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Five Clinical Vignettes on the Psychosocial Experiences of Patients with Terminal Digestive Cancer and Palliative Care in Abidjan

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Abstract

Terminal digestive cancer poses complex challenges for patients, their loved ones, and caregivers. This was a qualitative, prospective, descriptive study conducted on five patients with terminal digestive cancer in the general and endocrine surgery department of the Treichville University Hospital. Its objective was to describe their psychosocial experiences. The results of the study highlighted difficulties related to medical care. These difficulties mainly boiled down to the lack of palliative care for these types of patients. As palliative care is an integral part of medical, psychological, and social care, its absence in follow-up care has a negative impact on the psychosocial experiences of our respondents. On the other hand, our results also showed the existence of a number of worrying psychological states and social situations among our patients. However, a lack of psychological, social, and spiritual support was noted in the care of these patients and their families. This situation also exacerbates the already fragile psychosocial experience. In short, the absence of palliative care combined with a lack of psychological, social, and spiritual support are factors that negatively influence the psychosocial experience of patients in the terminal phase of digestive cancer. This study advocates for a holistic approach that includes all these aspects in order to better support patients with terminal digestive cancer and their caregivers during this phase of life.

Keywords

Terminal Digestive Cancer, Palliative Care, Psychosocial Experience

1. Introduction

Cancer is a chronic disease that can be kept stable for a long time through treatment (chemotherapy, radiotherapy, surgery, immunotherapy, targeted therapies, etc.). However, at a certain stage, the disease can escape curative treatment and enter its terminal phase. This phase is generally fairly easy to identify by both the doctor and the patient, whose general condition deteriorates suddenly and rapidly: extreme fatigue, loss of appetite, weight loss, pain. (National Center for End-of-Life Care and Palliative Care, 2023). Cancer is a major global public health challenge. Research continues to play a crucial role in understanding the mechanisms of cancer, its causes, the development of new treatments, and the improvement of care for cancer patients. A study conducted by a consortium of researchers and institutions entitled "The Cancer Genome Atlas (TCGA)" has developed the genetic aspect as a cause of cancer (National Cancer Institute, 2010-2015). Other authors have focused less on the disease and more on the sick person. These include Miller, who emphasized the psychosocial aspect of patient care, taking into account the emotional, social, and relational dimensions of his patients (Miller, 2022). However, certain aspects of end-of-life cancer are rarely addressed in the literature, yet they are just as important and deserve to be explored in detail. These include spirituality, financial issues, cultural diversity, the patient's experience, and improving palliative care. The concept of the patient's experience at the end of life refers to how they cope with their own death and how they feel and perceive this period of their life. This includes the patient's emotions, fears, needs, and wishes, as well as their experience of pain, suffering, and dignity at the end of life. This experience can vary from person to person, depending on their beliefs, relationships, health status, and personal experiences. Palliative care aims to relieve the physical, emotional, and spiritual suffering of terminally ill patients, but there are still gaps in the care of these patients.

The problem that arises and is of interest to this study is that the psychosocial experiences of patients at the end of life are not sufficiently taken into account in their care.

According to the WHO, cancer will cause nearly 10 million deaths in 2020, or almost one in six deaths, making it one of the leading causes of death worldwide (WHO, 2022). Cancer has reached epidemic proportions worldwide. In Côte d'Ivoire, cancer is a major problem due to its high morbidity and mortality rates. The number of new cases in Côte d'Ivoire was estimated at 17,300, including 9896 women and 7404 men. The five-year survival rate for stage 4 stomach cancer is 4% (Canadian Cancer Society, 2019). Digestive cancer has a major impact on society in terms of severity, frequency, consequences, and cost. Digestive cancer is therefore a real public health issue.

It is ideal to take these psychosocial dimensions into account in order to improve patients' quality of life and provide them with the best possible support during this difficult stage of their lives. By definition, palliative care strives to accompany patients at the end of their lives by helping them overcome physical pain or

psychological suffering. It mainly involves providing support during long-term illness. Thus, the complementary concepts of the WHO's definitions of health and palliative care, the concepts of Saunders, Kübler Ross, Dr. Frédéric's end-of-life concept, and Watson's theory of needs form the framework on which this research is based. In order to improve the care of patients with digestive cancer at the end of life, we ask the following research question: how do patients with terminal digestive cancer experience the end of their lives? In response to this research question, we have put forward three specific hypotheses:

- ✓ Difficulties related to medical care influence the psychosocial experience of patients with terminal digestive cancer.
- ✓ Difficulties related to psychological care influence the psychosocial experience of patients with terminal digestive cancer.
- ✓ Difficulties related to social care influence the psychosocial experience of patients with terminal digestive cancer.

