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Research Article

Following A Standardized Pathway- Patient Perspectives on Colorectal Cancer Care: A Qualitative Study

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Abstract

Background: Patients diagnosed with colorectal cancer follow standardized care pathways with diagnostic procedures and tailored treatment to ensure high-quality surgical care. The focus is primarily on surgical procedures and outcomes, and patients and healthcare professionals describe shortcomings in individual support and a lack of opportunities for participation. **Aims and Objectives:** To describe patient experiences within standardized care pathways for colorectal cancer. **Methods:** A qualitative descriptive design was used. The study was conducted at a surgery unit in southern Sweden. Convenience sampling was used and included sixteen patients. Data were collected using in-depth semi-structured interviews and analysed using qualitative conventional content analysis. **Results:** Three themes emerged in the analysis: Travelling along the colorectal cancer care pathway, bearing the mark of the disease, and telling one's story. According to the patients' narratives, interacting and continuous relationships with healthcare professionals were highlighted as important, feelings such as loneliness and the need for inclusion played a significant role to achieve participation. **Conclusion:** There is a discrepancy between the intentions of standardized care pathways and the patients experience within. Despite having access to healthcare professionals during standardized care pathways, patients may still experience feelings of loneliness and exclusion. Continuous contact with a specialist/contact nurse is seen as crucial to facilitate individual support and active participation. These insights underscore the importance of the role of specialist nurses in providing person-centered care within standardized care pathways, in bridging the gaps between clinical practice and patient expectations.

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Keywords: Colorectal cancer; Content analysis; Standardised pathway; ERAS; Person-centred care; Participation; Support; Contact nurse and Specialist nurse

Introduction

Colorectal Cancer (CRC) is one of the most prevalent types of cancer in developed countries [1]. With an aging global population, the number of people affected by CRC is increasing. Advances in screening and treatment have led to enhanced survival rates and longer life expectancy (WHO) [2]. In 2009, the Swedish government launched a national cancer strategy with Standardized Care Pathways (SCPs) for cancer diagnoses [3]. These are multidisciplinary care pathways, based on time-bound clinical guidelines to ensure quality and achieve success in diagnosis and treatment by minimizing waiting times, increasing patient satisfaction, and reducing regional disparities [3,4]. To ensure coherent care on the CRC pathway, patients are assigned a Contact Nurse (CN) at the time of diagnosis. The CN has in-depth knowledge of cancer care, and the role can be likened to that of a nursing navigator, with the overall responsibility to coordinate and maintain person-centred care (PCC) [4,5].

Person-centered care (PCC) is increasingly recognized as a key concept for delivering high-quality, safe care [6,7]. PCC has been found to lead to improved outcomes, including more efficient discharge processes, fewer hospitalizations, and enhanced quality of life for patients through increased motivation and satisfaction with their care [8]. The framework from Gothenburg of person-centred care (gPCC) is a philosophical model which endorse the individual´s resources, their interest, needs and preferences. From a gPCC perspective the essence of PCC is treating the patient as an individual, an equal partner in the healthcare team, acknowledging their unique needs and values, and fostering a holistic relationship [9]. This approach requires healthcare professionals to possess not only technical competence and self-awareness but also the ability to engage in shared decision-making in an equitable manner [6]. By embracing these principles, healthcare professionals can provide care that is respectful, responsive, and centered on the patient's unique context and preferences.

The cornerstone in treatment for nonmetastatic CRC is resection by surgery [10]. Enhanced Recovery After Surgery (ERAS) is used to ensure high quality and compliance in surgical care. This is an evidence-based concept defined as a clinical pathway designed with the intention of reducing surgical stress, accelerating recovery, and improving the physical outcome [11,12].

While the focus of SCPs and ERAS is primarily on procedures and outcomes, previous studies have shown disparities in patient experiences [13]. Although the SCPs and ERAS include information and support to patients, both patients and HCPs perceive shortcomings in individual support and information. They also describe the surgical environment as stressful and lacking the conditions for participation and PCC [14,15]. Some patients with CRC claim that the SCP process is too quick, allowing little time to reflect or understand the meaning of all its different phases [4].

