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Meaning-Making, Illness Acceptance, and Quality of Life Among Patients Living With Advanced Cancer: A Qualitative Inquiry

Kamdin. Parsakia[1], Seyed Hadi. Seyed Ali Tabar[1*]

[1] Department of Psychology and Counseling, Kman Research Institute, Richmond Hill, Ontario, Canada

*** Corresponding author email address**: h.alitabar@kmanresce.ca

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ABSTRACT

Objective: This study aimed to explore the experiences of meaning-making, illness acceptance, and quality of life among patients living with advanced cancer in Canada.
Methods and Materials: This qualitative inquiry was conducted among 26 adult patients diagnosed with advanced or metastatic cancer who were receiving oncology or palliative care services in Canada. Participants were selected through purposive sampling to ensure variation in age, gender, cancer type, treatment status, and care setting. Data were collected through semi-structured interviews, a demographic and clinical information form, and researcher field notes. The interviews explored patients' understanding of illness, experiences of acceptance, sources of meaning, perceived changes in identity and relationships, and definitions of quality of life during advanced disease. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis. Coding was performed through repeated reading, identification of meaning units, development of initial codes, formation of categories, and extraction of overarching themes. Credibility, dependability, confirmability, and transferability were supported through peer discussion, reflexive memo writing, an audit trail, and detailed description of the research context.
Findings: The analysis identified three major themes. The first theme, reconstructing meaning in the face of advanced illness, showed that participants attempted to preserve identity, reinterpret life priorities, confront mortality, and find coherence through relationships, spirituality, contribution, and reflection. The second theme, negotiating acceptance without surrender, indicated that illness acceptance was not experienced as giving up, but as a fluctuating process of living with uncertainty, maintaining agency, balancing hope and realism, and preparing emotionally and practically for the future. The third theme, redefining quality of life in advanced cancer, revealed that participants associated quality of life with relief from physical suffering, dignity, relational closeness, normalcy in daily life, freedom from being a burden, and peace in the present.
Conclusion: The findings suggest that meaning-making, illness acceptance, and quality of life are reciprocal and dynamic processes among patients with advanced cancer. Patient-centered palliative oncology should therefore address existential meaning, emotional adjustment, dignity, family concerns, symptom relief, and personal definitions of quality of life.
Keywords: *Advanced cancer; Meaning-making; Illness acceptance; Quality of life; Palliative care; Qualitative inquiry; Patient experience.*

1. Introduction

Advanced cancer represents one of the most complex conditions in contemporary oncology because it is not merely a progressive biomedical state, but also a deeply disruptive life experience that affects the body, identity, family relationships, expectations for the future, and the meaning of living itself. Patients with advanced cancer often face cumulative physical symptoms, uncertain treatment trajectories, psychological distress, functional decline, and difficult decisions about care priorities. In this context, the clinical goal is rarely limited to disease control alone; rather, it increasingly includes the preservation of dignity, relief of suffering, communication about values, and support for quality of life. Palliative oncology has therefore become an essential dimension of cancer care, emphasizing symptom management, psychosocial support, spiritual care, advance care planning, and shared decision-making for patients and families confronting serious illness (Strang, 2022). The experience of advanced cancer differs from earlier survivorship because the patient must live within an intensified awareness of mortality while simultaneously continuing treatment, maintaining relationships, and attempting to preserve a coherent sense of self. This makes advanced cancer a critical context for examining meaning-making, illness acceptance, and quality of life as interrelated dimensions of the patient experience.

Quality of life has become a central outcome in advanced cancer care, particularly because survival time alone cannot fully represent the burden of illness or the value of care from the patient's perspective. In palliative contexts, health-related quality of life includes physical comfort, emotional well-being, social connection, spiritual concerns, autonomy, and the ability to maintain meaningful roles despite disease progression. Studies using patient-reported outcomes have shown that patients' own assessments of their symptoms and quality of life may differ from assessments made by health care professionals, reinforcing the importance of listening directly to patients' subjective experiences (Matsumura et al., 2020). Symptom clusters such as pain, fatigue, appetite loss, dyspnea, insomnia, and emotional distress may significantly shape prognosis and daily functioning among terminally ill patients with cancer (Koyama et al., 2021). Similarly, research on postoperative health-related quality of life among patients with metastatic spinal cord compression secondary to lung cancer has shown that the burden of advanced disease requires attention not only to clinical outcomes, but also to patients' perceived functioning and well-being after major interventions (Fu et al., 2023). These findings suggest that quality of life in advanced cancer is a multidimensional and subjective construct that should be understood in relation to both bodily suffering and the patient's broader existential context.

The need for palliative care among patients with advanced cancer is substantial, yet identifying these needs and responding to them appropriately remains challenging across health systems. Recent research has emphasized the importance of identifying palliative home care needs among patients with advanced cancer, including symptom control, psychological support, family assistance, communication needs, and continuity of care (Liu et al., 2025). In acute and critical care environments, clinicians may experience difficulty identifying palliative care needs because the boundaries between active treatment, life-sustaining intervention, and comfort-oriented care are often unclear (Astuti et al., 2024). Observational research from tertiary cancer settings has also shown that end-of-life care practices are shaped by institutional routines, treatment culture, referral timing, and communication practices (Maurya et al., 2024). In patients receiving radiotherapy within palliative contexts, symptom relief and functional preservation are often major goals, but patients may still experience high levels of physical and psychosocial vulnerability (Devi et al., 2023). These studies collectively highlight the importance of exploring how patients themselves interpret the transition from disease-directed treatment to palliative priorities and how they understand acceptance, hope, and quality of life during this period.

Palliative care referral patterns are particularly important because delayed referral may limit opportunities for symptom management, advance care planning, emotional support, and family preparation. Research on opioid initiation timing and palliative care referrals in advanced cancer has indicated that palliative involvement is closely connected to symptom burden and care transitions, yet referral may occur late in the disease course (Wong et al., 2024). Studies of early palliative care integration among patients receiving systemic immunotherapy for renal cell carcinoma have similarly emphasized that modern cancer treatment can extend uncertainty, making supportive care necessary even when active treatment continues (Stout et al., 2023). Nationwide analysis has further shown that advance care planning may influence hospice utilization among patients with cancer, suggesting that conversations about preferences, values, and future care can affect whether patients receive care aligned with their needs near the end of life (Kim et al., 2025). At the same time, research on life-sustaining procedures and palliative care trends among patients with cervical cancer indicates that the use of aggressive procedures and the timing of palliative care remain important concerns in advanced gynecologic oncology (Min et al., 2021). These findings show that advanced cancer care involves not only clinical decision-making, but also value-based communication about what patients consider acceptable, meaningful, and dignified.

