Arch Physioter 2026; 16: 61-74
ISSN 2057-0082 | DOI: 10.33393/aop.2026.3853
ORIGINAL RESEARCH ARTICLE

How people with cancer experience the ethical dimensions of physiotherapy in cancer rehabilitation: a qualitative interview study

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ABSTRACT

Introduction: Cancer rehabilitation is increasingly recognized as a core component of cancer care, yet little is known about how people with cancer perceive its ethical dimensions. This study explored how patients experience autonomy, safety, equity, and relational care within physiotherapy-led cancer rehabilitation.

Methods: We conducted a qualitative interview study using reflexive thematic analysis (RTA). Twenty adults with a previous cancer diagnosis who had received physiotherapy related to cancer rehabilitation within the past three years were purposively sampled to maximize variation in age, gender, diagnosis, stage, care setting, and geographical area. Interviews were conducted online, audio-recorded, transcribed verbatim, anonymized, and analyzed inductively from a constructionist, experiential perspective.

Results: Five themes captured ethically salient aspects of rehabilitation experiences: (1) struggles for meaningful participation, where involvement in decisions was sometimes limited despite rhetoric of autonomy; (2) balancing safety and control, where professional caution was experienced as both protective and at times over-restrictive; (3) unequal access as systemic injustice, with geography, logistics, and poor information affecting access to services; (4) empathy and emotional presence, which fostered trust, dignity, and motivation; and (5) limits of standardized care, where rigid protocols and time pressure risked depersonalization unless offset by flexibility. Participants did not view rehabilitation as a merely technical intervention, but as an ethically charged practice shaped by everyday interactions, organizational contexts, and opportunities for agency.

Conclusions: People with cancer experience rehabilitation as an ethical as well as clinical practice. Flexible, dialogic, and equitable models of care may better support dignity, participation, and shared decision-making.

Keywords: Empathy, Ethics, Neoplasms, Patient participation, Physical therapy modalities, Rehabilitation

What is already known about this topic?

- *Patients' ethical perspectives on cancer rehabilitation are underrepresented. Evidence suggests tensions around autonomy, safety, access, and empathy, but most data come from clinicians rather than from patients' lived experiences.*

What does the study add?

- *For people with cancer, ethical tensions in rehabilitation are experienced through everyday physiotherapy practices such as assessment, goal setting, risk management, and relational engagement. The study highlights physiotherapists' central ethical role in negotiating safety, autonomy, and dignity within resource-constrained systems.*

Received: October 20, 2025
Accepted: March 19, 2026
Published online: April 23, 2026

This article includes supplementary material.

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Introduction

Cancer remains a leading cause of mortality and long-term disability worldwide, with approximately 20 million new cases and 9.7 million deaths reported in 2022 (1,2). Advances in early detection and treatment have contributed to improved survival rates, shifting the focus of care towards the management of long-term sequelae, including persistent physical limitations, cognitive impairments, psychological distress, and disruptions in social functioning (3,4). These multi-domain challenges often compromise people's autonomy, daily activities, and broader participation in society (4-6). In this context, cancer rehabilitation has become integral to comprehensive cancer care, with demonstrated benefits in restoring function, improving symptoms, and supporting psychosocial adjustment (7-10). As physiotherapy becomes increasingly integrated into oncological care pathways, attention has shifted towards the ethical complexities that arise in oncological clinical practice (11-14). Physiotherapists working with individuals with cancer—especially in advanced or palliative stages—are routinely confronted with ethically charged decisions (15,16). These include balancing therapeutic benefit against clinical risk, promoting patient autonomy while ensuring safety, and navigating systemic constraints without undermining compassion or fairness (15).

Previous studies have highlighted recurring ethical tensions in this setting, including the balance between safety and efficacy, the challenge of truth-telling in sensitive situations, the emotional labor of care, and the perceived limitations of rehabilitation itself (15-17). However, the patient perspective remains markedly underrepresented in the international literature, as little is known about how individuals receiving cancer rehabilitation interpret the ethical dimensions of their care.Qualitative research has increasingly explored the experiences of people with cancer in cancer rehabilitation, highlighting its role in restoring physical function, quality of life, and a sense of normalcy after or alongside oncological treatment (18,19). Previous studies have documented challenges related to symptom burden, fatigue, adherence, and access to services, as well as the emotional and relational dimensions of rehabilitative care (20-22). However, much of this literature has focused on outcomes, service organization, or patient satisfaction, rather than on how people themselves interpret rehabilitation encounters in ethical terms (23,24). In particular, the ethical dimensions of everyday rehabilitation practices—such as participation in decision-making, negotiation of safety and risk, equity of access, and relational care—remain underexplored from the patient's perspective, especially within physiotherapy-led cancer rehabilitation (12,25). Addressing this gap is relevant not only because rehabilitation is increasingly recognized as a core component of cancer care, but also because physiotherapy involves sustained, embodied, and relational engagement with patients over time, positioning physiotherapists at the intersection of technical expertise and everyday ethical practice (26).

Building on these findings, this qualitative study investigated how core principles of medical ethics—such as autonomy, beneficence, non-maleficence, and justice—are manifested within rehabilitation encounters from the patient's perspective. These findings may provide preliminary insights relevant to clinicians, policymakers, physiotherapists, and researchers by highlighting the cultural and systemic factors influencing access, equity, and ethical dimensions of cancer rehabilitation.

Methods

Study Design

This qualitative interview study aimed to explore patients' perceptions of ethically relevant aspects encountered during cancer rehabilitation (27-30). From an ethical perspective, this type of research falls under the domain of *descriptive ethics*, as it investigates individuals' moral views, concerns, and experiences without prescribing normative judgments (31). The study was conducted in accordance with the principles of the Declaration of Helsinki and approved by the University of Genova Research Ethics Committee (Comitato Etico per la Ricerca di Ateneo – CERA; 2025/53). All participants provided written informed consent and were assured of anonymity and confidentiality throughout the study.

We adopted a qualitative methodology grounded in a reflexive thematic analysis (RTA) as described by Braun and Clarke (32,33). The study was reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) - Supplementary File 1 (34).