Most existing studies on patients with CRC focus primarily on the period immediately before or after surgery and describe an absence of personalized information and emotional support [16,17]. There is sparse information on the experiences of patients with CRC throughout standardized pathways (whether SCPs or ERAS), meaning that this is incompletely understood [18]. Despite the importance of highly standardized, evidence-based care and PCC, there seems to be a gap between what is important to achieve in clinical practice and what patients inquire about. Therefore, this study was aimed at describing patients' experiences and needs within SCPs for CRC.

Methods

Ethical Issues/Approval

The Declaration of Helsinki (2022) [19] was the foundation for the study's ethical considerations. The study was approved by the head of the selected clinic where the study was conducted, and by the Swedish Ethical Review Authority [blinded for peer review].

Prior to the interviews, all participants were informed that their participation was voluntary and reassured they could withdraw from the study at any time without providing an explanation. All the participants were guaranteed confidentiality and an anonymous presentation of the findings.

Design

The study had a descriptive, qualitative design, with semi-structured interviews. Data were analysed using conventional content analysis in accordance with Hsieh and Shannon (2005) [20]. For reporting qualitative research, the Standards for Reporting Qualitative Research (SRQR) guideline was applied [21].

Setting

The study was undertaken at a surgical ward in a county hospital in southeast Sweden. The ward is a specialist colorectal surgery unit where perioperative care is structured based on ERAS guidelines [11] and all patients are offered a CN in accordance with the SCP.

Participants

Patient selection criteria were having CRC, being scheduled for elective surgery according to ERAS, and being able to speak and understand Swedish. In total, 34 consecutive patients were contacted by the surgery coordinator, and a written invitation to participate in the study was sent with the operation notice. Those who had signed the form for participation were contacted by one of the researchers (Å.P, a Specialist Nurse [SN] in surgical care working part-time in the selected unit) when at the hospital ward for surgery. Fifteen patients declined to participate, one did not answer, and two cancelled due to the ongoing COVID-19 pandemic. Thus, a total of 16 patients were included in this study (for the characteristics of the participants, see Table 1). With the intention of maximum variation of participants, we strived to include both female and male patients and a range of ages. The participants had a mean age of 75 years and their length of hospitalization ranged from 4 to 21 days. All participants underwent surgery, 8 of them had a permanent ostomy, 3 had an ostomy temporary (reversible) and 5 did not need to have an ostomy at all.

Characteristics	Number of participants (n = 16)
Age (years)	
40–60	3
61–80	10
> 81	3
Sex	
Female	9
Male	7
Household status	
Single	8
Living with partner	7
Living apart from partner	1
Education	
Grade school	5
Upper secondary school	8
University	3
Cancer type	
Colon cancer	5
Rectal cancer	11

Table 1: Characteristics of study participants.

Procedure

Patients who had consented participation were contacted by telephone after discharge (by Å.P) and were asked to decide on a time and place for the interview. All interviews took place in closed environments, to ensure confidentiality and prevent interruptions. Six patients chose to be interviewed in their homes. Nine interviews were conducted by telephone and one patient wished to be interviewed in the hospital. All interviews were conducted within four to six weeks of discharge.

Data Collection

The semi-structured interview guide was designed in collaboration between two of the authors, a specialist nurse (experienced in surgical care, PhD student) and an associate professor (with extended experience in qualitative research). The interview design was tested during interviews with the first three participants. These interviews were included, as adaption was deemed unnecessary. During the interviews, conducted by one of the authors (Å.P), patients were encouraged to freely describe their experiences within the CRC care pathway. There were a few pre-determined questions, serving to maintain the core of the interview (Table 2), and probing questions were used to gain deeper understanding. The interviews took place in January–May 2020 and lasted between 20 and 60 minutes (mean:40 minutes). The interviews were audio-recorded and transcribed verbatim by a professional transcription service. All the transcriptions were anonymized by replacing names with participant codes.

