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Walking a Heavy Road: A Descriptive Phenomenological Study of a Palliative Care Patient's Lived Experience in a Charitable Hospital in Pakistan

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Abstract

Palliative care remains underdeveloped in Pakistan, and little is known about how patients themselves experience life-limiting illness within low-resource charitable hospitals. This study explored the lived experience of a man receiving palliative care for advanced liver malignancy in a charitable hospital in Lahore, Pakistan. Using a descriptive phenomenological design informed by Husserl and guided by Bevan's method of phenomenological interviewing, one in-depth, semi-structured interview was conducted in the participant's home. Data were analysed through phenomenological reduction, transformation of meaning units, imaginative variation, and synthesis into a structural description.

The findings reveal a complex, deeply embodied and emotionally layered experience in which illness, poverty, spirituality and family responsibility are inseparably intertwined. The participant described illness as an all-encompassing disruption marked by severe physical suffering, fluctuating crises, delayed diagnosis and persistent uncertainty about death. Material hardship permeated his narrative, with poverty shaping access to care, travel, nutrition, and the ability to provide for his children. Spiritual reflection and surrender to divine will offered meaning, while humour and moral integrity helped preserve dignity. He expressed profound gratitude for the charitable hospital, describing the staff's compassion, clarity of communication and respectful treatment as life-affirming and protective. Near-death episodes heightened awareness of mortality, yet acceptance emerged not as a linear psychological stage but as a culturally grounded, spiritually framed process aligned with Islamic and Sufi-inflected understandings of life's cycles.

This study highlights the significance of culturally attuned, holistic palliative care that addresses physical symptoms alongside socioeconomic, familial and spiritual concerns. It underscores the centrality of compassion, trust and clear communication in restoring dignity for patients facing serious illness in resource-constrained settings. Phenomenological insights from this single case emphasise the need for expanding culturally informed palliative care research and practice in Pakistan.

Keywords: Palliative care, Phenomenology, Lived experience, Pakistan, Life-limiting illness, Spirituality and suffering, Poverty and health.

INTRODUCTION

Death

Life and death are complementary aspects of human existence. Death is universal, inevitable, and deeply meaningful for us all, yet every culture approaches and negotiates it in its own way (Gire, 2014). The process of dying brings individuals face to face with some of the most sensitive dimensions of human experience, including those rooted in identity, relationships, hopes, and fears (Kukla et al, 2022). A patient who is approaching the end of life often navigates uncertainty, loss of control, physical and emotional suffering, acceptance, and efforts to create or preserve meaning (Rodriguez et al, 2017). Within healthcare, medical professionals commonly prioritise the prolongation of life. As a result, there is often limited attention to the lived experience of patients who

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are undergoing treatment in specialist care settings, such as palliative care units (Black et al, 2018). Phenomenology is uniquely suited to illuminate the inner world of patients receiving palliative care, particularly those who are aware that death is inevitable (Rodriguez and Smith, 2018). The complexities of dying underline the need for kind, considerate, compassionate, and holistic care.

To achieve such care, it is essential to give careful attention to the experiences of patients who are treading this final path and making sense of this unavoidable phase of life within the cultural, social, and institutional environments that surround them.

Palliative Care

Advancements in healthcare and medical technology have contributed to increased life expectancy across the world. As people live longer, they become more vulnerable to frailty and age-related illnesses such as dementia (WHO, 2015). However, serious and life-limiting conditions such as cancer can affect individuals at any stage of life, often shortening its duration regardless of age. Longer survival with chronic illness is frequently accompanied by increased symptom burden (Huang et al, 2017). Many patients experience fragmented care pathways, inadequate symptom control, and avoidable hospitalisations, all of which negatively affect their overall wellbeing (Gott et al, 2013).

Palliative care has emerged in response to these challenges, offering a model of care that prioritises quality of life, symptom relief, and alignment of medical treatment with the values and preferences of patients (Kelly and Morrison, 2015). Over recent decades, there has been a growing recognition of the need to develop and integrate palliative care services within health systems globally. Palliative care is specialised medical care for people living with serious illness, aimed at relieving distressing symptoms and supporting patients and their families. Importantly, it is appropriate at any stage of illness and can be provided alongside curative or life-prolonging therapies (Temel et al, 2010). Central principles of palliative care include patient-centred practice, an emphasis on quality of life, clear communication about goals of care, and comprehensive support for families (Kelly and Morrison, 2015). Palliative care differs from hospice care, which is specifically focused on patients who are approaching the terminal phase of illness (Sheikh et al, 2022).

The population need for palliative care is rapidly increasing. Ageing demographics mean that more people are living with frailty, dementia, cancer, and end-stage organ diseases (Nicholson at al, 2020). Multimorbidity has become more common than isolated single illnesses, contributing to complex care needs. Persistent symptoms such as pain, breathlessness, fatigue, and anxiety are often inadequately addressed in routine clinical practice, and care requirements tend to escalate as illness advances (Kelley and Morrison, 2015). These trends underscore the rising demand for accessible, comprehensive, and integrated palliative care services.

Palliative care can be delivered through several service models, each tailored to patient and system needs. These include hospital-based palliative care consultation teams, outpatient palliative care clinics, home-based palliative care services, community teams working alongside general practitioners, and specialist inpatient palliative care units. Together, these models aim to provide coordinated, multidisciplinary care that supports patients and their families throughout the course of serious illness (Kelly and Morrison, 2015).

Palliative care services in Pakistan

In Pakistan, palliative care services are still evolving, with provision concentrated in a small number of tertiary centres and charitable hospitals (Ali and Khokar, 2019). Resource limitations, social stigma, physician training gaps, and restricted access to opioids for pain relief all influence the nature of care that patients receive. At the same time, Pakistani culture places a strong emphasis on family involvement, religious coping, and collective decision-making, which significantly shapes how individuals interpret their illness and their approach to dying. Despite these unique cultural and systemic factors, there is very limited qualitative research exploring patient experiences of palliative care within the Pakistani context (Ali and Khokhar, 2019).

Patient's Experience

Most existing work in Pakistan and the wider South Asian region has focused on clinicians' perspectives, caregivers' challenges, or structural barriers to service delivery (Khan, 2016). Very few studies have examined the first-person, lived experiences of patients who are themselves navigating life-limiting illness within palliative care settings. Even fewer have explored these experiences in charitable, low-resource hospitals, where socioeconomic constraints, spiritual beliefs, and institutional culture interact in distinctive ways (Khosla et al, 2012).

Understanding the lived experience of such patients is crucial for developing compassionate, culturally sensitive, and contextually relevant palliative care models in Pakistan (Naseem and Rashid, 2008). Phenomenological inquiry offers a powerful approach to capturing these experiences in depth, helping to illuminate how patients interpret suffering, seek meaning, negotiate dependence, and relate to caregivers in environments shaped by scarcity and community-based values (Coelho et al, 2016)

Literature search

An initial PubMed search was conducted in January 2020 using the key terms Pakistan and palliative care. This search did not identify any studies that explored the subjective experience of patients undergoing treatment in a palliative care setting within Pakistan. A repeat search was undertaken on 18 November 2025 during the preparation of the findings. This updated search returned 241 studies; however, none included interviews with patients or attempted to capture their lived or subjective experiences while receiving palliative care in Pakistan.

