

The relationships between a stomach cancer patient nursing essay

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Jane (not her real name) was a fifty year old high school teacher who was transferred to our institution for palliative care. She had been managed at a regional referral hospital for stomach cancer for about six months. When it was apparent that the cancer was not responsive to curative measures a decision was made to transfer her to the district hospital in her locality for palliation of symptoms. At the time of transfer she had been well informed about her diagnosis and prognosis. As we began our interaction in the consultation room she appeared anxious and afraid therefore the nurse and I had to make her at ease by reassuring her that we were going to do our best to assist her and her family through the illness. She later divulged that she had not been explained to what palliative care was about thus she had feared that it was a process to relieve her symptoms by making death quicker. She also admitted to having spent a lot of money since being diagnosed with cancer and was unwilling to spend more once it was clear that she could not be cured. We explained to her that palliative care is a holistic approach to care that employed a multi-disciplinary team to improve the quality of life of patients and families with life limiting illnesses without hastening or postponing death. After talking for a while, her anxiety was allayed and she started to open up to us on how we could help her live a better life. She was separated from her husband with whom they had three children, a daughter who was married and two sons who were away in college. She was very close to her daughter and very protective of her thus she did not allow her to come into the consultation room until she was sure of what she was dealing with. It appeared that she wanted to shield her from the pain and suffering she was experiencing. She later confessed that her

biggest worry was how her family was going to survive without her. Though initially Jane was guarded as we started this relationship, she eventually warmed up to us with time and trusted us enough to invite us into her home and allowed us to interact with her family and friends. This enabled us to identify her needs and to work together to ensure she had the best possible quality of life.

Feelings

Jane's case made me feel sad and I really empathized with her.

Evaluation

My evaluation will focus on the unit of care and the contributions made towards helping Jane and her family to cope with cancer. Diagnosis of a life limiting illness usually has a great impact on a person's total well being with the impact spreading on to the family and community at large.

Consequently, the patient and the family have a complex spectrum of needs that cannot be comprehensively met by a single professional thus require an inter-professional team sometimes referred to as a multidisciplinary team. A multidisciplinary team is a group of professionals from different disciplines working together towards shared goals (Pettifer 2007). The benefits of teamwork include free exchange of knowledge and skills, colleague support, provision of a wider scope of services and joint responsibility for actions and interventions which contribute to better patient outcomes (Donaghy et al 2002). We constituted a multidisciplinary team consisting of a doctor, nurses, a social worker, a psychologist, a priest and a physiotherapist to enable us provide holistic care. The nurse, nutritionist and I were charged with handling

physical symptoms which included generalised weakness, abdominal pain, nausea and vomiting. Although the patient had been on maximum dose of dihydrocodeine for pain, which is, JW, 24/02/2013? The maximum safe dose of dihydrocodeine is 180mg over 24 hours in divided doses. RNO 27/02/13 she was still experiencing moderate to severe pain. We therefore upgraded to morphine tablets 10mg to be given four hourly and added metoclopramide tablets to control her nausea and vomiting. The nutritionist prescribed a diet that consisted of small quantities of bland but nutritious foods to improve her energy and combat anaemia besides giving her haematinic and multivitamin supplements. She was also advised to increase her intake of fresh vegetables and fruits and avoid any stimuli or food that precipitated nausea. The social worker led the team in gathering social support for the patient. We made contact with the estranged husband and with the patient's permission disclosed her illness and prognosis to him. He was very co-operative and willing to assist her when called upon. In addition her children were made aware of their mother's condition and made effort to be available when needed. She was also a member of the church choir and was encouraged to continue participating in the sessions for as long as her strength enabled her. The psychologist organised counseling sessions for Jane alone initially then later on including the family and the team. This was done to explore the patient's and the family reactions to the bad news, to know their fears and expectations and to help them develop coping strategies. It was also through these sessions that the team was able to identify some of the family's needs and find ways to address them. Jane was worried about leaving her children when they needed a lot of parental

