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Original Article

Exploring cancer patients' experiences of end-of-life care in hospital settings: A qualitative

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Abstract

Background: Cancer patients in the advanced stages of illness often receive end-of-life care in hospital settings where intensive medical interventions, complex decision-making, and limited family involvement may influence their physical, emotional, and existential experiences. Hospital-based end-of-life care presents unique challenges, particularly in contexts where palliative care integration is limited and care delivery is shaped by institutional priorities. Understanding patients' lived experiences is essential to inform patient-centered and dignity-preserving end-of-life care practices.
Objective: This study aimed to explore cancer patients' experiences of end-of-life care in hospital settings.
Methods: A qualitative phenomenological design was employed to capture the lived experiences of adult cancer patients receiving end-of-life care in hospital settings in Africa. Purposive sampling was used to recruit participants who met the inclusion criteria. Data were collected through in-depth semi-structured interviews and analyzed using thematic analysis. Strategies to ensure trustworthiness included member checking, reflexive journaling, peer debriefing, and the development of an audit trail.
Results: Three main themes emerged from the analysis: experiencing physical and emotional vulnerability at the end of life, navigating relationships and communication in hospital-based end-of-life care, and seeking dignity and meaning during the final stage of life. Participants described persistent physical symptoms and emotional distress as central aspects of their end-of-life experiences. Limited communication and dependence on healthcare professionals shaped patients' sense of control and security. Participants also emphasized the importance of dignity, respectful care, and opportunities for reflection on life and death during hospitalization.
Conclusion: Cancer patients experience end-of-life care in hospital settings as a complex and deeply personal process influenced by symptom burden, communication quality, family involvement, and dignity-preserving practices. Hospital-based end-of-life care should prioritize holistic, patient-centered approaches that address physical, emotional, and existential needs.

Background

Cancer patients in advanced stages often experience complex physical, psychological, and existential challenges during end-of-life care within hospital settings, particularly when intensive medical interventions dominate the final phase of life (Rodenbach et al., 2021). Hospital-based end-of-life care frequently prioritizes life-prolonging treatments over comfort-oriented approaches, especially in emergency and acute care units, which can increase patient distress near death (Kim et al., 2022). The COVID-19 pandemic further intensified these challenges by disrupting communication, visitation, and continuity of palliative services for hospitalized cancer patients (Shin et al., 2022). Healthcare systems during the pandemic often implemented restrictive policies that altered traditional end-of-life care practices and limited family involvement at the bedside (Connolly et al., 2022). These systemic changes shaped how patients perceived dignity, comfort, and meaning during the dying process in hospitals (Kyota & Kanda, 2021).

Patients' subjective experiences of death and dying play a central role in shaping their understanding of illness, treatment preferences, and emotional preparedness at the end of life (Kim, 2021). Qualitative studies have shown that terminal cancer patients often interpret end-of-life care through personal values related to autonomy, hope, and dignity within hospital environments (Kyota & Kanda, 2021). Patients' perceptions of life and death are influenced by clinical encounters, symptom burden, and communication with healthcare professionals during hospitalization (Kyota et al., 2023). Inadequate alignment between patient values and hospital-based care practices may lead to emotional suffering and unmet end-of-life needs (Nedjat-Haiem et al., 2020). Understanding these lived experiences is essential to improve person-centered end-of-life care delivery in hospitals (Koh et al., 2024).

Family involvement constitutes a critical component of end-of-life care experiences for cancer patients in hospital settings, particularly during decision-making and emotional support processes (Xu et al., 2024). Family caregivers frequently encounter psychological distress and caregiving burden when end-of-life care occurs in acute hospital environments rather than at home or in hospice settings (Oh & Kim, 2023). Bereaved families often report dissatisfaction with communication quality and emotional support during the terminal hospitalization of cancer patients (Jeon, 2022). Limited opportunities for meaningful interaction between patients and families during hospitalization can negatively affect the quality of death and subsequent bereavement adaptation (Heo & Kwon, 2019). These experiences highlight the interconnectedness between patient experiences, family well-being, and hospital end-of-life care practices (Giorgali, 2022).

