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Organisational Problems and Solutions in Oncology: A Content Analysis of the Narratives of Italian Cancer Unit Professionals

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Abstract

The aim of this qualitative research is to explore the perception of the organizational climate in Italian cancer units. The survey was the first step of a two year action-research project, involving 14 hospitals and different professions (n=475). We report the methodology and the thematic clusters that emerged in analysing the answers to three questions: (i) perceived problems with colleagues, (ii) perceived problems with patients and their relatives, and (iii) coping strategies. Narratives were analysed through computer aided qualitative data analysis software. The results identify two main significant issues in describing problems and solutions: interpersonal communication and group cohesiveness.

Keywords

Cancer, Communication, Content Analysis, Health Psychology, Narrative CBT

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Organisational Problems and Solutions in Oncology: A Content Analysis of the Narratives of Italian Cancer Unit Professionals

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The aim of this qualitative research is to explore the perception of the organizational climate in Italian cancer units. The survey was the first step of a two year action-research project, involving 14 hospitals and different professions (n=475). We report the methodology and the thematic clusters that emerged in analysing the answers to three questions: (i) perceived problems with colleagues, (ii) perceived problems with patients and their relatives, and (iii) coping strategies. Narratives were analysed through computer aided qualitative data analysis software. The results identify two main significant issues in describing problems and solutions: interpersonal communication and group cohesiveness. Keywords: Cancer, Communication, Content Analysis, Health Psychology, Narrative CBT

Many studies have been published about communication and the relationship between cancer patients and professionals (Kissane, Bultz, Butow, & Finlay, 2010). The great emotional distress of such interactions highly influences treatment adherence and patient's trust in their physician (Hillen, de Haes, & Smets, 2011). Many studies have analyzed qualitative and quantitative findings about different approaches and protocols in communicating diagnosis (Baile et al., 2000) and dealing with end of life and death (Lacey & Sanderson, 2010). All the research shows that the styles and pathways of relationships seem to deeply influence patients' and professionals' responses. Major scientific achievements, such as the SPIKES protocol (Baile et al., 2000), focus on the idea of communication as something always reciprocal (Buber, 1958), something that always needs a shared and co-constructed choice. The increase in the number of qualitative studies follows this approach that is aimed at analysing the personal and social implications of each and every cancer narrative (Atkinson & Rubinelli, 2012). The common assumption among these studies is the necessity to highlight the personal experiences of the subjects enrolled in the study. "The situation itself does not directly determine how they feel or what they do; their emotional response is mediated by their perception of the situation" (Beck, 2011, p. 31). The high emotional distress caused by cancer specifically requires such an approach in order to help patients and professionals better adapt to the contexts and challenges associated with the illness. On the one hand, patients are faced with the necessity of a continuous re-construction of their personal experience (Lane & Viney, 2000): the illness is an event that disrupts their usual cognitive and emotional patterns, and continuously asks for the elaboration of new subjective meanings. On the other hand, health professionals cope with a

high emotional burden on a daily basis, that more or less covertly influences their professional and personal choices, and so causing a possible burn-out (Shanafelt & Dyrbye, 2012). Such a syndrome is characterised by exhaustion, cynicism, and sense of inefficacy that are due to such stressors as life and death decisions and interpersonal dynamics with colleagues (Maslach, 2003).

To better understand the psychological dynamics of all the agents involved, researchers have encouraged the application of qualitative studies in recent years. Therefore, we decided to explore the personal narratives of cancer professionals about how they define problems and solutions in their own work. We maintain that, despite epidemiological data and organizational management, the experience of the professionals shapes their job and the experiences of patients and relatives themselves. We have opted for a qualitative approach both in defining the hypothesis (i.e., how the cancer professionals construe problems and solutions with colleagues, patients and relatives) and in choosing the methodology (i.e., a qualitative content analysis methodology).

