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Patient participation decisions in reflective support within palliative care: task–patient–context fit and the boundaries of evidence-based inference

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Abstract

Background: Nurses in palliative care routinely decide whether, and under what conditions, a patient can take part in reflective support such as dignity therapy or meaning-centred psychotherapy. The Personhood Pentadigm framework describes physical stabilization as a "strict prerequisite" for such support. Yet the evidence a nurse has to hand does not always settle how that requirement should be carried into a decision about a particular patient.

Methods: This paper is a critical conceptual argument grounded in the literature. A purposive set of theoretical, clinical, and task-adaptation sources published between 1995 and 2025 was identified through PubMed, Europe PMC, Scopus, Web of Science, CINAHL, Embase, and CNKI, together with one source text known before the search. The sources were organized around three questions: what eligibility criteria can support about participation capacity, what participation-process outcomes can support about reasons for limitation, and what task-adaptation materials can support about participation improvement and preservation of core tasks.

Results: Three inferential leaps recur across the sources, and each needs its own warrant before it can guide clinical judgment. The first moves from study eligibility to task-related capacity. The second moves from participation outcomes such as refusal, dropout, and loss to follow-up to reasons for limitation. The third moves from task

adaptation to participation improvement and preservation of the original task's core requirements. The "somatic runway" necessity claim cannot be established by eligibility or participation-process data alone; the conditions, tasks, and contexts to which it applies have to be named.

Conclusions: Physical condition and participation should be judged within the specific patient, task, timing, and care context, not against a uniform physical threshold. The task–patient–context fit perspective gathers these elements into a single analytic lens for nursing assessment. Its clinical usefulness remains to be tested in prospective and implementation studies.

Keywords: palliative care; nursing; patient participation; reflective support; clinical judgment; decision-making; evidence-based inference

Background

Existential support in palliative care exists to answer the distress patients feel about meaning, identity, relationships, dignity, and death. Structured interventions such as Dignity Therapy [1], Meaning-Centered Psychotherapy, and CALM (Managing Cancer And Living Meaningfully) [2] pursue that end along different paths, while less structured activities, companionship, attentive listening, and the expression of spiritual needs, belong to a wider category of support. These activities ask different things of a patient's attention, recall, organization, and expression, and how effective or accessible they are depends further on symptom burden, functional decline, alertness, mode of communication, preferences, and the conditions of the service itself [3, 4]. It is not enough, then, to ask whether support works. The real question is the conditions under which a patient can take part in a particular form of support at an acceptable cost.

Patient participation is not one event but a process, running through invitation, consent, initiation, maintenance, and completion. Several distinctions follow. Being eligible for a study is not the same as being clinically able to participate; refusing a study is not the same as refusing support; and failing to finish follow-up is not the same as failing to finish an intervention. These materials carry useful clues about why participation is difficult, but each kind has its own reach, and swapping one for another

without saying so is what produces an inferential leap. This paper works through the logic of those leaps and the evidence each would need, without trying to count how often they occur in research or in practice.

Neo et al. use the "somatic runway" metaphor within the Personhood Pentadigm framework, linking physical stabilization to the delivery of reflective therapies and describing it as a "strict prerequisite" [5]. The expression is examined here at its original strength. The authors are not assumed to claim an absence of symptoms, a fixed scale threshold, or applicability to all existential support. What is at issue is narrower. The source text asserts that the "somatic runway" established through physical stabilization is a strict prerequisite for reflective therapies. The question this paper pursues is what conditions the phrase refers to, which tasks it governs, and what grounds its necessity. There is also a risk worth watching, namely that the expression could drift into an eligibility requirement for all support. The original authors have not made that move, and this paper does not attribute it to them.

The question examined here is not whether physical condition matters. It is how that importance gets translated into the decision about a particular patient. Study eligibility, participation outcomes, and task adaptation supply different kinds of information, and until the link between that information and a specific task is made explicit, restrictions on participation and their adjustable scope cannot be judged properly. The contribution is correspondingly specific. The paper does not restate the familiar point that participation varies by individual and by context. It scrutinizes three inferential leaps that recur in participation decisions: moving from study eligibility to task-related capacity, from participation outcomes to reasons for limitation, and from task adaptation to participation improvement or preservation of the task's core requirements.

These leaps carry particular weight in palliative care, because there they can pull in two opposite directions. A patient who could still benefit from reflective support may be denied it, on the grounds that their state falls short of a threshold borrowed from a research eligibility criterion. Or a burdensome structured task may be imposed early, because an adaptation study reported feasibility without showing that the core reflective requirement survived. Neither outcome is a harmless abstraction. Reflective support is

often offered near the end of life, when a second chance may not come, and the cost of an unsuitable task falls on a patient with little energy to spare. The paper therefore proposes the task–patient–context fit perspective, and sets it alongside person-centred care and relational autonomy to mark where it overlaps and where it parts company.

Methods

Analytic orientation and scope

This paper is a literature-supported critical conceptual argument. Its aim is to clarify the conceptual relationship between physical condition and participation in reflective support, not to compile a list of attributes or to estimate clinical effects. The analysis leans on what nursing concept-clarification scholarship has said about conceptual maturity, differentiation from neighbouring concepts, and contexts of use [6, 7, 8], but it does not claim to have run a standardized concept-analysis procedure. Source selection is purposive. Where the materials reviewed do not establish a proposition, that proposition is not treated as refuted, and the paper does not assume the inferential leaps it discusses are common in practice.

Scope delimitation. "Existential support" is used here as a broad term for responses to distress concerning meaning, identity, dignity, and death, and it forms a wider superordinate category. Within it, "reflective support" names the activities that require the patient to understand, recall, organize, or meaningfully express their own experience to some degree, and these activities are the primary object of analysis. "Reflective support tasks" are the unit of analysis for specific participation decisions. These are working terms adopted to mark different participation demands. They do not claim to be an established intervention classification, and "reflective therapies" is reserved for specific named therapies in the source literature, such as Dignity Therapy and Meaning-Centered Psychotherapy. Participation decisions in reflective support tasks are the paper's concern. Companionship and assisted-expression materials serve to draw the boundary of support, not to equate it with full psychotherapy.

