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Research Paper

Caring Beyond Cure: A Reflexive Thematic Analysis of Healthcare Professionals' Experiences in Cancer Care in Qatar

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ABSTRACT

Cancer care places complex emotional, relational, and professional demands on healthcare systems, extending far beyond biomedical treatment. Healthcare professionals play a central role in supporting patients across the cancer trajectory, yet their own lived experiences remain underexplored, particularly in non-Western contexts. This study aimed to explore how healthcare professionals make meaning of their experiences in cancer care in Qatar, focusing on the emotional, relational, and human dimensions of their work. Using purposive sampling, six healthcare professionals involved in cancer care were recruited. Semi-structured, in-depth interviews were conducted face-to-face, audio-recorded, and transcribed verbatim. Data were analyzed using Reflexive Thematic Analysis, allowing inductive, data-driven coding and theme development. Analysis revealed five interrelated themes: (1) Caring Beyond the Hospital Walls—seeing patients as whole persons rather than clinical cases; (2) Walking the Line Between Closeness and Protection—balancing empathy with emotional boundaries; (3) Guiding Patients Through Uncertainty and Supporting Agency—using honest communication to foster autonomy and hope; (4) Co-Creating Solutions Through Teams and Systems—relying on multidisciplinary collaboration and service innovation; and (5) Rooting Care in Spirituality and Moral Purpose—drawing meaning, resilience, and emotional steadiness from personal values and spiritual beliefs. Together, these themes highlighted a shift toward caring beyond cure, where purpose is constructed not through medical outcomes alone, but through presence, dignity, and relational support. These findings highlight the need to acknowledge and support the emotional and relational dimensions of cancer care for healthcare professionals. By offering insight from a Middle Eastern context, the study contributes to limited qualitative literature in this area and underscores the importance of organizational, psychological, and systemic support structures in sustaining the well-being and effectiveness of cancer-care professionals.

Keywords: *Cancer Care, Healthcare Professionals, Reflexive Thematic Analysis, Emotional Labour, Qatar*

Cancer is often spoken about in medical terms—cells, treatments, chemotherapy protocols, and survival rates (Sung et al., 2021; Fallowfield & Jenkins, 2004). It appears in charts, test results, and clinical decisions (Back et al., 2009). But for the

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people who face it, cancer is never just a medical condition (Bury, 1982; Frank, 2013). It interrupts routines, reshapes identities, and pulls individuals into a world defined by uncertainty and vulnerability (Little et al., 1998; Deimling et al., 2008). Life that once felt ordinary becomes unfamiliar, and the simplest activities—working, studying, parenting, or planning for the future—suddenly pause. In these moments, clinicians become a steady, trustworthy presence—someone patients can rely on emotionally, medically, and informationally, not just a provider of treatment (Back et al., 2009).

While global advances in oncology have improved survival and expanded treatment options, cancer remains an emotionally charged illness that affects every domain of a patient's life (Fallowfield & Jenkins, 2004). As survivorship improves, supportive and holistic models of care are increasingly emphasized alongside biomedical outcomes (Vaz-Luis et al., 2022). For healthcare professionals, this means navigating a landscape where medical decisions are deeply intertwined with fear, hope, and uncertainty (Back et al., 2009; Escritt et al., 2022). Breaking bad news, supporting families through distress, managing treatment setbacks, and caring for patients approaching end of life are not simply clinical tasks—they are deeply human encounters that require empathy, patience, and emotional stamina (Baile et al., 2000; Ptacek & Eberhardt, 1996; Fallowfield & Jenkins, 2004). Research has shown that repeated exposure to suffering and death can contribute to emotional strain, compassion fatigue, and burnout among oncology staff (Hlubocky et al., 2016; Shanafelt et al., 2015; Moghadam et al., 2022; Ryan et al., 2022). At the same time, psychosocial and supportive dimensions of cancer care remain central to patient wellbeing, highlighting the importance of emotional support alongside medical treatment (Dunn & Chambers, 2019; Fereidouni et al., 2024; Bansal & Raju, 2025).

Cancer care is rarely a short journey. Unlike acute medical conditions, oncology often unfolds across months or years. Professionals may meet the same patients across multiple stages—diagnosis, treatment, remission, relapse, survivorship, or end-of-life care. This continuity creates emotional bonds that are both meaningful and demanding. Over time, the work becomes personal in subtle ways, shaping how professionals view life, relationships, and even their own mortality (Frank, 2013). Many describe a delicate balance between staying emotionally present and maintaining enough distance to function effectively—a central tension in oncology practice (Harris et al., 2018).

