

Oncology nurses' experiences of meeting with men with cancer-related fatigue: a qualitative study

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Background: Cancer treatment often causes side effects, among which fatigue is common and can persist for years among disease-free cancer survivors. Living with fatigue can lead to reduced life expectancy and quality of life.

Aims and objectives: To describe oncology nurses' experiences of meeting with men with cancer and talking about cancer-related fatigue.

Design and Methods: The data were collected via semi-structured interviews with nine oncology nurses recruited using a purposeful sampling method and analysed using thematic content analysis. This qualitative design was conducted to describe and interpret the content of experiences.

Ethical issues and approval: The study was approved by a regional Ethical Review Board, and research ethical principles were followed.

Results: The analysis revealed one major theme, namely take the whole person into consideration, and three

subthemes: the importance of (i) establishing trust in the nurse–patient relationship, (ii) supporting the patient's understanding of cancer-related fatigue, and (iii) managing the challenging emotions experienced by patients. The major theme describes the oncology nurses' approach when meeting with men with cancer-related fatigue.

Conclusion: The results provide insight into how oncology nurses can increase their knowledge about fatigue to establish trust in nurse–patient relationships. They can acquire knowledge about how to make men with cancer-related fatigue feel safe when handling their daily lives despite their fatigue. Oncology nurses require knowledge, presence and commitment in their interactions with men with cancer-related fatigue to be able to take the whole person into consideration. This study demonstrates the importance of the approach oncology nurses take when interacting with men with cancer-related fatigue and the strategies required when talking about cancer-related fatigue.

Keywords: cancer nurse, content analysis, cancer-related fatigue, men with cancer, qualitative method.

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Background

Developments in screening methods and treatment options for cancerous diseases have resulted in not only more cancer survivors, but also an increase in the number of people dealing with the side effects of cancer (1). Treatment methods such as chemotherapy and radiotherapy often have acute side effects such as pain, nausea, skin soreness, hair loss and low blood cell production. Treatment-related side effects often persist for a long time and may further include fatigue, mood disturbances, somatic illness, sexual problems and cognitive difficulties (2). The most common treatment-related long-term side effect, fatigue, is described among 18% of cancer patients

(3). Fatigue is normally considered protective for the body as it helps maintain a balance between activity and rest (4). Cancer-related fatigue (CRF) strongly differs from the transient tiredness that healthy people feel (5) and is experienced as a lack of energy that cannot be corrected by adjusting activity levels and is not relieved by rest or sleep (6).

Cancer-related fatigue is a time-consuming phenomenon that affects the whole person as the exhaustion is constantly present (7). It impacts cancer patients' daily lives and their ability to work to a large extent (3). Numerous cancer patients also experience fatigue as affecting their well-being and quality of life (8,9). CRF may be a significant barrier to functional recovery in cancer patients and may lead to negative effects on patients' self-care capabilities and the desire to continue treatment (7). Providing adequate information to patients can reduce worries about side effects and the stress that many

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patients experience. Knowing that fatigue is a common side effect, there are others who are similarly affected, and the condition may last over time provides patients with increased knowledge and consequently the ability to better cope with their CRF (10).

Cancer-related fatigue is often underdiagnosed, and treatment is occasionally insufficient (11). Research has shown that communication barriers between patients and healthcare professionals about patients' experiences of CRF and intervention alternatives are possible reasons for this (10). CRF is experienced subjectively and may be misunderstood and misinterpreted by healthcare professionals. The subjective experiences of CRF are furthermore not always related to objective physical symptoms (11). Conversations about CRF can therefore have emotional significance for patients with cancer, but few cancer patients are offered the opportunity to specifically discuss the related emotional factors with healthcare professionals (10). Talking with patients about their experiences of cancer is important and can increase their knowledge of the disease and make them more cooperative about treatment. As cancer affects men more than women and gender is a significant determinant of health status (1), oncology nurses must take this into consideration when providing care to cancer patients. According to Peate (11), masculinity can be a barrier to conversations about cancer with men as they may experience difficulties opening up and talking about their condition and experiences of its side effects. Oncology nurses are therefore important people for these patients because oncology nurses have general and specialised competences that can be used to support men during this challenging process and can provide opportunities for person-centred care (12). Oncology nurses' responsibilities and functions involve carrying out comprehensive nursing care for cancer patients. Their experiences may therefore improve our understanding of men with CRF and allow healthcare professionals to meet the expectations and needs of these men better. The aim of this study was therefore to describe oncology nurses' experiences of meeting with men with cancer and talking about CRF.

