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Oncologist's Representations of Anticancer Treatments for Patients With Advanced-Stage Cancer: New Perspectives From the COVID-19 Crisis

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ABSTRACT

Introduction: In the context of the COVID-19 pandemic, scientific societies of oncology issued guidelines to limit the spread of the virus, in particular by limiting the prescription of cancer treatments with palliative intent. This qualitative study adopts a psychosocial perspective to explore how oncologists experienced these guidelines, and what this reveals about their representations and practices concerning end-of-life treatments.

Methods: Conducted in a comprehensive cancer center, the study is based on a mixed-method strategy involving 10 semi-structured interviews with oncologists and observation of 13 consultations.

Results: The oncologists stated that they were complying with the guidelines, which was perceived as an external argument of authority that made it easier to announce the cessation of treatment. The analysis highlights the sacralization of chemotherapy, a shared feeling of guilt at the idea of stopping cancer treatments, and a representation of palliative care as the moment when there is "nothing more to be done."

Discussion: The fact that the oncologists reported that previous practices had been reinstated once the health crisis had passed reveals the psychosocial logics at work in their decision-making and communication practices. This study recommends the creation of workshops to raise awareness of the psychosocial factors that influence chemotherapy prescriptions in the advanced stages of the disease.

1 | Introduction

The question of whether to continue or stop cancer treatments has been a subject of debate within the oncology community since the early 1950s [1]. Over the past 20 years, several French [2] and international [3] studies have highlighted the persistence—and even increase—of such prescriptions. Yet, despite therapeutic advances, the benefits of cancer treatments at an advanced stage of the disease remain modest, both in terms of survival and quality of life [4].

Research on the factors associated with these prescriptions in advanced stages showed that decisions are not based solely on biomedical logics but may also include other types of reasoning,

particularly psychosocial ones [5]. Among the identified determinants, some are microcontextual factors, such as the physician's perception of the patient's age [2, 6], the degree to which the patient is perceived as pleasant [5], or communication barriers around end-of-life discussions, such as lack of training or experience [7]. They may also stem from macrocontextual factors, such as the type of healthcare institution: for example, the study by Rochigneux et al. [6] showed that chemotherapy is more frequently prescribed at the end of life in comprehensive cancer centers (CCC) and private clinics than in university hospitals (HU) and general hospitals (GH).

The COVID-19 health crisis may serve as an example of a macrocontextual influence. Indeed, this period led to the institutional implementation of limitations on the use of cancer treatments, as cancer patients were identified as being at a higher risk of developing severe forms of COVID-19 infection [8]. In order to reduce hospital visits and infection risks while maintaining cancer control [9], several scientific societies of oncology, in line with the guidelines of the regional health agencies (ARS) and the French High Council for Public Health (HCSP), issued recommendations aimed at identifying clinical situations that could justify adapting or prioritizing treatments. These adjustments considered various criteria, such as the objective of chemotherapy (curative vs. noncurative intent), patient age, estimated life expectancy, and the date of diagnosis [10]. For patients whose cancer care followed a strategy with palliative intent, several scientific societies recommended minimizing the risk of COVID-19 infection by reducing contact with healthcare facilities, avoiding surgical interventions, and also limiting the administration of chemotherapy [11]. More specifically, for metastatic cancers, it was advised to delay treatment initiation [12] or to space out injections, opting for intervals of 3–4 weeks rather than weekly sessions [13].

These recommendations were then locally adapted by hospitals, including the CCC of the Institut Paoli-Calmettes (IPC) in Marseille, where our study was conducted. It should be noted that these adaptations were only intended for situations involving resource constraints. One key element that emerges from both national and local recommendations is the distinction between chemotherapy with curative intent and chemotherapy with palliative intent.

The European Society for Medical Oncology (ESMO) distinguishes between chemotherapy with curative intent, aimed at cure or a substantial increase in life expectancy, and chemotherapy with palliative intent, administered when cure is no longer possible and focusing instead on symptom relief and quality of life. In line with this definition, the present study adopts this terminology to describe treatment intent. However, in both clinical practice and the literature, ambiguity in the understanding and use of these terms persists, reflecting the conceptual and communicative challenges that surround treatment intent in advanced cancer care [14–16]. Patients do not always receive clear information about the effects of treatments or about palliative care alternatives [17].

In this regard, the COVID-19 context brought renewed visibility to the prescription of cancer treatments at advanced stages by formalizing prescription criteria. This moment of disruption thus provides a privileged analytical lens for a better understanding of the underlying issues of oncologists' practices and experiences related to prescribing cancer treatments at an advanced stage outside of this context. Indeed, little is known about how oncologists' representations of end-of-life chemotherapy evolved in the wake of COVID-19 recommendations, or how these representations influence communication with patients. How did oncologists experience the health crisis and the associated recommendations? To what extent can the links between this experience and their practices shed light on the sensitive nature of their decision-making and communication processes?