To date, there is a notable absence of phenomenological research that examines the moment-to-moment, first-person experience of patients receiving palliative treatment in charitable, resource-constrained Pakistani hospitals. Addressing this gap is crucial for informing the development of compassionate, culturally sensitive, and contextually grounded palliative care practices within the country.

Aims and Objectives

The aim of this study was to explore the lived experience of a patient receiving palliative care in a charitable hospital in Pakistan using a phenomenological approach.

METHODS

Design

This study adopted a descriptive phenomenological design to explore the lived experience of a patient receiving palliative care in a charitable hospital in Pakistan. The approach was informed by Husserlian phenomenology and guided by Bevan's structured method of phenomenological interviewing, which emphasises eliciting the lifeworld, attending to modes of appearing, and clarifying experience through imaginative variation (Bevan, 2014).

Setting

The study was conducted in a charitable hospital in Pakistan that provides palliative care services to patients with advanced, life-limiting illnesses. The setting is characterised by limited resources, high patient demand, and culturally embedded patterns of family involvement. This environment offers a distinctive context for understanding lived experiences of palliative care in a low-resource healthcare system.

Recruitment

A single patient receiving ongoing palliative care was purposively selected to provide an in-depth phenomenological account. Inclusion criteria included: being under active palliative care treatment, ability to participate in an interview, and willingness to articulate personal experiences related to illness and care. The patient was approached through clinical staff, provided with information about the study, and gave informed consent prior to participation.

Data Collection

Data were collected through one in-depth, semi-structured phenomenological interview conducted by the researcher. The interview followed Bevan's phenomenological interviewing structure, consisting of three domains (Bevan, 2014):

- Contextualisation: The participant was invited to describe the biographical and situational context of their illness, enabling reconstruction of their lifeworld in natural attitude (for example: "Tell me how you came to be in this palliative care unit")
- Apprehending the Phenomenon: Descriptive and structural questions were used to explore multiple modes of experiencing palliative care (for example: "Describe a typical day to receive treatment from palliative care team" or "Tell me what happens when you feel unwell")
- Clarifying the Phenomenon: Imaginative variation was applied to deepen understanding by asking the participant how certain aspects of their experience might differ under alternative conditions (for example: "How might your experience change if you have better resources…?")

The interview was audio-recorded and subsequently transcribed verbatim. Field notes were taken to support reflexivity and contextual interpretation.

Brief Demographic and Clinical Background of the Participant

The participant was a 42-year-old Pakistani man residing in a suburb of Lahore, Punjab. At the time of the interview, he was receiving care for advanced liver malignancy from a palliative care team in a charitable hospital in Lahore. He attended the day-care unit intermittently, depending on his treatment needs, and was admitted periodically for the management of acute symptoms and clinical crises.

The interview was conducted in his home, at his request, where he lived with his extended family. He had been under palliative care for several months. His account reflects the cultural, emotional, and relational dimensions of receiving treatment within a low-resource setting.

Data Analysis

Data were analysed using a descriptive phenomenological approach informed by Husserlian principles of reduction, bracketing, and openness to the lifeworld. The researcher engaged in repeated readings of the verbatim transcript to gain a holistic sense of the participant's experience while deliberately maintaining the phenomenological attitude. Reflexive notes were reviewed alongside the transcript to support awareness of pre-understandings.

The transcript was then divided into meaning units, representing shifts in significance within the participant's narrative. These meaning units were transformed into phenomenologically sensitive expressions that remained faithful to the participant's words but articulated the underlying experiential structure. Imaginative variation was applied to explore different possible meanings and to identify essential features of the experience. Finally, the constitutive elements of the experience were synthesised into a coherent structural description representing the essence of the participant's lived experience of palliative care.

Theme 1: Personal details in context of current circumstances

The participant described a life shaped by restricted educational opportunities, an early transition into manual trade work, and a small yet meaningful network of social support. He noted that everyday companionship is rare, explaining that "no one really has time these days for friendship," but he maintains two longstanding friends who visit him occasionally. Their visits offer both emotional closeness and practical kindness, as he shared, "they come to meet me every eight or ten days… they even bring me a thousand or two thousand rupees sometimes, just out of kindness."

His formal education ended at the primary level, though he expressed confidence in basic literacy skills, stating, "I studied up to the fifth grade… I can understand things — like basic reading and writing. I can manage simple written stuff." After leaving school, he learned a traditional trade and entered the workforce early, adopting the skills necessary for business through experience rather than formal instruction. As he explained, "I wasn't much into studying, but I picked up business skills instead. After that, I started working in business."

Much of his working life was spent in craft-based labour within local markets, producing ropes, saddles, and harnesses for livestock. He recalled, "We used to make ropes for cows and buffaloes… saddles and harnesses for horses… the leather harnesses used to control horses — we used to make those." These trades have largely disappeared, symbolising not only economic shifts but also the erosion of familiar ways of earning a living that shaped his identity.

Overall, his personal circumstances reflect the interplay of limited education, diminishing vocational opportunities, and a shrinking but deeply valued circle of social support. (Possible Identifiable information has been replaced with x)

Theme 2: Illness

The participant's account of illness is saturated with bodily suffering, delayed diagnosis, ambivalent experiences of care, and a constant mental preoccupation with death, family and faith. Illness is not described as a single event but as an ongoing, heavy journey that repeatedly disrupts his body, his everyday life and his sense of the future.

Subtheme 1: *"A very serious disease" – receiving a life-limiting diagnosis*

The participant situates his current experience within the moment he was told that his condition could not be cured. The doctor's words framed his illness as both medically limited and spiritually surrendered:

"The last time I went to the hospital, I met with the doctor. The doctor said that the illness I have now cannot be cured… if there are tumours in the liver, then it's all in Allah's hands now — we just have to rely on His will for however long life remains."

From this point, he understands his life as temporally foreshortened and contingent. Illness is experienced not only as physical damage but as an ever-present reminder that "everyone has to die one day," and that the remaining time is uncertain.

Subtheme 2: *A body under siege – intense symptoms, procedures and weakness*

The illness is described through vivid sensations of pain, jaundice, itching, burning and exhaustion. He recalls the onset as something apparently minor:

"It started with yellow urine, that's all. I said, never mind, it's nothing serious."

Over time, this progressed to severe systemic involvement. He describes "extreme" yellowness, burning urine, and an itch so intense that he felt like "pulling the skin right off my fingers." Pain is localised and overwhelming:

"There's a lot of pain — especially under the ribs — so much that it becomes unbearable."

He narrates repeated procedures and interventions, including endoscopies and insertion of drains to relieve bile obstruction:

"After that, they found out that there are tumours in my liver… these doctors operated on my liver. They inserted a tube and attached a drainage bag… The yellowness that used to stay inside the liver now comes out through the drain."

Episodes of swelling and weakness leave him unable to perform even the simplest tasks:

"Sir, this has made me completely weak. Now, even if I want to lift just two or four kilos with one hand, I can't do it. My bones have become so weak."

At its worst, he describes becoming "so swollen, so bloated" that he could not sit on a chair, with one leg feeling as if it weighed "about 20 kilos." Ordinary food and drink become almost impossible; he recalls surviving on half a cup of tea and a single biscuit for the whole day.

Subtheme 3: *"Spreading death" – harm and distrust toward unqualified practitioners*

A central part of his illness story is the prolonged delay and deterioration associated with unqualified "fake doctors." He describes spending a year moving between such practitioners, being reassured while his condition silently progressed: "For a whole year, I kept going around them. They used to give me medicines and say, 'You'll be fine, no problem.' … My illness got worse because of them."

