

Ethical tensions experienced by healthcare professionals in supportive cancer care: a qualitative study proposing a classification

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Abstract

Background: Supportive Cancer Care (SCC) improves the quality of life of patients with cancer and promotes treatment adherence. However, its prescription remains heterogeneous and inequitable due to numerous barriers to implementation. These constraints expose healthcare professionals to repeated situations of arbitration, generating ethical tensions that remain insufficiently explored in the field of supportive care. This study aimed to identify and analyse the ethical tensions experienced by healthcare professionals during the prescription of SCC, in order to propose a typology for classifying these tensions and a diagnostic tool to identify their recurrent causes.

Methods: A qualitative phenomenological study was conducted using semi-structured interviews with 11 healthcare professionals involved in SCC prescription in a French public hospital. Data were analysed using a dual approach: a deductive thematic analysis based on the ethical principles of Beauchamp and Childress (autonomy, beneficence, non-maleficence and justice), and a cross-case analysis aimed at identifying recurrent sources of tension.

Results: Two main forms of ethical tension emerged. Non-dilemmatic ethical tensions (NDET), in which an ethical principle (autonomy, beneficence, non-maleficence or justice) is constrained by external factors such as lack of resources, organisational rigidity or inappropriate timing. Dilemmatic ethical tensions (DET), involving conflicts between ethical principles, for example between respect for autonomy and beneficence, or between justice and non-maleficence. The cross-case analysis highlighted three recurrent causes of tension: the Patient, Temporality (patient-related and institutional), and Human and Structural Resources. These three dimensions form the PTR model (Patient, Temporality, Resources), designed as a diagnostic tool to identify recurrent causes of ethical tensions.

Conclusions: The prescription of SCC cannot be reduced to a technical act. It constitutes a complex ethical process, shaped by multiple tensions related to inequalities in access, which affect healthcare professionals' lived experience and moral distress. The NDET/DET typology allows these tensions to be classified, while the PTR model facilitates their diagnosis by identifying their recurrent causes, thereby supporting collective recognition and ethical reflection on improving access to SCC.

1. Introduction

Supportive Cancer Care (SCC) is defined by the MASCC (Multinational Association of Supportive Care in Cancer) as all forms of care aimed at achieving a lasting improvement in patients' quality of life (1). It encompasses a wide range of interventions offered to people undergoing cancer treatment, intended to prevent and relieve the effects of the disease and its treatments, throughout the care pathway and into the post-cancer period.

SCC is now considered a fundamental right for every patient with cancer, regardless of disease stage, cancer type, or patient resources (2). In France, it is officially integrated into the cancer care pathway and organised according to a distinction between "core" and "non-core" care (3). However, recent data from

the Association Francophone des Soins Oncologiques de Support (AFSOS) highlight persistent inequalities in access. Its third barometer survey found that patients report major barriers: difficulty with referral/orientation (66%), geographical distance (58%), delays in obtaining an appointment (56%), excessive out-of-pocket costs (53%), and, in some cases, no such care being offered at all within their institution (51%) (4).

Among healthcare professionals, the needs identified for improving access to SCC notably concern early needs assessment (78%), introducing SCC from the time of diagnosis (77%), and better coordination of available services (69%).

Because of how often they recur, these access difficulties become sources of tension for professionals. When facing the patient, the healthcare professional confronts implicit decisional difficulties: between the perceived need, the response judged appropriate to that need, and its actual feasibility in practice. Over time, these daily trade-offs take their toll, all the more so as formalised spaces for thinking through them collectively do not always exist.

The literature on ethical tensions is well established in oncology. Within the broader field of SCC, specific publications address them, notably in palliative care (5) and pain management (6). However, the ethical dimension of SCC prescription as a whole remains understudied (7). This gap may be explained by the very nature of SCC: on the one hand, its scope is particularly broad, spanning somatic, psychological, social and existential dimensions; on the other hand, its implementation involves a multiplicity of prescribers and stakeholders. This dispersion makes a unified approach difficult, helping to explain why the literature has not yet addressed the ethical tensions associated with SCC as a whole.

The present study aims to explore these specific ethical tensions as experienced and articulated by healthcare professionals who prescribe SCC. It proposes to build a typology and a tool for their collective recognition, and to inform prescribing practices in light of clinical realities and field constraints.

