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Addressing unmet supportive care needs in metastatic breast cancer: A qualitative exploration to inform models of care

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ABSTRACT

Background: Advances in diagnostics and treatments have resulted in many individuals with metastatic breast cancer living longer with the disease. A cohort has thus emerged with unique, complex and largely unmet supportive care needs. We performed a qualitative study to explore the views of individuals living with advanced breast cancer and healthcare professionals regarding supportive care services in this cohort.

Methods: Focus group discussions were conducted with two groups; individuals living with metastatic breast cancer (n = 10) and healthcare professionals (n = 11). Questions addressed: (1) unmet needs, (2) models and supportive care services, (3) barriers and facilitators in service delivery, and (4) future service development. Interviews were recorded, transcribed, and analysed using an inductive thematic content analysis.

Results: Focus group discussions revealed considerable unmet supportive care needs, varying across the trajectory of the disease. Themes included unmet supportive care needs; lack of services; unmet needs of specific groups such as males and those in the LGBTQI + community; effective types of supportive care and solutions to address unmet needs. Emphasis was placed on the need for accessible and reliable metastatic breast cancer-specific information, directed towards helping individuals live well with the diagnosis. The need for multipronged and coordinated approaches to support individuals across acute, community and palliative care services was highlighted. A shared care and patient-led model of survivorship care was preferred. Dedicated support hubs were suggested as well as improved financial and family support services.

Conclusion: Focus groups revealed the extent and diversity of the unmet needs of individuals living with metastatic breast cancer. Findings from this research can inform the development of comprehensive supportive care services in the future.

1. Introduction

In 2020, breast cancer became the most common form of cancer worldwide, with 2.26 million cases diagnosed globally, accounting for 12% of cancer diagnoses (Sung et al., 2021; WHO.int, 2020). Metastatic breast cancer (also called stage IV breast cancer or advanced breast cancer) is caused by the spread of cancer cells to beyond the primary breast and regional lymph nodes. Metastatic breast cancer is considered an incurable disease but with advancements in treatments, the 5-year survival rate is now approximately 25-30% (McClelland et al., 2015). Individuals are living longer with the disease (You et al., 2026); one study reported a median increase of 20 months in survival between 1985 and 2016, and another study reported an increase of 13.6 months between 1990 and 2010 (Sundquist et al., 2017; Welt et al., 2020). Recent research indicates that up to 10% of patients with metastatic breast cancer can achieve long-term undetectable disease, and as a result, will

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attain prolonged survivorship (Sytov et al., 2021). This growing cohort of individuals living with metastatic breast cancer have unique and complex care needs that are found to diverge from those of individuals living with primary breast cancer (Cardoso et al., 2018).

As the illness and associated treatment trajectory evolve, care needs shift dynamically over time. Improved survival is relatively recent; thus the supportive care needs of this cohort are understudied and underserved (Alfano et al., 2019; Mollica et al., 2020). Supportive care for people with metastatic breast cancer is often inconsistent, variably prioritised, and heavily influenced by individual clinicians and care settings (Franklin et al., 2026). Such fragmentation makes it challenging to systematically capture, define, or understand patients' supportive care needs. Supportive care, as defined by the Multinational Association of Supportive Care in Cancer, encompasses the prevention and management of the adverse effects of cancer and its treatment across the entire disease continuum, from diagnosis to end of life. This includes the management of both symptoms and side effects (MASCC, 2023). Moreover, supportive care is intended to be holistic and person-centred, addressing the diverse and evolving needs of individuals across their cancer journey.

The symptoms and treatment-related side effects experienced by people living with metastatic breast cancer are complex and affect all aspects of daily life, including psychological, physical, social, and financial wellbeing (Lyons-Rahilly et al., 2024). Unmet needs in these areas can negatively impact the individual's quality of life (Aranda et al., 2005; Kadravello et al., 2021; Williamson et al., 2018). Therefore, we conducted focus group discussions to explore the views of individuals living with metastatic breast cancer and healthcare professionals, regarding the unmet needs of individuals living with metastatic breast cancer and the possible development of supportive care services to meet those needs. It is hoped that the results of this study may be used to better guide the development of such services in the future.