Methods

Design

A qualitative design (13) was used to describe oncology nurses' experiences of meeting with men with CRF. A qualitative descriptive design is a comprehensive summarisation of specific events experienced by individuals or groups of individuals. The data were collected through individual semi-structured interviews, a recognised method for capturing experiences. The interviews were then analysed using a thematic content analysis method (14). This approach was chosen to enhance the understanding of the interviews by sorting the data into themes

and subthemes, and new implications for evidence-based practice can be formulated.

Setting

To reach oncology nurses with experiences of meeting with men with CRF, four different municipality healthcare departments in northern part of Norway were contacted. The healthcare departments represented eight homecare areas. The municipality healthcare department is the second level of care for cancer patients and a complement to the specialist care. In the municipality health care receive the patient medical follow-ups, care for treatment-related side effects and rehabilitation throughout the various phases of the illness.

Participants

The participants were selected using purposeful sampling (14). The inclusion criteria were as follows: (i) being an oncology nurse, (ii) having at least three years' experience as a oncology nurse in municipal health care, and (iii) having experience of meeting with men with CRF. Chiefs within the municipalities' healthcare departments received information about the aim of the study and forwarded an information letter with a consent form to ask oncology nurses if they wanted to participate in the study. The invitation was sent to 19 oncology nurses, and nine decided to participate in the study. The participants were between the ages of 36 and 56 years (MD = 47 years). Their work experience as oncology nurses varied between 2 and 21 years (MD = 10 years) (Table 1). One oncology nurse who only had two years' experience of cancer care was included as she was considered to have gained meaningful experience in working specific with men with cancer. After the oncology nurses agreed to participate in the study, the first author contacted them and gave them further information about the study. A time and place for the interviews were subsequently decided.

Data collection

Individual semi-structured interviews were conducted using an interview guide (15). This design was chosen to obtain data that would be as rich, detailed and complete as possible and to give the participants the opportunity to

Table 1 Participants' characteristics

	Oncology nurses
Number (n)	9
Age, MD (min–max years)	47 (36–56 years)
Gender	9 female
Work experiences, MD (min–max years)	10 (2–21 years)

speak specifically about their experiences. The interviews started with some broad questions: 'Please tell me about your experiences of meeting with men with CRF', 'Please tell me how you contributed to men finding meaning in their condition', 'Please tell me about the strategies you used to focus on the emotional aspects of CRF', and 'Please tell me about the strategies that made for good meetings with the men'. Furthermore, clarifying questions were asked during the interviews to elucidate the participants' experiences. These included 'Can you tell me more about that?' and 'Can you give me any examples?' All the participants were interviewed at their workplaces at their request. The clarifying questions increase the richness of the data, and only a few new issues came up in the last interviews which indicates data saturation (13). The interviews were recorded digitally and lasted between 30 and 80 minutes (MD = 55 minutes). They were later transcribed verbatim. In total, the interviews included 103 pages of text. Data will then be saved in accordance with current regulations (13) which means that data want to be archived for at least 10 years.

Analysis

To describe the participants' experiences, the data were analysed using the thematic content analysis method described by Graneheim and Lundman (14). First, the transcribed interviews were read through several times to obtain a sense of the whole. The text was then divided into meaning units (sentences or paragraphs) related to the aim of the study. Long meaning units were condensed while still maintaining the core content. The next step was to label the meaning units with codes and arrange them into subthemes that presented the manifest content in the data. The analysis process continuously moved back and forth between the whole and the parts of the text. The authors discussed the meaning units, the condensations and the codes, and finally validated the subthemes in the original text. Further, to understand the underlying meaning of the content, a latent analysis was conducted, and a major theme was formulated. According to Polit and Beck (13), creating themes is the core feature of thematic content analysis and threads of underlying meanings are gained through condensed meaning units, codes and subthemes, on an interpretative level. This analysis revealed one major theme.