Structured psychotherapy, spiritual-needs expression, picture-assisted communication, and family proxy narration are not treated as interchangeable. Each

support form is read through the demands it places on cognition, communication, emotion, and sustained participation. The argument's direct focus is on structured reflective tasks that require the patient to do some of the processing themselves. Low-structured communication, spiritual expression, and assisted-communication materials are used only to test where the concepts stop, and they are not offered as evidence of the capacity or effects of structured interventions. Task load is not read off the name of a therapy. It has to be judged against sustained attention, recall and organization, mode of expression, duration, number of repetitions, and emotional burden, since even a short session can be emotionally heavy. The discussion of "reflective support" is therefore wider than the "reflective therapies" named in the source text, but the core argument first concerns tasks that require structured processing of experience. Other low-structured forms only mark the boundary, and no conclusion about capacity or effect is drawn from them.

Working distinctions

Before the analysis, several sets of working distinctions used in this paper are defined (Table 1). These distinctions serve the argument and do not constitute new diagnostic classifications or measurement standards.

Table 1. Working distinctions used in this paper

Term	Meaning in this paper	Should not be conflated with
Physical stabilization	The necessity expression in the source text, still lacking adequate operational definition	Absence of symptoms, intact function, or reaching a fixed scale cut-off
Physical state	The patient's actual physical condition at a specific time point	The source-text term "physical stabilization"
Task-related capacity	The understanding, attention, expression, and tolerance conditions involved in completing a specific activity	Decision-making capacity in the legal or ethical sense
Willingness to participate	The patient's disposition to accept a particular support, topic, or format	A general attitude toward all support
Actual participation	Initiating, maintaining, or completing support activities at a specific time point	Meeting study eligibility
Capacity to participate	The participation opportunity jointly formed by patient condition, task requirements, and care arrangements	A validated new construct or scoring indicator

Physical symptoms, cognitive state, mode of communication, patient willingness, and care arrangements are kept distinct, but they are not assumed to act independently.

Conditions may pull together on participation, or one may work through another. A cognitive change may be the route by which disease, medication, or some other physical condition shapes participation, and assisted communication may soften the practical consequence of a physical limitation. What matters during analysis is to record what each study actually measured or reported, and to keep a connection between conditions separate from a conceptual equivalence. Cognitive and communication indicators are not read off as surrogate measures of physical stabilization.

"Physical condition" is used as a broader analytic term. "Physical stabilization" refers only to the expression in the source text, and "physical state" describes the patient's actual situation at a given moment. The three are not synonyms, and several pairings that look automatic should not be treated as such. Being mechanically ventilated is not the same as being unstable; being unable to vocalize is not the same as being cognitively impaired; cognitive impairment is not the same as being unable to take part in any support; and being ineligible for a study is not the same as being clinically unsuitable. Task-related capacity and informed decision-making capacity are likewise not equivalent, although they overlap, since both involve understanding, attention, and communication. The distinction drawn here between "task capacity" and "decision-making capacity" does not replace consent, refusal, and the assessments that attach to them. Nor does it imply that a patient who cannot complete a formal reflective task cannot choose a form of support or voice a preference. The point is simply to stop one English word, *capacity*, from silently covering two different things.

The starting proposition: what does the "strict prerequisite" need to qualify?

The source text describes the "somatic runway" established through physical stabilization as a "strict prerequisite" for reflective therapies ("Operationally, establishing a somatic runway via physical stabilization is a strict prerequisite for reflective therapies"; [5], p. 481). This wording makes a necessity claim, but the same text's accounts of the "somatic runway" refer separately to "symptom stabilization" (p. 482) and "physical and mental stability" (p. 485). These expressions are not judged here to be logically contradictory outright. They are instead treated as a scope issue that requires qualification in context. Specifically, what needs to be specified is which conditions are

required, for which reflective tasks, and to what timing and care arrangements the necessity judgment applies.

To read this claim, three notions have to be kept apart: a necessary condition, a facilitating condition, and a clinical priority. The first bears on whether a given participation outcome depends on the condition; the second on whether the condition makes that outcome more likely; the third on the order in which symptom management and support are arranged. The same physical condition can play different roles in different tasks and at different times. Acute symptoms, for example, may stop a patient tolerating a long structured session today, without stopping them from accepting a brief exchange or naming what support they need right now. Each of the three notions therefore has to be judged against a specific task and outcome, and the warrant for one cannot be traded for the warrant for another. What is under scrutiny, then, is the interpretable scope of this necessity expression in specific participation decisions, not a presupposition that it already amounts to a universal exclusion rule. The operationalization called for is not necessarily a single scale threshold. It is the specification of which physical conditions the term actually names, which support tasks it targets, and how that condition relates to the outcome that is expected.

Data sources

Three analytic questions, formulated before the search, structured the selection of evidence:

- **Q1**: What can eligibility criteria tell us about whether a patient can take part in a specific reflective task?

- **Q2**: What can participation outcomes, such as dropout, refusal, and loss to follow-up, tell us about why participation is difficult?

- **Q3**: What can task-adaptation studies tell us about whether an adapted task still preserves the patient's own reflective activity?

The source text under close reading [5] is the analytic starting point of this paper. It was a known document the author already held before the search, not a record the search

turned up, and it is therefore reported apart from the literature that came through searching and screening. Every clinical study and theoretical source that entered the substantive argument through the search was published before the search ran, with online publication dates no later than September 2025, so nothing that entered the argument through the search post-dates it.

The initial search was run in September 2026 across PubMed, Europe PMC, Scopus, Web of Science Core Collection, CINAHL Complete (EBSCOhost), Embase, and CNKI. The strategies were finalized before this search and left unchanged through screening and analysis; only their presentation in Additional file 1 was standardized and translated for reporting, so the strategies used for screening match those reported. Because this is a purposive conceptual argument rather than a systematic review, screening, reading, and analysis moved together as the argument developed, and the search built a pool of material around the three analytic questions rather than an exhaustive evidence base.

Before submission, the same strategies were re-run from 4 to 6 November 2026 as a check. The point was not to enlarge the evidence base but to see whether anything published after the initial search could shift the argument. Each newly retrieved record was tested against the same criterion used throughout, namely whether it offered verifiable material that directly answers one of the three analytic questions (eligibility–capacity, outcome–reason, adaptation–preservation). By that criterion the updated retrieval turned up nothing that needed to be added, so neither the analytic direction nor the twelve core materials changed. A final targeted supplementary search on 7 November, through the PubMed E-utilities interface, then checked three directions, task adaptation, possible counterexamples, and related theory, as a matter of due diligence. Its candidate records were assessed against the same criterion and none entered the substantive argument (see Additional file 1.4). The search dates, strategies, hit counts, retrieval counts, and cross-source deduplication methods for each source are reported in Additional file 1.