guidance but she discovered that they were determined to stay together and work hard to excel in their lives despite the circumstances. The children were afraid that their mother would experience a lot of pain and they would be helpless around her. Fortunately, when we re-assured them that the team was going to walk the journey with them they were more at ease. Jane was a devout catholic who attended church regularly so the priest was helpful in assisting her and the family to explore spiritual issues while facing death. She confessed that her deep faith is what gave her strength through her illness thus she was less afraid because she was a strong believer in a glorious and eternal afterlife. Her youngest son was particularly angry at God for causing his family so much suffering but eventually came round and accepted what he said was the will of God. There were both positive and negative aspects in our management of Jane and her family. One of the positive aspects was the employment of a multidisciplinary team which enabled us to address most of their needs. In addition, we had open communication between the family and the team and among team members which fostered good relationships and enhanced the quality of care. One of the shortcomings we had was inadequate time and personnel because we had many patients that needed our time and care. Some of the staff also felt incompetent due to not having received formal palliative care training and were slow to make decisions in the absence of the trained staff therefore delaying adequate care. Dear Ruth, this is a well outlined approach and the flow is in order. The different members of the team are very important and you have succinctly highlighted their roles. I feel that this is an interdisciplinary team as compared to a multidisciplinary one. In Palliative

Care, an interdisciplinary team is more focused on proper communication and shared decision making. Multidisciplinary team members work sequentially where the medical record is the chief means of communication. Interdisciplinary teams work collaboratively with regular meetings to discuss patient status and the evolving plan of care and I feel this is what your team work entails. Please proceed to the analysis and I look forward to reading the rest of your work, JW, 26/02/2013. Noted. RNO 27/02/13.

Analysis

A unit of care is made up of the patient's family and an interdisciplinary team with focus to provide patient and family centred care. The patient's family whether biological or chosen should be supported and encouraged to participate in assessment, treatment and decision making at all levels (Twaddle 2012). Good communication is an essential tool for interaction within the unit of care and is facilitated through interaction and sharing of knowledge (Demiris et al). To support this, Norris et al (2005) further state that important communication skills needed by the team include networking, interpersonal skills, conflict resolution, managing change and negotiation.

Models of teamwork Three main models of teamwork have been described: multidisciplinary, interdisciplinary and transdisciplinary team models (Crawford et al 2003). The multidisciplinary team model is likened to wedges in a pie because despite each member having a specific role in patient care, they work in isolation from each other with communication occurring through medical records. This model is not favoured in palliative care because it can lead to miscommunication and conflicting care plans. On the contrary, I think

it may be the only practical model where the practitioners are few and do not have adequate time to work together but can create their own time during their various shifts to provide the needed service to the patient and their family. In the interdisciplinary team model there is interdependent interaction of team members from various disciplines, working synergistically and actively communicating with each other directly rather than through medical records. This model is best exemplified by the hand analogy where individual fingers have different functions, abilities and dexterity but working together, the hand has more capacity than one finger (Twaddle 2012). This is the model that our team embraced as we provided palliative care to Jane and her family. We created time for team meetings to discuss the assessments, interventions and evaluation of progress and sometimes had meetings together with the family. Although theoretically this is the ideal, practically we encountered challenges such as inadequate time, unavailability of all members during certain shifts and interpersonal conflicts especially where we had overlapping roles. It was also a challenge when we had an acute problem where decisions needed to be made quickly not allowing enough time for consultation. The transdisciplinary team model involves the indiscriminate sharing of roles and responsibilities in a manner that each team member's expertise is not transparent to the client. This model however is rarely used in healthcare. Contributions of the carers to the needs of the dying person and their family Due to the complex and multi-dimensional needs of dying patients and their families, a teamwork approach is recommended to provide for physical, psychological, spiritual and emotional needs in a collaborative manner to improve the quality of care

