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Grateful but exhausted: Cancer patients write about hospital care

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ABSTRACT

Patients increasingly describe their experiences of cancer treatment online, yet such accounts are often reduced to measures of satisfaction or sentiment. This study used qualitative content analysis to examine 3,487 English-language, first-person posts about hospital-based cancer treatment. Each post was coded for the treatment phase it foregrounded, the treatment named, eight nonexclusive themes, emotional tone, and evaluation of hospital care, with tone and evaluation coded independently. Bodily burden was the most visible theme, present in 52.1% of posts, followed by uncertainty and waiting (46.8%) and explanation and communication (40.6%). Staff support and gratitude appeared in 35.1% of posts, and 80.8% contained two or more themes. Emotional tone did not track evaluation of care: 31.2% of favorable evaluations were distress-dominant, and 19.1% of critical evaluations carried hope or reassurance. Emphasis shifted across phases, with uncertainty most visible before treatment, bodily burden during it, and coordination after discharge. The interpretive synthesis suggests that waiting became troubling when its purpose was unclear, that praise for individual staff could coexist with difficulty navigating the treatment pathway, and that favorable care did not remove practical strain. Patient accounts are best read as connected dimensions of experience rather than as a single score of satisfaction or sentiment.

INTRODUCTION

People undergoing cancer treatment now often write about it in public or semi-public online spaces. They describe the side effects of a new cycle, the anxiety of waiting for a scan result, the nurse who stayed a few minutes longer, or the difficulty of getting to the hospital three times a week. These accounts are written for an audience. They may seek recognition, share practical knowledge, acknowledge good care, or ask whether others have faced the same situation. Research has suggested that sharing health experiences online can affect people through several routes, including finding information, feeling supported, and learning to tell one's own story (Ziebland & Wyke, 2012), and that patients' use of social media can alter their relationships with health professionals (Smailhodzic et al., 2016).

Online patient comments are also increasingly treated as a source of information about health care itself. There have been proposals to harness this "cloud of patient experience" to detect problems in the quality of care (Greaves et al., 2013). Such uses

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usually depend on summary measures that classify comments as positive or negative. For cancer treatment, that approach faces an obvious difficulty. A patient may be deeply distressed by illness and its treatment while being grateful for the care received, and another may be hopeful about recovery while sharply critical of how appointments were organized. A single sentiment score would conflate these quite different accounts.

This article reports a qualitative content analysis of 3,487 English-language posts in which cancer patients described hospital treatment. It addresses three questions. Which aspects of hospital treatment are made salient in patients' accounts? How do bodily discomfort, uncertainty, interpersonal care, and organizational difficulties appear together? And does the emotional tone of an account correspond to its evaluation of hospital care? The study concerns narrated experience, not clinical outcomes, adherence, or the comparative effectiveness of cancer therapies.

BACKGROUND

Uncertainty and Communication in Cancer Care

Uncertainty is a defining feature of serious illness. In Mishel's (1988) theory, uncertainty arises when a person cannot determine the meaning of illness-related events, and it is shaped by how familiar and predictable those events seem and by the explanations available from credible sources such as health professionals. The theory implies that the same delay or symptom may be experienced quite differently depending on whether the patient can place it within an understandable sequence. Communication is central to this process. Street et al. (2009) proposed several pathways through which clinician–patient communication can improve health outcomes, among them better patient knowledge, shared understanding, a stronger therapeutic alliance, and the management of emotions. These pathways suggest that the value of communication lies not only in the transfer of information but in whether patients can understand and use it.

Continuity and Dignity

Cancer treatment rarely consists of a single encounter. Patients move between diagnostic services, treatment units, wards, and follow-up care, often over many months. Haggerty et al. (2003) distinguished informational, management, and relational continuity, emphasizing that continuity is experienced by patients as care that is connected and coherent over time. Breakdowns in continuity may therefore appear in patient accounts as uncertainty about whom to contact or who is responsible, rather than as criticism of any particular professional. Dignity is a related concern. Chochinov (2007) argued that clinicians' attitudes, behavior, compassion, and dialogue shape whether patients feel recognized as persons rather than as conditions, and that dignity-conserving care is embedded in ordinary interactions.

