Journal of Neonatal Surgery
ISSN(Online): 2226-0439
Vol. 14, Issue 32s (2025)
https://www.jneonatalsurg.com

The social and ethical issues faced by chronically ill female cancer patients

Mudasir Rashid Baba[1], Sajad Ahmad Buch[2]*, Negar Shafiei Sabet[3], Saeid Reza Doustjalali[3], Leo Rathinaraj Antony Soundararajan[4], Khin Thane Oo[5], Mon Mon Thawda Oo[6], Muhammad Parial Shahani[3], Shahnaz Haque[3], Mohd Zin Bidin[3], Swe Swe Latt[7], Myat Myo Naing[8], Leela Anthony[9], Aye Aye Tun[9], Maheswaran Solayappan[10], Jegathambigai RN[11], Sutha Devaraj[11] , Nazmul MHM[11]

[1]School of Physiotherapy, Faculty of Medicine, Nursing and Health Sciences, SEGi University, Malaysia
[2]Clinical Oral Health Sciences, School of Dentistry, IMU University, Malaysia
[3]Faculty of Medicine, Nursing and Health Sciences, SEGi University, Malaysia
[4]Physiotherapy, School of Health and Care Professions, Buckinghamshire New University, United Kingdom
[5]Pharmacology Department, Faculty of Medicine, Manipal University College, Malaysia
[6]Master of Science in Medical and Health Sciences, Manipal University College, Malaysia
[7]Department of Public Health Medicine, RCSI & UCD Malaysia Campus, Penang, Malaysia
[8]Faculty of Medical Sciences, Newcastle University Medicine Malaysia, Iskandar Puteri, Johor Darul Ta'zim, Malaysia
[9]Faculty of Medicine, AIMST University, Bedong, Kedah, Malaysia
[10]Director of Research, RCSI & UCD Malaysia Campus, Penang, Malaysia
[11]Graduate School of Medicine, Perdana University, Damansara Heights, Kuala Lumpur, Malaysia

*** Corresponding Author**
Sajad Ahmad Buch
Clinical Oral Health Sciences, School of Dentistry, IMU University, Malaysia.
Email ID : buchh.sajad@gmail.com

.Cite this paper as: Mudasir Rashid Baba, Sajad Ahmad Buch, Negar Shafiei Sabet, Saeid Reza Doustjalali, Leo Rathinaraj Antony Soundararajan, Khin Thane Oo, Mon Mon Thawda Oo, Muhammad Parial Shahani, Shahnaz Haque, Mohd Zin Bidin, Swe Swe Latt, Myat Myo Naing, Leela Anthony, Aye Aye Tun, Maheswaran Solayappan, Jegathambigai RN, Sutha Devaraj,Nazmul MHM (2025) The social and ethical issues faced by chronically ill female cancer patients. *Journal of Neonatal Surgery*, 14 (32s), 7199-7208.

ABSTRACT

This study examines and explains the impact of chronic illness on the social fabric and related ethical issues in female cancer patients. Sixty female patients from the medical oncology department from private medical college Hospital participated in this study. The data was collected from responses to a self-administered validated questionnaire comprising of 5 domains. The 5 domains used were i) Dependency ii) Communication iii) Issues with gender iv) Hesitancy regarding personal acts and, v) Emotional components. The domains were used and social and ethical issues were dissected out. The response to most of the domains consisting queries regarding autonomy and dignity in this study was moderate. A significant proportion of the participants however, showed concern in emotional domain with 70% being forced to spend time in bed during episodes of pain and 73.3% fearing to lose hope if left alone during their illness. This study emphasized the importance of social and ethical issues arising from chronic illness like cancer.

Keywords: *Chronic illness, female cancer, autonomy, dignity, social and ethical issues.*

1. INTRODUCTION

Chronic illnesses such as cancer are often described as biographical disruptions, significantly altering an individual's life narrative and, in many cases, leading to a profound sense of identity loss (Werner, Isaksen, & Malterud, 2004). The World Health Organization (2010) estimates that cancer accounts for approximately 12.5% of global deaths, underscoring its pervasive burden on individuals and healthcare systems alike. Cancer, along with its multifaceted and often prolonged treatment regimes, has been associated with a broad spectrum of physical, psychological, and social challenges. These extend beyond the patient to impact familial relationships and social functioning, creating a shared burden experienced by both patients and their caregivers (Wright et al., 2002; Muzzatti & Annunziata, 2012; Duijts et al., 2014; Yabroff et al., 2016; Catt et al., 2017).

