INTRODUCTION

Taking into consideration all diseases, the diagnosis of cancer induces the strongest and most various emotional reactions(1), experienced by the patient, by those having an affective relationship with him and by the medical staff involved in the care process, particularly in advanced stages of the disease. Being a disease that irreversibly changes the lives of patients and their families, by altering psychology, lifestyle and quality of life, it should be treated as a disorder of the entire family.(2)

Over the last 20 years, palliative care has been focused on the patient and on his rights and interests, with limited attention paid to his experience within his family and social relationships. Contemporary bioethics recognizes the model focused on the patient’s autonomy and confidentiality, but it begins to recognize the need for a family-focused approach.(3)

The family often becomes the primary care support unit of the patients(4), meant to ensure psycho-emotional and social comfort and improvement of the quality of life (key characteristics of palliative care). Over time, few studies approached the interrelation between the healthcare team and the patient’s family (figure no. 1) and the importance of communication of these two units of the care team of the patient in the terminal stage of the disease, most of them having a theoretical approach. In the Intensive Care Units, the communication of the medical staff with the patients and their families was identified as “the most important factor and the most difficult to achieve in ensuring the quality of life”.(5) In addition, more than 70% of clinicians reported conflict situations with the patients’ families, particularly in cases with high risk of death. These conflicts were very often severe and associated with significant occupational stress, being a part of the motivation of burnout, in one third of physicians and half of nurses, resulting in feelings of uselessness and “overwhelming”.(5)

Moreover, communication with the patients’ families and their attitude towards the medical staff had been identified among the major stress factors for the medical team providing palliative care to cancer patients.(6)
The patients with high-grade cerebral gliomas have a poor prognosis, with rapid and unpredictable outcome (most commonly survival less than one year), characterized by severe neurocognitive and neurobehavioral deficits. (7) Thus, the family of patients with brain tumours play an important role in the daily care of the patient, so they will experience new responsibilities in the disease’s “journal”. Often, they become “mediators” between the patients and the outside world (8), spending the highest amount of time with the ill person, knowing the best his/her wishes, preferences, mimics and gestures. In these cases, family members undergo high levels of psycho-emotional stress, sacrifice their careers, make financial efforts and experience physical exhaustion. (7) The medical staff must recognize, in the case of patients with brain tumours, the central role of the family in care process. Communication of the medical staff with family members and the emotional support are extremely important, particularly in lowering their psycho-emotional discomfort, manifested by anxiety, feelings of guilt, hostility and depression. (8)

Intimate psychosocial needs of patients with cerebral glioblastomas tend to be increasingly high, due to the short time of adaptation and acceptance of the disease. (7) In such cases, the medical team must identify the family’s feelings: stress, characterized by insomnia, internal conflicts, feelings of guilt preventing them to receive information and interfering with the decisions making, denial which is a psychological mechanism of defence against bad news, sadness, desolation, frustration or anger which is a normal reaction to bad news and a way to express sadness. (9) By relating interpersonal communication within the palliative care team (patient-family-medical staff) with the most known example of organic communication, intercellular signalling, we can understand its importance in looking after patients with advanced stages of the disease. If in the latter case, any blockage of intercellular signalling leads to the development of diseases (10), in the first case it can lead to an imbalance within the team, with the aggravation of the psycho-emotional manifestations of both patient and his family and medical staff. In such situation, the greatest challenge is to handle the conflict, promote right decisions and decrease feelings animosity. (9)

Figure no. 1. Psycho-emotional interrelation between patient, family and medical team; any imbalance occurred in one of the coordinates implicitly leads to the imbalance of the other two

| Family | Patient | Medical team |

**Table no. 1. Medical staff questionnaire**

<table>
<thead>
<tr>
<th>Describe your feelings towards the patient, her husband and son.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your emotional response when you are called in the patient’s room?</td>
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<tr>
<td>What was the evolution of your feelings towards the patient as compared to the first day of admission?</td>
</tr>
<tr>
<td>Which are your dissatisfactions arising from this case?</td>
</tr>
<tr>
<td>Which are your job satisfactions in this case?</td>
</tr>
<tr>
<td>What will be the outcome of the patient and her family?</td>
</tr>
<tr>
<td>What are, according to you, the causes of the conflict between the medical staff and the family?</td>
</tr>
<tr>
<td>What is the correct approach in this case?</td>
</tr>
<tr>
<td>How often do you identify with the patient or someone in her family?</td>
</tr>
<tr>
<td>What could have been, according to you, the correct approach of the family to express dissatisfactions?</td>
</tr>
</tbody>
</table>

It was subsequently associated with the direct observation of the patient’s family during the daily visits by the attending physician in the patient room and during one meeting.
with the institutional psychologist (all of this, because the family refused to share their emotions, worries, anxiety and source of hostility with the healthcare team).

We intended to present a parallel between the psycho-emotional evolution of the family and of medical staff, to correctly identify the emotional and social needs of the family members. The patient’s family, mainly represented by her husband, did not want to answer the questions specifically selected, its attitude was interpreted by direct observation (subjective method) and assumptions that were correlated with the literature data and with similar situations experienced by other families and reported in publications. Subsequently, we analyzed the answers and assessed the attitude of the medical team towards the patient and her family (communication and care), established the way in which they reacted to stress caused by this conflict and identified adequate solutions.

**RESULTS**

The repeated blockage of the communication with the family was mainly caused, according to the medical staff, by her husband (56 points) and long-term hospitalization in the department (39 points) (figure no. 2).