At the core of this approach lie the concepts of in-depth analysis of human motivations and choices, and of methodological induction (Rhodes, 2014). On the one hand, qualitative data can integrate and help to explain the quantitative ones, by “looking to capture attitudes, opinions, or gain insight into how people behave” (Franklin, 2012, p. 171). On the other hand, the need for repeatable results urges the researcher to use an inductive approach that “means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (Patton, 1980, p. 306). In qualitative studies, this approach is frequently based on a rigorous analysis of the narrative contents expressed by the subjects involved. Such a methodology is usually defined as content analysis: “a research technique for making replicable and valid inferences from text (or other meaningful matter) to the contexts of their use” (Krippendorff, 2004, p. 18). It is therefore possible to support the usual qualitative inferences through a quantitative analysis of recurrences and co-occurrences of words and thematic clusters. Nowadays there are widely used scientific software packages that allow a standardization of the research design.

Computer Assisted/Aided Qualitative Data Analysis (CAQDAS) is the use of computer software to aid qualitative research in transcription, coding and text interpretation, content and discourse analysis. It allows to deal with large amounts of data and improve validity and auditability of the results (John & Johnson, 2004). Usually, CAQDAS studies employ the so-called Grounded Theory approach: “A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (Strauss & Corbin, 1990, p. 23).

From a Grounded Theory point of view the researcher ought to be “theoretically sensitive so that he can conceptualise and formulate a theory as it emerges from the data” (Glaser & Strauss, 1967, p. 46). Rather than beginning with the theoretical development of an abstract hypothesis, the first step is data collection, through a variety of methods. In the collected data, the key points are defined through a series of codes, which are extracted from the text. Coding is the basic process of breaking down data into distinct units of meaning and then systematically evaluating them for their inter-relationships. The codes are grouped together by similar concepts, in order to make them more manageable. From these concepts, categories are formed, which are the basis for the formulation of a theory. In such an approach “initial decisions are not based on a preconceived theoretical framework” (Glaser & Strauss, 1967, p. 45). The basic intent is to identify the core categories, the ones that capture the main concerns of participants and accounts for most variation in a pattern of verbal or non-verbal behaviour.

We assume it is extremely useful to have a solid understanding of the psychological representations and subjective meanings from the viewpoint of health professionals operating in a cancer unit. This is precisely because any improvement or training ought to start from an assessment of the actual problems as they are experienced by participants themselves (Dunn, 2010, p. 16). In fact, “the interpretation of a situation (rather than the situation itself), often expressed in automatic thoughts, influences one’s subsequent emotion, behavior, and psychological response” (Beck, 2011, p. 137). These data can be very valuable in developing coherent psychological interventions, aimed at fostering resilience and better coping skills in the individual, group and at organisational level (Cartwright & Cooper, 1995).

The present research comes from the ambition of delivering a tailored training for cancer professionals. Notwithstanding the well-known construct of burnout and the effectiveness of standardized psychometric tools, we decided to explore the personal narratives of cancer professionals as an informative and tailored way to assess the organizational contexts of cancer units. We assume that the more tailored is an assessment, the more engaging and concrete may be the consequent training or intervention. In fact, this paper aims to report the methodology and the main results of the very first phase of a specifically developed training for cancer professionals. We conducted a two-year national action-research in order to: (i) psychometrically assess the organizational burnout of 14 Italian cancer units (Cioffi et al., 2013), (ii) explore the personal narratives about problems and solutions in dealing with colleagues, patients and relatives (i.e., the present research), and (iii) conduct a specifically developed training for both oncologists and nurses. At the best of our knowledge, this project represents most extensive training for cancer professionals never delivered in Italy.

Methods

During our two year action-research project, we collected both quantitative and qualitative data, using two different tools. The first one was the Italian version (Borgogni, Galati, & Petitta, 2005) of the Organizational Check-up Survey (Leiter & Maslach, 2000) we have previously validated on our Italian oncology sample through structural equation modelling (Cioffi et al., 2013). The second one is the open questions questionnaire we describe in the present paper. The data of the two tools were used to identify the organisational targets of a tailored training. Two separate blind analyses were performed on the two different data types: one researcher worked on the quantitative data, another on the qualitative ones. They both ignored the results of the fellow researcher. In this paper we report the qualitative data analysis procedures and results. All the participants signed a copy of the Informed Consent Form. The research was approved and supported by the Italian Association of Oncology (AIOM).