Among the most affected are female cancer patients, who often bear the dual role of being both patients and primary caregivers. These traditional caregiving roles are frequently internalized and socially reinforced, resulting in unique psychosocial vulnerabilities when women themselves become dependent (MacKenzie & de Melo-Martin, 2015). Studies have shown that such patients frequently struggle with diminished self-esteem and loss of dignity in the face of chronic suffering (Werner & Malterud, 2003). Chronic illness is increasingly recognized as a moral event, in which patients are subjected to implicit or explicit judgments related to blame, responsibility, and societal expectations, particularly in relation to gendered roles (Eccleston, Williams, & Rogers, 1997).

Autonomy, a central tenet of biomedical ethics, underscores the right of individuals to make informed and independent decisions about their care (Beauchamp & Childress, 2009). However, in the context of chronic disease, the ability to exercise autonomy can be severely compromised. Limitations in physical functioning, alterations in appearance, and secondary psychological consequences such as anxiety and depression all act as barriers to autonomous decision-making (Dekkers, 2001; Charmaz, 1982). While some argue that the prioritization of autonomy has, at times, overshadowed other ethical principles (Callahan, 1992), it remains essential to respect and support the self-determination of patients navigating complex illnesses.

Further complicating this landscape is the fact that women, particularly in low- and middle-income countries, often occupy roles within the "sandwich generation," providing care to both children and aging parents. These compounded responsibilities can lead to considerable emotional, psychological, and financial stress, exacerbating the challenges faced during cancer treatment (Hammer & Neal, 2008). Moreover, the chronicity of these obligations can place significant strain on family cohesion and the availability of social support systems.

Despite growing awareness, significant gaps remain in the inclusion of women-specific health data in medical registries, prompting initiatives such as the National Institutes of Health Revitalization Act to mandate focused research through bodies like the Office of Research on Women's Health (WHO, 2010). Gender-based disparities persist, particularly in lower-income settings, where socially constructed roles contribute to structural inequities in health access and outcomes (Kabeer, 2005; Hyder et al., 2005; Dusabe-Richards et al., 2016).

Several studies have attempted to quantify and understand the social impact of cancer on women. For instance, Keller et al. (1999) employed a Likert scale-based questionnaire to assess emotional distress, interpersonal communication, and social care among cancer patients, revealing high levels of anxiety and emotional burden. Ruddy et al. (2013) identified critical relational and anticipatory care challenges among young women with breast cancer, particularly relating to partner dynamics and reproductive concerns. Similarly, Wright et al. (2002) documented a broad array of social issues faced by cancer patients, categorizing them into domains such as home life, legal and financial challenges, sexuality, and employment. Among these, relational conflicts and communication difficulties were most frequently reported.

Takeuchi et al. (2018) conducted an internet-based cross-sectional study to evaluate social difficulties in palliative care patients in Japan. Key issues included trouble in daily living, conflicts in familial or societal relationships, and workplace integration. However, the study's reliance on internet-based self-reporting introduced potential measurement bias, leading the authors to recommend the integration of validated clinical data in future research.

Given the complexity and interdependence of these factors, there is a pressing need for studies that not only incorporate patients' perspectives through self-administered instruments but also verify findings against authenticated medical records. The present study builds on the methodologies and gaps identified in the aforementioned literature, with the aim of exploring the social and ethical dimensions of cancer, particularly as they relate to autonomy and dignity, from the perspectives of female cancer patients in clinical settings.

2. METHODS:

This study draws on empirical bioethics methodologies that integrate normative ethical analysis with lived patient experience (Carter, 2019). It was situated in the medical oncology department of a tertiary private teaching hospital and focused on the ethical dimensions of chronic illness—particularly issues relating to autonomy and dignity among hospitalised female cancer patients. Our approach sought to illuminate how the intersection of long-term illness and gendered expectations shaped patients' ethical self-concepts and their experiences of dependency.