Trustworthiness

To achieve trustworthiness, the authors chose a purposeful sample based on selection criteria. According to Polit and Beck (13), this would contribute to a richer variation of the phenomenon under study. To accomplish trustworthiness in the analysis, the authors moved back and forth between the interview text, meaning units,

condensed meaning units, codes, subthemes and theme, until agreement was attained (14). With the intent of achieving credibility, quotations were selected from the interview texts and are presented in the results (13).

Results

A latent message in the results was interpreted as the major theme: take the whole person into consideration. Three subthemes were also identified as follows: the importance of (i) establishing trust in the nurse–patient relationship, (ii) supporting the patient's understanding of CRF, and (iii) managing the challenging emotions experienced by patients. The major theme and subthemes are presented below (Table 2) and illustrated with quotations from the interviews with the oncology nurses. The parenthetical number (P) after the quotation refers to the respective participant.

Major theme: Take the whole person into consideration

'Take the whole person into consideration' means that the oncology nurses had to focus on the men's overall life situations and achieve an appropriate understanding that recognised their situations and supported the men in handling their CRF. According to the oncology nurses, the men perceived CRF as an always-present feeling that involved the whole body, leading to feelings of hopelessness, fear and anger. The involvement of each patient's whole life situation meant that the oncology nurses had to be aware of the men's needs and resources. The oncology nurses had to integrate social, mental and physical aspects into the care of the men to see the whole person and to be able to take the whole person into consideration.

Subtheme: Establishing trust in the nurse–patient relationship. This subtheme refers to the importance of developing trust in the nurse–patient relationship based on continuity in healthcare meetings to help men discuss their CRF. This meant that the same oncology nurse should be responsible for the men's care to create continuity in the relationship. The oncology nurses explained that they needed to be sensitive during healthcare meetings to create a safe and comfortable environment. The

Table 2 Overview of the major theme and subthemes

Major theme	Subthemes
Take the whole person into consideration	Establishing trust in the nurse–patient relationship
	Supporting the patient's understanding of cancer-related fatigue
	Managing the challenging emotions experienced by patients

initial meeting was often the most difficult, and it was time-consuming to get to know the man. The oncology nurses found that many men acted formally in the first meeting and answered the questions about CRF sparsely and had few explanations about their needs. The oncology nurses therefore used a direct communication strategy, asking the men about their side effects, such as what felt good or was perceived as unpleasant in their experience of CRF. Another strategy was also to book regular follow-up meetings to help build trust in the nurse–patient relationship and make the men more confident in talking about their experiences of CRF. This ensured that there was continuity in the care. One oncology nurse explained:

It's important to meet the man many times to be able to discuss CRF, give information, and get to know each other. (P8)

The oncology nurses further stated that they had to address the men's vulnerabilities to create a shared understanding of each man's situation. They noted that younger men found it easier to open up and talk about CRF than older men. It was sometimes also easier to discover and discuss CRF when the men were by themselves, without family members present during the healthcare meeting. The oncology nurses experienced the conversations as more open during these visits, and having developed trust promoted the possibility of communication about more private things instead of a focus on the healthcare problems relating to the illness. When a family member was present, the men would often become more passive and let the family member, usually the wife or partner, speak for them. The nurses therefore felt that it was difficult to have a conversation with a man when a family member answered for them. One nurse shared the following:

Sometimes it's nice to meet the man alone. When one meets with his wife, she often talks and answers questions for the man. The man becomes passive and can't say what he wants to talk about. (P1)

On the other hand, family members' presence could also be perceived as security for a man during healthcare meetings. The oncology nurses clarified that family members could often support the man in explaining their experiences of CRF. This was particularly evident among the elderly men who were perceived as being more closed when talking about CRF. The oncology nurses indicated that the men with CRF were often pre-occupied with managing their illness and were sometimes unable to deal with new information, such as managing CRF. To make a man feel safe and add to his knowledge about CRF, the oncology nurses explained the importance of building trust with both the man and his family member as it facilitated the possibility of

communicating about and sharing an understanding of the man's situation.