The context of Qatar adds a unique dimension to this experience. In many countries, cancer brings a heavy financial burden that intensifies distress and can affect employment and long-term wellbeing (Mols et al., 2020). In Qatar, cancer treatment is provided free of charge to residents through the national healthcare system (The Peninsula, 2018). Alongside this, organisations such as the Qatar Cancer Society have funded treatment costs for many patients and developed mechanisms to support patients and families (The Peninsula, 2024). These efforts reflect a health system and community-based support structure that aims to reduce financial barriers while addressing emotional and social needs throughout the illness trajectory (Fereidouni et al., 2024). Healthcare professionals, in turn, accompany patients through these shifts, often providing not only clinical management but emotional grounding and reassurance (Back et al., 2009). The quality of oncology nursing care has also been associated with patients' resilience and hope, reflecting how caregiving can extend beyond cure (Sedri et al., 2024).

Cancer care in Qatar is delivered by multicultural teams working across diverse languages, beliefs, and expectations. While many professionals live with their immediate families, most do not have extended family networks in the country, which may limit personal support during emotionally demanding periods. Consequently, colleagues often become critical sources of emotional and practical support, and teamwork plays an important role in sustaining staff wellbeing (Harris et al., 2018).

Despite the profound emotional landscape of oncology work, much of the existing literature has focused on patient experiences, biomedical outcomes, and treatment efficacy. Far fewer studies have explored the lived experiences of healthcare professionals themselves, particularly in non-Western contexts. The voices of physicians, nurses, and allied professionals remain underrepresented, leaving gaps in understanding how they cope, make meaning, and sustain compassionate care in emotionally intense environments.

Against this backdrop, the present study seeks to explore the lived experiences of healthcare professionals involved in cancer care in Qatar. It aims to illuminate the emotional, relational, and deeply human dimensions of caregiving, including how clinicians navigate uncertainty, connection, and purpose in a field where caring often extends beyond cure. The study will use Reflexive Thematic Analysis to guide data analysis (Braun & Clarke, 2006; Braun & Clarke, 2019).

METHODOLOGY

Research Design

This study adopted a qualitative research design grounded in an interpretive, constructivist paradigm. The aim was to explore how healthcare professionals make sense of their experiences while working in cancer care. A qualitative approach was selected because it enables deep engagement with personal meanings, emotional realities, and subjective interpretations that cannot be captured through quantitative measures. Reflexive Thematic Analysis was chosen as the guiding analytic approach, allowing the study to identify patterned meanings across narratives while acknowledging the researcher's interpretive role.

Sampling

A purposive sampling strategy was used to recruit participants who had direct and meaningful involvement in caring for patients diagnosed with cancer in Qatar. This ensured that participants were information-rich and professionally positioned to speak about the emotional, relational, and clinical dimensions of cancer care. Eligible participants were healthcare professionals working in oncology-related roles in Qatar, including those supporting patients across diagnosis, treatment, survivorship, and palliative care.

Sample Size

A total of six participants (n = 6) took part in the study. In qualitative research, depth and richness of data are prioritized over numerical breadth. The sample size allowed for detailed exploration of individual experiences while still enabling identification of shared patterns across participants.

Mode of Data Collection

Data were collected through semi-structured, in-depth interviews conducted face-to-face. This format provided a flexible conversational space in which participants could describe their roles, challenges, emotional experiences, coping strategies, and reflections on patient

care. Each interview lasted between 45 and 90 minutes and was audio-recorded with prior consent. All recordings were transcribed verbatim to preserve linguistic detail and contextual meaning.

Procedure

Participants were approached individually and informed about the purpose and nature of the study. Once participation was confirmed, interviews were scheduled at a mutually convenient time in a private, professional setting. The interviewer encouraged open expression, used prompts to clarify key points, and allowed participants to guide the depth and direction of their narratives. Following transcription, each transcript was reviewed for accuracy by cross-checking with the original audio recordings multiple times.

Tools

Two tools were used in the data collection process:

1. **Semi-Structured Interview Guide** – outlining key questions related to professional roles, emotional demands, communication with patients and families, teamwork, coping strategies, and personal reflections.
2. **Demographic Information Sheet** – documenting basic details such as professional role, years of experience, and area of practice.

