all identifying collected information was removed from the transcripts and findings to further protect the participants' confidentiality.

Results

Participants information

A total of 16 participants were invited and agreed to participate in this study with their characteristics presented in *Table 1*. Their ages ranged between 23 and 55 years. A total of 12 participants were men and four were women. All participants were married with children. Nearly all of the participants (14) held a bachelor's degree in nursing. The majority of nurses (10) had more than 5 years of oncology department experience. All participants participated in online interviews from their own homes, with interviews lasting between 35 and 50 minutes, with an average length of 47 minutes.

Thematic categories and themes

Thematic categories, themes and exemplary quotes were generated from the analysis (T*able* 2). The experience of the 'erosion of nurses' work when coping with anxious attachments to patients and families' was the overarching theme in oncology nurses' views, characterised by the following five sub-themes framed within van Manen's four existential lifeworld themes (Van Manen, 1997):

- Stress and anxiety in caring for seriously ill patients and their families
- Existential distress and coping strategies
- Inadequacy of PC training and resources
- Serving humanity and pride in the profession.

Erosion of nurses' work when coping with anxious attachments to patients and families

Participants confirmed that their existential distress in caring for patients and their families had an impact on how well they provided nursing care. They were concerned about the quality of the care they gave to patients and their family caregivers. They experienced inner conflict and attempted to alleviate it by improving the care they provided. Participants reported that their capacity to provide care was impacted by the strong attachments they made with their patients, which made them feel anxious about the patients' futures. They also felt that their care was compromised by the lack of facilities to address the needs of patients and their families.

Lived relation (relationality)

The existential life world describes the lived relationships between oncology nurses, patients and their families (Van Manen, 1997). Relationality is the lived relationship maintained with others in the interpersonal space that is shared with others. A conversational relationship with others can enable people to move beyond their own individual concerns and perspectives. This relationality was captured as a sense of attachment to patients and families, and a feeling of anxiety about their futures and the care provided.

Stress and anxiety in caring for seriously ill patients and their families

All nurses reported that the nature and significance of the disease, as well as the recurrent prolonged hospitalisations that were common, fostered a strong caring relationship with patients and their families. The patients'

Table 1. Demographic characteristics of study participants (n=16)

Variables	Categories	Number of participants (n)
Age	Less than 30 years	8
	30–50 years	6
	More than 50 years	2
Gender	Male	12
	Female	4
Educational level	Diploma	2
	Bachelor	14
Years of experience in oncology departments	2–5 years	6
	More than 5 years	10

