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Article

Between Ideal and Actual Care: Patients' and Family Carers' Experiences of Cancer Care Relationships

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Abstract

Research on how patients and family carers experience their relationships with physicians and healthcare staff is limited, particularly regarding the gap between ideal expectations and actual care. This study explored patients' and family carers' perceptions of the ideal care relationship, their lived experiences, and factors shaping discrepancies between expectations and reality. A total of 143 semi-structured interviews (mean age = 56.7 ± 13.2; 61.4% women) were conducted with 57 cancer patients and 86 family carers in outpatient oncology clinics in Southern Italy. Transcripts were analysed using Thematic Analysis of Elementary Contexts (TAEC), a mixed-methods approach combining qualitative and quantitative techniques. Four thematic clusters emerged: "Variability in the experience," "The ideal care relationship," "Waiting times and delays in care," and "The luck of being cared for by a good physician." Participants emphasized the importance of emotional support and family involvement, while also reporting unpredictability, variability in quality, and limitations in continuity and timeliness of services. These findings suggest that strengthening patient- and family-centred care requires both relational improvements and organizational interventions aimed at enhancing service coordination, resource allocation, and overall quality of care.

Keywords: cancer patients; family carers; physician-patient relationship; ideal care relationship; perceived care experience; semi-structured interviews; thematic analysis

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1. Introduction

A serious illness such as cancer – still often culturally associated with a "death sentence" (Moser et al., 2021) – entails profound fear, anxiety, and uncertainty, and has substantial social consequences for patients and family carers (Guan et al., 2021; Mattock et al., 2025). Family members often take on practical, emotional, and social support roles when caring for a patient with cancer, which carry considerable physical, emotional, and social burden and can deeply affect everyday life (Ferrell & Wittenberg, 2017; Grycuk et al., 2022; Soh et al., 2025; Tan et al., 2018; Thompson et al., 2024).

Research increasingly conceptualizes cancer-related distress as a shared and interdependent experience, with patients and family carers showing parallel patterns of psychological adjustment over time (Badr et al., 2014; Pruchno et al., 2009). Recent qualitative research further highlights that caregivers actively shape patients' experiences by negotiating communication and meaning within clinical encounters, thereby influencing both access to and quality of care (Sterponi et al., 2024). These relational practices underscore that cancer care is not solely an individual experience but a socially embedded process, in which patients and family carers jointly navigate complex healthcare systems. From this perspective, cancer – like other chronic illnesses – can be understood as a "family affair" (Dieperink et al., 2018), in which meanings, emotions, and coping strategies are co-constructed within relational contexts.

The quality of the healthcare relationship plays a crucial role in shaping how cancer is experienced and made sense of by both patients and family carers. Users' perceptions of healthcare professionals – encompassing technical competence as well as communicative and relational style – are consistently associated with treatment adherence, engagement with care, health outcomes, and

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overall satisfaction (Di Blasi et al., 2001; Ohana & Mash, 2015; de Waard et al., 2018; Venuleo et al., 2019). Conversely, relational and experiential aspects of care frequently emerge as major sources of dissatisfaction and complaint (Mattarozzi et al., 2017; Reader et al., 2018; Venuleo et al., 2024). In Italy, where the present study is situated, complaints most commonly concern care system management – particularly waiting times – and relational aspects of care, reported in over half of cases (Mattarozzi et al., 2017). Users consistently report valuing respect, empathy, and attentiveness in their interactions with healthcare professionals (Venuleo et al., 2025).

Despite this growing recognition of the importance of relational care, patients' subjective experiences of their relationships with healthcare staff remain relatively underexplored, and empirical attention to family carers is even more limited. In many healthcare contexts, clinical practices continue to prioritize the patient as the sole focus of care, often positioning family members as "outsiders" (Coyne, 2013) or relegating them "to the sidelines" of care processes (Coyne et al., 2016). As a result, family carers' needs related to information, communication, emotional support, and involvement in care decisions frequently remain unmet (Chong et al., 2023; Liu et al., 2022).

Attending to users' subjective experiences is widely regarded as a cornerstone of the humanization of care (Cheraghi et al., 2017) and a key determinant of engagement, adherence, and satisfaction (Bombard et al., 2018; Vermeir et al., 2015; Venuleo et al., 2024). However, existing research has rarely examined these experiences by jointly considering patients and family carers, nor has it sufficiently addressed the discrepancy between ideal expectations of care and lived experiences within real-world healthcare systems shaped by organizational, temporal, and relational constraints.

Against this backdrop, the present study aimed to explore in depth patients' and family carers' experiences of healthcare professionals' responsiveness, defined as the extent to which health systems meet users' expectations regarding the non-clinical dimensions of care (WHO, 2000). Specifically, the study examines how patients and family carers represent what the care relationship should be like, how it is actually experienced, and how discrepancies between ideal and actual care are explained and made sense of.

2. Materials and Methods

Traditionally, users' views of healthcare have been assessed through patient satisfaction surveys, which require respondents to express their experiences within categories predefined by researchers (DiCicco-Bloom & Crabtree, 2006). Moreover, satisfaction studies often report high levels of satisfaction that do not necessarily indicate the absence of problems, but may instead reflect gratitude, social desirability bias, the enactment of a passive patient role, or beliefs about the legitimacy of one's expectations and reluctance to voice dissatisfaction (Schneider & Palmer, 2002).

To overcome these limitations, the present study relied on semi-structured in-depth interviews with patients and family carers, allowing participants to articulate what matters to them in their relationship with the healthcare system and to express perceived care needs in their own terms. From a constructionist perspective, narratives are relevant not because they offer a direct account of events, but as sites where meanings are produced and negotiated, revealing the interpretative frames through which experiences are understood and evaluated (Gergen, 1985). The analysis was aimed at identifying the underlying semantic and interpretative structures through which patients and family carers construct meanings around the care relationship, rather than providing a purely descriptive account of care experiences.

2.1. The Interview

The interviewers (all psychology graduates) received preliminary training to ensure consistency in interview administration, focusing on study objectives, key themes, and methodological procedures (Jacob & Furgerson, 2012). In line with a constructionist paradigm, interviewers adopted an active listening approach (Adhabi & Anozie, 2017), adapting questions in real time to encourage participants to articulate their experiences and meaning-making processes. This flexibility allowed narratives to be co-constructed within the interview setting rather than constrained by rigid

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questioning (Riessman, 2008). Particular attention was paid to creating a welcoming atmosphere and exploring responses in depth (Kallio et al., 2016).

Each interview was guided by four core questions (Table 1): three focused on the relationship with the physician and one on the relationship with healthcare staff more broadly. Participants were first asked to describe the key characteristics of a good doctor–patient relationship and then to reflect on their most recent hospital visit. Focusing on the last visit aimed to reduce recall bias and avoid selectively reporting particularly positive or negative experiences. Participants were subsequently asked to reflect on the factors they believed accounted for any discrepancies between their ideal and actual experiences. The fourth question addressed their overall experience with the healthcare staff encountered in the hospital. Finally, participants were invited to add any further comments.

Table 1. Interview guide - Open-ended questions used in the interviews.