To address these questions, a psychosocial perspective invites us to situate prescribing and communicative practices within the relational and symbolic frameworks (i.e., interpersonal and intergroup relationships between the physician and the patient) in which they are embedded, as well as within a broader sociocultural context shaped by ideologies, norms, and values related to illness and end-of-life. More specifically, the theory of social representations [18], taken in its paradigmatic perspective, provides a relevant analytical framework to problematize this topic and guide the analysis. It focuses on lived experience by examining how individuals and groups socially produce, share, and appropriate constructed knowledge in order to make sense of it [19]. Its comprehensive and phenomenological foundations [19] imply considering what oncologists would do rather than what oncologists should do and attempting to understand why they would do it this way. In addition, this theory is relevant to enlighten clinician–patient communication and practices since it pays attention to how this shared knowledge guides people's actions and communications.

This study examines oncologists' experiences with recommendations that limited the use of last-line cancer treatments during the COVID-19 crisis, exploring what these experiences reveal about their representations of such treatments and how they may have shaped current practices and the negotiation of treatment decisions within therapeutic relationships. It was conducted in a French CCC using a qualitative, single-center design that combined semistructured interviews with medical oncologists and observations of oncology consultations, in order to capture both discourse and practice.

1.1 | Objectives

This study has three objectives within this context: (i) first, it aims to explore oncologists' experiences with the recommendations issued by scientific societies concerning cancer treatments at advanced stages of the disease during the COVID-19 pandemic; (ii) second, it seeks to analyze what these experiences reveal about oncologists' representations regarding the prescription of such treatments; and (iii) finally, the study investigates how decisions about prescribing advanced-stage cancer treatments are communicated and negotiated between the actors involved in the therapeutic relationship.

2 | Methods

The Coreq checklist (Supporting Information) for interviews was used to draft this section. As part of a single-center study conducted in a CCC (IPC, UNICANCER Marseille), a qualitative investigation was carried out, combining semistructured interviews with oncologists and observations of oncology consultations. This multimethod approach aimed to collect different

types of data—specifically, to identify discourses about practices and to describe the practices themselves through the observation of communication between healthcare professionals and patients in relevant situations. Data collection was conducted between March and June 2024, while data analysis was performed as the collection progresses until December 2024. Participants were informed that their contribution to the research would remain confidential. They were advised about the researcher's professional background and the objectives of the study. Data relating to the oncologists were anonymized, and no identifying patient information was collected. Verbal nonopposition was obtained, and participants were informed of their right to withdraw from the study at any time.

2.1 | Interviews [= 10]

Fifteen oncologists from the CCC were contacted via the head of the medical oncology department and invited by email to participate in the study by two second-year master's students in health social psychology, completing their final internship. The email proposed participation in research on the representations and prescribing practices of chemotherapy during advanced stages of disease. Ten oncologists responded, but one withdrew during the interview, surprised by the mention of COVID-19, which had not been announced beforehand[1]. Three oncologists from the IPC were subsequently contacted through a palliative care physician, but only one agreed to participate. Finally, one oncologist, informed by a colleague, spontaneously expressed interest in taking part.

In total, 10 interviews [I], lasting between 16 and 52 min (average duration: 40 min), were conducted by the students. Among the participants, six were men and four were women, aged between 30 and 55 years ($M = 41$, SD = 7.9). These oncologists specialized in the management of solid tumors[2], including breast cancer [$n = 3$], gynecological cancers [$n = 2$], urological cancers [$n = 2$], and gastrointestinal cancers [$n = 3$]. Five of them reported having received training in palliative care. A semistructured interview guide was developed, with the initial instruction: "What can you tell us about the prescription of cancer treatments in advanced stages of disease during the COVID-19 period?" In keeping with the comprehensive approach to social representations, this question was phrased broadly to allow respondents to give spontaneous answers without the interviewers imposing preconceived categories on them. The guide was then structured around the perceived impact of the health crisis on current practices and the negotiation of therapeutic decisions with patients.

The 10 interviews were recorded, transcribed, and analyzed with a thematic content analysis [20] using an inductive approach nevertheless orientated by a psychosocial perspective since data analysis does not take place in an epistemological vacuum. Indeed, particular attention was paid to psychosocial aspects reflected in the discourse, such as norms or social categorizations. After an initial open reading of each interview, a vertical analysis was carried out by the two students, allowing them to identify themes such as "memories of the content of the recommendations," "the psychological function of treatment," "disagreements between oncologist and patient about stopping treatment," and "the difficult balance between offering too much hope and taking it away." Data collection ceased after reaching thematic saturation. A triangulated researchers' approach [21], involving the two masters' students, a palliative care clinician, a PhD in medical anthropology, and an associate professor in social psychology of health (three women and two men) experienced in qualitative methods, was implemented. These sessions were informed by both the theoretical knowledge of the various coders in the humanities and social sciences and their clinical experiences. For example, the master's students' experience with patients and oncologists during their internships led them to address issues related to life and death that are socially avoided or considered taboo and therefore taken into account in the analysis of data concerning normative and shared knowledge on these aspects. This led to the development of a shared analytical framework, revised and validated by the entire multidisciplinary research team.