Questions
Can you describe, in your own words, how you have experienced care at the surgery clinic up until today?
How have you experienced the support and information at the care unit?
What does it mean, in your mind, that you 'get support from healthcare'?
Can you describe how you got day-to-day care after the operation at the care unit?
Can you describe how you have experienced the support from healthcare after your operation?
Would you have wanted any other preparation/support or information ahead of your hospital visit?
Is there anything else you would like to say about this?

Table 2: Pre-determined questions.

Analysis

The analysis process started with two of the authors (Å.P and K.S) repeatedly listening to and reading all the interviews individually, to get a sense of the whole and grow familiar with the text. With the study aim in mind, the two authors individually identified meaning units, key thoughts, or sentences. In the next step, the two authors discussed commonalities, differences, and similarities until agreement was reached, and the initial codes were formed and categorized (Table 3). Then, subcategories were grouped into categories, and based on consensus in the group, the categories were merged into overarching themes (Figure 1).

Meaning unit	Code	Subcategory	Category	Theme
physically, I would say … it's been great, and I am healing … there aren't all that big scars on my stomach, and it is what it is, but where I'm not really healed is in my head, mentally speaking, I'm just not with it. But that's a different matter, because I haven't been able, there hasn't been the time to talk to anyone or like, no, not in that way. (P18)	Discrepancy between body and soul, the significance of intimate conversations	Existential values and conversations	The self- story	Telling one's story

Table 3: Example of the analysis process.

Findings

Three main themes and six categories were identified after the analysis.

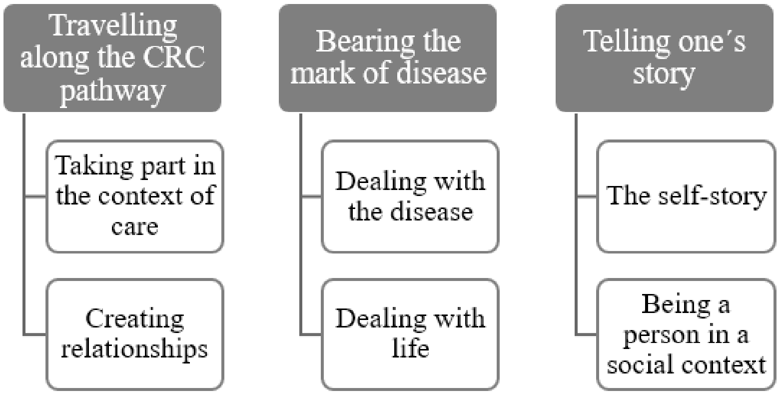

Figure 1: Structure of themes and categories.

Each theme is presented below, with its associated categories, illustrated using quotations from patients.

Travelling along the CRC care pathway

The participants described their CRC care pathway as a journey. They likened their experience to being on a predetermined route and emphasized the importance of continuity in care relationships.

Taking part in the context of care

All the participants described a fast and efficient investigation, with little time to think between the appointments on their SCP. Some of them even stated that they found the process to be too fast – they did not have time to process the diagnosis or the information. Further, the information was perceived as difficult to understand or deal with and they expressed feelings of shock related to the cancer diagnosis.

Additionally, the participants described the importance of continuity throughout their journey within the SCP, not only by meeting the same CN, but also in the meetings with surgeons. Continuity with HCPs was described in words like 'being in safe hands with people who know you'. This could give participants a sense of trust and confidence along the SCP. Having a CN was important, as it gave the sense of being involved and sharing decisions and information. Participants mentioned feeling a main character, being in the centre of the process. Others claimed the opposite: being left out, being excluded from their own care, and not understanding the SCP process.

I didn't have any demands regarding anything, that has really made things easier for them in their work ... I mean, if you are a layman, you don't have any knowledge about any of that, so you just have to do it and hope that they are right (P05)

Many of the participants expressed thoughts about the care context and their opportunities to be involved in their own care, especially around the time of discharge. Some of the participants felt prepared and ready to go home, whereas others were caught by surprise at being discharged on the same day as they got information about the discharge. These participants did not get time to either prepare for the journey home or inform their next of kin that they would be discharged. They stated that they were not listened to and felt excluded from the discharge process.

