Original Article

Emotional Bond: The Nature of Relationship in Palliative Care for Cancer Patients

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Abstract

Aim: Relationship between care providers and cancer patients is one of the main elements in providing healthcare to these patients. Understanding the characteristics and the nature of the relationship is a basis for further organization of palliative care and will enhance the performance of care providers. The purpose of this study was to investigate the nature of the relationship in palliative care for cancer patients. **Methods:** In this qualitative study, 16 participants with rich experiences in the field of cancer patient's palliative care were selected by purposive sampling. A semi-structured face-to-face interview was conducted with each of the participants. After data collection, all interviews were transcribed and reviewed, and then primary codes, sub-categories, and categories were extracted. **Results:** Data analysis emerged three categories; being alongside the patient, establishing and maintaining cordiality relationship, and mutual understanding with the patient. Moreover, an emotional bonding was the main theme that defined the nature of relationship between the care provider team and cancer patients in a palliative care approach. **Conclusion:** Effective relationship based on emotional bonding is the foundation of palliative care in cancer patients. Considering the structures and palliative care settings in health systems, it is possible to provide training programs regarding the strategies related to establishing emotional bond for effective delivery of palliative care.

Keywords: Cancer, palliative care, qualitative, relationship

Introduction

Today, cancer is one of the major diseases whose treatment poses a number of challenges to health and treatment systems. According to global reports, the number of cancer patients and its mortality rate is on rise every year.[1-5] During their illness, they experience a number of physical, mental, psychological, and social problems.[6] Over the recent years, to support these patients, provide effective care and control multiple problems, palliative care has been organized in different countries.[7,8] To achieve its goals, the palliative care approach requires a certain framework with specific steps. One of the basic principles for the formation of effective palliative care is the relationship of service providers (care team) with service recipients (patients). If this principle is ignored, care delivery may become difficult.[9,10] The principle of relationship in palliative care facilitates other key elements of palliative care, such as decision-making and interdisciplinary care.[11] On the other hand, the proper relationship between the care provider team and the patient results in the satisfaction of the patients with the received care and the ability to adapt with cancer.[12,13]

In various studies, relationship formation has been reported as a vital and important aspect in the quality of palliative care.[14,15] In the relationship process between the care teams and patients, the communication skills and strategies of the care team determine the characteristics and nature of the relationship and overcome the corresponding challenges of the caregiver system.[16] Understanding the nature of a process, such as relationship, helps the understanding the nature of the problem, and the relevant challenges. It can also contribute to the development and organization of that process and provide a specific functional framework. Therefore, by improving the quality of relationship between the care team and the patient, the potential goals of care provider systems are realized to optimize

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performance.[17] The nature of the care team relationship with patients according to the care approach is different. A few dispersed studies have referred to those features such as empathy, active listening, creating a safe atmosphere for talking about death, and explaining the goals of care.[18-20] However, in studies on the palliative care approach, these features have not been specifically identified for cancer patients, and the association and its features have been limited to the patient and a specific group of care team, such as doctors. On the other hand, any care approach, such as palliative care, also relies on the field of care, such as the existing culture of that field.[21-23] In different fields, various concepts with a range of characteristics can be part of the nature of a care approach. Given the fact that the nature of relationship in palliative care in Iran has not been investigated, this research focuses on the nature of relationship in the palliative care approach for cancer patients in Iran.

Methods

Study design and research question

This study attempted to investigate the nature of the relationship between palliative care practitioners and cancer patients. Considering the question of the present study about the nature of the communication and relationship in palliative care and the lack of previous studies on this topic; hence, the conventional content analysis approach was chosen to conduct this study to better understand the nature of the relationship in palliative care for cancer patients.

Participants

In line with the aim of the study, samples were taken from individuals with rich care experiences in the giving palliative care to cancer patients. Purposive sampling was used to choose those who provide service to cancer patients including nurses, psychologists, clergymen, and physicians. In the process of sampling, in addition to satisfaction to participate in the study, the participants' ability to express their experiences was considered. The research environment was a palliative care center at Firoozgar Hospital and Alla Charity Palliative Care Department. The sampling was done with the maximum diversity of participants regarding their gender, years of service, and various expertise in providing palliative care. Before the start of the study, each participant was informed about the purpose of the study as well as the method of the interview. Finally, 16 interviews were done with the service providers, patients, and their relatives (7 nurses, 2 homecare nurse, 1 physician, 2 psychologists, 1 social worker, 2 patients, 1 patient kin).