2.2 | Consultations [= 13]

Following the semistructured interviews, the two students asked the participating oncologists whether they could observe some of their consultations. The process of defining the inclusion criteria for these observations involved numerous back-and-forth discussions within the multidisciplinary research team, as detailed below in the methodological box.

Methodological Box—Tensions Surrounding the Definition of Inclusion Criteria of "Advanced Stage"

Defining the inclusion criteria for consultations in which the question of prescribing cancer treatments at an advanced stage was challenging at several stages of the research protocol development.

1. During the definition of the criteria:

Three physicians—one in palliative care and two oncologists—were involved in defining the criteria, and divergences emerged early on. Some criteria were proposed, such as a response rate below 15% or a median survival of less than three months. Another criterion was introduced—evidence of efficacy in terms of survival and quality of life—which was seen as more applicable in a context of uncertainty.

2. During the presentation of the inclusion criteria to oncologists and during the observations themselves:

At the end of the semi-structured interviews, the master's students clarified the inclusion criteria verbally, specifying that they were looking for consultations where the question of continuing or stopping cancer treatment was being considered.

Oncologists raised questions at the time of this clarification and sometimes again during the observation process. They pointed out the difficulty of identifying consultations that matched the criteria, judging them to be insufficiently precise or based on nonquantifiable criteria. For instance, the issue of how to define or prove uncertainty has been raised frequently.

3. During the selection of observations:

Lastly, the multidisciplinary research team experienced hesitation when selecting which consultations to retain for analysis particularly when a treatment interruption was decided.

When the interruption was temporary and a resumption of chemotherapy was being considered, the therapeutic uncertainty justified including the consultations. When there was no possibility of resuming chemotherapy, for example, given the patient's overall condition, the definitive nature of the decision led the research team to exclude the consultations.

The entire process—from defining the criteria to selecting the consultations—highlighted the difficulty of establishing a clear and unambiguous definition of what constitutes an "advanced stage." In our view, these tensions do not reflect a methodological bias, but bring to the light the complexity inherent to the research subject itself. Indeed, the blurred boundaries of this concept—both for clinicians and researchers[3]—are a research finding in themselves.

Fifty-five consultations [C] were observed by the two students. After the exploratory observation of two initial consultations, a systematic observation grid was developed, structured around the key stages of the consultation and the associated content of exchanges: reception (Stage 1), assessment of the situation and the patient's health conditions (Stage 2), announcement of results (Stage 3), and presentation of therapeutic options followed by decision-making (Stage 4). Note-taking was free-form during the observation, and the students completed the grid afterward.

Once all consultations had been observed, the research team met to select those that met the inclusion criteria. Here, the data collection was partly constrained by the time frame of the two students' internships. This led us to adopt a more "pilot approach" to this empirical operation. Among them, 13 consultations involving 10 interviewed oncologists and 12 patients with advanced-stage cancer were retained.

These thirteen consultations lasted between 15 and 55 min (average: 35 min) and involved seven women and five men, aged between 57 and 83 years ($M = 69.6$ years, SD = 9.5). The patients were diagnosed with pancreatic cancer [$n = 4$], biliary tract cancer [$n = 1$], breast cancer [$n = 3$], ovarian cancer [$n = 2$], cervical cancer [$n = 2$], and liver cancer [$n = 1$]. Two of these consultations concerned the same patient, seen by the physician 1 month apart, with a deterioration in her health condition between the two visits.

Data analysis was carried out using a triangulation approach involving the entire research team. In terms of content, the analysis focused on how treatments were discussed, their impact on quality of life and survival, the modalities of decision-making (whether the patient's opinion was solicited, whether the decision was made by the physician), the time allowed for reflection before making a decision, and whether or not the opinions of oncology and palliative care teams were considered.

From a formal standpoint, special attention was paid to the terminology used when discussing death, examining whether oncologists favored direct or euphemized language (whether or not they took the initiative to bring it up, and the vocabulary used when they did), as well as whether their interventions were phrased as questions or statements. Inspired by the VERONA observation grid [20], the analysis also explored the explicit or implicit expression of patient emotions and the caregivers' responses, assessing whether they encouraged or inhibited the discussion.