(Donaghy et al 2002). A collaborative model with the patient and family being at the centre has also been supported by others as capable of delivering the highest quality of care (McDonald 2010). As a team we set out to provide holistic care by addressing the needs that Jane and her family had, as described in detail in the evaluation section. The carers are also supposed to be sensitive enough to pick out the unvoiced needs of their clients by observing nonverbal cues. In the family life cycle, this family was undergoing the transition from child rearing to the stage where children are departing from home to be independent and this posed a challenge especially to their recently married daughter. The diagnosis of a life threatening illness tends to exert a centripetal pull on the family members who had left the household because they want to care for the sick member and find solace in being together at the time of distress. We tried to help Jane's daughter find a balance between the two families she had by suggesting involvement other caretakers in the extended family. Client practitioner relationships Client practitioner relationships have been at the centre of provision of palliative care. It has been shown that practitioners who develop trusting relationships demonstrate better understanding of patients suffering, are more aware of their needs and provide comfort while being competent and dedicated (Mok and Chiu 2004). When we first met Jane she was a bit guarded but after continued interaction she started opening up to us making it easier to understand her and her family's needs. This is understandable because in palliative care the patient may have to reveal intimate aspects of their lives at a time when they feel quite vulnerable thus it is important for them to know they have complete trust

and confidence in the practitioner. Therefore there has to be several interactions, negotiations and even evidence of commitment before a mutual relationship eventually develops between a client and a practitioner.

Depending on the duration of contact, commitment of the practitioner and the patients trust, the relationship can either be clinical, therapeutic, connected or over-involved relationship (Mok and Chiu 2004). Though it may sound difficult to develop a connected relationship with a patient while working in a team, I felt an emotional connection with Jane. She also seemed to feel secure with me and would share with me several issues some which, with her permission, I brought back to the team. One of the issues that came up was the need to safeguard her children's financial welfare as she was afraid her estranged husband and other relatives would plunder their inheritance. After we discussed this with the team we linked her up with a lawyer who helped her write a will in which she was able to divide her wealth among her children as she desired. Attending to patients who are dying can be very difficult and demanding due to constant stress, feelings of loss, constant exposure to the dying and re-awakening of own personal experiences of loved ones deaths. For palliative care workers not to succumb to constant stresses and professional demands they need self care, professional rejuvenation and social support as way of preventing burn-out (Rokach 2005). If the distress and ungrieved losses are allowed to accumulate, the worker may be unable to deal with further losses and this may manifest as anger, withdrawal, hostility, depression or physical symptoms. As a team we need to create time to talk about the patients we lose on a regular basis to allow debriefing. When a member feels particularly

overwhelmed by stress we encourage them to talk to the psychologist, but due to the inadequacy of staff at the hospital we rarely give them time off. However on a personal level I find some satisfaction in caring for the dying because they are usually neglected by most professionals and I find fulfillment in knowing that I can improve their quality of life and help them achieve a good and peaceful death. The rules that govern client and practitioner relationships are enshrined in medical ethics which ensure that both patient and the practitioner are protected. We consulted Jane on all major decisions and gave her truthful information at all times while keeping this information confidential. Some of the principles we upheld strongly were respect for autonomy, honesty, confidentiality, beneficence and we upheld her dignity and privacy throughout.

Conclusion

The diagnosis of a patient with life limiting illness impacts greatly on a patient and their family by presenting complex multidimensional needs which can only be best managed by an interdisciplinary team (Donaghy et al 2002). For effective palliative care to be achieved the unit of care have to work in a collaborative manner and embrace good communication skills. Development of a mutual relationship is central to delivery of quality care by enabling the practitioner to understand the patient's suffering and to provide comfort with competence (Mok and Chiu 2004). Studying this module and going through the reflective analysis has broadened my understanding on relationships in the palliative care setting and increased my knowledge on effective teamwork. With this knowledge and understanding, I will be a

better team player and relate better with my patients and their families to provide more effective palliative care.

Action plan

To further improve the practice of palliative care in the hospital as regards relationships with the dying, I plan to do the following;

Activity	Objective	By whom	When
1. To educate hospital staff on importance of teamwork. To help them understand why we work as a team and encourage them to join palliative care.	Myself	April 2013	2
2. To foster teamwork spirit in palliative care team by organising an outdoor team building exercise. To allow members to interact outside work in order to understand each other better.	Myself	Health administrator	Palliative care nurse
3. To lobby for more resource allocation to enable us to do more home visits. To improve service delivery and strengthen home based care.	Myself	Palliative care nurse	Ongoing
4. To encourage debriefing sessions and counseling for palliative care team members. To decrease incidences of stress and burn-out among staff.	Myself	Palliative care team members	Ongoing