2. Methods

Study design

This qualitative study is based on a phenomenological approach (8) aimed at exploring the ethical experience of healthcare professionals confronted with the prescription of supportive cancer care. The objective was to identify the ethical tensions perceived during these prescriptions, to classify them into a typology, and to propose a tool for recognising and diagnosing their causes, grounded in clinical realities.

Analytical framework

The analysis drew on a framework inspired by the principlism of Beauchamp and Childress(9), based on the four principles of autonomy, beneficence, non-maleficence and justice. This framework was used deductively, as a structuring but non-normative tool, allowing the narratives to be interpreted while leaving room for elements relating to other ethical sensibilities (care, solicitude, etc.) to emerge. This

methodological choice is consistent with the phenomenological stance adopted for data collection, which, according to Paillé(8), requires suspending overly hasty interpretive frameworks so that the narratives can speak for themselves before any categorisation. The four-principle framework was thus not applied as an exhaustive categorisation imposed on the data, but as a set of explicit ethical markers guiding the analysis, while leaving room for other ethical registers expressed in the narratives to emerge.

Data collection

Semi-structured interviews were conducted between January and May 2025 with healthcare professionals involved in SCC prescription. An interview guide was developed specifically for this study and has not been previously published; it was designed to explore three main dimensions and is provided in full, in both French and English, as Additional file 2:

- Prescribing practices and access
- Tensions and obstacles encountered
- Avenues for improvement

Each interview included main open-ended questions, follow-up questions adapted as the conversation progressed, and narrative questions inviting participants to illustrate concrete situations. An exploratory interview, not included in the analysis, was conducted beforehand to refine the interview guide.

Participants and setting

Purposive maximum-variation sampling was used to reflect the diversity of professional profiles (physicians, nurses, radiotherapy technologists). Participants worked in a French public hospital and had at least three years of experience in SCC prescription. Of 20 people invited, 11 interviews were conducted (7 remotely, 4 in person). Interview duration ranged from 17 to 50 minutes (Table 1).

Table 1
Aggregated characteristics of the sample of healthcare professionals interviewed

Characteristic	Value
Number of participants invited	20
Number of interviews conducted	11
Non-participation	9 non-responses to invitation; no explicit refusals recorded
Professions represented	Physicians, nurses, radiotherapy technologists
Minimum seniority in SCC prescription	≥ 3 years
Interview format	7 remote interviews, 4 in person
Interview duration	17 to 50 minutes
Individual demographic data (age, gender)	Not collected, in accordance with the anonymisation procedure adopted

An individualised (participant-by-participant) presentation was not adopted, in order to limit the risk of re-identification within this small, single-centre sample.

Ethical considerations

The project received a favourable opinion from the Ethics, Deontology and Scientific Integrity Committee of Nantes Université (CEDIS; n°11032025, IRB00013074). Informed consent was obtained in two stages: in writing at the time of invitation, and orally at the start of each interview. All data were anonymised and stored on a secure server.

Data analysis

Interviews were fully transcribed and then analysed using ATLAS.ti software. Deductive thematic coding was structured around the four ethical principles, with sustained attention to participants' lived experience, in keeping with the phenomenological stance. The analysis was conducted by the ethics researcher, herself an oncologist-radiotherapist, in regular dialogue with the research supervisor and the field supervisor. Data saturation, defined as the point at which interviews no longer yielded new elements, was reached at the ninth interview. Two further interviews were nonetheless conducted to confirm emerging elements. The cross-case analysis was carried out after sub-theme identification and enabled the development of the classification and diagnostic framework for ethical tensions. Illustrative verbatim quotations were extracted to support interpretation. Field notes were written during and/or after each interview. Coding was performed by a single coder (SAA), with consolidation of the thematic analysis through regular discussions with the research supervisor and the field supervisor, without formalised independent double coding.

Reflexivity of the clinician-researcher

The researcher who conducted the interviews is herself an oncologist-radiotherapist and a prescriber of SCC. This dual position, as both clinician and researcher, may introduce a bias of over-involvement, but it also constituted a resource: it allowed immersion in the realities of the field, a finely tuned ear for colleagues' accounts, and an ability to identify tensions that are often not articulated as such. A sustained reflexive effort was maintained, notably through regular dialogue with the research supervisor, who is external to clinical practice, and the field supervisor, a medical oncologist, in order to preserve a critical and distanced analytical stance.