- How would you describe the ideal relationship between physician and patient? (*Elicits participants' expectations and values regarding the doctor-patient relationship.*)
- Think about the last visit you made to this hospital. How would you describe the quality of the relationship between you and the physician? (*Encourages participants to reflect on their most recent lived experience.)*
- From your point of view, on whom or what does the difference that sometimes exists between an ideal doctor–patient relationship and the actual relationship depend? (*Explores perceived barriers and enablers affecting relational quality in healthcare settings*.)
- More broadly, how would you describe your relationship with the healthcare staff you have met in this hospital? (*Extends the focus from the doctor-patient relationship to the wider healthcare system*.)
- Is there anything else you would like to add? (*Allows participants to express concerns or insights that may not have emerged through the previous questions.*)

Participants' experience of the interview itself was explored through a closing question (e.g., "How do you feel at the end of this interview?"). To contextualise accounts, information on sex, age, and reason for attending the hospital was collected. Interviews lasted 20–40 minutes with additional time devoted to rapport building and post-interview debriefing. All interviews were conducted in a private room provided by the hospital, ensuring a confidential and comfortable setting. Sessions were audio-recorded and transcribed verbatim.

2.2. Recruitment and Procedure

A purposive sampling approach was used to recruit participants. Eligibility criteria required both patients with cancer and family carers to be aged 18 years or older. Individuals with known cognitive impairment (e.g., a diagnosis of Alzheimer's disease or dementia, or current use of anti-dementia medication) were excluded.

The study was conducted in the outpatient clinics of the oncology department of a hospital in Southern Italy, within a collaboration agreement between the Local Health Agency overseeing the hospital and the university department of the research team. Recruitment began in March 2024 and lasted three and a half months. The final sample size was deemed adequate based on the richness and complexity of the data in relation to the research aims (Braun & Clarke, 2021).

Nine interviewers rotated in the hospital, covering at least three mornings and three afternoons per week. Potential participants were approached in the oncology ward waiting room, where the study was also advertised via poster. During an initial briefing, study aims, voluntary participation, anonymity, and audio-recording procedures were explained. To reduce potential emotional challenges, interview topics were outlined in advance, and interviews were conducted in a private room (Whiting, 2008). Participants were reminded of their right to skip questions or pause the interview, and written informed consent was obtained after reading the information sheet.

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2.3. Participants

A total of 143 interviews were conducted (Mean age: 56.73 ± 13.19; women: 69.2%), including 57 with cancer patients (Mean age: 62.27 ± 11.15; women: 61.4%) and 86 with family carers (Mean age: 52.92 ± 13.19; women: 74.4%). All patients had received a diagnosis. Table 2 presents participants' characteristics.

Table 2. Descriptive Characteristics of participants.

Variables		Patients (n=57)	Family carers (n=86)	Total (N=143)	χ2	p-value
Sex	Men	22 (38.6%)	22 (25.6%)	44 (30.8%)	2.73	0.10
	Women	35 (61.4%)	64 (74.4%)	99 (69.2%)		
Age range*	18-30	0 (0.0%)	5 (3.7%)	5 (6.3%)	10.97	0.01
	31-50	10 (18.2%)	25	35 (31.3%)		
	51-65	24 (43.6%)	36	60 (45.0%)		
	> 65	21 (38.2%)	14	35 (17.5%)		
Role with respect to the patient	Son/Daughter		41 (47.7%)	41 (47.7%)		
	Brother/Sister		6 (7.0%)	6 (7.0%)		
	Spouse/Partner		24 (27.9%)	24 (27.9%)		
	Other Relative or Friend		15 (17.4%)	15 (17.4%)		
Reason why the respondent was in hospital**	First visit	7 (12.3%)	12 (8.6%)	19 (13.3%)	1.26	0.53
	Therapy	3 (5.3%)	9 (6.4%)	12 (8.4%)		
	Follow-up	45 (78.9%)	64 (45.7%)	109 (76.2%)		

*Percentages calculated on valid cases (Patients n=55; Family carers n=80; Total n=135). Eight responses were missing (2 patients, 6 family carers); **Percentages calculated on valid cases (Patients n=55; Family carers n=85; Total n=140). Three responses were missing (2 patients, 1 family carers).

2.4. Data Analysis

Interviews were transcribed verbatim, maintaining anonymity. A mixed-methods approach combining qualitative and quantitative techniques was used to analyse the transcripts, aiming to map the main themes underpinning the narratives. To this end, Automatic Co-occurrence Analysis for Semantic Mapping (ACASM; Gennaro & Salvatore, 2023; Salvatore et al., 2017) was applied to the entire corpus using T-LAB software, version 10 (Lancia, 2023). ACASM is a context-sensitive automated textual analysis method that detects word co-occurrences within a defined context unit (e.g., a paragraph). Its premise is that meanings are not inherent in isolated words but emerge from their co-occurrence within discourse dynamics (Salvatore et al., 2012). Unlike frequency-based approaches, ACASM examines co-occurrences at the level of Elementary Context Units (ECUs), which are small text segments representing meaning units. Lexical forms within ECUs are reduced to their corresponding lemmas (e.g., "go", "goes", "gone" → "to go"), and lemma co-occurrences are used to construct a semantic network. The resulting data matrix includes ECUs as rows and lemmas as columns, with binary values indicating lemma presence or absence, following T-LAB's standard unsupervised clustering procedure. Table 3 summarizes the dataset characteristics.

Table 3. Dataset.

	N
Texts in the corpus	143
Elementary contexts (EC)	1538
Types	6435
Occurrences (Tokens)	73585
Threshold of lemma selection	10
Lemmas in analysis	448

Note – Texts in the corpus: number of answers to the open question (corresponding to the number of participants) inserted in the text analysis; Elementary context: sections of text (e.g., sentences, paragraphs, or

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short texts) characterized by the same keyword patterns; Types: total number of words (i.e., including all linguistic forms) contained in the general corpus; Occurrences (Tokens): frequencies of a single lexical unit; Threshold of lemma selection: the value selected to include the lemma in the analysis; Lemmas in analysis: number of headwords inserted in analysis.

The T-LAB Thematic Analysis of Elementary Contexts (TAEC) was then used to identify recurring themes in participants' narratives. This unsupervised clustering method groups ECUs with similar lexical patterns, revealing emergent semantic structures (Lancia, 2023). After clusters were identified, a second data matrix (Clusters × Lemmas) was generated for interpretation, containing absolute lemma frequencies and their Chi^2 values indicating the degree to which each lemma characterizes a cluster.

Clusters were interpreted by identifying their shared thematic core, reflecting specific ways of representing experiences or expressing viewpoints (Gennaro et al., 2012; Marinaci et al., 2025; Venuleo & Guacci, 2014). The most representative ECUs, ranked by lexical proximity to each cluster, were used to support cluster labeling. Three authors familiar with ACASM and TAEC independently proposed descriptive labels using a double-blind procedure; discrepancies were resolved through consensus.

Finally, Correspondence Analysis (CA) was applied to examine associations between clusters and respondent role (patient vs. family carer), socio-demographic variables (sex, age), and contextual conditions (first visit, treatment, follow-up). Test-values exceeding ±1.96 were considered statistically significant ($p < .05$).

3. Results

3.1. Semantic Cores

Cluster analysis identified four main semantic cores, described below with reference to the most representative Elementary Context Units (ECUs) and the recurring lemmas characterizing them, highlighted in italics (Table 4). Any mention of specific physicians, hospitals, or departments in the text was anonymized and replaced with "Name of physician," "Name of hospital," or "Name of department," respectively.

3.1.1. Cluster 1: "Variability in the Care Experience"

This cluster reflects the variability of patients' and family carers' experiences with healthcare staff and the healthcare system (*hospital ward, healthcare staff, nurse*). Factors such as the perceived quality of medical care and the evolution of the patient's or family member's health condition play a crucial role in shaping overall satisfaction. While some narratives emphasize trust, gratitude, and relief, others highlight problems, inefficiencies, and dissatisfaction. Lemmas expressing appreciation (e.g., *thank_to_God, well, excellent, to work, to find [well/bad]*) co-occur with lemmas indicating criticism and dissatisfaction (e.g., *problem, complain*), reflecting a lack of uniformity in perceived healthcare quality. Verbs such as *to go* and *to send* point to an active search for adequate care, which sometimes entails travelling long distances or changing physicians to obtain better attention. Temporal adverbs (*every time, never again, always*) suggest absolutized evaluations of care experiences, whether positive or negative. A key element of this cluster is the unpredictability of medical experiences, making perceptions of care highly dependent on chance circumstances, such as changes in physicians at each visit or the ability to seek care elsewhere.