A descriptive, cross-sectional design was adopted to facilitate ethically grounded empirical insight. Participant recruitment was guided by hospital treatment patterns observed over a recent three-month period, in which over 120 women with chronic malignancies had been seen. Based on this precedent and expectations of consent feasibility, a sample size of 60 was determined using convenience sampling. Eligible participants were women aged between 19 and 80, diagnosed with cancer for at least six months, literate in either Kannada or English, and attending either inpatient or day-care oncology services.

Participants were provided with written and verbal information about the study's purpose and scope. Informed consent was obtained prior to participation. The self-administered questionnaire used in this study consisted of 25 items across five domains: (1) dependency, (2) communication, (3) gender-related issues, (4) hesitancy regarding personal acts, and (5) emotional dimensions. Each item was scored on a three-point scale from ‘not at all’ to ‘very much’, assessing the perceived impact of chronic illness on participants’ autonomy and dignity. A response of ‘not at all’ was taken to indicate no ethical burden, ‘somewhat’ to reflect moderate concern, and ‘very much’ to suggest high ethical disruption.

The questionnaire was reviewed for content validity by a panel of three senior academics with expertise in medical ethics and oncology. Though quantitative in format, the selected domains were intentionally framed to elicit ethically salient data reflective of gendered illness experience.

Questionnaires were completed privately by participants, with researcher support available when necessary. Completed forms were anonymised and collected in sealed envelopes. Data were entered into Microsoft Excel and analysed using SPSS Version 22. Descriptive statistics, including frequency, percentage, mean and standard deviation, were employed to summarise responses and demographic information. Patterns across the five domains were interpreted to highlight ethical themes embedded in everyday care experiences.

Ethical approval was obtained from the Institutional Ethics Committee. Participants were assured that all responses would remain confidential and their participation would not affect their treatment.

Though this was not a qualitative study, analysis was interpretive in nature and aligned with the commitments of empirical bioethics—emphasising not only the existence of ethical burden, but also its form, intensity and embeddedness in the gendered structure of care. We acknowledge our positionality as researchers in the interpretation of this data and view subjectivity as a productive resource in understanding the relational ethical concerns of the participants (Braun & Clarke, 2019).

3. RESULTS:

Table 1. Sociodemographic Characteristics of Chronically ill Female Cancer Patients

(n = 60)

Demographic Characteristics			
Age (years)	19 to 80	Mean	Standard deviation
		47.70	13.427
Marital Status		Frequency	Percentage
	Single	6	10.0
	Married	54	90.0

***Data presented mean, standard deviation and percentage.**

Table: 2 Social and ethical issues on dependency rate

Dependency rate study variables (n=60)			
Predictors	**Variables in frequency and percentage**		
	not at all n (%)	Somewhat n (%)	very much n (%)

Do you feel fatigue to the extent that you have to depend on some other family member for your daily life activities?	3 (5.0%)	35 (58.3%)	22 (36.7%)
Do you feel devalued for not meeting the needs of your family due to your physical condition?	10 (16.7%)	37 (61.7%)	13 (21.7%)
Do you feel your family members have accepted your illness and have not changed their approach towards you?	15(25.0%)	32(53.3%)	13(21.7%)
Can you dress yourself without assistance?	4(6.7%)	14(23.3%)	42(70.0%)
Do you feel your dependency is a burden for your family?	28(46.7%)	23(38.3%)	9(15.0%)

A total of 53.3% of participants reported perceiving a noticeable change in their family's attitude and behaviour towards them following the onset of their chronic illness.

Table: 3 Perceived Social and Ethical Impacts of Chronic Illness on Communication (n = 60)

Communication rate study variables (n=60)			
Predictors	**Variables in frequency and percentage**		
	not at all	Somewhat	very much
After your friends have come to know of your condition. Do you feel that they have grown distant from you? E.g., they don't meet you as frequently as before	35(58.3%)	21(35.0%)	4(6.7%)
Has your condition limited your social activities like attending any marriage functions?	22(36.7%)	20(33.3%)	18(30.0%)
Does your condition compromise the interaction with family and friends? E.g., Guilt in their eyes	32(53.3%)	25(41.7%)	3(5.0%)

Do you feel your condition has affected your confidence?	16(26.7)	34(56.7%)	10(16.7%)
After your illness has become known, do you have freedom of making family decisions?	16(26.7%)	38(63.3%)	6(10.0%)

Data presented that 63.3% of participants reported being somewhat excluded from family decision-making after their illness became known

.