Online Accounts as Communicative Acts

Online posts are not neutral records of events. They are selective accounts composed for readers. Media accounts of disease are similarly framed, so that the same outbreak can be presented through quite different frame packages (Kharazmi & Mohammadi, 2020). Sabbar and Matheson (2019) examined the relationship between social network users and the messages they choose to engage with, an approach that draws attention to the interplay between message content and network participation. A related perspective from virtual education highlights how social media platforms can facilitate information exchange, dialogue, and the formation of communities around shared concerns (Dastyar et al., 2023). Online discourse is also marked by emotional and rhetorical expression that cannot be reduced to factual description. The present study therefore treated each post as a communicative act, distinguishing what it described from how it evaluated care and from what it appeared to ask of its audience. It did not reproduce the design of earlier network studies or infer audience behavior from message characteristics.

METHOD

Approach

The study used qualitative content analysis supported by descriptive coding (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The analysis

focused on the organization and meaning of treatment experience: what patients found physically demanding, how they understood explanations, which interactions encouraged trust, and how difficulties continued across appointments and after discharge. Posts were treated as accounts addressed to an audience rather than as complete records of what happened in a hospital, which allowed emotional expression, evaluations of care, and requests for support to be examined separately.

Corpus and Unit of Analysis

The corpus comprised 3,487 English-language posts written in the first person about cancer treatment involving a hospital. To be included, a post had to contain an explicit self-description as a person receiving or having received cancer treatment and a substantive reference to a hospital encounter, procedure, treatment visit, admission, recovery period, or transition from hospital care. Posts about a relative's experience that did not present the writer's own treatment were excluded, as were promotional messages, institutional announcements, reposts without personal commentary, and general discussions of cancer without a treatment account.

Hospital treatment included both inpatient care and hospital-based outpatient encounters, since treatment visits and repeated procedures could carry substantial practical and emotional consequences. References to support after discharge were retained when they concerned continuity from a hospital episode. The corpus was defined by language and narrative eligibility rather than by country. Writing in English did not establish a writer's nationality, ethnicity, age, or the health system in which treatment took place, and these attributes were not inferred.

The post was the unit of analysis in every table. Because posts could not be linked to authors, the corpus does not represent 3,487 distinct patients, and repeated accounts by the same person could not be separated from independent contributions. Each post contributed once to a given code, however often it mentioned the issue, and a post could receive several thematic codes. Direct quotations, usernames, hospital names, and identifiable case descriptions are omitted from this report, and the findings synthesize meanings without presenting attributed testimony.

Coding Framework

Coding combined descriptive categories with interpretive reading. Each post received one code for the treatment phase it foregrounded: preparation, active treatment, recovery or discharge, follow-up or transition, or unclear. When a post referred to several episodes, it was classified by the episode receiving the main evaluative attention rather than the first event mentioned. A separate code recorded the treatment named: systemic treatment, surgery, radiotherapy, multiple treatments, or unspecified. These codes recorded explicit narrative references and did not establish a verified regimen, cancer type, stage, or treatment intent.

Eight nonexclusive themes were coded: symptoms and bodily burden; uncertainty and waiting; explanation and communication; staff support and gratitude; coordination and continuity; family and peer support; dignity and personal control; and financial and practical strain. Symptoms required an account of bodily difficulty rather than the mere naming of a diagnosis. Uncertainty included waiting for information and not knowing what would happen next. Communication concerned explanations, questions, listening, and understanding. Coordination concerned appointments, handovers, contact routes, discharge arrangements, and responsibility across services. Dignity concerned privacy, recognition, choice, and control within care. Practical strain included travel, work disruption, access costs, and other demands surrounding attendance.

The framework separated the presence of a subject from its evaluative direction. A helpful explanation and an unanswered question both counted as communication, while the post's appraisal recorded their different meanings; coordination, likewise, could be described as effective or as difficult. Theme counts therefore indicate how visible an issue was, not how often it was the subject of complaint. A symptom could appear alongside gratitude toward a nurse, and a

financial difficulty alongside a favorable view of clinical staff. The whole post remained the interpretive context for each code.