This study is reported in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist (see Additional file 1).

3. Results

3.1 Thematic analysis

The analysis, conducted using a deductive thematic approach consistent with the phenomenological stance adopted, made it possible to structure the narratives without imposing rigid interpretive frameworks, while allowing the meaning of participants' lived experience to emerge.

An initial familiarisation phase was followed by deductive manual coding based on the Beauchamp and Childress framework, aimed at identifying meaningful units (recurrent or dissonant) relating to autonomy, beneficence or non-maleficence, and justice. These elements were then grouped according to semantic proximity, in an iterative process combining horizontal reading (by interview) and vertical reading (by theme).

This work led to the construction of a structuring typology of the ethical tensions reported by participants, organised into two main categories:

Non-dilemmatic ethical tensions (NDET): when an ethical principle conflicts with an external constraint (organisational, material, temporal, etc.), without opposition between ethical principles.

Dilemmatic ethical tensions (DET): when a conflict emerges between two ethical principles, for example between patient autonomy and beneficence, thereby posing a genuine ethical dilemma.

These two categories, frequently intertwined in participants' accounts, were never explicitly named as ethical tensions by healthcare professionals, and were frequently expressed through relational negotiation, a sense of discomfort, or frustration, as illustrated by the following quotations:

"Sometimes we end up stuck, at a loss... we won't be as effective as we'd like to be."

"We're pretty much at a loss when it comes to pain management."

"What the guidelines say is all very well on paper, but in reality, we don't have the human or material means to implement it all. I feel like I haven't fulfilled my duty 100%."

3.1.1 Sub-theme 1: Non-dilemmatic ethical tensions (NDET)

These tensions, the most frequently reported, reflect a barrier to implementing SCC that embodies ethical principles, arising from constraints external to the care relationship (lack of time, unavailability of resources, organisational rigidity, etc.).

Examples of quotations illustrating NDET:

"We can't accommodate everyone who would like it, sometimes we have to choose who to offer this care to." This quotation illustrates a conflict between beneficence, which implies offering care to all patients who would benefit from it, and institutional constraints linked to limited available resources.

"Even if you have contacts in the community, sometimes there's no availability, or the patient can't afford it." This quotation highlights a conflict between beneficence, which drives professionals to offer care deemed useful even when not reimbursed, and the financial constraints faced by some patients, limiting the actual delivery of care.

"She needed psychological support, but how do you manage that with a patient who doesn't speak French?" This quotation illustrates a conflict between beneficence and external constraints related to the patient's language, as well as insufficient institutional resources to provide interpreting services during consultations.

"If a patient lives 20 km from the hospital and travelling is difficult, they won't necessarily be included in SCC pathways." This quotation shows a conflict between beneficence, which calls for guaranteeing access to care, and external constraints of a geographical and societal nature, such as the absence of reimbursable medical transport for SCC.

"Offering SCC also takes time, to be able to talk with the patient... Consultations are already overloaded." This quotation highlights a conflict between beneficence, which requires time to listen to and discuss with the patient, and organisational constraints linked to overloaded consultations.

3.1.2 Sub-theme 2: Dilemmatic ethical tensions (DET)

These tensions arise from conflicts between ethical principles in the decision to prescribe SCC.

Examples of quotations illustrating DET:

"Sometimes you know a patient would really benefit from seeing a psychologist, but you can't force a patient who refuses." This quotation illustrates a conflict between beneficence, which drives the

professional to offer beneficial psychological support, and the principle of patient autonomy, which preserves the patient's right to refuse this intervention.

"Some patients are very well informed and sign up for every supportive care service, while others don't even know it exists." This quotation highlights a conflict between individual beneficence, aimed at equitably meeting each patient's needs, and the principle of justice, which is placed under strain by social inequalities and unequal access to information.

"A patient with bipolar disorder wanted to take part in a workshop, but we refused her access to preserve the group atmosphere." This quotation illustrates a conflict between beneficence towards a specific patient, non-maleficence towards the group (preserving its balance), and justice, which requires equitable treatment among participants.

"We tell them, 'the best treatment is physical activity'... But when you say that to someone who's exhausted..." This quotation highlights a conflict between beneficence, motivated by promoting physical activity, and non-maleficence, which calls for not worsening the fatigue or suffering of a patient already exhausted by their treatments.