2. Materials and Methods

This was a qualitative, prospective descriptive study focusing on the psychosocial experiences of patients with terminal digestive cancer. The target population for this study was patients with terminal digestive cancer. They were selected by doctors based on clinical signs of the terminal phase. The following were therefore included in the study:

- ✓ Patients with terminal digestive cancer being treated at Treichville University Hospital, which included significant weight loss, extreme fatigue, deterioration in general health, digestive problems (abdominal swelling), and jaundice.
- ✓ Who gave their verbal consent to participate in the study.

For further information and to better understand the psychosocial experiences of these patients, we also interviewed the patients' companions/parents and the nursing staff responsible for their care.

We used two sampling methods. The purposive sampling method was used for patients with terminal digestive cancer. The accidental or convenience sampling method was used for the patients' companions/parents and the nursing staff. The application of these two sampling methods enabled us to obtain a heterogeneous sample, composed as follows:

- Patients with terminal digestive cancer who were in service at the time of the investigation and who met the criteria: 5,
- ▪ Caregivers/parents of patients: 5,
- ▪ Treatment staff consisting of 1 doctor and 2 nurses: 3.

In terms of data collection techniques, we used three sources of data to gather information on the experiences of patients with terminal digestive cancer:

- Documents,
- Observation,
- Information provided by the patient during a semi-structured interview.

We used several data collection tools, as follows:

- ✓ A data collection form consisting of items relating to sociodemographic characteristics and psychosocial experiences. This form is sent to the patient.
- ✓ Two interview guides, one for healthcare staff and the other for caregivers/parents.

To collect the data, we used two types of interviews: a clinical interview for research purposes (Castarède, 2013) with patients with terminal digestive cancer and a semi-structured interview with healthcare staff and accompanying relatives.

Before administering these data collection tools, the ethical considerations and aspects related to this type of study were taken into account. Thus, in order to respect human rights and research ethics, the following precautions were taken:

We received authorization from the Ministry of Health and Universal Health Coverage.

- We obtained authorization from the Treichville University Hospital Administration.
- We obtained verbal informed consent from patients and healthcare staff.
- We reassured respondents that their responses would remain confidential.

For this study, we opted for qualitative analysis to process and analyze the information collected. According to Paillé and Mucchielli (2012), qualitative data analysis is defined first and foremost by its purpose: the researcher attempts to extract meaning from a text, interview, or corpus, with or without the aid of computerized tools. In other words, qualitative analysis is an analytical technique that gives meaning and significance to the subjects' comments and the various texts obtained using field research instruments. This analysis led to an understanding of the overt and latent (hidden) content of the exchanges with patients and their loved ones in particular.

In order to understand our subject of study, we agreed on two (2) methods: the phenomenological method and the clinical method.

The phenomenological method, which emphasizes the subjects' lived experiences, allowed us to focus on each subject's point of view in order to learn about and understand their psychosocial experiences.

A clinical method based on observations and in-depth analyses of individual cases, i.e., unique phenomena. It aims to understand behavior from its own perspective, to record as accurately as possible the ways of being of a concrete and complete human being grappling with a situation (Pedinielli, 1999). In this study, the clinical method allowed us to deepen our understanding of the psychosocial experiences of cancer patients.

3. Results

Our study sample is predominantly composed of men (3 men and 2 women). The age of this sample ranges from 25 to 67 years old, with an average age of 48.2 years old. In terms of occupation, three (03) of our respondents are self-employed, one (01) is retired, and one (01) is a student. The majority of patients in our survey are in a relationship (4/5). All patients surveyed belonged to a religion. (**Table 1**)

Table 1. Synoptic table of sociodemographic characteristics.

