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COVER PAGE/ TITLE PAGE

Current perceptions of cancer nurses in France about their role and the evolution of nursing practices: Findings and perspectives

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Authors' contributions

EV and FC conceived the study

EV analysed, interpreted the qualitative data and wrote the first draft of the manuscript

VRD was a major contributor to the qualitative data analysis and interpretation

FC was a major contributor to the discussion section and the manuscript as a whole

EV and FC take responsibility for the integrity of the article

All authors contributed to the subsequence revisions

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Current perceptions of cancer nurses in France about their role and the evolution of nursing practices: Findings and perspectives

Introduction

2020 is the year that marks the bicentennial of Florence Nightingale's birth. The WHO has declared the year 2020 as the International Year of Midwives and Nurses. Recognized as the pioneer and mother of the modern nurse, Florence Nightingale said in 1859, 'No man, not even a doctor, ever gives any other definition of what a nurse should be than this: devoted and obedient. This definition would do just as well for a porter. It might even do for a horse. It would not do for a policeman.' (Nightingale, 1892) Florence Nightingale had managed, after years, to gain recognition that nursing care was based on scientific knowledge, even as doctors at the time associated nursing with simple household chores. (Koffi et al., 2010) Nursing care is increasing and evolving thanks to the transfer of scientifically validated evidence, in order to improve the nursing care of patients, in a global approach to them. Nursing sciences are thus part of so-called "applied" research. We know that the nursing culture (French) is highly dependent on doctors. In this regard, Feroni and Kober recalled Freidson's words about medical hegemony vis-à-vis other healthcare professionals, particularly nurses. Physicians largely define nursing activity, including delegating and prescribing tasks. (Feroni and Kober, 1995)

France begins a 180° turn with its new health policy focused on prevention and the patient-centred approach (Macron et al., 2018; Ministère des Solidarités et de la Santé, 2018), associated with the

challenge of supporting the growing number of cancer patients for the long term. (Organisation mondiale de la Santé, 2006; *plan cancer 2014-2019*, 2014) This new paradigm shift goes against the paternalistic traditions of French care. Nevertheless, patient empowerment has been a sought-after goal concerning chronic conditions for several years. The importance of the role of patients in the self-management of their chronic disease, especially in the context of cancer, no longer needs to be proved. (Carman et al., 2013; Casalino, 2005; Lorig et al., 2001) The importance of the role of nurses in supporting the empowerment of patients affected by chronic disease has also been well-established. (Barello et al., 2017; Bastas-Bratkic, 2017; Karazivan et al., 2015) A few years ago, the first results from the Unicancer Patient Expectations Observatory (Unicancer, 2016) and the French Cancer Plan III 2014-2019 (objectives 2 and 7) had stressed the importance of this necessary evolution towards a generalised approach to care of cancer patients. (Ministère des Affaires Sociales De la Santé et des Droits des Femmes, 2014) This paradigm shift in care requires adapting and evolving practices, particularly in nursing. However, the main results of our two previous oncology studies illustrated the continuum of strictly curative care and paternalistic care practices. (Verot et al., 2020b, 2019)

French public authorities have decided to open new qualification paths for individuals to become university professors or lecturers in nursing sciences. (Richard and Le Boulter, 2019) On the occasion of the bicentenary of Florence Nightingales's birth, and while France has just formalized the nursing sciences and the nursing education course in university, we wanted to take stock of cancerology nursing practices and to investigate the social representations of the nursing role: how

do French cancerology nurses fit into this changing professional environment, from the point of view of their role and practice?

The objectives of our research are (i) to describe the specifics of the nursing role nowadays in cancerology and (ii) to assess the evolution of oncology nursing practices.