3.2 Cross-case analysis

The cross-case analysis was conducted in addition to the thematic analysis, in order to identify recurrent elements across the full set of ethical tensions (NDET and DET). The aim was to highlight common areas influencing the emergence of tensions during SCC prescribing decisions.

This analysis proved complex, as prescribing decisions depend on numerous human and contextual factors, often interwoven within the narratives. The categories identified could not be considered in isolation, as they were so closely intertwined in clinical situations.

Three broad categories, regularly reported, structure most of the tensions described: the patient, temporality, and resources. These categories serve as concrete reference points in the reasoning of SCC prescribers.

The three categories identified, with illustrative examples:

Category 1: Patient

The "patient" category emerges as a recurrent trigger for ethical tensions in SCC prescribing. Various elements making up each person's singularity influence the decision to offer care, its practical feasibility, and its acceptability to the patient:

Psychological state

The patient's psychological state frequently plays a determining role in the decision-making dynamic. Healthcare professionals describe both states of shock at diagnosis disclosure, leading to an absence of

response to offers of support, and, conversely, attitudes of intense mobilisation or a need to control the course of care.

Aggressiveness, withdrawal, or systematic refusal of psychological support are also mentioned, as are patterns of over-investment in the workshops offered, often observed in patients adopting a combative stance towards the illness.

Physical state

Physical condition (fatigue, age, reduced mobility, sex or gender) influences the relevance and feasibility of SCC. Healthcare professionals highlight the difficulties encountered with patients exhausted by treatment, weakened by age, or isolated at home, for whom certain forms of care become inaccessible. Gender differences also emerge: women are described as more likely to seek out and engage with SCC pathways, whereas men are often more reserved or less aware of the services available.

Socio-occupational status

Socio-economic status appears to play a role in access to non-reimbursed SCC, as well as in its acceptability and patients' level of awareness. Healthcare professionals describe situations in which some patients, lacking sufficient resources, forgo non-reimbursed care (sexology, acupuncture, adapted physical activity). Conversely, patients with greater socio-cultural capital appear better informed, more comfortable navigating the healthcare system, and more inclined to spontaneously seek out these services.

Cultural and spiritual context

Cultural and spiritual beliefs influence the perception and acceptability of SCC. Refusals of sexology care for religious reasons, or of specific treatments for spiritual reasons, were reported.

Category 2: Temporality

Ethical tensions related to time emerge both in the patient's temporality and in that of healthcare professionals and institutions.

3.2.1 Patient temporality

Three key moments in the care pathway were particularly associated with specific tensions, as reported by participants:

Diagnosis disclosure and the start of care: a period often marked by a state of shock that makes it difficult to take in an offer of SCC.

"But even within a one-hour disclosure consultation, it's very hard to talk about everything, because what we're telling them is still the atomic bomb."

Treatment failure or relapse: a phase characterised by intensifying psychological and physical suffering, changes in treatment, and the emergence of new symptoms, requiring a reassessment of the relevance and timing of SCC offers.

Discontinuation of specific treatments (post-cancer or palliative care): a moment experienced as a void, often associated with a sense of abandonment, according to healthcare professionals. Some post-cancer patients struggle to maintain follow-up, while others encounter difficulties in the transition to palliative care, at the point when curative treatments come to an end.

3.2.2 Temporality of healthcare professionals and institutions

Organisational temporality, marked by lack of time, overlapping tasks, and limited availability of staff, restricts the ability to offer SCC at the right moment:

"Yes, I think we don't necessarily have the time... I don't necessarily have time to clearly explain supportive care, or to organise it."

"Guidelines are written for an ideal world. In reality, it takes time to discuss, assess, and offer care... and we don't always have that time."

Category 3: Resources

The issue of resources emerged as a major cross-cutting category among the tensions reported by professionals. Two main sub-categories were identified: human resources and structural resources.

Human resources – Multidisciplinarity

SCC prescribing involves a range of actors: specialist physicians, psychologists, beauty therapists, physiotherapists, social workers, etc. This multidisciplinarity is perceived as an asset, but becomes a source of tension when certain providers are absent or insufficient in number, as illustrated by the following quotations:

"When it comes to pain, our pain centre is almost non-existent. Care relies on whoever is prescribing for the cancer overall. We refer our patients to pain units at another hospital."