Records exported from the databases (6312 in total) were merged and deduplicated to form 3107 candidate records. The authors read the titles and abstracts of these 3107 records one by one and screened them manually according to research topic, study

population, support form, and relevance to the three analytic questions, with further full-text review of potentially relevant literature. This process aimed to identify materials relevant to the conceptual argument, rather than to conduct exhaustive evidence screening according to systematic-review standards.

On the basis of the preliminary manual screening and full-text review, the authors carried out purposive source selection according to the three analytic questions. A record was retained as a core material only when it satisfied all three of the following rules. The first rule was direct evidence mapping: the material had to report data or analysis that directly corresponds to one of the three analytic questions, such as an eligibility criterion together with actual participation outcome, dropout reason categories with stage-specific data, or an adapted task together with information on the patient's own reflective activity. The second rule was specification: the material had to state how the relevant condition was defined or measured, so that cut-offs and terms could be compared across studies rather than assumed equivalent. The third rule was boundary testing: the material had to support, limit, or contradict a proposition about capacity, reason, or preservation, while records that offered only neutral observation, such as a completion rate with no account of why participants did not complete, were set aside. Materials that examined task modification, including shortened sessions, family involvement, or assisted communication, were retained even when they did not focus on palliative reflective therapy, provided they bore on whether the core requirement of a task survives adaptation. In parallel, the authors deliberately sought materials that could offer alternative interpretive perspectives, around task adjustment, changes in participation form, and proxy narration, so that the argument would not rest only on confirmatory evidence. As recorded in Additional file 1.4, these candidate materials were assessed against the three analytic questions and none directly entered the substantive argument. Because the screening counts and exclusion reasons at each stage were not fully kept, this paper does not report stage-specific screening figures it cannot verify against records. The logic of source selection is shown in Table 2. Ultimately, 12 core materials were selected for substantive argument, comprising one source text, one theoretical source, and ten clinical studies, with additional relevant theoretical and methodological literature selected for conceptual positioning and description of analytic methods. These core

materials constitute the paper's core argument materials, and do not represent the completeness of evidence in the relevant field. The list and functional classification of each core material are provided in Additional file 2.

Table 2. Logic of source selection

Material category	Purpose of selection	Information to be extracted
Source text	Analyze the necessity claim	Original wording, context, applicable population
Study eligibility materials	Examine the relationship between eligibility and capacity	Inclusion criteria, exclusion criteria, measurement tools
Participation-process materials	Examine participation outcomes and reasons	Stage, timing, reasons, reporter
Task-adaptation materials	Examine adaptability	Adaptation content, patient contribution, completion
Competing materials	Test the boundaries of the argument	Remaining limitations, non-adjustable requirements

Analytic procedure

The analysis proceeded iteratively across the following activities, rather than in a strict, one-off sequence:

1. **Proposing the claim under scrutiny**: extract explicit assertions from the source text and record their context, including the original wording and location of expressions such as "strict prerequisite" and "physical stabilization".

2. **Specifying the additional warrant the inference needs**: identify what each type of material can directly report, and what further information is still missing before those facts can support a judgment about task capacity, reasons for limitation, or adaptation effects (see Table 4). Eligibility criteria and clinical capacity need a task basis; dropout outcomes and reasons for limitation need stage, timing, and reason data; task adjustment and participation improvement need implementation and outcome evaluation.

Table 4. Interpretive boundaries of different participation materials and their clinical judgment requirements

This table is a list of interpretation questions proposed by this paper, used to organize the evidence that needs to be supplemented in clinical judgment, and does not constitute an evidence grade or fixed decision rule.

Material type	Judgment directly supported	Possible inferential leap	Further warrant required
Study eligibility	Inclusion and exclusion scope of the study	Ineligibility = clinical inability to participate	Task correspondence, screening purpose, applicable population

Dropout or refusal	Events in the participation process	Dropout = insufficient physical condition	Stage of occurrence, timing, reasons, reporter
Completion	Activity completed as defined by the study	Completion = the patient's needs have been met, or the intervention has sufficient value for the patient	Definition of completion, patient goals, burden, and intention to stop
Task adaptation	Program change and its implementation	Adaptation = expansion of participation opportunities	Before/after adaptation comparison, actual new participants
Family-involved narration	Content source and contribution mode	Family narration = the patient has completed reflection	Patient contribution, confirmation, revision, and evaluation goals

3. **Comparing evidence fragments**: distinguish supporting, limiting, and indeterminate materials.

4. **Identifying and comparing competing propositions**: the authors made explicit the propositions that could support alternative readings, and tested them against the core materials and those found by targeted supplementary identification. The competing propositions include these: certain acute symptoms may temporarily stop a patient sustaining reflection; certain cognitive impairments may affect completion of particular structured tasks; shorter sessions may improve completion in particular populations; and some tasks may not preserve the patient's own reflective activity through proxy narration. Because the supplementary identification did not produce a complete, reproducible screening record, the comparison of competing material is not an exhaustive search for counterexamples.

5. **Revising the scope of claims**: record the reasons for narrowing a broader proposition to a narrower one.

A rule running throughout the analysis is that where materials cannot separate several plausible readings, the paper keeps the uncertainty and does not press them into evidence for or against necessity.

During the analysis, close reading of the original texts corrected the understanding of some materials, and the examples are recorded in Additional file 2. One study's PPS was first taken as an eligibility threshold, but the original text showed it was used only as a measurement variable for functional comparison, so it was no longer used to compare eligibility thresholds. Initial uncertainty about the nature of family involvement was

likewise resolved when the original text confirmed it as "proxy" narration, and the content source and the patient's contribution were then analyzed separately.

Principles of evidence interpretation

Three principles govern how the materials are read. The first is to keep the source of information straight. Patient self-reported reasons, study-process records, functional scores, and author interpretations are marked separately and not swapped for one another; direct quotations keep the original wording and note any translation, and paraphrase is kept distinct from the authors' own synthesis. The second is to keep levels of evidence distinct. A patient expressing a preference, attending a session, completing part of a task, and family proxy or co-narration each sit at a different level and cannot stand in for one another. The third is to hold interpretation within its scope. An evidence-limitation review tied to specific claims is carried out for the core materials (see Additional file 2.3), and supporting and opposing material are both recorded to avoid presenting one side only. The review delimits what each material can be read to support; it is not a formal quality appraisal or evidence grading.