He portrays these practitioners as morally and professionally dangerous:

"These fake doctors — the ones sitting there — none of them have proper credentials… they just speak very sweetly… while the patient's life and death are at stake."

Their actions are equated with lethal harm:

"What happened to me — and to so many others — is because of such so-called doctors… the truth is, they are spreading death."

In contrast, he wishes for a system that would "completely stop these people" and require "every doctor [to] be properly qualified," indicating a strong ethical and structural critique rooted in his own experience of delayed diagnosis.

Subtheme 4: *Relief, care and deep gratitude for hospital treatment*

Alongside his critique, the participant expresses profound appreciation and trust toward the staff and systems that eventually diagnosed and treated him. He contrasts "small, untrained doctors" with hospital teams who "explained everything… in a kind and clear way" and "really took my case seriously":

"Yes, we went to the hospital. They explained everything to us very well — in a kind and clear way… That's how we came to know what was really wrong."

Once under specialist care, the combination of investigations, procedures and medications brings tangible relief:

"Then the hospital staff really took my case seriously — they started proper treatment… Now, I can drink a few sips of buttermilk, I can have tea, I can drink a glass of milk if I want. I can eat anything I wish to eat — and that's all by Allah's grace."

He repeatedly frames doctors as instruments of divine mercy:

"Doctors — they are made by Allah for us. They exist for this very purpose — to help people like us."

Even when symptoms recur, each admission is described as bringing some degree of "comfort" and "peace," reinforcing a relational trust in the treating teams.

Subtheme 5: *A cyclical illness – fluctuating crises and ongoing uncertainty*

Illness is experienced as cyclical rather than linear. Periods of severe infection, pain and fever alternate with relative stability, requiring repeated hospital admissions:

"With every team that has treated me, I've felt an improvement… But then the problem returns again. It comes back, and I have to go again."

He describes a pattern in which symptoms flare, lead to hospitalisation and treatment, then recede:

"The problem starts again… an infection develops inside. Because of that, I start feeling cold, then a fever comes on… When they admit me to the hospital, they take good care of me — the fever goes away, and I start getting better."

These fluctuations generate ongoing uncertainty about the future. During episodes of severe pain, his thoughts narrow to the possibility of imminent death:

"When the pain becomes severe… only these thoughts — that life could end anytime, in any way. There's no escape once it reaches a certain stage."

Yet he simultaneously experiences a sense of gradual recovery — "thanks be to Allah, I'm recovering gradually" — conveying a constant movement between hope and resignation.

Subtheme 6: *Illness, family and the fear of leaving responsibilities unfinished*

The illness saturates his thoughts with concern for his family and the responsibilities he may not be able to fulfil. He describes his mind being "constantly" occupied with worries about his children, wife and parents:

"These thoughts — they're all about my home and family: my children, my wife, my parents. I just pray that Allah grants me good health so I can earn my own living… and feed my family myself."

His fears centre on not being able to provide, and on what will happen to his children if he dies:

"If I don't get better, then the children… well, life will go on as it does for everyone… Nowadays, things are such that when parents are around, the children can be kept on the right path — but without parents, nothing remains the same."

He longs to secure a basic shelter for his family before he dies:

"I just wish that, somehow, during my lifetime, I could manage to get something — maybe build a house for my family. A roof, a shelter — a place to live."

Illness therefore intensifies his sense of unfinished duty and heightens his anxiety about his children's future moral and material wellbeing.

Subtheme 7: *Spiritual reflection, acceptance and the "heavy road" of illness*

Throughout his account, the participant repeatedly frames his illness within an Islamic understanding of destiny, trial and divine mercy. He acknowledges the inevitability of death — "every soul must taste it" — while emphasising that receiving treatment brings "peace of mind." Periods of symptom relief are attributed to Allah's kindness:

"Allah has been so kind. He's brought me this far… When a person receives treatment, there's peace of mind."

At the same time, he describes the journey of illness as a profoundly difficult spiritual and emotional path:

"This journey — this road we walk — is a hard one. This path is heavy, very heavy indeed. It's not an easy one to pass through."

Courage, for him, comes from God but is mediated through human relationships — friends, siblings, relatives who visit and offer support:

"That's why courage is needed… Whoever gives even a little courage — that's a great blessing… A person alone can't truly be brave. Such courage comes from companionship, family, and loved ones."

His narrative ends with a prayer that others may be spared this "painful journey," rooting his experience of illness in both suffering and a wider moral–spiritual horizon.

Theme 3: Poverty and lack of resources – struggling to provide in the shadow of illness

The participant's narrative is permeated by material hardship. Illness does not occur in isolation but against a backdrop of deepening poverty, precarious housing, limited educational opportunities for children, and a strong wish to remain financially independent. His account shows how financial strain, crowded living conditions, and lack of social protection intensify his distress and shape his worries about the future.

Subtheme 1: *From modest stability to acute deprivation*

He contrasts a past in which daily labour provided enough for the household with the present reality of severe scarcity. Basic food insecurity becomes the most immediate marker of poverty:

"So, sir, right now we are going through such a time that there isn't even one kilo of flour at home. Believe me, there was a time when we used to come home after working hard and would manage to save five kilos of flour daily for food. But now poverty has become much worse, and we have become poor."

On top of this, the repeated costs of travelling for hospital treatment further erode what little remains:

"It's been two years since we started getting treatment… when we go by car, it costs us 3,500 to 4,000 rupees each time — and that drains all our blood."

Illness and poverty are experienced as tightly intertwined, each amplifying the other.

Subtheme 2: Crowded housing and constrained living space

The material limitations of the family home symbolise a broader lack of security and ownership. He describes a small, ageing house divided between relatives:

"There are three rooms — my younger brother lives in one. One is meant for the younger one who is to be married soon and will live there. And one is for our parents… It's an old house — about 25 to 50 years old — and the total area is about seven marlas."

Within this arrangement, his own sense of space and belonging is precarious:

"Now I have x* children, and one is my wife — that makes x* including me. And believe me, now even my own place doesn't feel like mine anymore."

He explains how sleeping arrangements are constantly negotiated, with him and his father effectively taking turns being "inside" or "outside":

"If I stay in my room, my father sleeps outside. If my parents sleep inside, then I stay outside. That's how it's come to this point."

Housing is not only structurally inadequate but emotionally laden, reinforcing his fear of leaving his children without any secure "roof" if he dies.

(* Numbers removed to ensure confidentiality)

Subtheme 3: *Intergenerational illness and stretched family resources*

Poverty is intensified by the fact that multiple family members are unwell and require treatment. He describes a large sibling group among whom several are seriously ill:

"We are x* sisters and x* brothers, out of whom three are very ill. Each of us is undergoing treatment, and we are facing a lot of difficulties. My youngest brother has a problem with his leg — it hasn't healed… We just wish that, by Allah's grace, we could find a doctor who could treat him properly."

His parents are elderly and no longer able to work, yet they remain a source of financial help that he feels compelled to draw on:

"My parents are old now. They are alive but can't work anymore. I've taken quite a lot of money from them and spent it on myself."

Illness therefore drains not only his own income but also the limited reserves of the wider family, compounding feelings of burden and guilt.

