Wiley
European Journal of Cancer Care
Volume 2026, Article ID 6222421, 19 pages
https://doi.org/10.1155/ecc/6222421

WILEY

Review Article

Palliative Care Stigma in Oncology: An Integrated Systematic Literature Review

R. Alexander,[1,2] **P. Meek**,[1] **and C. Stephens**[1]

[1]*College of Nursing, University of Utah, Salt Lake City, Utah, USA*
[2]*Huntsman Cancer Institute, University of Utah Health, Salt Lake City, Utah, USA*

Correspondence should be addressed to R. Alexander; rachael.alexander@hci.utah.edu

Received 18 February 2025; Revised 19 June 2025; Accepted 20 December 2025

Academic Editor: Tarcilia Silva

Purpose: To conduct an integrated systematic literature review to explore (1) the presence and impact of stigma surrounding palliative care (PC) in Oncology particularly related to the care of adults with advanced cancer and (2) how Oncology healthcare providers (OHCPs) may contribute and perpetuate PC stigma, a factor associated with the underutilization of PC.
Methods: A comprehensive search was conducted in four major databases using PRISMA guidelines. Thirty-two articles met the inclusion criteria focused on the perspectives of PC by OHCPs who treat adults with advanced cancer. Guided by Goffman's Theory of Stigma, articles were iteratively reviewed and stigma-related themes were generated.
Results: Six major themes emerged defining the concept of Oncology PC stigma and were categorized into two groups, which Goffman labels as "stigmatized" and "stigmatizers." Assumptions, fear, and discomfort are the three common perceptions OHCPs which drive their behaviors as the stigmatizers. Avoidance, undesired differentness, and negative association with the term "palliative care" are the three reoccurring behaviors and perceptions seen in adults with advanced-stage cancer, who are the stigmatized. A novel conceptual framework is presented with these six major characteristics of Oncology PC stigma with their corresponding outcomes.
Conclusion: Societal stigma associated with PC in Oncology is pervasive and driven by behaviors and perceptions of not only patients and their families who are reluctant to use PC but OHCPs themselves. Findings underscore the need for interventions that address OHCP's lack of understanding about how their own perceptions and behaviors may impact patient PC utilization and outcomes.

Keywords: advanced cancer; palliative care stigma; stigma conceptual framework; theory of stigma

1. Introduction

Palliative care (PC) is support given to help people live well despite serious illness, and it is key to high-quality Oncology care [1]. Prevention, early identification, comprehensive assessment, and management of physical issues—including pain and other distressing symptoms such as psychological distress, spiritual distress, and social needs—are all part of comprehensive PC [2]. Evidence suggests that when such PC is initiated early in the cancer treatment trajectory, patients and families report better symptom management, improved quality of life, and prolonged life expectancy [3–9].

Unfortunately, only one in four cancer patients who need PC actually receive it [10]. Why is that the case? Numerous studies discuss the myriad of barriers impeding the use of PC in advanced cancer [11–19]. The majority of these barriers relate to patient, family, and Oncology healthcare provider (OHCP)'s lack of knowledge and/or misperceptions about PC and its benefits [11]. Arguably, ungirding the root cause of these barriers to PC utilization is stigma [20]. Three prior systematic reviews validate that negative perceptions of PC do exist and meet the current societal definition of stigma—which is essentially a negative perception causing behavioral modification [11, 21, 22]. In

a previous scoping review on PC stigma, it was estimated that approximately 70% of people in 2019 had never heard of PC and of those who had, the majority (59%) equated PC to hospice [23]. However, hospice is distinct from PC and can be defined as specialized healthcare at the end of life (EOL) for those with a prognosis of less than 6 months [24]. PC's association with hospice and EOL is one of the most commonly cited reasons for not initiating PC early or at all [11].

The blurring together of hospice and PC has led to a stigma surrounding PC. This is especially apparent within the field of Oncology where PC ironically was originally designed to address the variety of distressing symptoms cancer and its treatment can cause [2]. PC stigma in cancer patients is further complicated by the American mentality of a "war on cancer," where the public perceives cancer as an enemy that must be fought to the end and it is looked down upon to "give up" [25]. When one receives a cancer diagnosis, the journey they are on is talked about as "battling cancer" within this ubiquitous war analogy [25, 26]. The general public embraces a sentiment that suffering is involved in war; therefore, it is almost expected in society that suffering is an inevitable and unavoidable part of one's cancer treatment [27–29]. This notion creates an additional complex public perception [26] that is evident when exploring Oncology PC stigma in the literature and introduces a somewhat unique factor that necessitates consideration when attempting to define Oncology PC stigma.

While prior studies have explored barriers to Oncology PC utilization, the clear connection between PC stigma as a root cause of underutilization of PC is not explicitly delineated nor well described in the literature. To our knowledge, no studies to date have clearly defined PC stigma in the specific context of advanced cancer. Guided by Goffman's Theory of Stigma [30], this integrative review explores the literature and extracts the documented evidence indicative of stigma via studies of societal perceptions and behaviors surrounding PC in Oncology. Specifically, the objectives of this integrated systematic review were to explore (1) the presence and impact of stigma surrounding PC in Oncology, particularly related to the care of adults with advanced cancer and (2) how OHCPs may contribute and perpetuate PC stigma. A novel conceptual model is presented that details PC stigma themes generated from the literature review to improve understanding of the multifaceted behaviors and perceptions that contribute to PC stigma in advanced cancer. This framework may help inform future targeted educational and research interventions, as well as improvements in cancer care institutional healthcare policies that address measures to increase PC utilization in this vulnerable population.

2. Conceptual Framework

Although PC stigma is not a new term, according to our knowledge, Goffman's Theory of Stigma has not explicitly been applied specifically to the Oncology PC context in the manner this review takes. According to Goffman's Theory of Stigma, stigma involves societal reactions and interactions that shape how individuals or "the stigmatized" are perceived and treated based on these attributes [30]. Goffman explains that the word stigma goes back to its Greek root meaning something akin to a bodily sign or mark that sets people apart from society in disgrace. Stigma has evolved into a metaphorical mark society still places on people based on a label such as a diagnosis. Goffman gives one characteristic of stigmatized people as having an "undesired differentness from what had been anticipated" [30]. Goffman frames stigma as the "management of a spoiled identity" [30]. Cancer patients' "normal identities" and anticipations of life have been "spoiled" by their unfortunate diagnosis, especially those with advanced or "incurable" cancer [31].

Stigma is perceived and, therefore, only present in relation to social normalcy. Goffman explains that the way to conceptualize stigma is to ask the question, "where does stigma lie?" He argues that stigma lies not in the person who is stigmatized, but in the "audience." The audience is the social context of a group of individuals in a societal structure who view certain individuals or a practice/behavior/social practice as different in a negative way [32]. For the purpose of this integrative review, adults with advanced-stage cancer are the "stigmatized" and the audience viewing them are the OHCPs who become the "stigmatizers." Thus, a primary goal of this review was to determine whether there is evidence of OHCPs' perspectives and behaviors contributing to the stigmatization of PC by adults with advanced cancer and how that may impact underutilization of PC.

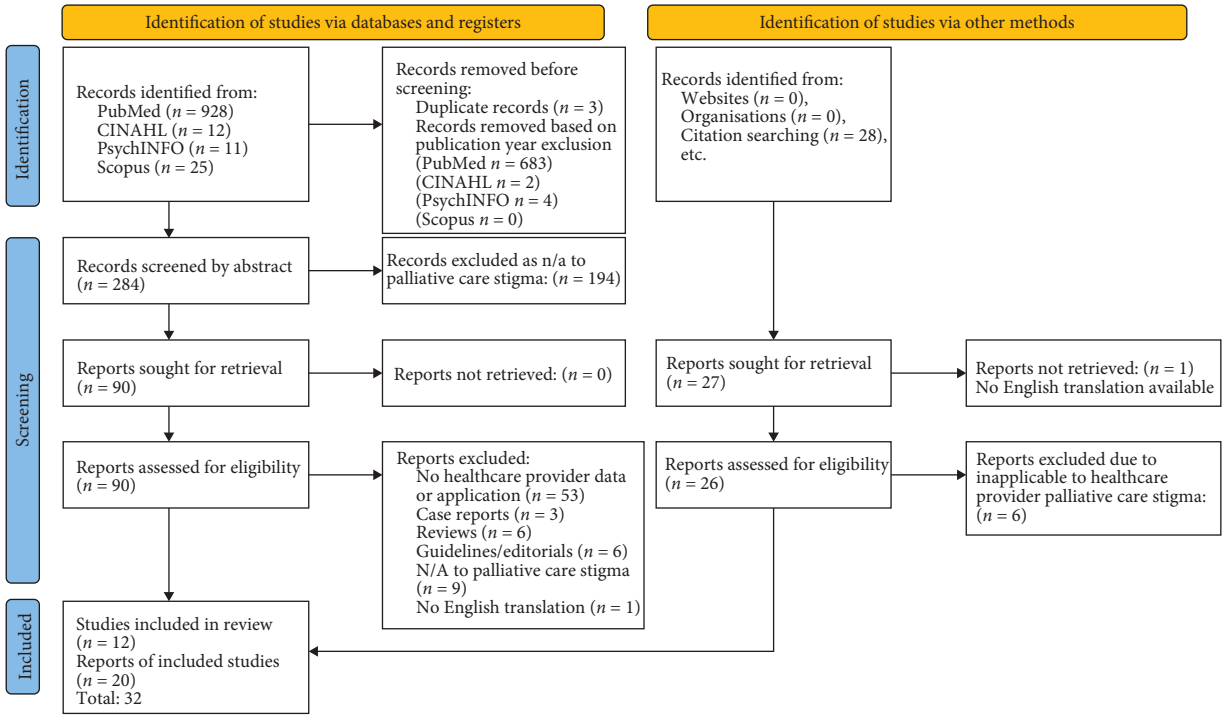
3. Methods

This integrated systematic literature review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) [33] (Figure 1). PubMed, CINAHL, PsychINFO, and Scopus were the major databases searched in October 2023. A total of 284 records published after 2015 for relevance were screened by title and abstract. Studies were excluded if they were not applicable to PC stigma; data-based (e.g., guidelines, editorials); cancer specific; focused on adults (e.g., pediatric centered); or available in English. Included were 32 articles that provided data or results pertaining to adults with advanced cancer, specifically containing PC perspectives of OHCPs.

A literature matrix was used (see Table A1) to categorize each article into the following domains: (1) whether it mentioned the word "stigma"; (2) how it defined stigma in the Oncology PC setting; (3) how PC stigma characteristics were discussed even if the term stigma was not explicitly used; and (4) categorization of the evidence into one of the six extracted themes informed by Goffman's Theory of Stigma.

4. Results

The majority (53%) of the studies were qualitative (17/32), over a quarter (9/32; 28%) were quantitative, and three were mixed methods (9%). Three systematic reviews (9%) were included for their robustness and historical context of the existence of this phenomenon dating as far back as 1990



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Figure 1: PRISMA flowchart of literature search, screening, and review process.

[11, 21, 22]. Examining these systematic reviews reveals the evidence of elements of Oncology PC stigma persisting for decades with little change in perceptions or increased understanding. Thirteen of the reviewed articles (41%) used the actual word stigma in reference to PC (see Table 1).

5. Perspectives of "Stigmatizers"

5.1. Assumptions. OHCPs' assumptions about PC were found as a reoccurring theme in 17 articles and appear to give rise to their own PC stigma. One systematic review concluded that a common barrier to PC utilization is providers' assumption that patients always want to fight their disease and are not interested in hearing about palliation or are not ready for PC [21]. This assumption was reiterated in a 2018 Canadian study, which found that OHCPs often give aggressive care regardless of the patient or families who may have a preference to focus more on comfort care because the provider assumed that they wanted "everything done" [34]. Another study in Israel discussed how in Judaism, the length of life is valued above all else, so extreme measures are commonly taken to extend life as long as possible using any possible cancer treatment options, no matter the cost [35]. They commonly do not consult the patient but make the medical decisions themselves based on their assumptions [35].

A paternalistic attitude of physicians—where they assume that they know what is best for their patients and what they would want [36, 37]—was also noted in Colombia [38]. In this study, only 17% of cases had physicians talking directly with the patient about impending death, assuming that family would relay decisions for them to the provider [38]. When probed why they did not talk directly to the patient, the answers given were typified by these quotes: "because the treatment option was 'clearly the best for the patient' or that it was 'not necessary to discuss treatment with the patient'" [38]. A Tawain study found that many OHCPs assume that patients with advanced cancer do not have treatment-making abilities [15]. In Belgium, OHCPs assumed that they knew how friends and families would feel about their loved ones death so based their care on assumptions instead of having direct conversations regarding PC [39]. An Indian study revealed physicians not directly ask patients about their EOL wishes and assumed that they as the primary provider and the relatives knew what was "best" [36].