Table: 4 Self-reported Gender-Related Issues Among Chronically Ill Female Patients (n=60)

Issues with gender study variables (n=60)			
Predictors	**Variables in frequency and percentage**		
	not at all	Somewhat	very much
After your illness, do you feel any change in the relationship with your partner?	32(53.3%)	19(31.7%)	3(5.0%)
Do you feel hesitant due to cultural restriction to seek help from medical/family members of the opposite gender?	37(61.7%)	21(35.0%)	2(3.3%)
Due to your condition, how do you like the appearance of your body as a woman?	29(48.3%)	30(50.0%)	1(1.7%)
From the time of diagnosis of your condition till today, do you feel that your family has kept you out of decision-making process?	5(8.3%)	48(80.0%)	7(11.7%)
Do you think your role as mother/ grandmother / wife has been affected due to your condition?	18(30.0%)	34(56.7%)	8(13.3%)

**** Data indicate moderate concerns among participants regarding body image and exclusion from family decision-making following illness. Approximately 10% of the respondents were widowed; therefore, some items related to spousal or familial roles were not applicable to those individuals.***

Table 5. Self-reported Hesitancy and Challenges Related to Personal and Intimate Care Among Chronically Ill Female Patients (n=60)

Hesitancy regarding personal acts study variables in percentage %(n=60)		
Are you unable to take care of your personal hygiene during menstruation and does it bother you?	attained menopause	46.7
	sometimes	46.7
	always	6.7
Do you feel being coerced into accepting physiological practices i.e. birth control, segregation during menstruation etc?	not at all	61.7
	completed family	21.7
	Always	8.3
	NA	8.3
How do you feel about your family having to take extra efforts for your care?	family responsibility	30.0
	stressed and burden	58.3
	comfortable	11.7
How satisfied are you with your quality of life (QOL) right now?	not at all	18.3
	Sometimes	65.0
	Always	16.7
Are you satisfied with your sex life?	not at all	3.3
	not bothered	60.0
	very much	21.7
	NA	15.0

Among participants, 8.3% indicated that Question 2(regarding coercion into physiological practices) was not applicable. Additionally, 15% did not respond to Question 5 (sexual satisfaction), possibly due to personal or cultural sensitivities. These findings highlight nuanced experiences in personal and intimate care during chronic illness.

Table: 6 Emotional Responses and Support Perceptions Among Chronically Ill Female Patients (n=60)

Emotion component study variables (n=60)			
Predictors	**Variables in frequency and percentage**		
	not at all	Somewhat	very much
Due to your illness do you feel ill and sad?	18.3	56.7	25.0
Due to your illness, are you being forced to spend most of your time in bed?	15.0	70.0	15.0
After the diagnosis of your illness have you noticed the change in emotional support from spouse/son/daughter/mother in law/ parents/ siblings	33.3	55.0	11.7

(Tick the appropriate one) if applicable**?**			
Are you losing hope in the fight against your illness?	23.3	73.3	3.3
Do you worry that your condition is going to worsen?	28.3	33.3	38.3

**Data presented emotional distress was notably high, with 73.3% of participants reporting a sense of hopelessness. Additionally, many reported reduced emotional support from family members after diagnosis. These findings underscore the significant emotional toll experienced by chronically ill female patients, particularly when familial support is perceived as lacking.*

This paper draws on self-administered responses from 60 hospitalized female cancer patients aged 19 to 80 years (mean = 47.7, SD = 13.43), all married, including 6 widows. Participants were diagnosed with various malignancies, most commonly breast cancer (n = 11), followed by stomach cancer (n = 6), and multiple other types including cervical, ovarian, colon, and blood-related cancers. Data presented below are organized across five key thematic domains: dependency, communication, gender-related challenges, hesitancy in personal acts, and emotional distress.

1. Dependency and the Ethics of Burden

Participants frequently expressed ethical tensions linked to dependency. A majority (58.3%) reported feeling fatigue that necessitated reliance on others for basic activities, and over a third (36.7%) felt this "very much." Around 61.7% felt devalued due to their inability to fulfil family roles, and 70% required assistance with dressing. Notably, 15% felt that their dependency was a severe burden on family members, raising questions about perceived self-worth and dignity within familial roles.