(* Numbers removed to ensure confidentiality)

Subtheme 4: *Pride in honest work and resistance to asking for help*

Throughout the narrative, there is a strong emphasis on earning through one's own labour and an aversion to seeking financial assistance, even in the face of extreme hardship. Work done "with ten fingers" is linked to dignity and inner satisfaction:

"May Allah Almighty grant us good health now. We want to earn an honest living for our children. We are not used to stretching out our hands before anyone to ask for money — that's not in our nature… when a person earns something with their own ten fingers, with their own hard work, that's when the true satisfaction of that thing is felt."

He describes how he has "never liked asking anyone for help," even though circumstances have become dire:

"Sir, as I told you — I really don't like asking anyone for help. But now times have become such… what can one do? Whom can we ask?… Everyone is busy with their own lives, earning their own living, feeding their own children — whom can I ask?"

He explicitly rejects the idea of resorting to dishonesty or crime, even when aware that such routes may bring quick money:

"All my life's honest hard work, earned with my ten fingernails, through sheer struggle and sweat, that's what has filled our stomachs. And when a person falls into dishonour — like stealing or robbing — yes, maybe they make five or ten lakh rupees, but what's the use?… We are not like that — not in our nature, not in our hearts."

Poverty is thus endured within a moral framework that values honesty and self-reliance, making the need to ask for help even more painful.

Subtheme 5: *Sacrificing and downgrading aspirations for children*

Lack of resources forces compromises in the education and future prospects of his children. While he strongly values schooling and had hoped to give his children better opportunities, financial constraints have meant settling for what is affordable:

"Earlier, I used to teach — privately, I mean — before I fell ill. I used to say that the children should get an education… But then we didn't have the means. So we got them admitted to a government school. And now, by the grace of Allah, they are studying in the government school."

Alongside this, there are hints of pressure for older children to contribute economically "before their time," reflecting the tension between wanting them to study and needing income (as you noted in your memo: seeking a job for the elder son who is still a child). His worry is less about his own comfort than about what his children will be left with if he dies:

"I think to myself — if I were to pass away today, there would be hundreds of problems left behind for my children… If they get nothing after me, what will they think? What will they say? 'What's left for us?'"

Poverty therefore reconfigures his parental role, shifting him from dreaming about advancement for his children to fearing that he may leave them with "nothing."

Subtheme 6: *Constant mental preoccupation with running the household*

Financial strain dominates his thoughts and emotional life. He portrays his mind as continually occupied by the question of how the household will survive:

"I just keep thinking about my home, sir — how will the household run? What will happen? What will we do? There's nothing else to think about, only about the home. My whole life I've only thought about my family — just that the household keeps going, that the system keeps running."

This preoccupation is closely linked to his sense of responsibility as a provider and to the poor condition of the house itself:

"The house is there, but it's in poor condition… At home, as you can see through the camera, there are three rooms — two belong to my brothers, and one is mine."

His most persistent wish is not luxury but simply to secure basic shelter for his family:

"These are the only thoughts I have, doctor sahib — what else can I tell you, over and over? I just wish that, somehow, during my lifetime, I could manage to get something — maybe build a house for my family. (Crying) A roof, a shelter — a place to live."

Material poverty thus becomes inseparable from existential worry: about his role as a father, the future of his children, and what his "life's honest hard work" will amount to after he is gone.

Theme 4: Regrets and Humour About the Self – looking back with sorrow, dignity and gentle self-mockery

Alongside the challenges of illness and poverty, the participant reflects on his past with a mixture of regret, sadness, pride and subtle humour. This theme reveals how he grapples with the mismatch between the life he once lived — defined by strength, responsibility and respect — and the vulnerable position he now occupies. His regrets are softened by moments of self-deprecating humour, which allow him to express pain without losing dignity.

Subtheme 1: *Regret over financial loss, sacrifice and lack of savings*

He describes a life of hard work and responsibility, in which he provided for the household, supported his parents and contributed to his siblings' weddings. However, he reflects with quiet sorrow that despite working tirelessly, nothing could be saved:

"I kept earning a living, feeding the household — taking care of my parents. I helped with my sisters' and brothers' weddings too. Saved nothing. It was a time of inflation."

His regret is not self-blame but a lament about circumstances and the harshness of life:

"After that, sir — this illness has become severe. We have spent a lot, a lot of money outside. The money has all finished."

His sense of having "given everything" and now being left with nothing intensifies his emotional burden.

Subtheme 2: *Longing for lost strength and respect*

He reminisces about a time when he was physically strong, respected and known by his community as a hard-working, powerful man:

"We used to be stronger than others. Everyone used to greet us with respect… Wherever we went, people would call me a wrestler, 'pehlwan, pehlwan.'"

His present weakness contrasts sharply with that earlier identity. The rhetorical question — *Where has that strength gone?* — expresses both sadness and bewilderment:

"Allah had given such strength. What were those things done for? For what purpose that strength was given? Where has that strength gone?"

This reflection captures a sense of identity loss and quiet mourning for the man he once was.

Subtheme 3: *Painful effort to protect the family — and the emotional cost*

He describes keeping his suffering concealed from his parents, trying to shield them from worry even while deteriorating physically:

"No, sir — I never troubled my family. I just kept my pain to myself. I told my parents, 'Thanks to Allah, everything's fine.'"

He recounts refusing his mother's wish to visit him in hospital:

"My mother said, 'Son, I'll come to see you.' I told her, 'No, please don't. Stay there, I'm fine.'"

This concealment feels like both love and burden. He highlights how unrealistic it is to maintain emotional strength indefinitely:

"Courage lasts for what? Two minutes? Four? Five? Ten?

Twenty minutes? Half an hour? An hour? Maybe a day? But two and a half years? No, sir — no one can keep going that long. In two and a half years, a person can completely break down."

Regret is intertwined with fatigue — the exhaustion of carrying worry alone.

Subtheme 4: Self-directed humour and pun as a coping strategy

Despite the gravity of his circumstances, he uses gentle humour, puns and a touch of irony to cope with the emotional weight. His remark about courage coming from the liver, delivered with a self-mocking laugh, reflects both acceptance and subtle sarcasm:

حوصلہ جگر نے ای دینا اے جیڑا وچارہ ٹھیک نہی-

"Courage — it's the liver (jigar) that has to give it, and when that poor thing isn't well, then how can courage remain?"

Here, *jigar* (liver) cleverly stands for both the physical organ affected by illness and the metaphorical seat of courage in South Asian idiom. The humour acknowledges his condition while preserving dignity.

This playful moment softens the sorrow in his narrative, revealing how humour becomes a gentle shield against despair.

Theme 5: Strengths – sustaining courage, faith and moral integrity in the face of illness

Despite describing a life-threatening and exhausting illness, the participant repeatedly returns to sources of strength that help him to endure. These strengths are experienced as a combination of inner courage, religious faith, moral integrity, and the emotional support that comes from family and loved ones. Strength is not portrayed as the absence of distress, but as the capacity to keep going, to protect others from worry, and to hold on to hope and dignity in the midst of suffering.

Subtheme 1: *Inner courage and the decision to keep going*

The participant emphasises that receiving a serious diagnosis demands considerable psychological strength. He describes courage as something that must be actively cultivated to prevent the illness from overwhelming him:

"When a person finds out about such an illness, it takes a lot of courage — real bravery. One must strengthen their heart; only then can one keep going. Otherwise, the illness becomes heavy."