Dada collection

The data were collected using semi-structured, face-to-face, and in-depth interviews. Interviews were held in a private room and lasted 45–65 min. They were conducted with only the interviewer and interviewee present. The content of the interviews was based on the participants' perception and their actual experiences of relationship in palliative care of cancer patients. First, the interviews started with open and general questions about participants' experiences of relationship with cancer patients. These included questions like "Express your experiences in communicating with cancer patients?" Then, based on the participants' responses and the research objectives, the interviews were continued with more detailed questions such as "Can you tell me more about it?" and "Can you give other examples in this regard?" All interviews were recorded by a digital voice recorder and then transcribed. The interviews continued until reaching data saturation.

Table 1: Main categories and subcategories of emotional bond

Theme	Main categories	Subcategories
Emotional bond	Being alongside the patient	Presence of the care team
		Presence of family members
		Presence of friends
	Mutual understanding with the patient	Accepting the patient's condition
		Emotional response through more attention
		Sympathy without pity
		Psychological health management by the palliative care team
	Establishing and maintaining cordiality relationship	Entering a person's emotional realm
		Friendly communication
		Maintaining supportive relationship

Data analysis

Data analysis was carried out concurrently with data collection using the five-stage method proposed by Graneheim and Lundman.[24,25] It included the immediate transcription of the data after each interview, a review of the whole interview texts to reach a general understanding of the content, determining meaning units and initial codes, the classification of similar initial codes in broader classes, and formulate themes as the expression of the latent contents of the text. To ensure a general understanding of the participants' statements, the recorded interviews were read several times and semantic units and codes were extracted. With constant comparison, the relationship between concepts and variables was identified and initial codes were sorted based on their similarities and differences. The codes were then integrated into one category by grouping the codes with a common semantic load. Eventually, the main categories of the study emerged through categorization and the relationships between the categories [Table 1].

Rigor

The four criteria of transferability, dependability, credibility, and conformability were used to increase rigor.[26] The credibility was established using prolonged engagement, the member- and the peer-checking techniques. Furthermore, the results were given to two palliative care nurses who did not participate in the study. They were asked to compare the results with their own work experiences. To perform peer check, in addition to the expert colleagues who were involved in the study, two qualitative researchers approved the primary

codes and categories. Transferability was attained through rich descriptions of the data, which allowed the readers to judge the accuracy and match the findings with their own contexts.

Ethical consideration

This study was approved by the Research Ethics Committee of Medical Sciences faculty at Tarbiat Modares University in Tehran (code: IR.MODARES.REC.1397.006). Before beginning the study, participants were informed about the purpose and procedures of the study. Participation was voluntary, and the informants were asked for their consent, including their consent to the use of recorder. They were assured that their anonymity would be preserved and that they could withdraw at any stage of the survey.

Results

Data analysis led to 157 primary codes, 68 original codes, and 10 subcategories and 3 categories: "being alongside the patient, establishing and maintaining cordiality relationship, mutual understanding with the patient," and finally "emotional bonding" that is main them.

Emotional bond

This theme or concept implies the establishment of a continuous relationship between the care providing team and patients during the course of their illness and treatment. The emotional bond represents the mutual combination of communication for care provider and patient, which is shaped following the unpleasant mental state of the patient and the care provider team concern to address this state. Care providing team, including patient's family, nurses, physicians, psychologists, and spiritual counselors, provide an effective and supportive relationship in this approach. There is an emotional bond in all or most of the members of the care team, and it is characterized by the following categories: being alongside the patient, establishing and maintaining cordiality relationship and having mutual understanding with the patient.