2. Methods

2.1. Study design

The LYSA Trial patient and public involvement (PPI) panel (Medved et al., 2025) highlighted the disparities in service access for women living with metastatic breast cancer versus curative breast cancer. This acted as a trigger point for this current study.

This study used a qualitative approach, making use of latent qualitative content analysis of focus group transcripts. The study is reported using the 32-item consolidated criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007) and the Standards for Reporting Qualitative Research (SRQR) checklist [Supplementary File 1] (O'Brien et al., 2014).

2.2. Participants

Eligible participants were over the age of 18 years, able to speak English and provide informed consent. The participants were from two groups, 1) individuals living with metastatic breast cancer and 2) healthcare professionals with an interest in metastatic breast cancer. Individuals living with metastatic breast cancer were eligible if they were diagnosed with metastatic breast cancer and had received treatment in Ireland. Healthcare professionals were eligible if they worked in Ireland and had an interest in the supportive care of individuals living with metastatic breast cancer.

Participant recruitment was multi-pronged. First, an email with study details and an approved study poster was sent out to healthcare professionals which invited them to take part in the study and to circulate the study details. Secondly, an advertisement was run by the Irish Cancer Society on their Twitter and LinkedIn platforms. The study was also advertised in a regional newspaper over three days. Finally, members of the research team attended metastatic breast cancer information events and visited hospital outpatient clinics to share details of the study.

Each eligible participant who contacted the team was sent an information leaflet, consent form, and sociodemographic questionnaire. Participants were instructed to return a copy of the consent form and keep a copy for their own records, and informed that the data would be anonymised for analysis.

2.3. Procedures

Participants were given the option of in-person or online focus groups; however, all participants chose the online option. Consenting participants were emailed a link to the Microsoft Teams Meeting. The focus group discussions were audio recorded and auto-transcribed using in-programme functions. The sessions were guided by a single facilitator (JH, GP or NM). Two further members of the study team were online for recording and transcription duties and technological support (GP, NM). Participants had no prior relationship with any of the facilitators.

The focus groups were 60 to 90 minutes long and were scheduled in the evenings. There was a maximum of six participants per session to allow for meaningful discussion, input by all individuals, and to ensure as many of the key topics were covered as possible.

The patient and healthcare professional cohorts were interviewed in separate focus group sessions. The semi-structured interview guide addressed the following: (1) unmet needs, (2) models and services to support survivorship care, (3) barriers and facilitators to delivering such services, and (4) future service development. The guide was iteratively developed after each focus group to include additional probes. Participants were not provided with the interview schedule in advance, and there were no repeated groups.

2.4. Data analysis

Following each session, the transcript was downloaded and reviewed against the audio recording to rectify any inaccuracies picked up by the auto-transcription function (JH, GP, NM). The transcript was anonymised, checked, and subsequently the audio recording was deleted. Details of this process were recorded in the data management plan.

Data was analysed using latent content analysis, in which the transcripts were coded, and themes and subthemes emerged (JH, GP, DK, NM). The stages of thematic analysis in the present research reflect those outlined by Vaismoradi et al. (2016), including the initialization, construction, rectification, and finalisation phases (Vaismoradi et al., 2016). The process of qualitative content analysis was multi-phase. This included reading and rereading the transcripts, creating and extracting units of meaning, creating codes, abstracting and collapsing codes, creating subthemes and overarching themes. This method was effective for the analysis of patterns or 'themes' within data, especially when employed inductively (Braun and Clarke, 2006). The aim was to interpret and understand the intrinsic narrative in what the participants discussed, how they discussed it and what framing they used.