Creating Relationships

Creating relationships with HCPs seemed important to the participants. Some of them described building familiarity with HCPs addressing them by name, talking about ordinary things, telling jokes, and just being regular people, which was appreciated by the participants. When the HCPs on the ward seemed too busy or lacked engagement, participants felt ignored and neglected, which was an obstacle to interacting.

they said that themselves, too, that they had a lot going on, that it was a lot, and then it's not easy to get that response ... It was worse being in there ... I found it hectic ... there was no real engagement (P16)

Further, the participants interacted with HCPs in different ways – some of them described HCPs as natural collaborators, whereas others perceived them to be more like conductors, telling the participants what to do. The contact with the SN (ostomy therapist) on the ward was mentioned as especially significant and highly valued. The SN seemed to always have time set aside for each participant. The SN was a person they trusted and respected for their professionalism in interacting and teaching each person individually.

I feel like the healthcare staff was there to make sure that you are doing okay, that you aren't in need of anything and 'You should drink this and take these pills' ... But then there was the ostomy therapist, who took care of the other part ... because, I don't know if I would have felt, talking to the others, about, because I did feel like, that it was the stomal therapist who took care of this and fixed this and helped me and that meant I would turn to her ... I got to know her ... and then, like, it's her answers I trust (P04)

Bearing the mark of the disease

The participants emphasized the importance of having multiple strategies for dealing with the disease and transitioning to a life beyond the disease.

Dealing with the disease

Although the participants described the disease as a life crisis, they also underline the importance of being informed about the SCP and participating in the process. Getting knowledge about the spread of the disease and what to expect was a way for participants to process and have the diagnosis confirmed for themselves.

Some participants managed the crisis by preparing for the 'worst-case scenario' of chemotherapy, getting an ostomy, or not surviving, and the process of preparing their next of kin before being left behind. These participants talked about the reason for their strategy: 'then it can only get better'. Other participants described their strategy as 'taking things as they come', i.e., not worrying beforehand.

but when I was on chemo, I assumed the same thing there, that I would get everything ... all the side effects that exist, losing your hair, so I assumed it would be really bad. But when you have that attitude ... then it can't get any worse, then it can really only get better (08)

The participants described the burden of the disease as being double-edged, they said they were not physically ill, despite having surgical scars, but emotionally affected. Some of the participants described an experience of being emotionally disconnected as if the disease did not concern them.

physically, I would say ... it's been great, and I am healing and it's like, I mean, there aren't all that big scars on my stomach, and it is what it is, but where I'm not really healed is in my head, mentally speaking, I'm just not with it (P18)

Dealing with life

The participants mentioned the importance of returning to their job and life as it was before. Some of them talked about the everyday activities that they had to deal with, involving changes to eating habits, trying new food, or even rebuilding the bathroom to accommodate new routines. Participants with an ostomy said it was life-changing. For some, the ostomy meant more control over their bowel movements, whereas for others it had an even greater impact on life, with leakage and dressing issues.

For some of the participants, life after surgery meant concerns regarding the uncertainty of their treatment and having a stoma – wondering if perhaps they should have 'asked for a second opinion' before the surgery. These thoughts gave the participants a feeling that it was difficult to move on, but they still felt that they had to accept life beyond the disease and adapt to everyday life again.

What I didn't understand from the very beginning was that ... That they could go back, so I wouldn't have to have the stoma forever, ... now I've understood that I have to have this, so I accept that ...

Well, in part, at least. Sometimes I'll have lower periods and curse about it ... because I do think it's a hassle. But that's something you have to live with (P03)

Telling one's story

Being listened to and being affirmed as a person within a social context was of great significance to the participants during their entire journey within the SCP.

The self-story

Many of the participants expressed a need to talk about themself, their lives, their emotions, and their experiences. Some of the participants felt supported by their next of kin, whereas others said that their next of kin did not understand them. A feeling of being left out was described. Some participants did not have anyone to talk to at all and described the opportunity to talk to the CN or someone on the ward or as particularly important.

