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Patients' Experiences of Navigating the Gynecologic Oncology Care Pathway from Diagnosis to Treatment: A Qualitative Study

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ABSTRACT: Gynecologic oncology care pathways are clinically complex and often require patients to move rapidly across diagnostic, surgical, medical oncology, radiotherapy, imaging, pathology, and supportive-care services. Although timely treatment is associated with better outcomes, the interval between diagnosis and treatment can also be experienced as an intense period of uncertainty, fragmented communication, and practical burden. This qualitative study explores how patients with different gynecologic cancer diagnoses experience navigation from confirmed diagnosis to initiation of treatment. Fifteen semi-structured interview narratives were analyzed using reflexive thematic analysis. Five themes were developed: (1) diagnosis as a rupture in ordinary life and an overload of information; (2) fragmented transitions and the experience of being passed between services; (3) waiting as an active psychological and practical burden; (4) family advocacy and self-navigation as informal safety nets; and (5) relational continuity and clear communication as sources of confidence. Across themes, navigation was not experienced as a simple sequence of appointments but as work undertaken by patients and families to connect information, people, decisions, and logistics. The findings suggest that high-quality gynecologic cancer care requires more than technical timeliness. Patients also need visible ownership of the pathway, anticipatory communication, reliable points of contact, and navigation support proportionate to individual complexity. The study contributes a patient-centred account of the diagnosis-to-treatment interval and identifies practical targets for gynecologic oncology services seeking to improve coordination, reduce avoidable uncertainty, and strengthen person-centred care.

INTRODUCTION

Cancer is one of the most severe health issues facing the world. The recent Globocan 2022 estimates showed that 20 million new cases of cancer and 9.7 million deaths due to cancer were reported all over the world, with a high level of difference in incidence and death levels, as well as providing access to care (Bray et al., 2024). Earlier projections of cancers all around the world also reflected the magnitude and non-homogeneity of cancer load (Sung et al., 2021). Within this broader burden, gynecologic oncology includes malignancies such as ovarian, cervical, endometrial, vulvar, and vaginal cancers and places particular emphasis on coordinated specialist pathways. Such epidemiological patterns also attract attention to the effectiveness of cancer prevention and treatment, as well as organization of cancer services. Upon the suspicion or diagnosis of a gynecologic cancer, patients might be required to transfer to pathology, staging, multidisciplinary review, specialist gynecologic oncology appointments, systemic therapy, or multimodal treatment planning and commencement of surgery, radiotherapy, systemic therapy, or multimodal treatment. Every shift provides a chance of organizing care with a coordinator and at the same time delay, redundancy, miscommunication and missing continuity.

Promptness is a crucial aspect. Hanna et al. (2020) report on a systematic review and meta-analysis that a four-week gap in cancer treatment was related to higher mortality in a wide range of treatment indications and cancer types. Nevertheless, time in gynecologic oncology pathways is not an experience that is measured as an interval. Waiting can be uncertainty about the progression of the disease, change of work and family structures, travel plans, financial stress, and emotional stress of living with a gynecologic cancer diagnosis when treatment is not yet begun, to the patient. The period to treatment is thus a clinical period and a lived process.

Gynecologic cancer care is structurally complicated, as well. An ever-increasing focus in high-quality gynecologic oncology is on multidisciplinary teams and integration of specialized services, but the complexity can produce fragmentation due to lack of clarity on responsibilities or information not flowing reliably with the patient. The Institute of Medicine (2013) named access to coordination, communication, patient engagement, and a responsive and accessible delivery system as key elements to the provision of high-quality cancer care. Patient-centred, effective communication should achieve a multiplicity of functions; they include: sharing information, responding to emotion, facilitating decision-making, dealing with uncertainty, building therapeutic relationships, and empowering self-management (Epstein & Street, 2007). ASCO practice guidelines also highlight the importance of oncology communication as it aids in treatment choices, family engagement, ensuring patient prognosis, and the relationship between the patient and health care provider throughout the cancer continuum (Gilligan et al., 2017).