Once the transcripts were coded, all codes were moved into a shared excel sheet with corresponding quotes from the participants to illustrate the point. All quotes were anonymised and denoted by their cohort origin. Three researchers continually cross-checked codes to ensure that no discrepancies in coding and analysis were present (JH, DK, NM). Quotes are used in the presentation of findings to further illustrate the meaning participants ascribed to sub-themes.

2.5. Reflexivity and trustworthiness

Each transcript was analysed by an author and cross-examined by a second author to strengthen credibility, increase dependability and minimise the risk of discrepancy throughout the coding process (Elo et al., 2014). The research team worked collaboratively to ensure that the emerging codes were a true reflection of the data. Credibility was

supported through neutral facilitation, rigorous, transparent analysis, and the involvement of multiple researchers in coding and interpretation of the data. Transferability was supported by detailed contextual reporting to enable comparisons across settings. An unabridged description of the data collection and analysis process is provided to maintain auditability. All researchers involved in facilitating focus groups were advised and guided throughout the course of the study by an experienced qualitative researcher (JH).

2.6. Ethical considerations and data management

This research received ethical approval from the Clinical Research Ethics Committee Cork (CREC Review Reference Number: ECM 4 (w) 22/02/2022). All interested individuals were provided with a detailed information leaflet and provided written consent. The anonymous transcripts, sociodemographic information and consent forms are stored on a password protected device, only accessible by members of the research team, for a period of ten years. Data management was carried out in accordance with national General Data Protection Regulations guidance.

3. Results

3.1. Participants characteristics

Ten individuals with metastatic breast cancer participated, two of whom chose not to fill out a sociodemographic questionnaire. The median age was 52.5 years and the median time since diagnosis was 24 months (range 6 to 24 months, Table 1).

Eleven healthcare professionals participated, including medical doctors (n = 4), nurses (n = 5), a dietitian (n = 1), and a physiotherapist (n = 1). Their healthcare experience ranged from 1 to 42 years, with a median of 24 years (Table 2).

3.2. Themes

The data were organised into five themes and 23 subthemes. The themes, associated subthemes and sample quotes are shown in Table 3.

Table 1
Sociodemographic information of individuals with metastatic breast cancer.

Characteristic		N
Total number of participants		8[a]
Age in years *Median (range)*		52.5 (40-77)
Gender	Male	0
	Female	8
Relationship status	Married/Domestic Partner	6
	Single, never married	2
	Widowed	0
	Divorced/Separated	0
Children	Yes	6
	No	2
	Have dependent Children	5
Living in ___ area	Urban	1
	Suburban	4
	Rural	3
	Very rural	0
Months post- metastatic breast cancer diagnosis *Median (range)*		24 (6-24)
Disease status	Bone metastasis	5
	Visceral metastasis	3
Active Treatment	Yes	8
	No	0

[a] *Two participants in this cohort chose not to return a sociodemographic questionnaire.*

Table 2
Sociodemographic information of healthcare professional participants.

Characteristic		N
Total number of participants		11
Gender	Male	1
	Female	10
Healthcare Professional	Oncology Nurse	6
	Medical Oncology Consultant	2
	Psycho-Oncology Consultant	1
	Dietitian	1
	Physiotherapist	1
Healthcare experience in years Median (Range)		24 (1 - 42)

3.2.1. Theme 1. The unmet supportive care needs of individuals with metastatic breast cancer

The breadth of unmet supportive care needs is reflected across the subthemes, with each one representing a distinct area of unmet need, as outlined in Table 3. Individuals with metastatic breast cancer have varying levels of supportive care needs which necessitates a tiered approach to supports particularly psychological support. Financial issues were also discussed as many are living longer post-diagnosis; thus, they are living longer in a state of financial insecurity. An example is the access to a medical care within the Irish Health System, which some participants noted difficulties in attaining access or limited access to some public services.