Sample

We enrolled 475 (m=128; f=347) cancer unit professionals recruited in 14 Italian oncology departments (see Tables 1-3). The assessment was part of a broad action-research procedure, in order to promote professional engagement and reduce burn-out symptoms. In every unit the procedure included an organisational climate survey (Cioffi et al., 2013) and three qualitative questions. All the professionals (see Table 4) were involved and included in the analysis.

Table 1: Sample divided by geographical zone

	Frequency	Percent
North	232	48.8
Center	55	11.6
South	188	39.6
Total	475	100.00

Table 2: Sample divided by gender

	Frequency	Percent
Male	128	26.9
Female	347	73.1
Total	475	100.00

Table 3: Sample divided by age

	Frequency	Percent
No answer	28	5.9
< 26	4	0.8
26-35	143	3.1
36-45	177	37.3
46-55	96	2.2
>55	27	5.7
Total	475	100.00

Table 4: Sample divided by professional role

	Frequency	Percent
No answer	30	6.3
Senior Physician	14	2.9
Physician	154	32.4
Coordinator	24	5.1
Nurse	180	37.9
Auxiliary Staff	16	3.4
Psychologist	22	4.6
Administrative Staff	16	3.4
Data Manager	16	3.4
Care Workers	2	0.4
Other	1	0.2
Total	475	100.00

Data Collection

Before the beginning of the project all the participants were asked to answer three open questions:

- a) Do you have any recurrent problems with colleagues and/or co-workers? If so, which ones?
- b) Do you have any recurrent problems with patients and/or their families? If so, which ones?
- c) How do you succeed in solving such problems?

The three questions were attached to the Organizational Check-up Survey (Leiter & Maslach, 2000) in a written form and then anonymously delivered to the research team, together with a signed consent form. We then tabulated all the answers in word-processing files.

Data Analysis

Analysis was performed using Atlas.ti Scientific Software (Version 5.0). Specifically, we used Atlas.ti to select text Quotations (respondents' exact words), to assign Codes (codes were user-defined, on the basis of the frequent thematic overlaps among answers, and common topics in psycho-oncology), as well as to create Axial Coding (comments on Codes and themes related to theoretical coding).

The Atlas.ti Families editing option and search features helped pull together, at the second level of coding (axial Codes), the passages identified by a user-defined set of Codes representing concepts that had semantic features in common. Third-level (selective) Codes were essentially theoretical constructs (sub-themes), created by connecting and consolidating second-level Codes and, at the same time, generalising the evidence contained in the emerging data (audit trial was performed when the coding work, implemented by the main coder, was submitted to another author).

Two main quantitative values were computed for each emerging cluster: Groundedness (G), that is the number of recurrences of a Code in the texts (i.e. the quantitative diffusion of that Code); and Density (D), that is the number of semantic connections between a Code and other Codes.

Results

In order to better understand the analysis and results, we report the expressed Codes for each research question. Colors in the figures are the output of the Atlas.ti 5.0 "Autocolor," which chromatically visualizes the groundedness of a code.

Question I

The first question (Do you have any recurrent problems with colleagues and/or co-workers? If so, which kinds of problems do you have?) was aimed at exploring the description of the professional context, the presence and typology of related problems. The Code-Family describes 41 semantic codes (see Figure 1).

specifically, leadership problems (G=13; D=2). The organisational issues, in the professional's representation seems to be the main cause of other problems: insufficient time and heavy work load.

The emergent conflicts among team members are likely to highlight problems concerning how they perceive each other's professional roles: colleagues are supposed to not respect each other (G=11; D=6).