…and in particular when you are single, then it's really important with contact, and that you can have someone to talk to every now and then ... about this journey, it's really important to talk to people (P02)

The environment on the ward was described as inaccessible and sometimes even lonely. Some of the participants talked in terms of 'claiming space'. When the HCPs seemed to be relaxed and not stressed, these patients took the opportunity to claim space by asking for help or simply talking. Other participants passively waited to be given space. If the HCPs were in the nurse's office, they were perceived as unavailable, and the participants said that they did not want to disturb them.

But then sometimes they have a lot to do and then you don't want to bother them when they're sitting there behind the computer and typing and whatnot, then you don't want to go in and bother them about something ... yeah, you think 'Oh, I'll say that later' ... will you remember to do it later? No, that's the thing: you don't (P02)

Some of the participants mentioned feelings of loneliness on the ward, for instance when they had been left alone in their room between nursing interventions. The participants described the loneliness as palpable especially during the times between different shifts, in the evenings, and on weekends when HCPs did not appear on the ward.

Interacting with other patients on the ward was described as important. This could mean anything from mundane chitchat, during mealtimes to confidential conversations about their diagnosis or life itself.

She and I really connected, because she had a stoma operation too. And we would sit and eat together – she was really nice ... at first it was more general and then, over time, we became more and more like confidantes ... So, it was nice and it was entertaining and then ... time passed more quickly and everything (P01)

The participants indicated that they, by sharing their story and experiences with peers, gained a sense of having shared the same journey. They stated that it was important for them not to be alone with that experience.

Being a person in a social context

Having the time and opportunity to have calm conversations with HCPs was important for the participants to feel affirmed as human beings. The environment on the ward did not often provide space for one-on-one conversations. The participants mentioned rounds as one example, with many HCPs entering a room, often shared with other patients. The participants did not dare ask questions in this situation, due to the lack of privacy. The conversation was held at a superficial level, and some of the participants' concerns and questions were left unanswered.

Being treated as an independent and able person was described as important. The participants wanted to be independent and involved in their own care, even though the time after surgery was described as vulnerable. Participants stated that they were amazed at what they had accomplished and achieved in their care, with the support of HCPs, such as changing stoma dressings and giving themselves subcutaneous injections. They felt strong and proud of what they had achieved and stated that encouragement from HCPs was of great importance.

Some participants mentioned the importance of feeling in control and described themselves as 'Google people', who wanted to know everything. These participants also mentioned wanting the opportunity to read their medical records and follow their process within the SCP. This gave them a feeling of being in control, being safe, and getting knowledge. For others, this was stressful. The feelings of being ordered was mentioned. The sense of being the last to know was described as difficult to handle.

Because I felt, really, like – you know that they had the conference on Wednesdays ... so maybe they could already on the Thursday ... disclose what – because then you know ... 'Oh, now they know on Wednesday what's going to happen to me, and I have to wait until Monday to find out' (P15)

After the operation and follow-up visits, the participants likened the SN or CN, to a long arm, that could be used if they needed to. A feeling of belonging was mentioned by the participants, but some of them described ending their contact with the HCPs as 'breaking up'. Not having anyone to talk to after the SCP had ended was discussed and some participants voiced a need of continued talks with someone. Some of them even spoke in terms of 'who do I belong to now?' and feelings of loneliness and concern were mentioned.

Discussion

Our results revealed patients' experiences of and needs within standardized care pathways for colorectal cancer. The patients' narratives reflected how their journeys differed – from feeling included and as part of the team to feeling excluded and experiencing loneliness – and how the HCPs affected the outcome.

According to the participants in our study, the experience of being invited and included in care was important. The dynamic between patients and HCPs within the ward setting was described as multifaceted and based on individual interactions and institutional factors. Participants in our study highlighted a spectrum of experiences, ranging from feeling actively included as part of the care team to perceiving a more authoritative, instructional approach from HCPs. Several factors contribute to this dynamic, e.g. short hospital stays, high turnover of staff, and rapid care pathways, may mean that HCPs are less likely to build relationships and trust with the patient [22].