In the following excerpts, the interviewees contrast different surgical experiences across hospitals and departments, showing how comparable clinical situations can be associated with markedly different outcomes and evaluations of care depending on organizational arrangements and relational encounters.

"A negative *experience* in another surgical *hospital department* where, organizationally, they are just bad and for them my mother was *inoperable.* They *sent* us to oncology, we went up to the second

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floor to the oncologic centre, we *went* to the admission and the people were helpful and polite, the nurse took everything all." (family carer, woman, age range: 51-65, follow up visit, IDnumber_31)

"Because I had *surgery* in NAME OF AN HOSPITAL, and I was fine. Here, honestly, at NAME OF AN HOSPITAL, I was not fine. I had a fibroid removed in the gynaecological *hospital department*, and I had a terrible *experience.* Then I *went* home, had a haemorrhage, and had to come back." (family carer, woman, age range: 31-50, follow up visit, IDnumber_111)

In another account, variability in care is managed through an active and deliberate choice to travel long distances in order to preserve a relationship of trust with specific physicians.

"It is (a) positive (experience). Even though I live in Parabita and could easily *go* to Gallipoli, because of the trust I have in these physicians and because we have felt comfortable from the beginning, we travel many kilometres, but we prefer to come here to Lecce" (family carer, woman, age range: 31-50, follow up visit, IDnumber_18)

A further excerpt illustrates how navigating between professionals and healthcare settings becomes a strategy to cope with fragmented or unsatisfactory care, with comparisons across locations shaping overall evaluations.

"With him we were fine, with my brother it was the situation, my brother was staying here and then he *went* to another oncologist. He's staying in Gallipoli. The colleague, rightly, when she saw him [my father] like this, told him "Have him followed by NAME_OF_PHYSICIAN who is not feeling well. They wanted to go Milan, as many people do, too much money. With dad, *thank_to_God*, we got along well." (family carer, woman, age range: > 65, follow up visit, IDnumber_1)

In this final excerpt, the interviewee explicitly links dissatisfaction to the lack of continuity with the same physician, framing the quality of care as dependent on unpredictable organizational arrangements.

"Discrepancies there were not; I did the visit, in a state that everything was fine, visit done without any major *problems* of note, and I repeat the *problem* is *always* that I did four or five visits and always with different physicians, which in my opinion should be otherwise, so that I always have a relationship with the same person" (patient, man, age range: > 65, follow up visit, IDnumber_76)

3.1.2. Cluster 2: "The Ideal Care Relationship"

This cluster encompasses narratives describing the ideal characteristics of physicians, including not only the ability to address medical problems, but also attentiveness to patients' psychological needs, exploration of emotions, timely communication of bad news, and guidance for family members on how to cope. Lemmas related to the physician–patient relationship (*patient, physician, relationship, oncologist*) co-occur with those highlighting the gap between the ideal relationship (*should, ideal*) and the actual experience (*lived*), as well as differences between public and private care or between local and foreign healthcare contexts (e.g., *Switzerland*). Lemmas expressing the need to be understood and to receive responses (*to understand, answer*) co-occur with lemmas emphasizing the importance of what is at stake (*aspect, to live, life, fundamental*) and the expectation that one's perceived rights will be respected (*to want, duty*).

The ideal care relationship is described in terms of emotional closeness and empathy, with participants emphasizing the importance of feeling welcomed and recognized as persons, despite awareness of physicians' workload and constraints.

"It *should be a relationship* much closer to the patient, in the sense that the physician should be a little bit more empathetic, and, I *understand* that it is difficult because, of course, they see so many patients, so many cases and so many issues however, the patient has to feel, in a way, welcomed, by the physician, which is not always the case or not for all *physicians*." (family carer, woman, age range: 31-50, follow up visit, IDnumber_97)

Alongside relational qualities, the ideal physician is expected to demonstrate technical competence and professional responsibility, reassuring patients and family carers through expertise, thoroughness, and appropriate clinical decision-making.

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"A *physician should* be concerned about the *patient*'s health. So, I expect that because he is a *physician,* he knows the various procedures to be followed so that the *patient* somehow can come out of his problem. I expect him to be a trained physician who is ready to do all the appropriate tests that a *patient* needs." (family carer, woman, age range: 31-50, follow up visit, IDnumber_24)

Participants also stress that professional roles should take precedence over personal dispositions, with physicians expected to adapt their communicative style to patients' needs, particularly in terms of information provision.

"It's not so much character, it's how you *stand,* in your personal life, you can have your character, however with *patients* I *think* a little bit they must leverage and change as well. If they are closed and don't say words, a *patient wants* to know instead a lot of information, so you have to give it to them, then at home you shut up if you don't *want* to talk. Character, I *think,* needs to be put aside a little bit." (family carer, woman, age range: 51-65, follow up visit, IDnumber_31)

A recurrent element of the ideal relationship concerns a holistic view of the patient, where emotional and relational dimensions are seen as fundamental and inseparable from clinical care.

"Meanwhile, there *should* be I *think* more empathy, a_times it happens that *physicians* are more concerned about treating only the pathology; instead, the *patient should* be seen as a whole, as a whole, so even the emotional *aspect,* which is *fundamental,* even welcoming with a smile, a_times it happens" (family carer, woman, age range: 51-65, follow up visit, IDnumber_80)

Finally, timely and clear communication is described as a moral duty toward both patients and family carers, particularly when decisions with profound existential implications are at stake.

"So, you can give us an *answer* on whether we can help her or whether we *should* let her die like this. But tell us because one organizes, organizes with her mom, takes care of her differently and we make her do something that maybe she has *lived* always working, poor thing. And so, they *should* tell us, they *should* be faster in giving this *answer,* they *should* be faster, just this." (family carer, woman, age range: 51-65, first visit, IDnumber_20)

3.1.3. Cluster 3: "Waiting Times and Delays in Care"

This cluster highlights the time spent waiting for care, both in the waiting room before a scheduled follow-up visit or therapy, and for diagnostic tests or results. Lemmas referring to temporal markers (*minute, days, months, week, afternoon, time, timetable*) co-occur with those related to waiting (*waiting, to wait, to wait for, long*), reflecting the substantial time required to access consultations, diagnostic exams, and treatments (*appointment, medical test, medical examination, therapy*). Action lemmas (*to call, to enter, to leave, to return*) point to the bureaucratic and administrative hurdles patients and family carers encounter while seeking diagnosis or care.

Participants frequently describe waiting as prolonged and stressful, particularly when communication about appointments or test results is delayed.

"So, when she told me this, I said OKAY, the physician told me to turn, space so without *waiting* for *appointments,* which then they *called* us back after one *month* and ten *days.* You can't *leave* the patient *waiting* after one *month* and ten *days,* meet once a *week at least every ten days* and communicate; you can't keep a person *waiting* who doesn't know what he has. (family carer, woman, age range: 51-65, follow up visit" IDnumber_31)

Even routine delays at reception or before therapy can accumulate, contributing to a sense of time being wasted and unpredictability in care.