Organisational fragmentation

The personal and social identity themes, referring both to personal and group identity, point out a core construct that we define as internal segregation (G=34; D=10). It refers to a group condition of continuous dispute and hostility, that covertly and overtly divides and puts people, groups and units in a structural conflict, one against the other. It is also functionally correlated with the lack of communication cluster and its sub-Codes, especially with the different perceptions about personal and professional roles issue.

This cluster is the Code we used to describe all the quotations related to lack of integration inside the team of health professionals. The recurrent absence of a perceived group core identity describes the lack of a supporting cohesiveness, one which allows the sharing of values and beliefs inside the team. It is a big obstacle, a psychological wall against effective and positive collaboration and communication.

These issues are well described by four broad (i.e., with high Groundedness) sub-themes:

a) Inadequate collaboration (G=39; D=4): this refers not only to the lack of communication, but also to the idea of a team that does not perceive itself as a supportive and cohesive team (respondents usually say: "we are not a group").

b) Respecting the role (G=11; D=6): as reported, this refers to relational problems described by a lack of or a low respect for the others professionals' roles ("they do not respect my role"). It usually points out group dynamics depicted by the following sub-theme.

c) Ambition-competitiveness (G=10; D=6): competitiveness inside a team is usually "a dirty war," between and among physicians' and nurses' professional sub-groups.

d) Problems in taking on a challenge (G=6; D=3): colleagues do not seem to personally and professionally invest in the team work.

Demotivation

This cluster group includes all the Codes correlated to lack of or low motivation, commitment, engagement, and also to professional negligence. It refers to five main sub-Codes:

a) Demotivation (G=9; D=5): professionals describe a condition in which they no longer wish to engage in team dynamics.

b) Lack of commitment (G=8; D=2): people usually do not usually engage themselves in team activities or challenges.

c) Resistance to change (G=6; D=2): people are often not interested in personal and group changes.

d) Lack of solidarity (G=10; D=9): people do not support each other.

e) Lack of professionalism (G=10; D=4): people, generally with a low level of commitment, do not carry out their own job in a professional manner.