"In lung cancer, the median age is 70... We know what should be done, but we don't do it very well, for lack of resources such as an available geriatric oncologist or pharmacists."

Human resources – Coordination

Coordination of SCC, whether within or beyond the hospital, also requires dedicated human resources. Participants stress that the absence of formalised coordination leads to delays, breaks in continuity of care, and inequalities in access to SCC.

"When it comes to links with community practitioners, it's very much dependent on the individual professional. Some GPs refuse to see their cancer patients again. Others are very involved."

"What's needed is institutional commitment: the multidisciplinary cancer coordination centre [3C] should play a much bigger role in coordinating supportive care."

Structural resources

The actual availability of SCC and its logistical accessibility determine its implementation. Professionals report intra-hospital structural constraints, such as a lack of specialised services or excessively long waiting times for certain workshops, as well as extra-hospital constraints, such as the non-reimbursement of certain forms of care or lack of transport coverage, creating inequalities in access.

"The main difficulty is that transport isn't covered for supportive care. Some patients can therefore be deprived of it, either because they live too far away or because they're not in a fit state to travel." "Ideally, if we wanted patients to have greater access to SCC, we'd need to bring it closer to where they live... We could also consider remote or home-based care."

3.3 Towards a model for recognising and diagnosing ethical tensions related to SCC: the PTR model

The two types of tension identified (NDET and DET), together with the three recurrent dimensions highlighted by the cross-case analysis, formed the basis for constructing the model for recognising and diagnosing ethical tensions.

The first step in the analytical reasoning consists of identifying the nature of the tension encountered: is it a non-dilemmatic tension (NDET), a dilemmatic tension (DET), or a tension displaying features common to both?

The second step aims to specify which of the three observed dimensions is involved: Patient, Temporality, or Resources. Given the constant interweaving of these areas of tension, a decision-tree representation was not adopted.

A synthetic model, named PTR (Patient, Temporality, Resources), was thus developed from these three recurrent dimensions.

The three components of the PTR model are defined as follows:

Patient

Who is the patient for whom SCC is being considered? Their individual characteristics include age, psychological and physical state, gender, socio-economic status, any linguistic or cultural barriers, and the presence or absence of a support network.

Temporality

At what point in the care pathway is the patient situated? (Diagnosis disclosure, relapse, end of specific treatments, palliative phase, or post-cancer phase.) How much institutional time is allocated to prescribing and coordinating SCC?

Resources

What human resources (multidisciplinary, coordination, community–hospital liaison) are available?
What structural resources can be mobilised, both within and beyond the hospital?

These three dimensions are rarely isolated and intersect in clinical situations (Fig. 1).

Participants described "tension-free" situations as those in which a coherent alignment was achieved between the patient's needs, the timing of the prescription, and the resources available.

Data saturation was reached at the ninth interview. Two further interviews were conducted to confirm the stability of the categories and to consolidate the relevance of the PTR model among new participants.

4. Discussion

Typology of ethical tensions and conceptual contribution

Our findings highlight the presence of multiple ethical tensions in the prescription of supportive cancer care (SCC). These tensions, often implicit and rarely named as such by professionals, reflect moral unease and a sense of powerlessness in the face of systemic and organisational constraints. Identifying two main forms of tension, non-dilemmatic (NDET) and dilemmatic (DET), makes visible a reality that is often experienced but rarely formalised in the literature.

While DET refer to explicit conflicts between ethical principles (autonomy vs beneficence, justice vs non-maleficence, etc.), NDET reflect an external barrier to implementing the ethics of care, linked to a lack of time, resources, or socio-cultural barriers.

This distinction constitutes an original conceptual contribution, resonating with recent literature on ethical tensions in care settings, which shows that such tensions are not limited to explicit dilemmas as described in the principlism of Beauchamp and Childress(9), but also include structural and organisational constraints affecting clinical situations (10, 11). This dual anchoring, in both ethical principles and real-world constraints, grounds an applied ethics approach centred on healthcare professionals' concrete experience.

This distinction between dilemmatic and non-dilemmatic tensions can also be considered in light of Jameton's foundational work(12), which distinguishes the moral dilemma (a situation in which two morally defensible actions conflict without either clearly prevailing) from moral distress, which arises when a professional knows which action would be most appropriate but is prevented from carrying it out

by external constraints (organisational, institutional, or resource-related). DET, as observed in our study, thus resemble the moral dilemma described by Jameton, while NDET align more directly with the concept of moral distress.