"The only flaw here is *waiting a long time* at the reception, you *wait* a lot, meaning they do not *respect the timetable.* I understand ten, fifteen, twenty *minutes,* even half an *hour*, but sometimes you *wait for* an *hour* and a half, even two *hours* before being *called,* and just as *long* before receiving *therapy*". (patient, man, age range: 31-50, visit therapy, IDnumber_4)

Waiting times are experienced as a structural feature of care, with patients sometimes feeling that they must "put their watch aside" and accept unpredictability as inevitable.

"Because that's what the *times* are, *time* to *come* in, *time* to talk, then you have to *wait for* the *therapy to come in* and you can also clear the chair to get the infusion done, then you have to do it; so, anyway

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that's what the *times* are. Let's say in the morning and even early *afternoon*, you know when you *come in* here, you have to put your watch aside." (patient, woman, age range: 51-65, follow up visit, IDnumber_127)

Delays between sequential procedures, such as medical examinations and therapy, further increase frustration, making the care pathway feel disjointed.

"Before doing the *therapy* then you *wait for* the *medical examination* at the reception, and for the infusion, so some *time* passes. I don't know, for example, this morning I was holding the *medical examination* at 10:20, and I did it 20 *minutes* ago, that is and *hour* and forty *minutes wait*, and that is not good for a patient" (patient, man, age range: 31-50, visit therapy, IDnumber_9)

Waiting can also cascade across appointments, creating administrative loops and prolonging uncertainty for patients and family carers.

"For example, the other *time*, she had to have the PET scan and she couldn't have the *medical examination* until they gave her the PET scan. She kept the *medical examination*; however, they still did not *call* her to do the PET scan. She came to the *medical examination*, and they said, whatever but without PET? How should I know if they didn't *call* me. So then again, make another *appointment* again. It's *long*." (family carer, woman, age range: 31-50, follow up visit, IDnumber_111)

3.1.4. Cluster 4: "The Luck of Being Cared by a Good Physician"

This cluster captures narratives describing positive experiences with competent, caring, and helpful physicians within a supportive ward. Adjectives consistently characterize the physician – and more broadly the healthcare staff – positively, highlighting competence, availability, friendliness, and humanity (*good, available, friendly, human approach*). However, the perception of a positive experience is linked to contingency (*difference,lucky*), reflecting the chance of encountering and being cared for by specific "good" physicians (*to find, to look for*) and the acknowledgment that not all physicians share the same attitude or approach toward patients.
Positive experiences are often framed as contingent on meeting the right physician, with participants acknowledging luck as a factor in the quality of care received and the comfort they felt.

"In my opinion, it *always depends* on the people and the physicians you meet because even if they are not all the same and I have to say that I was also *lucky* with my disease because I *found* the surgeon who operated on me for example was very *good*, humanly very *good*." (patient, woman, age range: > 65, therapy, IDnumber_51)

The sense of being "lucky" extends to the overall comfort and reassurance felt when good physicians are encountered repeatedly.

"We are lucky that *good* physicians were *always found*, and we felt comfortable. So, we are lucky on this side." (family carer, woman, age range: 51-65, follow up visit, IDnumber_17)

We *experience* this because of a line drawn very early between the physician and the patient, however, in the course of the disease we have *found good* physicians and oncologists, as we have *found* the figure I *look for*, so the one who keeps me most alive and motivated. But I have also *found* the opposite. I have often confronted and clashed with physicians. (family carer, man, age range: 51-65, follow up visit, IDnumber_34)

Competence alone is insufficient; relational qualities are equally important, and participants emphasize the human approach as a key determinant of positive experience.

"In my opinion you need the physician, but you also need the *human* approach with the patient. They referred him to us as a physician of excellence medically, however, …who you were *talking* to, this character is just his, this way, I *talk* about this physician. For example, then here at the oncology we *found* the physician *good* and *available*" (family carer, woman, age range: 51-65, follow up visit, IDnumber_29)

Even when continuity with the same physician is not guaranteed, strong relational interactions can sustain positive experiences.

Good, very *good*, I have a *good* relationship with everyone, in particular with the physician who follows me. But then, because every day we don't *find* the same physician we initially chose, but also

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others, however the relationship is *always* very *good*. I have never had anything to complain about. (patient, woman, age range: 31-50, follow up visit, IDnumber_32).

Table 4. Key lemmas characterizing the clusters.

Cluster 1 (25.6%)	χ2	Cluster 2 (32.33%)	χ2	Cluster 3 (18.5%)	χ2	Cluster 4 (23.6%)	χ2
Hospital ward	192.47	Should	317.70	Waiting	116.18	Good	192.44
Well	121.51	Relationship	55.65	To Wait	90.54	Available	135.11
Problem	82.98	Patient	48.48	Minute	80.99	To Find	47.68
To find [well/bad]	76.68	Ideal	27.81	Medical_test	54.55	Always	46.97
To go	65.68	Lived	23.30	Days	49.87	To look for	36.30
To send	38.37	Answer	18.77	To Call	45.17	Young	33.77
Excellent	31.97	To live	18.57	To come in	44.54	Positive	33.31
Chemotherapy	29.71	Physician	18.37	Medical_examination	38.43	HCS*	29.92
Thanks_to_God	29.62	To Think	18.30	Month	35.48	To Prepare	27.99
Never again	28.52	Life	16.78	Afternoon	33.81	Father	27.51
Every time	26.62	Manner	16.70	Timetable	29.05	To Talk	27.18
Against	21.00	To Understand	16.47	Week	25.61	Experience	26.49
To complain	18.67	Oncologist	15.69	Time	25.46	HCS**	25.80
Experience	18.25	Fundamental	15.38	To return	24.38	To see	24.60
Request	17.74	To want	15.20	Long (wait)	22.90	To Depend	21.42
Healthcare_staff	17.53	To stand	13.61	To respect	21.70	Our	19.99
Nurse	16.99	Aspect	13.25	Appointment	21.41	HA***	18.85
Always	14.65	Duty	13.24	To leave	20.07	Friendly	17.96
To work	13.69	Private care	13.17	Therapy	19.35	Difference	16.50
To operate (surgically)	13.23	Switzerland	12.70	To wait for	19.24	Lucky	15.79

*Healthcare_system; **Healthcare_staff; ***Human_approach.

3.2. Relationship Between Respondents' Characteristics and Clusters

As shown in Table 5, Correspondence Analysis (CA) indicated no significant differences in cluster distribution by respondents' role (patient or family carer) or sex. However, significant differences emerged for age and reason for being in the hospital. Specifically, younger respondents (18–30 years) were underrepresented in Cluster 1 and overrepresented in Cluster 2; respondents aged 31–50 years were overrepresented in Cluster 1, while those aged 51–65 were underrepresented. Participants attending the hospital for a first visit were underrepresented in Cluster 1, whereas those receiving treatment were overrepresented.

Table 5. Significant Associations Summary.

Variable	Cluster 1: Variability in the care experience	Cluster 2: The ideal care relationship	Cluster 3: Waiting Times and Delays in Care	Cluster 4: The luck of being cared by a good physician
Target				
Patient	-1.31	0.58	0.84	-0.06
Parent	1.31	-0.58	-0.84	0.06
Sex				
Women	0.39	-0.99	-0.78	1.40
Men	-0.39	0.99	0.78	-1.40
Age Range				
18-30	-2.06*	2.16*	-0.72	0.39
31-50	2.84*	-0.40	-0.60	-1.93
51-65	-3.33*	0.92	0.52	1.93
> 65	0.60	-0.43	-0.47	0.28
Reason for visit				
First visit	-2.93*	0.28	1.55	1.29

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Therapy	4.23*	-1.83	-0.89	-1.51
Follow-up	-0.28	1.06	-0.92	-0.06

Test-values above ±1.96 indicate a statistically significant association between category and cluster. Positive values indicate that the mode is more present in the cluster than the other modes, negative values indicate that the mode is underrepresented in the cluster.