He understands courage as both an inner resource and something bestowed by God:

"No, the courage — it comes from within oneself. It's a matter of bravery… Some people lose heart, while others keep fighting their illness. That courage, which comes by the will of Allah, is a great strength. And it's with that courage that we keep going, living life as it comes."

Even when intrusive thoughts about death and the future arise, he deliberately reminds himself that he is "still here in this world," framing survival itself as an act of ongoing bravery.

Subtheme 2: *Faith, hope and spiritual surrender as strength*

Religious faith is central to how he sustains hope. He repeatedly turns to prayer, placing his illness and its outcome in God's hands:

"We… keep praying to Allah Almighty: 'O Beautiful Lord, however we are to stand, it is only through You — we belong entirely to You, in Your care.'"

He holds on to the belief that divine forgiveness and mercy remain possible despite human weakness:

"We just keep presenting this plea before our Lord — that perhaps He will make us well… human beings are weak; they can make mistakes… but Allah forgives."

His identity as a member of the Prophet's community is itself experienced as a source of spiritual strength and dignity:

"May the Merciful Allah forgive us. We are from the Ummah of the Holy Prophet (peace be upon him)."

Alongside acknowledgment that "every soul must taste" death, he describes receiving treatment as bringing "peace of mind," suggesting that faith and medical care together support a sense of inner calm.

Subtheme 3: *Moral integrity and protecting loved ones from worry*

Another important dimension of strength lies in his efforts to shield his family from distress and to live in a way he considers morally "pure." He presents himself as someone who has tried not to burden relatives with his suffering:

"No, sir — I never troubled my family. I just kept my pain to myself… I told my parents, 'Thanks to Allah, everything's fine. There's nothing to worry about.'"

He recognises that sustaining such courage over years is extremely demanding, yet his instinct is still to protect them:

"I didn't let my family worry. I even showed courage — but… how long does courage really last?… In two and a half years, a person can completely break down."

He also describes moral cleanliness as a form of inner strength, contrasting a "pure" life with the fear associated with wrongdoing:

"If the body is pure, there's nothing to fear… But when there's impurity in the body, a person keeps living in fear — 'Oh, I did this wrong thing… what if I get caught?' But when the body is pure, then the mind too becomes pure, and then God's grace descends upon you. Even death becomes easy for such a person."

Strength here is not only physical or emotional, but ethical and spiritual.

Subtheme 4: *Drawing strength from family, companionship and small acts of support*

Although he often faces his thoughts alone at night, the participant emphasises that real courage is nurtured through relationships. Time spent with his children temporarily displaces the illness from the centre of his attention:

"When I come home, and stay around the children, seeing them play and laugh, talking and spending time with them — that gives me strength again. It lifts my spirits. The illness moves to the side for a while, and my focus shifts to the children. That's what brings courage back into a person."

He describes how visits from relatives and loved ones provide emotional energy:

"Whoever gives even a little courage — that's a great blessing, sir. A person alone can't truly be brave. Such courage comes from companionship, family, and loved ones. When a sister visits for a couple of days, or a relative drops by — that brings strength."

Past recognition from others also contributes to his sense of worth. He recalls a time when he was physically strong and respected, known as a "wrestler" in the community:

"I have lived a good life — a respectable life. We used to be stronger than others. Everyone used to greet us with respect… Wherever we went people would call me a wrestler, 'pehlwan, pehlwan.'"

Even when a visitor now cries upon seeing how much he has changed, he responds by affirming his acceptance of God's will, linking his former strength and current state within a continuous moral narrative.

Subtheme 5: *Acceptance of the "heavy road" and praying for others*

Finally, the participant's strength is expressed through his acceptance that illness is a "hard" journey and his desire that others be spared the same suffering. He depicts life as a cycle of days and nights marked by recurring thoughts, but sees courage as essential to walking this path:

"Every person goes out to do his work, but when night comes and thoughts return, he has to face them alone… That's why courage is needed… this journey — this road we walk — is a hard one. This path is heavy, very heavy indeed. It's not an easy one to pass through."

His response is not only to seek strength for himself, but to pray that others are protected:

"Our prayer is that Allah Almighty protects everyone from this difficult path, from this painful journey. May the Merciful Lord forgive us — for the sake of the good and the pure."

Strength, in his account, is therefore not simply individual resilience, but an ethically and spiritually framed capacity to endure, to care for others, and to hold on to hope in the midst of a "heavy" and uncertain road.

Theme 6: Gratitude to the Charity Hospital – experiencing care as compassion, protection and dignity

The participant's narrative conveys profound gratitude towards the charity hospital and its staff. He describes the hospital not merely as a place of treatment but as a space of emotional safety, compassion, and dignity, contrasting sharply with the hardship and neglect experienced elsewhere. For him, the hospital represents both life-saving medical care and a deeply human, almost familial source of comfort.

Subtheme 1: *Care experienced as kindness beyond obligation*

The participant repeatedly emphasises that the care he receives surpasses what he would expect even from close family. He frames this support as something that he "can never thank enough," expressing a lifelong debt of gratitude:

"The hospital staff helped us completely. We can never thank them enough in our entire life. For us, they are important both in this world and the next. They did for us what even one's own real brother wouldn't do."

The depth of his appreciation shows how strongly he perceives the hospital as standing in the gap left by social, financial, and emotional deprivation at home.

Subtheme 2: *The hospital as a refuge from suffering*

For him, crossing the hospital threshold brings immediate psychological relief, as though it suspends the burdens of his illness and poverty:

"When we get admitted to the hospital, once we are inside those doors, we don't feel any pain or suffering of the outside world."

The hospital becomes a protective environment where his physical symptoms feel more manageable, and where he feels emotionally safe.

Subtheme 3: *Compassionate professionals understood as nurturing, patient and forgiving*

The participant repeatedly compares the kindness of doctors and staff to maternal care:

"When we go inside, it feels as if our own real mother is giving us love — that's how much affection the doctors show us."

He describes the staff as extraordinarily patient, even when he is distressed or irritable because of medication:

"Even if we ever speak wrongly or out of turn because of the medicines… they never say anything back. Their kindness is such that they understand our hardship, our pain, our anger, and our moods."

This level of compassion is described as rare and exceptional:

"Such people don't exist anywhere else in the world."

For him, kindness is as important as clinical expertise.

Subtheme 4: *Clear communication and respectful explanation as care*

A key aspect of his gratitude is the way doctors communicate with him respectfully and clearly, helping him understand his condition:

"They explained everything to us very well — in a kind and clear way. They made us sit down and helped us understand… Otherwise, how would poor people like us ever know?"

He respects their knowledge and training, contrasting their professionalism with unqualified practitioners elsewhere:

"These doctors… have spent half their lives working in this field… Not like those ten-year-old boys giving injections everywhere."

Their explanations of dietary changes, precautions, and procedures allow him to feel informed and reassured.

Subtheme 5: *Life-saving treatment and restored bodily function*

The participant attributes significant improvement in his health to the interventions carried out at the hospital. He recounts complex procedures and the relief they brought:

"By the grace of Allah, these doctors operated on my liver… They inserted a tube and attached a drainage bag… And now, compared to before, we are better. My breathing feels easier now."

Multiple procedures involving tubes and drains are described as transformative, allowing him to breathe, digest, and function more normally.

Subtheme 6: *Enduring trust in the medical teams*

He expresses deep trust in the teams who have treated him across multiple admissions:

"My treatment has been done by two or three different teams… Every doctor who has been part of my team has looked after me with such kindness that I can't even describe it."