Another stigmatizing assumption by OHCPs is the belief that referring patients to PC is "giving their care away" [40]. This sentiment, mainly seen in the United States, was expressed by one oncologist who stated, "I think just that we take care of the patient from diagnosis until death, that part of that taking care of them at the end, I feel like is part of my job, that's why I chose this field, and I don't want to give my patient away completely" [40]. A large U.S. qualitative study found that some OHCPs assumed that their training was adequate to provide PC to their patients [40]. Many also assumed that they had inadequate access to PC specialists and they were confident they could provide PC themselves [40]. Physicians often do not refer to specialized PC services until there is "no other treatment option," reinforcing the misconception that it is only for EOL care [18]. OCHPs frequently experience feelings of guilt and shame for "giving

Table 1: Six stigma-related characteristics from the perspectives of "stigmatizers" and the "stigmatized" with associated outcomes.

Perspective of "stigmatizers" (OHCPs)	**Found in no. of articles**	**Outcomes**
1. Assumptions	17 (53%)	Assume they know best treatment option. Don't want to quell hope.
2. Fear	21 (66%)	Decreased communication/Lack of goals of care conversations.
3. Discomfort	23 (72%)	Late referrals to palliative care (PC).
Perspective of "stigmatized" (adults with advanced-stage cancer)		**Outcomes**
4. Negative association with term "palliative care"	12 (38%)	PC perceived as end-of-life care and hospice, don't want to "give up."
5. Undesired differentness	10 (31%)	Increased suffering in order to "fight on."
6. Avoidance	11 (34%)	Decreased quality of life and communication with loved ones and OCHPs.

up" themselves when they finally "surrender" and concede to refer a patient to PC [41]. This stems from their assumption equating PC with defeat, seeing themselves as an oncologist who is unable to beat the cancer [41]. Some cancer patient study participants reported that their primary healthcare professionals told them PC was EOL, suggesting a need to further educate the general healthcare community about PC's compatibility with cancer therapy to address this incorrect assumption [19].

The most prevalent assumption found in the literature was that OHCPs have preconceived notions that their patients already have a negative perception of PC, associating it with death and dying, and therefore are hesitant to discuss PC [14, 42]. OHCPs report not wanting to distress or "alarm" their patients, quell their hope, destroy optimism in cancer treatment, or give the perception that they are "giving up" on them [15, 26, 43]. Interviews with 31 oncologists revealed a theme of a common perception that specialist PC is usually only provided at the EOL, increasing the prevailing assumption that this is when PC referral is appropriate [44]. Oncologists themselves also associate PC with death and dying and believe that the stigma associated with PC can partly be overcome by a simple euphemistic change in the service name to "supportive care" [14, 42]. This desire for a name change reveals assumptions that when OCHPs use the term "palliative care," it has a negative connotation to their patients, further perpetuating their avoidance of discussing PC and using the term. These selected studies provide evidence that negative assumptions are a contributing factor preventing OHCPs from referring patients to PC and create a barrier to them even discussing PC.

5.2. Fear. Fear is a negative emotion and as such can be indicative of being a part of stigma [30] and surfaced in 21 articles reviewed. The most common fear OHCPs admitted they have in relation to PC discussions with their patients will cause distress or deprive them of hope [12, 15, 17, 18, 36, 43, 45]. This includes the behaviors of OHCPs using "ambiguous" language surrounding PC that they believe protects their patients from added stress and additional burdens [46]. OHCPs expressed using these language changes came from the fear of hurting their patients with more direct PC terms [21]. Some OHCPs stated that they are afraid to lose management or control of their patient's care with belief that as an Oncologist, they should be able to manage all their patient's care and not have a need to use PC services [11, 39–41, 44].

Fear of failure and "losing a valued relationship" was cited as a fear of OHCPs surrounding PC utilization [40]. One OHCP stated, "Doctors are meant to heal and they feel that it is their purpose in the world and if they fail to do it they have failed," exemplifying this fear of failure [35]. A large survey of American OHCPs found 90% concerned that the family would think their provider was giving up on their loved one if a referral was made to PC [47]. Many of the articles mention OHCP's fears of legal repercussions if they made a mistake, gave a wrong prognosis, or did not give the care that the family or patient wanted even when they were giving treatments with no evidence of effectiveness—often causing further harm with side effects [15, 17, 29, 34, 35, 48]. A qualitative study in Belgium concluded that many OHCPs fear giving false hope to patients within PC conversations [39].

Additional fears cited were OHCP's concerns about PC services themselves, such as PC specialists interfering with oncological treatment, inability to provide appropriate care, or overburdening them due to the lack of adequate staffing [22, 49]. An interesting study of radiation oncologists showed notable results of their fear of upsetting the referring medical oncologist by initiating goals of care (GOC) discussions, including offering PC, but fear precluded them from bringing it up [50]. A final fear mentioned in the literature was OHCPs expressing fear that patients with lower levels of intelligence or education would be unable to absorb information properly about PC, blaming low health literacy for not educating their patients on PC [13].

5.3. Discomfort. Discomfort was a theme that persistently stood out throughout the majority (72%) of articles as a defining characteristic of PC stigma. Multiple articles explained how OHCPs express discomfort in engaging patients in difficult conversations related to PC across various contexts [13, 35, 40, 45]. OHCPs reported having a lack of knowledge, formal training, and confidence on how to communicate effectively with patients regarding cancer treatment limitations and the inappropriateness of continued aggressive care, leading to challenges in saying "no" when necessary [13, 21, 40, 48]. General lack of confidence and training on specific communication skills were cited in several studies as a reason for discomfort in having PC conversations [15, 16]. This discomfort especially extended to age-related considerations, with OHCPs reporting experiencing greater difficulty recommending treatment discontinuation and PC in younger patients or those who had young children [13, 34]. A 2019 study of medical oncologists in the United States revealed that the majority had discomfort bringing up PC referral even when they describe integrating discussions about prognosis and end-of-life planning "within the first few visits" for incurable patients [46].

Furthermore, studies revealed the discomfort among OHCPs as manifested in their reluctance to initiate early discussions about PC, not wanting to jeopardize long-term relationships, and a desire to personally provide a broad spectrum of care [40, 44]. The characteristic of discomfort also extends to the term "palliative care" itself, as evidenced by oncologists voicing a preference for the term "supportive care" due to its potentially more favorable reception by patients [14, 18, 42, 51, 52]. A substantial proportion of OHCPs reported discomfort in managing depression and a lack of competence in treating various other challenging symptoms that PC specialists have training and comfort in addressing [50, 53]. OHCP's discomfort is not limited to

communication challenges but is also seen on the emotional toll it takes on them when discussing death and delivering news of poor prognosis, making PC referral an emotional burden [22, 40].

6. Perspectives of "Stigmatized"

6.1. Negative Association With Term "Palliative Care". A significant perception contributing to the stigma surrounding PC in Oncology is the negative association with the term itself. The societal perception of PC as synonymous with terminal care perpetuates PC stigma according to 12 of the studies [12]. A systematic review highlighted the prevalence of negative views among OHCPs toward the involvement of PC teams due to them having the name of their service including the term "palliative care" [11]. Patient uncertainty about prognosis and insufficient explanation of PC referrals can evoke panic that they are imminently dying, leading to the negative association of PC with EOL care [19]. Long-term relationships with physicians were found to influence the patient acceptance of PC referrals, emphasizing the need to address negative connotations associated with PC [40]. One Oncologist summed it up by stating, "The problem with the word "palliative" is that "palliative care" is a terrible word for most people. Because they confuse it with being terminal" [13]. PC's association with death and dying triggers negative emotions such as fear, anxiety, dread, and hopelessness in patients, which contributes to the stigmatization of PC [41].

Oncologists, expressing discomfort with the term "palliative care," delay referrals due to the persistent stigma they say their patients have connecting PC with death and dying [14, 42, 46]. The stereotype and misconception that PC requires forgoing cancer therapy and is synonymous with EOL prevails, contributing to the negative image of PC [21]. One study in France revealed many OCHPs holding negative representations of PC, viewing it as akin to "waiting on death row" [18]. This negative attitude of PC from OHCPs themselves may be passed onto patients, affecting their likelihood to accept PC, even when it is offered to them. Clinicians and patients alike misconceive PC as relevant only at the very last stage of life, contributing to this most obvious overall stigma attached to the term [22, 52].

6.2. Undesired Differentness. In the context of Oncology PC, "undesired differentness" emerges as a characteristic theme in 10 studies. Patients grappling with the intense nature of cancer diagnosis and treatment often exhibit a strong will to live and resist giving up, reflecting a desire to fight against the odds to beat cancer and return to "normalcy" in society [15]. Social network influences, messages, and societal pressures contribute to patients' concerns about being perceived differently, hindering PC acceptance [35]. Referral to PC may be viewed as a veiled message of impending demise, creating a sense of undesired differentness from the "norm" [19]. High social stigma associated with cancer in general, particularly in regions like India, amplifies the stigma surrounding PC, reinforcing the undesired differentness experienced by patients [36].

One study reported cancer patients who were navigating PC expressed experiencing feelings of devaluation, guilt, and shame, which contributed to a sense of undesired differentness [41]. Societal expectations and the pressure of filial piety described further emphasized patients' determination to face the challenge of treatment and "fight the disease" [37]. Some conveyed that deviating from the social norm of battling a "War Against Cancer" and "giving up" by accepting PC could lead to an undesired sense of differentness in cancer culture [15, 25]. A qualitative exploration found that adults with advanced-stage cancer prioritize attributes like not having a change in appearance; not exposing physical, mental, and emotional weaknesses; and aligning with societal norms as much as they can to avoid being perceived as "undesirably different" [39]. One systematic review described how unrealistic expectations influenced by societal perceptions and negative public views about dying "early," "fighting to the end," and "giving up" contribute to cancer patients' feelings of undesired differentness [22]. Advanced cancer patients expressed the desire to have the same curable treatment seen in other cancer patients in society, which highlighted the impact of undesired differentness driving their unrealistic care decisions [48].

6.3. Avoidance. The theme of avoidance appearing in 11 of the articles was seen as clearly shaping both patient and provider behaviors. For example, cultural influences significantly contribute to the avoidance of discussing prognosis with patients, as observed in cultures such as in India [36]. One study found that family and providers often refrain from directly disclosing prognostic information with the cancer patient, thereby aligning with societal norms and supporting this stigma characteristic of avoidance [36].

Patients, influenced by a desire to protect their relatives from emotional distress, often also engage in avoidance behaviors [16, 18, 21, 22]. One article highlighted how patients may present themselves as physically better than they are, thus perpetuating unrealistic expectations to their loved ones and OHCPs in an attempt to avoid the appearance of even "needing" PC [13]. Family members, in an attempt to shield patients from emotional distress, admitted to avoiding discussing disease prognosis, which contributed to a cycle of avoidance in patients and their caregivers in understanding and accepting the realities of the incurable nature of the cancer [13, 15]. Similarly, in Japan, cultural norms and the desire to be "unaware of death" contributed to avoidance behaviors, with patients commonly refusing to see visitors and favoring aggressive treatment as a means of avoiding the acknowledgment and acceptance of their prognosis [37].