3 | Results

In the Results section, findings from the interview corpus and the consultation observations are presented together to examine how oncologists' responses to the guidelines issued during the health crisis reveal decision-making and communication issues related to prescribing cancer treatments at an advanced stage. More precisely, the first line of analysis is based primarily on the results from the interview data, whose themes and subthemes are synthesized in Table 1. Indeed, it deals with oncologists' experiences with recommendations regarding the prescription of chemotherapy at an advanced stage during COVID-19. The second axis, on the contrary, was developed on the basis of the results cross-referenced between interviews and observations, based on their relevance to answering the questions addressed by the study and their originality in relation to the literature.

3.1 | Adherence to Prioritization Guidelines for Advanced-Stage Cancer Treatments During the Health Crisis

3.1.1 | Recommendations Readily Accepted Because of the Context

Analysis of the interviews shows that most oncologists [$n = 9/10$] embraced the rationale behind the guidelines, linking their acceptance to the exceptional circumstances of the pandemic. They explain that the objectives were, first, to avoid transmitting the virus to immunocompromised patients undergoing chemotherapy and, second, to establish priorities—when medical resources might be limited—between chemotherapies with curative or palliative intent. As one oncologist put it: "*Clearly, we have to prioritize patients for whom we are sure chemo will be useful over patients for whom it would be, in quotation marks, comfort chemotherapy*" [I1].

Some respondents added that postponing chemotherapy in advanced stages would not affect patients' survival time: "*Once the treatment is not going to make the patient live any longer, well, maybe it's not a big deal to tweak it a bit or push it back by a month or two*" [I2].

Several oncologists also stressed that the pandemic period actually simplified decision-making by providing precise recommendations that lessened the burden of choosing whether to use chemotherapy. They felt more able to tell patients with advanced-stage cancer that it was wiser to avoid chemotherapy, which would reduce immunity and thus increase the risk of contracting the virus: "*I think it was easier to announce than it is now*" [I3]. In this way, the COVID-19 health crisis could be perceived as an external argument of authority that relieved clinicians of part of the decision-making load. One oncologist summed up this dynamic when describing how some colleagues had invoked the guidelines, while distancing themselves from the decision: "*The way I felt about their feedback, it was almost like: wow, I'll be able to tell people we're stopping chemo, but it's not because of me, it's because of Covid. I wanted to tell them we're stopping chemo, but now it's fine, it's Covid. I pull out my card—my Covid joker—saying, no, we can't keep giving you chemo, because Covid*" [I3].

3.1.2 | Recommendations Enabling a Reflective View on Clinical Practice

According to the interviewed oncologists, the recommendations implemented during the pandemic encouraged critical reflection on their prescribing practices. They felt that this moment of disruption forced them out of routine and led them to reconsider

TABLE 1 | Themes and key subthemes reflecting oncologists' representations of anticancer treatments for patients with advanced-stage cancer in the context of the COVID-19 crisis.

Themes	Subthemes	
(I) Representations of recommendations during COVID-19	1- Perceived objectives of the recommendations 2- Lived experience of the recommendations 3- The perceived impact of recommendations on treatment prescriptions in the post-COVID-19 context	• Limit COVID-19 • Prioritize treatment with curative intent • Increase hospital capacity • Understanding the logic behind recommendations given the context • Recommendations allowing to avoid responsibility for decision-making by invoking COVID-19 crisis • Recommendations that encourage reflection on professional practices • Recommendations that could have helped to avoid "excessive chemotherapy" and should be generalized beyond the COVID-19 context • Back to pre-COVID-19 practices
(II) Challenges in daily practice when prescribing treatment for patients in advanced stages	1- Psychosocial issues 2- The levers of decision-making	• Sacralization of treatment • Feelings of guilt about stopping treatment • The complex relationship with the end of life/death • Include palliative care early on
(III) Communication practices regarding discontinuing treatment	1- Perception of good communication practices 2- Implementation of communication strategies	• Finding a balance between giving too much hope and taking it away • Finding a balance between what to say and what not to say • Not tell all the truth • Postpone • Communicate step by step

the risk–benefit balance: "*Maybe those Covid-related guidelines actually helped us think more clearly, that prescriptions aren't automatic [...] it was thanks to the recommendations that we could say: wait a minute! Unfortunately, given the extraordinary, unusual context, we need to reflect on our practices*" [I1].

They also emphasized that the pandemic-related recommendations provided a clear justification for limiting or stopping certain treatments, whereas previously, additional cycles of chemotherapy might have been prescribed while waiting for the patient's condition to deteriorate—making it easier to justify stopping treatment: "*Before, maybe we'd have said, OK, I still have one chemo left I could try, even if I know it won't work, I'll give it—and then, in 3 months, when the patient's worse, it'll be easier to announce*" [I3].