Healthcare professionals also face significant challenges in providing holistic end-of-life care to cancer patients within hospital settings, particularly during periods of high clinical demand (Kim et al., 2021). Nurses frequently report difficulties balancing technical care, emotional support, and ethical decision-making during end-of-life situations in hospitals (Yeo, 2020). The COVID-19 pandemic exacerbated moral distress among healthcare providers by limiting time, resources, and interpersonal communication with dying patients and families (Kim & Lim, 2023). These professional constraints may unintentionally reduce the quality of patient-centered end-of-life care experiences (Cheruku et al., 2022). Examining patient experiences offers valuable insight into how institutional conditions influence end-of-life care delivery (Connolly et al., 2022).

Bereavement outcomes among families are closely linked to the quality of end-of-life care and communication experienced by patients during hospitalization (Pearce et al., 2021). Families often experience prolonged grief when end-of-life care lacks emotional presence, clear communication, and compassionate support (Wallace et al., 2020). Hospital-based bereavement care remains inconsistently implemented, particularly during public health crises such as the COVID-19 pandemic (Morris et al., 2020). International evidence indicates that inadequate end-of-life experiences contribute to complicated grief and dissatisfaction with healthcare systems (Giorgali, 2022). These findings emphasize the importance of understanding patient-centered end-of-life experiences as a foundation for improving bereavement outcomes (Pearce et al., 2021).

Despite growing international literature on end-of-life care, limited qualitative research has focused specifically on cancer patients' lived experiences of end-of-life care within hospital settings (Kyota & Kanda, 2021). Existing studies predominantly emphasize clinical outcomes, healthcare utilization, or family perspectives rather than patients' own narratives (Slotman et al., 2024). A deeper exploration of cancer patients' subjective experiences can illuminate gaps between institutional care practices and patients' end-of-life expectations (Rodenbach et al., 2021). Understanding these experiences is crucial to inform compassionate, ethical, and patient-centered hospital end-of-life care models (Nedjat-Haiem et al., 2020).

Therefore, this study aims to explore cancer patients' experiences of end-of-life care in hospital settings using a qualitative approach.

Methods

Study Design

This study employed a qualitative research design using a phenomenological approach to explore cancer patients' lived experiences of end-of-life care in hospital settings. A qualitative design was selected to allow in-depth exploration of subjective meanings, personal interpretations, and emotional experiences that cannot be adequately captured through quantitative methods. The phenomenological approach was chosen because it focuses on understanding how individuals perceive and make sense of their experiences during critical life events, particularly the end-of-life phase. This design enabled the researchers to examine the essence of patients' experiences within the context of hospital-based care. The study was conducted in hospital settings in Africa, where end-of-life care practices are shaped by clinical, cultural, and systemic factors. The reporting of this study adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) to ensure methodological rigor and transparency.

Participants

Participants were adult cancer patients receiving end-of-life care in hospital settings at the time of data collection. A purposive sampling strategy was used to recruit participants who were able to provide rich and relevant information related to the research phenomenon. Inclusion criteria consisted of patients aged 18 years or older, diagnosed with advanced or terminal cancer, receiving inpatient hospital care, and cognitively capable of participating in an interview. Participants were required to have sufficient physical and emotional stability to engage in conversations about their experiences. Exclusion criteria included patients with severe cognitive impairment, acute medical instability, or inability to communicate verbally. Sampling continued until data saturation was achieved, indicated by repetition of themes and no emergence of new meaningful insights.

Data Collection

Data were collected through in-depth, semi-structured individual interviews to capture participants' experiences, perceptions, and emotions related to end-of-life care. An interview guide was developed based on the study objectives and refined through expert discussion to ensure clarity and sensitivity. Interviews were conducted in a private hospital setting to ensure confidentiality and participant comfort. Each interview was conducted by a trained qualitative researcher with experience in sensitive health-related interviews. Interviews were audio-recorded with participants' consent and lasted approximately 45–60 minutes, depending on participants' condition and willingness to continue. Field notes were taken during and after interviews to document non-verbal cues, emotional expressions, and contextual observations that enriched data interpretation.