Emotional tone and evaluation of hospital care were coded independently. Tone distinguished distress-dominant expression, mixed affect, hope or reassurance, and descriptive or emotionally unmarked writing. Mixed affect required substantive expression in opposing directions rather than a single reassuring word. Care evaluation distinguished favorable, critical, mixed, and no clear evaluation, the last applying when a post described illness or treatment without judging the service. These categories describe textual expression. They do not diagnose psychological states, measure satisfaction with a validated instrument, or certify the quality of care.

Interpretive Synthesis and Descriptive Comparisons

Thematic synthesis examined the connection between a narrated event and its significance for the writer. The analysis asked, for instance, whether a delay mattered because it prolonged uncertainty, disrupted practical arrangements, or suggested that responsibility had become unclear. It also attended to the scope of praise and criticism, keeping approval of a single staff interaction separate from evaluation of the whole treatment pathway. Contrasting accounts were used to test broad interpretations: waiting could be accompanied by reassurance when its purpose was understood, while rapid treatment could remain unsettling when explanations were hard to follow.

Counts and percentages described the corpus, with 3,487 as the denominator unless otherwise stated. Phase, treatment, tone, and care evaluation were mutually exclusive classifications, whereas the eight themes were multiple-response codes whose percentages may sum to more than 100. Phase comparisons used the number of posts in each phase as the denominator, and the cross-tabulation of tone and evaluation used row percentages to describe the emotional composition of each evaluative group. Selected pairs of themes were summarized by the number of posts carrying both codes and by the Jaccard (1912) index, the intersection divided by the union, which shows how often two issues shared posts relative to all posts containing either. This measure depends on coding boundaries and does not indicate direction or causal dependence. No significance tests or population confidence intervals were calculated, because unknown repetition by authors, source selection, and differing propensities to post would make inference based on independent observations misleading. The analysis emphasizes substantive contrasts over small numerical differences.

Ethical Considerations

Research on online health material raises particular questions about privacy and consent (Eysenbach & Till, 2001). The protocol required ethical review appropriate to such material, with attention to whether posts were publicly accessible, intended for a restricted community, or available only after joining a group. Public availability alone was not treated as consent for unrestricted reuse, and the protocol called for source permissions, retention limits, and access controls to be documented before collection. Searchable quotations and identifying combinations of clinical and personal detail are excluded from this report. The study did not involve contact with patients, assessment of individual risk, or verification through medical records.

RESULTS

Composition of the Accounts

Active treatment was the most frequently foregrounded phase, accounting for 1,438 posts (41.2%). Recovery or discharge accounted for 721 posts (20.7%), preparation for 534 (15.3%), and follow-up or transition for 492 (14.1%), while 302 posts (8.7%) lacked a clear phase reference (Table 1). The corpus therefore extended well beyond the delivery of treatment, to its anticipation and to the work of managing its aftermath. Phase codes describe the episode a post foregrounded; they do not reconstruct a chronological trajectory for any individual patient.

Table 1. Treatment Phase Foregrounded in the Posts

Phase	n	%
Preparing for treatment	534	15.3
Active treatment	1,438	41.2
Recovery or discharge	721	20.7
Follow-up or transition	492	14.1

Phase	n	%
Phase unclear	302	8.7
All posts	3,487	100.0

Note. Each post received one phase code. Counts refer to posts, not unique patients.

Systemic treatment was the principal treatment named in 1,232 posts (35.3%), surgery in 796 (22.8%), and radiotherapy in 494 (14.2%). Multiple treatments were foregrounded in 585 posts (16.8%), and 380 (10.9%) did not specify a treatment. These categories provide context but do not describe the clinical case mix, and they were not used to compare efficacy or adverse effects. Naming a treatment in a narrative does not convey its dose, duration, indication, or outcome.