Communication and knowledge transfer at the end of life are central to how patients understand their illness and participate in care decisions. When patients have incomplete or unclear knowledge about prognosis, treatment limitations, and care options, they may struggle to make sense of their condition or prepare emotionally and practically for the future. Research has raised concerns about knowledge gaps between patients and clinicians at the end of life, emphasizing that poor knowledge transfer can affect decision-making, expectations, and the quality of end-of-life care (Heuser et al., 2025). Oncology nurses and other clinicians are often positioned at the center of palliative and end-of-life conversations, where they must balance honesty, compassion, cultural sensitivity, and support for hope (Spine, 2022). Qualitative research examining shared perspectives of patients with advanced cancer and informal caregivers has also shown that essential aspects of care include communication, coordination, emotional support, respect, and attention to what matters most to the patient and family (Roij et al., 2021). Therefore, understanding patients' own meanings and interpretations is not an optional addition to care; it is a necessary foundation for patient-centered oncology and palliative practice.

Illness acceptance is another important but often misunderstood dimension of advanced cancer. Acceptance does not necessarily mean resignation, hopelessness, or passive surrender to disease. Rather, it can involve recognizing the reality of illness while continuing to search for agency, dignity, connection, and emotional balance. Patients with advanced cancer may move repeatedly between resistance, fear, hope, grief, adjustment, and partial reconciliation. The association between quality of life and prognostic awareness suggests that awareness of serious illness may interact with psychological adjustment in complex ways, potentially supporting realistic planning while also intensifying emotional distress if not accompanied by adequate support (Vlčková et al., 2021). Illness mindsets have also been associated with health-related quality of life among cancer survivors, indicating that the way patients cognitively and emotionally interpret illness may influence well-being and adaptation (Zeidman et al., 2022). Stress and depression among terminally ill patients further demonstrate that coping strategies are essential in serious illness, as patients must manage uncertainty, fear, functional losses, and emotional suffering while navigating the final stages of disease (Vaiphei, 2021). Thus, illness acceptance should be studied as a dynamic process embedded in the patient's meaning system, relational context, and perception of quality of life.

Meaning-making is especially relevant in advanced cancer because patients are often forced to reinterpret their lives under conditions of uncertainty and bodily vulnerability. Diagnosis and progression may disrupt assumptions about control, justice, identity, time, family roles, and the future. For some patients, meaning may be found in spirituality, relationships, legacy, gratitude, reconciliation, or contribution to others. For others, meaning may emerge through the preservation of ordinary routines, autonomy, personal values, or honest communication with loved ones. Supportive interventions in palliative care, including complementary and mind-body approaches such as yoga, may help patients connect physical comfort with emotional and spiritual well-being, although evidence may vary by setting and intervention type (Manjunath et al., 2025). In hepatocellular carcinoma and other advanced malignancies, palliative care has been discussed as a means of improving quality of life by addressing symptom burden and holistic patient needs (Syarifudin & Soares, 2022). Physical activity programs for medically underserved breast cancer survivors with metastatic disease also show the potential relevance of supportive interventions that help patients maintain function, social engagement, and well-being even in the presence of advanced disease (Lee et al., 2024). These studies indicate that patients' quality of life is shaped not only by medical treatment, but also by opportunities for agency, embodiment, connection, and meaningful activity.

The family context is inseparable from the experience of advanced cancer. Patients often interpret their own suffering in relation to the emotional, practical, and financial burden experienced by spouses, children, and other caregivers. Research on metastatic prostate cancer has shown that caregiver burden and patient quality of life are affected by clinical and socioeconomic factors, illustrating how advanced cancer becomes a shared family experience rather than an individual condition alone (Yıldırım et al., 2021b). A related study on metastatic prostate cancer patients and caregivers similarly emphasized the reciprocal connection between patient well-being, caregiver burden, and broader social circumstances (Yıldırım et al., 2021a). Systematic review evidence on metastatic spinal cancer family caregivers at home has shown that caregivers often experience unmet informational, emotional, and practical needs, particularly as patients become more dependent and care demands increase (Kardosod et al., 2023). Emergency department visits among advanced cancer patients receiving palliative care may also reflect gaps in symptom control, home support, and caregiver capacity, demonstrating how instability in the home-care environment can affect patient experience and health service use (Dumnui et al., 2022). For this reason, any investigation of quality of life and acceptance in advanced cancer must consider relational dependence, caregiver concerns, and the patient's desire not to become a burden.

Access to palliative care remains uneven across cancer types, geographic regions, and health systems. Studies in resource-limited countries have reported important patterns of referral to palliative care, including the complementary role of palliative care units in supporting patients with breast cancer when curative options are limited or symptom burden is high (Agodirin et al., 2022). Systematic review evidence on advanced cervical cancer in low- and middle-income countries has shown that access to palliative care may be constrained by health-system capacity, late diagnosis, limited resources, and sociocultural barriers (Ooko et al., 2023). In Central America, pediatric oncology palliative care programs have demonstrated pathways for improving serious illness care, while also showing the importance of contextually adapted service development (García et al., 2021). Rural palliative care telemedicine for advanced cancer patients has also been proposed as a strategy for improving access to specialist support when geography limits in-person care (Sánchez-Cárdenas et al., 2022). These findings are relevant even in high-resource settings such as Canada because access, communication, continuity, and culturally responsive support may still vary across urban, rural, institutional, and home-based care settings.

Advanced cancer often intersects with high-intensity treatment environments, including intensive care units, surgical oncology, radiotherapy units, and emergency departments. The profile of oncological patients receiving palliative care in intensive care units suggests that some patients enter palliative pathways only after substantial clinical deterioration, when opportunities for earlier communication and meaning-centered support may have already narrowed (Meneguetti et al., 2022). Retrospective research on palliative care consultations among patients undergoing cytoreductive surgery and hyperthermic intraperitoneal chemotherapy illustrates that aggressive treatments and palliative needs may coexist, challenging the false dichotomy between active treatment and supportive care (Rodriguez et al., 2021). Studies of patients with brain metastases referred to palliative care also show that advanced cancer populations often present with complex neurological, functional, and psychosocial needs that require timely and individualized support (Harrison et al., 2024). Research on urinary catheterization and quality of death in patients with advanced cancer further demonstrates that even specific clinical decisions can have implications for dignity, comfort, and perceived quality at the end of life (Higashibata et al., 2022). These findings reinforce the importance of examining how patients experience care decisions, bodily decline, and dignity from their own perspective.