Data Analysis

Data analysis was conducted using a thematic analysis approach to systematically identify patterns and meanings within the data. Audio-recorded interviews were transcribed verbatim, and transcripts were reviewed repeatedly to ensure accuracy and familiarity with the data. The analysis followed a stepwise process consisting of data immersion, initial coding, categorization, and theme development. Codes were generated inductively from the data rather than being pre-determined. Similar codes were grouped into categories, which were then refined into overarching themes representing participants' experiences. The research team engaged in regular analytic discussions to compare interpretations and resolve discrepancies. This iterative analytic process allowed continuous refinement of themes until a coherent and comprehensive understanding of the phenomenon was achieved.

Trustworthiness

Trustworthiness of the study was ensured through strategies addressing credibility, dependability, confirmability, and transferability. Credibility was enhanced by prolonged engagement with participants, in-depth interviews, and member checking, whereby participants were given opportunities to clarify or confirm key interpretations. Dependability was supported through detailed documentation of the research process and analytic decisions, creating an audit trail. Confirmability was maintained by reflexive journaling to minimize researcher bias and ensure findings were grounded in participants' narratives. Transferability was supported by providing rich descriptions of the research context, participant characteristics, and study procedures, allowing readers to assess applicability to other settings.

Ethical Consideration

Ethical approval for the study was obtained from the appropriate institutional ethics committee prior to data collection. All participants received detailed information about the study purpose, procedures, potential risks, and benefits before participation. Written informed consent was obtained from each participant. Participants were assured of confidentiality, anonymity, and the voluntary nature of participation, with the right to withdraw at any time without consequences. Emotional support was made available during interviews, and interviews were paused or terminated if participants experienced distress. All data were securely stored and accessible only to the research team to protect participants' privacy and dignity.

Results

A total of 18 cancer patients receiving end-of-life care in hospital settings participated in this study. Participants were recruited from inpatient wards providing palliative and end-of-life services. The age of participants ranged from 34 to 78 years, with a mean age of 56.4 years. The sample included 10 male and 8 female participants. Most participants were diagnosed with advanced-stage solid tumors, including gastrointestinal, breast, lung, and gynecological cancers. The duration since cancer diagnosis ranged from 6 months to more than 5 years, reflecting varied illness trajectories. At the time of interview, all participants were receiving hospital-based end-of-life care, including symptom management, supportive care, and decision-focused treatment discussions (Table 1).

The participant profile demonstrates a diverse representation of adult cancer patients experiencing end-of-life care in hospital settings. The predominance of participants in advanced and terminal stages highlights the relevance of exploring end-of-life experiences within acute care environments. A balanced gender distribution and varied cancer diagnoses provide a broad perspective on patient experiences across different illness trajectories. The extended duration since diagnosis among several participants suggests prolonged engagement with healthcare systems prior to entering the end-of-life phase. Hospitalization reasons centered mainly on symptom control and disease-related complications, emphasizing the clinical complexity faced by patients at the end of life.

Table 1. Sociodemographic and Clinical Characteristics of Participants (n = 18)

Characteristics	n	%
Age (years)		
30–39	2	11.1
40–49	4	22.2
50–59	5	27.8
60–69	4	22.2
≥70	3	16.7
Gender		
Male	10	55.6
Female	8	44.4
Marital status		
Married	13	72.2
Single/Widowed/Divorced	5	27.8
Cancer type		
Gastrointestinal cancer	5	27.8
Lung cancer	4	22.2
Breast cancer	4	22.2
Gynecological cancer	3	16.7
Other solid tumors	2	11.1
Stage of cancer		
Advanced (Stage III)	6	33.3
Terminal (Stage IV)	12	66.7
Time since diagnosis		
< 1 year	5	27.8
1–3 years	7	38.9
> 3 years	6	33.3
Primary reason for hospitalization		
Symptom management	9	50.0
Disease progression complications	6	33.3
End-of-life decision making	3	16.7

These characteristics establish a contextual foundation for understanding the experiential themes that emerged from the qualitative analysis.