Methods

Two qualitative studies were already carried out in three Comprehensive Cancer Centers. The first one aimed to explore the representations and practices of health professionals on patient empowerment -Paract study, funded-.(ClinicalTrials.gov Identifier: NCT03240341, n.d.) The Paract study (Verot et al., 2020a) questioned the implementation of an Evidence Based Practice tool (PAM-13) allowing to measure the level of activation of the patient to support his or her own empowerment.(Hibbard et al., 2004) The second, Preface study (Verot et al., 2020b) was focused on the interest of a motivational approach in cancer nursing cares, rather than a paternalistic and prescriptive nursing care approach, taking into account unresolved issues of addiction in the care process in cancerology (Benarous et al., 2014; ClinicalTrials.gov Identifier: NCT03706937, 2018) The choice to conduct qualitative studies is based on the potential that this type of research can contribute to understanding a problem in various dimensions or to study phenomena not yet detected.(Malterud, 2001)

The sites chosen are Comprehensive Cancer Centers (public hospital, specialist public hospital and private hospital) in a department heavily affected by the disease, and which includes the Hyg e

Centre (the only French pole of regional resources for cancer prevention, information and education).

2.1 Sample recruitment

We performed a secondary qualitative analysis, on the same dataset, focusing only on the nursing population, to answer a question not excavated through the two previous studies. We agree with the writings of Heaton (Heaton, 2008) who explains that secondary qualitative analysis means reusing pre-existing qualitative data from previous qualitative research. In our case, it means reusing the content of semi-structured interviews from two previous studies, retaining only the nursing population, to investigate new or additional research questions. (Heaton, 2008) Thus, we conducted a new research on qualitative data from the nursing population to answer a specific research question not elucidated in the two previously conducted qualitative research. It is important to note that Heaton asserts that this approach does not require the involvement of another independent researcher (or several other independent researchers), not invested in the research previously conducted. (Heaton, 2008)

Paract study: cancerology nurses met were all nominated by the site's investigating physician as they were directly involved in the care of patients treated for cancer by intravenous and/or immunotherapy means. They also shared contact details of the department executives, enabling us to arrange appointments.

Preface study: cancerology nurses involved were recommended to us by the nurses' manager of the different care units of the Comprehensive Cancer Center.

2.2 Inclusion and exclusion criteria

For both studies, the inclusion criterion consisted of an agreement by the nurse to the principle of participation in collecting data. Consent was given by email or verbally during the appointment arrangement process. The exclusion criterion was a refusal to take part in the study. All those designated have agreed to participate and have been met.

Our sample consisted of 20 cancerology nurses representing a wide variety of ages, seniority and experience. The sample included nurses working in oncology or haematology in different departments and contexts: day hospitalisation or full conventional hospitalisation, interdisciplinary positions (nurse navigator), the sterile services sector or the haematology transplant department.

See Table 1.

2.3 Interview grid

The Theoretical Domains Framework (TDF) was used to construct the base of the interview grid.

The TDF was developed by Michie et al to describe practices of healthcare professionals and identify elements of practices that should be targeted for the implementation of new recommendations. (Cane et al., 2012) In our case, the TDF was used to identify elements that either hindered or facilitated the implementation of new modes of care in everyday practice. This framework allowed us to explore barriers to and facilitators of change in cancerology nursing settings. (Atkins et al., 2017; Michie, S Atkins, L West, 2014; Michie et al., 2011) Each domain of the TDF represented behavioral determinants, mediators of behavior change. (Glasper and Rees,

2016) The TDF was composed of 12 original theoretical domains outlined in an interview guide.

The 12 domains: (1) knowledge, (2) skills, (3) social/ professional role and identity, (4) beliefs about capabilities, (5) beliefs about consequences, (6) motivation and goals, (7) memory, attention and decision processes, (8) environmental context and resources, (9) social influences, (10) emotion regulation, (11) behavioral regulation, and (12) nature of the behavior. (Michie et al., 2005) A back and forward translation of the prompt by Michie', Jonhson', Abraham' et al. named "Theoretical domains, component constructs, and eliciting questions for investigating the implementation of evidence- based practice" was carried out. (Michie et al., 2005) Then, 5 researchers reviewed the French version to ensure a good understanding in French. It was subsequently presented to 5 health professionals to confirm its relevance to the target audience.