Table 2. Summary of lifeworld themes and thematic categories

	Themes (n=theme frequency)	Exemplar comments from participants
Overarching theme	**Erosion of nurses' work when coping with anxious attachments to patients and families (n=14)**	'My close relationship with the patients and their families makes me worry about their future. I know that the patients will die one day, and I am anxious about the families that have a strong relationship with them ... I do not know how I can manage and support them after [they] pass away. Overthinking their future affects my nursing role and the quality of care I provide to patients with whom I have a strong relationship. You know, sometimes I try to lie to give hope to patients and their families. Sad to mention that … I am not sure if it is good or not, but I am trying to support them. I am not sure'. (Participant 9).
Lifeworld theme	**Five sub thematic categories**	
Lived relation (relationality)	**Stress and anxiety in caring for seriously ill patients and their families (n=11)**	'We frequently visit our patients' homes to give support to them through hospital duties, and sometimes at their request. Although physicians give the patients and their families enough information about the cancer journey, they still ask us about the future of their patients with cancer because of our strong attachments. The close attachment and relationship with them make us more curious and insecure about the future of the patients, which is mostly death. We try to manage ... stress and anxiety by approaching the psychology team and head nurse at the department and discuss this with them.' (Participant 7). '34 years old, diagnosed with lung cancer. She is married with five children—three daughters and two sons. Since her admission, she has asked me many questions about her status, and a strong relationship has been built with her. She told me not to notify her kids about her situation, and she told them that she had a chest infection and will recover soon'. (Participant 3) '… It is difficult to accept the death of somebod,y when you know him as a member of your family. I lived with him for 6 months, supporting and providing care to him and his family, and then he passed away after I gave him hope for recovery ... I am so tired and sad.' (Participant 11).
Lived body (corporeality)	**Existential distress and coping strategies (n=13)**	'To be honest, working in the oncology department broke my heart and affected all of my life. Of course, I am human and have the ability to accept shock, but really, it is not easy to adapt. After some time, I entered the room and closed the door, crying, and I went to a psychiatric doctor and asked him what I should do. He prescribed relaxant medication. I apologised to the doctor for finding my job difficult.' (Participant 3) 'I do not know what I should do with the patients … and the unavailability of equipment and pain medication restricts me from helping them' (Participant 2) 'During my 5 years of work in the oncology department, I was not affected because I recognised fatalism. I think this feeling may be related to my previous work, where I worked in the intensive care department. But the difference here in the oncology department is that some cases were diagnosed at an early age …' (Participant 2) 'My style differs from that of other nurses, and I can manage and separate work from my daily life. Sometimes my professional life is affected, but I try to separate it from my personal life; Allah has supported me to be patient '. (Participant 1)
Lived time (temporality)	**Inadequacy of palliative care training and resources (n=16)**	'I think that training in palliative care will help me deal effectively with patients. One of the problems I faced when working with new cases was that the patients and their families asked many questions about their status, and I had difficulties communicating and answering all questions. This is a big problem.' (Participant 1) 'Of course, I hope to have training in palliative care, not only for myself, but for all the nurses dealing with cancer patients. However, unfortunately, until now, no one has given us complete and integrated training on palliative care. Most have misunderstood palliative care as they have linked it with only pain treatment. They do not know that it is [only] part of palliative care, and that many aspects, such as psychological and spiritual should be considered. (Participant 12)
Lived space (spatiality)	**Serving humanity (n=15)**	'You know that my job is humanity in nature, and we are affected by deaths. However, we must serve their humanity.' (Participant 2) 'Working with cancer patients, whether old or young, at an early stage or a late stage, and their family members is a wonderful human endeavour.' (Participant 6)
	Pride in the profession (n=8)	'Every year, the nursing community celebrates International Nurses Day, and we see on social media many posts glorifying nurses' roles. This is good for nurses to feel proud of their vocation, and oncology nurses hope to celebrate the International Day of Oncology Nurses.'. (Participant 12)

family members approached participants to learn more about the disease and clarify a patient's prognosis. Nurses reported a strong bond was formed because they were close to each other, living in a small geographical area, the Gaza Strip, and shared the same religious and cultural beliefs and attitudes. Yet, these close relationships also generated insecurity about the patients' and families' anticipatory futures.

Participants gave families the time and space to talk about their concerns, and nurses sometimes visited patients' homes to provide family education. On occasion, participants even visited patients' homes outside of work hours at the request of their families. Participants often formed particularly close relationships with patients who were young, female and married, alongside those who had frequent contact with the healthcare system, such as those with recurrent admissions, who experienced long episodes as an inpatient in hospital. Such attachment and strong relationships could often be detrimental to a participant's health after the loss of a patient.

Lived body (corporeality)

The lived body describes how participants grasp their way of being in their work with people living with advanced cancer in an environment where PC services are lacking (Van Manen, 1997). The emergent thematic categories were the loss of meaning in their work experienced in existential distress.

Existential distress and coping strategies

The majority of nurses stated that working in the oncology department was stressful, and had an impact on their personal and professional lives. Working with people with cancer, particularly during night shifts, caused physical and mental stress. Two participants recalled instances of patients with cancer nearing the end of their lives, with few options available to relieve their suffering. Some participants experienced a sense of helplessness after each death. They sought an excuse not to report to work because the hospital setting reminded them of the person who had died.

Some nurses reported strategies for coping with mental and psychological stressors. A few sought the aid and assistance of psychiatric doctors. Other nurses described their profound religious ties to Allah or God. However, some nurses who had previously worked in intensive care units exhibited indifference toward working with people with cancer, as they had previously dealt with life-threatening conditions. They reported, however, that it was distressing to witness that the majority of newly diagnosed patients were young and with advanced disease.

Lived time (temporality)

Temporality refers to the experience of time and how people perceive and understand the passage of time (Van Manen, 1997). It includes how participants' experiences of the past, present and future influence their lived experiences while caring for people living with advanced cancer and their families. Temporality was captured as what limited or prevented nurses from providing optimum care.

