Supplementary File 1: COREQ checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

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Item No	Guide Questions/Description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group?	Pg 4
2. Credentials	What were the researcher’s credentials? E.g., PhD, MD	Suppl. File 2
3. Occupation	What was their occupation at the time of the study?	Suppl. File 2
4. Gender	Was the researcher male or female?	Suppl. File 2
5. Experience and training	What experience or training did the researcher have?	Suppl. File 2
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Pg 7
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research?	Pg 7
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Pg 7
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Pg 7-8 & Suppl. File 3
Participant selection		

Item No	Guide Questions/Description	Reported on Page #
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	Pg 6
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	Pg 6
12. Sample size	How many participants were in the study?	Pg 8
13. Non-participation Setting	How many people refused to participate or dropped out? Reasons?	Pg 8
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	Pg 7
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers?	Pg 7
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Pg 8 & Table 3
Data collection		
17. Interview guide	Were questions, prompts, and guides provided by the authors? Was it pilot tested?	Pg 6-7 & Table 1
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	Pg 8
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Pg 7
20. Field notes	Were field notes made during and/or after the interview or focus group?	Pg 7
21. Duration	What was the duration of the interviews or focus group?	Pg 6
22. Data saturation	Was data saturation discussed?	N/A
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Table 2
25. Description of the coding tree	Did the authors provide a description of the coding tree?	Table 2
26. Derivation of themes	Were themes identified in advance or derived from the data?	Table 2
27. Software	What software, if applicable, was used to manage the data?	Pg 7

Item No	Guide Questions/Description	Reported on Page #
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	Table 4 & Suppl. File 4
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Pg 8-9-10-11 & Table 4 & Suppl. File 4
31. Clarity of major themes	Were major themes clearly presented in the findings?	Pg 8-9-10-11 & Table 4 & Suppl. File 4
32. Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes?	Pg 8-9-10-11 & Table 4 & Suppl. File 4

Supplementary File 2 - Focus group facilitators's and researchers profiles

GB	GB is a physiotherapist and a PhD student at the University of Genova (Genova, Italy). GB has more than ten years of clinical experience in cancer rehabilitation, and he is a temporary lecturer in cancer and palliative rehabilitation at the BSc in Physiotherapy at the University of Brescia (Brescia, Italy). GB identifies as a man.
SB	SB is a physiotherapist with joint PhD in Neurosciences and Medical Science, a Research Fellow at the University of Salford (Salford, United Kingdom). SB identifies as man.
SP	SP is a philosopher with a PhD in bioethics and assistant professor at the University of Verona (Verona, Italy). SP identifies as a woman.
VC	VC is a physiotherapist with more than 5 years of clinical experience in oncological rehabilitation, and she is a temporary lecturer in oncological and palliative rehabilitation at the BSc in physiotherapy at the University of Milano Bicocca (Milano, Italy). VC identifies as a woman.

Supplementary file N°3 - Reflexive Thematic Analysis

We adopted Reflexive Thematic Analysis (RTA) for data analysis. RTA is an interpretive approach to qualitative data analysis "that facilitates the identification and analysis of patterns or themes in a given data set".[1,2] RTA is situated in a 'Big Q' qualitative paradigm characterised by adhering to a non-(post) positivist paradigm. [3] Thus, some qualitative practices do not apply to RTA (e.g., consensus coding, inter-coder reliability, data saturation, member checking, etc.) as they are infused "with assumptions about the nature of reality and meaningful knowledge" that follow a 'small q' (postpositivist) paradigm.[4,5] Besides, RTA is characterised by researchers' active and creative role in interpreting codes and themes, becoming a resource to tap into rather than a bias.[5] In our study, RTA was primarily conducted with an inductive approach: codes for focus group analysis were produced based on the content of the data.[6] From the perspective of epistemological conception, our study has adopted a constructionist approach as we appreciated meaning and meaningfulness as the main criteria in the coding process.[6] In the focus group analysis, the reflections on knowledge and competencies needed by the oncology rehabilitation physiotherapist were prioritised to answer our research question. An experiential orientation was used in the analysis of this study. This lens considered participants' thoughts, experiences, and feelings as a reflection of their states.[6] The data coding was mainly semantic as we do not think we always went beyond the explicit or surface meanings of the data.[2] Thus, the six steps of the RTA were followed for the focus group analysis (see Table 2).[2] No software was used to assist the coding process.

References:

1 Braun V, Clarke V. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res*. 2021;21:37–47.

2 Braun V, Clarke V. *Thematic Analysis: A Practical Guide*. SAGE Publications 2021. https://books.google.se/books?id=mToqEAAAQBAJ

3 Braun V, Clarke V. Is thematic analysis used well in health psychology? A critical review of published research, with recommendations for quality practice and reporting. *Health Psychol Rev*. 2023;1–24.