Personnel, process, and use of artificial intelligence

This is a literature-supported conceptual argument carried out collaboratively by the authorship team. The search, source selection, and extraction were done by the authors, who checked the records against the original texts. A general-purpose AI assistant (WorkBuddy) was used only to help correct search expressions and translation errors in the reported strategies, and to help tighten the English wording for clarity and fluency; the authors reviewed and confirmed every correction against the original sources. The AI did not run the database searches or verify the full texts, both of which the authors did themselves. The AI tools are not listed as authors. All literature content, evidence classification, and final inferences were judged by the authors from the original materials, and the authors take responsibility for them.

Results

The analysis identified three inferential leaps that recur across the materials, each describing a movement from one kind of research evidence to a clinical judgment that the evidence alone does not support. The three are examined in turn below. For each, the

section sets out what the material can report, what is still missing before it can guide a participation decision, and the specific wording and cut-offs that must be read in the original text rather than treated as interchangeable. The correspondence between each core material and the leap it bears on is tabulated in Additional file 2.1, together with the warrant that would be needed to close the gap.

First leap: from study eligibility to task-related capacity

Study eligibility criteria, such as Palliative Performance Scale (PPS) scores, Mini-Mental State Examination (MMSE) thresholds, or the phrase "no cognitive impairment or physical limitation impeding participation", can be doing several jobs at once: safety, feasibility, sample control, and management of the study procedure. The minimum capacity a clinical task requires cannot be read off their names or values. To interpret them one has to know what they were set up for and how they map onto the specific task in question.

In the report of the cited CALM feasibility trial, for example, the exclusion criteria listed cognitive impairment, screened by the Short Orientation-Memory-Concentration Test (SOMCT), and current in-hospital psychiatric or psychological treatment; the study treated a SOMCT score below 20 as the marker of cognitive impairment [2]. A prospective Dignity Therapy study used the inclusion criterion "no dementia and other cognitive impairment, no physical limitation impeding participation", a qualitative exclusion rather than a PPS or MMSE number, and in that study PPSv2 served only as a measurement tool comparing participants with non-participants, not as an eligibility threshold [3]. A Dignity Therapy feasibility study in long-term care, by contrast, used an MMSE of 21 or above to admit direct participants and described this cohort as "cognitively intact"; the present paper follows that wording to describe the sample without treating the score as a universal test of intactness. In the same study twelve cognitively intact residents completed Dignity Therapy, while the dignity-related concerns of another eleven cognitively impaired residents were answered or narrated by family members in a proxy capacity, some residents represented by more than one family member, which was a different eligibility pathway altogether [9]. The two groups differ in cognitive condition and in who supplied the primary content, and should not be

merged into a single requirement; cohort-specific records are in Additional file 2.1. Which tool a study used, SOMCT, MMSE, or PPS, the direction of the cut-off, whether it was an inclusion or exclusion criterion, and what else was attached to it, all have to be read in the original text rather than treated as interchangeable numbers.

None of this means eligibility criteria and task-related capacity have nothing to do with each other. A criterion may well be an operational condition a researcher set to make sure an intervention could be delivered. But that connection has to be read against the purpose for which the criterion was set, the demands of the particular task, and how participation actually went. Without that, eligibility mainly tells us how one study defined its own population, and it cannot be stretched, without argument, into a general clinical verdict about who can take part in a category of reflective support.

Second leap: from participation outcomes to reasons for limitation

Dropout, refusal, and loss to follow-up in the participation process are signals of interruption or change of state. Whether they reflect difficulties in support participation requires additional information on stage, timing, and reasons.

The first thing to establish is who supplied the reason data. Samuels et al.'s interim analysis reported dropouts as a proportion of "the sample after excluding those still in progress", and sorted the reasons into five categories: health deterioration or death, patient withdrawal, loss to follow-up, discontinuation of palliative visits, and other or unknown. These categories describe the composition of reasons among the 76 non-completers, not the share of each reason in the whole enrolled sample. The study also found more dropout among those with poorer functional status, which hints that functional status and the ability to stay in a study may be linked, but it does not show the mechanism, and it cannot put all dropout down to physical limitation [10]. Applebaum et al. reported withdrawal-related categories including "too sick", logistical barriers, death, loss of interest, and loss to follow-up. "Too sick" is a reason the patient gave; death and loss to follow-up are study-process records, death being an event and loss to follow-up a contact or measurement status, and they come from different places, so they cannot be bundled together as patient self-report [4]. Houmann et al. separated three outcomes: acceptance, refusal, and non-response after invitation [3]. Patient-reported reasons, then,

speak to subjective experience, burden, or the wish to stop; researcher categories and process records say how the study sorted things; and functional scores describe function. Each answers a different question, and none by itself sets a universal capacity threshold or stands as an objective measure of physical limitation. Sample sizes, the five-category percentages, p-values, and denominators for each study are in Additional file 2.

When reading reason proportions, it is worth checking whether the categories a study reports are mutually exclusive, whether more than one reason was allowed, which stage each reason belongs to, and what "most common" is measured against, the whole enrolled sample or only the dropouts with a recorded reason. Where this is not stated, one should not assume the categories are mutually exclusive and exhaustive, and one should not treat each reason as equally weighted simply because each carries a percentage. The denominators and the way reasons were recorded for each study are in Additional file 2.

The second thing to establish is where, in the process, the dropout happened. Houmann et al.'s process data separated several events: not assessed, not meeting inclusion criteria, non-response after invitation, refusal to participate, and deterioration before interview after acceptance [3; the complete flow is in Additional file 2]. These occur at different stages and are different in kind, and none can be read uniformly as insufficient task capacity. "Non-response" is a contact state after invitation, not necessarily deterioration. "Refusal" can involve the burden of study procedures and the patient's own preferences. "Deterioration before interview" happens after consent but before the interview, and belongs to the course of illness. So even when patients look functionally well at baseline, a later dropout can come from the illness, from preferences, from study burden, or from service arrangements, and it cannot be taken as proof of poor capacity at the start. Loss to follow-up, similarly, can happen after the intervention is over, and cannot be coded uniformly as "unable to participate". Cognitive state also moves over time: qualitative accounts of nursing home residents' experience of Dignity Therapy suggest cognitive impairment "may be temporary or permanent" [11], and patients in persistent pain can still show interest or preference for work about meaning [12]. Both point the same way. Willingness to participate and the conditions for it are not

fixed by a static physical or cognitive state; they have to be read against timing and context.