The same interview guide structure was used for both studies.

In order to complete the data by collecting the issues spontaneously raised by interviewees, a nondirective question: 'Could you tell me about the care of the patient being treated for cancer through intravenous means?' (Paract study) or 'Could you tell me about the management of addictions in cancer patient care?' (Preface study) was added at the beginning of the grid. The form and content of the interview guide were validated by a PhD medical anthropologist (VRD), specialized in the cancer research field.

2.4 Data collection phase

For both studies, data collection took place during the period from May 2017 to November 2018.

The semi-structured interviews were carried out by the first author, a female MSc nurse and PhD candidate, trained in qualitative research with no previous association to the nurses interviewed. The framework in which the collection took place was explained to each of the participants, ensuring their freedom of speech, data protection, anonymisation, and a policy of non-reporting to their hierarchy. All interviews took place in a quiet office, face to face and were recorded in their entirety on a digital audio recorder before being transcribed in verbatim form.

2.5 Qualitative data analysis

These data were analyzed, in order to generate themes that could be in the aftermath associated with the Theoretical Domains Framework of behavior change to investigate implementation problems.

(Atkins et al., 2017; Glasper and Rees, 2016; Michie, S Atkins, L West, 2014; Michie et al., 2011, 2005; Phillips et al., 2015)

Specifically, we applied the methodology framework proposed by Braun, V. and Clarke, V. (Braun and Clarke, 2006)

1. Familiarization with the data. This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content.
2. Generating initial Codes: this phase involves generating succinct codes that identify important features of the data that might be relevant to answering our research question. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis. Nvivo 11 pro software (QSR International) was used to perform the analyses

3. Searching for themes: the collection of codes was worked on in pair with the PhD researcher (VRD) to validate a comprehensive interpretation and a grouping of code elements into themes.
4. The resulting themes were compared to the TDF categories, independently by the 2 researchers, and then compared and discussed. Items that could not be included in the TDF framework were thematized separately.
5. Finally, a more refined coding was used for each part of the verbatim used to illustrate the themes.

2.6 Ethical considerations

Both studies met the ethical criteria.

Study Paract: The study protocol was approved by the Patient Protection Committee of Ile de France VIII (N° ID RCB: 2017-A00235-48).

Study Preface: The study protocol was approved by the Ethic Committee of the Saint Etienne University Hospital, France (IORG0007394/ N° IRBN712018/CHUSTE).

For both studies, all participants were given written and oral information about the study and gave informed consent to participate.

The COREQ checklist guided the preparation of this manuscript.(Tong et al., 2007)

3. Results

The main results of the two previous studies had underlined the following points (Verot et al., 2019):

- Caregivers' practices in oncology are generally frozen in a paternalistic model of care
- Practices mainly deal with an exclusive treatment focal point of cancer
- There is little spontaneous possibility of opening up to other modes of nursing care practices, such as sustaining patient's empowerment with patient centered nursing cares.

We concluded that it was necessary to rethink the initial training of caregivers and nurses, to include an adoption of evidence-based practices to allow for patient-centred care.

To present the two themes generated by this new qualitative analysis, we put theme 1 (related to our first objective to describe the specifics of the nursing role in cancerology nowadays) in the context of the quotation by Florence Nightingale mentioned in introduction section. Theme 2, related to our second objective (assessing the evolution of cancerology nursing practices) will contextualised nursing care in the evolution of the cancerology environment of care.

3.1 Theme 1: The myth of the inherent nursing role: 'Devoted' and 'Obedient'

In the inherent role of the nurse, as described here, he or she directs the patient toward other health professionals or specialists to address or find a solution to the problem detected through the former's clinical nursing expertise.

'When we detect tobacco addiction, we suggest that the patient see a tobacco specialist along their path of care. (...) We help, I don't know how to put it... apart calling the tobacco specialist, we don't do much more!' (nurse 2)

Nurses are aware that their role encompasses health education. But it seems to be limited to passing on information to patients so that they can, if they wish, invest this

field with a specialist. The educational approach has no place in routine oncology nursing care.