Inadequate palliative care training and resources

All participants concurred that learning pain management and communication skills is essential for overcoming distress and emotional challenges in their work. In addition, they hoped that training in PC would help them learn how to communicate with patients and expand their knowledge of pain-assisting and pain-relieving techniques.

Lived space (spatiality)

Lived space (spatiality) is the atmosphere of the environment, its contextual and spiritual aspects, that nurses experience. The experience of spatiality is described as 'felt space' that includes the internal feeling of participants to formulate their lived space and the external feeling of being in relation to place (Van Manen, 1997; 2023). In the context of providing care to individuals with advanced cancer, the experience was interpreted as a sacred role to serve humanity and fulfil the responsibilities of the profession.

Serving humanity

All nurses acknowledged the sacredness of their work to serve humanity, supporting people living with cancer. Despite the distress and suffering they encountered while working with patients and their families, participants also derived satisfaction from work and hoped to gain rewards from Allah. All nurses reported that their monthly salary was not sufficient, but that this was less of a concern because they viewed their work as an act of worshipping God.

Pride in the profession

The nurses underscored the nobility of the nursing profession. They mentioned that a noble nurse is polite, compassionate and sensitive. They confirmed that oncology nurses must possess moral principles. Senior nurses urged them to align their practice with patients and their families and reinforced that oncology nursing is one of the noblest pursuits.

Discussion

Exploring the oncology nurses' experiences of caring for patients with advanced cancer, in healthcare systems without formal PC infrastructure, is necessary to understand how they manage their lives, and reduce the stress and suffering they encounter while caring for patients. The present study contributes new knowledge about nurses' experiences in caring for people living with advanced cancer in a resource-limited country without PC services, formally integrated into their healthcare systems. Participants were conflicted about how to address patient and family questions and concerns, or were reluctant to discuss the likely trajectory of advanced cancer. Despite the tendency of participants to avoid such conversations, they reported experiencing high levels of tension and pressure, which influenced their social lives, as well as their quality of work caring for patients and their families.

Previous research has highlighted that distress is generally associated with reduced work performance, decreased productivity, and diminished patient care quality (Nabirye et al, 2011; Wazqar et al, 2017). There is also evidence that clinicians' health may be impacted by caring for clinically challenging cancer patients, dealing with the death of patients, forging close relationships with cancer patients, communication difficulties, achieving a balance between personal and professional lives and a lack of in-service training (Abdali Bardeh et al, 2016; Ko et al, 2016; Zareifar et al, 2017).

These problems resonated with the participants in this study. Understanding the psychological mechanisms that lead to care erosion is crucial for preventing its occurrence (de Vries et al, 2017a). Several theories have been adopted to explain how nurses reflect on and maintain quality of care. Based on the theory of cognitive dissonance (Festinger, 1957), where practice is substandard and inconsistent with nursing standards or expectations, nurses are likely to experience inner conflict and may attempt to reduce this feeling by enhancing the quality of care they provide. To prevent such adverse outcomes, it is crucial to ensure nurse education is provided with a focus on enhancing nursing skills and knowledge, before the experience of inner conflict (de Vries et al, 2017b).

In the present study, all participants acknowledged the importance of learning pain management and communication skills for overcoming stress and emotional challenges in their work. However, the majority of professionals in the Gaza Strip have reported inadequate knowledge and training in PC (Abu-Odah, Molassiotis, and Liu, 2022). A recent study, conducted in the Gaza Strip, confirmed that 75.1% of healthcare professionals wanted to learn about PC, and were interested in attending professional meetings, or workshops and taking an intensive course on PC (Abu-Odah et al, 2022). Enhancing nurses' knowledge and training about PC could assist them in managing and mitigating the distress they experience when caring for people living with advanced cancer. Therefore, the creation of context-specific PC training programmes should be prioritised.