Participants and Recruitment

We recruited adult participants (aged ≥18 years) with a previous diagnosis of cancer who had undergone physiotherapy as part of their cancer rehabilitation within the past three years. This timeframe was chosen to ensure sufficiently vivid recall of ethically salient rehabilitation experiences while capturing a recent period of healthcare delivery and organizational practice. We employed a purposive sampling strategy to ensure variation in terms of gender, age, cancer type and stage, and the type of rehabilitation received (e.g., hospital-based, outpatient). This approach aimed to capture a broad spectrum of experiences relevant to the research question (35). Participants were identified through the researchers' professional network, rehabilitation services, and patient associations. Patient associations involved in recruitment were non-profit organizations supporting people with cancer and their families at the local level (e.g., Medea – Medicina e Arte). Their role supported facilitating initial contact with potential participants by disseminating information about the study; they were not involved in study design, data collection, analysis, or interpretation. Inclusion criteria were the ability to provide informed consent and experience with physiotherapy explicitly related to cancer care. The sample size was determined using the concept of information power, rather than the commonly used but methodologically inappropriate notion of data saturation for RTA (36). Given the researchers' expertise in qualitative methods and bioethics in cancer rehabilitation, the strong theoretical underpinnings of the study, the specificity of the research question, and the purposeful sampling strategy adopted to ensure diversity in participants' experiences, an estimate of 15-20 participants was considered appropriate to yield conceptually rich and analytically relevant data (37).

Data Collection

An open-question-based interview guide (Table 1) was developed to explore the perspectives of people with cancer on ethically relevant aspects of physiotherapy within cancer rehabilitation (15). The guide was designed collaboratively by a physiotherapist experienced in cancer rehabilitation and qualitative research (GB), in consultation with a philosopher with expertise in bioethics (SPM) and with methodological input from SB. Relevant information about interview facilitators and researchers' profiles can be found in Supplementary File 2 (Interviews facilitator's and researchers profiles). All three authors are trained in qualitative methodologies and have experience in conducting interview-based research in healthcare contexts.

The development and reporting of the interview guide were informed by established methodological recommendations for semi-structured qualitative interviews, including the framework proposed by Kallio et al., which emphasizes alignment between research aims, use of prior knowledge,

TABLE 1 - Interview guide

Introduction and Icebreaker
To start, would you like to briefly describe your cancer journey and how you came to physiotherapy?
When did you feel that physiotherapy became an important part of your recovery path?
Could you describe, in your own words, what 'cancer rehabilitation' means to you?
Autonomy and Treatment Decisions
In our study, many physiotherapists said they respect the patient's autonomy. Did you feel you truly had a say in therapeutic choices, or did it seem like the physiotherapist made decisions for you?
Some physiotherapists believe that, in certain cases, it's better not to inform patients too much in order to avoid anxiety or uncertainty. Did you ever feel poorly informed or receive vague responses about your therapeutic options?
If you could choose, what level of involvement would you like to have in treatment decisions? Would you prefer a more collaborative approach or rather rely on the physiotherapist's guidance?
Risks and Caution in Cancer Rehabilitation
Many physiotherapists say they adopt a cautious approach to avoid clinical and legal risks. Did you ever feel that this caution limited your chances of physical improvement?
Some physiotherapists avoid potentially useful treatments out of fear of legal consequences or due to a lack of scientific evidence. Do you think this is the right approach, or should there be more room for personalized solutions?
If you could define the ideal approach to cancer rehabilitation, what would it be like? More cautious and standardized, or more open to experimentation?
Equity and Access to Care
Physiotherapists stated that they strive to ensure equity in access to care. Did you feel that all cancer patients have the same chances to receive rehabilitation, regardless of where they live or their economic situation?
Do you think cancer rehabilitation was a real support for your quality of life, or more of a 'complementary' service compared to primary treatments?
In your opinion, what could be improved to make cancer rehabilitation more accessible and effective for all patients?
Empathy and the Relationship with the Physiotherapist
Physiotherapists interviewed stated they value the relationship with the patient and empathy. Did you feel truly understood on a human level, or was the relationship more 'mechanical'?
Was there ever a moment when you wished the physiotherapist had been more empathetic, closer to you as a person and not just as a patient?
In your view, what should the ideal physiotherapist be like in terms of human and relational qualities?
Critical Aspects of Ethical Management
Physiotherapists said that the patient's well-being is their priority, but some patients reported feeling treated like 'numbers' in a system with little time to listen. Did you ever feel that way?
If you could speak directly to the physiotherapists who participated in this study, what message would you like to send them about managing ethical issues in cancer rehabilitation?
If you could design the ideal cancer rehabilitation system, what would its key features be to make it more humane and effective for patients?
Closing and Open Space
Before we finish, is there anything I haven't asked that you feel is important to share?
Is there anything you would have liked to add about your experience, or a message you would like to leave?

pilot testing, and transparent presentation of the guide (38). In line with a reflexive and exploratory approach, questions were designed as flexible prompts rather than standardized items, allowing participants' experiential accounts to guide the interview.

The guide was structured around four thematic areas: patient involvement in decision-making, perceptions of clinical prudence and risk management, fairness in access to rehabilitation services, and the relational and emotional dimensions of care (15). Each area included open-ended stimulus questions designed to elicit detailed, experiential narratives aligned with the research objectives.

To ensure that the questions were comprehensible and meaningful from the patient's point of view, the interview guide was reviewed by two individuals with lived experience of cancer and physiotherapy. Additionally, a pilot interview was conducted with a former oncology patient who had completed a rehabilitation program (39). This pilot interview served to test the clarity, acceptability, and emotional appropriateness of the guide and led to minor adjustments in wording to improve accessibility and relevance.

Individual interviews were conducted in June 2025 remotely via Microsoft Teams by GB, who had no prior relationship with any of the participants. Each interview lasted approximately 45-60 minutes and was audio-recorded with participants' consent. Transcripts were produced verbatim using the platform's automated transcription function and subsequently verified for accuracy by GB through comparison with the original recordings; salient para-verbal elements (e.g., pauses, sighs, hesitations) were noted when they contributed to the interpretation of meaning, in line with a latent RTA. Participants were anonymized using sequential identifiers (e.g., 'Participant 1', 'Participant 2'), and no identifying information was shared beyond the interviewer. Audio files were securely stored on an encrypted, password-protected university server, accessible only to the research team, and were deleted after transcription and verification.