Sociodemographic characteristics of patients surveyed					
Identity	Gender	Age	Occupation	Religion	Marital status/Number of children
Case 1 (BP)	M	67 years old	Retired	Christian	Married/5 children
Case 2 (DGE)	F	25 years old	Student	Christian	Single /no children
Case 3 (KM)	M	42 years old	Mini-market manager	Muslim	Married/3 children
Case 4 (KAE)	F	50 years old	Shopkeeper	Christian	Cohabiting/4 children
Case 5 (ET)	M	57 years old	Shopkeeper	Christian	Married/5 children

The psychosocial experience of patients with terminal digestive cancers is influenced by three factors: difficulties related to medical, psychological, and social care. (Table 2)

Table 2. Summary table of difficulties encountered by patients in their care.

	Difficulties encountered by patients in their care
Case 1 (BP)	**-Lack of psychological and spiritual support:** Upon receiving the diagnosis "That day, I was with my wife, and we were shocked by the diagnosis. We needed psychological preparation. We would have preferred the announcement to have been made under different circumstances." **-Lack of palliative care and assistance from healthcare staff:** According to the nurse in charge of BP's care, "doctors no longer make standard bedside visits to patients at the end of life." "Care is not multidisciplinary."
Case 2 (DGE)	- **Lack of psychological support:** When the diagnosis was announced, "I was shocked by the diagnosis given by the emergency room doctor. He just told me like that, he didn't prepare me for it." - **Lack of palliative care:** According to the nurse in charge of DGE's care, "due to a lack of resources, the parents are unable to fill the prescriptions. Faced with such cases, we often feel powerless."
Case 3 (KM)	- **Lack of psychological support:** When I was told the diagnosis, "I took it that way because he told me I was going to have surgery, so I had a glimmer of hope." - **Lack of empathy from healthcare staff:** According to the doctor in charge of KM's care, "The doctor must have an attitude of detachment towards the patient at the end of life. Caregivers must stifle their feelings in order to be effective." **-Lack of palliative care/lack of social assistance:** "I need financial help, family warmth, assistance on all levels."
Case 4 (KAE)	- **Lack of psychological support:** When she received the diagnosis, "I was already very tired, and hearing the diagnosis devastated me." - **Lack of palliative care:** It was difficult for her to fill her prescriptions since she was no longer working. According to the doctor in charge of KAE's care, "Patients like this need to be in a palliative care unit so that their needs can be addressed."
Case 5 (ET)	- **Lack of psychological support:** According to the patient, "I accepted it because I believe in God." - **Lack of palliative care:** According to the doctor in charge of ET's care, "Patients at the end of life should be in a palliative care unit to benefit from multidisciplinary care." - **Lack of spiritual support:** "I just need spiritual guidance; that's my priority."

Psychosocial experience of patients with terminal digestive cancer

1) Psychological experiences

- **Fear**

Patients with terminal digestive cancer may experience a range of feelings, including fear. This fear may manifest itself as anxiety related to pain, death, loss of

control, suffering, isolation, or other aspects of the disease. Fear can be felt more intensely and immediately and may be associated with physical reactions such as palpitations, tremors, or muscle tension. Here are some factors that contribute to feelings of fear in these patients.

Fear of death

Patients who are facing the end of their lives may experience intense fear of death. They may wonder what will happen to them after they die and how their loved ones will cope with their loss.

- BP expresses his fears with these words: "I am very attached to my wife, I am afraid she will feel lonely if I die."
- As for ET, the fear he feels is less related to the experience of death itself: "Death is just an excuse to leave, otherwise we are all going to die."

Fear of dependence

The progression of cancer can lead to a deterioration in the patient's health, which may require constant medical assistance. Some patients, such as:

- KAE, "I am afraid of becoming dependent on others for my daily needs," according to her caregiver, which can affect her self-esteem and dignity.
- This feeling is expressed by ET: "But I'm afraid of becoming dependent on others."

Fear of isolation

Patients may fear finding themselves alone and isolated while facing significant physical, emotional, and psychological difficulties. They may dread losing their social connections and the support of their loved ones.

- KM expresses fear of isolation: "My mother abandoned me to my sad fate; it is my wife who is by my side. If she abandons me too…"

Fear of pain

- DGE experienced intense, chronic pain, and the prospect of suffering more was terrifying for her: "I'm afraid of the slightest movement my body might make, so as not to be in pain, and sometimes the treatments increase the pain."

▪ **Sadness**

Sadness is a common feeling among patients with terminal digestive cancers, which can be caused by various factors, such as pain and physical symptoms associated with the disease and the aggressive treatments they may have undergone, a decline in quality of life, changes in their social and family roles, uncertainty about the future, and loss of control. This feeling of sadness is an understandable and natural reaction to a serious and potentially fatal illness.