Data Analysis

Data were analyzed using Reflexive Thematic Analysis, guided by Braun and Clarke's six-phase framework. The analysis was inductive and data-driven, meaning that codes and themes were extracted directly from participants' narratives rather than from pre-existing theoretical categories. Transcripts were read repeatedly, coded manually, and compared across cases to identify patterned meanings. Codes were clustered into subthemes and themes through an iterative, reflective process. Reflexivity was maintained throughout, acknowledging the researcher's active role in interpretation. The full analysis and interpretation are presented in a separate section of the manuscript.

Analysis and Interpretation

This section presents the findings of the study based on Reflexive Thematic Analysis of six semi-structured interviews with healthcare professionals involved in cancer care in Qatar. Themes were generated inductively from the data, without imposing pre-existing theoretical categories. At the same time, the interpretation of these themes is informed by existing literature on emotional labour, resilience, professional identity, spirituality, and boundaries in oncology and palliative care.

The analysis moved from initial line-by-line coding of each transcript, to clustering codes into sub-themes, and then developing broader themes that captured patterned meanings across participants. The final thematic structure comprises five overarching themes, each with related sub-themes. Together, they describe how professionals understand their work, navigate emotional exposure, and sustain themselves in demanding cancer care settings.

Caring Beyond the Hospital Walls

This theme captures how participants consistently refused to reduce cancer care to disease management alone. They described a shift from a narrow, hospital-based view to a life-centred perspective that attends to patients' families, social roles, education, employment, and long-term functioning.

Seeing the person behind the disease. Several professionals described a "blind spot" in traditional cancer care, where patients were treated as clinical cases rather than human beings with complex lives. One participant leading a national strategy explained that the system often saw patients "only as cases of disease, not as human beings with families, social lives, and vocational needs." Others spoke about the need to "humanise" care by understanding patients' fears, hopes, and roles beyond the ward.

This emphasis resonates with qualitative literature that conceptualizes cancer as both a biomedical and biographical disruption, requiring clinicians to attend to identity, relationships, and meaning, not just symptoms.

Life on hold and supporting reintegration. Several clinicians reflected on how cancer "suspends" patients' lives—education interrupted, careers paused, family roles disrupted. One described that only 20–30% of life happens in hospital, with the remaining 70–80% largely unsupported. Quality of Life (QoL) clinicians spoke of working explicitly on reintegration, helping patients return to school, work, or parenting roles through accommodations, workplace negotiations, and coordination with schools or employers.

One participant described a man whose appearance, speech, and confidence were altered after treatment but gradually regained independence through coordinated dental, speech, psychological, and occupational interventions. These accounts mirror survivorship research that highlights the importance of role restoration, participation, and social reintegration as markers of recovery, not only clinical remission.

Walking the Line Between Closeness and Protection

This theme reflects the **emotional exposure** inherent in cancer care and the strategies professionals develop to remain compassionate without being overwhelmed.

Being drawn in to patients' worlds. Participants recalled cases that deeply affected them—such as a young girl with osteosarcoma, a terminal patient who spent his end-of-service money on futile treatment, or long-term cancer patients who cycled between hope and deterioration. One physician described becoming so attached to a teenager that her decline led to his own emotional crisis and temporary withdrawal from practice.

These narratives reflect what the literature describes as emotional labour and moral distress in oncology: clinicians are not only performing technical tasks but also holding patients' grief, uncertainty, and family pain.

Learning controlled attachment and boundaries. Over time, professionals described learning what one participant called "controlled attachment and detachment"—entering each patient's room as if "watching a new story," engaging fully in the moment, but intentionally leaving the emotional weight at the door when exiting. Another participant emphasized listening to his own physical signals of stress (e.g., somatic tension) before responding.

Rather than detachment in the sense of cold distance, these strategies resemble what resilience research describes as flexible boundaries—remaining emotionally present while protecting one's capacity to care for the next patient. The notion of "not knowing only where to start, but knowing when to stop" captures a learned professional boundary that balances empathy and self-preservation.

Guiding Patients Through Uncertainty and Supporting Agency

This theme focuses on the centrality of communication, disclosure, and autonomy in participants' accounts.

