PHYSICAL ACTIVITY, EXERCISE AND CANCER

ORIGINAL ARTICLE

Humanized care in cancer: What about exercise?

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ABSTRACT

Introduction: The humanization of patient care seeks to address their needs comprehensively, considering more than a clinical diagnosis. In oncology, part of this comprehensive care involves addressing the physical consequences of the process mainly through exercise. Objective: to analyse whether cancer patients were indeed receiving recommendations for physical exercise and whether their experience was. Methods: This is descriptive mixed research. Quantitative data were collected through a questionnaire. Subsequently, participants who met the selection criteria were selected to form a discussion group and collect qualitative data. Results: The quantitative results (n = 40) show that cancer survivors had felt humanization in the health field (77.5%) and in the physical exercise services provided (n = 30; 93.1%). The referral or advice to perform physical exercise came mainly from patient associations (n = 30; 33.3%) and nursing staff (n = 30; 30.0%). In addition, it was stated that the professionalism and empathy of the health and physical exercise professionals were the key points for the perception of humanization. Conclusion: cancer patients perceive that the cares received was humanized both in the medical field and in physical exercise services. However, it is necessary to increase the role of oncologist in referral to this type of services.
Keywords: Patient care, Exercise therapy, Oncology, Oncology nursing.

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INTRODUCTION

Humanized care (HC) can be understood like as the holistic vision of the patient as a person (Diaz et al., 2023; Moro Gutiérrez & González Fernández-Conde, 2022). This procedure has been overriding when the person`s clinic situation is more delicate as in the case of cancer patients (Diaz et al., 2023; França et al., 2013; Grisales-Naranjo & Arias-Valencia, 2013; Moro Gutiérrez & González Fernández-Conde, 2022; Navarrete-Correa et al., 2021). Nevertheless, there is evidence that these patients perceive the care received as dehumanized (Grisales-Naranjo & Arias-Valencia, 2013) mostly due to errors in communication, lack of empathy or misinformation about therapeutic issues (Diaz et al., 2023).

These shortcomings could affect the referral of patients to complementary care services such as physical activity (PA) adapted to the oncology setting (Campbell et al., 2019) leading to unclear prescriptions or recommendations that are not adapted to the specific needs of patients (Martínez Aguirre-Betolaza et al., 2024). On the other hand, it is unknown whether PA professionals follow this holistic view of the patient and correctly complement healthcare. For all the above reasons, the objective of this research was to analyse the experience of a cohort of cancer survivors in terms of overall care and, specifically, in relation to PA services.

MATERIAL AND METHODS

This was mixed descriptive research with two phases: a first quantitative phase (questionnaire) and a subsequent qualitative phase (focus group). It was approved by the corresponding ethics committee and follows the COnsolidated criteria for REporting Qualitative research (COREQ) (Tong et al., 2007).

Participants

Convenience sampling was carried out in cancer survivor associations for the submission of the quantitative questionnaire. No inclusion or exclusion criteria were specified at this stage to avoid sampling bias, and all participants had to give prior consent to access the questionnaire. Also, in this phase, participants could present themselves as candidates for the focus group or not.

For the second phase, the inclusion criteria were: having written consent to participate; having performed PA adapted to the oncological context during or after treatments; and having availability of videoconference connection.

Procedures

The original questionnaire of Bermejo et al. (2011) (Bermejo Higuera et al., 2011) was modified considering the additional information of the subject to be evaluated (Giuliani et al., 2020; Todres et al., 2009). For the focus group, the specific objectives of the session, the sample selection criteria, the role of the authors and a timetable were established prior to the session (Llopis Goig, 2004). The meeting was conducted through a virtual meeting room (Blackboard Collaborate Blackboard Inc., Washington DC, USA), which was accessible by invitation.

Statistical analysis

Quantitative data were analysed through the Statistical Package for the Social Sciences software (SPSS Statistics® v.27, IBM, Armonk, NY, EEUU). Only descriptive analysis was carried out.

RESULTS

40 questionnaire responses were collected and 12 survivors (30.0%) gave their consent to participate in the focus group. For the latter, 6 people (named by an alphanumeric codes S1 to S6) were finally selected after applying the inclusion criteria (Figure 1).