- This is the feeling expressed by DGE in these words: "My brothers and sisters are doing well, so why can't I?"
- As for KAE, she feels discouraged: "I don't have the strength anymore, I'm exhausted, I'm discouraged."

Sadness can also be exacerbated by factors such as decreased physical activity, bodily changes, dependence on others, the financial impact that the disease can have on the patient and their family, and social isolation.

- This is the case for KM, who worked in a convenience store: "I'm struggling to make ends meet and pay for my prescriptions because of my illness."
- DGE was a student, received a scholarship, and ran a small business. "Being sick, I can no longer manage my business. I used all my scholarship money to pay for my prescriptions. I have no money left, and my parents have no money left either."

▪ **Anger**

The feeling of anger in patients with terminal digestive cancer is often intense and difficult to manage. These patients may feel anger towards their illness, towards their own bodies that are betraying them, towards the treatments they have undergone that have not produced the desired results, towards the healthcare professionals who cannot cure them, and towards life itself.

- Throughout the interview with KM, he spoke in an angry tone; he was angry with his mother for not visiting him in the hospital, as well as with the treatment: "I hoped that after the surgery I would feel better."
- DGE raised her voice at her mother, who was with her in the room, complaining about everything she did because of the intense pain she was constantly feeling.

▪ **Anxiety**

Patients may be concerned about their health, the pain and suffering they may experience, how their family will be affected by their illness, their future, and their dignity, among other things. This anxiety may manifest itself in concerns about their health, pain, comfort, loved ones, future, or decisions to be made. This feeling of anxiety was evident in all of our surveyed patients.

- DGE was concerned about her comfort because she was in severe pain.
- BP was worried about his family's future.
- KAE was concerned about his children's future.
- KM no longer had the means to support himself and feared ending up alone and abandoned.
- As for ET, he expressed less concern about his health than about being dependent on others.

Anxiety can be linked to many aspects of the disease and can be perceived as a feeling of concern or uncertainty about the future. Anxiety can have a negative impact on patients' quality of life and their ability to cope with their illness.

▪ **Body image perception**

Body image perception is often altered in patients with terminal digestive cancers due to physical changes and side effects of treatments, such as weight loss, fatigue, hair loss, and surgical scars. This alteration can lead to self-esteem issues and negatively impact the patient's quality of life. All patients surveyed were in the terminal stage of cancer with an altered general condition.

- The expression of DGE, a young student: "I can't get dressed anymore because my clothes don't fit me, but I also have bleeding."
- KM had oedema of the face and limbs.

- **Suicidal thoughts or attempts**

It is important to recognize that patients with terminal digestive cancer may sometimes experience suicidal thoughts due to physical pain, emotional suffering, loss of independence, and the prospect of imminent death.

- DGE had suicidal thoughts: "Very often I feel so bad that I want to stop everything, including treatment."

2) Social life

- **Disruption of interpersonal relationships**

The disruption of interpersonal relationships in patients with terminal digestive cancers is felt at the family level and in relationships with healthcare staff. These disruptions can be multiple and complex. Due to the serious nature of their illness, patients may experience significant emotional stress, which can influence their relationships with those around them. Firstly, patients themselves find it difficult to communicate with their loved ones and healthcare staff due to their own emotional distress related to the disease.

- This is the case with BP, who, according to his wife, spoke very little: "He doesn't talk, he keeps to himself." They find it difficult to express their needs, concerns, and feelings, which can lead to tension and misunderstandings in relationships.

The difficulty may be due to a lack of an appropriate person with whom to communicate effectively. Indeed, patients at the end of life are rarely visited by certain healthcare staff.

- According to the nurse in charge of a patient, "doctors no longer make standard bedside visits to patients at the end of life."

Loved ones may feel sadness, anger, frustration, and helplessness in the face of the situation, which can interfere with their ability to maintain healthy relationships with the patient. In addition, family dynamics are also disrupted, as the disease changes roles and responsibilities within the family.

- According to KM's wife, "He was self-employed, but because of his illness, I am the one who provides for the family and takes care of his treatment; I am a teacher."

- **Disruption of social activities**

Due to the severity of their condition, these patients find it difficult to participate in social activities such as outings with friends or family members, social events, or leisure activities.