Diagnosis and disclosure as a critical turning point. Several professionals identified the moment of diagnosis and disclosure as the most emotionally charged and consequential stage of the cancer journey. One palliative oncologist emphasized that revealing cancer to the patient is "life-changing" and that this is the phase where support is most needed, arguing for early integration of palliative care with oncology. Others echoed that hearing the word "cancer" generates profound uncertainty; patients "don't know what to expect, so they can't plan."

These accounts align with evidence that breaking bad news and managing uncertainty are among the most stressful tasks for clinicians, requiring skills in empathy, pacing, and truth-telling.

Fostering patient autonomy and practical empowerment. Beyond disclosure, professionals emphasized patient autonomy as the ability to use available resources, ask questions, understand the illness, and make informed decisions. One participant defined autonomy as "using one's abilities and available resources to address problems related to the disease"—including knowing about benefits, supportive care options, and rights.

Others described encouraging patients to see themselves not only as "diseased" but as persons still capable of working, studying, or fulfilling family roles. This insistence that patients live "as normally as possible" reflects a belief that psychological stance and identity influence outcomes, echoing literature on agency, coping, and post-traumatic growth in survivorship.

Co-Creating Solutions Through Teams and Systems

This theme highlights how participants viewed care as a **collective, system-level effort**, rather than an individual heroic act.

Multidisciplinary teams as the backbone of care. All participants described working in multidisciplinary teams (MDTs) with oncologists, hematologists, psychiatrists, psychologists, physiotherapists, occupational therapists, dietitians, social workers, and school or workplace stakeholders. One QoL clinician described MDT meetings where the team jointly explained disease, treatment options, and next steps to patients and families, staying present to support emotional reactions.

Others described how being physically present when patients met other specialists or received results helped maintain continuity, containment, and trust. This collaborative stance reflects research showing that MDTs in oncology enhance communication, shared decision-making, and psychosocial support.

Innovating within constraints and building new services. Some participants, especially those in leadership roles, described identifying systemic "blind spots" and then designing new pathways or services. Examples included a national holistic cancer care strategy, a transitional care model linking hospital and community, and a dedicated lymphedema service that emerged from physiotherapists' work with affected patients. Another described

creative solutions for a young leukemia patient from a resource-limited setting, such as arranging blood matching and transplant eligibility despite bureaucratic barriers.

These accounts illustrate how professionals move beyond individual coping to engage in structural resilience, shaping systems that better support patients and families. This aligns with literature on organizational citizenship and innovation in healthcare, where clinicians act as advocates and change agents.

Rooting Care in Spirituality and Moral Purpose

This theme reflects how participants draw on spirituality, values, and moral frameworks to sustain their work and understand their role.

Caregiving as a gift and moral responsibility. Several professionals described their work not only as a job but as a privilege and responsibility entrusted to them. One participant framed caregiving as a form of "passive income for the hereafter," encouraging his children to see acts of care as spiritual investment. Another emphasized that the real reward is not salary or recognition but the sincere prayers and gratitude of patients and families.

These accounts resonate with qualitative findings in psycho-oncology that spiritual and moral meaning-making can buffer emotional strain and anchor professional identity.

Spiritual and everyday practices for emotional steadiness. Participants described specific practices that support emotional steadiness, including prayer, spiritual reflection, walking, physical exercise (e.g., cycling, daily steps), reading, and hobbies such as maintaining cars. One clinician described balancing "cups" or domains of life daily to prevent emotional depletion. Another deliberately stopped sharing patient stories at home to protect family relationships and to prevent "spreading" grief.

These strategies illustrate how resilience is not a fixed trait but an ongoing, intentional practice. They echo broader research on self-care and spirituality among healthcare professionals, suggesting that integrating spiritual and lifestyle practices can help maintain capacity for empathic care.

Summary Table 1: Themes, Sub-Themes, and Illustrative Quotes

Theme	Sub-theme	Brief Description	Illustrative Verbatim (Example)
Caring Beyond the Hospital Walls	Seeing the person behind the disease	Moving from case-focused to person-focused care, recognising social, family, and vocational context.	"We found a blind spot: the system often sees patients only as cases of disease, not as human beings with families, social lives, and vocational needs."
	Life on hold and reintegration	Recognising how cancer suspends life and working to restore education, work, and roles.	"Only 20–30% of a patient's life is spent in hospital; 70–80% of their life outside remains unsupported… we work to help them return to school or work."