Being alongside the patient

Being alongside the patient is one of the features of the basic concepts of emotional bond formation. Being alongside the patient happens when the patient expresses concerns about the problems and the fear of the acute condition. In other words, the care team does not only accompany the patient for the treatment. This presence is to fulfil the patient's need and to support the patient's psychological well-being.

One of the manifestations of being alongside the patient is the physical presence. This is one of the basic concepts of emotional bond formation. The presence of the care team happens when the patient expresses concerns about the problems and the fear of the acute condition. In other words, the care team does not only accompany the patient for the treatment. This presence is to fulfil the patient's need and to support the patient's psychological well-being. Presence alongside the patient by all members of the care team is an important factor in patient's support and will calm him/her down.

"In one of my shifts, I went to beside a patient. She took my hand and said that I had a rapid heartbeat. After monitoring the patient and pulse oximetry and I explained to him that his heart and breathing were normal, but I realized that she needed someone beside her. Again she held my hand and I saw he she was in need of attention so I spoke to her and explained." (Participant 1: Nurse).

The presence of care team shows their attention to the patient and his/her state. The patient is mentally satisfied by observing the 24 h presence of the care team. Accordingly, one of the patients stated:

"Even if I call the doctor at midnight, he will answer. He told us to call him whenever the patient does not feel well. There were times when I called and he did not answer. Yet, after a while, he called back to check over us. We told the problem and he prescribed a drug on the phone. He even told us he would tell the pharmacist himself about it. Whenever I call him, he will answer. I swear." (Participant 9: patient).

One of the other manifestations and dimensions of being with the patient is the presence of family members beside the patient. One of the most important elements of palliative care is the family of patients. Their presence, particularly at the end of the patient's life, is more important compared to the presence of other members of the team. Participants 2 indicates that:

"The patient really was at the end stage, and we were constantly giving him anesthetics. His family was there; his mom, dad and brother who were a source of relief for him" (participant 2: Nurse).

Furthermore, a member of the patient's family quoted:

"When our patient is at home, either I or my sister is always with him. Since we became aware of his disease, we never left him alone for a single moment. Maybe he needs something. We don't want him feel we don't care; quite contrary, we like him to feel he is important to us." Contributor 14: Companion patient).

Another feature of being alongside the patient is the presence of friends. Under distressing circumstances such as end stage, this strategy can provide a sense of relief in the patient.

"We had a young patient. He had a friend who visited him every now and then. One day, the patient was not feeling well. We called his friend and told him about it. We told him to come and visit him. After his friend visited him, the patient felt a bit better although he passed away a few days later." (Participant 3: Nurse).

Mutual understanding with the patient

One of the features of establishing an emotional bond is to achieve a mutual understanding. Without a mutual understanding on the both sides of relationship, the bond will be weak. The solidity of the bond relies on the formation of a mutual understanding.

Achieving a mutual understanding with the patient begins by accepting the patient's condition. Cancer patients experience

a stagnation and repetition due to their clinical condition. This patient's clinical condition is accepted by the care team, and they help the patient to have true image of this clinical condition in order to overcome stagnation and repetition. For example, one of the participants states:

"They are tired of their illness; they repeatedly refer to the hospital for treatment, which makes them tired. The only thing I could do in that situation was to accept the patient's condition. It would be a good idea to go to them and keep telling them everything will be fine" (Participant 7: Psychologist).

Although the care team's effort is that the patient has a realistic image of his/her condition, they also take into account the psychological state of the patient. They try to help the patient adopts a better lifestyle along with his/her illness.

"Well, in addition to the fact that we accept the patient with his disease, we also look at the patient's psychological state of mind. If he/she is ready, then we gradually draw the patient's attention to his/her real condition, yet we don't abandon him/her. I tell the patient that all of these problems exist, but the life goes on" (Participant 16: Physician).

Another manifestation of mutual understanding is the emotional response through more attention to the patient. Mutual understanding is not the mere result of accepting patients' problems and clinical condition. The care team transfers the sense of being aware of the feelings of the patient to him/he. Thus, the patient knows that they care team has accepted his/her condition. The care team should also encourage the patient to express his/her feelings. In other words, the patient's condition is accompanied by an emotional response on behalf of the care team, which provokes more emotional expression of the patient with the care team.