Deriving "physical limitation is the reason for insufficient participation" from participation outcomes therefore requires supplementing stage, timing, and reason data. The dropout proportion alone cannot identify the specific reasons for limitation.

Third leap: from program adaptation to participation improvement and preservation of core tasks

The structure, content, or delivery of some reflective support programs can be redesigned. One adaptation study cut individual Meaning-Centered Psychotherapy to three sessions and shortened each from about an hour to about 30 to 45 minutes, delivered by nurses by telephone or video in home care, as a pilot randomized controlled trial. Of 33 participants in the intervention group, 31 finished all three sessions (94%). That figure measures completion of the intervention sessions, which is not the same as the feasibility and acceptability indicators, such as follow-up retention and satisfaction, that the study reported separately, and the two should not be merged into one overall completion or retention rate [13]. Another adaptation added a fourth "Essential Care" session to the three sessions of Meaning-Centered Psychotherapy–Palliative Care. This session brought in care planning and collaboration among patient, family, and team, and invited family or friends to join, so it went beyond shortening to reorganize content and restructure the intervention's goals. Of the 20 patients who received it, 19 completed all four sessions (nine individual, ten group) [14]. These studies show that Meaning-Centered Psychotherapy can take different implementation shapes through changes in session length, content, delivery, and care goals, and that each shape is workable in the population that enrolled. What they do not yet show is that the adapted shapes widened participation for people who were hard to include before, or that the adaptations are equivalent to the original in the patient's reflective process and its core requirements. Changing a task is not, by itself, proof that participation widened or that the core requirements survived.

Adaptation studies can answer at least three different questions: whether the program can be delivered, whether patients find it acceptable, and whether adaptation

actually widened participation for people who were previously hard to include. The third requires a before-and-after comparison of inclusion scope, participation structure, or actual opportunity; completion or satisfaction on their own cannot answer it. Nor are any of these three the same as improved efficacy, or as the preservation of the original task's core requirements, and they cannot stand in for one another.

To judge whether a task adaptation preserves the patient's own reflective activity, content-contribution modes are distinguished across contexts (Table 3). When the patient remains the source of the content and is only helped to convey it, the adjustment mainly changes the channel, that is, assisted expression. The picture-guided communication study in mechanically ventilated patients showed that people who could not vocalize could still name a spiritual affiliation and express emotion. That study enrolled ventilated patients free of delirium or dementia and able to use picture cards, so its result does not stretch to every ventilated patient; the material serves only to show that a blocked communication channel is not the same as a blocked expressive capacity, and it is not offered as evidence of the capacity for reflective therapy [15]. When the patient takes part while family help with understanding, recall, or organization, the adjustment offers relational support, that is, co-narration. When family mostly supply the content on the patient's behalf, it can be read as proxy narration, and whether the patient is present and whether they confirm or correct the content should be recorded separately rather than treated as the defining feature of proxy narration. The long-term care Dignity Therapy study gives a clear example: the dignity-related concerns of eleven cognitively impaired residents were answered or narrated by family in a proxy capacity, some represented by more than one relative, and this proxy cohort sits on a different eligibility pathway from the study's direct participants [9]. The same study described a resident who was cognitively intact but aphasic, whose pathway differed again, a further sign that the mode of content contribution cannot be read off a single diagnosis or functional label.

Table 3. Three content-contribution modes of family involvement

The following three modes are distinguished according to the primary source of narrative content and the patient's mode of contribution in content formation and expression, and are mainly used to analyze the third type of inferential leap. They are not mutually exclusive patient categories; the same patient may present different content-contribution modes in different narrative fragments, and may simultaneously involve family members expressing on the patient's

behalf and the patient partially confirming or revising. This distinction is an analytic distinction, not an empirically validated classification tool.

Content-contribution mode	Primary content source	Possible mode of patient participation	Outcome that cannot be directly inferred
Patient-led assisted expression	Patient	Conveying via pictures, tools, or others	The patient does not need communication support
Co-narration	Patient (primary or co-source)	Family members provide supplement, prompting, clarification, or assistance with organization	Both parties contribute equally
Proxy narration	Family member or proxy	May be present, confirm, or not directly participate	The patient has completed the reflective task

To evaluate whether an adaptation preserves the original task, one has to separate the goal, the participating subject, and the form of execution. Changing the form, shortening the session or switching to picture cards, need not distort the task. Producing the same product, such as the same legacy document, need not mean the same process happened; a patient's own reflection and a family member's narration on their behalf can leave similar documents while differing in where the content came from, how much reflection was the patient's own, and what outcome is the right one to measure. This paper therefore does not score "task change" as success or failure. It asks what was changed, what was kept, and what outcome should be evaluated. "Preserving the core requirements of the original task" means chiefly that the goal, core activity, and participating subject stay comparable, which is not the same as statistical equivalence of efficacy, a question that needs its own study and its own criteria.

Additional warrant required from materials to clinical judgment

What the three leaps share is this: participation materials are not useless for clinical judgment, but they have to be read for what they report, and the distance from that fact to a specific judgment has to be stated. Table 4 sets this out, listing for each type of material the information and boundaries it supplies and the warrant needed before it can be used in a further participation decision.

Discussion

Physical, cognitive, and communicative conditions can limit participation, but the materials gathered here cannot be used to set a single standard of physical stabilization that holds across tasks and contexts, and this says nothing about whether such warrant exists elsewhere in the evidence. The programs reviewed also show that some

requirements and delivery arrangements can be changed. Participation should therefore be read by looking at both the patient's condition and what the program asks, not by assuming that any mismatch is the patient's doing. The sections that follow take up the evidential implications of the three leaps, the limits of the necessity claim, and where task–patient–context fit stands in relation to theory and practice.

The three types of inferential leaps and their evidential implications

The three leaps point to a single lesson: nursing judgment has to do two things at once. It has to assess how the patient is now, and it has to ask whether the material in front of the nurse can actually carry the conclusion being drawn from it. Study eligibility, participation outcomes, and adaptation results describe different things: the boundary of a study population, events in a participation process, and how a program ran. Whether any of these means anything for a particular patient depends on there being a readable link between the material and the task, the patient's current state, and the care context. When eligibility screens, dropout records, or completion rates are converted directly into patient-level capacity judgments, what gets lost is the task requirement, the stage of participation, and the care conditions that could still be adjusted. So the nurse's job is not only to size up the patient. It is also to see what the material can and cannot support, and to name what is still missing between the research record and the decision at hand.