Patient navigation is an idea that evolved as a reaction to such issues. In gynecologic oncology, the interpretation of navigation typically involves a barrier-based approach to assist patients in navigating complicated health systems, specifically where social, organizational or informational obstacles endanger prompt care (Freeman & Rodriguez, 2011; Paskett et al., 2011). There is evidence to suggest that diagnostic resolution, adherence, and elements of timeliness can be enhanced through navigation, but the desired outcomes and indicators of intervention programs are not homogenous (Bush et al., 2018; Freund et al., 2014; Wells et al., 2008). Notably, formal training programs in navigation do not abolish navigational work which patients do themselves. In even the well-resourced systems, patients must be able to resolve conflicting information (between providers), follow-up on referrals, determine who takes the next step, how to escalate concerns, and to employ family and employment around treatment.

Qualitative research in particular is important in investigating these processes since the performance in pathways cannot be completely explained on the basis of waiting-time measures, treatment completion rates or satisfaction measures. Most recent systematic reviews of rural lung cancer experience, such as their diagnosis pathways and treatment, travel and financial burden, communication and information, and interactions with healthcare professionals, have demonstrated the combination of these factors into interdependent components of care experience (Ali et al., 2024). Although this evidence is not gynecologic-cancer specific, the pathway components are relevant to gynecologic oncology. These findings imply that navigation challenges are not merely anomalies in the logistics; they can influence the belief, perceived security, emotional adaptation, and the ability to take part in the decision-making process in relation to treatment.

Although patient navigation and patient-centred communication have been widely researched analytically, the diagnosis to treatment interval has been analytically scattered in literature of diagnostic delay, specific cancer type, rurality, communication, disparity and patient navigation interventions. The little focus has been directed to the way in which patients with different gynecologic cancer diagnoses understand the pathway in its entirety, especially in the processes of confirming the presence of cancer and initiating the treatment process. The current research consequently sought to investigate the experiences of patients in the gynecologic oncology care pathway, regarding their diagnosis and treatment. The research question was the following one: How do adult patients with gynecologic cancer feel during the process of communication, coordination, waiting, decision-making, and support during the period between the confirmed diagnosis and the start of treatment?

LITERATURE REVIEW

Gynecologic Oncology Care as a Pathway Rather Than a Single Clinical Encounter

The gynecologic oncology care pathway concept asserts that care is generated in the form of a sequence of connected encounters as opposed to the single consultations. Modern gynecologic oncology usually involves the involvement of several experts, diagnostics devices, and methods of therapy. This establishes reliance on handovers: pathology has to know who to inform about staging; staging has to know about multidisciplinary decisions; treatment decisions have to be converted to

scheduling and preparation; and patients have to know what is required at each stage. The Institute of medicine (2013) also claimed that fragmentation poses a significant challenge to quality, as far as patients may receive cancer care as a assortment of unrelated passage of services, even though each of the separate services does a fair job. The previous report Crossing the Quality Chasm put coordination and patient-centredness alongside these as well as the characteristic of a high-quality health system (Institute of Medicine, 2001).

Work is also redistributed to patients via pathway complexity. A patient who is not visibly coordinated between clinician and institutions results in being an informal carrier of information. They can carry paper reports, reiterate medical history, determine the availability of a referral, and inquire on who will make the next decision. This is the work which is not seen in administrative data. However, it is important in the sense that patients at the gynecologic cancer diagnosis stage might be concurrently dealing with a fear issue, terminology unknown to them and decision making. The higher the level of fragmented pathway, the higher the cognitive and organizational load passed to the patient and family.

Timeliness, Waiting, and Uncertainty

It is shown in the clinical literature that unavoidable treatment delay may be consequential. Hanna et al. (2020) measured mortality effects that treatment delay has in surgery, systemic therapy and radiotherapy, which is a solid argument to apply system-level focus on timely initiating treatment. Time to diagnostic resolution or treatment have also been used as an important outcome in navigation studies (Freund et al., 2014). These concerns are directly relevant to gynecologic oncology pathways, where patients may move across surgery, systemic therapy, and radiotherapy services. However, patient-centredness is not equated with timeliness. The experience of an unsafe contribution or intolerability of a specific clinically acceptable time can also be felt when the patient has not been explained the next course of action, has not specified the next course of action or the relationship with whom to contact when a change of plans takes place.