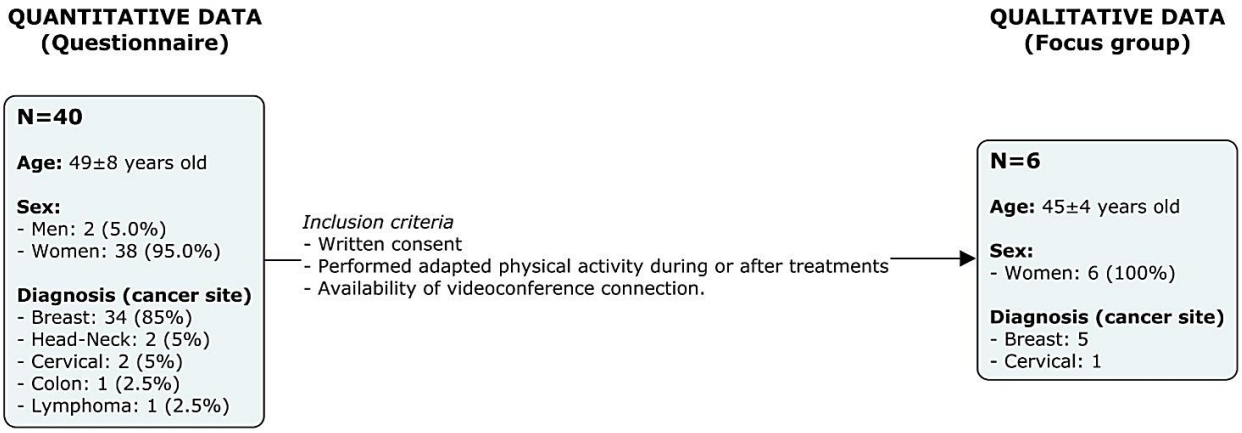

Figure 1. Descriptive data.

Table 1. Humanized care experiences. Quantitative data.

Humanized care experiences		
1. *Would you say that the care you received from health professionals was humanized*? (n = 40)	**Yes** **No**	31 (77.5%) 9 (22.5%)
2. Assign a score to the care received, from least to most humanized (0-5) according to the health professional. If you have not dealt with any of them, leave it blank (n = 40)		
	N	***Score***
Medical oncologist	40 (100%)	2.95 ± 1.66
Radiation oncologist	33 (82.5%)	3.12 ± 1.67
Surgeon	35 (87.5%)	3.46 ± 1.44
Nursery staff	40 (100%)	3.80 ± 1.34
Healthcare Assistants	36 (90.0%9	3.56 ± 1.34
3. *Did you perform physical activity adapted to your diagnosis during or after your cancer treatment?* (n = 40)	**Yes** **No**	30 (75.0%) 10 (25.0%)
4. If you answered "yes", how did you access to that exercise service? (n = 30)		
My oncologist told me about it		2 (6.7%)
Nursery staff (or healthcare assistants) told me about it		9 (30.0%)
A cancer exercise specialist told me about it.		5 (16.7%)
I found out from a patient's association		10 (33.3%)
Other (*I already practice exercise*)		4 (13.3%)
5. *Would you say that the care you received from cancer exercise specialist was humanized?* (n = 29)	**Yes** **No** **NA**	27 (93.1%) 2 (6.8%) 1 (0.1%)

Note. NA: no answer.

Humanized care in the health system

Quantitative data suggest a largely positive experience (Table 1). During the focus group it was suggested that deficiencies in humanization could be due to lack of time, an excessive workload and reduced resources.

The excellence and empathy of medical oncologist was highly valued. Regarding their empathy it was commented that "*these professionals work face to face with death, it is understandable that they establish an emotional barrier (…). Empathy is desirable but not mandatory*" (S6). Another participant added: "*We come to health care as a matter of survival, and you can't choose the oncologist or surgeon. You give yourself up because have no other choice, but you don't think about whether or not they're empathetic*" (S5).

Most of the sample undertook adapted PA after receiving information from patient associations or nursing staff. Those survivors with specific side effects were referred from the health system. In the focus group the main opinion was that this type of referral should be included in the conventional care of all cancer patients to provide truly comprehensive care.

Table 2. Humanized care beliefs. Quantitative data.