He fears being abandoned in the course of his illness and explicitly seeks reassurance from the doctors:

"I once asked them… 'Sir, my illness is quite serious; you won't leave me midway, will you?'"

This plea shows the emotional dependence built through the care relationship and the central role the hospital now plays in his sense of safety.

Theme 7: Near-death situations – confronting the possibility of dying

Across the narrative, the participant repeatedly describes moments when he felt that his life was nearing its end. These experiences are characterised by physical collapse, emotional withdrawal, and an acute awareness of mortality. His account of "being close to death" is not abstract: it is tied to vivid bodily deterioration, hospital admissions, and a sense of slipping away from normal life.

Subtheme 1: *Withdrawal from the world when death feels near*

During periods of extreme weakness, the participant describes disengaging from communication and everyday interaction, as though already preparing for death. He recalls a time when he stopped answering calls and distanced himself emotionally from his family:

"I used to think, 'Who knows how long life will last? Maybe a day, maybe two.' My family or some relatives would call from home, but I wouldn't answer… I had even stopped using the phone myself."

He explains this withdrawal as a combination of the illness itself and the effects of medication, leaving him drowsy and detached:

"At that time, the effect of medicines would make me drowsy, and the illness itself used to be quite severe."

These moments reflect how approaching death alters not only the body but also social connection and a sense of self.

Subtheme 2: *Bodily collapse as evidence of being close to death*

He recounts specific medical crises in which his body felt overwhelmed by illness, signalling to him that he might not survive. Severe jaundice, blocked ducts, and soaring bilirubin levels made death feel physically imminent:

"The waste that was trapped in the liver — the doctors inserted a tube… The yellowness that used to stay inside the liver now comes out through the drain. If it remains inside the liver for even a few days, then the same symptoms return — the same pain, the same weakness."

He experienced rising bilirubin as a marker of life slipping away:

"My bilirubin had gone up to 24,000 — twenty-four thousand!"

Extended hospitalisation confirmed to him how serious his condition had become:

"They had kept me admitted for nineteen days, sir — nineteen full days in the hospital."

These biomedical markers intersected with his subjective sense of being dangerously unwell.

Subtheme 3: *Narrow survival – recovery that feels like a return from the edge*

Moments of recovery are described almost as returns from near death. After multiple procedures and drainage of bile, he experienced dramatic improvement:

"After that… my whole system started improving. The urine began to flow properly again… that brought a lot of relief, sir — real relief."

He frames his survival as grace rather than certainty:

"Then, by the grace of Allah, I came back home."

The movement from being unable to answer the phone, anticipating death, to returning home after intensive treatment underscores a lived experience of crossing an invisible threshold between dying and living.

Theme 9: Circle of Life and Acceptance of Death – recognising life's cycles and surrendering to its inevitability

The participant repeatedly situates his illness within a broader philosophical and spiritual understanding of the human life cycle. His reflections resemble Sufi-influenced meditations on impermanence, generational continuity, and the inevitability of death. Rather than resisting mortality, he interprets his experience through a calm acknowledgement that life follows patterns of rising, falling, working, and returning. This acceptance provides both meaning and emotional grounding during illness.

Subtheme 1: *Life as a repetitive cycle of days, nights, work and return*

He describes life as a continuous rotation of day and night, work and rest, arrivals and departures — a pattern that mirrors the rhythms of nature. This cyclical view offers him a way to understand human struggle and death without despair:

"At night, when I lie down to sleep, some thought or another always comes to mind — and that's how the night passes. Then the day rises, evening comes, and the birds return to their nests — some make it back, some don't, and death takes away whoever is destined to go."

He repeats this imagery in Punjabi, emphasising the natural order of existence and the inevitability of death woven into daily life:

“دن چڑھیا تے شاماں پئی ی آں تے پنچھی کراں نوں
آئے او نہ آئے، پھر موت جنوں لے جائے... دن چڑھدا
اے، پھر روزی دی تلاش چے جاندا اے... اے چیزاں نے-
دن چڑھ دا اے.”

("Evening falls and the birds return home — some return, some never do, and death takes away whoever is destined. The day rises again; a person goes out to seek livelihood… this is life. The day rises again.")

Life, in his understanding, is not defined by dramatic events but by returning cycles that no one can escape.

Subtheme 2: *Acceptance of death as a natural continuation of life*

Instead of resisting the idea of dying, he views it as a stage in the cycle that every person must encounter. His tone is not fearful but contemplative — accepting that life's patterns do not stop with him:

"That's life, sir — the cycle goes on."

He speaks of death as an integral part of living, one that comes quietly as part of nature's rhythm, just as birds return or fail to return to their nests. His reflections merge spiritual humility with lived experience of suffering.

Subtheme 3: *Understanding generational succession — his life nearing its turn, and the next generation beginning theirs*

A major part of his acceptance comes from recognising that he is at the end of his "active" phase of life, while his children are only at the beginning of theirs. He reflects deeply on how difficult it is for a young person to gain competence and stability:

"A person's life — by the time he reaches forty — he gradually gains experience, learns his trade, earns his livelihood… Then his child starts again — a new beginning from scratch."

He describes the struggles the next generation must endure:

"The child has no experience yet. He will stumble… face scolding… hear harsh words… Some will treat him kindly, others harshly. Only after twenty to twenty-five years will he have experience."

These reflections reveal his sadness that just when he has reached maturity and wisdom, illness is pulling him away:

Interpretive note: He implicitly recognises that *his* twenty years of experience are now overshadowed by illness, just as his children need him most.

Subtheme 4: *The fragility of human effort — skill, experience, and the inevitability of decline*

He connects his personal decline to a wider truth about life: when an experienced person is gone, the work, skill, or livelihood they sustained can collapse. This becomes a metaphor for his own mortality:

"When an experienced person leaves, nothing of the shop remains. The shop is the same, the tools are the same — but it doesn't work anymore."

He sees this not only as a business reality but as a truth about human life — experience cannot simply be transferred, and its loss can unsettle everything:

"These are the kinds of things, Doctor Sahib, that mix deeply into life's reality."

This insight symbolises his recognition that his own departure will leave gaps that his children cannot immediately fill.

Subtheme 5: *Spiritual surrender — linking the cycle of life to Sufi-inspired acceptance*

His language, metaphors and tone reflect a Sufi-inflected worldview in which life, hardship, and death are all part of a divine plan. The circularity of life and inevitability of death are not only accepted but contemplated with humility:

"Then the day rises once more, and he goes out again in search of livelihood… That's life, sir."

In his phrasing, the cycle becomes a spiritual teaching — that hardship, work, loss and return are inseparable from human existence. Acceptance is not resignation but a form of alignment with divine will.

Theme 10: Theme: Gratitude and Emotional Closure – expressing appreciation at the end of the interview

As the interview draws to a close, the participant expresses deep emotion and gratitude toward the researcher. His closing words reveal not only appreciation for being heard, but also an understanding of the researcher as connected to the same compassionate institution that provides his treatment. This theme captures how being listened to becomes meaningful, validating and symbolically healing for him.

Subtheme 1: *Desire to speak but emotional exhaustion*

He conveys a strong wish to continue talking, to share more of his experience, but acknowledges that his emotional and physical strength is fading:

"I really feel like talking… I really feel like telling you everything — but now… it's like I can't speak anymore."