4 Braun V, Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *https://doi.org/101080/2159676X20191704846*. 2019;13:201–16.

5 Braun, V., & Clarke V. *Thematic Analysis: A Practical Guide*. SAGE Open Med 2021. https://uk.sagepub.com/en-gb/eur/thematic-analysis/book248481

6 Byrne D. A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Qual Quant*. 2022;56:1391–412.

Supplementary file 4 - Additional quotations

Theme 1: Navigating the Complexities of Non-Disclosure in Communicating Diagnosis and Prognosis	
Codes defined by the researchers	**Example of quotes extracted from the focus groups**
Navigating Diagnosis/Prognosis Disclosure: Implications on Informed Consent/Disagreement	‘In this context, unfortunately, when working with half-truths, we always find ourselves on difficult ground, a terrain where it might seem like the physiotherapist has an easier time managing the situation by avoiding saying everything. However, it forces us to live in this grey area, in this land of the unsaid, which is always a complex terrain. Being able to communicate clearly, directly, and precisely with a patient who knows their situation allows us to work with simpler and more linear objectives and methods. If a patient who knows the diagnosis wants to walk, even if it's an activity beyond their capabilities, we can attempt it, just as when the patient doesn't know the truth’ (P2 – Man – 54) ‘For example, I have many patients who come after undergoing surgery for breast cancer. I often find myself in the situation of having to explain to the patient the type of surgery she underwent because at the time of signing the informed consent documents at the referring institution where she underwent the operation, she has no idea of what the surgery entails in terms of postoperative care and subsequent surgeries already planned due to the nature of the initial intervention. This often happens with breast reconstructions, where the patient is put in a situation where she will be reconstructed with an expansion prosthesis, but she is not truly aware of the course of further surgeries she will have to undergo. Many of them come to the point of saying, if I had known, I wouldn't have undergone reconstruction, probably because both from a functional and from a point of view of everything they cannot have through the national health service as rehabilitative treatments. This affects both their perception of themselves and their function, as well as economically. It is an important issue’. (P30 – Woman – 30)
Bridging the Gap: Ethical and Legal Communication with Caregivers	‘Despite the law stating that the patient should be informed of the diagnosis, often this doesn't happen. So, we find ourselves at the patient's home facing huge difficulties because the family puts up a wall and tells us not to disclose the diagnosis. They ask us to come up with a more digestible illness. This seriously puts us in difficulty, even though we know what we should do. Dealing with a patient who is not informed of the diagnosis poses a series of care-related issues. Additionally, the patient's collaboration in physiotherapy is compromised. If the patient were informed about the progression of the disease and prognosis, they would understand the importance of early intervention by the physiotherapist, which could slow down the loss of function’ (P5 – Woman – 39) ‘Often, I find myself facing a dilemma during my shift, especially when we have a patient who hasn't been informed of their diagnosis and has a family that tends to shield them. Recently, I encountered a patient who also has musculoskeletal problems, which restrict their mobility. Additionally, they have bone metastases that increase the risk of fractures. I have to navigate between the family's requests, which sometimes oppose necessary procedures, and the patient's desire to remain active and engage in certain activities. However, the patient is unaware and doesn't know the real risks, and it's not easy in those situations’ (P6 – Woman – 28)
Addressing Uncomfortable Questions: Managing Patient Discomfort	‘And not to mention the question "Why me?" This is really difficult to deal with. For me, it's really hard to answer this question. My response is simply listening. I haven't found a right answer, so what is the right response here? And, of course, sometimes I try to approach it with