3.1.3 | A Return to Previous Practices, Between Normalization and Regret

The oncologists noted that the practices established during the pandemic—especially the reduction in advanced-stage treatment prescriptions—have not been sustained. As one of them put it: "*We've resumed treatments, even for patients at more advanced stages of the disease*" [I2]. One oncologist described what he perceived as a "*step backward*," attributing it to the return of old habits and the choice of "*the easier way*." The use of the conditional tense by some oncologists hints at normative concerns. One said, for example: "*In a way, Covid or no Covid, it should be the same [...] What's awful is when patients are on chemo and they die three days later, or even during chemo. In those cases—unless it was an unexpected complication—we didn't do our job properly*" [I1].

Several of them stated that the criteria used during the pandemic to prioritize treatments should be applied regardless of context, in order to avoid administering anticancer treatment with low benefit and high burden to patients nearing the end of life. Finally, one participant expressed regret and pointed to the resistance to changes in prescribing practices at the end of life. According to the oncologists interviewed, although the COVID-19 recommendations temporarily led to a reduction in prescription for advanced-stage cancer treatments, the end of the pandemic has brought back ethical challenges, particularly in terms of decision-making and communication with patients regarding the discontinuation of treatment.

3.2 | Decision-Making and Communication Challenges Related to Representations of Cancer Treatment Prescriptions at an Advanced Stage

3.2.1 | The Sacralization of Chemotherapy and Shared Guilt Associated With Its Discontinuation

Chemotherapy is described by some oncologists as the "*only known treatment to control cancer*" [C5], "*relieve symptoms*" [I4], or without which "*the disease course becomes a little more chaotic*" [I5].

In addition, some oncologists emphasize that for patients, chemotherapy sustains hope for a cure. One oncologist explains: "*patients expect to be cured [...] because people have hope*" [I7]. A patient attributes this belief in healing to the cancer center, using spiritual language to describe the institution: "*My gurus are the IPC—they saved my life*" [C4].

Chemotherapy thus appears to possess power that goes beyond its biomedical dimension, taking on a symbolic dimension as well. One might therefore speak of a form of sacralization. Oncologists, caught in a position of tension, describe the need to find a balance between preserving patients' hope and avoiding the creation of unrealistic expectations. Some therefore attempt to de-sacralize chemotherapy during consultations by using spiritual language themselves. They remind patients that it is not "*miraculous*" [C13], that the results of chemotherapy are not "*transcendent*" [C1], or even that "*we're not going to work miracles with this chemo*" [C1].

In this context, oncologists speak of a feeling of guilt experienced both by themselves and by patients when the decision is made not to pursue a new line of treatment. One of them confides: "*The lady [...] says she feels guilty for not wanting chemo. The doctor feels guilty for not giving it to her*" [I7]. Another oncologist shares the same feeling, saying: "*It's really hard, this phase of [...] not giving any treatment*" [I2].

This feeling of guilt also emerges during consultations. When a doctor notes that a patient's refractory symptoms persist, the patient responds: "*It's not my fault*," and the doctor reassures him: "*No, it's not your fault, it's because of this damn thing*" [C1]. Similarly, when a patient expresses difficulty in continuing chemotherapy, the physician anticipates her feeling of guilt: "*Don't beat yourself up about this—you're not to blame, it's not your fault if you don't feel up to doing chemo*" [C3]. While giving her a prescription for oral chemotherapy, the doctor encourages her to take the time to consider whether to continue treatment. Another patient, expressing a wish to stop chemotherapy, apologizes by saying: "*Maybe I'm being annoying*" [C6]. Her physician reminds her of the treatment's benefits for her quality of life. Together, they ultimately decide to continue.

3.2.2 | Representation of Palliative Care: "Doing Nothing"?

Oncologists frequently bring up the issue of palliative care during consultations [8/13], and at times they attempt to deconstruct its association with imminent death. One of them explains: "*Palliative doesn't mean you're dying, it means we need to palliate problems [ascites, pleural effusion, malnutrition] that are ruining your life*" [C1]. Another oncologist tells a patient: "*When we say the words palliative care, it may make you think of end-of-life, of a life-threatening situation [...] which is not the case here, based on what we're seeing*" [C5]. Nonetheless, this representation seems deeply ingrained in some patients. One patient who had initially agreed to meet with a team changed her mind: "*At first I said yes, but then I thought palliative care means it's over. If we rearrange my bed, if I get a cleaning lady, that's death. I tell myself as long as I can keep going, I'll keep going*" [C6].

Moreover, while some interviewed oncologists view palliative care as complementary to curative care, others appear to see it as something that follows curative efforts—a transition from a context in which they believe they can act on the disease to one where they believe there is "nothing left to do." Some oncologists project their patients' implicit expectations regarding the physician's role—that of prescribing treatments and offering solutions: "*It's chemo just to say we're doing something, because patients need to feel like we're doing something*" [I10]; "*Patients come to see us for answers to a problem, and they expect us to give them answers*" [I4].