The increasing use of electronic patient-reported outcome measures has expanded the ability to assess health-related quality of life among patients with breast and gynecologic cancers, yet quantitative instruments may not fully capture how patients interpret the meaning of illness and acceptance in advanced disease (Boutib et al., 2024). Standardized tools are valuable for monitoring symptoms, functioning, and well-being, but qualitative inquiry is necessary to understand the inner logic of patient narratives, including how individuals define a "good day," what they fear most, how they preserve dignity, and how they reconcile hope with uncertainty. The literature on advanced cancer and palliative care has provided important evidence on symptoms, referral patterns, prognostic awareness, caregiver burden, treatment practices, and quality-of-life assessment; however, less attention has been given to the integrated relationship among meaning-making, illness acceptance, and quality of life as lived and described by patients themselves. This gap is important because clinical care that addresses symptoms without understanding the patient's meaning system may remain incomplete, while psychological support that encourages acceptance without acknowledging suffering, uncertainty, and relational concerns may feel inadequate or invalidating.

A qualitative inquiry is therefore especially appropriate for exploring the subjective and relational dimensions of advanced cancer. Such an approach allows patients to describe their experiences in their own words and makes it possible to examine how they construct meaning, negotiate acceptance, and redefine quality of life within the realities of disease progression. In the Canadian context, where advanced cancer care may include oncology treatment, palliative services, home-based support, and institutional care, patients' experiences can provide valuable insight into the emotional and existential needs that remain beyond routine clinical assessment. Understanding these experiences may help clinicians develop more person-centered communication, support earlier and more sensitive palliative involvement, and recognize that quality of life in advanced cancer may depend on dignity, agency, relational connection, spiritual or existential peace, and relief from suffering as much as on biomedical outcomes.

The aim of this study was to explore the experiences of meaning-making, illness acceptance, and quality of life among patients living with advanced cancer in Canada.

2. Methods and Materials

2.1. Study Design and Participants

This study was conducted using a qualitative inquiry design to explore how patients living with advanced cancer construct meaning in the context of illness, accept the realities and limitations imposed by cancer, and perceive their quality of life during the advanced stage of the disease. The qualitative design was selected because the purpose of the study was not to measure predefined variables statistically, but to gain an in-depth understanding of patients' subjective experiences, interpretations, emotional responses, and coping processes. The study population consisted of adult patients diagnosed with advanced cancer who were receiving oncology or palliative care services in Canada. Participants were recruited through purposive sampling from oncology and palliative care settings in Canada, with attention to variation in age, gender, cancer type, duration since diagnosis, treatment status, and care setting in order to obtain rich and diverse narratives. The final sample included 26 patients living with advanced cancer. Inclusion criteria were being 18 years of age or older, having a confirmed diagnosis of advanced or metastatic cancer, being aware of the diagnosis, having sufficient physical and cognitive ability to participate in an interview, and being able to communicate in English. Patients were excluded if they were experiencing severe physical distress, acute psychiatric instability, cognitive impairment, or clinical deterioration that made participation burdensome or inappropriate. Recruitment continued until data saturation was achieved, meaning that additional interviews no longer produced substantially new concepts, meanings, or thematic insights related to meaning-making, illness acceptance, and quality of life. All participants were informed about the aims and procedures of the study, the voluntary nature of participation, confidentiality of their information, and their right to withdraw from the study at any stage without any effect on their treatment or care

2.2. Measures

Data were collected using a semi-structured interview guide, a demographic and clinical information form, and researcher field notes. The semi-structured interview guide was developed in accordance with the objectives of the study and was designed to elicit detailed descriptions of participants' lived experiences of advanced cancer. The interview questions focused on participants' understanding of their illness, the ways in which they made sense of cancer in relation to their life history and personal values, their experiences of accepting or struggling with the illness, perceived changes in daily life and identity, sources of emotional and existential support, and their interpretation of quality of life while living with advanced cancer. The interview format allowed participants to speak freely and reflectively, while also enabling the researcher to ask follow-up questions and probes when clarification or deeper explanation was needed. Examples of guiding questions included asking participants how they understood the meaning of their illness, what helped or hindered acceptance of their condition, how cancer had changed their relationships and priorities, and what quality of life meant to them at the current stage of illness. The interview guide was reviewed by experts in qualitative health research, psycho-oncology, and palliative care to ensure clarity, relevance, and sensitivity to the clinical condition of the participants. Prior to the main data collection, the guide was pilot-tested with a small number of patients with similar characteristics, and minor revisions were made to improve the wording and flow of the questions.

The demographic and clinical information form was used to collect background information necessary for describing the participants and contextualizing the qualitative findings. This form included items on age, gender, marital status, educational level, employment status, cancer type, time since diagnosis, disease stage, current treatment status, and type of care being received. Clinical information was obtained based on participants' self-report and, where available and ethically permitted, confirmed through the care team or medical documentation. This form was not used for statistical comparison, but rather to support a more comprehensive understanding of the participants' social and clinical contexts. In addition, field notes were recorded by the researcher immediately after each interview. These notes included observations about the interview context, nonverbal expressions, emotional tone, pauses, signs of fatigue or distress, and the researcher's preliminary reflections. Field notes served as a complementary source of data and were used during analysis to enrich interpretation, support reflexivity, and preserve contextual details that were not fully captured in the audio recordings.

2.3. Data Analysis

Data analysis was conducted using thematic analysis. All interviews were audio-recorded with participants' permission and transcribed verbatim. The transcripts were reviewed several times to ensure familiarity with the data and to develop a comprehensive understanding of each participant's narrative. Analysis began with open coding, during which meaningful units related to meaning-making, illness acceptance, emotional adjustment, relational experiences, spiritual or existential reflections, and perceived quality of life were identified and labeled. Codes were then compared across interviews to identify similarities, differences, recurring ideas, and patterns of meaning. Related codes were grouped into broader categories, and categories were subsequently organized into overarching themes that reflected the central dimensions of participants' experiences. The analysis moved continuously between individual transcripts and the entire data set to ensure that the emerging themes remained grounded in participants' accounts.

To enhance the rigor and trustworthiness of the analysis, several strategies were used. Credibility was supported through prolonged engagement with the data, repeated reading of transcripts, peer discussion among the research team, and the use of direct participant narratives to ensure that the themes reflected the experiences expressed in the interviews. Dependability was strengthened by maintaining a clear audit trail of coding decisions, theme development, analytic memos, and revisions made during the research process. Confirmability was addressed through reflexive note-taking, in which the researcher documented assumptions, emotional responses, and interpretive decisions in order to reduce the influence of personal bias. Transferability was supported by providing a detailed description of the study context, participants, recruitment process, and analytic procedures, allowing readers to judge the applicability of the findings to similar clinical and cultural settings. Data collection and analysis were conducted concurrently, and sampling was discontinued when thematic saturation was reached and no new major themes emerged from the interviews.