Humanized care beliefs (n = 40)		
5. *Indicate your level of agreement: ¿How important do you think each of these aspects are in the humanization of care?* (1: unimportant; 2: little importance; 3: moderately important; 4: important; 5: very important)		
	Professionalism	4.38 ± 1.07
	Commitment, motivation and vocation	3.75 ± 0.74
The professional (doctor, nursery staff, trainer…)	Training	3.75 ± 0.74
	Ethic	3.70 ± 0.75
	Holistic view of treatment	3.75 ± 0.74
	Personal involvement	3.78 ± 0.69
Established relationship with the professional	Communication skills	3.83 ± 0.67
	Empathic attitude and active listening	3.85 ± 0.58
	Resources, comfort…	3.72 ± 0.71
Facilities and organizational issues	Existence of work teams, coordination of personnel	3.83 ± 0.67
	Care for staff	3.85 ± 0.58

6. *Order by priority, from least to most important (0-5), the following characteristics of the professional (healthcare or not) associated with humanization.*

7. *According to each context (healthcare or physical activity services), indicate based on your experience what is the greatest cause of dehumanization*

	Healthcare (n = 40)	**Physical activity services (n = 30)**
The professional	6 (15%)	6 (20.0%)
The established relationship	7 (17.5%)	13 (43.3%)
The facilities	27 (67.5%)	11 (36.6%)

Humanized care in physical activity services

In terms of HC, the experience in PA services was perceived positively commenting in this regard that "*When you go to the medical service, you don't perceive that humanized care because you go in fear. In the gym, the tension drops because you exercise for another purpose than to cure an illness*" (S2). In addition, it was

established that cancer exercise specialist "*are not insisting on the same topic (the disease) all the time*" (S2) and "*During training we are treated as people who have a disease and not as if we were «a disease*»" (S5).

Moreover, those survivors who were forced to manage their own needs added that this allowed them to select a specific type of services and professionals with whom they could connect on a personal level.

Humanized care beliefs

Based on the quantitative results (Table 2) it was discussed in the focus group whether the defining characteristics of HC should be different for professionals in each area. In response, most participants stated that they would not value each professional differently, although others argued the opposite: "*The expectations of each professional are different: I go to the oncologist to save my life, I prioritise that"* (S5).

Thus, when comparing both professional roles, the health professional's excellence was valued more while for the PA professional´s empathy was the priority: "*There are many excellent oncologists and not so many empathetic ones. I will prioritize excellence of my doctor*" (S6). On the contrary, for other participants, empathy has to be implicit in professionalism and independent of academic preparation.

For the last, the hospital facilities and the need to modify their aesthetics were discussed. Considered the most dehumanizing factor in healthcare, they insisted that "*the space where they give you bad news is just important as how they give you that bad news*" (S5).

DISCUSSION

The data suggest that the perception of treatment received by the cohort followed premises of humanisation in both health care and physical activity services. However, the health system did not facilitate referral to such additional care services.

As Leininger (2006) explains, caring to help someone heal is not the same as giving them care considering their human condition in all its dimensions (Leininger, 2006). In this sense, our results suggest that survivors received comprehensive care, as has been noted in other studies (Navarrete-Correa et al., 2021). Nevertheless, it's necessary to highlight that the advice and referral of patients to perform adapted PA did not come from oncologist except in very few exceptions. These data differ from what was previously published (Martínez Aguirre-Betolaza et al., 2024) as well as some consensus documents requests (Herrero López et al., 2024), having even gone so far as to suggest that no recommending PA could constitute a lack of professional ethics (Segarra Vidal, 2024). In relation to this this lack of referral to additional care was excused citing already established reasons: lack of time, work overload, resources limitations and organizational circumstances (Beltrán-Salazar, 2014; Diaz et al., 2023).

In terms of the perceived experience in PA services, the possibility of choosing the professional and the type of service and the fact that professionals in this field were perceived as more empathetic were key. However, the relationship established between professional and patient is considered crucial.

Considering the above and that it has been suggested that effective communication is basic to building a humanised service (Diaz et al., 2023), it is worth highlighting certain guidelines to avoid during communication with the patient, such as the abuse of technicalities, making promises that are not guaranteed or not adapting to the patient's level when giving information (Moro Gutiérrez & González Fernández-Conde, 2022).

In conclusion, although HC was perceived by patients, some gaps have been detected suggesting that communication skills need to be further improved and the importance of referral to additional care services to provide comprehensive care for the individual needs to be emphasised.

Either way, this work is not without limitations, mainly the limited sample size. However, the mixed data collection strategy has allowed us to go deeper into the subject through the personal experiences of the patients collected during the focus group.

CONCLUSION

Although some deficits were detected, cancer survivors perceived HC, also in PA services. It was proposed that excellence, empathy and the quality of the human relationship between patient and professionals are key to maintaining this perception.

AUTHOR CONTRIBUTIONS

The research question was proposed by A.S.; the methodology was designed jointly by A.S. and A.T.; the statistical analysis of the data and the first draft of the text were prepared by A.T.; the final version of the article was reviewed and approved by both authors.

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DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

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