Data Analysis

We collected basic demographic information from participants, including age, gender, and geographic area of residence, to describe our sample. Data were analyzed using RTA, following the six-phase procedure: familiarization with the data, generation of initial codes, construction of themes, review of themes, definition and naming of themes, and report production (Table 2) (33). The analysis was conducted primarily inductively. Ethical concepts such as autonomy, safety, equity, and relational care were not used as predefined coding categories. However, we cannot rule out the possibility that perspectives from relational autonomy and the ethics of care were not adopted at the interpretive level. Therefore, ethical theory might have been unconsciously adopted to support sense-making and interpretation, rather than to structure or constrain theme development. This approach was chosen for its flexibility and its capacity to explore experiential and meaning-oriented data, particularly suited to the aims of this study (40). More details on the analysis process through RTA can be found in Table 2 (six steps of RTA) and in Supplementary File 3 (Theoretical standpoint).

Results

A total of 20 people with cancer participated in the interviews (Mean age: 53.5 ± 9 years; 12 women, 8 men) (Table 3). Participants were recruited from oncology rehabilitation centers across Italy, and all had undergone physiotherapy as part of their cancer rehabilitation within the past three years.

The sample included patients from the North (n = 10), Centre (n = 6), and South and Islands (n = 4), capturing regional variations in access and service delivery across the Italian healthcare system. A variety of cancer types were represented, including breast, colorectal, lung, prostate, lymphoma, and pancreatic cancers, alongside less frequent cases such as ovarian and head and neck cancers. Both early-stage (n = 9) and advanced-stage (n = 11) participants were included, providing insight into how ethical issues might shift across the illness trajectory. In this study, *early-stage* referred to individuals who had completed primary cancer treatments and were in a stable or remission phase, whereas *advanced-stage* referred to those living with metastatic or recurrent disease, including some who were receiving palliative or end-of-life care at the time of rehabilitation.

Settings of care also varied, with 11 participants receiving outpatient rehabilitation and 9 receiving hospital-based interventions. This diversity allowed the study to explore how structural, relational, and organizational dynamics manifest across different institutional contexts.

We developed five themes that capture how participants experienced and understood ethically salient aspects of cancer rehabilitation.

The five themes are:

1. *Patients' Struggle for Meaningful Participation*
2. *The Balance Between Safety and Control in Cancer Rehabilitation*
3. *Unequal Access as Systemic Injustice*
4. *Empathy and Emotional Presence*
5. *Limits of Standardized Care*

The following sections detail each theme; quotations are embedded in the Results; additional excerpts are provided in Table 4.

Theme 1: Patients' Struggle for Meaningful Participation

Participants described rehabilitation decision-making as marked by tension and ambiguity. Although autonomy was frequently invoked within rehabilitation encounters, many participants experienced a gap between being formally informed and being genuinely involved in decisions about their care. Several accounts suggested that treatment plans were often perceived as predetermined, with limited space for patients' perspectives or preferences. As one participant noted, *"Sometimes I had the feeling that decisions were made for me"* (P01), while another stated, *"They told me what to do, they didn't ask me what I thought"* (P08). This sense of exclusion was reinforced when participants felt that decisions had already been finalized before their arrival, as expressed by P13: *"Everything was already decided when I got there."*

A key factor underpinning this experience was informational asymmetry. Participants often described receiving instructions without a clear understanding of the rationale behind them, which constrained their ability to engage meaningfully in shared decision-making. As P10 explained, *"In theory, there's a lot of talk about autonomy… but then you just end up following orders."* Similarly, P07 reflected, *"I didn't really understand what we were doing, I just trusted them."* In these accounts, trust in professional expertise coexisted with limited comprehension, resulting in a form of passive participation rather than active involvement.

At the same time, participants consistently acknowledged and valued physiotherapists' expert knowledge, which shaped how autonomy was enacted. For some, deference to professional authority initially felt appropriate and even reassuring. As P04 recalled, *"It felt like they knew everything,*

TABLE 2 - Six steps of the RTA

Phases	Process	Authors' Involvement	Authors' Actions
1) Data familiarisation	All authors read and reread several times the transcriptions of the interviews. This process is fundamental to getting in contact with the data and taking notes of any insights.	All authors engaged in this phase, and they met to reflect upon their first insights.	- Document theoretical and reflective thoughts: GB documented field notes ("Memos" and diary) during and after each interview to promote reflexivity. - Keep records of all data field notes, transcripts, and reflexive diary - Prolong engagement with data and triangulate different data collection modes to increase the probability that the research findings and interpretations will be found credible: GB and VC read and reread the data (transcripts of the interviews, memos, and reflexive diary)
2) Coding	In this phase, two researchers systematically coded the data through an open, evolving and organic process.	GB and VC systematically coded the data. They adopted semantic data coding.	- Peer debriefing: memos were shared during research meetings for reflexive thoughts. - Audit trail of code generation: GB and VC coded data through the entire data set to identify interesting aspects in the data items that may form the basis of themes across the data set. - Documentation of all team meetings and peer debriefings to help researchers examine how their thoughts and ideas evolve as they engage more deeply with the data
3) Generating initial themes	The researchers generated initial themes from the codes, clustering similar or related codes.	GB and VC generated initial themes separately, clustering similar codes together.	- Diagramming to make sense of theme connections: GB and VC generated initial themes through a reflexive, inductive process of pattern construction across the dataset.
4) Reviewing and refining themes	The researcher reviewed the initial themes, reworking or discarding some until finding a final set of themes fitting the data.	All authors reviewed the coding and initial themes separately and then jointly, and generated five themes that fit the data the most. GB and VC reviewed the agreed themes against the codes and the entire dataset.	- Themes vetted by team members: the research team frequently met to refine the themes and clearly show how each theme was derived from the data.
5) Defining and naming themes	The 'story' of each theme is developed by finalizing theme names and their definition.	All authors finalized the final themes and definitions to set the basis of the written report.	- Peer debriefing and team consensus on themes: the research team met until the final themes were reached. - Documentation of theme naming.
6) Producing the report	The authors produced the final report and refined it if necessary.	GB and VC selected the illustrative quotations from the interviews, and all authors reviewed and agreed. GB, SB and SPM led the writing of the paper, and all authors participated in this phase.	- Producing the report using direct quotes from participants. - Report on reasons for theoretical, methodological, and analytical choices throughout the entire study.