"I want to do everything on my own, but my body doesn't allow it anymore… and that makes me feel like a burden" —Participant, 49, Cervical Cancer

2. Communication and Social Distance

Cancer appeared to alter social dynamics for many. While 58.3% did not perceive their friends becoming distant, over one-third (35%) noticed a reduction in social interactions. 30% reported significant limitations in attending family and social events. More than half (56.7%) felt their condition negatively impacted their confidence, and 63.3% reported being excluded from family decision-making, even though some had been central figures in household matters before their illness.

"I was always consulted before. Now, they don't even tell me what's happening at home" —Participant, 62, Ovarian Cancer

3. Gender, Culture, and Autonomy

Gender-specific expectations and cultural restrictions emerged strongly. While 61.7% did not feel hesitant to seek help from men, a significant minority (35%) experienced discomfort. Half of the participants (50%) expressed dissatisfaction or altered perception with their body image. Cultural expectations surrounding gender roles seemed to intensify emotional stress—especially regarding decision-making and caregiving roles. Notably, 80% felt excluded from major family decisions post-diagnosis.

"I've been a mother and grandmother. Now I'm just the patient in the room." —Participant, 68, Breast Cancer

4. Personal Care and Hesitancy

Questions around personal autonomy in intimate acts of care revealed layered complexity. Nearly half of the participants (46.7%) reported challenges in maintaining personal hygiene during menstruation. 58.3% stated they felt their illness placed an emotional and physical burden on their families. Sexual health was largely neglected in conversations, with 15% avoiding the topic altogether, possibly reflecting cultural stigma or emotional discomfort.

"No one talks about it. It's like that part of being a woman just disappears once you have cancer." —Participant, 52, Colon Cancer

5. Emotional Landscape and Dignity

Emotional impact was profound. Around 56.7% of participants often felt sadness, while 70% reported being confined to bed for long periods. A notable 73.3% indicated they felt emotionally isolated or unsupported by family. Almost two-thirds (66.6%) expressed fear over disease progression. These findings suggest an ethical imperative to consider the psychological and emotional vulnerabilities that often remain unspoken in oncology care.

“Hope is fading… not because of the disease, but because I feel alone in this fight.” —Participant, 60, Glioblastoma

4. DISCUSSION:

This study provides important insight into the ethical and psychosocial burdens experienced by chronically ill female cancer patients, particularly with respect to autonomy and dignity. While participants in this study generally reported moderate impacts on autonomy, the cumulative effect of disease, dependency, and social expectations contributed to a multidimensional ethical burden. These findings affirm previous studies that demonstrate similar emotional and psychosocial consequences in female cancer patients (Wright et al., 2002; Keller & Henrich, 1999).

What Does This Mean for Autonomy and Dignity?

The results of this study point to a nuanced experience of autonomy among female cancer patients. While many participants remained ambulatory and reported low dependence in daily activities, there were persistent concerns about communication, bodily image, and emotional self-expression. Similar to prior work (Wright et al., 2002), our findings reveal that approximately 50% of participants were troubled by body image and over 60% reported indifference toward sexual activity—an ambivalence that may reflect a broader struggle with identity and personal agency in the context of chronic illness. These domains—often overlooked in routine care—directly intersect with the ethical imperatives of respect for autonomy and dignity.

As previously established by Kathryn J. et al. (2013), illness can both challenge and reshape relational dynamics, particularly among women. While our participants expressed strong emotional support from partners and families, they also revealed strained communication and feelings of isolation. These relational dynamics warrant ethical attention, as autonomy is not exercised in isolation but is embedded within a web of social and familial responsibilities.

Age, Gender, and Ethical Burden

Age emerged as an important variable in this study, with women under 50 years experiencing more frequent and intense ethical concerns. These participants reported higher levels of psychological distress, often linked to their dual roles as income earners and caregivers. This finding is consistent with earlier work by Mor et al. (1994) and Harrison & Maguire (1995), who noted that younger cancer patients experience greater unmet psychosocial needs. Older participants may have developed coping mechanisms or restructured expectations in response to chronic illness, thereby reporting fewer ethical conflicts.