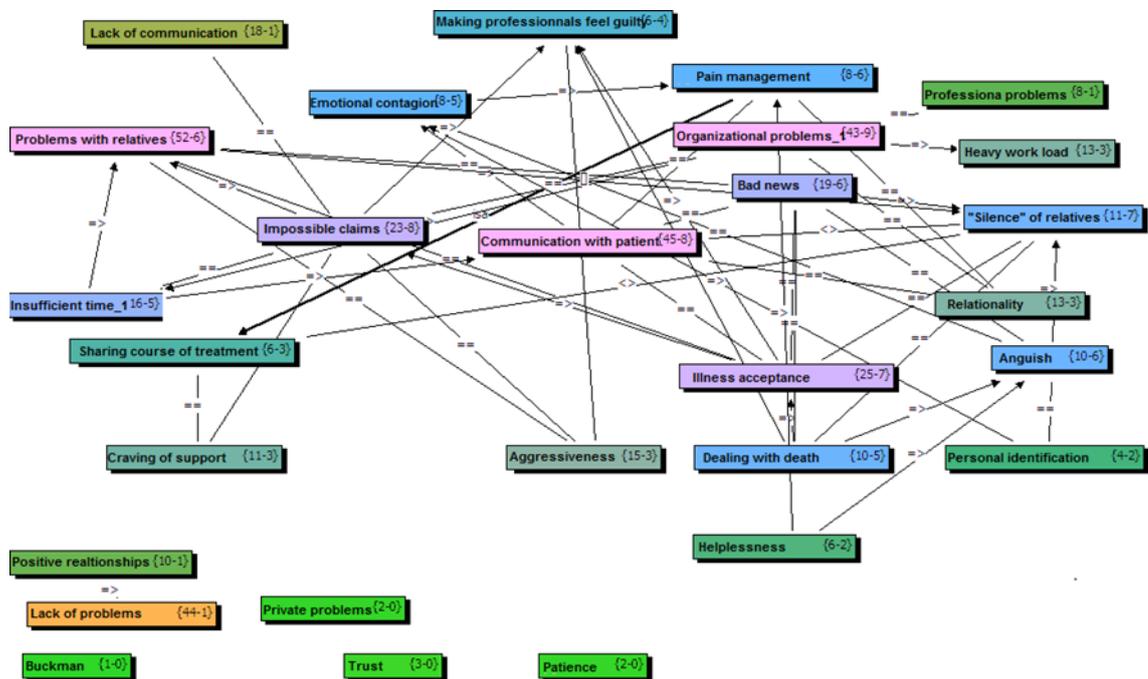
Collaboration

This describes the positive collaboration (G=16; D=12), between and within professional groups. It is usually correlated with the lack of problems (G=40; D=1), and with narrative descriptions in which the group is perceived as a supporting one, with a sense of membership (G=4; D=4).

Question II

The second question (Do you have any recurrent problems with patients and/or their families? If so, which ones?) replies the first question’s structure, focusing on the external relations rather than on the internal group relations: that is the relationships with the care context. Health professionals highlighted problems that could be categorised along different themes (see Figure 2).

Figure II – Problems with patients and their families



Communication with patients

This cluster refers to problems in dealing with patients’ emotional distress; problems in letting patient and family accept the illness and its consequences; problems in breaking bad news. The core structure, that is the core construct of the whole Code-Family, identifies the

problems in communication with patients (G=45; D=8). Professionals frequently describe such problems as consisting of two sub-constructs:

a) Emotional contagion (G=8; D=5): communication problems are often caused not by information biases, but by the emotional distress in dealing with the psychological and physical pain of patients (G=8; D=6). As in front of a mirror, they describe how “exhausting [it is] to see them suffering, knowing that there is no hope.”

b) Illness and death acceptance: From the narratives, it is very difficult to identify an accurate boundary between difficulties in accepting illness (G=25; D=7) and the possible death (G=10; D=5) of the others, or the professional shortfall in breaking bad news (G=19; D=6). We might hypothesise an overlapping between professionals and patients difficulties in facing with death and dying.

Impossible claims

Another perceived recurrent criticality is related to the unrealistic claims from patients and families (G=23; D=8). Such demands refer to relational, therapeutic and organisational issues. This cluster proves to be a very core construct in health professionals, and is better explained by three themes:

a) Insufficient time (G=16; D=5): professionals depict organisational problems as insurmountable barriers around “what we can do.” Sometimes it is not clear if the subjects describe an unrealistic demand of the patients, or if they are just sharing and agreeing with patients about a significant lack of time and organisational resources in their daily workplace.

b) Illness acceptance/dealing with death: they describe patients and families as “blaming” them, rather than accepting the inevitability of suffering and death.

c) Problems with relatives (G=52; D=6): unrealistic demands (about therapeutic, organisational, psychological, relational issues) by families are a recurrent theme. They are usually described and correlated with a perception of aggressiveness, unattainable requests, organisational problems.

Acceptance of illness and death

This psychological issue is one of the most significant. The core question is the acceptance of illness (G=25; D=7) and of its clinical course and possible complications. The most significant functional correlation is in the dealing with death issues (G=10; D=5), that seems to be a common denominator connecting all the emotional and relational problems. Indeed, other issues prove to be very connected, such as: breaking bad news (G=19; D=6); communication with patients (G=45; D=6); problems with relatives (G=52; D=5); silence imposed by relatives (G=11; D=7); impossible claims (G=23; D=8).

Professionals describe two significant dimensions that well explain their construction of communication problems: (i) the family-imposed silence (G=11; D=7) over the patients (very common in Italian healthcare culture) is perceived as a defensive, avoidance strategy by the family that complicates medical communication with patients themselves; (ii) making professionals feel guilty (G=6; D=4) seems to be another recurrent strategy that relatives use when they are dealing with therapeutic limits. It seems to be their ultimate desperate challenge in defining and symbolically controlling illness, death, and consequent distress. We suppose

such a psychological control may arise through a psychological attribution of guilt and accusations to the healthcare professionals.