Subtheme: Supporting the patient's understanding of CRF. This subtheme describes the importance of supporting men with CRF in their understanding of how CRF could affect their daily lives. The oncology nurses indicated that when the men did not understand the information being shared, they found it difficult to participate in decision-making. The oncology nurses further interpreted having CRF as more challenging for men than for women. Furthermore, in general, the men they met were rarely informed about CRF and had little understanding of the condition and its consequences for daily life. Significant others were less understanding of tiredness in men with CRF, and the oncology nurses explained that the men would often hide their experiences of CRF. In such cases, the oncology nurses would focus on creating greater understanding of CRF so that these men were aware that they were not alone with their condition. To create a genuine dialogue with these men, the nurses gave them opportunities to ask questions and obtain answers, which was a main goal for the oncology nurses.

The oncology nurses further stated that an important task in supporting an understanding of CRF was to discuss how CRF affected social responsibilities, such as giving support, getting involved, and still having concern for family members. They learned that many men had difficulties returning to work and working in the same way as before, and this was interpreted as an important goal after finishing cancer treatment. Furthermore, the oncology nurses explained that the men needed support on how they should tell their significant others about their CRF without losing their dignity. The oncology nurses had to support the men's sense that CRF was not taken seriously by others. Many men they met wished for understanding, but they rarely raised the topic of CRF as they were afraid of not being taken seriously.

I feel that the man is concerned that, if he informs others about his fatigue, he will not be taken seriously. (P3)

The oncology nurses had to make the men understand that CRF could be understood as controlling their lives and that every task could take a longer time to perform and complete. It was therefore important to explain the effects of CRF to others to gain support and understanding. The nurses explained that it could affect them differently at different times, with some good days and some bad days, yet together with the men, solutions could be found, and a balance restored to daily life. The oncology nurses had the important task of teaching the men to prioritise important activities so that they could save energy, which would make it easier to manage their CRF. Supporting the men's understanding of CRF included also

identifying their care needs in relation to CRF. Despite the men's own responsibility for managing their CRF, the oncology nurses felt it necessary to inform and teach the men to manage their CRF and not be afraid of it. The offer was made to each man to meet with others in the same situation as one way of supporting their understanding of CRF.

Subtheme: Managing the challenging emotions experienced by patients. Within this subtheme, the oncology nurses described how CRF encompasses many challenging emotions, including anger, hopelessness and powerlessness among men with cancer. The oncology nurses noted that many men talked less about these emotions with physicians than with oncology nurses and that depression often was underreported. CRF presented considerable challenges, and the oncology nurses frequently called for additional assistance of a psychological nature for the men to better support them and their families.

Many times, it takes time before the man opens up and comes up with things that are hard to talk about. (P9)

The oncology nurses further indicated that men's expectations did not always match their reality and that the men struggled with emotions of shame and guilt when they failed to perform their established duties and roles. For example, the men expected that they could return home and perform the same activities as they did before the cancer. One task for the oncology nurses was thus to support the men and their family members to accept the men's cancer. Another important task was to support the men in discussing their condition within their families so that their families could understand how the CRF affected them emotionally since CRF often caused concern among family members. The nurses therefore had to convince the men to talk about CRF to better manage their emotions. They stated that the men tried to spare their closest family members by appearing to be better than they actually were.

It's difficult to convince the man to talk about CRF with relatives as they want to protect their closest. (P1)

The oncology nurses also had to inform the men that the cancer treatment could change them as people and their ability to carry out activities, which many times would also affect their families. This was described as an important but difficult task. The oncology nurses therefore had to support and prepare the men in their struggles, particularly since their families would expect them to be the same as they were before once treatment had ended.

The expectations from his family—and not least his own expectations—were strong. It became very

tough for him to know that he couldn't be the same person. (P2)

The oncology nurses described how CRF was a significant challenge for all the men but was an even greater challenge for the younger men than the elderly as they were in a position in life where they were gaining social experiences and forming networks. Younger men often chose isolation as a solution, so the oncology nurses had to motivate the younger men to participate socially and be open about their condition.