3.2.2. Theme 2. Lack of services which contribute to unmet needs in individuals with metastatic breast cancer

The second theme, made up of three subthemes, focused on the current healthcare system and the idea that the current model of follow-up care is not the most effective for individuals living with metastatic breast cancer. Oversaturation of existing services, a lack of metastatic breast cancer -specific information, and follow-up care that focuses on disease surveillance rather than living well with their diagnosis were points of discussion. Many felt there was a lack of information on how to live well with their diagnosis, and limited support for managing side effects from treatments. Healthcare professionals felt that efforts to expand services were not extensive enough, especially in terms of palliative care. The benefits of early referral based on an early integrative palliative care model are negated by the need to discharge patients who are 'well'.

Both participant groups highlighted the lack of sustained development of services and the lack of distinction between care pathways for early-stage and advanced breast cancer as contributors to unmet needs. Some participants felt the current model of care in the Irish context was unsuitable and tended to focus on monitoring disease rather than addressing serious side-effects or assisting them to live well.

3.2.3. Theme 3. Unmet needs of specific groups and the heterogeneity of the metastatic breast cancer cohort

Metastatic breast cancer is a heterogeneous disease and participants felt that they formed an extremely diverse group, in terms of disease progression, ages and life-stages. Healthcare professionals highlighted the unmet needs of males with metastatic breast cancer, discussing the gendered language, use of colour, imagery and settings associated with metastatic breast cancer. The LGBTQI + community was also a point of consideration for participants looking to future development of inclusive metastatic breast cancer services. Participants discussed the need to extend the idea of supportive care beyond the patient, particularly for individuals with children, to include services for the family, such as educational and emotional support throughout the trajectory of the disease. As there is significant variation within the cohort, it is essential to develop a multi-pronged solution to address these differences.

Table 3
Themes and subthemes.