4. Discussion

This cross-sectional study explored how cancer patients and family carers describe their expectations and experiences of care at a Local Hospital in Southern Italy. Cluster analysis identified four semantic cores reflecting key aspects of the care experience, revealing how these are deeply shaped by organizational arrangements, resource distribution, and the institutional conditions that enable or constrain relational continuity, communication, and trust within healthcare encounters.

In Cluster 1 (Variability in the care experience) – where respondents aged between 31 and 50 years and waiting in the hospital for treatment are overrepresented –, satisfaction or dissatisfaction with care was closely related to the perceived evolution of one's own or a family member's health condition and to the competence and attentiveness of encountered specialists. While many participants expressed appreciation for physicians, they emphasized marked variability in care quality, encapsulated in the perception that "physicians are not all the same." Ensuring appropriate care often required changing doctors or travelling long distances, reflecting structural inequalities within the Italian healthcare system. Healthcare services in Southern regions are commonly perceived as lower in quality than those in the North, particularly in terms of treatment standards and waiting times (Greco, 2025; Toth, 2014). In this context, the so-called *viaggi della Speranza*—journeys undertaken to seek cancer care in Northern Italy—remain widespread (Greco, 2019), illustrating how geographical mobility becomes an informal strategy to compensate for territorially uneven provision of care. These findings resonate with qualitative research conceptualizing cancer survivorship as a process of "wrangling" with healthcare systems, understood as the everyday struggle to navigate complex, uneven, and sometimes unwelcoming institutional pathways. Importantly, the capacity to successfully engage in this practice depends on the availability of economic, cultural, and social capital, thereby contributing to the reproduction of inequalities in access to care and in access to stable, continuous, and meaningful relationships with healthcare professionals (Dew et al., 2024).

Clusters 2 (The ideal care relationship) – where respondents aged between 18 and 30 years are overrepresented – and 4 (The luck of being cared by a good physician) emphasize expectations of physicians who attend not only to disease but to patients as biopsychosocial beings, acknowledging fears, anxieties, and concerns (Bush et al., 2019). Participants highlighted empathy, respect, compassion, and attentive listening, viewing technical competence as necessary but insufficient. Physicians were also expected to support family members and to communicate bad news in a timely and sensitive manner, consistent with previous findings (Primeau et al., 2024; Gonella et al., 2019; Venuleo et al., 2022). Although transparent communication supports emotional adjustment and decision-making, physicians may withhold or filter information due to concerns about patients' emotional reactions or uncertainty about how to convey difficult news (Berkey et al., 2018). Consistently, Legese et al. (2021) reported that many breast cancer patients perceived the information received as insufficient, contributing to distress and uncertainty.

Cluster 4 highlight how participants often describe very positive experiences with physicians, who are portrayed as exceptionally kind, attentive, and humane. The physician is idealized: he or she is not merely a professional fulfilling a duty, but an exceptional figure, deserving of mention and gratitude. This idealization and full confidence in the physician can be understood, on one hand, as a cognitive process – first needing to trust the physician and then preserving the consistency of one's beliefs by assuming the physician possesses the qualities required to warrant that trust – and, on the other hand, as an emotional stance to face the uncertainty of the health condition and gain a subjective

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sense of safety. Notably, when the actual relationship matches the ideal, it is narrated as a matter of "luck" rather than as an expected outcome of a well-functioning healthcare system. In other words, the feeling of being cared for in a way that meets one's expectations is not recognized as the product of a larger, well-organized system staffed by trained and competent professionals, but rather as the result of contingency. Such narratives implicitly normalize systemic failures by reframing adequate care as exceptional. One reason for this perception is the lack of continuity in care: physicians may change at each visit, preventing stable relationships. Previous research indicates that regularity of contact is more important than frequency, particularly for patients facing uncertainty (Dyer et al, 2022; Turner et al., 2007). In Italy, the context of the present study, the lack of regularity must also be framed in the light of a health system suffering from a progressive decrease in resources allocated for public health, characterized by insufficient availability of medical personnel, as well as of products and physical structures. The perception that empathic care is not the norm is also consistent with research on healthcare complaints, which shows that dissatisfaction often concerns relational rather than technical aspects of care (Mostafapour et al., 2024a; 2024b). Physicians may underestimate communication difficulties and patients' emotional distress (Gössi et al, 2025), and communication failures remain a frequent source of complaints (Alamo-Palomino et al., 2020; Kee et al., 2018; Mack et al., 2017.). Despite its recognized benefits, patient- and family-centred care remains insufficiently embedded in routine practice, constrained by biomedical models, professional norms favoring emotional detachment, time pressures, and organizational demands (Halpern, 2014; Martínez-Morato et al., 2021). Physicians may fear that engaging emotionally with patients is time-consuming, yet evidence shows that allowing patients to speak freely requires minimal time and enhances satisfaction and adherence (Langewitz et al., 2022). At the same time, structural stressors – such as staff shortages, heavy workloads, the high-pressure environment of oncology departments, and limited managerial support – further heighten the risk of burnout and reduce empathic engagement (Ashouri, 2018; Holland, 2010).

Cluster 3 (Waiting Times and Delays in Care) focuses on waiting as a central dimension of care experience. Time spent in waiting rooms was described as "suspended" time, requiring patients and carers to set aside work and family commitments. Previous studies show that prolonged waiting marginalizes everyday life in favour of illness-related demands (Hall et al., 2021; Paul et al., 2012). Participants reported waiting times of several hours, consistent with earlier findings (Bielen & Demoulin, 2007; McKinnon et al., 2006; Venuleo et al., 2024). Delays in appointments and diagnostic results align with OECD data identifying long waiting times as a major policy concern (OECD, 2025) and is particularly pronounced in Southern Italy (ISTAT, 2023). Such delays are associated with distress, uncertainty, and reduced satisfaction, whereas shorter waits enhance perceptions of staff compassion (Liddy et al., 2024; Söderlund, 2023;).

No significant differences emerged between patients and family carers in the distribution of semantic cores, indicating shared expectations and interpretative frameworks. This convergence suggests that cancer is experienced as a relational condition, characterized by jointly negotiated meanings, emotional attunement, and shared vulnerability (Wang & Feng, 2022). Carers' narratives closely mirrored patients' concerns, particularly regarding empathic communication, continuity of care, and timely access to services. The absence of differences should therefore not be read as a lack of specificity in carers' experiences, but as evidence of the deeply shared nature of cancer-related meanings. These findings reinforce the relevance of a family-centred perspective, in which patients and carers are understood as a relational unit interacting with the healthcare system.

Limitations

This study has some limitations. First, it was conducted in only one oncology department in southern Italy, and the results are not generalizable. Results may vary depending on culture and context. Second, no data were collected on the characteristics of those who declined participation, which could represent a potential selection bias. For example, it is possible that those who accepted the invitation to participate in the study were mainly the patients and family members who were

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most satisfied with their experience of care. Third, the cross-sectional design provides a snapshot of experience; longitudinal studies are needed to examine changes over time and the role of socio-demographic (e.g., educational level, social status) and clinical (e.g., indication, type and amount of treatment) characteristics that could be a source of variation in the perceived quality of the interaction.

5. Conclusions

This study provides insights into dimensions of cancer care experience that traditional quality and safety indicators often fail to capture (Råberus et al., 2019; Reader et al., 2014). By including both patients and family carers, it highlights the relational nature of cancer care and shows how expectations and evaluations of the care relationship are jointly constructed.

Although participants generally report positive experiences and express gratitude toward physicians, they also describe care quality as precarious and contingent, marked by variability, lack of continuity, and delays in diagnosis and treatment, fostering the perception that satisfactory care depends on chance rather than on a reliable healthcare system.