Discussion

The results of our study highlighted the importance of taking the whole person into consideration by focusing on patients' overall life situations and integrating the social, mental and physical aspects of their lives to understand their experience of CRF. The results described how oncology nurses were able to achieve a personal relationship of understanding to support the men with CRF. To succeed, the oncology nurses had to be aware of the men's needs and resources. This corresponds with a person-centred approach (16), which means considering the needs, values and uniqueness of each person within the care context (called a sympathetic presence) to create person-centred outcomes. In professional care, the nurse–patient relationship is the primary human contact and is thus fundamental to the provision of good care.

Furthermore, the results of this study showed the importance of establishing trust in the nurse–patient relationship based on continuity in healthcare meetings to help men talk about their experiences of CRF. Having a cancer diagnosis, together with side effects such as fatigue, places men in a vulnerable situation, and oncology nurses need knowledge and communication skills to build trust. A trustful relationships can be described as constituting the social fabric of life, and the nurse–patient relationship is unique in this respect (17). What characterises such professional trustful relationships is having enough time for communication and ensuring adequate opportunities for both the patient and the healthcare professional to ask each other questions. Supportive, patient-oriented communication skills are therefore important for healthcare professionals as a lack of communication between the patient and the healthcare provider negatively affects the patient's experience of the quality of care received (18). When healthcare providers establishing a trustful relationship by a mutual dialogue, a sense of meaning is created for the patient (19). A motivating force is thereby made through a shared feeling of meaningfulness in the nurse–patient relationship (20). Establishing trust in the nurse–patient relationship also includes the ethical aspects of quality care and is a prerequisite for good and professional care (16). Such relationships should therefore be

based on a confirmation and understanding of the patient's experiences. Meeting the patient regularly, as the oncology nurses in this study describe, makes the patient more confident in communication about their experiences and could be a first step towards a trustful and dignified relationship (21). Where trust has been built, patient-oriented communication might have a significant impact on the patient and professional's relationship and in turn the patient's health and well-being outcomes (22). When patients being informed about CRF and how to cope with it, the knowledge can help cancer patients handle the side effects more easily (23), a result also described in this study.

The oncology nurses in this study noted that men with CRF generally avoid talking about their experiences with the condition. Research (24) has shown that cancer patients often experience CRF as a new sensation and therefore have difficulty finding the words to describe it. Studies (25,26) have demonstrated that fatigue is often an unexpressed symptom and that there is a belief among patients that fatigue has to be managed alone because other people do not want to hear about or understand their condition. Furthermore, CRF is frequently perceived as difficult to define by patients, healthcare professionals and researchers, and they all describe it differently (27). Healthcare professionals, therefore, need to be careful when selecting words to describe CRF to ensure they acknowledge the reality of the patient's experiences and can facilitate the patient in 'talking it out'. An important task for oncology nurses is thus to inform patients that CRF often differs from their past experiences of tiredness and to explain the functional loss that fatigue creates (28). The clinical expression of CRF is multidimensional, making the evaluation of a patient who is experiencing fatigue challenging as it is expressed differently by each patient (29). The patient's personality and coping style must thus be taken into consideration as patients who lack information about their health conditions or do not participate in decision-making may have difficulties in achieving good treatment results (22). Information about the illness and its symptoms may also validate a patient's experience, while a lack of information may negatively influence their experience of being ill (30).

The results of this study also showed that CRF encompassed many challenging emotions among the men the oncology nurses met with. According to Sercekus and Baskale (23), oncology nurses should encourage patients to share their feelings so that they can develop positive coping behaviours as patients who lack knowledge of cancer and its treatment often feel uncertainty and fear. Oncology nurses are therefore an important source of information for patients and their relatives. Indeed, the oncology nurses in this study

indicated that many patients preferred to talk with a nurse instead of their physicians. Furthermore, the patients sometimes did not expect the oncology nurses to meet their emotional needs. Being aware of the type, timing and source of supportive communication that patients find valuable are therefore of importance for oncology nurses (31) as these can help protect patient integrity and dignity (22).