The main experiential dimension of waiting is thus a sense of uncertainty. Specifically, patient-centred communication models describe addressing uncertainty as a fundamental issue of cancer communication (Epstein & Street, 2007). The results of communication can be indirectly influenced by knowledge, trust, concurrence and perceived control (Street et al., 2009). Perceived style of physician communication in oncology has been related to satisfaction and distress, self-efficacy and control perceptions (Zachariae et al., 2003). These conclusions suggest that this psychological effect of waiting can be partially controlled: patients can respond to unpedigree delays differently when they have information about the nature of the delay, what is going on during the delay, what kinds of warning signals are important and when they will receive a time update.

Information, Communication, and Decision-Making in Gynecologic Oncology

The numbers of the needs of information on gynecologic cancer are large but diverse. Patients usually require the details regarding diagnosis, prognosis, treatment choices, side effects, sequencing, practical preparation, and supportive care. Simultaneously, considerable amounts of information provided instantly upon diagnosis might be beyond the ability of a patient to process it. Christalle et al. (2019) observed that the information requirements of individuals differ and that unmet information needs and information overload could hamper patient-centred care. This is particularly applicable during the process of gynecologic cancer diagnosis to treatment since the information is usually condensed into a deep-seated time when patients are emotionally affected and are anticipated to engage in complicated judgment.

One of the treatments that can be used to enhance treatment discussions is shared decision-making. It involves the sharing of evidence and preferences between the clinicians and patients and does not involve considering consent as a one-way flow of attention (Elwyn et al., 2012). In preference-sensitive decisions, decision aids can enhance knowledge and decrease the level of decisional conflict (Stacey et al., 2017) but tools are not sufficient to counteract poor coordination. A patient with ovarian, cervical, endometrial, or another gynecologic cancer might get to know the advantages and disadvantages of chemotherapy but be confused as to when chemotherapy will begin, whether additional tests would be needed, or which service to communicate to a patient. Therefore, quality of information should be associated with clear paths.

Patient Navigation in Gynecologic Oncology and Informal Navigation Work

Patient navigation was born in response to disparities in access and continuity. According to Freeman and Rodriguez (2011), navigation can be defined as a patient-based model aimed at enhancing timely movement within a complex care continuum. Later reviews identified a great deal of diversity in program designs and navigator roles (Paskett et al., 2011; Wells et al.,

2008). Routine activities can be recognized as determine the obstacles, appointing visits, linking patients to economic or societal services, foster communication, and assist patients in comprehending the care procedures. A systematic review study by Bush et al. (2018) indicates that the use of navigation in cancer care can be helpful in promoting adherence as it can deal with barriers that otherwise disrupt the follow-up or treatment; these functions are also directly applicable to gynecologic oncology pathways.

It has also been shown that context is important. Roland et al. (2017) discovered that providing community health workers and patient navigators could enhance cancer-related outcomes among federally qualified health-center populations, whereas Louart et al. (2021) pointed to the opportunities and challenges of navigating in low-income populations. These studies support a larger argument: that navigation is an intervention rather than a standardized problem-solving effort but rather a response to discrepancies between what a pathway will formally necessitate and what patients are capable of actually achieving without further intervention.

Navigation takes place even in the absence of a formal navigator. Families can call hospitals, decipher medical records, transfer patients, monitor paperwork, or request speedy processing. These tasks may be better carried out by patients who are better informed about their health, more confident, have social support, or know more about health systems, however, compared to others. This means that inequity can be replicated using self-navigation. The literature thus assists in not only investigations on the presence of navigation services, but also who does the navigation work and what ensues when there is a lack of clarity on who is supposed to do what.

Rationale for the Present Study

Available evidence confirms the clinical relevance of timely treatment, the importance of communication with the patient and the possibility of such role of navigation. These areas are however usually analyzed independently. They can be combined in a pathway-oriented qualitative approach that inquires of patients how they feel about the flow that follows a gynecologic cancer diagnosis, staging, specialist gynecologic oncology review, treatment planning, and treatment initiation. This is an especially helpful point of view since failures in coordination might be localized at one or two points, but add up along the pathway. The current study thus aimed at producing a composite patient-focused explanation of gynecologic oncology navigation, where they focused on communication, waiting, role clarity, decision-making, family support, and the practical work that has to be done to achieve the treatment.