Organisational deficiency

This refers to the lack of temporal, human, material resources. It is often correlated with unattainable requests both of patients and their families, and with the communication with them. Organisational problems (G=43; D=9) perhaps show two main functions in the professionals' narratives: (i) it depicts a narrative and linking connection between caring teams and patients/relatives; and (ii) especially points out an explanatory attribution that seems to decrease and cover personal distress in emotional and relational problems. It is interesting to note that professionals often describe organisational deficiencies as the main cause of problems in managing patients' pain.

Pain management

A specific and core psychological theme emerging from the data is the issue of pain management (G=8; D=6), that shows the emotional and relational relevance of the companionship that professionals offer to patients and families. Despite the low Groundedness, this cluster is defined by personal and abundant narratives that highlight the empathic effect of being in touch with the physical and psychological pain of the others.

Problems with relatives

Professionals express a high level of distress in dealing and being in close contact with the relatives of their patients (G=52; D=5). Such a relationship seems to be connoted by very complex and ambivalent dimensions. While patient-professional relationships are more focused on caring emotions, relative-professional relationships seem to depict a complex triangular dimension (professionals – family – patients). Professionals perceive a relational aggressiveness (G=15; D=3) toward them from the families, that often imposes a silence (G=11; D=7) regarding the patients' condition, and guilty (G=6; D=4) on the professionals. This is, in the healthcare professionals narratives, a recurrent criticality in managing the breaking of bad news to their patients.

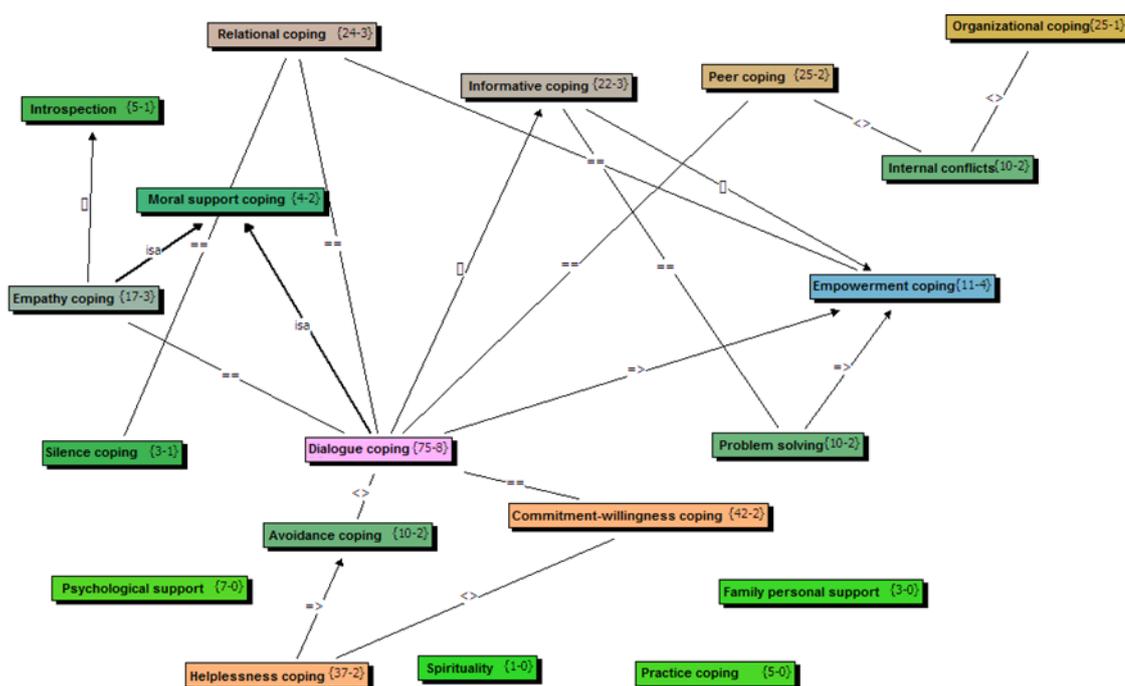
Lack of problems

This cluster refers to short texts reporting only "no problem"-type answers" (G=44; D=1). The "absolute absence of problems" seems to be in sharp contrast with the aforementioned difficulties, and is often doubted to be related to defensive instances. Similarly, the explicit ability in construing and maintaining positive relationships (G=10; D=1) with patients, despite any contextual problems, involves only ten subjects.