‘As nurses, we still have a preventive and educational role. A preventive role can be reminding someone of the dangers of tobacco or other addictions. Educational can be giving them some ideas: directing them towards the right healthcare professionals.’ (nurse 9)

The role of the navigator nurse seems to be to reinforce the nurse in his or her inherent role which consists of detecting problems and then referring the patient to a third-party professional to resolve them. Overall monitoring and assessment of care no longer seem to be part of the nurse’s specific role.

‘Since we hardly have any time, we bring in this navigator nurse (...) So I think that ever since we have these navigator nurses, that there is patient education, several things that have been developed... I think it's good, but because of that, it may have taken away a little bit from our role in relation to the patients... I don't know how to express myself, you know what I mean!’ (nurse 5)

In establishments without navigator nurses, nurses want to create a position for a navigator nurse, so that the patient's problems can be solved by the latter. The navigator nurse is perceived as the patient's referral. He/she is perceived by conventional oncology care nurses as a particular nurse, who takes on the role of finding answers to the patient's problems, to provide him/her with

comprehensive care. This perception of the role of the nurse pivot appears to strengthen conventional care nurses to remain in a posture of obedience that is limited to performing technical nursing procedures.

‘Me, what I would really like them to have here is a navigator nurse that they can call as soon as they have a problem.’ (nurse 16)

‘The navigator nurses have an important role and really have their place because, for the benefit of nothing, the navigator nurse is someone who the patient can rely on. This is extremely reassuring for them, they know that if they have a problem, they will join the navigator nurse.’ (navigator nurse, nurse 11)

The navigator nurses’ vision is not so clearly defined regarding their role in taking overall charge of the patient. It seems that this method of care is questioned as soon as the patient is hospitalised. In fact, the care then becomes fragmented between the different actors of care, who work in their individual departments, each toward a different goal of care.

‘When I give my overview, I’m going to talk about everything. For me, the patient is the same person, we talk about everything. But who gets involved? So we have the tobacco specialist who will take care of the tobacco issue; if there is an addictionologist, he takes care of the addictology sphere, if there is a dietitian, he takes care of dietetics, the social worker takes care of the social sphere and then I try to make the link with everyone, but it works more or less well because everyone is compartmentalised and sometimes, making everyone work together is difficult!’ (navigator nurse, nurse 8)

Nurses working in the day hospital sector describe their position as prescription administrators.

‘It’s true that at the day hospital, they mainly put in place their chemotherapy; they arrive in the morning and leave in the evening.’ (nurse 9)

As our previous results had demonstrated, cancer nursing care is focused exclusively on the treatment of the disease. The role of administering prescribed care is thus predominant, both in cases of day hospitalisation (as seen above) and full hospitalisation.

‘It’s a little bit vague... apart from administering the prescribed therapies (...) I don’t find right now that we’re putting things in place that can be really appropriate, apart from respecting the prescriptions so that the patient is better, beyond that, afterwards, we don’t do a whole lot more.’ (nurse 7)

3.2 Theme 2: Very little change in oncology nursing practices in spite of an evolving environment

Whatever department the nurse evolves in, it seems entrenched in representations that the nurse cannot be proactive in modifying established methods of care.

‘Of the things that we could offer, us, it’s clear that I don’t think we have much to offer!’

(nurse 3)

It appears that subordination to the doctor is a reason for this lack of proactivity. This subordination limits the nurse's ability to question usual practices or to become an agent of change.

‘We aren’t doctors and there, it gets complicated sometimes! It’s complicated...

so as to what we could implement as a tool, me, honestly, I don’t see it.’ (nurse

17)

‘Afterwards, we might have to think of a department project to build something solid. It’s true

that at my level, then, all by myself, I can share it with the doctor, that's all!’ (nurse 9)

Nurses seem to retain their positions as intermediaries, mandated to send information from the field of practice to specialists (directing the patient's trajectory towards third-party resources as previously seen) as well as to the organisational hierarchy. The feasibility of being able to act differently certainly raises questions, but without opening itself to a field of possibilities. Thus, it seems that the nurse's room for manoeuvring to become an agent of change remains very limited.