The convergence between patients' and carers' narratives underscores the importance of a patient- and family-centred approach that recognizes emotional, relational, and communicative needs alongside clinical ones. Participants emphasize the role of empathy, attentive communication, and support for family carers, suggesting that interventions should target patients and families together.

However, promoting compassionate and family-centred care cannot rely solely on individual physicians' skills. Institutional and policy-level actions aimed at improving resources, staffing, and continuity of care are equally crucial. As shown during the COVID-19 emergency, organizational pressures and resource shortages contribute to burnout among healthcare workers (Marinaci et al., 2020; 2023), undermining professionals' capacity to provide relationally attuned care. Ultimately, ensuring equitable, high-quality cancer care requires addressing the broader structural conditions shaping both patient vulnerability and providers' responsiveness. Relational quality, communication, and continuity are not optional "soft" dimensions of care but core elements of health system performance that demand strategic investment and governance.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

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Informed Consent Statement: Written informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The dataset is qualitative and contains several quotes that could potentially identify participants. Therefore, the raw dataset will not be available. However, additional quotes supporting each theme can be provided upon request from the corresponding author.

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References

Adhabi, E., & Anozie, C.B. (2017). Literature review for the type of interview in qualitative research. *International Journal of Education, 9*(3), 86-97. http://dx.doi.org/10.5296/ije.v9i3.11483

Alamo-Palomino, I.J., Matzumura-Kasano, J.P., & Gutiérrez-Crespo, H.F. (2020). Patient complaints in the adult emergency department of a tertiary referral hospital. *Rev Fac Med Hum, 20*(2), 246-253. http://dx.doi.org/10.25176/RFMH.v20i2.2916

Ashouri, E., Taleghani, F., Memarzadeh, M., Saburi, M., & Babashahi, F. (2018). The perceptions of nurses, patients and family members regarding nurses' empathetic behaviours towards patients suffering from cancer: a descriptive qualitative study. *Journal of Research in Nursing, 23*(5), 428-443. https://doi.org/10.1177/1744987118756945

Badr, H., Gupta, V., Sikora, A., & Posner, M. (2014). Psychological distress in patients and caregivers over the course of radiotherapy for head and neck cancer. *Oral Oncology, 50*(10), 1005-1011. https://doi.org/10.1016/j.oraloncology.2014.07.003

Berkey, F.J., Wiedemer, J.P., & Vithalani, N.D. (2018). Delivering bad or life-altering news. *American Family Physician, 98*(2), 99-104.

Bielen, F., & Demoulin, N. (2007). Waiting time influence on the satisfaction-loyalty relationship in services. *Managing Service Quality: An International Journal, 17*(2), 174-193. http://dx.doi.org/10.1108/09604520710735182

Bombard, Y., Baker, G.R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., ... & Pomey, M.P. (2018). Engaging patients to improve quality of care: a systematic review. *Implementation Science, 13*, 1-22. https://doi.org/10.1186/s13012-018-0784-z

Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Busch, I. M., Moretti, F., Travaini, G., Wu, A.W., & Rimondini, M. (2019). Humanization of care: Key elements identified by patients, caregivers, and healthcare providers. A systematic review. *The Patient-Patient-Centered Outcomes Research, 12*, 461-474. https://doi.org/10.1007/s40271-019-00370-1

Cheraghi, M.A., Esmaeili, M., & Salsali, M. (2017). Seeking humanizing care in patient-centered care process: A grounded theory study. *Holistic Nursing Practice, 31*(6), 359-368. https://doi.org/10.1097/HNP.0000000000000233

Chong, E., Crowe, L., Mentor, K., Pandanaboyana, S., & Sharp, L. (2023). Systematic review of caregiver burden, unmet needs and quality-of-life among informal caregivers of patients with pancreatic cancer. *Supportive Care in Cancer, 31*(1), 74. https://doi.org/10.1007/s00520-022-07468-7

Coyne, E. (2013). The strengths and resources used by families of young women with breast cancer. *Australian Journal of Cancer Nursing, 14*(2), 10-16. https://search.informit.org/doi/10.3316/informit.700360046696839

Coyne, E., Grafton, E., Reid, A., & Marshall, A. (2017). Understanding family assessment in the Australian context; what are adult oncology nursing practices? *Collegian, 24*(2), 175-182. https://doi.org/10.1016/j.colegn.2016.01.001

de Waard, C.S., Poot, A.J., den Elzen, W.P.J., Wind, A.W., Caljouw, M.A.A., & Gussekloo, J. (2018). Perceived doctor-patient relationship and satisfaction with general practitioner care in older persons in residential homes. *Scandinavian Journal of Primary Health Care, 36*(2), 189-197. https://doi.org/10.1080/02813432.2018.1459229

Dew, K., Chamberlain, K., Egan, R., Broom, A., Dennett, E., & Cunningham, C. (2024). Accessing diagnosis and treatment: The experience of cancer as wrangling with the system. *SSM - Qualitative Research in Health, 5*, 100418. https://doi.org/10.1016/j.ssmqr.2024.100418

Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: a systematic review. *The Lancet, 357*(9258), 757-762. https://doi.org/10.1016/S0140-6736(00)04169-6

DiCicco-Bloom, B., & Crabtree, B.F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314-321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

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Dieperink, K.B., Coyne, E., Creedy, D.K., & Østergaard, B. (2018). Family functioning and perceived support from nurses during cancer treatment among Danish and Australian patients and their families. *Journal of Clinical Nursing, 27*(1-2), e154-e161. https://doi.org/10.1111/jocn.13894

Dyer, S.M., Suen, J., Williams, H., Inacio, M.C., Harvey, G., Roder, D., ... & Caughey, G.E. (2022). Impact of relational continuity of primary care in aged care: a systematic review. *BMC Geriatrics, 22*(1), 579. https://doi.org/10.1186/s12877-022-03131-2

Ferrell, B., & Wittenberg, E. (2017). A review of family caregiving intervention trials in oncology. *CA: A Cancer Journal for Clinicians, 67*(4), 318-325. https://doi.org/10.3322/caac.21396

Gennaro, A., & Salvatore, S. (2023). The themes of texts: automatic co-occurrence analysis for semantic mapping (ACASM). In S. Salvatore, G.A. Veltri, & T. Mannarini (Eds.), *Methods and Instruments in the Study of Meaning-making* (pp. 83-105). Cham: Springer International Publishing. https://doi.org/10.1007/978-3-031-21995-5_4

Gennaro, A., Venuleo, C., Auletta, A.F., & Salvatore, S. (2012). The topics of psychotherapy research: An analysis based on keywords. *Research in Psychotherapy: Psychopathology, Process and Outcome, 15*(1), 1-9. https://doi.org/10.4081/ripppo.2012.117

Gergen, K.J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266–275. https://doi.org/10.1037/0003-066X.40.3.266

Gonella, S., Basso, I., De Marinis, M.G., Campagna, S., & Di Giulio, P. (2019). Good end-of-life care in nursing home according to the family carers' perspective: A systematic review of qualitative findings. *Palliative Medicine, 33*(6), 589-606. https://doi.org/10.1177/0269216319840275

Gössi, F., Arpagaus, A., Gross, S., Zumbrunn, S.K., Bissmann, B., Hunziker, S., & Becker, C. (2025). Physician responses to patients' emotional cues and concerns and their association with patient-related outcomes. *Patient Education and Counseling, 109386*. https://doi.org/10.1016/j.pec.2025.109386

Greco, C. (2019). Moving for Cures: Breast Cancer and Mobility in Italy. *Medical Anthropology, 38*(4), 384–398. https://doi.org/10.1080/01459740.2019.1592171