Question III

The third question (How do you succeed in solving such problems?) refers to resources and strategies used by healthcare professionals in order to cope with the problems that have come to light in the first two questions. During the analysis, we found 19 semantic Codes (see Figure 3). It is interesting to note that the answers to this questions were usually the shortest ones.

Figure III – Solutions and coping strategies



Dialogue coping

The most frequently cited coping resource is the one described as dialogue (G=75; D=8). Moreover, its recurrence in the answers (n=75) is the most prevalent throughout all the research. The high Groundedness is also correlated with the wide explanatory attribution that professionals make about this resource. This resource is highlighted and perceived as a sort of universal solution, applicable to very different contexts and problems. Its recurrence is well explained by the similar recurrence of the lack of communication problems in the answers to the first question. From this point of view, although it is a bit too generic answer, it clearly underlines the perceived centrality of relational and group-related issues in oncological professional contexts.

As we previously anticipated, a meaningful communication and a relational sharing culture in the work-place seems to be a superordinate concept, that distinguishes functional and cohesive teams from the dysfunctional and conflicting ones.

Internal conflicts

This refers to group problems in the workplace. Internal conflicts (G=10; D=2) are often referred to as tensions between physicians and nurses, and usually linked with organisational problems and personal disengagement and professional failure. Indeed, we note that organisational coping (G=25; D=1) focuses on operations allowing better professional relations and sharing among colleagues.

Helplessness

Probably the most relevant dysfunctional strategy to cope with problems, is the one described in our Codes as helplessness (G=37; D=2). It refers to the coping strategy of personal disengagement, detachment, in other words it is the belief that “here nothing can be done” in order to improve personal and professional conditions. Respondents avoid getting engaged and

involved with painful problems, emotions and distress arising at work. Such helplessness (in therapeutic, organizational, and personal contexts) usually enables an avoidance coping strategy (G=10; D=2) that utterly complicates relationships and communication with colleagues, patients and families.

Commitment-willingness

As a coping strategy, the commitment solution (“we need to improve our professionalism and commitment”) is widespread diffused among the personnel (G=42; D=2), but it seems to be related to more individualistic dimensions than other organisational or group strategies. It appears to be somewhat separate and independent from other types of coping strategies.

Relational coping

These coping strategies (G=24; D=3) include some similar approaches in dealing with problems. These approaches are characterised by an active relational and emotional approach, at first with patients but also with colleagues. There are three main constructs:

a) Empathy coping (G=17; D=4): this highlights the relevance of sympathy and emotional sharing, in the perception and response to emotions and distress of others.

b) Moral support coping (G=4; D=2): this describes the idea of “encouraging patients and families”; it is semantically overlapping with the previous construct.

c) Relational coping (G=24; D=4): this points out the relevance of kindness and awareness in being in touch with the others, developing and promoting significant relationships.

This cluster seems to extend the meaning of the aforementioned dialogue-based coping strategy. Despite the low recurrence of this construct, it is interesting to point out that this cluster has a high recurrence with constructs like introspection (G=5; D=1), the availability of valuing and being aware of conditions and changes in relationships. However, as we have said, only a few professionals seems to be interested in a personal, explicit and intensive reflection on the relational meaning of their distress.