Distribution and Overlap of Themes

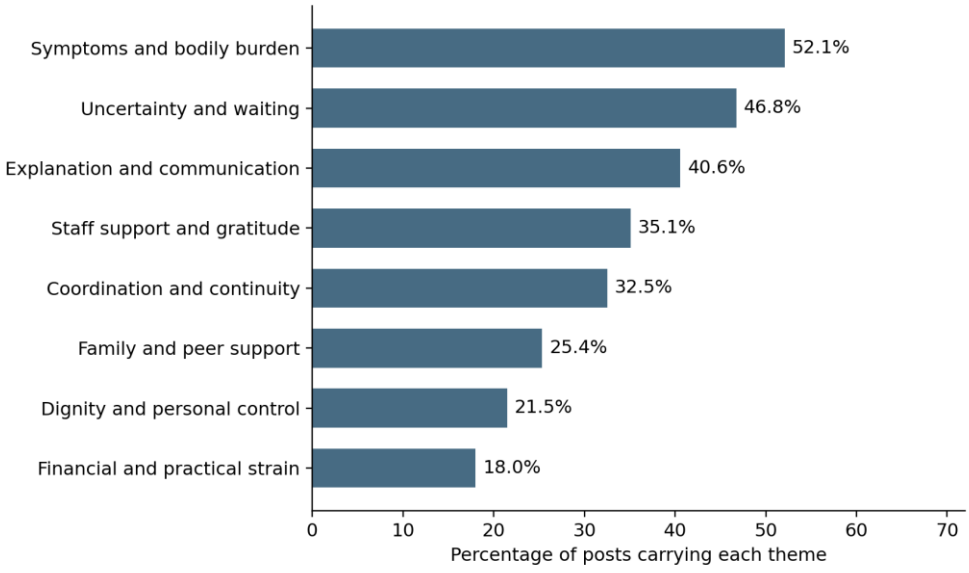
Symptoms and bodily burden appeared in 1,817 posts (52.1%), uncertainty and waiting in 1,631 (46.8%), and explanation and communication in 1,415 (40.6%). These three themes made physical experience and the interpretation of care especially visible. Staff support and gratitude appeared in 1,224 posts (35.1%), showing that difficulty did not exhaust the vocabulary of the corpus. Table 2 and Figure 1 report all eight themes.

Table 2. Themes Represented Across the Corpus

Theme	n	%
Symptoms and bodily burden	1,817	52.1
Uncertainty and waiting	1,631	46.8
Explanation and communication	1,415	40.6
Staff support and gratitude	1,224	35.1
Coordination and continuity	1,134	32.5
Family and peer support	884	25.4
Dignity and personal control	749	21.5
Financial and practical strain	628	18.0

Note. N = 3,487 posts. Themes are nonexclusive. Each count indicates posts containing a theme in any evaluative direction and is not a count of complaints.

Figure 1. Visibility of Themes Across Treatment Accounts



Note. The denominator is 3,487 posts for every bar. A post may contribute to several themes.

Two or more themes appeared in 2,818 posts (80.8%). This overlap matters for interpretation, because a treatment account typically connected the body, the institution, and everyday life rather than isolating one domain. An account of fatigue might also describe travel, waiting, or reliance on relatives. Such combinations broadened the significance of a symptom without establishing its medical cause. Less frequent themes remained analytically important when they explained why an apparently ordinary event had become difficult to manage.

Bodily Burden and the Work of Enduring Treatment

The first interpretive pattern located treatment in the patient's body. Accounts were organized around discomfort, tiredness, disrupted routines, and the effort required to attend and recover from care. Hospital treatment appeared as something to be endured over time, with consequences extending well beyond the procedure or appointment itself. The significance of bodily difficulty depended partly on whether the patient had expected it, understood its place in treatment, and felt able to seek help. The analysis therefore distinguished an account of burden from an accusation that care had failed.

A contrasting pattern appeared where bodily difficulty coexisted with recognition of staff effort. Symptoms and staff support co-occurred in 626 posts (18.0% of the corpus). A patient could remain distressed while describing reassurance, attentive listening, or help with an immediate need. Gratitude in such accounts was specific rather than all-encompassing: appreciation of an interaction did not erase the physical demands of treatment. Equally, an account of symptoms did not by itself establish toxicity or inadequate management. The narratives conveyed experience as the writer described it, often without the clinical explanation.