Patient-centred dimension

The prescription of SCC appears inseparable from the singularity of the patient: physical vulnerability, fatigue, anxiety, isolation, life trajectory, preferences, and relationship to care. These elements show that offering care is not merely a technical response, but is rooted in a unique encounter between a patient and a professional, in which the patient's values, expectations, and capacity for engagement shape what is offered.

Professionals describe situations in which the patient's voice is implicit, sometimes difficult to hear or interpret. Noorulhuda et al.(13) showed that ethical concerns expressed by patients and their families are often implicit and rarely recognised as such by healthcare professionals. This communication asymmetry, also observed in our study, creates a gap between perceived need and institutional response, and illustrates how understanding the patient extends beyond the purely clinical register.

On a theoretical level, Ricoeur(14) and Tronto(15) remind us that the ethics of care rests on recognising vulnerability and otherness. Gilligan(16) extends this approach by showing that vulnerability is not a weakness, but a moral resource that enables a responsive and humane response.

Finally, Bertaud et al.(17), from the perspective of a relational ethics of care, note that the rightness of a care situation depends on the quality of the relationship and the reciprocity of concern, more than on strict conformity to a norm.

Thus, every SCC prescription takes place within a space of solicitude, in which clinical appropriateness stems not only from medical efficacy but also from the professional's capacity to recognise the patient's singularity and vulnerability, within a logic of shared responsibility.

Temporal dimension and the kairos of care

Time emerges as a central dimension in SCC prescribing. Healthcare professionals describe several pivotal moments in the cancer pathway (diagnosis disclosure, relapse, end of specific treatments, or transition to palliative care) at which offering SCC becomes particularly delicate. These moments are marked by heightened patient vulnerability and by the need for professionals to find the right moment to raise the possibility of support or introduce it.

This rightness of timing, or kairos, as defined by Frédéric Worms(18), corresponds to the opportune moment at which care takes on meaning in responding to the vulnerability of the other. It expresses the ongoing tension between the patient's lived time, often singular and unpredictable, and the institutional time of care organisations, structured by constraints and protocols.

Our observations align with those of Murphy et al.(19), who show how trust can influence the timing of clinical situations and, at times, make them more complex to articulate. Similarly, Sterie et al.(20) note that the timing of a decision shapes the perception of its ethical rightness, for patients and professionals alike.

Finally, Bertaud et al.(17) propose considering attention to kairos as a moral indicator of quality of care, on a par with clinical appropriateness.

Resources, justice and organisational equity

The question of justice runs throughout the interview material. Healthcare professionals describe inequalities in access linked to economic, cultural, or geographical resources, confirming the findings of Bourgeois et al.(21). The work of Ullrich et al.(22) illustrates how organisational constraints affect both patients and their families, revealing organisational justice that is unevenly embodied depending on context. The prescription of SCC thus appears as an ethical indicator of institutions' capacity to guarantee equitable access to supportive care and to translate the principles of equality and beneficence into practice.

Recognition of tensions and reflexive stance

An essential contribution of this study lies in bringing to light tensions that are experienced but not named as ethical. Healthcare professionals express their unease in terms of frustration or powerlessness, rather than in moral language. This lack of naming, already described by Crico et al.(11) and Noorulhuda et al.(13), hinders the collective elaboration of value conflicts.

Recognising these situations as ethical tensions is a first step towards their institutional management. Spaces for ethical discussion integrated into clinical practice, as suggested by several recent authors in applied ethics, offer a concrete lever for reducing moral distress and strengthening team cohesion.

In this respect, narrative medicine, according to Charon(23), provides a framework for welcoming and sharing these experiences of tension. Authors such as Gâteau(24) and Delorenzo(25, 26) extend this approach by showing that attention to the narratives of patients and professionals can transform situations of constraint into opportunities for shared meaning. This narrative stance aligns with the reflexivity advocated by contemporary models of care, giving voice to the lived ethical dimension of care.