With limited time for interaction, both patients and HCPs may feel pressured to establish a relationship quickly, potentially impacting the depth of the relationship. The standardized nature of care often leaves little room for direct patient participation, and common goals are seldom set beyond medical intervention [8,22,23].

Although, continuity of personal contact was described by the participants as a springboard to achieving a trusting relationship, and as a prerequisite for participation. The participants specifically underlined the importance of having a CN or SN, a person they portrayed as having abilities such as trustworthiness, competence, and a personal approach. Especially for participants without any next of kin, the CN/SN was a rock to hold on to, get support from, or simply talk to. By being person-centred and acting as a source of knowledge, the CN coordinates patients and their next of kin along the cancer pathway, based on continuity and a trustful relationship [5,24]. Even though all patients with colorectal cancer are always offered a CN, this does not mean that all patients use this contact. This decision could be influenced by a lack of understanding of the CN's role by the patient or their next of kin, or concerns about potential interference or time constraints [25]. Despite a national description of the CN's mission, the role is described as inadequately and inconsistently defined and their implications in CRC care are sparsely studied and further research is requested [5,26]. The findings of our study confirm the importance of continuity and professionalism provided by CNs and highlights the crucial role that CNs play in ensuring consistent care and maintaining a high standard of professionalism for patients with CRC.

Further in our study participants with a stoma emphasized the importance of the dedicated time spent with the SN (ostomy therapist) on the ward, describing it as a valuable privilege-a privilege that was not granted to those without a stoma. This insight was new to us and is indeed significant. It raises important questions about the experiences of patients who do not receive a stoma and, consequently, do not have the opportunity to spend time with a SN during their stay on the ward.

The results of our study thus clarify the importance of an SN in the clinical inpatient care, and not only the importance of an CN, before and after surgery. This indicates an increased demand for all patients to receive equal care, with access to an SN during the time at the ward, regardless of ostomy or not. The support of a CN/SN would seem to be an integral link between the standardized care concept and PCC, ensuring a high quality of both life and health during a patient's journey through the SCP. Understanding the potential implications of this disparity is crucial for improving care and ensuring equitable access to specialized support. Further research in this area can help shed light on the specific needs and challenges faced by patients without a stoma and, consequently without a SN, and inform strategies to bridge gaps in their care.

The participants further described the importance of being listened to and getting the opportunity to talk about their experiences and needs. The environment on the ward was an obstacle to good conversations and rarely provided the opportunity for confidential conversations, which meant many thoughts and needs were left unspoken and not visible. Consequently, this can be challenging in a stressful environment, like on a surgery ward, with a high HCP workload. Studies have suggested that HCPs tend to distance themselves from patients in stressful situations and prioritize tasks rather than the patient [25]. The same goes for patients: they keep an eye on HCPs and will distance themselves if they perceive them to be stressed, busy, and not inviting, they will not share their stories or emotions with the HCPs [8]. For the participants in our study, this was described as feelings of being excluded and alone. Loneliness was described as particularly common during evenings and weekends when HCPs were few/ unavailable. But even on a day-to-day basis on the ward, surrounded by HCPs around the clock, the participants described the feeling of loneliness. This confirms the result that the participants did not want to interfere with either physical or emotional needs, even despite obvious needs for care, which is in line with the findings of other studies [27,28]. Loneliness was also described by the participants regarding their relationships with next of kin. Some participants mentioned not having next of kin to confide in or having next in kin who did not understand the significance of what they were going through. In addition, participants tended to protect their next of kin and avoided discussing their emotions with them [23]. Even with support from HCPs and next of kin, the participants could feel a sense of isolation, indicating unfulfilled needs extending beyond medical care [23].

Some participants sought support beyond the framework of healthcare, by talking to and interacting with other patients in the ward to reduce loneliness. According to Hajdarevic et al (2022) [29] HCPs tends to deliver information in a standardized format with focus on medical treatment and fails to offer any other support. Through mutuality and shared experiences with a fellow patient, the sense of community is created, as a supportive interaction that counteracts the experience of loneliness [29]. As the participants in our study indicated, contact with a fellow patient can offer experiential empathy, or just someone to talk to about ordinary things. Acknowledging the ambivalence in relationships between fellow patients is crucial, as sharing similar experiences can be both supportive and challenging. HCPs should provide appropriate guidance to help navigate these relationships effectively and be mindful of these dynamics to ensure that individuals involved are supported in an equal and respectful manner. The support of a fellow patient seems to be a double-edged phenomenon and its impact for patients within SCPs requires further study.