Uncertainty as a Problem of Information and Time

Waiting carried meaning beyond the passage of time. Accounts linked uncertainty to questions about what would happen next, when information would arrive, and who could explain an unfamiliar situation. Uncertainty co-occurred with bodily burden in 899 posts (25.8%), the largest overlap among the selected pairs, and with explanation and communication in 703 (20.2%). A delay could disrupt a patient's ability to arrange transport, work, or family responsibilities, while uncertainty about a treatment step could make the same interval harder to bear. The analysis treated these as different consequences of waiting rather than as a single measure of service speed.

A contrary pattern involved waiting that was understood. When the purpose of an interval or the timing of the next contact was clear, an account could remain apprehensive about illness without becoming critical of the hospital. Explanation mattered because it placed an event within a recognizable sequence. This does not imply that more information removed anxiety or improved outcomes. It shows how accounts distinguished unavoidable uncertainty about disease from uncertainty about the organization of care.

Communication and Continuity Across Encounters

Communication involved the opportunity to ask questions and the intelligibility of the answers, as well as the delivery of information. Accounts could praise professional knowledge while describing difficulty following an explanation or identifying a clear next step. The problem, in these accounts, lay in the use of information within an encounter rather than simply its availability. Timing also mattered: information adequate for one appointment could leave uncertainty about what to do after leaving the hospital.

Coordination and continuity extended the account from an interaction with one professional to the movement between services. The theme covered appointment arrangements, handovers, discharge instructions, and contact routes. Favorable accounts emphasized knowing whom to approach; difficult accounts described repeated efforts to locate responsibility. This was distinct from criticism of any particular staff member. A patient could appreciate the conduct of individuals while remaining uncertain about the organization that linked them.

Table 3. Selected Pairs of Themes Appearing in the Same Posts

Theme pair	n	% of corpus	Jaccard
Symptoms and bodily burden + Uncertainty and waiting	899	25.8	.353
Uncertainty and waiting + Explanation and communication	703	20.2	.300
Explanation and communication + Coordination and continuity	488	14.0	.237
Staff support and gratitude + Coordination and continuity	378	10.8	.191
Symptoms and bodily burden + Staff support and gratitude	626	18.0	.259
Family and peer support + Financial and practical strain	159	4.6	.118

Note. Pairs were selected for interpretive relevance. The Jaccard index is the number of posts carrying both codes divided by the number carrying either. Pair counts overlap.

Communication and coordination co-occurred in 488 posts (14.0%; Jaccard = .237), and staff support and coordination in 378 (10.8%). These combinations reinforce the distinction between interpersonal care and the wider treatment pathway. Co-occurrence alone does not reveal whether coordination was effective or difficult in a given post; that depends on the evaluative context.

Dignity, Support, and Practical Dependence

Dignity and personal control concerned whether patients felt recognized as people with questions, preferences, privacy, and responsibilities beyond treatment. The theme appeared in ordinary interactions as well as in exceptional complaints, and it included the importance of being listened to and of understanding what choices were available. Personal control did not mean independence from professional expertise. It concerned the patient's position in encounters where specialized knowledge and physical vulnerability were unevenly distributed.

Family and peer support appeared as both a practical and an interpretive resource. Relatives helped with travel, remembering information, and managing daily responsibilities, while peers offered recognition of an unfamiliar experience. These roles were not interchangeable. Family help could ease an immediate logistical problem without supplying the experiential understanding sought from another patient. Online posting made it possible to seek that understanding outside the hospital, although no response data were available to show whether requests were answered or support was effective.

Financial and practical strain placed treatment within the organization of everyday life. Travel, interrupted work, and repeated attendance could become difficult even when the clinical encounter was evaluated favorably. The theme was not restricted to direct medical charges, and its presence did not identify a particular insurance arrangement or health system. Its significance lay in how the obligations surrounding care affected patients' ability to organize their time and secure help. Family support and practical strain co-occurred in 159 posts (4.6%). This theme guards against reading a favorable evaluation of care as an absence of burden.