The PTR model: practical contributions and applications

This model is not intended to eliminate ethical tensions, but to make them explicit and to provide a framework enabling professionals to identify them, name them, and analyse their recurrent causes. The PTR model (Patient-Temporality-Resources) formalises the three interdependent dimensions identified in the study and offers a framework for identifying and analysing ethical tensions suited to clinical practice. It is not intended as a normative framework, but as a dynamic tool, grounded in teams' everyday practice,

aimed at making ethical tensions visible and supporting their discussion rather than resolving them prescriptively.

This positioning warrants clarification. In the earlier formulations of this work, PTR had been envisaged as a decision-support model for prescribing. Following discussions with the thesis examination board and a critical post-thesis review, this positioning was refined: given the sample size and the single-centre nature of the study, presenting PTR as a tool for diagnosing recurrent causes of tension, rather than as a decision-support tool in the strict sense, appeared both more methodologically prudent and more faithful to the actual scope of the data collected, identifying and naming tensions rather than prescribing a course of action.

The model can be used at several levels:

- Supporting the identification and understanding of ethical tensions, helping to anticipate possible tensions and adjust prescribing to real-world constraints;
- Serving as a teaching tool, in initial and continuing education, to foster reflexivity and a culture of ethical questioning;
- Strengthening organisational coordination, particularly in multidisciplinary team meetings (SCC MDTs) or within regional care networks, by facilitating collective deliberation around complex situations.

This model aligns with the work of Sterie et al.(20) and Haan et al.(27) on collective ethical deliberation, and is in keeping with the perspective of moral case deliberation (Bartholdson et al.(28)).

Through its use, the PTR model fosters shared recognition of tensions and interdisciplinary dialogue around care situations, without aiming to standardise decisions.

Limitations and perspectives

The limitations of this study relate to the small sample size and its single-centre nature. The analysis relies exclusively on healthcare professionals' perceptions, without direct integration of the perspectives of patients or their families.

Several perspectives can be considered:

- Incorporating the voices of patients and families through participatory studies, in order to compare tensions perceived by professionals with patients' lived experiences.
- Exploring the use of the PTR model as a tool for analysing clinical situations, without prescriptive intent.
- Developing indicators of institutional ethical maturity based on the PTR model, to measure organisations' capacity to recognise and manage everyday ethical tensions.

- Subjecting the PTR model to a formal validation process, for example with other teams or in other clinical settings, in order to assess its robustness and generalisability.

These perspectives extend the original aim of the study: contributing to the recognition of ethical tensions related to SCC prescribing, by articulating values, actors, and constraints within a logic of shared responsibility.

Conclusion

This qualitative study shows that the prescription of supportive cancer care (SCC) constitutes a complex ethical process, shaped both by contextual constraints (NDET) and by dilemmas (DET). The three dimensions identified (Patient, Temporality, and Resources) structure the PTR model, conceived as a tool for recognising, classifying, and analysing ethical tensions. Bringing these tensions into visibility and mapping them provides a framework for a more reflexive and coherent practice, situated at the intersection of the singular (the patient) and the systemic (the organisation).

Declarations

Clinical trial number

Not applicable.

Ethics approval and consent to participate

All procedures involving human participants in this study were performed in accordance with the Declaration of Helsinki and relevant institutional guidelines and regulations. This study received a favourable opinion from the Ethics, Deontology and Scientific Integrity Committee of Nantes Université (CEDIS), reference n°11032025 (IRB registration: IRB00013074). Written information was provided to all potential participants prior to enrolment, and informed consent was obtained in two steps: at the time of invitation, and orally at the start of each interview after the information note had been re-read. The information note and consent form explicitly stated that findings, including anonymised participant quotations, would be disseminated in academic conferences and peer-reviewed journals in oncology and supportive care, and participants consented on this basis.

Consent for publication

Not applicable. No identifying images, videos, or personal details of individual participants are reported. Verbatim quotations have been selected and, where necessary, lightly de-identified to prevent indirect identification of participants or patients described therein.

Availability of data and materials

The interview transcripts generated and analysed during the current study are not publicly available in order to preserve participant anonymity and confidentiality, as agreed in the consent process, but de-identified excerpts are available from the corresponding author on reasonable request. The interview guide is provided in Additional file 2.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

SAA conceived and designed the study, conducted all interviews, performed the qualitative analysis, and drafted the manuscript. PT supervised the study throughout its conception, methodological design, and analysis, and critically revised the manuscript. GD, as a member of the examination board for the underlying Master's dissertation, provided critical feedback that substantially enriched the analysis and discussion, and approved the manuscript for publication. ICZ supervised the clinical fieldwork, facilitated participant recruitment on site, and critically revised the manuscript for important intellectual content. All authors read and approved the final manuscript.