The societal stigma of early premature death further reinforces avoidance, with common barriers reported in studies involving patients and families denying the

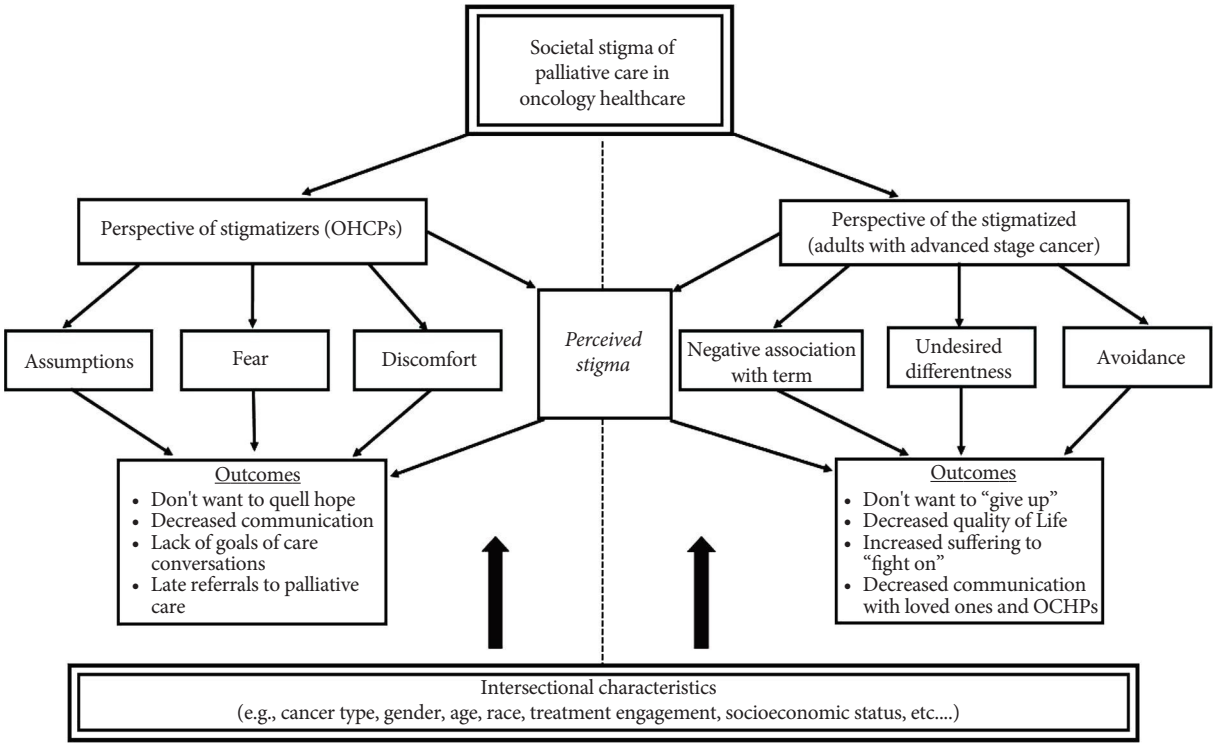


Figure 2: Alexander's Oncology Palliative Care Stigma Framework. This framework was adapted from Fox, A.B., Earnshaw, V.A., Taverna, E., & Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. Stigma and Health, 3 (4), 348–376.

terminal nature of their disease, leading to resistance in accepting PC [18, 21, 22, 39]. OHCPs also describe patients who avoid accepting the truth about having no treatment options left and clinging to unrealistic hope, further emphasizing the pervasive role of avoidance in the context of PC [17]. PC stigma, fueled by associations with death and dying, evokes fear, anxiety, and hopelessness in patients, leading to avoidance behaviors ranging from fear of abandonment to potential perceived loss of care [16, 18, 22].

6.3.1. A New Model for Understanding Oncology PC Stigma: Alexander's Oncology PC Stigma Framework. While only thirteen articles (40%) actually used the word stigma, defining it as the negative societal perception equating PC to EOL care, the results of this review reveal that the phenomenon of Oncology PC stigma is much more complex than that simple explanation. As a result, a novel theoretically and empirically driven conceptual framework was developed to better explain the complex nature of stigma in advanced cancer care and how that translates to the underutilization of PC (Figure 2). Specifically, this model postulates that societal stigma in Oncology care is driven by two main factors: (1) the perspectives of the stigmatizers (OHCPs) and (2) the perspectives of the stigmatized (adults with advanced-stage cancer). Underneath each of these two overarching umbrellas are three characteristics associated with stigma, which all lead to associated outcomes as discussed throughout the literature. Directionality is shown through arrows displaying the interplay of the factors, characteristics, and outcomes, which, in turn, each reinforce perceived stigma. Intersectional characteristics of the stigmatized woven throughout all the reviewed articles that can have an impact on stigma perceptions are things such as specific cancer types, age, gender, race, socioeconomic status, and level of treatment engagement.

7. Discussion

As established by previous research and clinical guidelines, PC is essential to high-quality Oncology care [1]. Professional cancer organizations along with the American Society of Clinical Oncology recommend that all patients diagnosed with advanced-stage cancer receive specialized PC treatment within 8 weeks of diagnosis [8, 54]. This robust literature review unfortunately reaffirms that most OHCPs

are still not in alignment with these recommendations. Guided by Goffman's theory of stigma [30], this review of the literature found substantial evidence supporting the existence of a decades old societal stigma associated with PC in the field of Oncology, which contributes to PC underutilization. Findings suggest that OHCPs still view PC in many of the same ways as thirty years ago with little change in their perceptions, which therefore continues to perpetuate the stigma.

This integrated literature review is the first to conceptually and empirically examine PC stigma in the context of advanced cancer. It presents Oncology PC stigma in a novel way through a theoretically driven conceptual framework integrating stigma characteristics with their associated behaviors to view the impact they may have on patient outcomes. The six themes are universal as they were extracted from 32 articles from 21 differing countries, revealing similarities in the "stigmatized" and "stigmatizer" perspectives across different cultures globally. In all the articles reviewed, PC stigma was not explicitly defined. However, the concept of stigma was implicitly assumed, enabling the generation of six recurring themes to provide a clearer understanding of Oncology PC stigma and creation of a conceptual framework. The cumulative evidence highlights a research gap in PC education for both patients and OHCPs and a pressing need for strategies to reframe perceptions to dispel the negative associations of PC in Oncology healthcare.

The "Alexander Oncology Palliative Care Stigma Framework" (Figure 2) derived from this review further explicitly highlights the importance of integrating stigma knowledge from the perspectives of both providers and patients into OHCP clinical practice. Applying this conceptual framework in clinical practice may provide a drive for OHCPs to initiate PC discussions with their patients and increase PC referrals earlier as they will now have a high-level overview of the implications of not doing so. OCHPs being conscious of potential fears and discomfort that can occur surrounding PC issues can help them address these emotions appropriately before they affect their clinical practice. The cross-cultural perceptions around PC assumptions reinforces that medical paternalism remains acceptable in healthcare across the world, even among the United States, which signals a need to change OCHP assumptions [15, 18, 22, 37]. Measures can be taken to purposefully educate OHCPs, cancer patients, and their caregivers in a more direct manner on the true nature of PC to correct the most common misconception that PC is hospice or EOL care, which has led to the negative association of the term "palliative care." The recognition of undesired differentness is pivotal for OHCPs in fostering more compassionate and patient-centered approaches in Oncology PC to help reduce the feeling of being stigmatized in advanced cancer patients. The synthesis of findings reveals the critical need to address avoidance behaviors as part of comprehensive intervention strategies to reduce stigma and improve the acceptance and utilization of PC in Oncology.

A primary goal of this literature review was to specifically target reported perceptions of OHCPS to allow them an opportunity to self-reflect on their perceptions of PC in comparison with what is in the literature. Increasing knowledge of Oncology PC stigma and integrating this new theory-driven model can promote changes in clinical practice and positively impact advanced cancer patient outcomes. Future research should focus on targeted interventions aimed particularly to address one of the six characteristics of stigma explored in this review. This framework can provide a guide for testing such stigma reducing interventions in the specific areas identified.

8. Conclusion

Findings from this theoretically driven integrative review add to the current knowledge of PC stigma in Oncology by precisely delineating the defining features of stigma and making the implicit explicit. By improving our understanding of what specific perceptions and behaviors contribute to Oncology PC stigma, stigma can be more comprehensively acknowledged as a significant factor contributing to the underutilization of PC in the field of Oncology. Moreover, the framework developed from this review can inform future targeted interventions aimed at reducing stigma in the field of Oncology healthcare with the overarching goal to increase PC utilization in this vulnerable patient population.

Appendix A

Table A1: Literature matrix.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(1) Bennardi, M., Diviani, N., Gamondi, C., Stüssi, G., Saletti, P., Cinesi, I., & Rubinelli, S. (2020). Palliative care utilization in Oncology and hemato-Oncology: a systematic review of cognitive barriers and facilitators from the perspective of healthcare professionals, adult patients, and their families. BMC Palliative Care, 19(1), 47. https://doi.org/10.1186/s12904-020-00556-7	Studies published between 1995 and 2018. 11 countries: USA Belgium Japan Iran Australia UK Netherlands Turkey Canada Brazil China	Systematic review of 52 studies extracted from PubMed, PsycINFO, IAHPC/CINAHL, and CMMC based on exclusion and inclusion criteria from 9411 articles. Four themes were identified: awareness of palliative care, collaboration and communication in palliative care-related settings, attitudes and beliefs toward palliative care, and emotions involved in disease pathways. The results showed that cognitive barriers and facilitators are involved in the educational, social, emotional, and cultural dimensions of palliative care provision and utilization. In particular, these barriers and facilitators exist both at the healthcare professional level (e.g., a barrier is a lack of understanding of palliative care applicability, and a facilitator is the strategic visibility of the palliative care team in patient floors and hospital-wide events) and at the patient and family level (e.g., a barrier is having misconceptions about palliative care, and a facilitator is patients' openness to their own needs). Conclusions: To optimize palliative care services utilization, awareness of palliative care, and healthcare professionals' communication and emotion, management skills should be enhanced. Additionally, a cultural shift, concerning attitudes and beliefs toward palliative care, should be encouraged.	Yes (1)	"One of the main reasons impeding patients with oncological conditions experiencing physical suffering and high distress, who certainly would benefit from palliative care services, to use these can be attributed to the lack of collaboration and communication skills necessary to properly address discussions with patients and family, as well as to the general stigma attached to palliative care. Therefore, discussion of palliative care options is often avoided, especially due to lack of openness of communication on diagnosis and prognosis between patients and family, or between HPs and patients. Training to increase collaboration and communication skills in palliative care settings should be available to HPs. In addition, it might be relevant to implement the use of relevant tools for disclosing unfavorable information"	Large discussion section under the heading of attitudes and beliefs of palliative care using terms such as "negative view" of OCHPs of palliative care team involvement and fear of losing patient management
(2) Buckley de Meritens, A., Margolis, B., Blinderman, C., Prigerson, H. G., Maciejewski, P. K., Shen, M. J., Hou, J. Y., Burke, W. M., Wright, J. D., & Tergas, A. I. (2017). Practice Patterns, Attitudes, and Barriers to Palliative Care Consultation by Gynecologic Oncologists. Journal of Oncology practice, 13(9), e703–e711. https://doi.org/10.1200/JOP.2017.021048	2015 USA	Members of the Society of Gynecologic Oncology were electronically surveyed regarding their practice of incorporating palliative care services and to identify barriers for consultation. Descriptive statistics were used, and two-sample z tests of proportions were performed to compare responses to related questions. Results of the 145 respondents: 71% were attending physicians and 58% worked at an academic medical center. The vast majority (92%) had palliative care services available for consultation at their hospital; 48% thought that palliative care services were appropriately used. 51% thought that they were underused, and 1% thought that they were overused. The main barrier for consulting palliative care services was the concern that patients and families would feel abandoned by the primary oncologist (73%). Ninety-seven percent of respondents answered that palliative care services are useful to improve patient care.	No	N/A	"Misconceptions by patients, their families and physicians about the breadth and benefits of palliative care." Aim of study was to explore attitudes to the integration of palliative care series among gynecologic oncologists. Fear: 90% of providers concerned that family would think provider was giving up on the treatment of patient if referred to PC. 80% providers responded that a barrier was family resistance. 21% OHCPs responded they have had negative experience with palliative care team, making them reluctant to consult in the future—assume will be the same in the future. Major conclusion of the study was result that the main barrier preventing providers to refer pts to PC is that patients and their families will feel abandoned.
(3) Calvache, J. A., Moreno, S., Prue, G., Reid, J., Ahmedzai, S. H., Arango-Gutierrez, A., Ardila, L., Arroyo, L. I., & de Vries, E. (2021). Knowledge of end-of-life wishes by physicians and family caregivers in cancer patients. BMC palliative care, 20(1), 140. https://doi.org/10.1186/s12904-021-00823-1	May 2019–May 2020 Colombia	Online questionnaire and telephone-based surveys were performed with physicians and family caregivers, respectively, in three teaching hospitals in Colombia, which had been involved in the EOL care of 138 deceased cancer patients. Obtained responses from physicians and family caregivers. 261 physicians and 176 caregivers of 341 identified patients (response rate, 76.5 and 51.6%, respectively). Median time between death and the physicians completing the survey was 9 days.	No	N/A	"In Colombia, there is a strong taboo on talking about death and dying. This can lead to sub-optimal decision-making processes, poor communication, potentially inappropriate care and symptom management." One of the three questions asked in survey was—Did the patient receive palliative care? Survey was done on patients with estimated 3 months left to live and study focuses mainly on EOL care, indicating providers in Colombia equate PC to EOL care, reinforcing misconception. Assumption/undesired differentness—in only 17% of cases, physicians reported talking with the patient about impending death, assumed family would make decision. "In the absence of a conversation about EOL physicians indicated they had not discussed this because the treatment option was 'clearly the best for the patient' or 'not necessary to discuss treatment with the patient'. . . . Paternalistic attitude of physicians, where they could decide on what would be best for the patient. . .."
(4) Dhollander, N., De Vleminck, A., Deliens, L., Van Belle, S., & Pardon, K. (2019). Barriers to the early integration of palliative home care into the disease trajectory of advanced cancer patients: A focus group study with palliative home care teams. European journal of cancer care, 28(4), e13024. https://doi.org/10.1111/ecc.13024	2016 Belgium	Because palliative care home care (PHC) is organized differently compared with PC in a hospital setting, the identification of barriers to the early integration of PHC is needed. Methods: Six focus groups ($n = 51$ participants in total) were held with PHC teams in Flanders, Belgium, made up of palliative care physicians, palliative care nurses, and PC psychologists. Discussions were transcribed verbatim and analyzed using constant comparative analysis. Results: Findings confirmed many barriers found in previous studies, such as the perception of PC as terminal care. Oncologists' lack of knowledge about the content and role of PC is also confirmed.	Yes (1)	In all focus groups, participants reported the societal perception of PC as terminal care as a major barrier. Despite these recommendations and despite the positive results of previous interventions, both clinical practice and society still do not acknowledge the relevance and advantages of early PC. Even though oncological diseases are becoming more and more treatable and there are demonstrable advantages to receiving PC from diagnosis, the stigma around "palliative care" still exists. Also, as found in the literature, physicians still have concerns about loss of hope and fear of negative patient reaction when introducing PC early	"Fear of depriving patient of hope" "Given the societal perception of PC as terminal care."