Study strengths and limitations

This study sought to describe oncology nurses' experiences of meeting with men with cancer and talking about CRF. Nine oncology nurses were recruited using a purposeful sampling method and subsequently participated in the present study. This number was considered sufficient to maintain depth in the analysis and offered an excellent opportunity to study the various experiences of oncology nurses. The sample size in qualitative research should be large enough to achieve variations in experiences yet small enough to permit a deep analysis of the data (32). A further strength of this study was the rich data collected using questions that followed a semi-structured interview guide. The shortest interview lasted 30 minutes but was substantial as it contributed and complemented the other interviews with important data.

The study also had limitations. For example, one of the participants had worked as an oncology nurse for a shorter period than stipulated in the inclusion criteria, which required participants to have had at least three years' experience as an oncology nurse in municipal health care. This participant motivated for their participation based on the rich experience of meeting with men with CRF. Finally, the results of this study cannot be generalised, but they can be transferred to similar situations (13).

Conclusion

Our results showed that when dealing with men with cancer-related fatigue, it is important for oncology nurses to take the whole person into consideration by focusing on the men's overall life situations. They also need to gain an approach that understands and supports men with cancer-related fatigue. In the experience of the oncology nurses in this study, cancer-related fatigue is an ever-present feeling that involves the whole body, leading to feelings of hopelessness, fear and anger among men. Furthermore, cancer-related fatigue is an invisible symptom that controls men's daily lives, yet it is not spoken about. This observation indicates the importance of making experiences of cancer-related fatigue visible. Oncology nurses therefore have a responsibility to ask

about cancer-related fatigue and to make the men in their care aware of the symptom. Increased patient knowledge of this condition can support oncology nurses as they attempt to facilitate individual fatigue management among men.

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Author contributions

I-L R performed the data collection and the analysis. Both authors designed the study, contributed to writing the manuscript, and read and approved the final manuscript.

References

- Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2018; 68: 394–424.
- Bennion AE, Molassiotis A. Qualitative research into the symptom experiences of adult cancer patients after treatments: a systematic review and meta-synthesis. *Support Care Cancer* 2013; 21: 9–25.
- Curt GA, Breitbart W, Cella D, Groopman JE, Horning SJ, Itri LM, Johnson DH, Miaskowski C, Scherr SL, Portenoy RK, Vogelzang NJ. Impact of cancer-related fatigue on the lives of patients: new findings from the fatigue coalition. *Oncologist* 2000; 5: 353–60.
- Young K, White C. The prevalence and moderators of fatigue in people who have been successfully treated for cancer. *J Psychosom Res* 2006; 60: 29–38.
- Krishnasamy M. Fatigue in advanced cancer — meaning before measurement? *Int J Nurs Stud* 2000; 37: 401–14.
- Berger AM, Mooney K, Alvarez-Perez A, Breitbart WS, Carpenter KM, Cella D, Cleeland C, Dotan E, Eisenberger MA, Escalante CP, Jacobsen PB, Jankowski C, LeBlanc T, Ligibel JA, Loggers ET, Mandrell B, Murphy BA, Palesh O, Pirl WF, Plaxe SC, Riba MB, Rugo HS, Salvador C, Wagner LI, Wagner-Johnston ND, Zachariah FJ, Ma Bergman, Smith C. Cancer-related fatigue, Version 2.2015. *J Natl Compr Canc Netw*. 2015;13:1012–39.
- Yennu S, Urbauer DL, Bruera E. Factors associated with the severity and improvement of fatigue in patients with advanced cancer presenting to an outpatient palliative care clinic. *BMC Palliat Care* 2012; 11: 16–16.
- Mohandas H, Jaganathan S, Mani M, Ayyar M, Thevi G. Cancer-related fatigue treatment: an overview. *J Cancer Res Ther* 2017; 13: 916–29.
- Scruggs B. Fatigue: assessment and management. *Home Health Care Manag Pract* 2009; 22: 16–25.
- Bonito A, Horowitz N, McCorkle R, Chagpar AB. Do healthcare professionals discuss the emotional impact of cancer with patients? *Psycho-Oncology* 2013; 22: 2046–50.
- Peate I. The community nurse, cancer and men. *Br J Community Nurs* 2013; 18: 70–72.
- Yesilbalkan OU, Karadakovan A, Göker E. The effectiveness of nursing education as an intervention to decrease fatigue in Turkish patients receiving chemotherapy. *Oncol Nurs Forum* 2009; 36: E215–222.
- Polit DF, Beck CT. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, 10th edn. 2016, Wolters Kluwer, Philadelphia.
- Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004; 24: 105–12.
- Kvale S, Brinkmann S. *InterViews: Learning the Craft of Qualitative Research Interviewing*, 2nd edn. 2009, Sage Publications, Los Angeles.
- Ekman I, Swedberg K, Taft C, Lindseth A, Norberg A, Brink E, Carlsson J, Dahlin-Ivanoff S, Johansson I-L, Kjellgren K, Lidén E, Öhlén J, Olsson L-E, Rosén H, Rydmark M, Sunnerhagen KS. Person-centered care — Ready for prime time. *Eur J Cardiovasc Nurs* 2011; 10: 248–51.
- Peplau HE. Peplau's theory of interpersonal relations. *Nurs Sci Q* 1997; 10: 162–7.
- Skär L, Söderberg S. Patients' complaints regarding healthcare encounters and communication. *Nurs Open* 2018; 5: 224–32.
- Eriksson K. *The Suffering Human Being*. 2006, Nordic Studies Press, Chicago.
- Chow J. *Vårdandets symfoni: fenomenet vårdrelation i skenet av två världsbilder. [The Symphony of Care: The Phenomenon of Care Relationships as Reflected in Two Perspectives]*. Doctoral dissertation, Linnéuniversitetet. 2013, Linnaeus University Press, Växjö, Sweden.
- Kitson A, Marshall A, Bassett K, Zeitz K. What are the core elements of person-centered care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *J Adv Nurs* 2012; 69: 4–15.