Boundaries of the necessity claim of physical stabilization

Failing to establish a universal scale threshold does not deny that some tasks need a minimum of alertness, understanding, expression, or tolerance, and prioritizing symptom management in acute dyspnea, severe pain, or delirium does not mean every form of support must wait for full stabilization. Nor does the failure to prove that physical stabilization is necessary for every task mean physical condition is irrelevant to any of them. The concern is narrower. When the "strict prerequisite" is applied to a specific decision, the conditions, tasks, and contexts have to be qualified, so that the necessity wording does not harden into a unified eligibility rule the source text never proposed.

On the evidential requirements for a necessity claim. Scrutinizing a necessity claim starts with naming the task, the participation outcome, and the conditions it actually targets. Correlational material from study eligibility or participation processes can hint at

a limitation, but it cannot by itself establish that a physical condition is necessary for a given task. To test the claim one has to record the patient's actual state, the task's demands, the help available, and how the task went, and then ask whether the participation observed still answers to the task and outcome the original proposition names.

There is one further condition that is easy to overlook, namely whether the way a patient completes a task depends on some form of substitutive support. Testing a necessary condition means distinguishing the condition as stated from the forms that might stand in for it. Watching a patient finish a task with assistance does not necessarily overturn a broad necessity claim; it only tells you which stated condition the assistance actually replaced. A patient who cannot speak, but completes part of a reflective activity through assisted communication, may refute the claim that independent verbal expression is necessary, without refuting the narrower claim that some workable channel of expression is necessary. A necessity judgment therefore cannot stop at whether the task was finished. It has to look at what support carried it through. Simply observing that people who did not meet the condition did not participate proves nothing about necessity, and observing that people who met it did not participate overturns nothing either. When a task was completed under substitutive support, what the observation refutes depends entirely on which stated condition that support replaced.

The use value of the metaphor cannot be read off participation studies. The dignity model and related care frameworks already include physical, cognitive, psychological, and social conditions [1], so in its constituent parts the "somatic runway" introduces no new dimensions. Participation studies can show that physical conditions and task arrangements matter, but they cannot show whether the metaphor improves understanding or decisions. Whether it earns its keep against existing formulations has to be judged against specific definitions. The source framework itself tries to integrate the physical, the sensory, role narrative, volitional behavior, and consciousness, rather than proposing a one-dimensional physical-first model. The critique here targets the evidence and the applicable boundaries of its necessity proposition, not the whole framework reduced to physical condition deciding participation. If the metaphor cannot serve

directly as an eligibility criterion, its value may lie elsewhere: in reminding nurses to watch how physical symptoms and reflective support are coordinated, and how physical state and psychological support are arranged, and in prompting a multidisciplinary look at the patient's present state and the timing of support. That is a value it may turn out to have, not an effect this paper has shown.

Applying the metaphor in the clinic can pull in two risky directions: holding back light support that could have been accepted, on the grounds that the body is "not yet stabilized", or pressing ahead with heavy structured reflection while ignoring acute symptoms and what the patient can tolerate. No study here measured these misuses, so they are risks to guard against and to test, not consequences already observed. What the paper discusses is the expansive reading the "strict prerequisite" wording may invite, not a claim that the original authors want to refuse or delay all existential support [5].

Theoretical positioning of task–patient–context fit

Framing participation as whether the patient has enough "runway" risks pulling attention too far toward the individual's state, and away from what the task itself demands and how the service is organized. Some of what looks like a patient's inability to participate may in fact be a mismatch of session length, timing, mode of expression, or access. From this angle, a participation difficulty does not automatically mean the patient lacks capacity; it may mean the format, the relationship, or the arrangement does not fit what the patient needs right now.

Existing work has already brought out the relational and contextual side of patient participation, from different theoretical levels. Kvæl et al. trace the dynamic, context-bound character of patient participation through concept analysis [16]. McCormack and McCance fold the care environment into their person-centred framework [17]. Wang et al. read the decision-making among patients, family, and nurses through relational autonomy [18]. These are important foundations, but their objects, analytic levels, and care settings do not fully coincide, and none can be equated straight across to participation decisions in reflective support.

The conceptual contribution is therefore not the observation that patient participation is relational or contextual. That point is already well made. What is added here is an account of the three inferential leaps that occur when existing research materials are turned into a decision about reflective support, together with an explicit statement of the warrant each inference needs. These are organized under the heading of task–patient–context fit, which holds the patient's current state, the demands of the specific task, the care arrangements, and their changes over time in a single frame. The purpose is to help a nurse see whether a participation difficulty sits in the patient's state, in the task, or in the arrangements around them. It is a perspective built from this argument, not an established model, an assessment tool, or a validated predictor.

Accordingly, "task–patient–context fit" is given concrete form as a set of analytic dimensions for nursing assessment, not as a clinical assessment tool. The dimensions are drawn from the literature-based argument and organize what clinical judgment should examine. They are not a validated tool, a mature model, or a quantitative predictor; they are not a scoring criterion or eligibility checklist, and they do not replace professional judgment. Table 1 distinguishes concepts that are easily conflated in participation decisions, while Table 5 arranges them into patient, task, context, and the dynamic dimension running across all three.

Table 5. Analytic dimensions of task–patient–context fit

These dimensions are derived from this paper's conceptual argument and are intended to organize clinical reasoning; they are neither exhaustive nor empirically validated assessment domains, and should not be interpreted as a clinical instrument or eligibility checklist.

Core level	Specific analytic content
Patient	Physical and cognitive state (pain, fatigue, symptom burden, cognition, and consciousness), communication conditions, willingness and preferences
Task	Reflective requirements, duration, number of sessions, emotional burden
Context	Care arrangements, assistance support, delivery method, and environmental conditions
Dynamic dimension (running through the above levels)	Changes over time in patient state, task requirements, and care arrangements

Judging whether a patient can take part in reflective support should not stop at the question of whether they reach some physical threshold. It should also ask whether their present state matches the demands of the particular task, the mode of communication

available, and the care context. This paper does not claim to have built a full theory of "fit". Its contribution is to set out, systematically, what must be shown when three kinds of research material are turned into clinical decisions, and to gather those requirements into the single perspective of task–patient–context fit. The three movements are these: from eligibility criteria to task-related capacity, from participation outcomes to reasons for limitation, and from task adaptation to participation improvement or preservation of core tasks. The perspective organizes what clinical judgment should look at, and the propositions it implies for practice are there to be tested by later empirical work, not to be adopted as a finished model.

