Oncology care humanization in adults: a scoping review protocol

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ABSTRACT

Objective: The goal of this review is to identify and map health professionals' attitudes and behaviors that promote humanization of the care provided to adults with cancer, regardless of disease stage or treatment nature, in all health care provision contexts.

Introduction: In the challenging context of oncology care, it becomes imperative to adopt a humanized care paradigm. This paradigm should foster a relationship of respect and compassion between health professionals and people, and its interventions should be sensitive to their values, culture, and human dignity.

Inclusion criteria: Studies involving health professionals' attitudes and behaviors focused on promoting humanization of the health care provided to people with oncological diseases will be considered for this review.

Methods: This review will follow the JBI methodology for scoping reviews. Publications will be identified via MEDLINE Complete, CINAHL Complete, MedicLatina, Psychology and Behavioral Sciences Collection, Scopus, and Web of Science. Additionally, backward and forward citation searches will be conducted, as will a thorough investigation of the gray literature. The studies identified will be screened by 2 independent reviewers based on their title and abstract, and then reviewed at the full-text level. The data will be extracted using a tool developed by the authors. The results will be summarized and presented in tables accompanied by a narrative summary.

Review registration: Open Science Framework https://osf.io/56ev9/

Keywords: attitude of health personnel; behavior; humanism; neoplasms; patient care

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Introduction

Oncological diseases are increasing significantly worldwide. According to data from the International Agency for Research on Cancer (IARC), the number of new cancer cases globally by 2050 is estimated to reach 35.3 million, which corresponds to a 77% increase compared with 2022. Simultaneously, mortality is expected to rise to 18.5 million by 2050, corresponding to a 90% increase compared with 2022.[1]

A cancer diagnosis not only imposes physical strain on people but also emotional stress, inducing an increase in vulnerabilities and, potentially, negative impacts on health care outcomes.[2] Treatments often require prolonged health assistance, exposing individuals to factors that directly affect their health status and well-being.[3] Approximately 20% to 40% of people with oncological disease experience some type of emotional distress that may be characterized by physical symptoms or by a sense of missed opportunities in the present and uncertainty about the future.[4]

Humanized care becomes essential in this context. Identifying vulnerable people's needs presents a challenge for professionals. This emphasizes the urgent need for a proximity practice, understood as a care approach that fosters close, empathetic, and personalized

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interactions with individuals, supported by health care systems adopting policies to promote a humanized care culture.[3–5] Although advancements in therapeutic and diagnostic approaches are directly related to higher disease survival rates, their management has become increasingly more fragmented and materialized, drawing health professionals to a more biomedical model–centered approach.[6] Deepening of knowledge and technological advancements has led to increasingly sophisticated practices, contrasting with the growing disconnection between health professionals and people, making the latter more vulnerable when dealing with overly technical and less humanistic practitioners.[7–9] Several theories have been developed in the realm of nursing, countering standardized and impersonal treatments that can be implemented in health care settings. Jean Watson's Theory of Human Caring stands out, which emphasizes the inclusion of values such as hope, trust, and spiritual support in health care.[10,11] In addition, the Transcultural Nursing Theory developed by Leininger argues that health care professionals should respect the patient's values and beliefs about health and illness, as well as the standard behaviors of individuals from different cultures, tailoring specific care planning and implementation for optimal health care outcomes.[12,13]

In the pursuit of excellence in clinical practice for people with oncological diseases, it is imperative to implement a humanized paradigm, fostering a relationship of respect and compassion between health professionals and people, with attitudes and behaviors sensitive to values, culture, and human dignity.[14,15]

However, the concept of humanizing health care often overlaps with other concepts, such as person-centered care. While person-centered care appears to focus on mainly understanding each person's characteristics and their relationship with the dynamic environment, humanization encompasses it, extending its scope to the attitudes and behaviors adopted by the entire health care system and its stakeholders.[16–19]

Thus, humanized care in oncology goes beyond clinical competence, emphasizing specific attitudes and behaviors that foster a deeper connection between health professionals and people. Some studies consider that humanized care involves, for example, professionals welcoming individuals in an empathetic manner, allowing them to express their feelings, identifying areas that may prove problematic, and defining their support sources.[15,20] In this sense, humanized care is exemplified by professionals introducing themselves to the person, presenting the treatment environment, and providing a contact number for follow-up questions, which shows a clear interest in fostering a collaborative model between patient and professional.[15,20]