TABLE 3 - Demographic and clinical characteristics of interviewed participants

ID	Gender	Age	Region	Cancer Type	Stage	Setting
P01	Female	43	North	Breast	Early	Outpatient
P02	Female	55	Centre	Colorectal	Early	Hospital-Based
P03	Female	62	North	Lung	Advanced	Hospital-Based
P04	Female	58	South & Islands	Breast	Advanced	Outpatient
P05	Female	64	North	Lung	Early	Outpatient
P06	Male	55	South & Islands	Prostate	Early	Outpatient
P07	Female	34	Centre	Lymphoma	Advanced	Hospital-Based
P08	Male	58	North	Colorectal	Early	Outpatient
P09	Male	61	South & Islands	Pancreatic	Advanced	Hospital-Based
P10	Female	42	Centre	Breast	Advanced	Outpatient
P11	Male	62	North	Colorectal	Advanced	Hospital-Based
P12	Male	59	North	Head and Neck	Early	Outpatient
P13	Male	41	Centre	Lymphoma	Advanced	Hospital-Based
P14	Female	43	North	Ovarian	Advanced	Hospital-Based
P15	Female	50	North	Breast	Advanced	Outpatient
P16	Male	59	South & Islands	Colorectal	Advanced	Hospital-Based
P17	Female	68	Centre	Breast	Early	Outpatient
P18	Female	56	Centre	Breast	Advanced	Outpatient
P19	Male	52	North	Prostate	Advanced	Outpatient
P20	Female	48	North	Breast	Early	Outpatient

TABLE 4 - Quotes leading to the generation of each theme

Theme 1: Patients' Struggle for Meaningful Participation	
Codes defined by the researchers	**Example of quotes extracted from the Interviews**
Perceived vs actual autonomy	"Sometimes I had the feeling that decisions were made for me, without me fully understanding the options. (P01)" "In theory, there's a lot of talk about autonomy, but in practice, you're often just a spectator. (P10)"
Informational asymmetry	"No one really explained what we were doing or why. I trusted them, but I didn't understand much. (P08)" "I didn't always understand what was happening. Only with the physiotherapist did I feel I could ask questions. (P11)"
Value attributed to expert knowledge	"I thought they knew everything, and I knew nothing. I just followed along. (P04)" "At the beginning, I just said yes to everything. Only later did I realize I had the right to ask why. (P12)"
Variable preferences in decision-making	"I didn't want everything on my shoulders, but I also didn't want to be treated like a child. (P19)" "Being young, I had a lot of questions, but I often felt dismissed. (P07)"
Theme 2: The Balance Between Safety and Control in Cancer Rehabilitation	
Codes defined by the researchers	**Example of quotes extracted from the Interviews**
Caution as protection	"The therapist adapted the session depending on how I was feeling. That was respect" (P07). "Knowing that each activity was assessed and adjusted for my safety made me feel protected. (P01)" "The physiotherapist always explained what we could or couldn't do, and why. That made me feel safe. (P02)"
Caution as an obstacle	"It felt like their fear of making mistakes outweighed their willingness to help me improve" (P10) "I wanted to do more, but they held back. (P05)" "Sometimes I felt they avoided more advanced techniques out of fear of complications. (P06)"

Self-limiting strategies	“I moved slowly, always afraid to do something wrong. (P03)” “Even when the therapist said I could do more, I was scared to try” (P20). “They looked scared, so I started to be scared too. I didn’t want to push because I didn’t want them to worry” (P14) “There were days I couldn’t even sit up for long. The therapist would adapt everything. (P07)”
Perception of defensive caution	“The physiotherapist seemed more concerned with covering their back than helping me. (P09)” “I could feel their fear. It wasn’t about me—it was about them being afraid to get it wrong” (P15). “It felt like everything was forbidden – ‘too risky’, ‘not allowed’ – but no one explained why. (P13)”
Theme 3: Unequal Access as Systemic Injustice	
Codes defined by the researchers	**Example of quotes extracted from the Interviews**
Territorial disparities	“If you live in the right postal code, you get help. If not, you’re out of luck. (P13)” “Rehabilitation shouldn’t depend on your zip code. But often, it does. (P12)”
Economic and logistical barriers	“Without my family’s help, I wouldn’t have managed. Transport and costs are a real burden. (P05)” “Some had to travel many kilometers or even give up. That’s just not fair. (P01)”
Lack of proactive information from the system	“No one ever mentioned physiotherapy until I insisted. (P14)” “I found out about physiotherapy on the internet. No one in the hospital had mentioned it. (P10)” “In the support group, some women didn’t even know rehab existed” (P18)
Role of personal networks	“Only because an acquaintance, a nurse, told me... otherwise I would have missed it. (P02)” “If it weren’t for a nurse who told me, I wouldn’t even know it existed. (P03)”
Theme 4: Empathy and Emotional Presence	
Codes defined by the researchers	**Example of quotes extracted from the Interviews**
Authentic vs superficial empathy	“Excellent technique, but cold as ice. I needed humanity, not just exercises. (P10)” “The therapist didn’t treat me like a patient, but like a person with plans, even while in bed. (P07)”
Importance of relational time	“Even just two minutes to talk made me feel human again. (P12)” “He could listen even when I couldn’t speak. That’s what made me feel respected” (P12) “She didn’t say much, but I felt safe just by how she looked at me” (P09) “Even her hands said ‘I’m here with you’. That mattered more than any explanation” (P17). “Just a few extra minutes would have made a huge difference. (P02)”
Effects of empathy on motivation	“My therapist knew when to push and when to slow down. That helped me through the hardest days. (P06)” “He could tell if it was a good day or if I just needed to breathe. That meant everything. (P18)”
Different expectations based on the physiotherapist’s gender and age	“Younger therapists seemed more sensitive. (P04)” “Younger professionals seemed more open to adapting the session to how I felt. (P17)”
Theme 5: Limits of Standardised Care	
Codes defined by the researchers	**Example of quotes extracted from the Interviews**
Perception of impersonal standardization	“It felt like a fixed protocol, regardless of who you were. (P03)” “Everything felt like it followed a strict schedule. People aren’t machines. (P02)”
Overload of healthcare professionals	“They were always rushing. Some days it felt like a conveyor belt. (P10)” “Sometimes it felt like we were just there to tick a box. (P09)”
Inadequate time and space	“We changed rooms three times. No locker room, no privacy. Is that really care? (P18)” “With more calm, I felt respected. With rush, I felt like a number” (P11) “It’s not just the exercises, it’s the attention. A few minutes of real attention changes everything” (P08). “We had to change rooms three times. No privacy. That’s not what care should look like. (P18)”
Desire for flexibility and adaptability	“We had a plan, but we adjusted it every week based on how I was doing. (P20)” “They always asked how I was feeling and adapted accordingly. That made a difference. (P16)”