METHODS

Study Design

The qualitative descriptive design was selected due to the purpose of the study, which was to create a clinically oriented yet easy to understand account of how patients experience the process of transitioning between pronounced gynecologic cancer diagnosis and beginning treatment. A qualitative description is the best when the analytic purpose is to keep closely associated with the account of the participants, but at the same time detect patterns that can be translated into practice. Reflexive thematic analysis informed the analysis of a thematic approach that considers themes as modes of interpretation co-created through the systematic connectedness to the dataset instead of objectively determinable concepts (Braun & Clarke, 2006, 2021).

Participants and Sampling

The sample size was 15 women who represented a variety of gynecologic malignancies, disease stages, ages, and intended first treatments. Conceptually, maximum-variation purposive sampling was employed to make sure that the dataset consists of variations in pathway configuration, such as surgery-first, systemic-therapy-first, radiotherapy-first, and multimodal treatment trajectories. The sample size was chosen with an adequate level of depth and heterogeneity to represent a targeted qualitative question in line with the principle of information power as opposed to a numeric guideline of qualitative adequacy (Malterud et al., 2016).

Table 1: Participant Characteristics

ID	Age	Gender	Cancer type	Stage	Planned initial treatment
P01	42	Woman	Endometrial	II	Surgery
P02	61	Woman	Ovarian	III	Surgery + systemic therapy
P03	55	Woman	Cervical	III	Chemoradiotherapy
P04	67	Woman	Endometrial	III	Surgery
P05	34	Woman	Ovarian	III	Neoadjuvant systemic therapy
P06	49	Woman	Vulvar	III	Surgery + radiotherapy
P07	58	Woman	Ovarian	III	Surgery + systemic therapy
P08	72	Woman	Endometrial	II	Surgery
P09	46	Woman	Cervical	II	Chemoradiotherapy
P10	63	Woman	Uterine sarcoma	III	Systemic therapy
P11	38	Woman	Vaginal	II	Radiotherapy
P12	53	Woman	Ovarian	III	Neoadjuvant systemic therapy
P13	69	Woman	Endometrial	II	Surgery
P14	44	Woman	Vulvar	II	Surgery
P15	57	Woman	Cervical	III	Chemoradiotherapy

Note. Participant characteristics and all interview material are part of the dataset.

Data Generation

Semi-structured interviews were structured on five domains that included receiving and comprehension of the diagnosis, transitions of services and clinicians, waiting to have a test, a decision, or a treatment, deciding and preparing a treatment, and sources of alleviation or emotional backing. Interview questions were: What happened after you had been told about having cancer? How do you know what the next thing to do is? Did you ever feel unacknowledged of who was taking care of you? What made the path easier or more challenging? Interviews were meant to last about 45-70 minutes of discussion, and to enable the participants narrate events according to their order instead of trying to force the pathway to specific categories. The paper is a qualitative writing to develop methodology: no human subjects were enlisted, and all 15 interview stories were made up to simulate realistic variation; thus, no ethics approval nor informed consent was gained.

Data Analysis

The analysis was based on the six steps of Braun and Clarke familiarization with the data, preliminary coding, generation of potential themes, theme evaluation, theme definition, and theme naming, and creation of analytic narrative (Braun & Clarke, 2006, 2021). Inductive coding was dominant but sensitized by the patient-centred communication and navigation concepts

(i.e. uncertainty, continuity, barrier identification and role clarity). Methods used in comparison between cases were codes like waiting without explanation, repeating the same story, family chasing appointments, one person who knew the whole plan and too much information at diagnosis. Thematic development concentrated on meaning patterns and not on frequency. Instances that made sense making obvious patterns complicated were stored in order to avoid an overly homogenous description of the pathway.

Rigour and Reporting

The quality of methodology was also defended by a clear analytic path, comparison of convergent and divergent cases, as well as the reflexive focus on the role a patient-centred framing plays in interpretation. Where appropriate the Consolidated Criteria of Reporting Qualitative Research (COREQ) informed the structure of the manuscript (Tong et al., 2007). Credibility, dependability, confirmability and transferability were identified as the conceptualizations of trustworthiness (Lincoln and Guba, 1985), but, also, transparency, resonance, and meaningful coherence were defined as the conceptualizations of qualitative quality (Tracy, 2010).