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(5) Earp, M. A., Sinnarajah, A., Kerba, M., Tang, P. A., Rodriguez-Arguello, J., King, S., Watanabe, S. M., & Simon, J. E. (2018). Opportunity is the greatest barrier to providing palliative care to advanced colorectal cancer patients: a survey of Oncology clinicians. Current Oncology (Toronto, Ont.), 25(5), e480–e485. https://doi.org/10.3747/co.25.4021	Canada 2018	The Michie Theoretical Domains Framework (TDF) and Behavior Change Wheel (BCW), together with knowledge of previously identified barriers, to develop a 31-question survey on barriers to PC. The survey was administered online using the REDCap Web application 60/150 (40%) response rate of email recipients of OHCPs for advanced colorectal cancer patients (33% Oncology clinic nurses) oncologists (31%)	No	N/A	OHCPs have "discomfort with engaging patients in difficult conversations." High result on survey that OHCPs perceive negatively that PC referral increases patient's distress. Fear of "patient distress at the term palliative," which was perceived as a barrier by 53% of respondents.)
(6)Ellen, M. E., Perlman, S., & Shach, R. (2021). Too Much Cancer Care?: Nurses' Perspectives on the Unnecessary Use of Oncology Services. Cancer nursing, 44(4), E236–E243.	2020 Israel	In-depth, semistructured interviews were conducted with a convenience sample of 20 Oncology nurses currently practicing in Israel. Interviews were recorded, transcribed, and analyzed thematically.	No	N/A	*OCHP* discomfort—nurses state inexperienced physicians "lack knowledge. . .regarding how to say 'no' to patients" that "it's enough." Fear: Participants reported a desire to do their utmost for the well-being of patients and their families and recognized similar or stronger desires among physicians. Many participants described it was difficult to "give up" and explained that providers feel that they need to "give one more chance" (009) to patients. Some nurses felt that, at times, providers either are afraid of "making mistakes" or have "fear of lawsuits." Participants stated that providers, particularly physicians, feel that their purpose is to heal and, therefore, will do what they think is necessary to succeed in treating cancer patients, for example, "Doctors are meant to heal and they feel that it is their purpose in the world and if they fail to do it they have failed." Assumption: In Judaism, the length of life is valued above all else, and extreme measures may be taken to extend life as long as possible. Participants noted that "because we are Jews it's as if life is holier than everything and if it gives them another day then it is worth it, even at a terrible price." Providers assume their patients want everything done. Patients: Undesired difference/avoidance: Don't want to give up, will to live. Nurses recognize that their patients, particularly those having difficulty coping with and accepting their disease, exhibit a will to live and to keep fighting while disregarding the odds, for example. "A person really wants to feel that they really are fighting to the end," don't want to disappoint families.
(7) Ethier, J. L., Paramsothy, T., You, J. J., Fowler, R., & Gandhi, S. (2018). Perceived Barriers to Goals of Care Discussions With Patients With Advanced Cancer and Their Families in the Ambulatory Setting: A Multicenter Survey of Oncologists. Journal of palliative care, 33(3), 125–142. https://doi.org/10.1177/0825859718762287	2014 Canada	Methods: DECIDE (DECIsion-making about goals of care for hospitalized meDical patiEnts) survey distributed to oncologists from 12 centers in Ontario, Canada. Physicians were asked to rank the importance of various barriers to having GOC discussions (1 = Extremely Unimportant to 7 = Extremely Important). Results: Questionnaires were completed by 30 (24%) of 127 physicians. Respondents perceived patient- and family-related factors as the most important barriers to GOC discussions. Of these, patient difficulty accepting prognosis or desire for aggressive treatment were perceived as most important. Patients' inflated expectation of treatment benefit was also considered an important barrier to discontinuing active cancer-directed therapy. While physician barriers were ranked lower than patient-related factors, clinicians' self-identified difficulty estimating prognosis and uncertainty regarding treatment benefits were also considered important. Patient's refusal for referral was the most highly rated barrier to early palliative care referral.	No	N/A	Assumption of OHCPs: "High-intensity life support is often provided even when patients or their families may prefer to focus on comfort care." Fear: Uncertainty surrounding prognosis and desire to maintain hope were identified as important barriers to early palliative care by OHCPs. Discomfort with patient age as OHCPs had more difficulty recommending treatment discontinuation in younger patients. "This study actually captures physician perceptions about barriers that may or may not exist at the patient and family level, and thus, these finding could in fact be considered physician-related barriers" because of their assumptions of patient and family's perceptions of palliative care
(8) Formagini, T., Poague, C., O'Neal, A., & Brooks, J. V. (2022). "When I Heard the Word Palliative": Obscuring and Clarifying Factors Affecting the Stigma Around Palliative Care Referral in Oncology. JCO Oncology practice, 18(1), e72–e79. https://doi.org/10.1200/OP.21.00088	2018 USA	A qualitative descriptive design using grounded theory components was designed to investigate barriers to PC referrals for patients receiving treatment at an outpatient cancer center. Interviews with patients, caregivers, and Oncology professionals ($n = 44$) were audio-recorded, transcribed, and independently coded by three investigators to ensure rigor. Participants were asked about their perceptions of PC and PC referral experiences. Stigma around PC as EOL is well-documented, and it remains unclear what affects the strength of that stigma. This study explored factors that obscure or clarify the stigma around PC referrals and associations with EOL from the perspectives of patients, caregivers, and Oncology clinicians.	Yes (19)	Directly used in title, "the Stigma Around Palliative Care Referral in Oncology." Defines PC stigma as association of PC with EOL (eight times). Data show that prior PC knowledge may not be sufficient for dismantling the stigma if this prior knowledge is inaccurate or if the referral communication within the context of their own care did not clearly explain the goals of PC—addressing misperceptions about PC directly was reported by patients and caregivers as particularly helpful	Negative association: "When patients were unsure about their prognosis and/or when the PC referral was not well explained, they were fearful that PC meant EOL. Undesired differentness: Social network influences sometimes discouraged patients from PC. Worried referral to PC was veiled message they were dying. When patients and caregivers were familiar with PC, had prognostic confidence, and/or experienced clear referral communication, they less often felt unease about PC being an end-of-life signal." Participants reported that some healthcare professionals told them PC was EOL (assumption), suggesting a need to further educate the general healthcare community about PC's compatibility with cancer therapy. Discusses the continued pattern of referrals late in the disease trajectory, as described by participants and previous research, worsens confusion, and reinforces the belief that PC is predominantly for EOL. Discomfort: "difficult for clinicians to navigate prognostic communication in cancer care"

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(9) Gidwani, R., Nevedal, A., Patel, M., Blayney, D. W., Timko, C., Ramchandran, K., Kelly, P. A., & Asch, S. M. (2017). The Appropriate Provision of Primary versus Specialist Palliative Care to Cancer Patients: Oncologists' Perspectives. Journal of palliative medicine, 20(4), 395–403. https://doi.org/10.1089/jpm.2016.0399	2015 USA	Method: Qualitative. Semistructured telephone interviews with 31 oncologists analyzed using matrix and thematic approaches to characterize medical oncologists' perceptions of PC that closed-ended surveys cannon. Results: seven themes emerged (4/7 show stigma characteristics as indicated in last column. "Although the perception of PC as end-of-life care has been mentioned in the literature as a barrier to PC referral in U.S. Oncology, respondents in our sample viewed PC as appropriate at multiple stages in the disease trajectory. This is in line with other empirical evidence and may represent a change in how the role of PC is viewed more generally. Despite this attitude, oncologists we interviewed reported that the provision of PC remained in practice predominately relegated to EOL, not due to oncologists' perceptions but rather due to structural factors."	No	N/A	"Theme 1: Specialist PC is an extra layer of support that is perceived as appropriate at any point in the disease trajectory, but it is usually provided at EOL." Assumption that this is when PC referral is appropriate. Theme 2: Oncologist views on PC fall into three distinct schools of thought: 1—discomfort indicated by oncologists not seeing themselves as providers of PC due to limited training or time to focus on palliation and a preference for focusing on oncologic skills such as chemotherapy. 2—Fear that they would be unable to properly elicit patients' goals or preferences or that there were symptoms or patient personality types that posed large challenges they couldn't address as well as PC specialist. 3—Assumptions: Oncologists who saw themselves as the sole providers of PC and did not typically refer patients to PC specialists. These oncologists noted that their medical training provided them with the skills necessary to provide PC that they had inadequate access to PC specialists within their medical center or rural environment or that good PC was an integral component of high-quality oncologic care. Theme 5: PC specialists are a "team of outsiders" that some oncologists viewed positively and others denoted negatively and that impacts patient care: Negative view reflects the fear of losing rapport with patient by letting "strangers" take over symptom management, believe as oncologist should manage all of patient's care needs. Theme 6: PC provides too narrow a focus of care: Assumption that PC is too focused on GOC or advanced directives and "not very helpful" with a limited scope
(10) Gramling, R., Ingersoll, L. T., Anderson, W., Priest, J., Berns, S., Cheung, K., Norton, S. A., & Alexander, S. C. (2019). End-of-Life Preferences, Length-of-Life Conversations, and Hospice Enrollment in Palliative Care: A Direct Observation Cohort Study among People with Advanced Cancer. Journal of palliative medicine, 22(2), 152–156. https://doi.org/10.1089/jpm.2018.0476	2018 USA	Methods: Multisite cohort study of 231 hospitalized patients with advanced cancer who consulted with PC and audio-recorded the initial consultation and coded conversations for all statements regarding expectations for how long the patient will live. (Length-of-life talk.) Patients were then followed for up to 6 months to determine EOL treatment utilization, including hospice enrollment. Patients completed a brief interviewer-facilitated questionnaire at study enrollment. Results: 44% (101/231) of observed conversations contained at least one statement about expectations for length of life, and 60% of patients (139/231) enrolled in hospice during the 6 months following these conversations. The association between length-of-life talk and hospice enrollment was strong among those (155/231) who endorsed treatment preferences favoring comfort over longevity in the last weeks to months of life (odds ratio [OR] adj = 2.98; 95% confidence interval [CI] = 1.34–6.65) and weak/absent among others (69/231; ORadj = 0.70; 95% CI = 0.16–3.04).	No	N/A	The result that talking about expectations for the remaining length of life during PC consultation is strongly associated with rates of hospice enrollment during the subsequent 6 months demonstrates the misconception that PC is the same as hospice
(11) Harding, R., Nair, S., & Ekstrand, M. (2019). Multilevel model of stigma and barriers to cancer palliative care in India: a qualitative study. BMJ open, 9(3), e024248. https://doi.org/10.1136/bmjopen-2018-024248	2017–2018 India	Method: This cross-sectional qualitative study sampled advanced cancer patients ($n = 10$), their family caregivers ($n = 10$), and oncologists ($n = 10$). Grounded theory procedures were utilized to analyze transcripts, and a theoretical model generated. Patient eligibility criteria included being at least 18 years old, having a cancer diagnosis, being referred to the palliative care department, understanding and speaking either English or Kannada (the local language), and having an adult family member who was willing to be interviewed about their caregiving needs and experiences with palliative care. Conclusion of results recognized that the responsibility for improving palliative care access lies with the oncologist	Yes (40)	Study participants "reported frequent disease-related misconceptions and an unwillingness to discuss sensitive topics, such as a poor prognosis and. . . family members appeared to feel ashamed over the diagnosis of their loved one, this shame, together with misconceptions regarding the disease, fear and lack of communication likely drove stigma and led to sub-optimal treatment." The model explains how stigma associated with communicating a diagnosis of advanced cancer is enacted by treating oncologists, family members, and community. This leads to patient expectations of cure and futile treatment uptake. Patients commonly only present needs with respect to pain, not within psychological, social, or spiritual domains, likely due to the lack of patients' insight into their diagnosis and prognosis. As a result of oncologists' and families' unwillingness to disclose the prognosis, and patient focus on pain due to their lack of insight, (avoidance) palliative care clinicians view their services as under-utilized, and patients perceive palliative care as a pain management service that is not "different" from other clinical services.	Assume relatives know best, fear of upsetting patient, and do not disclose prognosis often in this country. Undesired differentness: high stigma of cancer in India—"A small study of cancer survivors, oncologists and the general population cancer in India perceived both community and internalized stigma to be driven by their own and others' beliefs that cancer is the result of sins of the past life, with social rejection due to the lay belief that cancer is an infectious disease." Patients and families described feeling stigmatized and socially ostracized from their community after prognosis disclosed