Emotional Tone and Evaluation of Care

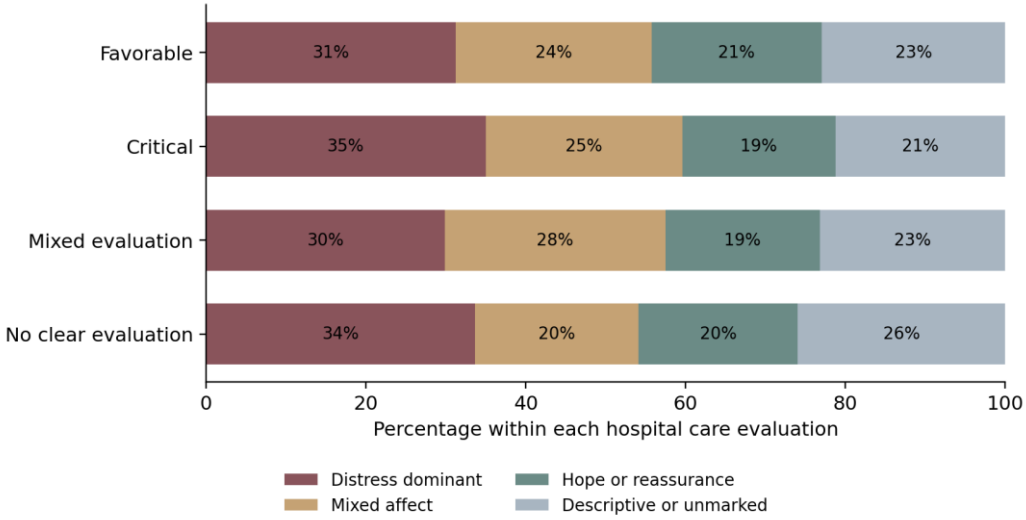
Tone and care evaluation offered different descriptions of the same material. Distress-dominant expression characterized 1,128 posts (32.3%), mixed affect 865 (24.8%), hope or reassurance 693 (19.9%), and descriptive or unmarked writing 801 (23.0%). Care was evaluated favorably in 919 posts, critically in 1,067, and in mixed terms in 978, while 523 posts contained no clear evaluation. A post's tone did not determine its evaluation of care (Table 4 and Figure 2).

Table 4. *Emotional Tone Within Each Evaluation of Hospital Care*

Care evaluation	Total	Distress	Mixed affect	Hope	Unmarked
Favorable	919	287 (31.2)	225 (24.5)	196 (21.3)	211 (23.0)
Critical	1,067	373 (35.0)	263 (24.6)	204 (19.1)	227 (21.3)
Mixed	978	292 (29.9)	270 (27.6)	189 (19.3)	227 (23.2)
No clear evaluation	523	176 (33.7)	107 (20.5)	104 (19.9)	136 (26.0)

Note. Cells show n (row %). The four tone categories sum to the total for each evaluation group. Tone and care evaluation were coded independently.

Figure 2. *Emotional Tone Across Evaluations of Hospital Care*



Note. Each bar totals 100% of its care-evaluation group. Labels are rounded row percentages; counts appear in Table 4.

Of the 919 favorable evaluations, 287 (31.2%) were distress-dominant. Conversely, 204 of the 1,067 critical evaluations (19.1%) carried hope or reassurance. The emotional composition of the four evaluative groups was broadly similar, with distress-dominant posts forming roughly a third of each. These intersections show why a general positive-versus-negative sentiment score would give an incomplete account of treatment experience. Distress may refer to illness and its physical demands while praise refers to care, and hope may coexist with criticism of the service.

Differences in Emphasis Across Phases

The visibility of themes varied with the treatment phase a post foregrounded (Table 5). Uncertainty appeared in 58.2% of preparation posts but in 36.6% of recovery or discharge posts. Bodily burden appeared in 57.7% of active-treatment posts and 40.8% of preparation posts. Coordination and continuity reached their highest level, 39.0%, in recovery or discharge accounts. These contrasts are consistent with different narrative priorities at different points: anticipating treatment, enduring it, and arranging what follows. Because writers could not be linked across phases, they do not establish a developmental sequence.