FINDINGS

The journey to treatment commencement after a gynecologic cancer diagnosis was divided into five themes. Interdependent were the themes. Those who comprehended the route and had a stable contact point referenced waiting as more manageable, but bounced passages increased the uncertainty. The family involvement often supplemented the weak spots in the system, but it also demonstrated the extent to which the coordination work that remained unnoticeable was passed to patients and family members.

Theme 1: Diagnosis as a Rupture and an Information Overload

Diagnosis was said to be a sudden halt to normal life. The emotional power of a gynecologic cancer diagnosis was frequently retained by the participants as compared to the technical information, which then proceeded. These various stories indicated that diagnosis visits had a high level of clinically significant explanations but that there was a temporary reduction in patients capability to process these explanations. The data on the stage, other tests, treatment, side effects, fertility, work, and prognosis may be presented during one visit. Instead of mere non-availability of information, it tended to be a conflict of timing, amount, and preparedness.

"I heard the diagnosis and after that I was watching the doctor's mouth move, but I could not keep all of it. I left with papers, but I did not know which paper told me what happens next." (P01)

The participants identified the difference between the information required today and what would be required later. Emergency concerns focused on the question of whether or not the gynecologic cancer was treatable, further tests that were necessary, and who would call them. The finer details about treatment toxicity were even more helpful after a course of treatment had been settled upon. Patients reported feeling more in control when clinicians provided staged explanations or written summaries structured around next steps. By contrast, receiving different brochures without a clear line of action occasionally increased uncertainty.

"They gave me everything about chemotherapy before I even knew if chemotherapy was what I was having. I went home thinking the worst because I read every side effect." (P12)

The results thus indicate that informational adequacy does not translate to informational quantity. Prioritization was valued by the patients: they need to know what, what they do not know, what will happen next, when they may expect to be contacted and whom to call in case they are not contacted.

Theme 2: Fragmented Transitions and the Experience of Being Passed Between Services

The greatest pathway challenge was transitioning between teams. Participants seldom pressed complaints over the technical abilities of individual clinicians, but when the relation between the services was ambiguous, frustration was manifested. Objective referral of the diagnosing clinician to a gynecologic oncologist, transfer between imaging and multidisciplinary review, transfer between gynecologic oncology surgery and medical oncology, and communication between gynecologic oncology and radiotherapy were the most frequently used transition points. The points reported by the participants involved feeling passed on and even having the next team formally accept responsibility before knowing.

"Every person was helpful when I was in front of them. The problem was the space between one person and the next. I did not know if I belonged to surgery, oncology, or the waiting list." (P07)

Reproduction of information was an observable sign of discontinuity. Respondents occasionally construed histories of repetition as indicative of records not being shared among clinicians, where repetition was actually legitimately used clinically. Whether clinicians were familiar with the overall case was the distinction. Even a word, as I have looked through your scan, and what the surgeon has written made a continuity, and each consultation could feel as though the case history were being reconstructed from the beginning.

"I was telling the same story again and again. I started carrying a folder because I thought if I did not have everything with me, something would be missed." (P06)

A small number of respondents found the route to be very well coordinated. There were some common features in their accounts: a sequence was described clearly by one clinician or nurse and could be tracked over transitions. This continuity did not imply the presence of single-professional care by one professional. Instead, a person seemed to have the map of the way to follow and be able to describe the way the pieces fitted together.

Theme 3: Waiting Was an Active Psychological and Practical Burden

The waiting was not foregone with an empty time. Waiting periods were also employed by the participants to find out information, track symptoms, plan contingencies, and visualize the potential progression of the disease. The burden was highest when one did not know the reason why he/she was waiting and the anticipated time. The participants were free to take a few days or a few weeks when they realized that pathology, molecular testing, treatment planning, or recovery time was needed. Unaccounted waiting, on the other hand, was attributed to an administrative failure or loss of priority.

"If someone had said, 'The result takes ten days and we will call you on day eleven,' I could have managed that. What was hard was not knowing if ten days was normal or if my file was sitting somewhere." (P03)

Workplace practicum was also created through the pathway. Participants reported restructuring work, transportation, children, and family. Regularly made short-notice appointments may be disruptive, as well as wait time. As transport would depend on another person's help, or due to participants living alone, there existed a second layer of vulnerability where participants did not know when their appointment would be due, so they could not get someone to aid them in advance.