This captures the tension between the need to express himself and the exhaustion imposed by illness.

Subtheme 2: *Appreciation for empathy, presence and being heard*

He frames the researcher's presence as an act of care, expressing heartfelt gratitude for being listened to with genuine concern:

"Thank you for feeling for us, for caring about us, for showing us love. Thank you very much."

His words suggest that the interview is not experienced as a formal research encounter but as an emotionally supportive interaction.

Subtheme 3: *Linking the researcher to the trusted institution that cares for him*

For the participant, the researcher symbolically represents the same institution that has treated him with compassion. His thanks extend beyond the individual to the system of care that he has come to trust:

Interpretive note: He perceives the researcher as an extension of the caring environment of the charity hospital, reinforcing his sense of being valued and supported.

The closing expressions therefore blend personal gratitude with institutional trust, completing the interview on a note of emotional warmth and connection.

DISCUSSION

This study set out to explore the lived experience of a man with a life-limiting illness receiving palliative care in a charitable hospital in Pakistan. Using a descriptive phenomenological approach, the study sought to illuminate how illness, poverty, spirituality and care intersect to shape his daily life and sense of self. The findings reveal a deeply layered experience in which physical suffering, economic hardship, responsibilities towards family and spiritual reflection are intertwined. His narrative is characterised by profound courage, sorrow, humour, acceptance and gratitude. These findings offer valuable insights into the subjective experience of serious illness in a low-resource setting, while also highlighting the importance of culturally attuned, compassionate palliative care.

Illness as an all-encompassing change in the lifeworld

The participant's account illustrates how life-limiting illness alters the entire lifeworld. His descriptions align closely with phenomenological theorists such as Toombs and Svenaeus, who emphasise that illness disrupts one's fundamental way of being-in-the-world. Bodily disruption is not experienced solely as pain or weakness; it brings about a re-ordering of daily routines, relationships, priorities and identity. His narrative conveys the ongoing oscillation between episodes of acute deterioration and partial recovery, which he describes as a "heavy road" that he must repeatedly walk. These cycles of illness parallel phenomenological descriptions of uncertainty, vulnerability and loss of embodied control.

This sense of disruption is intensified by his role as the family's provider. The illness not only damaged his body, but also dismantled his ability to earn, to protect his children's future and to uphold cultural expectations of masculinity and honour. The convergence of bodily decline and role loss resonates with global palliative care research showing that in low-to-middle income countries, serious illness is often accompanied by economic collapse, reduced social status and emotional suffering.

The emotional landscape of illness: revisiting Kübler-Ross through a cultural lens

The participant's emotional responses bear some resemblance to the stages described by Elisabeth Kübler-Ross (denial, anger, bargaining, depression and acceptance), but they do not follow a linear or universal trajectory. Instead, they appear as fluid, overlapping states that emerge and recede in response to physical symptoms, financial stress and spiritual reflection.

There are moments that echo withdrawal or despair, particularly when he anticipated imminent death and disengaged from communication with his family. There are elements of sorrow, fear and profound fatigue. However, these emotions are interwoven with spiritual surrender, humour, hope and gratitude. The participant's movement toward acceptance is not the endpoint of a psychological journey, but a continuing alignment with religious belief, cultural values and the realities of life in poverty.

Acceptance, in his case, is a spiritual and existential posture, not a psychological "stage". He interprets illness and death through an Islamic worldview shaped by concepts of divine will (qadr), trust in God (tawakkul), and Sufi-influenced metaphors of the cycle of life. In this sense, his acceptance differs from Western individualised interpretations of end-of-life coping. His narrative supports critiques of the Kübler-Ross model that argue it lacks cultural flexibility and fails to address spiritual meaning-making in non-Western contexts. What he expresses is not a detached acceptance but a spiritually-rooted surrender that affirms both human limitation and divine grace.

The cycle of life, temporality and Sufi-inflected acceptance

A striking feature of the participant's narrative is his reflection on the circularity of life. He repeatedly describes the pattern of day and night, birds returning (or not returning) to their nests, and people going out to seek livelihood and then returning home. These metaphors of natural cycles are characteristic of Sufi poetic traditions in the subcontinent, where the rhythms of creation are used to express the inevitability of loss, the fragility of human existence and the certainty of death.

His reflections give existential depth to the phenomenological theme of temporality. The future is not imagined as a linear path, but as a continuation of the same cycles that have always governed life. He recognises that he has reached the age of experience and maturity, but that life has placed before him an "uneasy time", while his children stand at the beginning of the same long road. These insights highlight the intergenerational dimension of existential suffering in collectivist societies, where one's own trajectory is intimately tied to the wellbeing and futures of one's children.

Strength, humour and moral integrity as culturally embedded resilience

Resilience in this narrative is not framed as individual psychological coping, but as a culturally grounded expression of character, responsibility and honour. He draws strength from religious faith, from the presence of his children, from the memory of past physical strength and from a lifelong identity rooted in hard work and honesty. His use of humour — particularly the pun on jigar (liver) as the seat of courage — illustrates an important culturally specific coping mechanism. Humour allows him to acknowledge sorrow without collapsing under it, and to maintain dignity in the face of decline.

In South Asian cultures, courage is closely tied to masculinity, responsibility and moral integrity. His insistence that he "never troubled" his family and his reluctance to ask for financial help reflect cultural norms regarding honour and self-respect. These findings align with anthropological studies of Pakistani and Punjabi masculinities, which describe a strong emphasis on protection, emotional restraint and providing for family. When illness disrupts these roles, men may experience deep emotional distress, hidden behind expressions of courage or humour. (Lyon, 2002; Shaheed, 1999; Rehman, 2017)

Poverty as an ever-present force shaping suffering

The participant's account demonstrates that in low-resource settings, poverty is not a separate theme but a fundamental structure that shapes every aspect of illness. His narrative shows how a serious condition can trigger a cascade of financial strain, disruption of children's education, household instability and psychological distress.

International literature on palliative care in low-income contexts highlights this "double burden" of illness and poverty (Pestrana et al, 2024). The participant's inability to afford travel to the hospital, the lack of food at home and his anxiety about leaving his children without shelter reflect structural inequities. His narrative underscores the need for palliative care models that address not only physical symptoms but also socioeconomic suffering.

He also expresses regret that despite a lifetime of honest labour, he has been unable to secure material stability for his family. This sense of failure is not about personal inadequacy, but about the injustice of illness arriving at precisely the moment when he should be passing on experience to the next generation.

Compassionate institutional care as dignity-restoring

A unique and powerful finding of this study is the participant's profound gratitude toward the charity hospital. He describes the staff as "like a mother", offering kindness, explanation, patience and forgiveness. When he enters the hospital, he feels sheltered from the pain of the outside world. This contrasts sharply with his earlier experiences with unqualified practitioners, whom he describes as "spreading death".

International evidence supports the importance of compassionate communication and trust in improving end-of-life outcomes (Engel et al, 2023). In Pakistan, where many patients fear mistreatment or exploitation, the presence of a caring, trustworthy institution can dramatically alter the illness experience. For this participant, the hospital not only manages symptoms but also offers dignity, security and a sense of being valued. His gratitude for the researcher at the end of the interview reflects this broader trust in the institution and in the individuals who represent it.

Implications for practice

These findings suggest several implications:

- Holistic palliative care is essential. Physical symptoms, economic hardship, spiritual distress and family responsibility must be addressed together.
- Spiritual and cultural frameworks should be integrated into care.