Greco, C. (2025). The political context of breast cancer in Europe. In *Assemblage of cancer. Experiences and contexts of breast cancer in the UK, France and Italy* (pp. 27-50). Manchester University Press. https://doi.org/10.7765/9781526171467.00005

Grycuk, E., Chen, Y., Almirall-Sanchez, A., Higgins, D., Galvin, M., Kane, J., ... & Leroi, I. (2022). Care burden, loneliness, and social isolation in caregivers of people with physical and brain health conditions in English-speaking regions: Before and during the COVID-19 pandemic. *International Journal of Geriatric Psychiatry, 37*(6), 1-13. https://doi.org/10.1002/gps.5734

Guan, T., Qan'ir, Y., & Song, L. (2021). Systematic review of illness uncertainty management interventions for cancer patients and their family caregivers. *Supportive Care in Cancer, 29*, 4623–4640. https://doi.org/10.1007/s00520-020-05931-x

Hall, E. T., Sridhar, D., Singhal, S., Fardeen, T., Lahijani, S., Trivedi, R., … & Schapira, L. (2021). Perceptions of time spent pursuing cancer care among patients, caregivers, and oncology professionals. *Supportive Care in Cancer, 29*, 2493–2500. https://doi.org/10.1007/s00520-020-05763-9

Halpern, J. (2014). From idealized clinical empathy to empathic communication in medical care. *Medicine, Health Care and Philosophy, 17*, 301–311. https://doi.org/10.1007/s11019-013-9510-4

Holland, J. C. (2010). *Psycho-oncology*. New York: Oxford University Press.

Huynh, T. N., Hartel, G., Janda, M., Wyld, D., Merrett, N., Gooden, H., … & Beesley, V. L. (2023). The unmet needs of pancreatic cancer carers are associated with anxiety and depression in patients and carers. *Cancers, 15*(22), 5307. https://doi.org/10.3390/cancers15225307

ISTAT. (2023). *Indagine conoscitiva sulle forme integrative di previdenza e di assistenza sanitaria nel quadro dell'efficacia complessiva dei sistemi di welfare e di tutela della salute* [Survey on supplementary forms of social security and health care in the context of the overall effectiveness of welfare and health protection systems]. Roma, 5 Maggio 2023. Retrieved from: https://www.quotidianosanita.it/allegati/allegato1678270270.pdf / Accessed July 20, 2025.

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Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report, 17*(42), 1–10. https://doi.org/10.46743/2160-3715/2012.1718

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kee, J. W., Khoo, H. S., Lim, I., & Koh, M. Y. (2018). Communication skills in patient-doctor interactions: Learning from patient complaints. *Health Professions Education, 4*(2), 97–106. https://doi.org/10.1016/j.hpe.2017.03.006

Lamba, N., Niemierko, A., Martinez, R., Leland, P., & Shih, H. A. (2020). The interaction of waiting time and patient experience during radiation therapy: A survey of patients from a tertiary cancer center. *Journal of Medical Imaging and Radiation Sciences, 51*(1), 40–46. https://doi.org/10.1016/j.jmir.2019.08.008

Lancia, F. (2023). *T-LAB Pathways to Thematic Analysis*. Retrieved from: http://www.tlab.it/en/tpathways.php /Accessed January 20, 2025.

Langewitz, W., Denz, M., Keller, A., Kiss, A., Rütimann, S., & Wössmer, B. (2002). Spontaneous talking time at start of consultation in outpatient clinic: Cohort study. *British Medical Journal, 325*(7366), 682–683. https://doi.org/10.1136/bmj.325.7366.682

Legese, B., Addissie, A., Gizaw, M., Tigneh, W., & Yilma, T. (2021). Information needs of breast cancer patients attending care at Tikur Anbessa specialized hospital: A descriptive study. *Cancer Management and Research, 13*, 277–286. https://doi.org/10.2147/CMAR.S264526

Liddy, C., Cooper, L., Bellingham, G., Deyell, T., Ingelmo, P., Moroz, I., … & Buckley, N. (2024). Patient-reported wait times and the impact of living with chronic pain on their quality of life: A waiting room survey in chronic pain clinics in Ontario, Manitoba, and Quebec. *Canadian Journal of Pain, 8*(1), 2345612. https://doi.org/10.1080/24740527.2024.2345612

Liu, H., Wang, C., & Khoo, S. (2022). Unmet needs, anxiety, and depression among caregivers of adolescents and young adults with cancer: Associations and implications. *Asia-Pacific Journal of Oncology Nursing, 9*, 100108. https://doi.org/10.1016/j.apjon.2022.100108

Mack, J. W., Jacobson, J., Frank, D., Cronin, A. M., Horvath, K., Allen, V., … & Schrag, D. (2017). Evaluation of patient and family outpatient complaints as a strategy to prioritize efforts to improve cancer care delivery. *The Joint Commission Journal on Quality and Patient Safety, 43*(10), 498–507. https://doi.org/10.1016/j.jcjq.2017.04.008

Marinaci, T., Carpinelli, L., Venuleo, C., Savarese, G., & Cavallo, P. (2020). Emotional distress, psychosomatic symptoms and their relationship with institutional responses: A survey of Italian frontline medical staff during the Covid-19 pandemic. *Heliyon, 6*(12), e05766. https://doi.org/10.1016/j.heliyon.2020.e05766

Marinaci, T., Venuleo, C., Infurna, M. R., & Di Maria, F. (2025). What Mafia do we have in mind? An exploratory study on mafia representation among ordinary people. *Culture & Psychology*. https://doi.org/10.1177/1354067X251315738

Marinaci, T., Venuleo, C., & Savarese, G. (2023). The COVID-19 pandemic from the health workers' perspective: Between health emergency and personal crisis. *Human Arenas, 6*(3), 478–498. https://doi.org/10.1007/s42087-021-00232-z

Martínez-Morato, S., Feijoo-Cid, M., Galbany-Estragués, P., Fernández-Cano, M. I., & Arreciado Marañón, A. (2021). Emotion management and stereotypes about emotions among male nurses: A qualitative study. *BMC Nursing, 20*(1), 114. https://doi.org/10.1186/s12912-021-00641-z

Mattarozzi, K., Sfrisi, F., Caniglia, F., De Palma, A., & Martoni, M. (2017). What patients' complaints and praise tell the health practitioner: Implications for health care quality. A qualitative research study. *International Journal for Quality in Health Care, 29*(1), 83–89. https://doi.org/10.1093/intqhc/mzw139

Mattock, R., Martin, A., Beckett, A., Lindner, O. C., Stark, D., & Taylor, R. M. (2025). Impact of a cancer diagnosis on educational, employment, health-related quality of life, and social outcomes among young adults: A matched cohort study of 401 cancer survivors aged 15–24 in England. *Social Science & Medicine*. https://doi.org/10.1016/j.socscimed.2025.118078

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Preprints.org (www.preprints.org) | NOT PEER-REVIEWED | Posted: 24 February 2026 doi:10.20944/preprints202602.1445.v1

McKinnon, K., Crofts, P. D., Edwards, R., Campion, P. D., & Edwards, R. H. (1998). The outpatient experience: Results of a patient feedback survey. *International Journal of Health Care Quality Assurance, 11*(5), 156–160. https://doi.org/10.1108/09526869810230858

Moser, R. P., Arndt, J., Jimenez, T., Liu, B., & Hesse, B. W. (2021). Perceptions of cancer as a death sentence: Tracking trends in public perceptions from 2008 to 2017. *Psycho-Oncology, 30*(4), 511–519. https://doi.org/10.1002/pon.5596