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(12) Hay, C. M., Lefkowits, C., Crowley-Matoka, M., Bakitas, M. A., Clark, L. H., Duska, L. R., Urban, R. R., Chen, L. M., Creasy, S. L., & Schenker, Y. (2017). Gynecologic Oncologist Views Influencing Referral to Outpatient Specialty Palliative Care. International journal of gynecological cancer: official journal of the International Gynecological Cancer Society, 27(3), 588–596. https://doi.org/10.1097/IGC.0000000000000893	2015–2016 USA	Method: Qualitative interview study at six National Cancer Institute–designated cancer centers with well-established outpatient palliative care services. Thirty-four gynecologic oncologists participated in semistructured telephone interviews focused on attitudes, experiences, and preferences related to outpatient specialty palliative care. A multidisciplinary team analyzed transcripts using constant comparative methods to inductively develop a coding framework. Through an iterative, analytic process codes were classified, grouped, and refined into themes	No	N/A	Participants noted that patients were more likely to accept referral from a physician with whom they had a longitudinal relationship due to better physician ability to address negative connotations of palliative care. Discomfort with PC because OHCPs "felt long-term relationships with patients decreased use of outpatient specialty palliative care; they attributed this to their desire to maintain a longitudinal relationship and continue to personally provide a broad spectrum of care." Quote: "I think just that we take care of the patient from diagnosis until death, that part of that taking care of them at the end, I feel like is part of my job, that's why I chose this field, and I don't want to give my patient away completely." (assumption that PC gives away care) Fear of "losing that valued relationship when referring to PC." Half of participants voiced concern about referral, leading to loss of control and awareness of patient care.
(13) Hmaidan, S., Goulder, A., Bos, L., Shen, M. J., Wellman, J. D., Prescott, L., & Brown, A. (2023). Too Close for Comfort? Attitudes of Gynecologic Oncologists Toward Caring for Dying Patients. The American journal of hospice & palliative care, 40(11), 1168–1173. https://doi.org/10.1177/10499091221145165	2022 USA	Gynecologic oncologists were surveyed using validated measures to assess stigmatizing attitudes toward palliative care, anticipated stigma of palliative care, acceptance of palliative care, and willingness to refer to palliative care. Descriptive statistics were calculated. Analysis was performed using linear regression. Results: 1200 physicians received the survey and 108 (9%) completed it. limited in its small sample size and low response rate and demographics. Most were female (69.4%) and white (82.4%). Most practiced in academics (64.8%) in urban environments (71.3%). Respondents did not have anticipated stigma surrounding palliative care referral (mean score 1.89, range 1–7, higher score indicating more stigma), were accepting palliative care (mean score 1.45, range 1–7, higher score indicating less acceptance), and were willing to refer patients to palliative care (mean score 5.75, range 1–7, higher score indicating more willingness to refer). Linear regression demonstrated females had less anticipated stigma surrounding palliative care ($B = .213$, $p = .04$) and higher acceptance of palliative care ($B = .244$, $p = .01$)	Yes (43)	A barrier to palliative care utilization is physician stigma surrounding palliative care. Stigma is defined as society's negative evaluation of a particular individual or entity. Palliative care stigma consists of both the perceived and experienced stigma from patients and caregivers, as well as stigmatizing attitudes from healthcare providers. Palliative care stigma may occur because of palliative care's association with death and dying, which can provoke fear, anxiety, avoidance, and hopelessness in patients, caretakers, and providers. Stigma has been demonstrated in other healthcare contexts such as lung cancer, mental healthcare, and HIV/AIDS. In these contexts, stigmas-related to these health issues reduced rates of medical care seeking. Stigma associated with palliative care may lead to both: (1) lack of acceptance of referrals to or utilization of palliative care by patients and (2) lack of referrals to palliative care by providers	Both patients who transition to palliative care and their healthcare providers frequently experience feelings of guilt and shame for "giving up" (assume PC = giving up). Patients may also experience devaluation (undesired differentness) and fear of abandonment/loss of care. This fear and avoidance of palliative care among advanced cancer patients and the reduced/delayed referrals to palliative care by healthcare providers suggests that palliative care stigma may impact not only patients but also providers.
(14) Horlait, M., Chambaere, K., Pardon, K., Deliens, L., & Van Belle, S. (2016). What are the barriers faced by medical oncologists in initiating discussion of palliative care? A qualitative study in Flanders, Belgium. Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer, 24(9), 3873–3881. https://doi.org/10.1007/s00520-016-3211-5	2013–2014 Belgium	Methods: Qualitative interviews of 15 medical oncologists were semistructured with open-ended questions and were supported by a topic list. The transcripts were analyzed during an iterative process using the grounded theory principles of open and axial coding until a final coding framework was reached.	Yes (6)	Palliative care stigma Oncologists frequently reported that talking about palliative care was avoided because of the stigma surrounding it and its associations with terminal care, death, and giving up hope. Among patients and even among the general public, there is an important misunderstanding of the concept "palliative care," which withholds the oncologists to openly use the word "palliative." "Referring a patient to or even talking about palliative care is giving up hope, or giving up on the patient. Many oncologists in this study expressed concern that a referral to palliative care would destroy a patient's hope."	Discomfort: "Before referring patients to a palliative care ser-vice, oncologists need to inform them about disease stage and discuss prognosis, treatment options and possible advantages of specialized palliative care (SPC). They often find this a complex and emotionally difficult task. As a result, they may refer their patients to PC too late in the disease course or even not at all." If the patient was someone young or with young children, they found it very difficult to bring up palliative care. During their medical education, they had received very little or no formal training on how to handle or initiate difficult discussions. Additionally, the medical education that they had received focused mainly on treating and curing and ignored the key principles of palliative care. "It is assumed that the medical oncologist is responsible for the initial conversation about palliative care." Assumptions about relatives responses: "feel hampered by the emotional reactions of relatives." The patient's level of intelligence or education seen as a barrier to discuss palliative care because they fear that these patients are unable to absorb the information properly. Avoidance: Patients often tend to protect their relatives by presenting themselves physically better than they actually are. This creates or nourishes the unrealistic expectations of the relatives Negative association of term PC: "The problem with the word 'palliative' is that 'palliative care' is a terrible word for most people. Because they confuse it with being terminal."

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(15) Hui, D., Bansal, S., Park, M., Reddy, A., Cortes, J., Fossella, F., & Bruera, E. (2015). Differences in attitudes and beliefs toward end-of-life care between hematologic and solid tumor Oncology specialists. Annals of Oncology: official journal of the European Society for Medical Oncology, 26(7), 1440–1446. https://doi.org/10.1093/annonc/mdv028	2014 USA	120 hematologic and 120 solid tumor Oncology specialists surveyed at a tertiary care cancer center to examine their attitudes and beliefs toward PC. 182 (76%) responded. Discussed a previously conducted survey of Oncology specialists at their cancer center to examine clinicians' beliefs toward the service names "palliative care" and "supportive care." When asked whether the "service name can decrease hope in patient and families," 61% of Oncology specialists agreed with this statement for palliative care in contrast to 15% for supportive care. When asked whether the "service name is a barrier for me to refer patients," 44% agreed for the term "palliative care" compared with 11% for the term "supportive care." This led them to change their program name from palliative care to supportive care in 2007, without changing the nature of service. More referrals and earlier referrals among outpatients occurred after the name change, supporting their hypothesis that the term "supportive care" facilitates palliative care access	Yes (10)	Term palliative care has negative connotation as the defining feature of the stigma associated with it. Listed among reasons for delayed referral by oncologists persistent stigma that palliative care is associated with death and dying. Stigma is associated with the phrase "palliative care."	Oncologists significantly preferred the service name "supportive care" over "palliative care" as name change was perceived as less likely to be "synonymous with hospice," and less likely to decrease hope in patients and families (fear and assumptions).
(16) Hui, D., Park, M., Liu, D., Reddy, A., Dalal, S., & Bruera, E. (2015). Attitudes and Beliefs Toward Supportive and Palliative Care Referral Among Hematologic and Solid Tumor Oncology Specialists. The oncologist, 20(11), 1326–1332. https://doi.org/10.1634/theoncologist.2015-0240	2014 USA	120 hematologic and 120 solid tumor Oncology specialists surveyed at a tertiary care cancer center to examine their attitudes and beliefs toward PC. 182 (76%) responded. No significant difference was found between how hematologic and solid tumor specialists perceived the terms "palliative care" and "supportive care," but they did support the name change reporting they would more likely refer their newly diagnosed cancer patients to palliative care if it was named supportive care.	Yes (10)	PC stigma is persistent because the phrase or term palliative care is associated with death and dying	The stigma associated with palliative care can partly be overcome by a simple change in the service name to "supportive care," which was well received by many clinicians (assumptions about what patients negatively associate term PC with and discomfort with PC term, express more comfort with supportive care)
(17) Kalies, H., Schöttmer, R., Simon, S. T., Voltz, R., Crispin, A., & Bausewein, C. (2018). Barriers for the implementation of guidelines in palliative care-results from a national survey of professionals. Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer, 26(6), 1943–1952. https://doi.org/10.1007/s00520-017-4030-z	2015 Germany	Methods: National survey sent to all 4768 German Association of Palliative Care members. $N = 1031$ completed 62-item questionnaire to evaluate professionals' knowledge, motivation, and outcome expectancy toward already existing recommendations for palliative care and to evaluate the self-experienced competence in five medical key topics presented in the New German Guideline for Palliative Care in patients with incurable cancer. Independent predictors for identified barriers were analyzed using multivariable logistic regression analyses.	No	N/A	Assumptions: Discussed skepticism toward and rejection of PC guidelines among palliative care professionals. Lack of knowledge—almost one-half of professionals did not know any key recommendations concerning PC. Nurses and other professions showed a more than fourfold higher lack of knowledge than physicians Discomfort depression was the symptom with the lowest perceived competence
(18) Kruser, T. J., Kruser, J. M., Gross, J. P., Moran, M., Kaiser, K., Szmuilowicz, E., & Kircher, S. M. (2020). Medical oncologist perspectives on palliative care reveal physician-centered barriers to early integration. Annals of palliative medicine, 9(5), 2800–2808. https://doi.org/10.21037/apm-20-270	USA 2019	Methods: Qualitative, four focus groups with 31 medical oncologists to characterize their perceptions of PC referral in their practices and to uncover important barriers to palliative care and EOL care planning from the perspective of medical oncologist. Results found that medical oncologists follow a practice pattern that reserves palliative care referral for late in a patient's course of illness and they feel a strong sense of responsibility for and authority over decisions about PC referral and are skeptical of efforts by other clinical team members to initiate these referrals.	No	N/A	Patient negative association and assumptions from OHCPs: "one reason for the low utilization rate of early palliative care is a perception from patients and caregivers that palliative care equates to EOL care and a terminal prognosis, and therefore there is a resistance to early palliative care integration from patients." Discomfort: Most oncologists described, but maintained this practice pattern as separate from palliative care referral. Fear: To add stress to patient to see an additional provider and it is difficult for them adding burdens. Assumption: Medical oncologists depicted themselves having authority over the timing of PC referrals
(19) Lin, C. P., Evans, C. J., Koffman, J., Sheu, S. J., Hsu, S. H., & Harding, R. (2019). What influences patients' decisions regarding palliative care in advance care planning discussions? Perspectives from a qualitative study conducted with advanced cancer patients, families and healthcare professionals. Palliative medicine, 33(10), 1299–1309. https://doi.org/10.1177/0269216319866641	2018 Taiwan	Qualitative: 45 participants were interviewed in person (n = 15 from each group of advanced cancer patients, families and healthcare professionals) to explore each group's perspectives and the decision-making processes and drivers of receiving palliative care in advance care planning discussions. Thematic analysis with analytical rigor enhanced by dual coding and exploration of divergent views was used. One of the four key elements identified in the study's conclusions was the importance of ensuring patients understand the term "palliative care," as misunderstandings or stigma surrounding the term can significantly influence future care planning.	No	N/A	*Patients'* undesired differentness: Facing the challenge of treatment: "I want our daughter to know that dad has been fighting against the disease. Dad has no fear." Describe the societal pressure of filial piety. Avoidance: "Family members tried to protect patients from potential emotional distress by avoiding discussing the disease prognosis, while patients suggested they knew nothing about their prognosis to pacify their family members. This was achieved by attempting to cover up their emotions related to their conditions and uncertain future." OHCPs Discomfort: Some healthcare professionals reported they lacked the necessary communication skills to engage in the difficult con-versations required to discuss PC with patients. Physicians may avoid frank discussions out of concern for causing patient distress, often using carefully chosen language to soften or obscure prognosis, and may also fear potential legal challenges if the care provided does not align with patient or family wishes. Assume patients with advanced cancer do not have treatment-making capabilities. Assumption: OHCP said: "We are under pressure because people think that initiating palliative care represents 'giving up'. This is passed on to people from the older generations such as their parents and elders. [Patients don't receive palliative care] because 'filial piety' is very important."