Theme 1: Experiencing Physical and Emotional Vulnerability at the End of Life

This theme captures participants' experiences of profound physical decline accompanied by emotional distress during hospital-based end-of-life care. Participants described the hospital as a space where bodily suffering and emotional vulnerability intensified simultaneously. The experience of advanced illness made participants feel increasingly dependent and exposed, both physically and psychologically. Hospitalization at the end of life often amplified awareness of bodily limitations and the proximity of death. Participants expressed that physical suffering was inseparable from emotional distress, creating a cumulative sense of vulnerability. This theme reflects how end-of-life hospitalization shaped participants' lived experiences through intertwined physical and emotional challenges.

Table 2. Themes and Subthemes Derived from Qualitative Analysis

Theme	Subthemes
Theme 1: Experiencing Physical and Emotional Vulnerability at the End of Life	1. Persistent physical suffering and symptom burden 2. Emotional distress and fear related to dying in hospital
Theme 2: Navigating Relationships and Communication in Hospital-Based End-of-Life Care	1. Limited communication and understanding of care decisions 2. Dependence on healthcare professionals for guidance and reassurance
Theme 3: Seeking Dignity and Meaning During the Final Stage of Life	1.Desire for dignity, respect, and comfort in hospital care2 2.. Reflection on life, death, and unfinished personal matters

Subtheme 1.1: Persistent physical suffering and symptom burden

Participants described persistent pain, breathlessness, fatigue, and loss of bodily control as dominant features of their end-of-life experience in the hospital. Many participants reported that symptoms were present continuously despite medical interventions, leading to exhaustion and frustration. Physical discomfort often disrupted sleep, mobility, and the ability to engage in meaningful activities. Participants perceived their bodies as increasingly fragile and unresponsive, which reinforced feelings of helplessness. One participant stated, *"My body feels weaker every day, and even simple movements are painful here in the hospital" (P7).* Another participant expressed, *"No matter how many medicines they give, the pain always comes back, especially at night" (P12).*

Subtheme 1.2: Emotional distress and fear related to dying in hospital

Alongside physical symptoms, participants reported intense emotional distress characterized by fear, anxiety, and sadness. Many participants expressed fear of dying alone or dying in an unfamiliar clinical environment. Hospital routines, alarms, and frequent medical procedures heightened participants' awareness of mortality. Emotional distress was often exacerbated by uncertainty about disease progression and prognosis. One participant shared, *"I am afraid that I will die here without my family beside me" (P3).* Another participant reflected, *"Being in this hospital makes me think about death all the time" (P15).*

Theme 2: Navigating Relationships and Communication in Hospital-Based End-of-Life Care

This theme reflects participants' experiences of interpersonal relationships and communication within hospital-based end-of-life care. Participants described complex interactions with healthcare professionals that shaped their understanding of care decisions and emotional security. Communication processes influenced how participants perceived control, trust, and reassurance during the end-of-life phase. Participants often relied heavily on healthcare providers for information and emotional guidance. However, inconsistent communication sometimes contributed to confusion and distress. This theme illustrates how relational dynamics within hospitals shaped participants' end-of-life experiences.

Subtheme 2.1: Limited communication and understanding of care decisions

Participants reported difficulties in fully understanding medical information and treatment decisions related to their end-of-life care. Medical explanations were often perceived as rushed, technical, or unclear. Some participants felt excluded from decision-making processes due to time constraints or clinical priorities. Limited communication contributed to feelings of uncertainty and loss of control. One participant explained, *"The doctors talk fast, and I don't always understand what they decide for me" (P9).* Another participant stated, *"Sometimes decisions are made without asking how I feel about them" (P6).*

Subtheme 2.2: Dependence on healthcare professionals for guidance and reassurance