‘At our level, I think it’s not for us to say. We can send the information up the ladder, but from there to really putting things into place so that things change... I think it's not... I mean, I don't know, it's a real question, I don't know!’ (nurse 18)

Additionally, nurses seem to be deprived of possibilities to seek to inform themselves about the existence of other methods of care and practices.

‘I think it’s complicated to take out even more time if we were to get involved in a project. And then, means or tools, for the moment I don't know any. Maybe there are things that exist, but it's complicated.’ (nurse 11)

Faced with the possibility of implementing a change in practice via an evidence-based tool, the difficulty lies in the risk of disrupting the continuum of the established order. It seems highly

complicated to imagine modifying the methods of treatment, the existing organisation, the practices used.

‘Things are evolving, after that, it’s clearly about how we set it up, how it’s structured (...) how do we include it in our current organisations?’ (nurse 15)

The nurses' reluctance towards possible modifications to usual practices could also be explained by the difficulty in perceiving added value compared to their current mode of exercise. The question of work overload generated by a change in practices is very generally put forward.

‘I don't know if it would bring us anything, if we could do something... because we have a lot of work so taking care of a patient properly takes time.’ (nurse 17)

‘Me, I think it will be difficult to set up anyway because we already have a lot of work, so it seems very difficult to me.’ (nurse 14)

4. Discussion and implications

Since 2009, the French frame of reference of nursing care education has incorporated research in teaching curriculum. 2010 marked the arrival of the first calls for hospital nursing research projects financed by public funds. From the 2000s, the License-Master-Doctorate (LMD) track was established for nurses. Adding the university dimension of nurses' education should make it possible

to face the increasing burden of chronic diseases and the ageing of the population in a context of medical shortage. The ambition was notably to introduce Evidence Based Practice (EBP) into the nursing culture to allow nurses to act autonomously in their area of expertise.(Dariel et al., 2014)

France contrasts with the Anglo-Saxon countries, which have deployed university education for nurses for several decades. (Adamson et al., 1995) Adamson et al. recall that Hazelton suggested in the 90s that this Anglo-Saxon process of the university education for nurses revealed the willingness of nurses to mobilize the terms of their historical subordination to doctors. Indeed, he explained that universitarisation would be a trigger for nurses' empowerment capacities, in particular to participate in new health policy guidelines focused on holistic patient care. (Adamson et al., 1995)

Le Bouler, Head of French Ministry for the University Integration Project for the Nursing Profession and nursing education course, explained in 2019 that, regardless of the progress made over the last ten years, nursing education course is still conducted in France outside of the University. He remains that it is not the case for many of countries, in Northern Europe or North America, where nursing departments exist within universities, sometimes for a very long time. (Richard and Le Bouler, 2019) He underlines in particular that the lack of inclusion of nursing education course at the University has effectively excluded it from the production of nursing knowledges by research. (Richard and Le Bouler, 2019) The importance of university institution is stressed by Richard and Le Bouler, regarding the specificity of the French context : “ *The creation of new disciplines [nursing sciences] has a twofold impact: it is equivalent to institutionally recognizing the research fields concerned, and it enhances universities' involvement in paramedical training.* [nursing

training] *Focusing on these two areas-research and pedagogy on the one hand, and organization on the other-is one of the keys to university integration.*” (Richard and Le Bouler, 2019)

Our results corroborate this and demonstrate the difficulty that nurses still encounter in developing their practices and empowering themselves to be proactive towards a change in the modalities of nursing care in oncology, by using and integrating Evidence Based Practices to update their nursing practices.