3. Findings and Results

The findings were derived from semi-structured interviews with 26 patients living with advanced cancer in Canada. Participants ranged in age from 38 to 79 years, with a mean age of 61.7 years. The sample included 15 women and 11 men. In terms of marital status, 17 participants were married or living with a partner, while 9 were single, divorced, separated, or widowed. The participants represented a range of cancer diagnoses, including breast cancer, lung cancer, colorectal cancer, pancreatic cancer, ovarian cancer, prostate cancer, and hematologic malignancies. The time since diagnosis of advanced or metastatic disease ranged from 5 months to 4 years. At the time of the interviews, 18 participants were receiving active palliative oncology treatment, including chemotherapy, immunotherapy, targeted therapy, radiotherapy, or combined treatment approaches, while 8 participants were receiving primarily supportive or palliative care focused on symptom management and quality of life. Participants differed in functional status, symptom burden, family support, and religious or spiritual orientation; however, all were able to participate in an in-depth interview and to describe their experiences of living with advanced cancer. The interviews generated rich narratives about how patients interpreted the meaning of their illness, how they understood and negotiated illness acceptance, and how they redefined quality of life in the context of uncertainty, physical decline, relational dependence, and existential reflection.

Table 1

Thematic structure of meaning-making, illness acceptance, and quality of life among patients living with advanced cancer

Main theme	Subtheme	Core meaning	Manifestation in participants' narratives
Reconstructing meaning in the face of advanced illness	Confronting mortality as a turning point	Advanced cancer forced participants to recognize the limits of time and reconsider what mattered most in life.	Participants described diagnosis and disease progression as moments that interrupted ordinary life and made mortality more immediate, leading to reflection on unfinished goals, relationships, and personal values.
Reconstructing meaning in the face of advanced illness	Searching for coherence in illness experience	Participants attempted to understand why the illness had occurred and how it could be integrated into their life story.	Some participants explained cancer through spiritual, moral, biographical, or existential frameworks, while others accepted that no complete explanation was possible.
Reconstructing meaning in the face of advanced illness	Preserving identity beyond the patient role	Participants tried to maintain a sense of self that was not fully defined by cancer.	Narratives emphasized being a parent, partner, friend, worker, believer, volunteer, or independent person despite the clinical identity imposed by advanced disease.
Negotiating acceptance without surrender	Moving between resistance and accommodation	Acceptance was not described as a single event, but as a fluctuating process involving emotional struggle, adjustment, and partial reconciliation.	Participants moved between fear, anger, sadness, hope, and calm, often accepting some aspects of illness while resisting others.
Negotiating acceptance without surrender	Accepting uncertainty rather than accepting death	Many participants framed acceptance as learning to live with unpredictability rather than giving up on life.	Participants described uncertainty about prognosis, treatment response, symptoms, and future plans, but gradually shifted toward living day by day.
Negotiating acceptance without surrender	Maintaining agency within limitation	Acceptance was strengthened when participants felt they still had choices, dignity, and some control over daily life and care decisions.	Participants valued involvement in treatment decisions, symptom management, family communication, and choices about how to spend their remaining time.
Redefining quality of life in advanced cancer	Quality of life as relief from suffering	Symptom control, reduced pain, sleep, appetite, and physical comfort were central to participants' definitions of quality of life.	Participants often linked quality of life to manageable pain, less fatigue, breathing comfort, mobility, and the ability to rest without distress.
Redefining quality of life in advanced cancer	Quality of life as relational connection	Emotional closeness, family presence, communication, and not feeling abandoned were major sources of well-being.	Participants described meaningful conversations, shared meals, visits, phone calls, and being remembered by loved ones as central to feeling alive and valued.
Redefining quality of life in advanced cancer	Quality of life as dignity and normalcy	Participants valued ordinary routines and being treated as persons rather than only as patients.	Maintaining self-care, privacy, humor, small responsibilities, and familiar daily activities helped participants preserve dignity.
Redefining quality of life in advanced cancer	Quality of life as peace with the present	Participants increasingly defined quality of life through emotional calm, gratitude, acceptance of limits, and appreciation of small moments.	Participants described sitting with family, enjoying nature, prayer, listening to music, or waking without severe pain as meaningful indicators of quality of life.

Table 1 shows that the participants' experiences were organized around three interconnected thematic domains: meaning-making, illness acceptance, and quality of life. These domains were not separate psychological states, but mutually related processes that shaped how patients lived with advanced cancer. Meaning-making helped participants interpret the disruption caused by illness and protect a sense of personal identity. Illness acceptance emerged as a dynamic and incomplete process in which participants learned to accommodate uncertainty while still preserving hope and agency. Quality of life was redefined away from conventional expectations of productivity, independence, and future achievement toward more immediate and relational forms of well-being, such as comfort, dignity, emotional connection, and peace in the present. Across the interviews, patients did not describe advanced cancer only as a biomedical condition; rather, they described it as a profound life event that altered their relationship with the body, time, family, spirituality, autonomy, and the meaning of everyday life.

Table 2

Theme one: Reconstructing meaning in the face of advanced illness

Subtheme	Description of the experience	Interpretive dimension	Illustrative meaning expressed by participants
Confronting mortality as a turning point	Participants described advanced cancer as a moment that made the finitude of life visible and difficult to ignore.	Awareness of limited time became a catalyst for reassessing priorities.	Participants commonly expressed that cancer changed the meaning of time and made them focus more strongly on relationships, forgiveness, unfinished matters, and what they still wished to communicate.
Searching for coherence in illness experience	Participants tried to understand the illness by connecting it to personal history, stress, fate, biology, spirituality, or randomness.	Meaning-making was used to reduce emotional chaos and create narrative order.	Some participants interpreted cancer as part of a spiritual test or life journey, while others emphasized that the disease had no clear reason but still required a response.
Reordering personal values	Participants reported that many previous concerns lost importance after disease progression.	The illness produced a shift from external achievement to emotional, relational, and existential priorities.	Participants described becoming less concerned with material success, social expectations, or minor conflicts and more concerned with love, presence, gratitude, and emotional honesty.
Preserving identity beyond the patient role	Participants resisted being reduced to diagnosis, treatment schedules, and physical decline.	Identity continuity was central to psychological survival.	Participants emphasized that they remained parents, partners, professionals, believers, friends, and individuals with preferences, memories, and values despite being medically categorized as advanced cancer patients.
Making meaning through contribution	Some participants found meaning by helping family members prepare, offering advice, participating in research, or leaving emotional legacies.	Contribution supported dignity and reduced the feeling of helplessness.	Participants described meaning in writing letters, organizing family matters, sharing life lessons, supporting others with cancer, or participating in the study so that their experience might help future patients.
Spiritual and existential reflection	Participants varied in religious belief, but many engaged in spiritual or existential reflection.	Spirituality functioned as a resource for hope, acceptance, continuity, or peace.	Some participants referred to prayer, faith, divine presence, or life after death, whereas others described spirituality as connection with nature, family, memory, or a sense that life still had value.