Despite communication challenges, participants described strong dependence on healthcare professionals for emotional reassurance and guidance. Nurses and doctors were viewed as central figures who provided comfort, explanations, and a sense of safety. Participants expressed trust in healthcare professionals, especially when they demonstrated empathy and presence. Emotional support from staff helped participants cope with fear and uncertainty. One participant noted, *"When the nurse sits and listens to me, I feel calmer" (P2).* Another participant shared, *"I rely on the doctors because they are the ones who understand what is happening to my body" (P11).*

Theme 3: Seeking Dignity and Meaning During the Final Stage of Life

This theme describes participants' efforts to preserve dignity and find meaning while facing the end of life in hospital settings. Participants reflected on personal values, life achievements, and unfinished matters. Hospital-based care influenced how participants experienced dignity, respect, and personal identity. Participants expressed a desire to be treated as individuals rather than as medical cases. Reflections on life and death emerged as participants confronted mortality. This theme highlights the existential dimension of end-of-life experiences within institutional care.

Subtheme 3.1: Desire for dignity, respect, and comfort in hospital care

Participants emphasized the importance of being treated with respect and dignity during end-of-life care. Simple acts such as privacy, gentle communication, and respectful handling were perceived as meaningful. Participants expressed discomfort when care felt impersonal or rushed. Maintaining dignity was closely linked to feeling valued as a person. One participant stated, *"I want them to see me as a human being, not just as a patient" (P5).* Another participant expressed, *"Comfort and respect matter more to me now than treatment" (P14).*

Subtheme 3.2: Reflection on life, death, and unfinished personal matters

Participants engaged in deep reflection about their lives, relationships, and unresolved personal issues. Many participants expressed a desire to reconcile with family members or complete unfinished responsibilities. Hospitalization created moments of introspection about legacy and meaning. Participants described a need for peace and acceptance as death approached. One participant reflected, *"I think about my life and what I leave behind for my children" (P8).* Another participant shared, *"I want to find peace before I go" (P17).*

Discussion

This study revealed that cancer patients experienced end-of-life care in hospital settings as a condition marked by physical suffering, emotional vulnerability, relational challenges, and existential reflection. The findings indicate that persistent symptom burden and emotional distress formed the core of patients' lived experiences during hospitalization at the end of life (Kim, 2021). The results demonstrate that hospital-based care often intensified patients' awareness of bodily decline and mortality through continuous clinical interventions (Kim et al., 2022). The findings align with evidence showing that aggressive medical care near death may increase patient discomfort and psychological distress (Slotman et al., 2024). These experiences highlight the need to reconsider the balance between curative intent and comfort-focused care in hospital end-of-life settings (Connolly et al., 2022). Overall, the findings emphasize that end-of-life care experiences are shaped by complex interactions between physical, emotional, and institutional factors (Cheruku et al., 2022).

The first major theme demonstrated that physical suffering and emotional distress were deeply interconnected in patients' experiences of end-of-life hospitalization. Participants described persistent pain, fatigue, and breathlessness as dominant aspects of daily life, which contributed to emotional exhaustion and fear (Kim et al., 2021). These findings are consistent with previous research indicating that uncontrolled symptoms significantly affect patients' psychological well-being at the end of life (Rodenbach et al., 2021). Hospital environments often reinforced patients' sense of vulnerability due to frequent procedures and limited personal autonomy (Kyota & Kanda, 2021). Emotional distress intensified when patients perceived their symptoms as inadequately controlled or poorly communicated by healthcare providers (Kim & Lim, 2023). These findings suggest that symptom management and emotional support should be addressed simultaneously to improve end-of-life care quality (Cheruku et al., 2022).

The second theme highlighted the central role of communication and relationships in shaping patients' end-of-life care experiences. Participants reported limited understanding of medical decisions, which contributed to uncertainty and reduced sense of control (Nedjat-Haiem et al., 2020). These findings align with evidence that inadequate communication negatively affects patients' participation in end-of-life decision-making (Kim et al., 2022). Participants' reliance on healthcare professionals for guidance reflected both trust and dependency within hospital care structures (Yeo, 2020). Effective communication from nurses and physicians was perceived as a critical source of reassurance and emotional stability (Kim et al., 2021). These results reinforce the importance of clear, compassionate, and patient-centered communication in hospital-based end-of-life care (Connolly et al., 2022).