Ethical approval

The study was performed in accordance with the recommendations of the Helsinki Declaration and approved by the regional Ethical Review Board (Norsk Samfunnsvitenskaplig Datatjeneste, NSD, Dnr 43722). Before starting the data collection, the participants were informed about the nature of the study, gave their informed consent and were told that they could voluntarily withdraw from the study at any time. The participants were guaranteed confidentiality and an anonymous presentation of the findings as no individual characteristics were disclosed.

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- 22 McCormack B, McCance T. *Person-centred Nursing: Theory and Practice*. 2010, Wiley-Blackwell, Chichester.
- 23 Serçekuş P, Başkale H. Living and coping with cancer: experiences of cancer blog users in Turkey. *Holist Nurs Pract* 2015; 29: 144–50.
- 24 Wu H-S, McSweeney M. Cancer-related fatigue: “It’s so much more than just being tired”. *Eur J Oncol Nurs*. 2007; 11: 117–25.
- 25 Stridsman C, Lindberg A, Skär L. Fatigue in chronic obstructive pulmonary disease: a qualitative study of people’s experiences. *Scand J Caring Sci* 2014; 28: 130–8.
- 26 Repping-Wuts H, Uitterhoeve R, van Riel P, van Achterberg T. Fatigue as experienced by patients with rheumatoid arthritis (RA): a qualitative study. *Int J Nurs Stud* 2008; 45: 995–1002.
- 27 Potter J. Fatigue experience in advanced cancer: a phenomenological approach. *Int J Palliat Nurs* 2004; 10: 15–23.
- 28 Williams LA, Bohac C, Hunter S, Cella D. Patient and health care provider perceptions of cancer-related fatigue and pain. *Support Care Cancer* 2016; 24: 4357–63.
- 29 Mitchell SA. Cancer-related fatigue: state of the science. *PM&R* 2010; 2: 364–83.
- 30 Attree M. Patients’ and relatives’ experiences and perspectives of ‘Good’ and ‘Not so Good’ quality care. *J Adv Nurs* 2001; 33: 456–66.
- 31 Liu J, Mok E, Wong T. Perceptions of supportive communication in Chinese patients with cancer: experiences and expectations. *J Adv Nurs* 2005; 52: 262–70.
- 32 Sandelowski M. Sample size in qualitative research. *Res Nurs Health* 1995; 18: 179–83.