Theme	Sub-theme	Brief Description	Illustrative Verbatim (Example)
Walking the Line Between Closeness and Protection	Being drawn into patients' worlds	Emotional impact of close, long-term relationships, especially in young or terminal cases.	"She became like my own child… when her condition worsened, I could not cope and even left for a while."
	Learning controlled attachment and boundaries	Developing strategies of controlled attachment/detachment to remain able to care.	"I enter each room fully, but I leave the emotions behind when I exit. The key is not only when to start, but when to stop."
Guiding Patients Through Uncertainty and Supporting Agency	Diagnosis and disclosure as turning point	Diagnosis as psychologically critical stage requiring maximum support.	"Revealing cancer is life-changing; this is the stage when they need us most, not only for treatment but for emotional support."
	Fostering autonomy and practical empowerment	Encouraging questions, explaining rights, enabling patients to live as normally as possible.	"Patient autonomy means using your abilities and resources to solve problems—asking, understanding, knowing your benefits and support."
Co-Creating Solutions Through Teams and Systems	Multidisciplinary teamwork	MDT meetings, shared explanations, joint planning to support patient and family.	"We sit together—the oncologist, physician, QoL team—to explain the disease and options while we stay to support the family's reactions."
	Innovating within constraints	Creating new services or pathways when gaps are identified.	"We realised there was no service for lymphedema… our physiotherapists built a dedicated clinic after seeing patients' needs."
Rooting Care in Spirituality and Moral Purpose	Caregiving as calling and responsibility	Care seen as spiritual work, privilege, and moral duty beyond employment.	"This is a gift and responsibility from God… the real reward is the prayers of patients and their families."
	Spiritual and everyday practices for steadiness	Use of prayer, movement, hobbies, and boundaries to sustain emotional balance.	"Prayer for me is meditation… cycling and cars with my family help me clear my mind and return ready to care again."

Ethical Considerations

This study adhered to standard ethical principles for qualitative research. Participation was voluntary, and all individuals were informed about the purpose of the study prior to data collection. Written consent was obtained, and participants were assured of their right to

withdraw at any stage without consequence. To maintain confidentiality and anonymity, identifying information was removed and participants were assigned codes (Participant 1–Participant 6). Interview data were stored securely and used solely for research purposes. No personal, clinical, or institutional identifiers were disclosed, and the study was conducted with respect for participants' dignity, privacy, and professional boundaries.

CONCLUSION

This study explored the lived experiences of healthcare professionals involved in cancer care in Qatar, highlighting how their roles extend beyond clinical treatment into emotional, relational, and human-centered support. The findings demonstrate that caring for cancer patients involves navigating uncertainty, sustaining therapeutic presence, and balancing professional responsibilities with personal emotional boundaries. Participants described cancer care as a process that requires empathy, flexibility, and meaning-making, often grounded in teamwork, spirituality, and a commitment to improving patients' quality of life. The overarching insight—*caring beyond cure*—reflects how professionals construct purpose not only through medical outcomes but through the comfort, dignity, and continuity they provide to patients and families. This study contributes to the limited qualitative literature on Cancer care professionals in non-Western contexts and underscores the need to acknowledge and support the emotional and relational dimensions of cancer care.

Limitations

As a qualitative study with a small purposive sample of six participants from a single national context, the findings are not intended to be statistically generalizable. Participants were drawn from cancer-related services in Qatar, which may limit transferability to other countries, healthcare systems, or cultural settings. Data were based on self-reported narratives, which may be influenced by recall, professional identity, or social desirability. The study relied on a single method of data collection—semi-structured interviews—without triangulation through observation or additional data sources. Finally, the researcher's interpretive role in Reflexive Thematic Analysis means that findings reflect a co-constructed understanding shaped by the researcher's perspective, which, while intentional in qualitative research, may limit replicability.

Suggestions for Future Research

Future studies could expand the sample to include a wider range of healthcare professionals—such as nurses, transplant coordinators, psychologists, and allied health staff—to capture diverse perspectives across the cancer care spectrum. Comparative research across different institutions, countries, or cultural settings could provide insights into how context shapes professional experiences. Longitudinal qualitative designs may help explore how professionals' coping strategies and identities evolve over time, particularly in relation to repeated exposure to relapse, remission, and end-of-life care. Mixed-method or multi-method approaches—including observational data or psychometric measures of burnout and resilience—could deepen understanding and strengthen applicability for policy and practice. Finally, research that integrates patient and provider perspectives may offer a more holistic view of relational care and support needs in cancer journeys.

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Conflict of Interest

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