The first theme, reconstructing meaning in the face of advanced illness, reflected participants' efforts to understand their lives after the disruption of cancer progression. For many patients, the advanced stage of cancer created an intense awareness of mortality and uncertainty, but this awareness did not simply result in despair. Instead, it often initiated a process of reassessment in which participants reconsidered what gave their lives value. Several participants described a movement from future-oriented goals toward present-centered meaning. Long-term plans became less reliable, but everyday experiences became more emotionally significant. Participants frequently spoke about love, reconciliation, gratitude, family communication, spiritual reflection, and leaving something meaningful behind. Meaning-making also involved attempts to preserve continuity of identity. Participants did not want to be seen only as ill, dependent, or dying; they wanted others to recognize the whole person behind the diagnosis. This theme shows that meaning-making among patients with advanced cancer was not necessarily about finding a positive interpretation of illness, but about integrating illness into a broader life narrative without allowing it to erase personal dignity, relationships, values, and selfhood.

Table 3

Theme two: Negotiating acceptance without surrender

Subtheme	Description of the experience	Emotional process	Behavioral or relational expression
Moving between resistance and accommodation	Participants did not describe acceptance as a stable or final state; rather, it changed across days, symptoms, treatment results, and emotional moments.	Acceptance coexisted with fear, anger, sadness, disbelief, and hope.	Participants sometimes felt calm and realistic, but at other times became distressed by scans, pain, functional loss, or conversations about prognosis.
Accepting uncertainty rather than accepting death	Many participants said that they were not ready to "accept death," but they were learning to accept unpredictability.	The central challenge was living without certainty about time, treatment response, and future decline.	Participants avoided rigid planning, focused on short-term goals, and tried to live in smaller time frames such as the current day, week, or treatment cycle.
Distinguishing acceptance from giving up	Participants strongly rejected the idea that acceptance meant passivity or loss of hope.	Acceptance was compatible with treatment, hope, and active participation in care.	Participants continued treatment, sought information, managed symptoms, and made decisions while also acknowledging the seriousness of their condition.

Maintaining agency within limitation	Patients experienced acceptance more positively when they retained some control over care and daily life.	Agency reduced helplessness and supported dignity.	Participants valued choosing visitors, food, activities, treatment preferences, place of care, communication boundaries, and how openly to discuss illness with family.
Protecting family while needing support	Acceptance was shaped by family relationships, including the desire to avoid burdening loved ones.	Participants balanced honesty, emotional protection, dependence, and fear of causing distress.	Some participants minimized symptoms to protect family members, while others found acceptance easier when they could speak openly with loved ones.
Preparing practically and emotionally	Acceptance often included practical preparation, although this was emotionally difficult.	Preparation helped participants feel responsible and less anxious, but also made disease progression feel more real.	Participants discussed wills, care preferences, funeral wishes, memory-making, family finances, or conversations with children and partners.

The second theme, negotiating acceptance without surrender, demonstrated that illness acceptance was complex, unstable, and deeply personal. Participants rarely described acceptance as a complete emotional resolution. Instead, acceptance appeared as a process of repeatedly adjusting to new information, new symptoms, and changing levels of physical ability. A central finding was that participants distinguished acceptance from giving up. They often accepted that the illness was serious and that the future was uncertain, but they did not interpret this as abandoning treatment, hope, or personal agency. This distinction was important because many participants associated “giving up” with emotional defeat, whereas acceptance was described as a way of conserving energy, reducing conflict with reality, and focusing on what could still be lived meaningfully. Acceptance was also relational. Some participants found it difficult to accept the illness because they worried about the suffering of spouses, children, or parents. Others reported that acceptance became easier when family members allowed honest discussion rather than forcing constant optimism. This theme indicates that acceptance in advanced cancer should be understood not as resignation, but as an active psychological and relational negotiation between realism, hope, autonomy, preparation, and emotional protection.

Table 4

Theme three: Redefining quality of life in advanced cancer

Subtheme	Description of the experience	Meaning for quality of life	Examples of quality-of-life indicators described by participants
Relief from physical suffering	Participants placed strong emphasis on symptom control and physical comfort.	Quality of life was closely connected to the ability to live without overwhelming pain, fatigue, nausea, breathlessness, or insomnia.	Having a day with manageable pain, being able to sleep, eating a small meal, walking short distances, breathing comfortably, or sitting without severe discomfort.
Preserving dignity and self-respect	Participants valued being treated as persons rather than as fragile bodies or clinical cases.	Quality of life required privacy, respect, emotional recognition, and participation in decisions.	Being spoken to directly, having choices explained, maintaining hygiene, choosing clothing, preserving modesty, and not being infantilized.
Maintaining normalcy in daily life	Ordinary routines became meaningful because they protected continuity and reduced the dominance of illness.	Quality of life was experienced through familiar activities that made life feel recognizable.	Making tea, watching television with family, reading, gardening, going outside, preparing a simple meal, or keeping a small household responsibility.
Relational closeness and emotional presence	Participants described relationships as one of the strongest sources of well-being.	Quality of life was not defined only by physical function, but by feeling loved, remembered, and emotionally accompanied.	Conversations with family, visits from friends, physical touch, shared silence, laughter, phone calls, and being included in family decisions.
Freedom from being a burden	Many participants were distressed by dependence and the possibility of burdening family members.	Quality of life decreased when patients felt they were causing exhaustion, financial pressure, or emotional suffering for others.	Worrying about caregivers, apologizing for needing help, avoiding requests, or feeling relief when professional support reduced pressure on family.
Peace, gratitude, and present-focused living	Participants increasingly evaluated quality of life through moments of emotional calm and appreciation.	Quality of life was redefined as the ability to experience peace despite disease.	Enjoying sunlight, music, prayer, nature, grandchildren, humor, memories, or a day without bad news.