4.1 Barriers and levers to adopting a new paradigm of the nursing role

4.1.1 The absence of Evidence Based Practice (EBP) in standard nursing practice

Adamson et al. recall that in 1984, Freidson conceptualized medical dominance over nurses through 4 dimensions: (Adamson et al., 1995)

1/ The work and knowledge of the nurses are approved by the doctors and comes from the medical knowledge

2/ Doctors make diagnoses and decide on treatments

3/ The tasks performed by nurses are usually requested and supervised by doctors

4/ Nurses do not have the same status as doctors, who are the dominant profession.

Our results showed that oncology French nurses remain “devoted”. We can bring this closer to dimension 4 of Freidson. Nurses also remain “obedient”. This posture is related to Freidson dimensions 2 and 3. Finally, we can link the continuity of oncology nursing care practices to

dimension 1, despite changes in their environment. Thus, oncology nurses do not feel they have a legitimate role to play in bringing about change.

However, in its 'Global strategic directions for strengthening nursing and midwifery', the WHO states the need for 'ensuring an educated, competent and motivated nursing workforce within effective and responsive health systems at all levels and in different settings'.(World Health Organization, 2020)

The WHO particularly insists on the importance that should be given to the updating of evidence-based practices.

Our results in France illustrate a constancy in the methods of practice in nursing care in oncology, despite the environmental reforms and evolutions. The mentalities and modes of care remain a curative approach of acuteness in spite of the chronicisation of treatment paths of cancer patients.

(Verot et al., 2019) Lefebvre et al. had already pointed out that French nurses were not naturally inspired by scientific knowledge to lead them to question their practices.(Lefebvre et al., 2013) They added that the nursing sciences could help meet the challenge of this paradigm shift. According to Richard and Le Bouler, research should be considered for its contribution to improving nursing practices, but also in terms of educational investment. Nursing research appears as essential for developing a more reflective practice in terms of training because nursing research is at the intersection of two dimensions: academic training and course and practical training and course. (Richard and Le Bouler, 2019)

The nurse, through his or her inherent role, enjoys autonomy and a capacity for judgment and initiative. From this perspective, nurses are responsible for the decisions they have made and their subsequent implementation. However, as seen in the results section, the characteristic role in oncology is expressed by merely directing the patient's trajectory towards a resource professional, although being capable of potentially providing an answer to a patient's problem, detected beforehand. The paradox resides in the strong capacity of French oncology nurses to use their clinical sense to isolate a problem, and yet a failure to proceed to evaluate this type of initiative, or even to question the usual nursing practices to adapt them to health care evolutions.

4.1.2 Nursing Sciences to acculturate nurses to EBP

As Spiva et al. reminded us, there is no longer any need to prove the positive influence of the implementation of EBP on the quality of care, patient health outcomes and care safety.(Spiva et al., 2017) Jacinthe Pépin claimed, 'what makes the contribution of nurses important is not so much what nurses do, but what they know.' (Pépin, 2015)

The nursing sciences have just been created in France; everything must be built. Nursing sciences should allow French oncology nurses to give themselves permission to be part of a dynamic of empowerment. They could thus utilise their knowledge to update their practices and adapt them to the challenges of tomorrow. In 2018, Diane Morin stressed that nurses in Switzerland and Canada are not very familiar with the rigorous research process, despite a wide range of nursing training course offers in scientific evidence-based practices, or the availability of all this information with

modern technologies. (Morin, 2018) Our results bear witness to the difficulty that French oncology nurses encounter in imagining a modification of the system in which they are evolving in order to welcome the adoption of EBP to their field. To help them, support for the research and adoption of EBP should be handled by their organisation. On this subject, the WHO has also unveiled a specific theme in its global strategy: ‘Working together to maximise the capacities and potentials of nurses through intra and interprofessional collaborative partnerships, education and continuing professional development’.(World Health Organization, 2020)

In the French system, continuing education that culminates in a University Diploma in nursing research could be a first source of motivation. The study by Spiva et al. goes towards this direction by recommending that to promote and support EBP within an organisation, care management must provide nurses with continuing education and resources to evaluate EBP initiatives and support integrating EBP into standard practice.(Spiva et al., 2017)

4.1.3 Nursing research projects and advanced practice nursing as springboards for the integration of EBP into standard practices