Figure no. 2. Factors that lead to the blockage of communication with the family

![Figure 2](image2.png)

The psycho-emotional stress of the palliative care team was generated, to large extent, by the husband’s attitude towards the medical staff (57 points) and, to a very low extent, to the daily care of the patient (21 points) or patient’s attitude (10 points) (figure no. 3).

Figure no. 3. Occupational stress factors of the healthcare team

![Figure 3](image3.png)

Five solutions to sort out the conflict situation were identified: limitation of family access to patient care within the department (52 points), patient referral to another healthcare unit (40 points), active involvement of the psychotherapist in this case (31 points), a new communication approach (24 points), and change of the medical team attitude (13 points).

The medical staff members proved to be, in a proportion of 93.75%, fully interested in the care provided to the patient within the department and most of them consider that medical services provided were good or very good, due to the collaboration of a medical team (100%) and the collaboration with the family (50%) (figures no. 4 and 5). 68.75% of the medical staff members were empathetic towards the patient and 25% were over-involved; in terms of the attitude towards the family only 12.5% showed empathy, 50% indifferent attitude, 37.5% over-involvement and no member of the medical team had a conflict or neglecting attitude toward the patient or her family (figure no. 6).

Figure no. 4. Quality of the healthcare services provided within the Department of Oncology, Palliative Care for Chronic Patients

![Figure 4](image4.png)

Figure no. 5. Collaboration within the palliative care team

![Figure 5](image5.png)

Figure no. 6. Medical staff attitude towards the patient and her family

![Figure 6](image6.png)

**DISCUSSIONS**

The palliative care team is structured around the core, *i.e.* the patient and has as basic components: family and medical staff. Close relationships are established, between the three entities along the duration of the disease. Any psycho-emotional, social, spiritual and medical distress of either component, negatively affect, by default, the other two. This, finally decrease the quality of life of patient, family and medical team.(11) The interrelation must be based on respect, truth and trust. If one of these is missing, it shows lack of confidence, poor communication, decrease of professional performances, feelings of frustration, anxiety and aggressiveness.(12) Some life partners become over-protectors or “controllers”. This
affects the exchange of information, both within the family and with the medical staff.(13) Often, they try to take control, becoming “experts” in the treatment of the disease.(14)

Here are some statements from the experience of families who looked after persons with brain glioblastoma: “I am very sad and very angry. I see him suffering and turning from an athletic person in one who moves very difficult. Because of the tumour location he has a major speech deficit. I feel I am going crazy looking after him by myself. I feel guilty when I walk away from him to do things that we used to do together, but now he is no longer able to accompany me.”(14)

In our case, the patient’s family was represented by the husband, her son and daughter-in-law. Based on the nurse interview and direct observation, we found out that the patient’s husband is forced to go through this situation alone, without the help of the other family members (75% of the medical staff members said they did not know the patient’s son, and his only encounter with the attending physician was in full conflict, when he stated that “his mother only lives due to the care provided by the patient’s husband”, although she was hospitalized for more than 9 weeks. Furthermore, when the husband was proposed, after a long period of hospitalization and increasingly high demands, to discharge his wife and continue the palliative care at home, with the possibility of readmission according to her needs, he asked us to continue the treatment and recovery program in hospital, because he is “alone” and has no help at “home”, living in rural area, although he had family members living in Bucharest. We responded positively to the needs of the patient and her husband, the duration of the hospitalization period being approved by the Medical Board of the Department. Upon the daily visit of the patient in the patient’s room, her husband was always sad, sometimes angry, always concerned about the imminent and irreversible complications of the disease, always blaming the medical staff at any attempt of communication or was crying; in the last period of hospitalization he even avoided the presence in the patient’s room during the visit. Often, instead of looking after the patient, he communicated with other patients and their families hospitalized in other rooms or followed the medical staff in its daily activity, having an offensive attitude, requiring the presence of nurses at his wife, often, for unjustified reasons. All these were interpreted by the medical staff, either in the context of the state of depression, anxiety, anger and because of being “unprepared to respond emotionally to the worsening of the disease and the death of his wife” or because of his type of personality (contentious), with attempts of to take control on the treatment and daily care and looks for guilt in the Healthcare System. “The outcome of the patient will be unfavourable and the husband’s behaviour will get worse and he will become increasingly aggressive”, “which will lower the quality of life of the patient and medical staff”. In terms of the dissatisfactions of the medical team in this case, the husband’s behaviour was fully highlighted, who always speaks “roughly, disrespectfully and was always unhappy”. The interviews and questionnaires filled in indicate that the medical team’s attitude towards the patient was consistently the same - “with professional attitude, as any other patient within the department”, without the conflict situation affecting the feelings of empathy and the medical services provided to her. Unfortunately, most of the medical team members experienced feelings of frustration and job dissatisfaction, and the attitude towards the family members was indifferent in 50% of cases and empathetic in only 12.5%. The communication with the family could have been achieved if “the patient’s husband had shown more understanding, more gracious and more respectful towards the medical staff”, “given that he knew the diagnosis and had information regarding the evolution of the disease”. The patient was referred, through the Medical Board of the Department, to another healthcare unit, with appropriate human resources (sufficient healthcare staff).

In approaching the case, the medical team shown maturity, succeeding not to reflect the negative effects of the conflict with the family in the daily care of patients, to correctly identify the causality links, to find viable solutions in order to sort out the situation, protecting all members of the healthcare team and also succeeded to maintain the balance and proper communication between the team members.

CONCLUSIONS

Within the palliative care team, communication should be based on mutual respect, trust and truth. Communication gap affects equally the central element of the team (the patient) and the other members (family, medical staff). Families of advance stage cancer patients can benefit from an educational planning helping them to develop necessary skills to solve their own problems and frustrations and proper communicate with the medical staff.

REFERENCES