The third theme, redefining quality of life in advanced cancer, showed that participants’ understanding of quality of life became more immediate, relational, embodied, and existential as the illness progressed. Participants did not define quality of life only in terms of survival or treatment response. Although they valued medical treatment, they repeatedly emphasized that life quality depended on whether they could experience comfort, dignity, connection, and some degree of normalcy. Physical symptoms were highly influential, particularly pain, fatigue, nausea, breathlessness, poor sleep, and loss of appetite. However, the findings also showed that physical comfort alone was not sufficient. Participants described quality of life as being treated with respect, having choices, preserving privacy, remaining emotionally connected to loved ones, and continuing ordinary routines that affirmed personhood. The fear of becoming a burden was one of the most emotionally difficult aspects of reduced quality of life. At the same time, many participants reported that small moments became more meaningful than before the illness. A peaceful morning, a conversation with a loved one, a visit from grandchildren, a day without severe pain, or the ability to sit outdoors could become powerful indicators of quality of life. This theme demonstrates that, for patients living with advanced cancer, quality of life was not necessarily dependent on the restoration of previous functioning, but on the preservation of comfort, dignity, relational belonging, and meaningful presence within the limits imposed by illness.

Figure 1

Integrative model of meaning-making, illness acceptance, and quality of life among patients living with advanced cancer

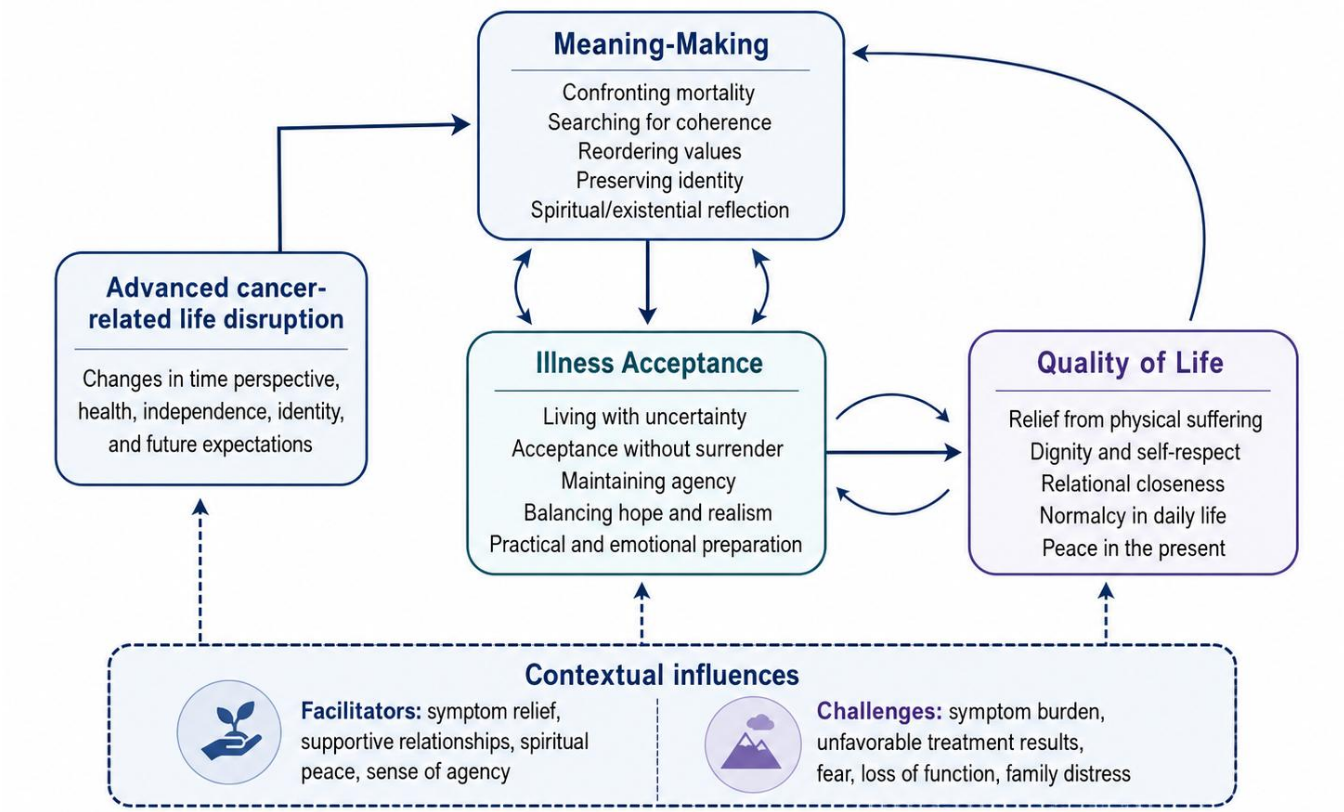

Figure 1 illustrates the interpretive relationship among the three major themes identified in the study. The model shows that advanced cancer created a central disruption in participants' lives by altering their assumptions about time, health, independence, identity, and the future. In response to this disruption, participants engaged in meaning-making processes that helped them reinterpret their lives, identify what remained valuable, and preserve continuity of self. These meaning-making processes supported illness acceptance, particularly when acceptance was understood as living with uncertainty rather than surrendering to death. Acceptance, in turn, influenced how participants evaluated quality of life by shifting attention from cure, productivity, and long-term planning toward comfort, dignity, emotional connection, autonomy, and peace in the present. The relationship among the themes was reciprocal rather than linear. When symptoms worsened or treatment results were unfavorable, acceptance could become more difficult and meaning could feel threatened. Conversely, when participants experienced supportive relationships, symptom relief, spiritual peace, or a sense of agency, they were more able to accept uncertainty and perceive their lives as meaningful despite advanced illness. The figure therefore presents quality of life not as an isolated outcome, but as an experience shaped by the interaction between existential interpretation, emotional adjustment, bodily suffering, relational support, and preserved dignity.

Overall, the findings indicate that patients living with advanced cancer experience meaning-making, illness acceptance, and quality of life as interconnected and evolving processes. Advanced cancer was described as a condition that disrupted the body and the future, but also intensified reflection on values, relationships, identity, and the meaning of remaining time. Participants did not experience acceptance as simple resignation; instead, they negotiated acceptance while continuing to hope, make decisions, protect family members, and preserve agency. Quality of life was redefined through the realities of advanced illness and became increasingly associated with comfort, dignity, normalcy, emotional closeness, spiritual or existential peace, and freedom from overwhelming suffering. These findings highlight the importance of understanding advanced cancer not only through clinical indicators, but also through the subjective and relational meanings that patients attach to illness, living, dying, and the preservation of personhood.