The findings also revealed that family involvement significantly influenced patients' experiences of end-of-life care in hospitals. Participants expressed concern about limited family presence and communication during hospitalization, particularly during critical moments near death (Jeon, 2022). Previous studies have shown that restricted family engagement can negatively affect both patient comfort and family bereavement outcomes (Morris et al., 2020). Family caregivers often experience emotional distress when excluded from end-of-life care processes in hospital settings (Oh & Kim, 2023). The quality of patient–family interaction during end-of-life care plays a crucial role in shaping families' adaptation after bereavement (Heo & Kwon, 2019). These findings underscore the need for hospital policies that support family-centered end-of-life care practices (Giorgali, 2022).

The third theme demonstrated that patients actively sought dignity and meaning during the final stage of life despite institutional constraints. Participants emphasized the importance of being treated with respect, compassion, and humanity within hospital care environments (Kyota & Kanda, 2021). These findings are consistent with qualitative evidence showing that dignity-preserving care is a central concern for terminally ill cancer patients (Kyota et al., 2023). Hospital routines that prioritize efficiency over personalization may undermine patients' sense of identity and self-worth (Kim, 2021). Participants' reflections on life, death, and unfinished matters highlight the existential dimension of end-of-life experiences (Nedjat-Haiem et al., 2020). These results suggest that end-of-life care should integrate existential and spiritual support alongside medical treatment (Koh et al., 2024).

The impact of the COVID-19 pandemic emerged as an important contextual factor influencing end-of-life care experiences. Participants' experiences reflect broader disruptions in communication, visitation, and care continuity reported during the pandemic (Shin et al., 2022). Previous research has shown that pandemic-related restrictions intensified emotional distress among cancer patients at the end of life (Kim & Lim, 2023). Healthcare systems during the pandemic often prioritized infection control over holistic end-of-life care needs (Connolly et al., 2022). These conditions contributed to feelings of isolation and unresolved grief among patients and families (Pearce et al., 2021). The findings highlight the long-term implications of pandemic-related care disruptions for end-of-life care quality (Wallace et al., 2020).

Taken together, these findings contribute to a deeper understanding of cancer patients' experiences of end-of-life care in hospital settings. The study extends existing literature by centering patients' voices and highlighting the interplay between physical suffering, communication, family involvement, and dignity at the end of life (Kyota et al., 2023). The results support calls for earlier integration of palliative care within hospital systems to reduce aggressive care near death (Slotman et al., 2024). Hospital-based end-of-life care should prioritize symptom relief, communication quality, and dignity-preserving practices (Cheruku et al., 2022). These findings provide important implications for improving patient-centered end-of-life care policies and clinical practice in hospital settings (Connolly et al., 2022).

Conclusion and Recommendation

This study demonstrates that cancer patients experience hospital-based end-of-life care as a multidimensional process shaped by physical suffering, emotional vulnerability, communication dynamics, family involvement, and the search for dignity and meaning. The findings indicate that persistent symptom burden and emotional distress remain central challenges for patients during end-of-life hospitalization. The results highlight that limited communication and decision-making involvement can intensify patients' uncertainty and dependence on healthcare professionals. The study also reveals that family presence and supportive interactions significantly influence patients' comfort and end-of-life experiences. Furthermore, the findings emphasize that dignity-preserving care and recognition of patients' existential needs are essential components of quality end-of-life care in hospital settings. Overall, this study underscores the importance of patient-centered, compassionate, and holistic end-of-life care approaches to improve the quality of care for cancer patients in hospital environments.

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Declaration of conflict of interest

The authors declare no competing interests.

Declaration on the Use of AI

The authors declare that the research has no using AI tools in this manuscript.

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