	humour, not to diminish, but simply to say that this, for better or worse, is everyone's fate, isn't it?’ (P13 – Woman – 45) ‘I often find myself facing complex and uncomfortable questions: to what extent can I express my opinions or address certain issues without encroaching on the role of other professional figures? It's a delicate aspect that I often have to deal with, especially considering how empathy is fundamental in our work’ (P11 – Woman – 26)
Theme 2: Managing Patient Expectations between Hope and Realism	
Codes defined by the researchers	**Example of quotes extracted from the focus groups**
Aligning Patient Expectations with Physiotherapist Goals	‘A common issue I often notice is that patients arrive with rehabilitation expectations because they've been told they'll be transferred to a hospice for extensive physiotherapy, to get back on their feet, and then return home. These patients often have unrealistic expectations and sometimes beyond my timeframe. They believe they've come to a rehabilitation facility and therefore expect intensive physiotherapy. Fortunately, I work in a team with a psychologist and doctors always available, and we are very unified in our communication. Together, we try to explain to patients that they are not there to undergo extensive physiotherapy but will receive what is necessary based on their capabilities’ (P27 – Woman – 59) ‘My will is aligned with that of the person I have as a patient, so I often find myself facing this issue, namely how much my willpower weighs in comparison to the rehabilitation proposals and the actual needs of the patient. I believe that the theme of the physiotherapist's expectations versus the patient's needs is crucial. Personally, I have realized that sometimes my expectations were excessive compared to the real needs of the patient. I am gradually learning to manage this better, relying more on empathy and taking into account the actual needs of the patient’ (P13 – Woman – 45)
Harmonizing Caregiver/Family Expectations with Physiotherapist/Team Objectives	‘It is important to consider the sharing of goals and expectations not only with the patient but also with the caregiver. At times, the caregiver may prefer that certain information not be disclosed to the patient, creating a dual aspect of uncertainty. I may desire to be honest with the patient about certain topics rather than creating an illusion, but this may conflict with the caregiver's preferences. Therefore, harmonizing the caregiver's expectations with achievable goals becomes crucial’ (P17 – Woman – 28) ‘When I suddenly find myself facing the patient during the assessment, I have to evaluate the situation on the spot. In these cases, the patient's and the family's expectations are often very high, which can make the situation complicated. I always try to be honest with the patient, explaining that before seeing significant improvement, it's necessary to carefully assess the conditions and that I don't want to foster false hopes. The main difficulty in these cases is communication, so I try to discuss the situation with the team to ensure there's uniform and clear communication. If this communication doesn't happen, the patient's and the family's unrealistic expectations can become a problem’ (P16 – Man – 37)
Theme 3: Balancing Efficacy and Safety in Cancer Rehabilitation	
Codes defined by the researchers	**Example of quotes extracted from the focus groups**

Rehabilitation: Handling Clinical Outcomes and Risk Management	‘The patient has metastases throughout the spine. We know very well that there isn't a brace for the entire spine. However, the patient has no pain and wants to get up. What do you do in that case? In good conscience, you tell him no, but he says he doesn't care. I know perfectly well what I have, I want to get up anyway. At this point, it becomes an ethical issue again. From my professional point of view, I cannot condone such a thing. At the same time, I may not deny him the possibility of getting up. I still have to protect myself somehow, so again, I say okay, I acknowledge his decisions, maybe we'll discuss it briefly in a mini-team, with the doctor, with the team-leader’ (P14 – Man – 60) ‘As for sharing objectives and bearing risks, it's clear that when facing patients who aren't fully aware, there's a risk of future lawsuits because they expected certain outcomes or because there wasn't enough clarity on objectives or prognosis. It's evident that, to meet the family's demands, one exposes oneself both professionally and legally. The risk is always looming, especially in today's times, where lawsuits are rather common. We must be very cautious’. (P8 – Woman – 43)
Advancing Research in Cancer Rehabilitation	‘When proposing an interventional research project, there's a great deal of expectation from patients. Some are deeply involved in research, hoping to find benefits for themselves and others. It's a generous and admirable motivation, but sometimes I get the feeling that patients don't fully understand what we're trying to study. There are different expectations compared to what we can actually offer them. We often ask them to attend additional appointments and fill out lengthy questionnaires, but I always wonder if I'm truly doing them good. It's an ethical dilemma that haunts me, because I want patients to participate, but at the same time, I want to make sure I'm not further exhausting them’ (P26 – Woman – 52)
Theme 4: Deciding on Discontinuation of Care	
Codes defined by the researchers	**Example of quotes extracted from the focus groups**
Identifying Therapeutic Futility: Determining When Treatment Becomes Ineffective	‘One issue we often discuss is when to stop treatment. Some colleagues choose to stop when the patient refuses further treatment or becomes too weak, while others, like myself, believe in accompanying the patient until the end, as there's always something we can do to help. This lack of clear guidelines means each of us decides what we think is best. Personally, I feel it's important to continue providing care, especially in palliative situations where both the patient and their family need our support until the end’ (P5 – Woman – 39) ‘In practical terms, sometimes the patient accepts you because they see a glimmer of hope. Perhaps they are aware of their illness. However, even knowing they are facing death, they try to cling to anything, and so they see the physiotherapist as a hope to continue living. However, at times we are faced with a clinical condition where physiotherapy, so to speak, is no longer appropriate or indicated. So, the first question that comes to mind is when to suspend physiotherapy or even whether to start it at all.’ (P19 – Man – 27)
Emotional Management in Treatment Withdrawal	‘Sometimes I find myself wanting to proceed with a treatment, but the patient is not on board at that moment, so accepting therapeutic discontinuation becomes challenging. In those situations, the session itself becomes difficult. You approach the patient, and they no longer want to participate. Emotionally, it's not easy to accept.’ (P17 – Woman – 28) ‘Regarding training, it's also important to know how to communicate and manage our emotions when we have to suspend treatments. For example, I started practicing mindfulness and other

	techniques on my own. These are things that I have studied and continue to study for myself, but also to be able to propose them to patients as possible therapies' (P13 – Woman – 45)