Themes and Subthemes	Illustrative Quotes
Theme 1: The unmet supportive care needs of individuals with metastatic breast cancer	
Financial uncertainty and need for support	"All these things that you're trying to work out like can you afford not to work? You have to try and manage [work] then a six-month course of chemotherapy. It's a thing that nobody talks to you about. Nobody helps you with." (Participant with MBC, FG1)
The need for psychological support and the types of support needed changes over time	"Initially you're in shock and you're in self-preservation mode. There's only so much you can take on. Some days you're fine and some days you're not, you're never going to know which days" (Participant with MBC, FG2)
Need for support for specific symptoms and issues	"I'm in hospital every week, so I'm being watched very closely but [not] when it comes to simple things like lymphedema or cording …" (Participant with MBC, FG4)
Needs that diverge from primary breast cancer	"Metastatic breast cancer [patients] don't have the same supports as the adjuvant [patients]. It's a completely different disease and they're a completely different cohort of patients" (Nurse, FG1)
Metastatic breast cancer as a chronic illness with debilitating long-term effects	"You're living with a chronic illness, but it's cancer. If it was a chronic illness, would it be treated the same? It is like a chronic illness you're going on for years, there's an upheaval in that respect" (Nurse FG1)
The need to promote wellness through physical activity	"I'd love to be doing classes. I walk every day [but] that might not be suitable. [We] need guidance with these extra things." (Participant with MBC, FG2)
Theme 2: **Lack of services which contribute to unmet needs in individuals with metastatic breast cancer**	
Oversaturated services	"There was only one psychologist and a nurse … They didn't know when they could give me another [counselling session] after the first and [I was told] that some people were in worse states" (Participant with MBC, FG2)
Poor signposting and more information needed on living well with cancer	"There was no information about living with cancer. None of the breast cancer information via the [Health Service] mentioned metastatic breast cancer in any kind of shape or form. It was either terminal cancer, how to tell your children its terminal, life after chemo etc. Nothing about living with cancer and living with ongoing treatment that's going to be indefinite" (Participant with MBC, FG2)
A healthcare system that is not organised to meet the supportive care needs of individuals with a metastatic disease	"In our health service, access to GPs [Family Physician] is very hard, if we ask [patients] to go to their GP's, they can't for [a] few days. Their GP say they're having cancer treatment, go back to their medical team, puts them in an awful situation." (Nurse, FG1)
Theme 3: **Unmet needs of specific groups and the heterogeneity of the metastatic breast cancer cohort**	
Males with metastatic breast cancer	"Everything we do is for women, taking out the gender is a problem, the big numbers are female. Men bring their own needs and individual needs." (Nurse, FG1)
Family members of individuals with metastatic breast cancer	"If somebody is diagnosed with metastatic breast cancer, [there's a] huge ripple effect across siblings, parents, children … as the patient, you can't really support them but you're the only one getting the information [and] it's very hard to offload" (Participant with MBC, FG2)
Children of individuals with metastatic breast cancer	"We have been referring patients to a social worker trained in family work, trying to be a therapeutic intervention for the children … Unfortunately, they're not accessible, a more specialised kind of family support would be great" (Doctor, FG3)
LGBTQI + specific needs	"There's gender, LGBT in our community, we don't look at that at all in Ireland and that is coming … they have different needs and that feeds into their sexuality needs, how they see themselves, how they fit into communities." (Nurse, FG1)
Heterogeneity - no typical profile of individual with metastatic breast cancer	"Just to reiterate that MBC is a very diverse group, diverse in terms of the spectrum of disease, spectrum of ages, socioeconomic statuses, urban versus rural. There are huge differences within the cohort." (Doctor, FG3)
Theme 4: **Supportive care for individuals with metastatic breast cancer**	
Information, understanding and reliable sources of information	"I prefer to know that there is a backup plan [when it comes to drugs]. They've loads of backup plans. If I knew at the start that there were all these backup plans, I would have said oh look we've loads of options. I never knew that there was lots of options" (Participant with MBC, FG4)
Support groups	"I think being brought together with other people in your region would be hugely powerful and empowering" (Participant with MBC, FG2)
Workshops and seminars	"[I found] the seminar that was facilitated in [support house one] brilliant. What really helped me was the understanding of the science behind metastatic breast cancer and the fact that there's so many different types and so many different types of treatments. It reassured me as to what I was actually dealing with" (Participant with MBC, FG2)
Theme 5: **Solutions to address the array of unmet supportive care needs**	
Multi-pronged integrated tiered solution	"Accurate information, linkage to people who are in a similar situation and then at a dedicated nurse with the skill set to deal with that cohort specifically" (Doctor, FG3)
A shared care model	"This could work really well with a shared care type thing, the treatment and side effects are dealt with within the hospital setting, scans, follow up then the other issues like psychosocial care the dietitian, the OT [occupational therapist] all that kind of stuff if that could be done outside the hospital." (Nurse, FG1)
Relevant, accessible and digestible information	"Some way of guiding [patients] towards information relevant to themselves so they're not reading a broad range of information that's not relevant" (Doctor, FG3)
A person-centred approach	"MDT supports in a place that's suitable and accessible, build on self-management … It's getting them to manage what they have and where they're at, self-management is logical. If they have new issues they have quick access to clinic, that is led by the patient" (Nurse, FG1)
Dedicated metastatic breast cancer nursing team and metastatic breast cancer hub	"I just wonder, do we need some place [a hub] where women living with metastatic cancer can actually

(*continued on next page*)

Table 3 (*continued*)

Themes and Subthemes	Illustrative Quotes
	continuously access different types of programs to suit their needs? As they constantly evolve and change." (Participant with MBC, FG2)
Symptom assessment and management via virtual platforms	"[Name of Clinical Trial 1] is coming to us twice and then follow-ups are all virtual … these virtual platforms [mean] being able to pick up the phone to speak to a dietician or go on to a video call to have that conversation" (Allied Healthcare Professional, FG1)

Abbreviations: FG, Focus Group; MBC, metastatic breast cancer.