"I told the patient that I knew he was in pain and trouble. I said I knew he was afraid of the future… as soon as I spoke to him, he was relieved and started to talk …" (Participant 5: homecare nurse).

However, this emotional response is only valuable to the patient and care team when it is followed by a friendly reaction and performance within palliative care, which is an important factor in the formation of emotional bond between the patient and care team.

"The patient's sister asked the doctor if they should get his drugs or not! He had a chemotrophic prescription, yet he was in such a bad condition that his sister easily and sadly said that! When a patient is in such a critical condition, I understand him/her better. The patient can't be treated and I can't do anything, yet I can relieve his/her pain and do something for him/her. For instance, I gave anesthetics for this patient sooner; I even helped him in his personal chores; I assisted him in getting up and lying down." (Participant 10: Nurse).

Sympathy without pity is another feature of having a mutual understanding with the patient. During achieving a mutual understanding, the care team sometimes feels sympathy for the patient because this feeling is inseparable from human nature. It is possible that every human being experiences sympathy for others. This feeling is more often observed while providing palliative care to cancer patients. The important issue is how to transfer this feeling to patients. They should not feel pity, which is not a pleasant experience, instead of sympathy.

"I do not say that this sympathy has not happened before; of course it has happened. It is a part of human nature. However, it is important how it is transmitted to the patient. If a patient feels pity, he/she usually does not take it well. For example, during my relationship with a patient, I never tell him/her how miserable he/she is." (Participant 11: Psychologist).

"I hate pity. I can feel it in the eyes and behaviors of those around me. I can't say anything about it; you should feel it yourself. The thing is they don't say anything special. They might say, for example, how bad your condition is or why you are feeling like that. It makes you feel bad. They may tell you look pale and in pain, yet they should not say that. They should encourage the patient. This does not mean they are doing it with ill intentions, but pity is different from sympathy." (Participant 8: Patient).

Another dimension of having a mutual understanding with the patient is the psychological health management by the palliative care team. Having a mutual sense with a patient who is experience a harsh disease such as cancer can have a negative impact on anyone. This negative impact could affect all aspects of the patient's life. That is why despite the effort to achieve a mutual understanding, the care team members try to protect their mind and spirit. Thus, they try to prevent from becoming too close to the patient. For example, one participant states that:

"If I get too much involved with patients, I will be really upset. We are human beings too and we need to manage ourselves. If I get sad for all patients, I'm will get sick too" (Participant 4: Nurse).

Establishing and maintaining a cordiality relationship

Another essential component of emotional bonding is the establishing and maintaining cordiality relationship and more importantly, preserving the relationship. Cordiality and its preservation are the result of achieving a mutual understanding with the patient, which leads to more unity between the patient and the caregiver.

Establishing and maintaining the relationship with patients begins through caregivers' attempt to help the patients and the patients' trust in the care team. Without the formation of such a relationship, the continuation of the care process will be difficult. Starting and forming a friendly relationship means entering a person's emotional realm. However, entering into the patient's emotional realm is hard for the caregivers, but they eventually manage to do it.

"At the beginning of my shift, I always used to talk to them. First, it's very difficult to start communicating with them,

even saying hello to them. However, our constant efforts to start a relationship will finally work and they are engaged in an intimate atmosphere" (Participant 3: Nurse).

"I was talking to him like himself. For example, he was obsessed. He said," please do this for me", and I answered" I'll do it for you. I will work for you and place the ostomy pouch.". That's why he began to trust me. He even used to call the clinic and ask for my presence. I also gave him my number, although I usually do not give out our number. But, I sometimes give my number to some special patients" (participant 15: Homecare nurse).

Friendly communication is one of the main manifestations of establishing and maintaining a cordiality relationship between two people. This form of communication involves emotional intimacy, respect, and affection between the two sides. In delivering palliative care to cancer patients, the participants reported their experiences in getting close to the patients, as well as the use of affectionate words to establish an effective relationship.