Mostafapour, M., Fortier, J. H., & Garber, G. (2024a). Exploring the dynamics of physician-patient relationships: Factors affecting patient satisfaction and complaints. *Journal of Healthcare Risk Management, 43*(4), 16–25. https://doi.org/10.1002/jhrm.21567

Mostafapour, M., Smith, J. D., Fortier, J. H., & Garber, G. E. (2024b). Beyond medical errors: Exploring the interpersonal dynamics in physician-patient relationships linked to medico-legal complaints. *BMC Health Services Research, 24*(1), 1003. https://doi.org/10.1186/s12913-024-11457-3

OECD. (2025). *Health at a glance 2025: OECD indicators.* OECD Publishing. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en.html

Ohana, S., & Mash, R. (2015). Physician and patient perceptions of cultural competency and medical compliance. *Health Education Research, 30*(6), 923–934. http://dx.doi.org/10.1093/her/cyv060

Paul, C., Carey, M., Anderson, A., Mackenzie, L., Sanson-Fisher, R., Courtney, R., & Clinton-McHarg, T. (2012). Cancer patients' concerns regarding access to cancer care: perceived impact of waiting times along the diagnosis and treatment journey. *European Journal of Cancer Care, 21*(3), 321–329. https://doi.org/10.1111/j.1365-2354.2011.01311.x

Primeau, C., Chau, M., Turner, M. R., & Paterson, C. (2024, June). Patient experiences of patient–clinician communication among cancer multidisciplinary healthcare professionals during "breaking bad news": A qualitative systematic review. *Seminars in Oncology Nursing, 4*(4), 151680. http://dx.doi.org/10.1016/j.soncn.2024.151680

Pruchno, R., Wilson-Genderson, M., & Cartwright, F. (2009). Self-rated health and depressive symptoms in patients with end-stage renal disease and their spouses: A longitudinal dyadic analysis of late-life marriages. *Journals of Gerontology: Series B, 64*(2), 212–221. https://doi.org/10.1093/geronb/gbp006

Råberus, A., Holmström, I. K., Galvin, K., & Sundler, A. J. (2019). The nature of patient complaints: a resource for healthcare improvements. *International Journal for Quality in Health Care, 31*(7), 556–562. https://doi.org/10.1093/intqhc/mzy215

Reader, T. W., Gillespie, A., & Roberts, J. (2014). Patient complaints in healthcare systems: a systematic review and coding taxonomy. *BMJ Quality & Safety, 23*(8), 678–689. https://doi.org/10.1136/bmjqs-2013-002437

Riessman, C. K. (2008). *Narrative methods for the human sciences.* SAGE.

Salvatore, S., Gelo, O. C. G., Gennaro, A., Metrangolo, R., Terrone, G., Pace, V., … & Ciavolino, E. (2017). An automated method of content analysis for psychotherapy research: A further validation. *Psychotherapy Research, 27*(1), 38–50. https://doi.org/10.1080/10503307.2015.1072282

Salvatore, S., Gennaro, A., Auletta, A., Tonti, M., & Nitti, M. (2012). Automated method for content analysis: A device for psychotherapy process. *Psychotherapy Research, 22*(3), 256–273. https://doi.org/10.1080/10503307.2011.647930

Schneider, H., & Palmer, N. (2002). Getting to the truth? Researching user views of primary health care. *Health Policy and Planning, 17*(1), 32–41. https://doi.org/10.1093/heapol/17.1.32

Söderlund, R. (2023). Waiting times in healthcare: a literature review. *International Journal of Telemedicine and Clinical Practices, 4*(1), 16–42. https://doi.org/10.1504/IJTMCP.2023.136158

Soh, X. C., Hartanto, A., Ling, N., Reyes, M., Sim, L., & Majeed, N. M. (2025). Prevalence of depression, anxiety, burden, burnout, and stress in informal caregivers: An umbrella review of meta-analyses. *Archives of Gerontology and Geriatrics Plus, 100197.* https://doi.org/10.1016/j.aggp.2025.100197

Sterponi, L., Fatigante, M., Zucchermaglio, C., & Alby, F. (2024). Companions in immigrant oncology visits: Uncovering social dynamics through the lens of Goffman's footing and Conversation Analysis. *SSM – Qualitative Research in Health, 5*, 100432. https://doi.org/10.1016/j.ssmqr.2024.100432

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Preprints.org (www.preprints.org) | NOT PEER-REVIEWED | Posted: 24 February 2026 doi:10.20944/preprints202602.1445.v1

Tan, J.-Y., Molassiotis, A., Lloyd-Williams, M., & Yorke, J. (2018). Burden, emotional distress and quality of life among informal caregivers of lung cancer patients: An exploratory study. *European Journal of Cancer Care, 27*(1), e12691, 1–11. http://dx.doi.org/10.1111/ecc.12691

Thompson, T., Coats, J., Croston, M., Motley Jr, R. O., Thompson, V. S., James, A. S., & Johnson, L. P. (2024). "We need a little strength as well": Examining the social context of informal caregivers for Black women with breast cancer. *Social Science & Medicine, 342*, 116528. https://doi.org/10.1016/j.socscimed.2023.116528

Toth, F. (2014). How health care regionalisation in Italy is widening the North–South gap. *Health Economics, Policy and Law, 9*(3), 231–249. https://doi.org/10.1017/S1744133114000012

Turner, D., Tarrant, C., Windridge, K., Bryan, S., Boulton, M., Freeman, G., & Baker, R. (2007). Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments. *Journal of Health Services Research & Policy, 12*(3), 132–137. https://doi.org/10.1258/135581907781543021

Venuleo, C., & Guacci, C. (2014). The general psychologist: A case study on the image of the psychologist's role and integrated primary care service expressed by paediatricians and general practitioners. *Psicologia della Salute, 1*, 73–97. https://doi.org/10.3280/PDS2014-001004

Venuleo, C., Gelo, O., Marinaci, T., AURORA@COVID19-EU Team. (2022). *Manual for Direct Agents – Articulating a Unified Response to the Covid-19 Outbreak Reconstruction After Loss in Europe.* Maia: UMAIA Press.

Venuleo, C., Marinaci, T., Cucugliato, C., & Giausa, S. (2024). It is time to take complaints seriously? An exploratory analysis of communications sent by users to a public healthcare agency before, during and after the COVID-19 pandemic. *International Journal of Environmental Research and Public Health, 21*(10), 1299, 1–21. https://doi.org/10.3390/ijerph21101299

Venuleo, C., Salvatore, S., Venezia, A., Mossi, P., & Savarese, G. (2019). Representations of physician's role and their impact on compliance. *Psicologia della Salute, 2*, 100–121. https://doi.org/10.3280/PDS2019-002005

Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., … & Vogelaers, D. (2015). Communication in healthcare: A narrative review of the literature and practical recommendations. *International Journal of Clinical Practice, 69*(11), 1257–1267. https://doi.org/10.1111/ijcp.12686

VIII Rapporto RBM—Censis sulla Sanità Pubblica, Privata ed Intermediata. (2018). La salute è un diritto di tutti [VIII RBM—Censis Report on Public, Private and Intermediate Health Care. Health is a Right of Everyone]. Palazzo Colonna, Roma, 6 Giugno 2018. https://www.quotidianosanita.it/allegati/allegato5933767.pdf

Wang, Y., & Feng, W. (2022). Cancer-related psychosocial challenges. *General Psychiatry, 35*(5), e100871, 1–6. https://doi.org/10.1136/gpsych-2022-100871

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard (through 2013), 22*(23), 35–40. https://doi.org/10.7748/ns2008.02.22.23.35.c6420

World Health Organization. (2000). *The world health report 2000: Health systems: Improving performance.* World Health Organization.

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