Implications for nursing practice

The recommendations below follow from the analysis of how evidence is used, and from a nursing stance that respects patient choice and tries to reduce burden. They are not effects that the reviewed studies verified.

Participation should not be graded only by whether prescribed procedures were completed. A patient can get what they need from a single limited exchange, or can choose to stop once they understand the options, and stopping on their own terms should not be written off as failure. When reading participation outcomes, then, look beyond procedural completion. Ask whether the patient got the chance to express what they wanted to, whether the burden was bearable, and whether stopping matched their wishes.

As a normative clinical implication, an unvalidated physical threshold should not by itself be used to shut someone out of existential support. The decision still turns on willingness, task load, safety, and urgency. Where necessary, a heavy task can be paused while the comfort, companionship, or other light support the patient will accept is kept going. Two clinical moves need to be kept apart. When a patient cannot take part for now because of pain, fatigue, or delirium, the matter can, with their consent, be revisited when the state changes. But when a patient has clearly refused, repeated invitation cannot be dressed up as dynamic assessment. Reassessment looks again at the patient's state, needs, and what was already agreed, not at persuading someone who has said no. Respect for refusal, for pause, and for a change of mind comes before any completion rate.

Around these dimensions, a nurse can go on to ask: what support is the patient willing to accept; what is disturbing them now; what does this task actually require; which of its demands can be changed; and when, and on what ground, to look again. Accepting one support does not mean accepting every topic or procedure, nor does it mean the patient cannot stop. Symptom burden does not by itself mean inability to participate, and the goal of a support is not the same as the form it takes. It matters to separate what the patient cannot do from what the service has not arranged, and a temporary mismatch is not the same as permanent unsuitability, just as reassessment is not the same as asking again someone who has refused. These questions are prompts for thinking, not a validated instrument, and they are not scoring tools or standard procedures.

Reduced to a sequence, the judgment runs in four moves. First, name the task: what it asks of attention, recall, expression, and endurance, and what it is for. Second, read the patient as they are now, in alertness, pain, cognition, communication, and expressed preference, not as a score taken out of context. Third, look at what surrounds the task, the timing, the help available, the format that could be changed, and whether the same person will be there throughout. Fourth, judge the fit, and say plainly whether any gap is a temporary one that could close, or a stable one that calls for a different form of support. The point of the four moves is not to produce a verdict from a rule. It is to make the three elements explicit before a decision is reached, so that a refusal, a deferral, or an adaptation is attached to the reasons that justify it.

Two patients make the point concretely, because the judgment turns on fit rather than on any single threshold. The first has metastatic cancer. She reports pain of six out of ten, but she is alert, scores 26 on the MMSE, and asks to leave something behind for her family. She is tired, and that tiredness makes a full-length dignity therapy session a poor fit today. It is not a reason to exclude her. The fitting response is to offer a shorter session now and return to the full version once her pain is under better control; her opioid use is part of her clinical state, not an eligibility criterion. The second patient has advanced dementia and is ventilated in the intensive care unit, sedated as needed, and in no position to sustain a full narrative task. Here the fitting response is not a categorical

exclusion under a unit protocol, but a judgment that the full task fits poorly while adapted forms remain possible: a family member co-narrating what is known of the patient's values, or a deferral until after extubation if that is expected. What separates the two cases is not that one passes a test and the other fails. It is that the task, the patient's state, and the context fit differently, so the same questions lead to different actions.

Limitations and scope

This paper is a literature-supported conceptual argument, not a systematic review, a clinical trial, or a validation study, and its claims stay within those limits. What it does and does not do are set out here, so that the contribution can be read at its proper strength.

The paper maps the logical structure of three recurrent movements by which research evidence is turned into participation decisions, and it states the warrant each movement needs. It does not count how often these movements occur, in the literature or in practice, because the twelve core materials were chosen purposively to develop an argument, not drawn as a representative sample from which prevalence could be estimated. It does not offer a validated assessment tool, scoring system, or eligibility checklist, and it does not test whether the task–patient–context fit perspective changes decisions or outcomes. Its material comes mostly from advanced cancer and palliative care in high-income settings, with limited representation of home care and non-Western systems, and nothing here is claimed to transfer to every serious-illness population.

Three further limits follow from how the analysis was done. First, only one source text on the "somatic runway" expression was read closely, so the critique addresses the use and necessity claim within that text rather than every use of the term in the literature. Second, the search was meant to build a purposive pool, not an exhaustive base, and the stage-by-stage screening counts and exclusion reasons were not fully kept, so how much may have been missed cannot be estimated. Third, no formal quality appraisal of the core studies was done, and the evidence-limitation review in Additional file 2 marks interpretive scope rather than standing in for such an appraisal. Selection, interpretation, and citation-confirmation bias may remain even though the reasons for selection and the verification records were kept.

These limits point to what should come next, in three directions. The first is prospective: does a nurse reasoning through task–patient–context fit reach different, and better, participation decisions than current practice, and does that reduce both the false exclusion of patients who could benefit and the premature inclusion of patients who would be burdened. The second is comparative: where does this perspective add something over person-centred care and relational autonomy, and where does it restate them. The third is across settings and systems of care, since the material here is weighted toward advanced cancer in high-income services, with little from home care, the intensive care unit, or non-Western systems. The value of the paper is conceptual clarity, not empirical proof of effectiveness; what it offers is a sharper account of what evidence can and cannot support before a judgment is made, and it is offered in place of, not on top of, clinical experience.

Conclusions

The core claim of this paper is not to diminish the importance of physical condition in palliative care. It is to require that, when translating physical state into participation decisions, the specific task, the patient's current condition, the timing of participation, and the available care support be specified. Study eligibility, recruitment results, and follow-up status cannot alone represent task-related capacity. Program adaptation and proxy narration likewise cannot be uniformly interpreted as participation improvement or as preservation of the original task's core requirements.