However, palliative care does not always seem to be considered among those potential answers. As such, stopping cancer treatments tends to be perceived as equivalent to "doing nothing." An oncologist explains to his patient: "*There's also the option of doing nothing and letting the disease progress, without any treatment—or only palliative care*" [C3].

Some patients associate palliative care with filling a void, which appears to trigger anxiety. One patient asks his oncologist: "*What are we going to do during this period where we're doing nothing?* " and later insists again: "*So what's actually happening now, concretely? Nothing?* " The oncologist, hesitant, responds: " *Well, not really nothing, because that would mean, we have to—but I'm not sure I can say—I think you've understood the situation is complicated*. " [C9]

3.2.3 | The Delicate Balance Between Saying and Not Saying

Communicating about the end of treatment—associated with the topic of incurability and death—appears to be a significant challenge for oncologists. One describes a "*difficulty in verbalizing [...] in front of the patient the failure of treatment, the approaching death, the fact that we can no longer save them*" [I1]. Offering a new line of chemotherapy can thus serve to postpone discussions about end-of-life.

This situation highlights both ethical and prescriptive issues concerning the information to be shared with the patient. Recurrent expressions such as "*we must*" or "*we're obliged to*" reflect a tension between the norm of transparency in health information and the difficulty of adhering to it. One oncologist confides, for example: "*We shouldn't lie to them or be afraid to—but it's not always easy, you know, and I don't always manage it—to say: well, we're not going to cure you*" [I1]. Others acknowledge a gap between what they know they should say and what they actually say. One highlights how "*talking about end-of-life [...] if the patient isn't at all in a mindset where we feel the message will be received, or if, as soon as we start talking about it, we feel the patient completely shuts down—it's difficult*" [I9].

These difficulties lead to the implementation of communication strategies. Oncologists report filtering information—what they say versus what they withhold: "*We don't say we're stopping treatment, we say we're going to limit it to comfort care*" [I3]. Thus, announcing end-of-life happens gradually: "*We go step by step; we don't drop it on them all at once,*" the goal being to "*ease the psychological burden a bit*" [I2] and "*help them understand that [...] it's not that we don't want to see them anymore, or care for them anymore*" [I1].

Patients seem aware of the taboo surrounding certain information, such as the end of treatment or entry into palliative care. One patient expresses doubt about the doctor's sincerity when he mentions a third-line treatment, and her daughter asks whether it's the last option.

Doctor: "*No, it's not the last resort*."

Patient: "*But he's not going to tell us*."

Doctor: "*No, I'm being honest with you. If I have no other options, then I have no other options*." [C2]

In the observed consultations, several patients express a desire for things to be stated frankly. One patient, for instance, insists that the oncologist be as transparent as possible regarding the progression of his cancer:

Doctor: "*Unfortunately, this scan doesn't look great, if you want [...] on the scan, the lesions have grown a bit*."

Patient: "*Speak frankly, doctor. What does that mean—doubled, tripled?*" [C9]

The oncologist then suggests they look at the scan images together—a way of conveying more information without answering the question too directly. In this exchange, both sides adjust their approach in an effort to strike a balance between the need for transparent communication and the desire to ease the discomfort of the conversation.

4 | Discussion

This qualitative research project combining semistructured interviews and consultation observations allowed us to analyze oncologists' experiences with the recommendations issued by scientific societies during the COVID-19 pandemic, as well as their perceived impact on current practices. It also enabled us to explore their representations of chemotherapy prescriptions at the end of life and to examine how these decisions were negotiated within the therapeutic relationship.

Even in the absence of resource constraints, the interviewed oncologists reported having adopted the scientific societies' recommendations in the context of the health crisis, before gradually returning to their prior practices. This return—regretted by some, who saw the recommendations as a form of support for decision-making—highlights the psychosocial dynamics surrounding end-of-life prescriptions. Among these, the sacralization of chemotherapy and a shared sense of guilt related to its discontinuation appear to sustain the representation of palliative care as equivalent to "doing nothing," leading to hesitation in communicating what can or should be said.

Outside the context of the health crisis, the literature showed that recommendations issued by scientific societies are received ambivalently by oncologists. Some studies indicated that they may be perceived as conflicting with physicians' autonomy [21] or as difficult to apply to the uniqueness of clinical situations [22]. Other studies, by contrast, described them as resources used as decision-making tools in clinical practice [23, 24]. Nevertheless, they are often seen as insufficiently explicit, which leads to the decision to discontinue treatment to rely more heavily on intuitive judgment—described as the moment when "enough is enough" [25].