People living with advanced cancer face unique existential challenges that can cause substantial distress (Vehling et al, 2019). The progression of disease and the threat of death typically generate feelings of loss and fear of the future (Kissane, 2012). This fear may, in turn, generate needs for attachment, emotional support and intimacy (Hales, 2016). Participants in this study reported that patients often seek such attachment and emotional support, not only from their families, but also from nurses. Many nurses build strong attachments with patients and their families, and this attachment may lead to existential distress, as patients experience painful symptoms and die. According to Travelbee's grand theory of human-to-human relationships (Travelbee, 1963), the goal of nursing is only attained when a strong relationship with other humans is established, as nursing is an interpersonal process, and these relationships can be achieved and are effective when participation and involvement are present.

In their qualitative investigation, Borhani et al (2013) found strong attachments between oncology nurses and patients, which is consistent with the findings of the present study. In addition, qualitative meta-synthesis revealed that nurses are the most patient-sensitive professionals (Sekse et al, 2018), which may explain the reciprocal involvement experienced by participants in this study. The strength and closeness of the relationships between nurses and patients in the study could be attributed to the nature of life in the Gaza Strip, where a large and relatively homogeneous population lives within a small geographical area, making it easy for nurses to visit patients and their families at their homes.

The high level of distress found in oncology nurses in the Gaza Strip appears to be due in part to the high level of psychological distress among their patients (Abu-Odah et al, 2022, Abu-Odah et al, 2023), their poor prognoses, and their limited ability to relieve their physical and psychological suffering (Abu-Odah et al, 2022). These factors, alongside customary close relationships with patients, may contribute to reports of professional inadequacy and guilt (Brajtman et al, 2007). This burden can become overwhelming, when oncology nurses lack the experience, skills, control and social support to manage their mental health (Sabo, 2008).

Future research is needed to explore optimal approaches to delivering palliative care training within Gaza, to develop methods of ongoing assessment of the needs and wellbeing of oncology nurses, and to develop interventions to promote professional resilience for oncology nurses.

Strengths and limitations

A notable strength of this study is the use of hermeneutics to bring to the fore the experiences of oncology nurses. Despite this, it is important to highlight the following limitations. The study focused on a resource-limited environment, with a unique socio-cultural context, which may have influenced how participants experienced caring for patients with cancer. Consequently, work across other resource-constrained settings is required to provide comparative data.

Implications for clinical practice and future research

Based on the findings of this study, there may be a need to enhance training and support relating to competencies in the management of distress for oncology nurses in palliative and end-of-life care. It is crucial to prioritise nurse education to enhance their skills and knowledge before they encounter any internal conflicts. This is essential for mitigating potential challenges in providing patient care. Nurse leaders and nursing regulatory bodies should collaborate with the Palestinian Ministry of Health (i.e., the governmental body responsible for setting up health policies and guidelines for developing the healthcare system), and universities to urgently deliver training on PC for nurses within the Gaza healthcare system. Future research is required to determine optimal approaches to contextualised PC training, and to assess for and ameliorate distress experienced in the delivery of care to cancer patients.

Conclusion

Oncology nurses in the Gaza Strip reported emotional distress related to the limited treatment options and poor prognoses of their patients. Despite this, oncology nurses report strong attachments to their patients and feel proud of their humanistic work. The enhancement of PC training and resources to include distress management should be prioritised, and it may lead to improvements in the delivery of nursing care in contexts without palliative care services. *IJPN*

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CPD reflective questions

- How does caring for patients in advanced stages of cancer affect oncology nurses?
- How can existential distress among oncology nurses be alleviated in settings where palliative care services are not available?
- How can the knowledge, training and skills of oncology nurses in palliative care be improved using non-traditional teaching and training methods?

Key points

- Nurses play a crucial role in providing care to people with cancer and their families, and they frequently spend significant amounts of time with them during challenging circumstances
- Nurses must be prepared, knowledgeable and aware of methods, skills, and approaches that can be used to assist people living with cancer and alleviate their suffering and pain
- Oncology nurses confirmed that their existential distress (i.e., anxiety relating to death and other concerns across relational, spiritual, religious, and other levels) when working with patients and their families had an impact on how well they provided nursing care
- The erosion of work (i.e., a gradual decline in care standards) was reported by oncology nurses as they coped with the anxiety attached to patients and their families
- The findings indicate an urgent need for training in the delivery of palliative and end-of-life care training for oncology nurses working in settings without palliative care services.