Acceptance of death for this participant is rooted in Islamic belief and Sufi-inflected understandings of temporality, not in linear psychological models. Care teams should acknowledge and support these frameworks.

- Compassionate communication is a therapeutic intervention. The participant's gratitude underscores that kindness and clear explanations can be as meaningful as procedures in restoring hope.
- Palliative care in Pakistan must consider economic strain.

Financial barriers are central sources of suffering and must be addressed through policy, community support and institutional planning.

Strengths, Limitations and Future Research

A key strength of this study is that it provides an in-depth, richly contextualised view of palliative care in a charitable hospital in Pakistan, a context that remains under-researched. However, as with any single-case phenomenological study, the findings reflect one person's experience and do not aim to generalise. Future studies could explore experiences across gender, socioeconomic groups, and different types of palliative care settings. Further inquiry into spiritual meaning-making, masculine identity, and the role of charitable care institutions could offer deeper insights.

CONCLUSION

The participant's account shows that the experience of life-limiting illness in Pakistan is shaped not only by bodily decline, but by the interplay of poverty, spirituality, identity, responsibility and care. His narrative illustrates that acceptance is not a final psychological stage, but a culturally embedded, spiritually grounded process. It emerges through cycles of suffering, reflection, courage and surrender.

By illuminating the patient's lifeworld, this study highlights the need for palliative care models that honour the spiritual and socioeconomic realities of patients' lives, and that offer the kind of compassionate, dignity-affirming care that this participant so deeply valued.

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Initially the plan was made to recruit six patients, however the hospital needed closure due to COVID-19 pandemic and further interviews were not carried out especially when the key researcher moved out of the hospital and had to move out of the country.

The information leaflets and consent form were all made in Punjabi language and the interview was also carried out in the same language. The interview of transcribed verbatim writing Punjabi in standard Nastaliq Urdu font. The entire script was later translated into English by the lead researcher and data interpretation was carried out utilising NVIVO-10 software.

DISCLOSURE OF INTEREST

None.

ETHICAL APPROVAL

SKMCH&RC, Lahore holds the Joint Commission International (JCI) Gold Seal of Approval for Hospital Accreditation. The approval process involved presenting the case to The IRB (referred to as "Institutional Review Board, SKMCH&RC") that is an Independent Hospital Ethical Committee responsible for reviewing and approving all clinical research projects undertaken at SKMCH&RC or involving its patients/data. It aims to safeguard research participants (including vulnerable populations such as children, pregnant women, prisoners, economically or educationally disadvantaged individuals) and makes decisions after the scientific content of a study has been validated.

The IRB approved the protocol after formal discussion in relevant meeting. The author therefore asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013.

The registered IRB Number for this study was: IRB-20-10

INFORMED CONSENT

Written informed consent was obtained.

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REFERENCES

1. Ali MM, Khokhar MA. Issues regarding end-of-life care in Pakistan. J Palliat Care. 2019;35(3):174-175. doi:10.1177/0825859719855953
2. Asadi-Lari M, Packham C, Gray D. Unmet health needs in patients with chronic illness: qualitative study. Int J Qual Health Care. 2004;16(6):409-415. doi:10.1093/intqhc/mzh068
3. Bevan MT. A method of phenomenological interviewing. Qual Qual Health Res. 2014;24(1):136-144. doi:10.1177/1049732313519710
4. Black A, McGlinchey T, Gambles M, Ellershaw J, Mayland C. The 'lived experience' of palliative care patients in one acute hospital setting – a qualitative study. BMC Palliat Care. 2018;17:91. doi:10.1186/s12904-018-0345-x
5. Coelho A, Parola V, Escobar-Bravo M, et al. Comfort experience in palliative care: a phenomenological study. BMC Palliat Care. 2016;15:71. doi:10.1186/s12904-016-0145-0
6. Engel MA, van der Heide A, Onwuteaka-Philipsen BD, et al. Effective communication in palliative care from the perspective of patients and relatives: a systematic review. Palliat Care. 2023;21:1-14. doi:10.1177/1478951523001165
7. Gire J. How death imitates life: cultural influences on conceptions of death and dying. Online Read Psychol Cult. 2014;6(2). doi:10.9707/2307-0919.1120
8. Huang IC, Chen ML, Lin YK, et al. Differential impact of symptom prevalence and chronic conditions on quality of life in cancer survivors and non-cancer individuals: a population study. Cancer Epidemiol Biomarkers Prev. 2017;26(7):1124-1132. doi:10.1158/1055-9965.EPI-16-0959
9. Kelley AS, Morrison RS. Palliative care for the seriously ill. N Engl J Med. 2015;373:747-755. doi:10.1056/NEJMra1404684
10. Khan RI. Palliative care in Pakistan. Indian J Med Ethics. 2016;13(2):1-6. doi:10.20529/IJME.2017.007
11. Khosla D, Patel FD, Sharma SC. Palliative care in South Asia: a systematic review of the evidence. J Clin Oncol. 2012;30(9):e91–e91. doi:10.1200/JCO.2011.39.2352
12. Kukla H, Herrler A, Strupp J, et al. "My life became more meaningful": confronting one's own end of life and its effects on well-being—a qualitative study. BMC Palliat Care. 2022;21:58. doi:10.1186/s12904-022-00950-3
13. Lyon S. An anthropological analysis of honour and masculinity in rural Punjab, Pakistan. Ethnos. 2002;67(2):213-231. doi:10.1080/0014184022000031212
14. Naseem A, Rashid S. Palliative care in Pakistan: current situation and challenges. J Pediatr Hematol Oncol. 2008;30(6):409-412. doi:10.1097/MPH.0b013e318165b13

15. Nicholson C, Morrow EM, Hicks A, Fitzpatrick J. Supportive care for older people with frailty: a joint perspective from gerontology and palliative care. Age Ageing. 2020;49(6):965-969. doi:10.1093/ageing/afaa131
16. Pastrana T, De Lima L, Goodwin CP. The value and economic benefits of palliative care in primary health care settings: reducing the burden of medical-poverty traps in low-income countries. Ann Palliat Med. 2024;13(2):158-167. doi:10.21037/apm-24-122
17. Rehman Z. Masculinity, honour, and family wellbeing in Pakistan: an ethnographic perspective. J South Asian Stud. 2017;40(3):651-667. doi:10.1080/00856401.2017.1315062
18. Rodríguez-Prat A, Monforte-Royo C, Porta-Sales J, Escribano J, Balaguer A. Understanding patients' experiences of the wish to hasten death: a systematic review of qualitative evidence. BMJ Open. 2017;7(9):e016659. doi:10.1136/bmjopen-2017-016659
19. Shaheed F. The cultural articulation of patriarchy. In: Zia A, Mumtaz S, editors. Women, Health and Culture in Pakistan. Karachi: Oxford University Press; 1999. p. 65–89
20. Sheikh M, Saqib A, Aljunid SM, et al. Hospice vs palliative care: a comprehensive review for internist and primary care physicians. J Fam Med Prim Care. 2022;11(8):e3635-e3641. doi:10.4103/jfmpc.jfmpc_2262_21
21. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non–small-cell lung cancer. N Engl J Med. 2010;363(8):733-742. doi:10.1056/NEJMoa1000678
22. World Health Organization. World report on ageing and health. Geneva: World Health Organization; 2015.