4. Discussion

The present qualitative inquiry explored how patients living with advanced cancer in Canada experienced meaning-making, illness acceptance, and quality of life. The findings showed that advanced cancer was not experienced only as a medical diagnosis or a stage of disease progression, but as a profound life disruption that affected participants' understanding of time, identity, autonomy, family relationships, bodily integrity, and future expectations. Three main themes were identified: reconstructing meaning in the face of advanced illness, negotiating acceptance without surrender, and redefining quality of life in advanced cancer. Across these themes, participants described advanced cancer as an experience that forced them to confront mortality while simultaneously searching for ways to preserve dignity, maintain agency, remain emotionally connected to others, and live meaningfully within the limits imposed by illness. These findings support the view that palliative oncology should not be limited to symptom control or end-of-life planning, but should also address existential, relational, psychological, and value-based dimensions of care (Strang, 2022).

The first major finding was that participants engaged in active meaning-making after the disruption caused by advanced cancer. Diagnosis and progression forced them to reconsider what mattered most, reinterpret their life story, and protect a sense of identity beyond the patient role. This finding is consistent with evidence showing that serious illness often changes patients' understanding of quality of life and requires clinicians to attend to patients' subjective interpretations rather than relying only on biomedical indicators (Matsumura et al., 2020). Patients in the present study did not necessarily describe meaning-making as finding a positive explanation for cancer; rather, they described it as a process of creating coherence, preserving personal identity, and identifying what remained valuable despite uncertainty. This aligns with research indicating that illness mindsets are associated with health-related quality of life among individuals affected by cancer, suggesting that how patients interpret illness may influence their emotional adjustment and well-being (Zeidman et al., 2022). The finding also corresponds with the broader palliative care literature, which emphasizes the importance of supporting patients' emotional, spiritual, and existential needs alongside physical care (Manjunath et al., 2025; Syarifudin & Soares, 2022).

The second important finding was that illness acceptance was experienced as a dynamic process rather than a fixed psychological state. Participants frequently moved between fear, sadness, hope, resistance, accommodation, and partial reconciliation. They strongly distinguished acceptance from giving up, explaining that accepting the seriousness of illness did not mean abandoning treatment, dignity, hope, or personal agency. This finding is consistent with studies emphasizing the complexity of prognostic awareness and quality of life in advanced cancer, where realistic understanding of illness may support planning and communication but can also create psychological distress when patients do not receive adequate emotional support (Vlčková et al., 2021). It also aligns with evidence showing that stress, depression, and coping strategies are central issues among terminally ill patients with cancer, because patients must manage fear, uncertainty, physical decline, and relational concerns while trying to maintain psychological balance (Vaiphei, 2021). In this sense, acceptance in advanced cancer should be understood as an active and fluctuating adjustment process, not as resignation.

The finding that participants accepted uncertainty more readily than death itself is particularly important. Many participants described living day by day, focusing on small achievable goals, and avoiding rigid future planning because treatment outcomes and disease progression were unpredictable. This pattern is consistent with recent research showing that advanced cancer care often involves uncertain transitions between active treatment, palliative support, and end-of-life care (Stout et al., 2023; Wong et al., 2024). In modern oncology, patients may continue receiving chemotherapy, immunotherapy, radiotherapy, targeted therapy, or other interventions even while facing incurable illness, which can make acceptance more complex. Evidence on palliative care consultations among patients undergoing aggressive oncological procedures also demonstrates that palliative needs and disease-directed treatment can coexist rather than represent opposite care pathways (Rodriguez et al., 2021). Similarly, end-of-life care practices in tertiary cancer centers show that clinical decisions are often shaped by treatment culture, institutional routines, and communication patterns, which may affect how patients understand their illness and prepare for the future (Maurya et al., 2024).

The third major finding was that participants redefined quality of life in immediate, embodied, relational, and existential terms. They described quality of life less as cure, productivity, or long-term independence and more as relief from suffering, dignity, emotional closeness, normalcy, and peace in the present. This finding is supported by studies showing that symptom clusters among terminally ill patients with cancer influence prognosis and quality of life, particularly when pain, fatigue, appetite disturbance, dyspnea, and other symptoms occur together (Koyama et al., 2021). It is also consistent with research on patients with metastatic spinal cord compression secondary to lung cancer, which highlights the importance of assessing health-related quality of life in advanced disease because functional impairment and treatment burden can deeply affect patients' well-being (Fu et al., 2023). Participants in the present study often described a "good day" as one with manageable pain, rest, family presence, and emotional calm, confirming that advanced cancer quality of life must be interpreted through patients' own standards and priorities.

The emphasis on dignity and personhood in the findings is also consistent with studies showing that specific clinical decisions and care practices can affect comfort, quality of death, and the patient's sense of dignity. For example, research on urinary catheterization in patients with advanced cancer indicates that even routine clinical interventions may influence the quality of dying and patients' comfort in palliative settings (Higashibata et al., 2022). Studies of palliative radiotherapy patients similarly show that individuals receiving symptom-focused treatment often remain physically vulnerable and require care that protects comfort and dignity (Devi et al., 2023). The present findings extend this literature by showing that dignity was not limited to medical procedures; it was also reflected in communication, privacy, decision-making, being treated as a whole person, and maintaining small routines that preserved identity.

Relational connection emerged as one of the strongest components of quality of life. Participants described family presence, honest communication, shared memories, and emotional support as central to living meaningfully with advanced cancer. This finding is consistent with qualitative evidence showing that patients with advanced cancer and informal caregivers share essential concerns about communication, coordination, support, and care that respects what matters most to the patient and family (Roij et al., 2021). It also corresponds with systematic review findings on metastatic spinal cancer family caregivers, which demonstrate that caregivers often have substantial emotional, practical, and informational needs at home (Kardosod et al., 2023). The findings further align with studies of metastatic prostate cancer showing that patient quality of life and caregiver burden are closely related and influenced by clinical and socioeconomic factors (Yıldırım et al., 2021a, 2021b). Therefore, patient quality of life in advanced cancer should be viewed as relationally embedded rather than individually isolated.

The participants' fear of becoming a burden was another important finding. Several participants worried that their physical decline, dependence, or care needs would exhaust family members or cause emotional distress. This concern may help explain why some advanced cancer patients delay asking for help, minimize symptoms, or avoid difficult conversations. Research on emergency department visits among advanced cancer patients receiving palliative care suggests that inadequate symptom control, home support limitations, and caregiver strain may contribute to acute care use (Dumnui et al., 2022). Studies identifying palliative home care needs among patients with advanced cancer similarly emphasize that home-based care requires attention to symptom management, psychological support, family needs, and service continuity (Liu et al., 2025). The present study supports these findings by showing that patients' perception of quality of life is influenced not only by their own suffering, but also by how they believe their illness affects those around them.