3.2.4. Theme 4. Supportive care for individuals with metastatic breast cancer

To understand what supportive care services should be developed in future, it is important to first understand what existing types of supports are useful and effective. Participants felt that accessible, digestible and reliable information was crucial in supportive care. Information services such as seminars are beneficial because they are a reliable source of information and reduced the burden of sourcing information for themselves. Support groups were praised and described as safe, friendly spaces where realistic information can be obtained. Participants expressed a preference for having access to both in-person and online support groups and emphasised the importance of regulating online support groups. Misinformation and overwhelming amounts of irrelevant information online were highlighted as obstacles.

3.2.5. Theme 5. Solutions to address the array of unmet supportive care needs

Participants agreed that any solution would have to take a multipronged approach to supportive care, addressing the needs of an individual in a multitude of domains. A transition towards a shared care model was discussed, articulated as a community-based physical space supported by a virtual metastatic breast cancer hub. Participants envisaged the hub to include support services, information and a social aspect as individuals living with metastatic breast cancer emphasised the benefits of seeing others living well with the same diagnosis. Healthcare professionals spoke of the need for dedicated metastatic breast cancer nurse-led teams. Central to all solutions presented was the idea that they must be person-centred and led, allowing the individual to discuss and address their needs and priorities. Participants felt the current medical model was laser focused on treating and monitoring disease progression to the point where serious side effects of treatment were not being prioritised, thus, impacting the individual's quality of life.

3.3. Targeted support measures to address the unmet needs

Together, the themes and sub-themes culminate in a comprehensive vision that highlights the importance of developing an advanced cancer pathway alongside integrated supportive care services for people living with metastatic breast cancer (Fig. 1). The pathway incorporates an integrated care model with expanded community-based services; a dedicated metastatic breast cancer Hub that combines a physical space with a digital support platform; specialist nurses and nurse-led services tailored to individual needs; comprehensive education and support for families; and targeted interventions designed to address specific symptoms and challenges (Table 4). Seen through a broader, more holistic lens, the pathway represents a shift toward enabling individuals to live well with metastatic breast cancer.

4. Discussion

This research presents the breadth of unmet needs within this cohort of individuals reflecting both the diversity of those needs and the heterogeneity of the population. Several recommendations emanate from this research, one of which being the development of inclusive information, services and settings relating to metastatic breast cancer. To achieve this, future development of supportive care services must recognise the heterogeneity of the group. Accessibility of supportive care should be addressed through the development of accessible and reliable information and the development of an information platform dedicated to living well with metastatic breast cancer. A physical space dedicated to metastatic breast cancer support was suggested, a central location for metastatic breast cancer specific courses, support groups, and socialising. A transition towards shared care is necessary and should

Fig. 1. How to support the individual living with metastatic breast cancer.

Table 4
Targeted support measures to address the unmet needs.

Targeted Support Measures to Address the Unmet Needs
1. Integrated Care Pathways
Create a structured, tiered pathway that links oncology, primary care, psychological support, and symptom management so patients aren't left navigating fragmented services alone.
2. Metastatic Breast Cancer Hub
Develop a central, continuously accessible hub offering programs, information, virtual check-ins, and signposting tailored specifically for MBC and the changing needs of patients.
3. Specialist Nurse and Nurse-Led Services
Implement MBC-specialist nurse roles to deliver rapid advice, triage symptoms, coordinate care, and provide ongoing psychosocial guidance as needs evolve.
4. Education and Support for Families
Introduce structured family-focused interventions and signposted services (including for children) to reduce patient burden and address the ripple effect of diagnosis.
5. Tailored Interventions
Provide personalised support options that consider gender, age, LGBTQI + identity, socioeconomic status, and disease presentation to ensure truly inclusive care.
6. Shifting Focus to Living Well with Metastatic Breast Cancer
Offer guidance on exercise, lifestyle, long-term symptom management, and wellness strategies to support people in living fully with a chronic, ongoing illness.