During the pandemic, this function of recommendations as a resource appears to have become more pronounced. The emergence of a climate of uncertainty—marked by limited knowledge of the virus and corresponding to one of the levels of medical uncertainty identified by Fox, namely, that which stems from "the limitations of medical knowledge itself" [26]—may have intensified the uncertainty already inherent in decisions about whether or not to prescribe anticancer treatment at the end of life.

In this context, the formulation of practical and explicit recommendations by scientific societies appears to have taken on a particularly valuable role of reducing uncertainty. Coutellec and Tarantini [27] analyzed the role of recommendations concerning intubation in hospital settings during this period and noted that "in those first weeks of the crisis, such recommendations served as a significant support for physicians, despite difficulties in grounding them on sufficient levels of evidence."

Our study aligns with this perspective by showing how the recommendations issued by scientific societies could be taken up as an institutional framework that offered a degree of stability in a time of uncertainty. Moreover, other research has shown that the reduction of anxiety linked to uncertainty did not rely solely on recommendations but also on the development of more collective forms of care [28].

This moment—at the boundary between the so-called treatments with curative or palliative intent—described by Baszanger [1] as a phase of "bricolage" is marked by the unique role occupied by chemotherapy as an anticancer agent. Indeed, our study shows that chemotherapy is imbued with a form of sacralization, evidenced by the use of sacred language to describe it and its perception as a symbol of hope. This sacralization can be analyzed within the broader framework of pharmaceuticalization. This anthropological concept, which builds upon that of medicalization, refers to the "process by which social, behavioral, or bodily conditions are treated or deemed to require pharmaceutical intervention by patients, physicians, or both" [29]. It highlights the central role of pharmaceuticals in contemporary biomedicine, as well as the symbolic meanings they carry, through the "cultural construction of their efficacy" [30]. By adopting this lens, our study considers treatment not only in its biomedical function but also as a "concentrate of symbolic social logics" [29].

Several studies have already employed the concept of pharmaceuticalization in oncology. Davis [31], in particular, demonstrated how representations of anticancer treatment—both from the perspective of patients and healthcare professionals—are influenced by cultural, political, and institutional dimensions. Besle et al. [30], for their part, focused on the case of a patient who, despite therapeutic failure and uncertainty regarding the benefit–risk balance, chose to continue treatment in an advanced stage of illness—thus making a "bet on hope." According to the authors, this reflected a form of "chosen pharmaceuticalization," insofar as the treatment was no longer grounded in biomedical rationale but rather aligned with the patient's personal project.

In this context, where biomedical and psychosocial logics coexist, the decision to discontinue anticancer treatment can lead to feelings of guilt shared between caregivers and patients. It can also generate moral distress, fueled by emotional and ethical tensions when professionals feel prevented from providing the care they deem appropriate or from ensuring a "good death" [32–36].

Guilt, as a social and moral emotion, reveals how each actor in the therapeutic relationship seems to invest in the meaning of chemotherapy in relation to the other, considering it as a source of expectations and hope.

Through the concept of the moral and political economy of hope, Derbez [37] illustrates how clinical trials generate hope among actors with diverse interests—patients, relatives, healthcare professionals, and researchers—forming a network of exchanges where "molecules and emotions" intertwine. He notably distinguished the hope of researchers, who anticipate positive trial outcomes for the benefit of the collective, from the hope of patients, oriented toward "life prolongation, symptom improvement, disease remission, or even cure." In the context of COVID-19, the specific recommendations issued by scientific societies may have served as an external argument of authority, functioning to externalize the emotional burden of guilt.

The shared guilt surrounding the discontinuation of anticancer treatment also appears to be fueled by social representations of palliative care. In this regard, our study adds a new dimension by revealing that palliative care is not only associated with death—as previous studies have already shown [30, 38]—but is also perceived as equivalent to the moment when there is "nothing left to be done."

Our study highlights a gap between the public health definition of palliative care as "relief of pain and other symptoms, as well as on improving the overall physical, psychosocial, and spiritual well-being of patients" [31] and a representation that appears to be socially constructed and shared by the actors in the therapeutic relationship within the studied context. As Moscovici [39] points out, "people do not live by information alone; they also need meaning." Indeed, even when caregivers and patients receive information about the content and goals of palliative care, the social representations surrounding the notion of palliative care—as associated with emptiness and imminent death—remain deeply rooted. This gap underscores the limitations of a purely informational approach and the difficulty of transforming social representations of a social object with strong symbolic anchoring.