and I knew nothing." Over time, however, some participants described a gradual shift toward greater confidence and engagement, learning that questioning and dialogue were possible within the therapeutic relationship: *"At first I said yes to everything, then I realized I could ask questions"* (P12).

Importantly, preferences regarding participation were not static. Several participants articulated ambivalence about decision-making, expressing a desire to be heard and involved without bearing full responsibility for choices. This highlights participation as a dynamic and context-dependent process rather than a fixed expectation. As P19 stated, *"I liked being involved… but I didn't want to have to decide everything myself."* Similarly, P06 noted, *"I want to be listened to, but I don't always have the energy to speak up."* These accounts illustrate how meaningful participation requires ongoing calibration, sensitive to patients' emotional resources, health status, and changing needs throughout the rehabilitation trajectory.

Theme 2: The Balance Between Safety and Control in Cancer Rehabilitation

Participants articulated a nuanced and often ambivalent experience of clinical caution within physiotherapy-led cancer rehabilitation. For many, prudence was initially perceived as a source of reassurance and protection during a period marked by physical vulnerability and uncertainty. Careful monitoring and adaptation of exercises fostered trust and a sense of being safely guided through recovery. As one participant noted, *"It gave me confidence to know that every exercise was carefully assessed"* (P01), while another reflected, *"I was scared, but knowing they were cautious really helped me"* (P14).

However, this sense of safety was frequently accompanied by frustration when caution was perceived as excessive or rigid. Several participants described feeling restrained by therapists' reluctance to allow progression, interpreting prudence as an obstacle rather than a support. As P10 observed, *"It felt like they were afraid to let me move too much,"* and P17 similarly stated, *"I would have liked to push myself a bit more, but they seemed held back."* In these accounts, protective intentions risked limiting opportunities for challenge, exploration, and the reclaiming of physical agency.

Beyond external constraints, some participants described internalizing a climate of caution, leading to self-imposed limitations even when therapists encouraged advancement. Fear of causing harm persisted despite professional reassurance, shaping how participants engaged with rehabilitation tasks. As P20 explained, *"I was afraid of doing damage… even when the physio said I could do more,"* while P03 noted, *"I did the movements slowly, because I was afraid of making mistakes."* These experiences suggest that prolonged exposure to risk-averse messaging may influence patients' self-perception and behavior, fostering caution that extends beyond clinical recommendations.

In other accounts, caution was interpreted less as individualized care and more as defensive practice, driven by perceived institutional pressures or concerns about liability. Participants sensed that therapists' decisions were sometimes shaped by fear rather than by a tailored assessment of their readiness. As one participant remarked, *"The physiotherapist seemed more concerned about covering themselves"* (P09), and another recalled being repeatedly told, *"Better not to take risks,"* even when feeling prepared to progress (P11). Such interpretations intensified feelings of vulnerability, as professional caution was experienced as distancing rather than supportive.

Overall, clinical caution was not experienced as a neutral or purely technical feature of rehabilitation. Instead, it was interpreted, embodied, and at times contested by participants. While prudence could convey care and respect, excessive or insufficiently explained caution risked constraining agency and reinforcing asymmetries within the therapeutic relationship. These accounts point to the ethical importance of negotiated safety, transparent rationales for clinical decisions, and calibrated challenge that aligns professional judgement with patients' evolving goals, capacities, and perceptions of risk.

Theme 3: Unequal Access as Systemic Injustice

Participants commonly described access to cancer rehabilitation as uneven, fragile, and contingent on factors unrelated to clinical need. Geographic location emerged as a primary determinant, with marked disparities across regions shaping whether and how rehabilitation could be accessed. These differences were not perceived as occasional shortcomings but as structural inconsistencies within the healthcare system. As one participant stated bluntly, *"Don't call it a right to health if it depends on the postcode where you live"* (P09). Another contrasted their experience with that of a peer, noting, *"A friend of mine had a completely different pathway just because she lived in another region"* (P02).

Beyond territorial variation, participants highlighted financial and logistical barriers that further constrained access. Costs associated with transport, time off work, and administrative procedures added strain during an already demanding phase of recovery. For some, these burdens made attendance practically impossible without external support. As P05 explained, *"I couldn't afford the taxi to get to physiotherapy,"* while P14 noted, *"Without my daughter's help, I wouldn't have managed to go."* In these accounts, access to rehabilitation depended not only on service availability but also on personal resources and social support.

Information gaps were described as a pivotal barrier. Several participants reported discovering oncology rehabilitation services by chance, rather than through structured institutional pathways. This lack of proactive communication reinforced the perception of rehabilitation as an optional extra rather than an integral component of cancer care. As one participant recalled, *"I found out about cancer rehabilitation by accident"* (P02), while another stated, *"No one ever told me about these possibilities in the hospital"* (P13). Such experiences contributed to feelings of abandonment, particularly during the vulnerable post-treatment phase.

In this context, informal personal networks often became the primary gateway to care. Access was frequently facilitated through acquaintances, friends within the healthcare system, or peer support groups, rather than through formal referral mechanisms. As P18 explained, *"A nurse who's* *a friend of mine told me about it… otherwise, nothing,"* and P15 similarly noted, *"Only thanks to the support group did I understand where to go."* Reliance on such networks further amplified inequities, privileging those with social capital, insider knowledge, or assertiveness.