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(20) Llewellyn, H., Neerkin, J., Thorne, L., Wilson, E., Jones, L., Sampson, E. L., Townsley, E., & Low, J. T. S. (2018). Social and structural conditions for the avoidance of advance care planning in neuro-Oncology: a qualitative study. BMJ open, 8(1), e019057. https://doi.org/10.1136/bmjopen-2017-019057	2017 UK	Method: Qualitative Semistructured interviews were conducted with 15 HCP participants who work in Neuro-Oncology to explore their assumptions and experiences of Advanced Care Planning (ACP). Data were analyzed thematically using the well-established framework method culture of "shared avoidance" created by framework based on the results.	No	N/A	Fear of all OHCPs of "upsetting" patient and family by bringing up discussions of ACP and EOL that they equated to palliative care in article. Assumptions about how patients viewed their roles and "concern about disrupting optimistic nature of care"
(21) Miyashita, M., Kawakami, S., Kato, D., Yamashita, H., Igaki, H., Nakano, K., Kuroda, Y., & Nakagawa, K. (2015). The importance of good death components among cancer patients, the general population, oncologists, and Oncology nurses in Japan: patients prefer "fighting against cancer." Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer, 23(1), 103–110. https://doi.org/10.1007/s00520-014-2323-z	2008 Japan	Mixed method. The objectives of this study were to compare the importance of 57 attributes divided into 10 core components of a good death among cancer patients($n = 310$), the general population ($n = 353$), oncologists ($n = 109$), and Oncology nurses($n = 366$). Aim was also to explore which patients preferred "fighting against cancer." Multiple regression analysis used to see factors associated with "fighting against cancer." Results: The major findings of this study were (1) the importance of good death components differed for patients and the general population compared to oncologists and Oncology nurses; (2) patients favored fighting against cancer, especially on "fighting against the disease until one's last moments"; and (3)patients who emphasized maintaining hope and pleasure, unawareness of death and good relationship with family favored fighting against cancer. However, those who emphasized physical and psychological comfort preferred not to fight.	No	N/A	Assumptions: In Japanese culture, medical paternalism has predominated for a long time. In addition, Japanese patients tend to leave medical decisions to physicians (omakase-iryo). Japanese patients fear abandonment by physicians and often feel that a physician who stops aggressive treatment such as chemotherapy is abandoning them. Discomfort: Japanese oncologists have a difficult time speaking to patients about discontinuing anticancer treatment. Avoidance: Patients often have unrealistic desires for the prolongation of life and favor aggressive treatment because they wish to be "unaware of death." Undesired differentness: "Other attributes that were more important to patients than to medical professionals were not having a change in one's appearance and not exposing one's physical and mental weakness to anyone else." Sometimes, patients will refuse to see visitors, such as colleagues, friends, and even family. (avoidance)
(22) Mohammed, S., Savage, P., Kevork, N., Swami, N., Rodin, G., & Zimmermann, C. (2020). "I'm going to push this door open. You can close it": A qualitative study of the brokering work of Oncology clinic nurses in introducing early palliative care. Palliative medicine, 34(2), 209–218. https://doi.org/10.1177/0269216319883980	2016–2017 Canada	Methods: A constructivist qualitative grounded theory study was conducted using semistructured interviews with A total of 20 nurses (six staff nurses, 10 nurse practitioners, and four advanced practice nurses) in a comprehensive cancer center to conceptualize the psychosocial processes involved in the introduction and provision of palliative care by Oncology nurses.	Yes (4)	Defines stigma as patients' misconception of PC with association between palliation and late-stage dying and nurses education efforts to educate to correct their assumptions about PC. "Participants attributed patients' misconceptions not only to the curative culture of the Oncology clinic, but also to widespread misperceptions about the effectiveness of all cancer treatment: In our healthcare in our society, cure is the focus. The people think maybe I'm giving up the fight or. It's because it's a misconception with palliative care."	Discomfort using word "palliative care" in "brokering" work of "selling" PC benefits to patients because assume PC has negative association with dying for patients and families.
(23) Ndiok, A., & Ncama, B. (2021). Barriers and benefits of model development for integration of palliative care for cancer patients in a developing country: A qualitative study. International journal of nursing practice, 27(3), e12884. https://doi.org/10.1111/ijn.12884	2016 Nigeria	Methods: Qualitative using in-depth interviews with four stakeholders and focus group discussions with 19 nurse managers using purposive sampling utilizing interpretive paradigm method to identify barriers and benefits in establishing a model for integration of palliative care of cancer patients in daily clinical practice in tertiary health institutions.	No	N/A	"Until recently, PC was considered only once the patient had reached the terminal stage of the disease and was seldom offered for patients and their families in an early stage of disease." Discomfort and fear: A lot of us lack the ability to communicate either we are afraid or we are shy to tell people the truth. Avoidance: Nigeria is one of the few countries in sub-Saharan Africa that upheld strongly to cultural beliefs especially diagnosis of cancer. This is one of the major barriers affecting cancer care; because cancer is associated with wrong belief of a disease resulting from curse from gods, it is difficult to get them convinced about care by the scientific method. Here, the situation of outright rejection of diagnosis is predominant.
(24) Nierop-van Baalen, C., Grypdonck, M., van Hecke, A., & Verhaeghe, S. (2019). Health professionals' dealing with hope in palliative patients with cancer, an explorative qualitative research. European journal of cancer care, 28(1), e12889. https://doi.org/10.1111/ecc.12889	2012 Belgium	Methods: Qualitative analysis using interpretive description of three focus group discussions of health professionals (total $n = 22$) to explore the ways in which the participating health professionals interpret hope in palliative individuals with cancer and their behavior toward these hopeful palliative patients are shaped by their reliance on their own normative ideas. The results show that the health professionals' conduct is based on normative ideas. These normative ideas seem to be judged as valid for all patients and have the following in common: the concept of a good death: a death that takes leave-taking from beloved ones into account, so they can go on with their lives. This requires the acceptation of and resignation to the truth on the part of the patient, expressed in stopping treatment when the doctor proposes it. Health professionals relate hope mainly to a cure or a stable illness, while the literature also describes other dimensions such as social, spiritual, and existential dimensions of hope. We carefully examined in the interviews what the professionals referred to when talking about hope. The professionals focused on the (false) hope of their patients and their hope to live longer than medically possible. The professionals did not mention any existential and spiritual dimensions of hope	No	N/A	Discomfort: Health professionals experience difficulties in dealing with hope in palliative patients. Undesired differentness: "Health professionals' experiences, attitudes and behaviors are shaped by normative ideas about how the final phase of life should proceed." Patients' hopefulness generally violates these norms and is, therefore, considered a problem that requires intervention. The framework that follows consists of eight normative concepts that health professionals tend to ascribe to regarding palliative patients. Fear of giving false hope to patients. Assumption: Denial (avoidance) can be corrected by informing the patient properly. "Participants consider it important that patients face the unavoidable fact that death is near." Health professionals try to prevent patients from "going down fighting" because they are aware that friends and family of the patient may feel discomfort about this after the death of the patient Discomfort: The participants give little or no attention to the meaning of the patient's existential suffering in dealing with a short life expectancy. This may be related to a tendency to avoid difficult conversations with dying patients