Table 5. Selected Themes by Treatment Phase

Phase	n	Symptoms	Uncertainty	Communication	Continuity
Preparing for treatment	534	40.8	58.2	48.3	27.7
Active treatment	1,438	57.7	48.5	40.1	31.7
Recovery or discharge	721	51.5	36.6	38.3	39.0
Follow-up or transition	492	48.4	47.0	37.6	31.3
Phase unclear	302	53.0	42.4	39.4	31.5

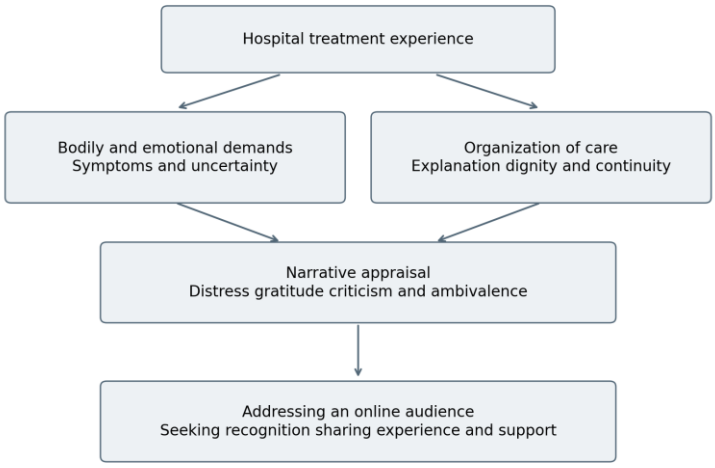
Note. Values are percentages of posts within each phase. Codes overlap. The table compares posts, not change within the same patients.

The phase comparison also qualified the thematic synthesis. Preparation made explanations and expected events salient, with communication appearing in 48.3% of these posts; active treatment foregrounded the immediate demands of attendance and bodily experience; and discharge and transition made contact routes and responsibility more visible. Yet every phase contained all the selected themes. The phases describe tendencies in where attention was directed rather than separate worlds of experience. A writer could be physically burdened before a procedure, grateful during a difficult admission, or uncertain after receiving clear discharge information.

Figure 3 brings together the bodily demands of treatment and the organization of care. Accounts were shaped both by what happened to the patient and by how that event was explained, managed, and carried into the next encounter. Appraisal emerged from the relationship between these dimensions rather than from either alone. Online publication added an audience-facing purpose: the writer could seek recognition, share a difficult experience, acknowledge helpful care, or ask how others had managed a similar situation. The analysis identifies these communicative possibilities without claiming that readership or responses were measured.

An Integrated Account

Figure 3. Relationships Among the Principal Dimensions of Treatment Experience



Note. Arrows organize interpretive relationships. They are not estimated causal pathways, and the model does not predict treatment outcomes.

DISCUSSION

This study set out to understand how cancer patients represent hospital treatment when they write about it online. The accounts were dominated by the body, by uncertainty, and by the work of understanding and navigating care. Yet the most consequential finding concerns the relationship between feeling and judgment. Emotional tone did not track evaluation of care. Nearly a third of favorable evaluations were dominated by distress, and almost a fifth of critical evaluations expressed hope. Patients distinguished, in their own writing, between what illness and treatment did to them and how the hospital treated them.

This distinction has practical implications for efforts to use online patient comments as indicators of care quality (Greaves et al., 2013). In cancer care, a sentiment classifier that reads distress as dissatisfaction would mistake the burden of illness for a failure of service, and one that reads hope as approval would miss criticism of how care was organized. AI models may handle complex data better than traditional statistical techniques, yet their interpretability and fairness remain open challenges (Habib Zadeh Khiyaban & Sabbar, 2022). Any attempt to learn from these accounts needs to separate the object of an emotion from its intensity. Coding emotional tone and care evaluation independently, as in this study, is one way to do so.