- DGE expresses his sadness: "I don't hear from my friends; they don't come to see me. My brothers are healthy, but I'm not…"
- Associated symptoms such as pain, fatigue, loss of appetite, and nausea limit patients' ability to participate in social activities. This is the case for KM: "Before I got sick, I used to go out regularly with my wife to visit friends."
- As for ET, he expresses his need to attend church services as he did before he got sick.

- **Disruption to economic and professional activities**

The disease and its symptoms lead to a reduction in working capacity, or even

total incapacity, which can have a significant impact on the income of patients and their families.

- According to KM, "I can no longer carry out my work; my wife helps me a lot."

Drug treatments, frequent medical appointments, and hospitalizations can make it difficult or even impossible to continue working.

- DGE: "I have trouble keeping up with my classes at university." DGE: "I submitted a sick leave request to the school, but the deadline passed and I couldn't renew it."

In addition, the costs associated with the disease (medication, medical expenses, etc.) place a heavy burden on the budgets of patients with terminal digestive cancer, exacerbating their financial situation.

- KM's wife explains, "*We have school-age children, and it's difficult to take care of them with the expenses here at the hospital.*"

4. Discussion

Sociodemographic characteristics of the patients surveyed

Our study sample is predominantly male (3 men and 2 women). The age of this sample ranges from 25 to 67, with an average age of 48.2. Our results are similar to those reported in the 2018 study by the Belgian Cancer Foundation, which stated that adults over the age of 20 accounted for more than 99% of the 70,468 cases of cancer recorded. Men were more affected (37,649) than women (32,819). One in three men and one in four women will be diagnosed with cancer before their 75th birthday (Cancer Foundation, 2018).

In terms of employment, three (03) of our respondents are self-employed, one (01) is retired, and one (01) is a student. However, all of our respondents had to interrupt their occupational activity due to illness. This interruption of professional activity due to illness is highlighted by the League Against Cancer, which stated that most cancer patients feel unable to work during treatment due to pain, fatigue, and side effects (League Against Cancer, 2013).

The majority of patients in our survey are in a relationship (4/5). However, it should be noted that the intrusion of the disease into the couple's relationship has caused disruptions in interpersonal relationships and family dynamics. In this regard, the case of BP, who spoke very little according to his wife, "he doesn't talk, he keeps to himself." This reality, found in our study, is mentioned in a publication by the French National Cancer Institute, which emphasized that dialogue within the couple often becomes difficult. The experience and future of the disease prevents the couple from making life plans.

Cancer has changed the roles and responsibilities within our patients' families. The disease may force the patient or those around them to give up, either completely or partially, certain tasks that they would normally do, such as driving the children to school, preparing meals, or helping elderly parents with household chores. If the role of the patient changes, so do the roles of other family members. This observation made by the Canadian Cancer Society in 2023 is confirmed by

our results. In fact, all of our respondents were accompanied by either a parent, spouse, or child. Their presence at the hospital disrupted their daily routines (Canadian Cancer Society, 2023).

All patients surveyed belonged to a religion. They also expressed a need for spiritual support. These results are consistent with those of a study conducted by the National Library of Medicine in October 2001. According to this study, spiritual patients can use their beliefs to cope with illness, pain, and the stress of life. Those who engage in regular spiritual practices tend to live longer (Jobin et al., 2017). This reality was verified by one of our respondents who is still alive (ET) and who was very interested in spirituality.

Psychosocial experience

In this section, we will assess the validation of the research objectives and hypotheses.

With regard to the first specific hypothesis, the results reveal that the difficulties associated with the medical care of patients lie in the disease and treatment. These difficulties are felt by our end-of-life patients who are not receiving palliative care. In the application of palliative care, medical, psychological, and social care are inseparable. According to the WHO (2020), palliative care is an approach to improving the quality of life of patients and their families facing problems related to life-threatening illnesses. They prevent and relieve suffering through early recognition, accurate assessment, and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Failure to provide palliative care has negative consequences on the patient's life, such as physical, emotional, and spiritual distress. It also places an additional burden on the patient's family and caregivers and generally results in a poor quality of life for the patient at the end of life. These findings were highlighted in a study conducted by Balfour et al. (2007). According to this author's conclusions, patients at the end of life were very often abandoned and the responses of caregivers were inadequate. This indicates psychological distress (Balfour et al., 2007). After analysis, we find that these results are similar to ours.