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(25) Parajuli, J., & Hupcey, J. E. (2021). A Systematic review on barriers to palliative care in Oncology. The American Journal of Hospice & Palliative care, 38(11), 1361–1377. https://doi.org/10.1177/1049909120983283	2008–2019 12 countries: USA Australia Belgium Europe Canada Germany Japan India Iran Turkey Colombia France	Method: Systematic review on barriers to palliative care in Oncology 29 studies (8 quant, 18 qual, and 3 mixed methods). Studies ranged from 10 to 313 participants. Articles included only if they 1—focused on cancer, 2—examined and discussed barriers to palliative care and 3—were peer reviewed with full-access in English. Used PRISMA guidelines. Search used PubMed, CINAHL, PsycINFO identifying 2445 articles from 2008 to 2020 for abstract/title screening, 109 full articles reviewed, and 86 excluded with final being 29 articles. Quality appraisal done with MMAT tool	Yes (7)	Some studies found patients and families possessed negative stereotypes about PC and lacked knowledge about their disease trajectory and felt stigmatized by their communities following the cancer diagnosis. They believed that PC required forgoing cancer therapy and equated PC with EOL care.	Results of barriers to palliative care categorized into three areas and two relevant to stigma: 1—related to patient and family (7). Discuss stereotypes/negative images of PC; belief that PC requires foregoing any cancer therapy and equals EOL care. Another common barrier to PC was patients and families' denial of the terminal nature of the disease (avoidance). 2—Related to HCPs (22). Identify the lack of knowledge and training in PC. Providers believe patients want to fight their disease and not interested in hearing about palliation or not ready for PC. (Assumption) Fear and discomfort: HCP communication barriers—use of ambiguous language to "protect" patients
(26) Pfeil, T. A., Laryionava, K., Reiter-Theil, S., Hiddemann, W., & Winkler, E. C. (2015). What keeps oncologists from addressing palliative care early on with incurable cancer patients? An active stance seems key. The oncologist, 20(1), 56–61. https://doi.org/10.1634/theoncologist.2014-0031	2013 Germany	Qualitative in-depth interviews were conducted with physicians ($n = 12$) and nurses ($n = 6$) working at the Department of Hematology/Oncology at the university hospital in Munich, Germany. The data were analyzed using grounded theory methodology and discussed from a medical ethics perspective. A major impediment to the proactive approach was uncertainty about the right timing for EOL discussions and about the balancing the medical evidence against the physician's own subjective emotional involvement and the patient's wishes. Conclusion. These findings provide explanations of why EOL communication is often started rather late with cancer patients.	No	N/A	Physician: Afraid not to honor patient's wishes for treatment even when there is no evidence of effectiveness. "This is difficult to endure, when you know that somebody will die but struggles on and fights because he/she clings to a hope which is probably 99% unrealistic." (Avoidance) And to be in this dilemma is for me the most difficult. (Discomfort) Unrealistic expectations of patient (undesired differentness). Discomfort: Data show Oncologists are overwhelmingly reluctant to provide patients with prognostic information and are hesitant to prepare patients for dying and death due to the fear of negative emotions or destroying hope prematurely.
(27) Salins, N., Ghoshal, A., Hughes, S., & Preston, N. (2020). How views of oncologists and hematologists impacts palliative care referral: a systematic review. BMC palliative care, 19(1), 175. https://doi.org/10.1186/s12904-020-00671-5	Articles from 1990 to 2019 10 countries: Belgium Cyprus Israel Japan Australia USA UK Canada Hungary France	Systematic review of 23 studies (10 Qualitative, 10 surveys, three mixed methods) for synthesis and development of five themes exploring how oncologists and hematologists views impact palliative care referrals.	Yes (17)	Stigma is a societal barrier associated with palliative care and palliative care referral. Stigma associated with palliative care Palliative care referral equals death, EOL, terminal. Negative perception about palliative care precludes the use of the term "negative connotation associated with palliative care"	Assumption: Oncologists feel that patients do not like to be referred to palliative care and referral means abandoning their patients. Moreover, oncologists have concerns about expertise of palliative care physicians and feel that they may discourage or interfere with oncological treatment. (Fear) Discomfort: Discussing death is stressful and a taboo, emotional toll while making palliative care referral and emotional burden associated with delivering news of poor prognosis. Assumption: Patients and families get alarmed by mention of palliative care. Avoidance: Patient and family unwilling to discuss prognosis and noncurative approach or referral to PC. Negative association: negative public perception about death and giving up fighting cancer
(28) Sarradon-Eck, A., Besle, S., Troian, J., Capodano, G., & Mancini, J. (2019). Understanding the Barriers to Introducing Early Palliative Care for Patients with Advanced Cancer: A Qualitative Study. Journal of palliative medicine, 22(5), 508–516. https://doi.org/10.1089/jpm.2018.0338	2015–2017 France	Methods: Qualitative; semistructured in-person one-on-one interviews with 13 oncologists and 19 palliative care specialists (PCSs), audio-recorded and transcribed, then used the grounded theory coding method to analyze interviews (inductive iterative process)	Yes (1)	Stigmatization of palliative care defined as "professionals used to have—or still have—very negative representations. In other words, they picture palliative care like waiting in the death row." Misconceptions of and confusion on what PC actually means some oncologists viewed PC negatively	Fear to discuss PCS to patients to instill loss of hope or distress. Assumption: Avoidance of the word "palliative," all oncologists said they were more likely refer patients to palliative care if renamed "supportive care." Discomfort: Early palliative care (EPC) along with cancer treatment is a poorly understood concept even among oncologists. Physicians often do not refer to palliative care until "no other treatment option" reinforcing stigma that it is only for end-of-life care. "…it's difficult to talk about palliative care and palliative medicine also reflects the inclination to shy away from death." Avoidance: PC stigma highlights society's denial of death. "In the society we live in, death, illness, and old age tend to be pushed aside."
(29) Sorensen, A., Wentlandt, K., Le, L. W., Swami, N., Hannon, B., Rodin, G., Krzyzanowska, M. K., & Zimmermann, C. (2020). Practices and opinions of specialized palliative care physicians regarding early palliative care in Oncology. Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer, 28(2), 877–885. https://doi.org/10.1007/s00520-019-04876-0	2018 Canada	Method: Survey on distributed to physicians who provide PC in Canada to describe the practices and opinions of specialized palliative care (SPC) physicians regarding early palliative care for patients with cancer, determine characteristics associated with receiving early referrals, and solicit opinions regarding renaming the specialty supportive care. Results: The response rate was 71% (531/746), of whom 257 (48.4%) practiced SPC. Of these SPC physicians, 84% provided mainly cancer care; > 90% supported early palliative care referral in Oncology and had referral criteria facilitating this, but only 20% received early referrals (> 6-month prognosis).	Yes (1)	Stigma arises from the misconception among clinicians and patients alike that palliative care is relevant only at the very end of life	A majority of SPC physicians agreed that patients have a negative perception of the term palliative care (60%). More than one-third agreed that a change in name from palliative care to supportive care would increase comfort with early referral among referring physicians (39%) and patients (35%).

Table A1: Continued.

Citation	Year of study and country	Methods and relevant results	Use word stigma? (how many times)	How stigma is defined in Oncology PC context	Characteristics of stigma
(30) Suwanabol, P. A., Reichstein, A. C., Suzer-Gurtekin, Z. T., Forman, J., Silveira, M. J., Mody, L., & Morris, A. M. (2018). Surgeons' Perceived Barriers to Palliative and End-of-Life Care: A Mixed Methods Study of a Surgical Society. Journal of palliative medicine, 21(6), 780–788. https://doi.org/10.1089/jpm.2017.0470	USA	Mixed-method survey tool used to evaluate and identify surgeon-perceived barriers to palliative and end-of-life care for patients with Stage IV colorectal cancers. Thematic analysis done on open-ended questions. $n = 131$ surgeons. Results: Five emergent themes were integrated with closed-ended (quantitative) survey item responses and summarized	No	N/A	Discomfort: The absence of knowledge regarding opportunities for and delivery of palliative or end-of-life care, along with minimal to no training was cited as a critical barrier. Discomfort with diverse cultural norms and customs with respect to dying, death, and grief. Fear of making wrong decision: One surgeon reported, "I had a patient in the ICU with florid sepsis and multisystem organ failure. The entire care team began to wonder how long we should continue to press on with a patient who clearly could not survive. Days later he is awake and alert, off pressors, on trach collar, and fully communicative. . .sometimes even experienced clinicians cannot predict when a patient will die or recover." Fear of legal liability for forgoing life-sustaining treatments. Fear of prescribing opioids and sedatives because of concern about side effects. Undesired differentness: Disagreements between patients/families and care teams about care goals were reported by 43.5% of surgeons, noted multiple occasions when disagreements negatively impacted end-of-life care including ". . .the patient's advanced disease meant he had weeks to months at the most. I attempted to convince him to do hospice. He wanted testing and options for cure. Unfortunately, by the time he was discharged he was much weaker and no longer able to do any activities he might have been able to do had he decided quickly to accept the inevitable."
(31) Wei, R. L., Mattes, M. D., Yu, J., Thrasher, A., Shu, H. K., Paganetti, H., De Los Santos, J., Koontz, B., Abraham, C., & Balboni, T. (2017). Attitudes of radiation oncologists toward palliative and supportive care in the United States: Report on national membership survey by the American Society for Radiation Oncology (ASTRO). Practical radiation Oncology, 7(2), 113–119. https://doi.org/10.1016/j.prro.2016.08.017	2015–2016 USA	Method: Electronically surveyed 4093 practicing radiation oncologists in the United States. The survey consisted of 16 questions in five sections: 1—demographics, 2—PSC training, 3—domains of PSC, 4—perceived barriers as a radiation oncologist to initiate advanced care planning, and 5—discussion of prognosis. $N = 649$ (response rate, 16%).	No	N/A	Fear of upsetting referring medical oncologist when wanting to initiate GOC discussions. Discomfort in ability to manage depression, anxiety, anorexia, and fatigue
(32) Yang, G. M., Yoon, S., Tan, Y. Y., & Liaw, K. (2018). Experience and Views of Oncology and Palliative Care Professionals on a Corounding Model of Care for Inpatients With Advanced Cancer. The American journal of hospice & palliative care, 35(11), 1433–1438. https://doi.org/10.1177/1049909118778863	2016 Singapore	A qualitative study nested within a pre–post study of the corounding model of care, with semistructured interviews of 11 doctors and nurses using thematic analysis to explore the views and experience of Oncology and palliative care professionals on the corounding model compared to an inpatient palliative consult service.	No	N/A	Fear of overreliance on the palliative care services and want to take care of patient needs themselves. Fear of over taxing the system and referring too early and over burdening palliative medicine. "Then the patients who really need help won't get it in time."

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Disclosure

All authors read and approved the final manuscripts.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Study conception, design, material preparation, data collection, and analysis were performed by R. Alexander under mentorship of P. Meek. The first draft of the manuscript was written by R. Alexander, and all authors commented on previous versions of the manuscript.

Funding

No funding was received for this manuscript.

References

[1] K. Jordan, M. Aapro, S. Kaasa, et al., "European Society for Medical Oncology (ESMO) Position Paper on Supportive and Palliative Care," *Annals of Oncology* 29, no. 1 (2018): 36–43, https://doi.org/10.1093/annonc/mdx757.

[2] L. Radbruch, L. De Lima, F. Knaul, et al., "Redefining Palliative Care-A New Consensus-Based Definition," *Journal of Pain and Symptom Management* 60, no. 4 (2020): 754–764, https://doi.org/10.1016/j.jpainsymman.2020.04.027.

[3] M. W. Haun, S. Estel, G. Rücker, et al., "Early Palliative Care for Adults With Advanced Cancer," *Cochrane Database of Systematic Reviews* 6 (2017): CD011129, https://doi.org/10.1002/14651858.CD011129.pub2.

[4] P. Strang, "Palliative Oncology and Palliative Care," *Molecular Oncology* 6, no. 19 (2022): 3399–3409, https://doi.org/10.1002/1878-0261.13278.

[5] S. Ryan, J. Wong, R. Chow, and C. Zimmermann, "Evolving Definitions of Palliative Care: Upstream Migration or Confusion?" *Current Treatment Options in Oncology* 21, no. 3 (2020): 20, https://doi.org/10.1007/s11864-020-0716-4.

[6] C. Zimmermann, N. Swami, M. Krzyzanowska, et al., "Early Palliative Care for Patients With Advanced Cancer: A Cluster-Randomised Controlled Trial," *Lancet (London, England)* 383, no. 9930 (2014): 1721–1730, https://doi.org/10.1016/S0140-6736(13)62416-2.

[7] M. Hoerger, G. R. Wayser, G. Schwing, A. Suzuki, and L. M. Perry, "Impact of Interdisciplinary Outpatient Specialty Palliative Care on Survival and Quality of Life in Adults With Advanced Cancer: A Meta-Analysis of Randomized Controlled Trials," *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine* 53, no. 7 (2019): 674–685, https://doi.org/10.1093/abm/kay077.

[8] B. R. Ferrell, J. S. Temel, S. Temin, et al., "Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update," *Journal of Clinical Oncology* 35, no. 1 (2017): 96–112, https://doi.org/10.1200/JCO.2016.70.1474.

[9] D. Hausner, C. Tricou, J. Mathews, et al., "Timing of Palliative Care Referral Before and After Evidence From Trials Supporting Early Palliative Care," *The Oncologist* 26, no. 4 (2021): 332–340, https://doi.org/10.1002/onco.13625.

[10] D. Fortuna, L. Caselli, F. Banchelli, M. L. Moro, and M. Costantini, "How Many Cancer Patients Need Palliative Care? A Population-Based Study," *Journal of Pain and Symptom Management* 63, no. 4 (2022): 468–475, https://doi.org/10.1016/j.jpainsymman.2021.12.030.

[11] M. Bennardi, N. Diviani, C. Gamondi, et al., "Palliative Care Utilization in Oncology and Hemato-Oncology: A Systematic Review of Cognitive Barriers and Facilitators From the Perspective of Healthcare Professionals, Adult Patients, and Their Families," *BMC Palliative Care* 19, no. 1 (2020): 47, https://doi.org/10.1186/s12904-020-00556-7.

[12] N. Dhollander, A. De Vleminck, L. Deliens, S. Van Belle, and K. Pardon, "Barriers to the Early Integration of Palliative Home Care Into the Disease Trajectory of Advanced Cancer Patients: A Focus Group Study With Palliative Home Care Teams," *European Journal of Cancer Care* 28, no. 4 (2019): e13024, https://doi.org/10.1111/ecc.13024.

[13] M. Horlait, K. Chambaere, K. Pardon, L. Deliens, and S. Van Belle, "What Are the Barriers Faced by Medical Oncologists in Initiating Discussion of Palliative Care? A Qualitative Study in Flanders, Belgium," *Supportive Care in Cancer* 24, no. 9 (2016): 3873–3881, https://doi.org/10.1007/s00520-016-3211-5.

[14] D. Hui, M. Park, D. Liu, A. Reddy, S. Dalal, and E. Bruera, "Attitudes and Beliefs Toward Supportive and Palliative Care Referral Among Hematologic and Solid Tumor Oncology Specialists," *The Oncologist* 20, no. 11 (2015): 1326–1332, https://doi.org/10.1634/theoncologist.2015-0240.