Despite its importance and prominent role in clinical practice, the nature and boundaries of humanistic care represent a challenge for health professionals. In order to face this problem, Busch et al. developed a systematic review aimed at clarifying the concept and identifying its key elements. The authors propose key elements that can be considered guidance for all stakeholders involved in care, and are presented in 3 areas: relational, organizational, and structural.[19] For these authors, providing humanized care requires an empathetic and respectful approach. Sufficient material and human resources combined with a balanced workload are also required, so that a meaningful relationship can be established between health professionals and people.[19] In an effort to render this concept more operational, another concept analysis was performed by Taghinezhad et al. Based on their findings, "humanistic care is a multifaceted and dynamic process that requires the client's 'readiness and acceptance' and 'need' for care, as well nurses' educational background and moral and personality trait."[21(p.88)] This study contributes attributes and contextual factors to the definition of humanistic care. Nurses can better offer humanized care if they have a specific educational infrastructure, as well as suitable personality and moral and spiritual characteristics. However, both studies suggest that further research should be conducted to fully examine specific practices of humanized care in different clinical settings. Research on care humanization should not only focus on building consensus on the existing literature, but also on trying to design humanistic approach guidelines according to different care areas.

In order to support humanism in health care, the Arnold P. Gold Foundation gathers efforts to empower all stakeholders and create more humanized systems. They define humanism in health care as a relationship between professionals and people, based on respect and compassion. This reflects attitudes and behaviors sensitive to values and cultural backgrounds. They provide a framework for humanism based on 7 attributes: integrity, excellence, compassion and collaboration, altruism, respect and resilience, empathy, and service (IECARES framework).[22]

It is assumed that the concept of humanism is incorporated as a set of attitudes and behaviors that constitute health professionals' fundamental values.[23]

In this sense, to fully understand the ability for humanized care, it is essential to clarify the attitudes and behaviors that characterize it.[24] To structure humanized care, health professionals must understand themselves and others, translating this knowledge into action while being aware of the values and principles guiding such action.[25]

People's actions in their daily lives involve judgments about objects, themselves, and those around them.[26] An attitude is a mental process developed by an individual that triggers a more or less rapid, favorable or unfavorable response to a situation, event, or person. [27] Attitudes reveal an organized predisposition to perceive, understand, think, feel, and behave in a certain way. They are summary evaluations of an object comprised by cognitive, affective, and behavioral components.[27] The cognitive component refers to beliefs, thoughts, knowledge, and positive and negative attributes regarding an object; in turn, the affective component relates to the feelings or emotions associated with that object; finally, the behavioral component refers to how attitudes influence our actions or behaviors. Individually, each of these components is central to constructing and transforming attitudes, just as attitudes exert a reciprocal impact on beliefs, emotions, and behaviors.[26,27]

For some authors, humanized oncology care is based on an attitude of acceptance and listening, as well as on creating and maintaining therapeutic environments.[21] In clinical practice, decisions are often made in multidisciplinary teams without involving the patients; however, some authors emphasize the need to study health professionals' attitudes regarding patient representation.[16,28] Salazar[16] also emphasizes the need to reflect on nurses' attitudes during care provision based on a humanized approach. Health professionals are also concerned with optimizing time management and patient engagement during treatments as a way to humanize care.[15,16] In clinical practice contexts involving prolonged hospitalizations, the person may value simple humanistic behaviors, whereas in contexts like palliative care, humanizing care often involves more complex and multidimensional aspects, such as providing spiritual support.[14] Therefore, it is relevant to include the different contexts in which care is provided to people with cancer as well as the different phases of the disease, including palliative assistance, aiming to achieve a broader and more representative range of results.

Humanized care for people with oncological diseases is a current necessity that requires health professionals to analyze their actions in any circumstance, regardless of its complexity.[5,14] The multidimensionality of the care provided to people with oncological diseases and the specific needs of this population are the main reasons for this review.

Consequently, the purpose of this review is to identify and map health professionals' attitudes and behaviors that promote humanization of the care provided to adults with cancer, regardless of disease stage or treatment nature. A preliminary search in the Cochrane database, *JBI Evidence Synthesis*, MEDLINE, and CINAHL did not identify any systematic or scoping reviews on this topic. This scoping review aims to identify professionals' attitudes regarding care for people with oncological diseases and the observable behaviors that guide the humanized care principles.

Review question

Which attitudes and behaviors of health professionals have been reported in the literature as promoting humanization of adult oncological care?

Inclusion criteria

Participants

The review will consider studies focused on health professionals who take care of adults with cancer across the disease continuum. The studies should concentrate on professionals who are qualified to provide health care, excluding those who are still in training.

Concept

This review will consider studies that explore health professionals' attitudes and behaviors that promote care humanization in people with oncological diseases. The term *humanized care* is interpreted as an approach to a person with cancer and their family using a relationship where 1 or more humanistic behaviors can be detected. As previously stated, this is a complex and multidimensional concept that requires a structured framework for analysis. In the context of this research, the Arnold P. Gold Foundation definition of humanism and its attributes will be the reference. Humanistic health care will present the following attributes derived from the IECARES framework: integrity, excellence, collaboration and compassion, altruism, respect and resilience, empathy, and service.[22] This model integrates multiple related concepts under single attributes to emphasize the interconnectedness of certain behaviors and attitudes that contribute to humanistic care.