Abbreviations: MBC, metastatic breast cancer.

prioritise multipronged, integrated and coordinated approaches to support individuals with metastatic breast cancer across acute, primary, and palliative care services. A further priority should be the expansion of supportive care services to include the family. Increased financial support for individuals with life-limiting illnesses such as metastatic breast cancer needs to be addressed.

By ascertaining the opinions of both individuals living with metastatic breast cancer and healthcare professionals, this research has the potential to explore the intersection of supportive care needs and supportive care delivery, the unique perspectives of each cohort and where they overlap. While the involvement of healthcare professionals in this research was novel, the five themes that emerged, reiterated research carried out on the supportive care needs of individuals living with metastatic breast cancer and advanced cancer globally, spanning decades (Table 3).

The present research emphasises that it is necessary to change the approach to supportive care for individuals with advanced and life limiting diagnoses. Suggestions in this research echo those of previous research which advocated for shared care and the shift away from disease surveillance toward self-management (Corner, 2008; Fallowfield et al., 2023). A 2019 study suggested that a care model distinct from the curative pathway is necessary for the supportive care in advanced cancer (Alfano et al., 2019). A 2015 study also suggested that the needs of individuals with metastatic breast cancer should be addressed in a manner distinct from those on a curative pathway with more attention given to the impact of treatment side-effects (Lewis et al., 2015).

Studies from the US and Europe consistently identify high unmet supportive care needs among women with metastatic breast cancer, encompassing psychosocial, physical and functional, health system and information, and sexuality and fertility domains, with European data reporting prevalence rates of 86% - 93.5% across these needs (Çinar et al., 2025; Moreno et al., 2023).

The present study adds to the growing evidence base by identifying informational needs as a key unmet priority, with participants consistently describing the need for accessible, understandable, and relevant information about metastatic breast cancer, alongside prior findings that patients often rely heavily on healthcare professionals for disease-related information (Lewis et al., 2015). This aligns with broader literature highlighting multilevel barriers to supportive care and the need for personalised, comprehensive physical, emotional, and psychosocial support (Buchanan et al., 2025), as well as more recent evidence of ongoing unmet needs and fragmented, inconsistent delivery of supportive care across settings, reinforcing calls for standardisation (Franklin et al., 2026). Patient-led work in Ireland and Northern Ireland further supports these findings by proposing system-level improvements including routine supportive care referrals, access to health records, and the development of national clinical guidelines (Gaynor et al., 2024), with the present study strengthening the global call for standardised supportive care pathways and guideline development.

A Malaysian study of individuals with metastatic breast cancer identified three core unmet needs relating to information, finances, and support, despite the presence of universal healthcare, with gaps in treatment availability and social security contributing to perceptions of inadequate public sector support (Kadravello et al., 2021), a pattern reflected in the present study regarding difficulties in obtaining medical cards entitling individuals to free or subsidised primary care. More broadly, financial toxicity and unmet support needs are consistently reported across the literature, including in a systematic review of patients and caregivers (Hart et al., 2022) and in qualitative work highlighting preferences for disease-specific resources and support among women with metastatic breast cancer (Marshall et al., 2025).

Shifting from tumour- and host/institution-directed approaches, the National Comprehensive Cancer Network's 2024 Call to Action for metastatic breast cancer emphasises patient-centred decision-making, including evaluation of current care models, development of robust outcome frameworks, and attention to factors such as health literacy, engagement, and equity (Rocque et al., 2024), while a recent systematic review similarly concludes that existing models remain inadequate due to pervasive gaps in support across patients' lived experiences (Lyons-Rahilly et al., 2024). Emerging evidence further suggests that standardised care pathways may offer a structured approach to integrating complex oncology and palliative care needs, including within metastatic breast cancer care delivery (de Matos et al., 2025).