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Figures

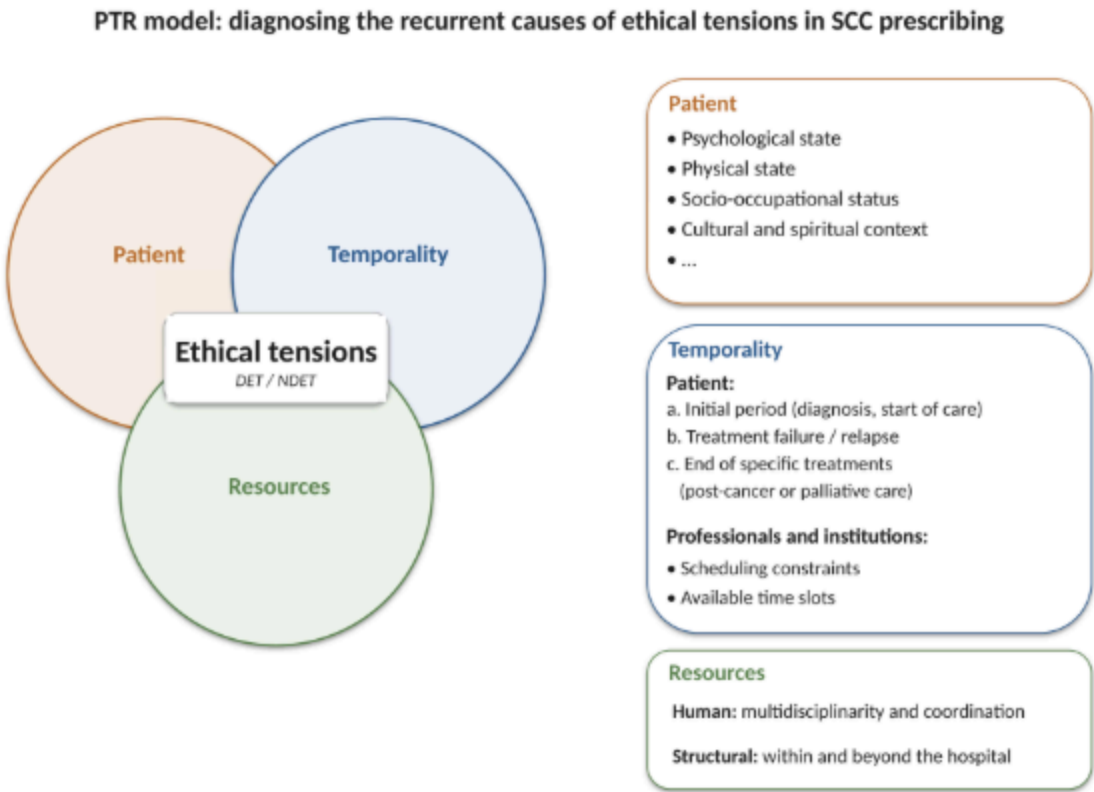


Figure 1. PTR model (Patient, Temporality, Resources) — ethical tensions (DET/NDET) emerge from the interweaving of these three dimensions, rarely isolated in clinical situations.

Figure 1

PTR model (Patient, Temporality, Resources): diagnosing the causes of ethical tensions in SCC

The PTR model represents the three recurrent dimensions identified by the cross-case analysis as sources of ethical tension in the prescription of supportive cancer care (SCC). The Patient dimension refers to the patient's individual characteristics (age, psychological and physical state, gender, socio-economic status, linguistic or cultural barriers, support network). The Temporality dimension encompasses both the point in the care pathway at which the patient is situated (diagnosis disclosure, relapse, end of specific treatments, palliative phase, or post-cancer phase) and the institutional time available for prescribing and coordinating SCC. The Resources dimension covers human resources (multidisciplinarity, coordination, community-hospital liaison) and structural resources that can be mobilised, both within and beyond the hospital. These three dimensions are rarely isolated: they intersect in clinical situations and combine to generate ethical tensions, whether non-dilemmatic (NDET) or dilemmatic (DET). The PTR model thus constitutes a tool for identifying and diagnosing these recurrent causes.

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