In light of the above, we can confirm our initial hypothesis that difficulties related to medical care influence the psychosocial experience of patients with terminal digestive cancer.

According to the results obtained, our surveyed patients experienced sadness, anger, anxiety, depression, fear, worry, body image issues, suicidal thoughts, emotional distress, and a lower quality of life. These different feelings experienced by our patients reflect a certain degree of psychological suffering. These different states justify the lack of psychological care observed in the study. When patients at the end of life do not receive psychological care, it can lead to the negative consequences mentioned above. Several authors have addressed this subject, notably Kübler-Ross et al. (1975), a Swiss psychiatrist known for her work on palliative care and the stages of grief. She emphasizes the importance of psychological care for patients at the end of life to help them cope with their emotions and find mean-

ing in their existence. Finally, in 1989, Yalom, an American psychiatrist and psychotherapist, also addressed the issue of psychological care for patients at the end of life in his work. He emphasized the importance of presence, listening, and psychological support in helping people at the end of life to experience this difficult time with greater serenity. Drawing on Watson's theory, in 1979, the concept of "caring," or the theory of the needs of the person receiving care, became the foundation of the nursing approach. Need is a fundamental concept in palliative care. For optimal patient care, the caregiver must be able to assess the patient's needs in order to best adapt their care.

Therefore, in light of the above, we can confirm our second hypothesis, which states that difficulties related to psychological care influence the psychosocial experience of patients with terminal digestive cancers.

The difficulties experienced by the patients surveyed are felt at the family, friendship, and professional levels. Relationship difficulties, isolation, opinions not being taken into account, abandonment by certain family members, stigmatization, withdrawal from colleagues and friends, and neglect by the healthcare team are the difficulties faced by patients at the end of life. According to Sherbourne and Stewart, social support plays several roles: emotional support, instrumental support, informational support, and affectionate support. Emotional support is defined as being empathetic and understanding, having a positive impact, and encouraging the patient to express their feelings. Instrumental support is task-oriented social support: receiving help, ideas, or advice to solve problems encountered in carrying out one's work. Providing the patient with financial assistance, transportation assistance, or home help. Informational support: offering information, guidance, and advice to the patient. Affectionate support: expressing love and affection to the patient. (Sherbourne & Stewart, 1991) According to Helgeson et al. (2006), social relationships improve patients' mood and give them a sense of identity and camaraderie. Social support can impact patients' quality of life and sense of meaning by helping them cope more effectively with their suffering and making them feel valued, loved, and cared for (Helgeson et al., 2006). Similarly, Mikulincer and Shaver (2022) argue that close social relationships that transcend physical death can provide protection, enabling patients to better cope with the reality of death. They suggest that these close relationships promote self-preservation, help patients deal with death-related anxieties, and help them realize the meaning and value of their lives. In Côte d'Ivoire, much remains to be done. Family support structures are limited and often depend on NGOs and patient associations. Palliative care infrastructure is still in its infancy or under development, although progress has been made, particularly by the National Center for Cancer Research and Control (CNRAO). The Palliative Care Association of Côte d'Ivoire (ASPI) is an important player, but access to specialized palliative care and staff training remain major challenges.

In light of the above, we can confirm that our third hypothesis, which states that difficulties related to social care influence patients' psychosocial experiences,

is verified.

5. Conclusion

Patients with terminal digestive cancer face considerable emotional, social, and family difficulties. They must cope with anxiety, depression, spiritual distress, loss of independence, and the possible need for frequent interactions with healthcare professionals. Terminal digestive cancer poses complex challenges for patients, their loved ones, and caregivers. The medical aspects are obviously critical, but it is equally important to understand the psychosocial implications of this end-of-life disease. This study analyzes the personal, psychological, and social factors that influence the experience of patients at the end of life.

The results show that the study population is predominantly male (3 men and 2 women) with an average age of 48.2 years. Patients feel unable to work during treatment due to pain, fatigue, and side effects. The intrusion of the disease into their relationships caused changes or tensions in their relationships. The presence of loved ones at the hospital with patients disrupted their daily routines. This study is based on the hypotheses that difficulties related to the lack of palliative care and psychological, social, and spiritual support influence the psychosocial experience of patients with terminal digestive cancer. These hypotheses were confirmed by the results obtained. It would be beneficial to establish support groups for psychosocial distress and to strengthen the capacity of caregivers to treat patients with advanced cancer.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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