[15] C. P. Lin, C. J. Evans, J. Koffman, S. J. Sheu, S. H. Hsu, and R. Harding, "What Influences Patients' Decisions Regarding Palliative Care in Advance Care Planning Discussions? Perspectives From a Qualitative Study Conducted With Advanced Cancer Patients, Families and Healthcare Professionals," *Palliative Medicine* 33, no. 10 (2019): 1299–1309, https://doi.org/10.1177/0269216319866641.

[16] A. Ndiok and B. Ncama, "Barriers and Benefits of Model Development for Integration of Palliative Care for Cancer Patients in a Developing Country: A Qualitative Study," *International Journal of Nursing Practice* 27, no. 3 (2021): e12884, https://doi.org/10.1111/ijn.12884.

[17] T. A. Pfeil, K. Laryionava, S. Reiter-Theil, W. Hiddemann, and E. C. Winkler, "What Keeps Oncologists From Addressing Palliative Care Early on With Incurable Cancer Patients? an Active Stance Seems Key," *The Oncologist* 20, no. 1 (2015): 56–61, https://doi.org/10.1634/theoncologist.2014-0031.

[18] A. Sarradon-Eck, S. Besle, J. Troian, G. Capodano, and J. Mancini, "Understanding the Barriers to Introducing Early Palliative Care for Patients With Advanced Cancer: A Qualitative Study," *Journal of Palliative Medicine* 22, no. 5 (2019): 508–516, https://doi.org/10.1089/jpm.2018.0338.

[19] T. Formagini, C. Poague, A. O'Neal, and J. V. Brooks, "'When I Heard the Word Palliative': Obscuring and Clarifying Factors Affecting the Stigma Around Palliative Care Referral in Oncology," *JCO Oncology Practice* 18, no. 1 (2022): e72–E79, https://doi.org/10.1200/OP.21.00088.

[20] J. Alcalde and C. Zimmermann, "Stigma About Palliative Care: Origins and Solutions," *Ecancermedicalscience* 16 (2022): 1377, https://doi.org/10.3332/ecancer.2022.1377.

[21] J. Parajuli and J. E. Hupcey, "A Systematic Review on Barriers to Palliative Care in Oncology," *American Journal of Hospice*

and Palliative Medicine 38, no. 11 (2021): 1361–1377, https://doi.org/10.1177/1049909120983283.

[22] N. Salins, A. Ghoshal, S. Hughes, and N. Preston, "How Views of Oncologists and Haematologists Impact Palliative Care Referral: A Systematic Review," *BMC Palliative Care* 19, no. 1 (2020): 175, https://doi.org/10.1186/s12904-020-00671-5.

[23] A. L. Grant Back and N. S. Dettmar, "Public Perceptions of Advance Care Planning, Palliative Care, and Hospice: A Scoping Review," *Journal of Palliative Medicine* 24, no. 1 (2021): 46–52, https://doi.org/10.1089/jpm.2020.0111.

[24] National Hospice and Palliative Care Organization (Nhpco), "NhpcO Facts and Figures 2022 Edition," (2022), https://www.nhpco.org/wp-content/uploads/nhpco-facts-figures-2022.pdf.

[25] A. Kamalyan, Y. Margaryan, J. Arakelyan, L. Safaryan, G. Tamamyan, and S. Arakelyan, "Cancer and Armed Conflict: Crossing Realities," *Journal of Clinical Oncology* 40, no. 27 (2022): 3222–3224, https://doiorg.ezproxy.lib.utah.edu/10.1200/jco.22.00663, https://doi.org/10.1200/jco.22.00663.

[26] M. H. Bodd, N. C. Daniels, H. L. Amonoo, T. Tate, K. W. Herring, and T. W. Leblanc, "'More Than Conquerors': A Qualitative Analysis of War Metaphors for Patients With Cancer," *Supportive Care in Cancer* 31, no. 1 (2023): 1–11, https://doi.org/10.1007/s00520-022-07552-Y.

[27] Y. J. Surh, "The 50-Year War on Cancer Revisited: Should We Continue to Fight the Enemy Within?" *Journal of Cancer Prevention* 26, no. 4 (2021): 219–223, https://doi.org/10.15430/JCP.2021.26.4.219.

[28] D. J. Hauser and N. Schwarz, "The War on Prevention II: Battle Metaphors Undermine Cancer Treatment and Prevention and Do Not Increase Vigilance," *Health Communication* 35, no. 13 (2020): 1698–1704, https://doi.org/10.1080/10410236.2019.1663465.

[29] N. Alam, "50 Years Later: Impact of 1971s National Cancer Act Marked," (2021), https://nihrecord.nih.gov/2021/12/10/impact1971s-national-cancer-act-marked.

[30] E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Prentice-Hall, 1963).

[31] American Cancer Society, "Understanding Advanced and Metastatic Cancer," (2023), https://www.cancer.org/cancer/managing-cancer/advanced-cancer/whatis.html%23;:%223c;:text%3d;advanced%20cancer%20is%20most%20often,ongoing%20(or%20chronic)%20illness.

[32] A. E. R. Bos, J. B. Pryor, G. D. Reeder, and S. E. Stutterheim, "Stigma: Advances in Theory and Research," *Basic and Applied Social Psychology* 35, no. 1 (2013): 1–9, https://doi.org/10.1080/01973533.2012.746147.

[33] M. J. Page, J. E. Mckenzie, P. M. Bossuyt, et al., "The PrisMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews," *BMJ* 372 (2021): n71, https://doi.org/10.1136/bmj.n71.

[34] J. L. Ethier, T. Paramsothy, J. J. You, R. Fowler, and S. Gandhi, "Perceived Barriers to Goals of Care Discussions With Patients With Advanced Cancer and Their Families in the Ambulatory Setting: A Multicenter Survey of Oncologists," *Journal of Palliative Care* 33, no. 3 (2018): 125–142, https://doi.org/10.1177/0825859718762287.

[35] M. E. Ellen, S. Perlman, and R. Shach, "Too Much Cancer Care?: Nurses' Perspectives on the Unnecessary Use of Oncology Services," *Cancer Nursing* 44, no. 4 (2021): E236–E243, https://doi.org/10.1097/NCC.0000000000000814.

[36] R. Harding, S. Nair, and M. Ekstrand, "Multilevel Model of Stigma and Barriers to Cancer Palliative Care in India: A Qualitative Study," *BMJ Open* 9, no. 3 (2019): e024248, https://doi.org/10.1136/bmjopen-2018-024248.

[37] M. Miyashita, S. Kawakami, D. Kato, et al., "The Importance of Good Death Components Among Cancer Patients, the General Population, Oncologists, and Oncology Nurses in Japan: Patients Prefer 'Fighting Against Cancer'," *Supportive Care in Cancer* 23, no. 1 (2015): 103–110, https://doi.org/10.1007/s00520-014-2323-Z.

[38] J. A. Calvache, S. Moreno, G. Prue, et al., "Knowledge of end-Of-Life Wishes by Physicians and Family Caregivers in Cancer Patients," *BMC Palliative Care* 20, no. 1 (2021): 140, https://doi.org/10.1186/s12904-021-00823-1.

[39] C. Nierop-Van Baalen, M. Grypdonck, A. van Hecke, and S. Verhaeghe, "Health Professionals' Dealing With Hope in Palliative Patients With Cancer, an Explorative Qualitative Research," *European Journal of Cancer Care* 28, no. 1 (2019): e12889, https://doi.org/10.1111/ecc.12889.

[40] C. M. Hay, C. Lefkowits, M. Crowley-Matoka, et al., "Gynecologic Oncologist Views Influencing Referral to Outpatient Specialty Palliative Care," *International Journal of Gynecological Cancer* 27, no. 3 (2017): 588–596, https://doi.org/10.1097/IGC.0000000000000893.

[41] S. Hmaidan, A. Goulder, L. Bos, et al., "Too Close for Comfort? Attitudes of Gynecologic Oncologists Toward Caring for Dying Patients," *American Journal of Hospice and Palliative Medicine* 40, no. 11 (2023): 1168–1173, https://doi.org/10.1177/10499091221145165.

[42] D. Hui, S. Bansal, M. Park, et al., "Differences in Attitudes and Beliefs Toward end-Of-Life Care Between Hematologic and Solid Tumor Oncology Specialists," *Annals of Oncology* 26, no. 7 (2015): 1440–1446, https://doi.org/10.1093/annonc/mdv028.

[43] H. Llewellyn, J. Neerkin, L. Thorne, et al., "Social and Structural Conditions for the Avoidance of Advance Care Planning in Neuro-Oncology: A Qualitative Study," *BMJ Open* 8, no. 1 (2018): e019057, https://doi.org/10.1136/bmjopen-2017-019057.

[44] R. Gidwani, A. Nevedal, M. Patel, et al., "The Appropriate Provision of Primary Versus Specialist Palliative Care to Cancer Patients: Oncologists' Perspectives," *Journal of Palliative Medicine* 20, no. 4 (2017): 395–403, https://doi.org/10.1089/jpm.2016.0399.

[45] M. A. Earp, A. Sinnarajah, M. Kerba, et al., "Opportunity Is the Greatest Barrier to Providing Palliative Care to Advanced Colorectal Cancer Patients: A Survey of Oncology Clinicians," *Current Oncology* 25, no. 5 (2018): e480–e485, https://doi.org/10.3747/co.25.4021.

[46] T. J. Kruser, J. M. Kruser, J. P. Gross, et al., "Medical Oncologist Perspectives on Palliative Care Reveal Physician-Centered Barriers to Early Integration," *Annals of Palliative Medicine* 9, no. 5 (2020): 2800–2808, https://doi.org/10.21037/apm-20-270.

[47] A. Buckley de Meritens, B. Margolis, C. Blinderman, et al., "Practice Patterns, Attitudes, and Barriers to Palliative Care Consultation by Gynecologic Oncologists," *Journal of Oncology Practice* 13, no. 9 (2017): e703–e711, https://doi.org/10.1200/JOP.2017.021048.

[48] P. A. Suwanabol, A. C. Reichstein, Z. T. Suzer-Gurtekin, et al., "Surgeons' Perceived Barriers to Palliative and end-Of-Life Care: A Mixed Methods Study of a Surgical Society," *Journal of Palliative Medicine* 21, no. 6 (2018): 780–788, https://doi.org/10.1089/jpm.2017.0470.

[49] G. M. Yang, S. Yoon, Y. Y. Tan, and K. Liaw, "Experience and Views of Oncology and Palliative Care Professionals on a Corounding Model of Care for Inpatients With Advanced Cancer," *American Journal of Hospice and Palliative Medicine* 35, no. 11 (2018): 1433–1438, https://doi.org/10.1177/1049909118778863.

[50] R. L. Wei, M. D. Mattes, J. Yu, et al., "Attitudes of Radiation Oncologists Toward Palliative and Supportive Care in the United States: Report on National Membership Survey by the American Society for Radiation Oncology (ASTRO)," *Practical Radiation Oncology* 7, no. 2 (2017): 113–119, https://doi.org/10.1016/j.prro.2016.08.017.

[51] S. Mohammed, P. Savage, N. Kevork, N. Swami, G. Rodin, and C. Zimmermann, "'I'M Going to Push This Door Open. You Can Close It': A Qualitative Study of the Brokering Work of Oncology Clinic Nurses in Introducing Early Palliative Care," *Palliative Medicine* 34, no. 2 (2020): 209–218, https://doi.org/10.1177/0269216319883980.

[52] A. Sorensen, K. Wentlandt, L. W. Le, et al., "Practices and Opinions of Specialized Palliative Care Physicians Regarding Early Palliative Care in Oncology," *Supportive Care in Cancer* 28, no. 2 (2020): 877–885, https://doi.org/10.1007/s00520-019-04876-0.

[53] H. Kalies, R. Schöttmer, S. T. Simon, R. Voltz, A. Crispin, and C. Bausewein, "Barriers for the Implementation of Guidelines in Palliative Care-Results From a National Survey of Professionals," *Supportive Care in Cancer* 26, no. 6 (2018): 1943–1952, https://doi.org/10.1007/s00520-017-4030-Z.

[54] C. B. Smith, T. Phillips, and T. J. Smith, "Using the New Asco Clinical Practice Guideline for Palliative Care Concurrent With Oncology Care Using the Team Approach," *American Society of Clinical Oncology Educational Book* 37 (2017): 714–723, https://doi.org/10.1200/EDBK_175474.