Despite the wide-ranging results - from feeling included to experiencing exclusion and loneliness-the patients all expressed one wish. They wanted to be seen not only as a patient with needs and desires, but also-and more importantly-as a person with resources. This can be viewed as a patient request for PCC and can be understood using the gPCC ‘s framework [8,9]. The development of equal, effective, and person-centred care is a priority in Swedish healthcare [30] and the framework of gPCC ‘s can be applied to our results, as the participants in the study pointed out the importance of continuity in the caring relationships to be able to tell their story and to be treated as a person with significant resources. Factors such as initiating, working, and safeguarding the partnership between patients and HCPs are cornerstones in the framework. Routines that embody the framework include capturing the patient’s narrative, co-creating a health plan based on the narrative (resources, barriers, and goals), and safeguarding the partnership by documenting the health plan [9]. To create PCC and support in a care process, HCPs must go beyond standardized routines and adapt their professionalism to meet the evolving needs of patients. Incorporating PCC principles into SCPs could address patients’ needs for acknowledgment, inclusion, and active participation throughout their cancer journey.

Patients’ feelings of exclusion, loneliness, and their need to be confirmed as individuals during the struggle to resume life, indicate that the cancer experience is a complex process. The patient’s needs for support are still not fulfilled and do not end with the SCP - supportive care must be adapted and follow each patient’s unique path [31]. Individual and tailored PCC from HCPs is important for well-being and quality of life, both within and outside SCPs.

Conclusion

The journey through a standardized pathway is a unique pathway toward life beyond disease and tailored person-centered care is crucial in supporting patients with colorectal cancer. Feelings of loneliness and abandonment can be obstacles to the patient’s commitment. In colorectal cancer care, specialist nurses play a significant role, not only by contribute with their expertise, but also to bridge gaps within standardized care pathways through their person-centered approach. There is a need for improved care quality for patients with CRC as regards to combine PCC and SCPs.

Strength and Limitations

This study has both strengths and limitations that need to be mentioned. The choice of analysis was determined because of the method’s ability to do justice to the understanding and meaning of communicative processes, its consequences, and its concepts [20]. This study was performed in a Swedish context, and the interviews were performed at only one unit, which might be a limitation. Thus, all interviews were informative and contained data with depth and richness, which is seen as a strength. According to Graneheim., et al (2017) [32], a sample size should be large enough to provide variations in the narrated experiences, but small enough to permit a deep analysis of the data. There is also a risk of that transferability may be affected by characteristics of the participants. It is possible that patients with a preferred prognosis experienced a better sense of participation, compared to those with a less favorable prognosis. These factors should be carefully considered when interpreting the results to ensure the trustworthiness of the study [32].

Methodological accuracy was strengthened by performing peer debriefing as a recurring element throughout the study, which contributed to credibility throughout the process [20]. During some parts of the study, all authors were involved, which contributed to the reliability of the study [32]. The analysis retains closeness to data, as do the categories and themes, which represent the thoughts and emotions of the participants, increasing the trustworthiness of the results [33-36].

Relevance to Clinical Practice

The findings of this study have implications for clinical practice in surgery units using a CRC care pathway or ERAS, as they provide insight into what patients with CRC consider to be important. By listening to and recognizing each patient as a person, HCPs could tailor care based on that patient’s unique resources and needs. The CN has a cross-organizational function that provides continuity and PCC before and after surgery. Access to a CN/SN should be provided throughout the care within the SCPs. This knowledge can be used to design and deliver relevant supportive cancer care. The person-centred framework of gPCC can be used to bridge the different dimensions of clinical standardized pathways and individual needs, in both clinical practice and HCPs' education programs.

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Conflict of Interest Statement

None declared.

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