"We had blood cancer patient. He was about 22 years old. It was soon after his marriage that the disease was diagnosed, and the chemotherapy had started. After 4 or 5 months, his wife divorced him because he was ill. At the same time, he worked to make a living, but he was suspended from his job as well. He had lost everything with no energy and hope. Every time I was there, I used to sit beside him on the chair and talk to him. I used to be very kind to him and be his confidant. I also told him about my personal life. We became friends after a while" (Participant 6: Nurse).

In providing palliative care to patients with cancer, in addition to forming a relationship, maintaining that relationship was another significant experience of the participants. Since the patients go back and forth between the hospital and their home, in order to maintain communication, the participants often give their own telephone numbers, and guidance is given over the phone to support the patient.

"For more and better communication, I give my phone number to patients, so if there is any problem, they instantly call me. I will guide them over the phone and if their condition is critical I advise them to call the center. Since the center does not visit the patient at night, they call me as soon as they have a basic problem, for example, nausea. This usually happens when the patient goes home after his/her blood chemotherapy. Nausea easily distresses them, and there were times when they call me to say the patient is not feeling well because of nausea. The symptoms easily get them distressed and worried. Then, I call them down and remind them that the symptoms are natural. I also tell them what to do. However, the calls do not only concern symptoms and problems. Sometimes, they just call me to say that everything is fine and they could eat without any problem. They did this to maintain their relationship with me. I will respond to them freely and without even the slightest inconvenience. I try to give them positive energy over the phone to make them feel good." (Participant 12: Nurse).

This continuing relationship is not always in response to the needs of patients, and the care team will contact the patient in order to support and continue their communication with the patient. They follow the patient's general and clinical condition. For example, one participant states that:

"One of my patients was from Northern Iran. When he goes back home, I always call him to check over him. We always keep in touch. Once I called him, and he asks if I called to make sure he is dead or alive; of course, he was joking. His wife was also sick. After a while, I called him again. This time as he picked up, I said I called to check over his wife, not him (joking). He told me to feel free to call whenever I want. He also said when I call them, they feel good." (Participant 13: social worker).

Discussion

The purpose of this study was to explain the nature of the relationship in providing palliative care to cancer patients. In this study, the care team creates an emotional bond with the patient in order to establish a proper relationship while giving palliative care to cancer patients. An emotional bond means the emotional connection between two individuals (care team and patient) with a set of emotions and perceptions between the two sides of communication. This is a supportive connection that allows cancer patients to have a calm and high-quality life. In the present study, the establishment of emotional bond was characterized by being alongside the patient, cordiality relationship and a common mutual with the patient.

Being alongside the patient means being present beside patients and understanding their circumstances. This concept is one of the basic concepts in nursing theories, especially humanistic theories[27] and is an integral part of care. However, given the particular and difficult conditions of cancer patients, this concept is more serious in providing palliative care to them, which is approved by the experiences of the participants in the study. In providing palliative care, the presence of members of the professional care team (e.g., the physician and nurse), family members, and close friends was one of the main components of emotional bond with the patients. In line with the present study, various studies have underlined the effectiveness of the presence of the care team. This effect has manifested in various aspects such as the presence of a care team alongside cancer patients as a nursing art and a response to the communication needs of patients,[28] presence as an important spiritual care for patients,[29] reliable presence as a key strategy in providing prompt and accessible hospice care,[30] and presence as facilitator in building a reliable communication.[31] In addition to the fact that the presence of the family with the patient was a strong source of support in the present study, the nurses also tried to use the presence of close relatives and friends of the patient as a source of emotional support. This usually happens when the patient faces a critical

physical and mental problem. In line with the current study, Rutkowski *et al*.[32] pointed out that patients received emotional and instrumental support from their families and close friends in the palliative care program, which provided emotional support through the strategy of presence and instrumental support through the use of transportation strategy while moving the patient in care centers. It can be concluded that this kind of support indicates the effective presence of the family and close relatives of patients along with him/her. The important aspect of being alongside the patient is that the presence of family and close friends completes the professional care team. On the other hand, the presence of family and friends on its own does not support the patient emotionally, and there is a need for the presence of a professional team. Although palliative care is not available 24 h at home in Iran, the palliative care team is available for patients even outside office hours for the patient. The care team can support them emotionally. This can establish an intimate relationship between the care team and the patient.