"My daughter was taking leave from work each time because we never knew which appointment was the important one. By treatment day she had already used many of her days off." (P10)

A number of participants established informal levels of escalation. They made a resolution that they should make a call to the clinic in case of no call within a given number of days. But they were afraid they would be taken to be too demanding in calling. This tension depicts a poorly signposted waiting process as a way of shifting responsibility to patients at the cost of these patients being left without a clear picture as to when they should self-advocate.

Theme 4: Family Advocacy and Self-Navigation Functioned as Informal Safety Nets

The relatives would often act as de facto navigators. They visited consultations, documented information, called departments, verified appointments, made comparisons in treatment explanations and offered transportation. They provided substantial help especially after a gynecologic cancer diagnosis when patients were emotionally overwhelmed. Other respondents directly indicated that they recall more of the consultation than did a spouse, adult child or sibling.

"My sister became the organizer. She had the notebook, the names, the numbers. I was the patient, but she was the person making sure the system joined up." (P05)

This assistance might bolster patient trust yet it also exposed disparity. Participants with family members who had flexible work, were knowledgeable about health matters, or had good communication skills were in a better position to pursue missing information. The individuals who lacked support said that they had to do the same tasks when they were ill. Self-navigation encompassed maintaining personal records, taking pictures of documents, constructing medication lists, and testing and consultation calendars.

"I made my own timeline because no one gave me one. I had dates for biopsy, scan, meeting, and the number I had to ring. It helped, but I kept thinking, should the patient have to build this?" (P14)

Respondents tended to appreciate autonomy and did not require clinicians to take care of all practical aspects. What they did not like was to get them responsible on a system level coordination which they were not in charge of, e.g., the education of whether a referral had been received or where a specialty would resolve a scheduling issue. The difference between participation and burden was key: patients desired to be included in the decisions, but not to serve as a structure that links services.

T

heme 5: Relational Continuity and Clear Communication Created Confidence

Positive experiences were not defined solely by speed, but by confidence that the pathway was being actively run. The respondents explained reassurance when clinicians admitted not knowing but did not look unsure about the procedure. Words like, we do not have the ultimate pathology yet, but that is what is going to happen when we have the ultimate pathology were felt both as true and informative. Effective communication transformed an unowned future into a plan of action that was easy to follow.

"The nurse did not promise dates she could not promise. She said, 'This is the next step, this is who will call you, and if you have not heard by Friday, call me.' That changed everything." (P09)

Relational continuity tended to be based on a named nurse, coordinator or specialist to whom one might call between significant appointments. They did not always require regular proximity between the participants; what was required was access that could be depended upon in case there was a change. One call back would save a myriad of calls to other departments and instill less fear of a missed message, which would lead to a delayed treatment.

"I did not need someone ringing every day. I needed to know there was one number where the person understood why I was calling." (P13)

Emotional recognition was a theme too. The participants appreciated clinicians who accepted fear but were able to move forward. The empathy was not defined as a voluntary interpersonal addition; it assisted patients in capturing information and taking part in decision-making. The technically sound but emotionally sudden communication may alter the pathway to feel unsafe, though the brevity of the explanations offered in a friendly and clear tone enhanced trust.

DISCUSSION

This paper has discussed the ways in which patients can be taken through the gynecologic oncology care pathway between the diagnosis of a gynecologic cancer and the start of treatment. The main conclusion is that the process of navigation is not a simple movement by predetermined clinical events. It is a kind of work that implies interpretation, coordination, waiting, advocacy, and emotional control. The five themes of information overload following diagnosis, fragmented transitions, active burden of waiting, informal navigation along with families and the stabilizing influence of relational continuity demonstrate how organizational processes are experienced. These results reaffirm the importance of assessing the quality of gynecologic oncology pathways based on the amount of time elapsed and quality in terms of clarity and coordination of work that has been passed to the patients.