The success of the Australian programme, ‘The Cancer Nursing Professorial Precinct’, based on a strategy of collaboration between academic researchers and oncology nurses, presents a way of thinking to meet the challenge of adopting EBP into standard nursing practices.²⁹

The WHO, through its global strategy, advocates that we ‘create leadership opportunities and positions for interprofessional education and collaboration for nurses and midwives and mechanisms for involvement in leadership roles.’(World Health Organization, 2020)

The French hospital nursing research programmes provide an opportunity to work across disciplines between academic nurse researchers, field nurses, other health professionals and managers.

Interventional research and the science of implementation, emerging fields in France, provide means of transferring science-based knowledge to the field, enabling it to secure, adjust and improve the quality of nursing care.

The science of implementation seeks to understand the context in which this knowledge is utilised, while also identifying impediments and facilitators. This addresses the barriers to adopting EBP tools and/or practices. It has been enriched with frameworks or theoretical models allowing professionals to ensure a successful and sustainable introduction of interventions in usual nursing practice. (Curtis et al., 2017; Nilsen, 2015)

Nevertheless, according to Toffel and Longchamp, even though legally the profession of nurse has autonomy through the issuance of a diploma of its own and a hierarchy within its profession, doctors continue to determine part of its practice. Despite the very recent transformation of this profession, particularly with advanced practice in nursing, part of the medical profession remains resistant to emancipation from the nursing profession. (Toffel and Longchamp, 2017)

Diane Morin explains that many studies have highlighted the importance of the role of advanced nursing practice in training and empowering registered nurses. Indeed, advanced practice nurses enable their role, academic training and professional attitude to facilitate the transfer of knowledge (from research to action) in the context of evidence-based nursing. (Morin, 2018)

Our results showed no difference in perceptions among different categories of nurses on the need to use EBP in nursing. We can therefore rely on advanced practice nurses in oncology, to highlight their leadership and stimulate the different categories of oncology nurses towards empowerment.

Diane Morin pointed out that advanced practice nurses have to play training, guidance, advice and coaching roles in changing care practices. (Morin, 2018) We can therefore consider them a major asset to provide leadership to oncology nurses. The development of advanced practice nursing in oncology will help acculturate and unite oncology nursing teams around the research culture, the nursing sciences and the need to transfer EBP into nursing to adopt best oncology nursing practices.

Limitation of the research

The sample did not include advanced practice nurses because Comprehensive Cancer Centers are not yet equipped with them widely. This research should be continued on a wider scale, once advanced practice nursing has been deployed and installed in cancer treatment centers, to collect further results.

The small size of the sample cannot be used to extract representative quantitative statistical data due to lack of power. However, the sample size is compatible with reliable qualitative analysis.

(Saldana, 2009)

5. Conclusion

The French culture of nursing in oncology still rhymes with obedience and devotion. The nurses remain under the domination of the medical field. However, nurses possess knowledge and their

own expertise, which they must valorise to question their practices and help develop in order to optimise care paths. The involvement of nurses in research is essential to improving the quality of care. Education in research from the initial training stage is fundamental to stimulating critical thinking and considering scientific validity as vital. Continuing education is also a strong lever to acculturate professional nurses to gaining empowerment, improving their ability to question practices, helping them adapt to increasing quality and making nursing care more efficient. Research education for nurses is the challenge in France, so that the nursing profession can become more independent.

Conflict of interest statements

The authors declare they have no conflicts of interest

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N = 20	N (%)
Profession Nurse manager- Oncology unit Oncology nurse- In patient unit Oncology nurse- Day hospital Haematology nurse- Sterile unit Haematology nurse- Transplant unit Navigator nurse	 2 (10 %) 5 (25 %) 5 (25 %) 2 (10 %) 2 (10 %) 4 (20 %)
Age [20-45] years old [46-65] years old	 15 (75 %) 5 (25 %)
Female Male	 19 (95 %) 1 (5 %)

Table 1. Participants characteristics