In this sense, our study reveals that the issue is not so much about mastering language as it is about what can be thought, accepted, and imagined. When it comes to addressing end-of-life matters, oncologists appear to filter information or even introduce an additional line of treatment to avoid the discussion altogether—thereby preserving a favorable psychological state for both themselves and their patients. This difficulty echoes the findings of Mino et al. [25] on the use of euphemisms and omissions around treatment discontinuation. Perceived as "unhearable," this announcement is often postponed until the patients raise the issue themselves. It also aligns with the observations of Faizang and Collins [40], whose results showed that the criteria guiding the decision to inform a patient are largely social. For example, one of the most common conditions for disclosing information or stating the "truth" is whether the patient is deemed able to understand and/or cope with it. In our study, this condition seems to extend to all actors in the therapeutic relationship. Indeed, the discomfort surrounding the topic of end-of-life appears to be shared and seems to fall within what several authors have described as a specifically social repression of death [41, 42], relegated in contemporary European societies "to the backstage of social life." Thus, this issue encompasses psychological, social, and cultural dimensions, illustrating how life and death are collectively conceived within a given sociocultural context.

4.1 | Limitations and Future Directions

Several limitations should be considered when interpreting these results. First, this is a single-center study, and it would be

relevant to extend the research to other hospital settings. This would allow for the examination—highlighted in some studies [6, 43]—of the influence of institutional culture, particularly the role of palliative care culture, on these practices. More broadly, the results obtained do not shed light on the wider cross-cultural discussions about end-of-life decision-making in oncology. Finally, in the context of longitudinal or comparative studies, it would be interesting to further explore how the representations held by patients, their relatives, and professionals regarding end-of-life issues evolve in the post-pandemic period, and how interventions might contribute to question them.

Furthermore, while the sample size is indeed limited, this is counterbalanced by the triangulation of methods and the involvement of multiple researchers from a multidisciplinary team, which contributes to the credibility and depth of the data analysis.

4.2 | Applied Perspectives

These findings underscore the relevance of early integration of palliative care and advance care planning, together with dedicated training in emotional awareness and reflexivity for oncologists, to foster ethically informed and emotionally sustainable approaches to end-of-life decision-making [44–46]. More precisely, it would be useful to consider implementing initiatives such as workshops, raising awareness about the psychosocial factors influencing chemotherapy prescriptions in advanced disease stages. In addition, the issue of confronting uncertainty and approaching death should be integrated into both the initial and continuing education of oncologists. However, implementing these recommendations may be challenging in resource-limited settings [47].

5 | Conclusion

The study highlights a deeply entrenched conception of anticancer treatment as a central component of oncologists' professional identity. An analysis grounded in the concept of pharmaceuticalization, as developed in the sociology of health, sheds light on the central role occupied by medication in the management of end-of-life care in oncology. The findings show that clinical decision-making is largely structured around prescribing practices, in line with analyses that define pharmaceuticalization as a process through which complex human situations are primarily framed, understood, and managed via pharmaceutical interventions. In this context, medication is not merely a therapeutic tool but becomes a key vehicle for the legitimacy of care. Treatment discontinuation therefore appears as a symbolic and moral rupture, difficult to conceive outside an exceptional framework of justification, such as the COVID-19 pandemic. This discontinuation seems all the more difficult to consider in a social context where death is not an option and where social knowledge toward palliative care makes it seem marginal. This is reflected in communication practices, rooted in social relationships between patients and doctors, tinged with discomfort and moral distress.

In conclusion, by analyzing the role of representations and socioaffective logics that shape how the various actors in the therapeutic relationship engage with the decision-making and communication challenges associated with prescribing treatments in advanced stages of illness, this study underscores the importance of questioning the multiplicity of rationalities at work in medical practices in sensitive contexts.

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Ethics Statement

This study received approval from the Clinical Research Project Selection Group (GSPC) of the Clinical Research and Innovation Department (DRCI) of the IPC.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Endnotes

[1]The decision to begin the interview by situating the research within the context of the pandemic, without specifying this in the invitation to participate, was methodological, intended to elicit the most spontaneous responses possible.

[2]*Hematologic* cancers were excluded, as the criteria used to assess the quality of end-of-life care have been validated in solid tumor oncology and not all are recognized in hematology.

[3]This difficulty also resurfaces in current debates surrounding the draft law on end-of-life care, where the notion of an "advanced stage" is likewise the subject of discussion—particularly regarding the criteria for accessing assisted dying. https://www.lemonde.fr/politique/article/2025/05/11/aide-a-mourir-catherine-vautrin-va-completer-le-texte-pour-definir-la-phase-avancee-et-retablir-le-delai-de-reflexion-de-48-heures_6605147_823448.html

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. *(Supporting Information)*

COREQ checklist. Completed Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist indicating where each reporting criterion is addressed in the manuscript.

Figures and tables: Themes and subthemes table. Detailed presentation of the themes and key subthemes identified in the qualitative analysis of oncologists' representations of anticancer treatment decisions during the COVID-19 crisis.