Informative coping

Informative coping (G=22; D=3) seems to be in contrast with the previous relational coping strategy. Informative type strategies include rationalistic attitudes and technical-oriented approaches that consider practical information and rationality as the only basis to communicate with patients and to manage the emotional difficulties of the oncological work. This problem-solving type of strategy (G=10; D=2) could be useful in communicating clinical information, but it seems somewhat constraining and ineffective in coping with the ambiguities and personal involvement issues of this type of work (Fellowes, Wilkinson, & Rivera Mercado, 2004).

Bridging strategies

Two coping strategies emerged as interesting functional bridges, as explicative links between different types of problems and solutions:

a) Empowerment coping (G=11; D=4): This refers to the idea that patients and their relatives should receive support in building up their own illness-coping skills from healthcare professionals, thus allowing a continuous sharing among professionals, patients and relatives. Hence, this strategy could lead to emotional advantages for all the actors involved.

b) Peer coping (G=25; D02): This describes that peer-to-peer support modalities, also in the healthcare professionals' own representations, could be one of the most effective solutions. It seems to allow a co-construed problem analysis and resolution, by integrating organisational and interpersonal dimensions.

Discussion

The most of the studies about oncology staff stress and related interventions report a high level of burnout and a need for training aimed to promote communication and engagement (Vachon, 2010). Similarly, the Italian studies highlight high level of workload and a lack of communication (Cioffi et al., 2013; Cheli & Velicogna, 2015). The present research is aimed to extend the previous results, by exploring the personal narratives of cancer professionals about problems and solutions with colleagues, patients and relatives.

The analysis and the following reflections seem to be based on a large sample (n=475) of Italian professionals who work in cancer units (The leading thread in each of the three questions seems to be the theme of communication and dialogue. The high recurrence of this theme cannot be just a semantic generalisation. Rather it emerges as a relevant belief, at the core of the representations and subjective meanings of most of the respondents. Whenever they describe problems or solutions about their daily team-work (see question I and III), they repeatedly express many semantic units related to interpersonal and group communication, and the need to be a cohesive group. The second question (i.e., problems with patients and relatives) also implies the presence or the absence of a strong sharing and relational communicating competence towards patients and their families.

The results might be influenced by the survey context, namely an assessment included in a training project. We may surmise that the participants were motivated to highlight their psychological insight, the same one they perhaps expected to deal with in the training itself. In any case, the professionals underlined and stressed the relevance and the need for better group functioning and intra-/inter-group communication (at varying levels: inter-personal, inter-professional, organisational ones). In other words, we suppose that perceiving "to be alone in facing of cancer" is the main psychological threat, not only for the patients (Bell et al., 2010; Cavalli-Björkman et al., 2012), but also for the healthcare professionals.

In order to better understand the meaning of this need for relational sharing, two reflections might be helpful. First of all, the reported problems describe a widespread relational and organisational fragmentation. This fragmentation proved to be both as the cause and the effect of the teams' difficulties. Subjects recurrently describe a constant conflict between people, professions, sub-groups and units. Whenever problems are reported, a lack of a "shared culture" and group cohesion is often highlighted. Secondly, subjects usually describe the problems as something that is separate off from their own personal and emotional life. They mostly talk about communication problems as something that is caused by "someone else" (the

colleagues, the patients, the relatives) or “something else” (heavy work load, insufficient time, etc.).

The assumption itself of a dialogue, that is a reciprocal relationship between all the involved agents (Buber, 1958), seems to be forgotten or underestimated. Professionals probably have a few core beliefs (Beck, 2011) that validate the elusiveness of a peer-to-peer support and maintain an avoidance coping strategy (Cartwright & Cooper, 1995). They often outline a vague need for a meaningful exchange with colleagues and patients. The theme of lack of time and resources probably channelizes their construction of communication as a quest for technical and informative procedures. In any case they are faced with the relational and emotional meaning of communication. Indeed, whenever they propose solutions to their problems they talk again about dialogue. Problems with colleagues and patients seem to have one recurrent focus: a continuous and inescapable relationship with suffering and death.

Further studies are needed in order to validate the relevance of communication both in defining possible criticisms and in delivering training programs for cancer professionals, by especially considering such dimension in terms of effectiveness.

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