Taken together, these recurring patterns across settings and diagnoses indicate that access to rehabilitation was perceived as shaped by geography, resources, and chance, rather than by equitable clinical criteria. Participants' attribution of barriers to organizational and policy-level factors supports an interpretation of these experiences not merely as individual hardship, but as manifestations of systemic injustice. In this sense, rehabilitation was often experienced as a privilege rather than a right, sitting uneasily with the rhetoric of equal access underpinning contemporary cancer care.

Theme 4: Empathy and Emotional Presence

For many participants, the presence—or absence—of empathy fundamentally shaped the rehabilitation experience. When physiotherapists were emotionally attuned, respectful, and genuinely present, participants described feeling supported beyond physical recovery, with increased motivation and trust in the therapeutic process. Conversely, when empathy was perceived as lacking or superficial, rehabilitation was experienced as mechanical, distant, or alienating, diminishing engagement and reinforcing a sense of being treated as a case rather than as a person. As one participant remarked, *"They were skilled, yes, but cold. Not even a look in the face"* (P10), while another reflected, *"Sometimes I felt invisible"* (P07).

Empathy was not understood primarily through verbal reassurance, but through subtle yet powerful relational cues. Participants emphasized the moral and emotional significance of non-verbal communication—such as tone of voice, gaze, posture, and touch—which conveyed attentiveness and care. Even within time-constrained settings, brief moments of relational presence were experienced as deeply meaningful. As P12 explained, *"Even just two minutes of talking made me feel human,"* and P06 similarly noted, *"We didn't have much time, but he used it well."* These accounts suggest that the ethical quality of care was not measured by the quantity of time available, but by how presence was enacted within it.

Participants also described empathy as a key driver of motivation and self-efficacy during rehabilitation. Feeling listened to and believed in by the physiotherapist encouraged greater effort and engagement, reinforcing a sense of agency in recovery. As one participant stated, *"When he listened to me, I felt like giving my best"* (P15), while another reflected, *"If I saw that she believed in me, I believed in myself"* (P01). In this sense, empathy functioned not only as an interpersonal quality but as a therapeutic force shaping patients' confidence and commitment.

Some participants further reflected on perceived patterns in the expression of empathy, occasionally attributing greater emotional attunement to therapists' age or gender. These observations were not framed as universal claims, but as personal perceptions grounded in lived experience. As P04 commented, *"Younger female physiotherapists seemed more sensitive,"* while P19 noted, *"With a young male therapist, I felt more at ease talking about pain."* Such accounts highlight how empathy is experienced as both a relational disposition and a skill enacted within specific interpersonal contexts, suggesting that emotional presence is shaped by individual characteristics as well as by professional training and organizational culture.

Theme 5: Limits of Standardized Care

Participants frequently described rehabilitation as taking place within systems that prioritized standardization over personalization. Protocol-driven approaches were often perceived as insufficiently responsive to individual needs, rhythms, and circumstances, contributing to experiences of depersonalization. As one participant observed, *"It felt like a fixed protocol—it didn't matter who I was"* (P03), while another remarked, *"Every patient has different needs, but there it was all the same"* (P09). In these accounts, standardization was not criticized as a clinical safeguard per se, but as a practice that risked obscuring personal identity and lived experience.

Importantly, this rigidity was rarely attributed to individual physiotherapists. Instead, participants consistently located its origins in systemic pressures, including workload, staffing shortages, and organizational demands for efficiency. Therapists were often perceived as constrained by time scarcity and high patient turnover, which limited opportunities for relational engagement. As P11 explained, *"They were always rushing… there was never enough time,"* and P18 similarly noted, *"They did their best, but there were too many patients."* These reflections point to a shared awareness of structural strain, tempering blame toward clinicians while highlighting institutional responsibility.

Time and space emerged as ethically salient dimensions of care rather than mere logistical variables. Participants interpreted the availability of time and the quality of presence as moral signals of recognition and worth. Conversely, rushed interactions conveyed a sense of being undervalued. Environmental factors further reinforced this perception: frequent room changes, noise, and lack of privacy symbolized organizational fragmentation and invisibility. As one participant recalled, *"We changed rooms three times… it felt like moving house"* (P13), while another stated, *"There wasn't a space to do things calmly"* (P06). Such conditions shaped how care was experienced, often amplifying feelings of disconnection.

Despite these constraints, participants also recounted moments in which flexibility and collaboration restored a sense of fit and dignity. When physiotherapists adjusted plans in response to patients' energy levels, mood, or goals, care was experienced as personalized and ethically attentive. As P20 noted, *"They listened to me and adapted the program to me,"* and P14 similarly reflected, *"We had a plan, but we adjusted it every week."* These instances demonstrated that even within standardized and resource-limited systems, small acts of adaptability and presence could counter depersonalization and re-humanize rehabilitation.

Overall, participants did not seek perfection or unlimited time, but space—space to be heard, respected, and recognized as individuals. Their accounts suggest that the ethical quality of rehabilitation is shaped not only by protocols and resources, but by how clinicians navigate constraints through attentiveness, flexibility, and relational commitment.

Discussion

This study aimed to explore how people with cancer perceive ethical issues during cancer rehabilitation, with a particular focus on the role and approaches of physiotherapists. The findings reveal a complex web of ethical tensions—particularly concerning autonomy, risk, access to care, and relational dynamics—that shape the rehabilitation experience in ways that are deeply meaningful to patients. These insights highlight opportunities to strengthen ethical responsiveness within the therapeutic relationship, ensuring that rehabilitation practices remain grounded in professional standards while being sensitive to patients' values, needs, and lived experiences.

Notably, the sample included both people who underwent rehabilitation in more standardized hospital contexts and those who experienced it within outpatient, often more flexible, services. Overall, this heterogeneity enriched the qualitative dataset and helped surface a wide range of perspectives on ethical tensions in rehabilitation. It supported a nuanced understanding of how themes such as participation, caution, empathy, and access were experienced not as abstract principles, but in relation to real-life variables, including geography, clinical history, and organizational setting.