Communication and knowledge transfer were also implicit across the findings. Participants' ability to make meaning, accept uncertainty, and preserve agency depended partly on whether they understood their illness, treatment options, and care trajectory. This aligns with research showing that knowledge gaps between patients and clinicians at the end of life may affect decision-making, expectations, and care experiences (Heuser et al., 2025). It is also consistent with clinical oncology nursing literature emphasizing the importance of best practices in palliative care and end-of-life conversations (Spine, 2022). Participants in the present study valued honest communication, but they also needed such communication to be emotionally sensitive and paced according to their readiness. This suggests that information alone is insufficient; communication must also support dignity, hope, relational preparation, and psychological safety.

The findings also highlight the importance of timely palliative care referral and integration. Participants' narratives showed that meaning-making, acceptance, and quality of life were shaped by symptom relief, care coordination, treatment decisions, and opportunities for advance care planning. This is consistent with research showing that advance care planning can influence hospice utilization among patients with cancer (Kim et al., 2025). It is also supported by studies on palliative care referral patterns, including breast cancer referrals in resource-limited settings and palliative care access challenges among patients with advanced cervical cancer in low- and middle-income countries (Agodirin et al., 2022; Ooko et al., 2023). Although the present study was conducted in Canada, the findings indicate that access to palliative care is not merely a structural issue; it is also a matter of whether patients receive support early enough to address existential distress, family communication, and personal definitions of quality of life.

The role of care setting is also relevant. Some patients with advanced cancer experience palliative needs in intensive care units, emergency departments, or highly specialized oncology environments, where the focus on disease management may delay attention to meaning, acceptance, and quality of life. Studies of oncological patients in intensive care units show that palliative care is often introduced during severe clinical deterioration (Meneguetti et al., 2022). Research on brain metastases referred to palliative care similarly indicates that patients may have complex neurological, functional, and psychosocial needs requiring specialized support (Harrison et al., 2024). In critical care environments, the identification of palliative care needs can be difficult, especially when clinicians and families are still oriented toward intensive intervention (Astuti et al., 2024). The present study contributes to this literature by emphasizing that patients' inner experiences of acceptance and meaning may begin long before the final phase of illness and should therefore be addressed earlier in the care trajectory.

The findings also have implications for assessing quality of life. Electronic patient-reported outcome measures have become increasingly important tools for assessing health-related quality of life among patients with breast and gynecologic cancers (Boutib et al., 2024). However, the present qualitative findings suggest that standardized tools may not fully capture how patients redefine quality of life through dignity, relational closeness, peace, and preserved identity. Research on physical activity programs for medically underserved breast cancer survivors with metastatic disease also indicates that supportive interventions may help preserve function and well-being among patients living with advanced disease (Lee et al., 2024). In addition, telemedicine approaches to rural palliative care may improve access to supportive services for advanced cancer patients when geographic barriers exist (Sánchez-Cárdenas et al., 2022). These studies support the need for flexible, patient-centered assessment and intervention models that combine symptom monitoring with deeper exploration of values, meaning, acceptance, and relational needs.

5. Conclusion

Finally, the findings support an integrated conceptual understanding of advanced cancer experience. Meaning-making, illness acceptance, and quality of life were reciprocal rather than linear. When participants experienced symptom relief, supportive relationships, spiritual peace, and agency, they were more able to accept uncertainty and perceive life as meaningful. Conversely, when symptom burden, unfavorable treatment results, fear, loss of function, or family distress intensified, meaning and acceptance became more difficult. This reciprocal pattern aligns with the broader literature showing that advanced cancer care is shaped by clinical, psychological, relational, socioeconomic, and system-level factors (García et al., 2021; Min et al., 2021). The study therefore adds to existing evidence by showing that quality of life in advanced cancer is not simply an outcome of medical care, but an evolving experience constructed through the interaction of bodily comfort, existential interpretation, emotional adjustment, family relationships, and preserved dignity.

6. Limitations & Suggestions

The present study has several limitations. First, because this was a qualitative study with 26 participants recruited from oncology and palliative care settings in Canada, the findings should not be interpreted as statistically generalizable to all patients with advanced cancer. Participants who were physically and cognitively able to take part in interviews may have differed from patients with more severe deterioration, uncontrolled symptoms, communication difficulties, or acute psychological distress. Second, the study relied on self-reported narratives, which may have been influenced by memory, emotional readiness, social desirability, or participants' desire to protect family members or present themselves as coping well. Third, although variation in age, gender, cancer type, treatment status, and care setting was considered during recruitment, the sample may not fully represent the cultural, linguistic, socioeconomic, Indigenous, immigrant, rural, and medically underserved diversity of patients living with advanced cancer in Canada. Fourth, because interviews captured experiences at one point in time, the study could not fully document how meaning-making, acceptance, and quality of life change across disease progression, treatment transitions, hospice referral, or the final days of life.

Future research should examine meaning-making, illness acceptance, and quality of life through longitudinal qualitative designs that follow patients across different phases of advanced cancer, from diagnosis of metastatic disease to treatment transitions, palliative care involvement, home-based care, hospice care, and end-of-life decision-making. Future studies should also include more diverse populations, particularly patients from rural communities, minority cultural and linguistic groups, Indigenous communities, younger adults with advanced cancer, patients living alone, and those with limited family support or limited access to palliative services. Mixed-methods studies may be useful for combining qualitative narratives with patient-reported outcome measures, symptom scales, caregiver burden measures, and clinical indicators. Additional research should also explore dyadic perspectives by interviewing both patients and family caregivers, because acceptance, meaning, and quality of life are often relationally constructed. Intervention studies are needed to evaluate meaning-centered, dignity-conserving, spiritually sensitive, and communication-based approaches designed to support patients' agency, emotional preparation, and quality of life in advanced cancer.

In practice, the findings suggest that clinicians should approach advanced cancer care through a holistic and person-centered framework that addresses not only symptoms and treatment options, but also patients' values, fears, sources of meaning, family concerns, and definitions of quality of life. Health care professionals should avoid equating acceptance with giving up and should instead support patients in balancing hope and realism while preserving dignity and agency. Routine care should include sensitive conversations about what matters most to the patient, what makes life feel meaningful, what forms of suffering are most difficult, and what kinds of support would help the patient live as well as possible. Palliative care should be introduced early and framed as supportive care that can coexist with active treatment. Clinicians should also recognize the emotional burden of dependence and provide support for both patients and caregivers, including symptom management, family meetings, psychosocial care, spiritual care when desired, and practical planning. Such practices can help patients living with advanced cancer experience care that respects their personhood, supports acceptance without surrender, and promotes quality of life within the realities of serious illness.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed to this article.

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