There is a particular reason to raise this now. Over the past decade existential support in palliative care has moved in two directions at once. Interventions such as Dignity Therapy, Meaning-Centered Psychotherapy, and CALM have become more structured and protocol-driven, which is a real gain, since it makes them teachable and testable. At the same time the language of a physical prerequisite has grown more prominent in frameworks and guidance, and this framing, however well meant, carries a risk. When structured protocol meets prerequisite language, two opposite harms become possible. A patient in moderate pain or mild cognitive impairment, who could take part in a short guided reflection, may be shut out altogether on a threshold borrowed from a study criterion that was set for research feasibility, not for her. Or a team, reading an

adaptation study's completion rate as a green light, may roll out a shortened therapy in a setting where the patient's own reflection cannot happen, so that a sedated patient receives a task designed for reflection without the capacity to reflect. This paper does not resolve those harms. It pauses the logic that produces them, by insisting that the task, the patient, and the context be named before a decision is reached, and by keeping a necessity claim, a facilitating condition, and a clinical priority from being traded for one another. Task–patient–context fit offers a lens for doing that naming. Asking fit for what task, with what patient, in what context is hardly new; in a field where participation decisions are increasingly driven by protocol and eligibility criteria, it is nonetheless a question that needs to be asked, and the test of this perspective now lies in prospective and implementation studies.

List of abbreviations

CALM: Managing Cancer And Living Meaningfully; CNKI: China National Knowledge Infrastructure; ICU: Intensive Care Unit; MMSE: Mini-Mental State Examination; PPS: Palliative Performance Scale; SOMCT: Short Orientation-Memory-Concentration Test.

Declarations

Ethics approval and consent to participate

Not applicable. This is a literature-supported conceptual argument that did not involve human participants, primary data collection, or identifiable personal data.

Consent for publication

Not applicable.

Availability of data and materials

This study reports no new empirical data. The bibliographic records, search strategies, and core-material characteristics underlying the analysis are described in Additional files 1 and 2.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

X.G. conceived and designed the study, developed the central conceptual argument, led the search and source selection, and carried out the data curation and formal analysis; she also wrote the main manuscript text and revised it critically for intellectual content. Y.M. contributed to the search, source selection, data curation, and formal analysis, and helped draft the manuscript. Z.Y. and W.L. contributed to the formal analysis and reviewed and edited the manuscript. W.S. provided conceptual guidance, supervised the work, and reviewed and edited the manuscript. All authors read and approved the final manuscript.

Use of artificial intelligence

A general-purpose AI assistant (WorkBuddy) was used only to help correct search expressions and translation errors in the reported search strategies, and to revise English wording for clarity and fluency. All corrections were reviewed and confirmed by the authors against the original sources. The AI tools did not execute the database searches or perform the full-text verification of the original literature; all analysis, inferences, and conclusions were the authors' own work.

References

1. Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M. Dignity and psychotherapeutic considerations in end-of-life care. J Palliat Care. 2004;20(3):134–142.

2. Lo C, Hales S, Chiu A, Panday T, Malfitano C, Jung J, et al. Managing Cancer And Living Meaningfully (CALM): Randomised feasibility trial in patients with advanced cancer. BMJ Support Palliat Care. 2019;9(2):209–218.

3. Houmann LJ, Chochinov HM, Kristjanson LJ, Petersen MA, Groenvold M. A prospective evaluation of dignity therapy in advanced cancer patients admitted to palliative care. Palliat Med. 2014;28(5):448–458.

4. Applebaum AJ, Lichtenthal WG, Pessin HA, Radomski JN, Simay Gökbayrak N, Katz AM, et al. Factors associated with attrition from a randomized controlled trial of meaning-centered group psychotherapy for patients with advanced cancer. Psychooncology. 2012;21(11):1195–1204.

5. Neo HY, Fa C, Zhou J. The Personhood Pentadigm: A transcultural framework for analyzing existential distress in palliative care. Int J Nurs Sci. 2026;13(5):481–488.

6. Morse JM. Exploring the theoretical basis of nursing using advanced techniques of concept analysis. Adv Nurs Sci. 1995;17(3):31–46.

7. Kong EH. Agitation in dementia: Concept clarification. J Adv Nurs. 2005;52(5):526–536.

8. Stanek S. Goals of care: A concept clarification. J Adv Nurs. 2017;73(6):1302–1314.

9. Chochinov HM, Cann B, Cullihall K, Kristjanson L, Harlos M, McClement SE, et al. Dignity therapy: A feasibility study of elders in long-term care. Palliat Support Care. 2012;10(1):3–15.

10. Samuels V, Schoppee TM, Greenlee A, Gordon D, Jean S, Smith V, et al. Interim analysis of attrition rates in palliative care study on dignity therapy. Am J Hosp Palliat Care. 2021;38(12):1503–1508.

11. Hall S, Goddard C, Speck P, Higginson IJ. 'It makes me feel that I'm still relevant': A qualitative study of the views of nursing home residents on dignity therapy and taking part in a phase II randomised controlled trial of a palliative care psychotherapy. Palliat Med. 2013;27(4):358–366.

12. Winger JG, Ramos K, Steinhauser KE, Somers TJ, Porter LS, Kamal AH, et al. Enhancing meaning in the face of advanced cancer and pain: Qualitative evaluation of a meaning-centered psychosocial pain management intervention. Palliat Support Care. 2020;18(3):263–270.

13. Saracino RM, Park EY, Pessin H, Onorato N, McDonald MV, Demirjian C, et al. A pragmatic randomized controlled pilot trial of brief meaning-centered psychotherapy in home care. Cancer. 2025;131(18):e70082.

14. Quílez-Bielsa E, Barrado-Moreno V, Lastra Del Prado R, Arbonés-Mainar JM, Sebastian-Sanchez M, Ventura-Faci T. An adaptation of meaning-centered psychotherapy integrating "essential care": A pilot study. Palliat Support Care. 2022;20(4):496–504.

15. Berning JN, Poor AD, Buckley SM, Patel KR, Lederer DJ, Goldstein NE, et al. A novel picture guide to improve spiritual care and reduce anxiety in mechanically ventilated adults in the intensive care unit. Ann Am Thorac Soc. 2016;13(8):1333–1342.

16. Kvæl LAH, Debesay J, Langaas A, Bye A, Bergland A. A concept analysis of patient participation in intermediate care. Patient Educ Couns. 2018;101(8):1337–1350.

17. McCormack B, McCance TV. Development of a framework for person-centred nursing. J Adv Nurs. 2006;56(5):472–479.

18. Wang Y, Avilés L, Chandler C. Patient participation in decision-making during nursing care: A relational autonomy perspective. J Adv Nurs. 2026;82(6):6401–6415.

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