The findings on uncertainty fit Mishel's (1988) account of how uncertainty in illness depends on the predictability of events and the explanations available from trusted sources. Waiting was not troubling simply because it was long. It became troubling when its purpose was unclear, when the next step was unknown, or when no one seemed able to explain what was happening. Understood waiting, by contrast, could coexist with apprehension about illness without becoming a complaint about the hospital. This suggests that clear explanations of why an interval exists and when contact will follow may matter as much to patients as shortening the interval itself.

Communication, in these accounts, was about usability rather than volume. Patients could respect a clinician's knowledge and still leave an appointment unsure what to do next. This is consistent with the view that communication affects outcomes through shared understanding and patients' capacity to act, not merely through the transfer of facts (Street et al., 2009). Communication and coordination often appeared together, and the visibility of coordination after discharge points to a recurring vulnerability: the moment when a patient leaves the hospital and must manage the next stage alone.

The separation between interpersonal care and the treatment pathway is one of the clearest patterns in the data. Patients frequently praised individual staff while describing difficulty with appointments, handovers, or contact routes. In the terms used by Haggerty et al. (2003), relational continuity could be strong while informational and management continuity were weak. For health services, this means that positive comments about staff should not be taken as evidence that the pathway works well, and complaints about coordination should not be read as criticism of individual professionals.

Dignity and practical strain, though less frequent, help explain why some ordinary events became difficult. Being listened to, understanding available choices, and having privacy respected appeared within routine encounters, consistent with the view that dignity is conserved or eroded in everyday clinical behavior (Chochinov, 2007). Practical strain, meanwhile, placed treatment within patients' wider lives. Travel, work, and repeated attendance could weigh heavily even when care was evaluated favorably. Family and peers offered different kinds of help: relatives addressed logistics, while other patients offered recognition. The online setting itself may serve this second purpose, in line with research on how sharing experiences online can provide support and help people make sense of illness (Ziebland & Wyke, 2012).

For practice, the findings suggest several priorities. Patients may benefit from explanations that place each step within a clear sequence, from a named point of contact across transitions, and particularly from attention to the period after discharge. Services seeking to learn from online accounts should read them for their specific content

rather than their overall tone. Where automated tools are used for this purpose, persistent concerns about algorithmic opacity, fairness, and trust call for human-centered design (Habib Zadeh Khiyaban & Sabbar, 2026). And recognition of practical burdens, such as travel and work disruption, belongs within the scope of care even when they fall outside the clinical encounter.

LIMITATIONS

Several limitations qualify these findings. The corpus reflects the selective character of online publication: people who post about their treatment may differ from those who do not, and a single episode may prompt several posts. Because posts could not be linked to authors, counts refer to posts rather than patients, and repetition by the same writer could not be identified. Clinical context was incomplete and unverified, and the absence of an issue from a post is not evidence that it was absent from the experience. Restricting the corpus to English excludes other linguistic communities, and the writers' countries and health systems were unknown. No sampling frame was available, so the counts do not estimate prevalence among cancer patients. Coding boundaries shape both the theme counts and the Jaccard values. Finally, the study cannot attribute differences in accounts to particular hospitals, treatments, or patient characteristics, or evaluate clinical effectiveness.

FUTURE RESEARCH

Future studies could link online accounts to authors over time, with appropriate consent, to examine how experiences and evaluations change across a treatment trajectory. Comparative analyses across languages and health systems would show whether the separation between emotional tone and evaluation of care holds in other settings. Research combining narrative analysis with service data could also examine whether the coordination problems that patients describe correspond to identifiable gaps in continuity. Finally, studies of responses to posts could clarify how online communities answer requests for recognition and practical advice.

CONCLUSION

Cancer patients writing online about hospital treatment described a demanding bodily experience, persistent uncertainty, and continual effort to understand and navigate care. Their accounts connected the body, the institution, and everyday life, and they separated feeling from judgment: distress could accompany praise, and hope could accompany criticism. Uncertainty was most troubling when explanations failed to place events in a recognizable sequence, gratitude toward staff could coexist with difficulty navigating the pathway, and favorable care did not remove practical strain. These accounts are best understood as connected dimensions of experience, and efforts to learn from them should resist reducing them to a single score of satisfaction or sentiment.

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