Before engaging with the specific ethical themes developed through analysis, it is important to highlight the profound meaning participants attributed to physiotherapy. Rather than being perceived as a technical adjunct, physiotherapy was often described as a transformative and essential part of care—a safe space in which individuals could reconnect with their bodies, restore dignity, and regain a sense of control. Participants depicted rehabilitation as central to their quality of life, not only physically but also emotionally and existentially. This symbolic value of physiotherapy shaped how ethical issues—including involvement in decision-making, professional caution, equity, and relational care—were understood and narrated.

Rather than treating ethics as a set of abstract principles applied to practice, our findings suggest that participants experienced rehabilitation as an ethical practice enacted through relationships, dialogue, time, and organizational arrangements. This interpretation aligns with relational accounts of autonomy and with the ethics of care, which emphasize attentiveness, responsiveness, and the moral significance of everyday interactions.

While the experiences described here may resemble those reported in previous qualitative studies, our analysis shows that participants consistently interpreted these experiences through an ethical lens, attributing moral significance to everyday rehabilitation practices rather than to isolated clinical decisions.

A central theme was the tension between autonomy and paternalism in clinical decision-making. While patients acknowledged and respected physiotherapists' expertise, many felt sidelined or excluded from key decisions about their care. This pattern suggests that autonomy in physiotherapy is often enacted rhetorically rather than relationally, revealing a gap between formal consent and lived participation. These experiences echo longstanding concerns in the literature about the limited implementation of shared decision-making in physiotherapy, particularly when professional routines and time pressures dominate the care process (41-43). Although some participants experienced more collaborative interactions, most felt their preferences were pre-empted by clinical protocols. This highlights the need to move beyond one-way information sharing toward more collaborative models of care—where clinical expertise and patient perspectives are integrated through transparent dialogue, negotiated flexibility, and mutual respect (41). Moreover, respecting patient autonomy should not be conflated with abandonment (44). Several patients expressed ambivalence: while they appreciated being involved in decisions, they also felt overwhelmed or unprepared to take full responsibility. This underscores the importance of calibrating patient participation based on individual capacity, clinical context, and emotional readiness—ensuring that involvement is meaningful without becoming burdensome (45).

The results also shed light on a core ethical tension in physiotherapy: how to reconcile professional interpretations of beneficence—with their emphasis on caution and safety—with patients' autonomous understandings of what is meaningful and beneficial for their recovery, especially when protective approaches are perceived as excessive, rigid, or disempowering over time. Many expressed a desire to challenge themselves, reclaim agency, and push recovery boundaries—yet felt constrained by overly risk-averse attitudes. This resonates with literature emphasizing the importance of "therapeutic challenge" in physiotherapy as a way to support not only physical progress, but psychological empowerment (46). When patients are assumed to be fragile or incapable, the result may be a therapeutic environment of overprotection, leading to self-restrictive behaviors (47). Some participants internalized caution even when physiotherapists encouraged progress, revealing how atmospheres of professional fear can influence patient identity and behavior over time. Ethical rehabilitation requires that safety parameters be dynamically negotiated, considering both clinical rationale and patients' evolving perceptions of risk, effort, and resilience (15).

From a clinical physiotherapy perspective, these ethical tensions translate into everyday decisions regarding assessment, goal setting, progression, and risk management. Participants' accounts highlight how initial assessment is not only a technical act, but an ethical encounter in which patients gauge whether their vulnerability, preferences, and capacities are recognized. Similarly, goal setting emerged as a moral practice: goals perceived as imposed or protocol-driven undermined engagement, whereas goals negotiated through dialogue fostered trust and motivation. Risk management, a core responsibility of physiotherapists, was experienced by participants as ethically meaningful when safety rationales were made explicit and open to discussion. Conversely, unexplained or rigid caution was interpreted as over-control or defensive practice. These findings suggest that ethical physiotherapy practice involves not the avoidance of risk per se, but its transparent negotiation, where clinical judgement is combined with patients' experiential knowledge of effort, fear, and readiness. Therapeutic decision-making in cancer rehabilitation thus appears as a situated, relational process rather than a purely technical application of protocols. Physiotherapists occupy a distinctive ethical position, as they work directly with patients' bodies, fatigue, pain, and fluctuating capacities, often across repeated sessions. This longitudinal, embodied engagement places physiotherapists at the center of everyday ethical work, where attentiveness, adaptability, and calibration of challenge become integral to both clinical effectiveness and moral practice.

Access to care emerged as another urgent issue. Participants reported facing multiple barriers—geographical distance, financial constraints, and institutional fragmentation—that made rehabilitation difficult to access. In many cases, patients discovered available services only through informal channels, such as word of mouth, or by taking personal initiative. This lack of clear, proactive communication from healthcare institutions—a form of what we might call *informational neglect*—left several participants feeling unsupported or abandoned during a particularly vulnerable phase of their recovery. Participants' repeated accounts of unequal access across regions, reliance on informal networks, and attribution of barriers to organizational and policy-level factors support an interpretation of these experiences not merely as individual hardship, but as manifestations of systemic injustice.

In this context, the potential role of e-health and telerehabilitation deserves closer examination. Digital interventions could help mitigate geographic and logistical inequalities by improving continuity and decentralizing access to care (48,49). However, such solutions must be critically implemented: digital health is not automatically equitable (50). Without investment in digital literacy, infrastructure, and patient support, technology risks replicating the very inequalities it seeks to solve (50,51).

The therapeutic relationship was consistently described as the most critical element of the physiotherapy experience. Patients emphasized the value of empathy, presence, and emotional resonance. When these qualities were absent, care was perceived as mechanical and dehumanizing. These findings align with existing research that links empathic communication to improved clinical outcomes, patient satisfaction, and engagement in oncology and physiotherapy (52). Empathy was not limited to verbal expressions (53); nonverbal cues—tone, touch, gaze—were often remembered as profound signs of care. This suggests that emotional presence is not ancillary to physiotherapy, but central to its impact (54).

In participants' accounts, dignity was not described as an abstract value, but as something sustained—or undermined—through concrete relational practices, such as being listened to, having time, and being treated as a person rather than a case.

Training programs should reflect this by incorporating modules on relational competence, affective communication, and trauma-informed care alongside technical skills (55,56).