In the present study, achieving a mutual understanding with the patient was one of the characteristics of emotional bonding. A mutual understanding happens when a therapeutic team is emotionally within the range of the patient's emotions. In the relationship between the care team and the patient, a mutual understanding on behalf of the palliative care provider towards the cancer patient is the most important path to the formation of mutual understanding. According to a study by Michael *et al*.,[33] patients and families ask the care provider to consider their preferences, requests, and values during care, which is directly related to the mutual understanding of the patient. The findings of the present study suggest that mutual understanding is a result of accepting the patient's condition, emotional response through more attention to the patient and sympathy without pity. In the present study, to achieve a mutual understanding, the patient is accepted by the care team given his/her whole condition, while at the same time, a realistic image is provided for him/her. This finding shows the attempt to balance the emotions in a specific situation, which Shimoinaba *et al*.[34] have proposed, as well as the level of emotions associated with the concept of human-to-human communication. Nevertheless, the psychological state of the patients and supporting them was emphasized in this study. Providing the patient with a realistic picture does not mean the sudden disclosure of bad news, yet it means that the patient is not given a false hope and gradually accepts his condition. This is discussed in the findings of various studies, and it relies on a number of factors including the culture, rules, and personal characteristics.[35-38] Accepting the patient's conditions and understanding these conditions places the caregiver in a mutual emotional path, which creates sympathy with the patient. This sympathy does not simply end with an emotional response by the caregivers to put themselves in position of the patient, and it is often followed by a reaction or response. The findings of other studies referred to this strategy as one of the basic goals of palliative care.[39,40] In the present study, the performance that followed the emotional response to the bond between the patient and the caregiver was an important factor. It manifested as the "sympathy for the patient." This emotional response is also related to the concept of being alongside the patient and the friendly relationship. The emotional response is a positive and supportive strategy for a cancer patient, which could be influenced by various factors such as the attitude of care team and community culture. In the context of Iranian palliative care, this emotional performance ultimately leads to intimacy and an emotional bond. This practice is described differently in various studies, for example, attention even to small details of patients[41] and performance with affection toward patients.[42,43] In the present study, some participants had already encountered the patient's experiences, which made them feel sympathy for the patient. Sympathy is a result of human nature characteristics, social communication in society and the attitude of people toward a phenomenon such as cancer, but the important thing is not to transfer the sense of sympathy to the patient so that the patient does not feel pitied. The study by Sinclair *et al*.[40] has shown the notion of sympathy as an unpleasant feeling for patients. In fact, the patient's perception of the sympathy shown by care team determines whether it is suitable or not for palliative care. In this study, the care team paid considerable attention to this issue that is considered by the care team in the present study. To achieve a mutual understanding with the patient, in addition to considering the psychological state of the patient, the care team also attempts to manage their own spirits so that they do not suffer in the long term. Recent studies have shown that long-term work with patients who are in a life-threatening condition can cause psychosocial distress in care providers, and ultimately affect the process of effective care.[44-47] In fact, long work that has been known as the reason for various stresses shows a frequent and long-term relationship between the care team and patients with life-threatening illnesses. In the present study, the caregivers tried to prevent stress and psychological damage by managing their mind; however, it should be noted that a long-term emotional bond may break the emotional and psychological boundaries between the patient and caregivers, and consequently cause mental health damage to the care team. To address this issue, appropriate communication strategies should be used, and the care team needs to receive necessary training in this regard. Orellana-Rios *et al*.,[48] in their study, have shown that proper sympathy and free minds are the most important strategy to stay away from these stresses. However, Sinclair *et al*.[49] pointed out that working with patients who experience life-threatening conditions makes caregivers better understand the meaning of life, live at the moment, and grow spirituality. This does not contradict with the prevention of mental health and self-protection.