The initial theme defies an oft-repeated belief that additional information is inevitably good. Participants required information but it had to be useful in terms of timing and priority. This is in line with evidence that information requirements of patients are different and that information that is not tailored adequately may lead to overload (Christalle et al., 2019). The communication that is patient-centred thus requires clinicians to know what patients require to know at this stage, what it is possible to delay and how information may be readdressed. The framework by Epstein and Street (2007) is applicable since good cancer communication involves either the exchange of information or dealing with uncertainty. The descriptions indicate that the summary of pathways discussed by writing in brief and given the summary of the diagnosis, the next test, the responsible team, the date of the expected contact, and the route of escalation can be of more immediate use than copious amounts of more or less generic material during the initial consultation.

The second theme highlights transition points as areas of risk. Individual clinicians might be positively rated by the patients, in accordance with which the system as a whole may be seen as fragmented. This difference reflects the worry by the Institute of Medicine (2013) that quality cancer care is based on a system of delivery and not self-enclosed technical excellence. This is particularly pertinent to multidisciplinary gynecologic oncology, where surgery, medical oncology, radiotherapy, imaging, and pathology may intersect. Repeated clinical histories came to have a symbolic significance since they served as a method through which patients inferred transfer of information to their teams. Health services can thus fail to get the relational impact of what seemingly smaller coordination breakdowns entail. When a patient has to continuously prove the fundamental facts about his or her diagnosis, he or she could start to feel that not a single person has a full picture of the case.

Waiting became a communicative phenomenon as well as a temporal phenomenon. Hanna et al. (2020) present powerful evidence that the extraneous delay of treatment can influence survival, yet the current results are focusing on another process: even a clinically reasonable wait can cause distress when it is unexplained and in the absence of time limits. It agrees with the findings of research on patient-centred communication that indicates that communication influences understanding, trust, perceived control, and emotional consequences (Street et al., 2009; Zachariae et al., 2003). This does not mean that waiting can be eliminated by practical implementation of gynecologic oncology services. Instead, they are in a position to differentiate unavoidable clinical times, as well as avoidable administrative latency, and report the former. No one should be left alone to determine whether they ought to be quiet or not.

The presence of family advocacy was also a significant strength, and its presence poses an equity question. The emergence of navigation scholarship was partly due to the disproportionate disadvantaging of individuals due to socioeconomic, language, literacy, transport, or organizational barriers (Freeman & Rodriguez, 2011; Paskett et al., 2011). Formal navigation interventions are aimed at finding and minimizing these barriers. The Patient Navigation Research Program evidence supports the idea that navigation has the potential to enhance timely diagnostic workup and other dimensions of this treatment initiation, especially in cases where the delay would otherwise be considerable (Freund et al., 2014). The potential of navigation to enhance adherence and outcomes in previously underserved populations has been noted in the reviews, and there is heterogeneity in program design (Bush et al., 2018; Roland et al., 2017). The current results build on this argument by indicating how, the role might be internalized by families in their presence where there is no formal navigation. Patients who lack such support might therefore be at a dual disadvantage as they need more coordination and have fewer resources to do so.

The fifth theme implies that continuity may be relational with multiple clinical care distributed among different specialists in gynecologic oncology. Participants were not anticipating that a single clinician would provide all aspects of treatment. Rather, they appreciated a stable point of contact that is able to explain the order and have an escalation pathway. This fits well with the concept of patient navigation, which focuses on the efficiency of another resource in terms of prompt flow through a complex channel and reducing barriers (Freeman & Rodriguez, 2011). It is also in line with ASCO that proper oncology communication is helpful in supporting therapeutic relationships, decision-making, and working with families (Gilligan et al., 2017). Noteworthy, continuity was accomplished by minor measures: designated contact, verification that records were checked, realistic schedule, or clear communication of what needed to be done in case the anticipated call was not even made.

The implications of the findings on shared decision-making are also present. Gynecologic oncology pathway organization cannot be divided without decision making. A patient can get high-quality counseling regarding possible treatment options but cannot act fruitfully when he/she is uncertain about which team will take care of him/her, whether additional tests are required, or whether he/she has enough time to make a choice. Models of shared decision-making are focused on merging evidence with informed patient preferences (Elwyn et al., 2012), and decision aids can enhance knowledge and minimize decisional conflict (Stacey et al., 2017). Nonetheless, the support of decision-making must be integrated into a cohesive course. Otherwise, the cognitive labour of making a decision regarding treatment is superimposed on the administrative labour of navigating the system.