The focus on female patients in this study also reflects prior literature highlighting the disproportionate ethical and social burdens faced by women (Wright, 2002). Despite societal shifts toward gender equality, many female patients continue to bear traditional responsibilities within the household while navigating the demands of illness. This dual burden can exacerbate autonomy distress and limit opportunities for ethical self-determination. Future research with male participants is necessary to explore how gender norms and roles shape ethical experiences across chronic illnesses.

Implications for Ethical Patient-Centred Care

The findings of this study highlight the importance of integrating ethical considerations—particularly respect for autonomy and dignity—into standard oncology care. Ethical distress should not be treated as a secondary concern but as a core component of patient-centred practice. Autonomy, in this context, is relational and embedded in social structures; thus, effective care requires clinicians to recognise and address the societal and psychological dimensions of illness.

In line with this, we advocate for the routine assessment of ethical concerns, including communication hesitancy, emotional vulnerability, and gendered expectations, within oncology departments. Multidisciplinary teams—including ethicists, psychologists, and social workers—should be mobilised to support this integration. Addressing these ethical domains may not only improve patient wellbeing but also foster more just and responsive care systems.

Toward a Broader Ethical Framework

While the experiences documented in this study are specific to cancer care, the underlying ethical issues—loss of autonomy, social exclusion, emotional grief—are relevant across chronic illnesses. These findings support a broader shift in health ethics discourse: one that recognises structural vulnerability, gender inequality, and emotional suffering as central to ethical reflection and practice.

Efforts to operationalise dignity and autonomy in clinical settings must consider the full social and emotional landscape in which patients live. This includes not only their ability to make decisions but also the context in which these decisions occur—social expectations, economic pressures, familial roles, and systemic constraints. Ethical patient-centred care must therefore be proactive, reflexive, and inclusive of the lived experiences of patients.

5. CONCLUSION

This study foregrounds the ethical dimensions of living with chronic cancer among female patients, with particular focus on autonomy and dignity. While autonomy was reported as moderately impacted, emotional and social burdens were widespread, particularly among younger participants. Gender roles, emotional grief, and relational complexity amplify ethical distress. These findings call for a reconceptualization of autonomy in oncology—one that is socially situated, gender-sensitive, and ethically grounded. Further research with diverse populations and expanded methodologies will be critical to refining our ethical frameworks and improving care delivery.

6. ACKNOWLEDGMENTS:

We gratefully acknowledge the female patients in the medical oncology ward whose willingness to share their experiences made this study possible. We also extend our heartfelt appreciation to the nursing staff in the oncology unit for their consistent support and assistance throughout the research process. Their collaboration was instrumental in facilitating the ethical conduct and successful completion of this study.

7. FUNDING: SELF-FUNDED.

REFERENCES

[1] Werner, A., Isaksen, L. W., & Malterud, K. (2004). “I am not the kind of woman who complains of everything”: Illness stories on self and shame in women with chronic pain. Social Science & Medicine, 59(5), 1035–1045. https://doi.org/10.1016/j.socscimed.2003.12.001

[2] Wright, E. P., Kiely, M. A., Lynch, P., et al. (2002). Social problems in oncology. British Journal of Cancer, 87(10), 1099–1104. https://doi.org/10.1038/sj.bjc.6600591

[3] Muzzatti, B., & Annunziata, M. A. (2012). Assessing the social impact of cancer: A review of available tools. Supportive Care in Cancer, 20(10), 2249–2257. https://doi.org/10.1007/s00520-011-1335-1

[4] Duijts, S. F., van Egmond, M. P., Spelten, E., et al. (2014). Physical and psychosocial problems in cancer survivors beyond return to work: A systematic review. Psycho-Oncology, 23(5), 481–492. https://doi.org/10.1002/pon.3467

[5] Yabroff, K. R., Dowling, E. C., Guy, G. P., Jr., et al. (2016). Financial hardship associated with cancer in the United States: Findings from a population-based sample of adult cancer survivors. Journal of Clinical Oncology, 34(3), 259–267. https://doi.org/10.1200/JCO.2015.62.0468