Future research should explore the experiences of men with metastatic breast cancer, as inclusive language and spaces may not fully aligned to their unique needs. Based on our research, and that of others referenced; now is the time to drive change to offer optimal care for individuals living with metastatic breast cancer and their families. This can be achieved through multidisciplinary collaboration across the health service and collaborating partners in academia, charities, industry, policy makers and individuals living with metastatic breast cancer.

5. Strengths and limitations

This research has several strengths and limitations. One key strength was the use of focus group methodology which encourages participants to tell stories and share experiences. This allows researchers to obtain saturation in key research topics and to get a fuller understanding of the diversity of topics, perspectives and experiences that encompasses living with metastatic breast cancer and caring for individuals with metastatic breast cancer. Furthermore, small focus groups ensured that every participant had the chance to share input and allowed for follow up with probing questions. A significant strength in this research was the contribution of a PPI panel towards the research question, design and study process.

There were two significant limitations to this research. Firstly, the participants with metastatic breast cancer were all female. Secondly, recruitment challenges contributed to a smaller sample size, which is not uncommon in studies involving both busy healthcare professionals and

individuals living with advanced illness. Within the current healthcare environment, staffing pressures and high clinical demands may have limited professionals' availability to participate. For individuals with metastatic breast cancer, fluctuating health and the unpredictability of a metastatic cancer diagnosis could make research involvement difficult to plan. Nonetheless, the rich insights provided by participants offered meaningful depth and contributed substantially to the study's findings.

6. Conclusion

Advances in understanding the molecular pathways and biological subtypes of metastatic breast cancer have improved treatments and survival rates, while simultaneously increasing the complexity of symptom management, expectations of patients and families, and the need to safeguard quality of life. This study illuminates the substantial and multifaceted unmet supportive care needs of individuals living with metastatic breast cancer, revealing critical gaps across psychological, informational, financial, and symptom-management domains that current service structures in Ireland are not equipped to address. By integrating insights from both individuals with metastatic breast cancer and healthcare professionals, the findings underscore the urgent need for a dedicated, person-centred supportive care pathway that moves beyond disease surveillance toward enhancing quality of life. Participants articulated a clear vision for integrated and community-anchored models of care, inclusive of a dedicated hub, improved access to reliable information, regulated support options, and expanded family-focused supports. These results align with international evidence calling for system-level reform and emphasise the pivotal role of supportive care in advancing coordinated, equitable, and evidence-informed supportive care. To ensure future models are inclusive and responsive, further research must capture the experiences of under-represented groups, including men and LGBTQI + individuals. Collectively, this study strengthens the call to reconfigure supportive care delivery for metastatic breast cancer across Europe, toward models that empower individuals to live well beyond a cancer diagnosis.

Disclosures

Josephine Hegarty has received research grant funding to her institution from Pfizer Ireland in the past.

Roisin M Connolly has received research funding for clinical trials from Daichii Sankyo and Astra Zeneca all to her institution. Roisin M Connolly has consulted for Lilly. She has received travel/conference support from Novartis, Roche, Gilead and Daiichi Sankyo.

Authors have not used AI or AI-assisted technologies in the writing process for this manuscript.

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CRediT authorship contribution statement

Danielle Keane: Formal analysis, Investigation, Methodology, Project administration, Resources, Validation, Writing – original draft, Writing – review & editing. **Nicola Mitchell:** Data curation, Formal analysis, Investigation, Methodology, Resources, Validation, Writing – original draft, Writing – review & editing. **Katie E. Johnston:** Validation, Visualization, Writing – review & editing. **Grace Philips:** Data curation, Formal analysis, Investigation, Methodology, Resources, Validation, Writing – review & editing. **Kate O'Connell:** Methodology, Resources, Validation, Writing – review & editing. **Roisin M. Connolly:** Conceptualization, Funding acquisition, Methodology, Resources, Supervision, Validation, Writing – review & editing. **Josephine Hegarty:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Writing – original draft, Writing – review & editing.

Declaration of competing interest

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