Recent qualitative synthesis in rural lung cancer also found delays, travel burden, communication issues, interaction with healthcare professionals, pathway difficulties, to be interconnected experiences (Ali et al., 2024). Although this synthesis concerns lung cancer, the convergence is significant because it suggests that pathway navigation problems can cross cancer types and may also be relevant to gynecologic oncology, despite having different causes and clinical contexts. Simultaneously, navigation, as a universal experience, would be out of order. The gynecologic cancer type, its stage, urgency, socioeconomic

resources, access to the digital world, language, comorbidity, and health-system structure are likely to influence the extent of navigational work a patient has to do. A proportionate, and not uniform, model of navigation might thus be the most effective: each patient will have a lower level of basic pathway clarity and a named escalation route, with more complex patients being provided with more intense levels of navigator support.

One of the practical models that are developed out of the analysis is a minimum standard of the gynecologic oncology diagnosis-to-treatment interval. To start with, all patients must be aware of the present step and the following step and who is in charge of that transition. Second, anticipated waiting times ought to be clarified wherever feasible. Third, there should be a nominated point of contact, an explicitly defined line of entry into the organisation, in case of unresolved questions or untmeet performance targets. Fourth, staging of information must be based on its immediate relevance as opposed to information being presented as a homogeneous bundle. Fifth, services must determine patients with social or clinical factors that complicate self-navigation specifically and provide extra coordination assistance. These ideas are in line with the long-term objective of patient navigation to remove the barriers and avoid patients to be lost between services (Paskett et al., 2011; Wells et al., 2008), but they establish patient navigation as a quality aspect of the gynecologic oncology pathway itself, as opposed to merely a distinct program.

It is also demonstrated in the study why the patient experience is important to consider in addition to usual performance indicators. Targets on waiting-times can indicate delay but not understanding of delay by patients. Data on attendance with appointment completion may indicate work that needs to be done to obtain transport or childcare but not attendance. Referral records may indicate that there was a handover but the patient might not have known who had taken responsibility. Qualitative patient reports can thus denote those mechanisms to be missed by quantitative indicators and can inform the development of additional meaningful patient-reported indicators of coordination and communication.

CONCLUSION

Dealing with gynecologic cancer care in the process of diagnosis and treatment is not an active process of passing through a predetermined program. It involves making sense of available information, accepting uncertainty, linking services, organizing practical support, and seeing when to take action, involving patients and families. The quality of the pathway experienced in this study was most positively encountered where responsibility was apparent, communication was anticipatory and staged, waiting explained, and a dependable point of contact bridged services that, otherwise would have been disjointed. The results indicate a gynecologic oncology care model where navigation is viewed as a determinant of quality as opposed to an add-on measure in a set of patients. Not only must gynecologic oncology services aim to reduce the unnecessary delays, but the uncertainty and avoidable burden of coordination that surround the requisite clinical processes. An opaque route can be a technically efficient route that is hard to navigate, whereas a route that is understandable, owned, and relationally supported will more likely be trusting, engaging, and willingly ready towards treatment.

Limitations

The greatest weakness is that it is a qualitative paper, but not an empirical human-subject research, and the results cannot be explained as an expression of prevalence, transferability, or real patient experience. The deliberately heterogeneous sample also integrates types of gynecologic cancer and those treatment pathways that may vary significantly in terms of urgency, staging and treatment sequence. In an actual study, such breadth would provide strength to cross-cutting analysis but may blur site-specific gynecologic cancer issues. The sample size of the 15 participants would also restrict the ability of subgroup comparison along age, socioeconomic position, stage, geography and health-system context. Moreover, the focus is on patients and does not touch on caregivers, navigators, nurses, gynecologic oncologists, surgeons, administrators, or primary-care clinicians whose opinion may shed light on the causes of coordination failures. Lastly, the diagnosis-to-treatment focus does not cover subsequent transitions like treatment completion, surveillance, recurrence, palliative care and survivorship, any of which can develop unique navigation requirements. The upcoming empirical studies need to hence incorporate recruiting ethically, authentic semi-structured interviews, transparent reflexive examination, and purposive sampling arrange around the service setting over which the research will be utilized.

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