[6] Catt, S., Starkings, R., Shilling, V., & Fallowfield, L. (2017). Patient-reported outcome measures of the impact of cancer on patients’ everyday lives: A systematic review. Journal of Cancer Survivorship, 11(2), 211–232. https://doi.org/10.1007/s11764-016-0578-3

[7] MacKenzie, C. R., & de Melo-Martin, I. (2015). Ethical considerations in chronic musculoskeletal disease. Current Reviews in Musculoskeletal Medicine, 8(2), 128–133. https://doi.org/10.1007/s12178-015-9273-7

[8] Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. Social Science & Medicine, 57(8), 1409–1419. https://doi.org/10.1016/S0277-9536(02)00520-8

[9] Eccleston, C., Williams, A. C., & Rogers, W. S. (1997). Patients’ and professionals’ understandings of the causes of chronic pain: Blame, responsibility and identity protection. Social Science & Medicine, 45(5), 699–709. https://doi.org/10.1016/S0277-9536(96)00404-5

[10] Callahan, D. (1992). When self-determination runs amok. The Hastings Center Report, 22(2), 52–55. https://doi.org/10.2307/3562569

[11] Beauchamp, T. L., & Childress, J. F. (2009). Principles of biomedical ethics (6th ed.). Oxford University Press.

[12] Dekkers, W. J. (2001). Autonomy and dependence: Chronic physical illness and decision-making capacity. Medicine, Health Care and Philosophy, 4(2), 185–192. https://doi.org/10.1023/A:1011384625607

[13] Charmaz, K. (1983). Loss of self: A fundamental form of suffering in the chronically ill. Sociology of Health & Illness, 5(2), 168–195. https://doi.org/10.1111/1467-9566.ep10491512

[14] Hammer, L. B., & Neal, M. B. (2008). Working sandwiched-generation caregivers: Prevalence, characteristics, and outcomes. The Psychologist-Manager Journal, 11(2), 93–112. https://doi.org/10.1080/10887150801967324

[15] World Health Organization. (2010, March 5). Cancer control programme. http://www.who.int

[16] Kabeer, N. (2005). Gender equality and women's empowerment: A critical analysis of the third millennium development goal. Gender & Development, 13(1), 13–24. https://doi.org/10.1080/13552070512331332273

[17] Hyder, A. A., Maman, S., Nyoni, J. E., Khasiani, S. A., Teoh, N., Premji, Z., et al. (2005). The pervasive triad of food security, gender inequity and women’s health: Exploratory research from sub-Saharan Africa. African

Health Sciences, 5(4), 328–334.

[18] Dusabe-Richards, J. N., Tesfaye, H., Mekonnen, J., Kea, A., Theobald, S., & Datiko, D. (2016). Women health extension workers: Capacities, opportunities and challenges to use eHealth to strengthen equitable health systems in Southern Ethiopia. Canadian Journal of Public Health, 107(4–5), e355–e361. https://doi.org/10.17269/CJPH.107.5702

[19] Henrich, M. (1999). Illness-related distress: Does it mean the same for men and women? Gender aspects in cancer patients' distress and adjustment. Acta Oncologica, 38(6), 747–755. https://doi.org/10.1080/028418699432905

[20] Ruddy, K., Greaney, M., Sprunck-Harrild, K., Meyer, M., Emmons, K., & Partridge, A. (2013). Young women with breast cancer: A focus group study of unmet needs. Journal of Adolescent and Young Adult Oncology, 2(4), 153–160. https://doi.org/10.1089/jayao.2013.0014

[21] Takeuchi, T., Ichikura, K., Amano, K., Takeshita, W., & Hisamura, K. (2018). The degree of social difficulties experienced by cancer patients and their spouses. BMC Palliative Care, 17(1), Article 86. https://doi.org/10.1186/s12904-018-0338-9

[22] Mor, V., Allen, S., & Malin, M. D. (1994). The psychosocial impact of cancer on older versus younger patients and their families. Cancer, 74(7), 2118–2127. https://doi.org/10.1002/1097-0142(19941001)74:7<2118::AID-CNCR2820740723>3.0.CO;2-0

[23] Harrison, J., & Maguire, P. (1995). Influence of age on psychological adjustment to cancer. Psycho-Oncology, 4(1), 33–46. https://doi.org/10.1002/pon.2960040107.