In the present study, entering the emotional sphere of a patient in order to start a relationship has been reported. However, this needs to be approved by the patient. In other words, it is necessary to win the patient's trust so that the caregivers experiences the patient's emotional experience. In similar studies,[50,51] winning patients' trust is one of the main factors in

creating a deep emotional bond between oncologists and cancer patients. Tanco *et al*.[52] showed that the continuity of trust and staying in the emotional sphere relies on factors such as age, level of depression, and level of patient's hope. Entering into the emotional sphere of the patient in the present study was related to factors such as sex, age, language and geographical culture, and the participants pointed to these factors in forming the emotional relationship. However, the care team formed a regular supportive and cordiality relationship in providing palliative relief to cancer patients to stay in the emotional sphere of the patient. This suggests that if the care team does not create a regular cordiality and supportive relationship with the patient, it will be a critical factor that drives the care team out of the patient emotional sphere. Seccareccia *et al*.[20] refer to creating friendly communication as a close relationship with patients and their family. Such a relationship gives patients a sense of belonging and makes them feel that they are receiving real care. In the present study, the care team members used intimate terms such as "mom" or "dad" while speaking to the patients. In the same vein, Seccareccia *et al*.[20] believe that using the name of the patient and his/her family members is one of the most important elements of establishing a friendly relationship, which has satisfied the patients with the quality of care. The use of words such as mother, father and the name of the patient can vary in different cultures and care settings. The use of such words facilitates the cordiality relationship in Iranian society. Furthermore, in a study by Palumbo *et al*.,[53] establishing a friendly and cordiality relationship created a supportive and relaxing atmosphere for the patient. In the present study, cordiality relationship has a supporting aspect and is aimed at protecting the mental health of the patient. In addition, the care team in this study has tried to keep this connection uninterrupted and lasting. This regular and uninterrupted relationship was in line with the patient's support, which can reflect the need of cancer patients in various physical, mental, and psychological problems. To overcome their physical problems, the patients tried to maintain a lasting relationship with the care team while on the other hand, the care team did not end its relationship with the patients in order to support them psychologically. Similarly, Sekse *et al*.[31] emphasized that spending more time with patients and having regular relationship with them prepares both nurses and patients to create a special bond. However, this particular bond must have features that are characterized in the present study through the establishment of an emotional bond. Cordiality relationship was the most important feature of the emotional bond in the palliative care system in Iran. That is because the issue of friendship and intimacy relies on the personal characteristics of the people and the culture of the health-care system. This issue has been emphasized in palliative care in this study. In fact, it can be seen that in Iranian context, the creation of cordiality is cornerstone of the relationship between the patient and the care team. This relationship is extended into the emotional sphere, and it has become more widely considered in cancer patients due to the severity of their condition. Furthermore, in order to achieve intimacy, time is one of the most important factors. Cancer patients are exposed to the disease for a long time and thus, they are engaged with the care team for the same amount of time, which a reason for the formation of the relationship between patients and care teams.

Conclusion

The experience of participants in this study suggests that being alongside the patient, achieving a mutual understanding with the patient and creating a cordiality connection forms the nature of relationship in the provision of palliative care. The care team members try to form a relationship in which the patients are emotionally supported, while at the same time, they avoid any psychological damage. In other words, good and effective relationship based on emotional bonding is the basis for supporting cancer patients while providing palliative care and improving quality of care.

The findings of the present study can be used in future research and implementation programs in health systems, especially in countries that are at the early stages of palliative care organization. First, despite the formation of a proper relationship between the caregiver and the patient, in order to optimize this relationship, training programs can be effective for care teams as well as the family; these educational programs can be in line with the concepts of the present study: being alongside the patient, mutual understanding and friendly relationship. Second, creating a proper structure for providing palliative care in a variety of environments, especially hospitals and homes, plays a huge role in the formation of an effective relationship with the patient and development of this relationship. Furthermore, due to different structures in different areas, the nature of the relationship between the care team and the patient can vary. Consequently, different studies should be carried out to discover the characteristics and strategies related to the nature of the relationship.

However, concepts obtained in this study can be applied in almost similar areas. However, the limitations of the present study include a small number of palliative care centers in Iran. The mentioned centers also had limitations in the provision of care services such as workforce, which undoubtedly could have an impact on the delivery of care services.

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Conflicts of interest

There are no conflicts of interest.

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