Also, time emerged as more than a logistical constraint. Patients interpreted the availability and quality of time as an ethical signal of recognition and dignity. When physiotherapists were present, unhurried, and attentive—even briefly—patients felt valued. In contrast, rushed interactions were experienced as dismissive and impersonal (57). While health systems continue to prioritize efficiency, research increasingly challenges the assumption that "fast" care is necessarily "better" (58). The real issue may lie in structural underfunding, staffing shortages, and burnout—all of which limit professionals' capacity for presence (59). This creates a tension between individual ethical ideals and systemic limitations: patients need time to heal, yet professionals operate within resource-constrained environments where time is unequally—and often unfairly—distributed. Rather than judging this scarcity as inherently unethical, it can be understood as a challenge to distributive justice: how to allocate limited time fairly without undermining the relational quality of care.

In this context, discussions of ethical care must consider not only interpersonal dynamics but also institutional arrangements. Ethical care is not defined solely by patients or professionals, but is co-shaped by their interactions, contextual constraints, and broader societal choices—including policy decisions on resource allocation (60). Closely related is the perception of rigidity and depersonalization within care structures. Patients described protocols as inflexible and inattentive to their uniqueness. While standardization ensures safety, over-reliance on protocols can obscure human variation and reduce care to a checklist (61). This critique aligns with broader literature calling for "value-sensitive flexibility," where protocols guide but do not dictate care (62). Participants in this study recognized and appreciated when clinicians exercised discretion, adjusting plans weekly, responding to fluctuations in energy or mood. Such flexibility does not oppose professional standards; rather, it represents their ethical application (63).

These reflections gain further weight when considered alongside insights from physiotherapists in comparable studies (12-14,17).

Clinicians, too, report feeling constrained by systemic pressures such as time scarcity, inflexible protocols, and heightened risk aversion—yet they interpret these barriers through a professional lens. Where patients experience dismissal or over-control, therapists often describe overwork, insufficient support, and fear of legal consequences. This divergence reveals a relational disconnect: both groups are navigating the same system, but from different positions and with different stakes.

This raises a broader ethical and political question: who decides how care should be organized, and whose perspectives are included in shaping these decisions? Bridging this gap requires spaces not only for interprofessional dialogue but also for participatory deliberation that involves patients and citizens in setting priorities, shaping guidelines, and even contributing to the formulation of professional codes and policies (64).

Future research should expand beyond those who successfully accessed rehabilitation and actively seek out the voices of those who were excluded—whether due to geography, socioeconomic status, or lack of referral. Understanding these absences is essential to designing more inclusive and responsive care systems.

Taken together, these findings suggest that ethical rehabilitation requires more than goodwill on the part of individual clinicians. It demands a care infrastructure capable of listening, adapting, and redistributing power. Physiotherapists need not only technical and relational skills, but also ethical literacy and systemic awareness. Educational institutions and healthcare organizations have a responsibility to cultivate these capacities, while policymakers must create the conditions for care models that recognize the patient not simply as a recipient of services, but as a partner in the moral and organizational architecture of care.

Several limitations of this study should be considered when interpreting the findings. As a qualitative inquiry conducted in selected regions of Italy, the results reflect a specific social and institutional context and are not intended to be generalized to all people with cancer or settings. Recruitment through professional networks and associations may have favored participants who were more informed or engaged with rehabilitation pathways. Although most interviews were conducted remotely via Microsoft Teams, this mode of interaction did not appear to hinder rapport or depth of reflection; participants were generally at ease and communicative. The sample was predominantly drawn from Northern and Central Italy, with limited representation from Southern regions and the Islands. As such, the findings primarily reflect experiences within these geographical contexts and should be interpreted with caution when considering national-level systemic disparities. Future research should specifically explore the perspectives of people with cancer in Southern Italy to better capture regional variations in access and rehabilitation experiences.

Conclusion

In conclusion, this study underscores the ethical relevance of designing cancer rehabilitation as a process that recognizes patients as relational agents with diverse capacities, challenges, and priorities. Rather than suggesting that care should be shaped solely around individual preferences, the findings highlight the importance of developing flexible and dialogic models—within ethically and professionally grounded frameworks—that allow space for patient voices to be heard and considered meaningfully. When these findings are viewed alongside recent studies on physiotherapists' ethical perspectives in cancer rehabilitation, a striking convergence emerges: both patients and clinicians emphasize compassion, relational care, and the restoration of dignity, yet they interpret ethical tensions from different standpoints. Patients describe experiences of over-control or invisibility, whereas physiotherapists point to systemic constraints, defensive practices, and institutional risk aversion. Bridging these perspectives requires organizational and educational strategies that foster shared reflection, mutual understanding, and co-responsibility in clinical decision-making. For physiotherapists, this entails recognizing assessment, goal negotiation, progression of exercises, and management of risk as ethically charged components of everyday practice, rather than as neutral technical steps. Ethical competence in cancer rehabilitation, therefore, includes the ability to explain clinical reasoning, negotiate safety, and adapt interventions responsively over time. Ultimately, cancer rehabilitation can be reframed as an ethical practice of reciprocity—where patients and professionals jointly negotiate meaning, goals, and limits of care within systems that support responsiveness and justice.

Acknowledgments

We thank all participants for generously sharing their time and experiences. We are grateful to the patient reviewers who commented on the interview guide.

Disclosures

Conflicts of interest: The authors declare that there is no conflict of interest regarding the publication of this article.

Funding statements: The authors declare that no funds, grants, or other support were received during the preparation of this manuscript.

Ethics approval: Approved by the University of Genoa Research Ethics Committee (CERA – Comitato Etico per la Ricerca di Ateneo), protocol 2025/53; conducted in accordance with the Declaration of Helsinki. Written informed consent was obtained from all participants.

Authors contributor role: GB: Conceptualization – Data Curation – Formal Analysis – Investigation – Writing original draft - Writing review & Editing; SB: Conceptualization – Investigation – Methodology – Supervision - Writing review & Editing; VC: Investigation - Writing review & Editing; MT: Conceptualization – Project administration – Supervision - Writing review & Editing; SP: Conceptualization – Project administration – Supervision - Writing review & Editing.

Data availability statement: The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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