- *Integrity* refers to congruence between expressed values and adopted behaviors.
- *Excellence* is related to clinical expertise: the professional's clinical skills and knowledge acquired by study, training, or practice.
- *Collaboration and compassion,* while they may seem different, are combined within the framework to highlight how both are critical in the context of patient care. *Compassion* refers to health professionals' ability to understand and address patients' suffering, while *collaboration* reflects the teamwork and shared decision-making required to relieve that suffering effectively. In oncology care, for example, these 2 elements oftentimes go hand in hand: compassionate care is strengthened through collaborative efforts among health professionals, patients, and their families.
- *Altruism* refers to prioritizing the needs and interests of others over one's own.
- *Respect and resilience,* similarly, are combined to underscore the mutual dependence of these qualities. *Respect* refers to acknowledging the patient's autonomy, values, and dignity, while at the same time, *resilience* relates to health professionals' ability to maintain their commitment to these values despite challenges such as emotional stress, workload, or care complexity. In combining these attributes, the framework suggests that respect for a patient is maintained through a health professional's resilience in facing the difficulties inherent to oncology care.
- *Empathy* is the ability to put oneself in another person's situation, for example, physicians or nurses being aware of a patient's thoughts and feelings.
- *Service* reflects a person's willingness to dedicate their talent, time, and resources to those in need; to give more than is necessary.[22]

The eligible sources included will focus on or describe these attributes of humanization and its potential relationship with direct or indirect care, without neglecting the organizational, bureaucratic, and structural aspects of the health care provided to these people. Attitudes and behaviors will be considered throughout their entire spectrum and dimensions, as long as it is possible to observe and evaluate a relationship between the actions and intentions to promote humanized health care.

Context

This review will consider studies conducted in or related to health care services that diagnose, refer, treat, or provide professional support for adults with cancer. These may include primary care centers, public and private hospitals, hospices, and home hospitalization. All studies will be considered, regardless of geographic location, as long as cancer is the main disease. Studies where the diagnosis is not clearly identified as cancer, is focused on a coexisting condition (pregnancy, acute non-carcinogenic state, or others), is not applicable to humans, or concerns the pediatric population (under 18 years old) will not be considered. Caregiver-centered studies will be excluded.

Types of sources

This scoping review will consider both experimental and quasi-experimental study designs including randomized and non-randomized controlled trials. In addition, observational studies, including prospective and retrospective cohort studies and cross-sectional studies, will be considered for inclusion. This review will also consider descriptive observational study designs, including case series, individual case reports, and descriptive cross-sectional studies, for inclusion. Given the nature of the question, qualitative studies and text and opinion papers will be considered for inclusion in this scoping review. Reports, guidelines, working and white papers, and websites will be identified in the database searches and screened as if they were full-text articles. All types of reviews, including systematic and scoping reviews, will be excluded; however, the reference lists of relevant reviews will be hand-searched for additional papers.

Methods

This scoping review will be conducted in accordance with the JBI methodology for scoping reviews[29] and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).[30] The protocol has been registered in Open Science Framework (https://osf.io/56ev9/).[31] (https://osf.io/56ev9/)

Search strategy

Two reviewers developed the search strategy, which was peer-reviewed by a third expert. The search strategy will aim to locate both published and unpublished studies. As previously stated, an initial limited search

was undertaken to identify articles on the topic of the review. The keywords contained in the titles and abstracts of relevant articles and the index terms used to describe the articles were used to develop a full search strategy for MEDLINE Complete (EBSCOhost; Appendix I). The search strategy, including all keywords and index terms identified, will be adapted for each database including MEDLINE, CINAHL, MedicLatina, Psychology and Behavioral Sciences Collection (all via EBSCOhost), Scopus, and Web of Science.

Protocols, working and white papers, and websites will be identified through targeted searches in specific databases that index gray literature, such as Science.gov, and MedNar. Additionally, backward and forward citation searches will be performed on identified sources to locate relevant non-academic materials. We will not restrict our searches by language; however, any relevant sources identified in languages other than English, Spanish, or Portuguese, will be translated into one of those languages using translation tools such as DeepL (DeepL, Cologne, Germany). Any full-text sources in a language other than the ones identified will be verified by someone proficient in the language.

All sources (academic and non-academic) will be screened according to the predefined inclusion criteria. Specifically, a 2-step screening process, conducted independently by 2 reviewers, will be applied: i) initial screening of titles and abstracts or summaries, and ii) a full-text review for eligible items. There will not be any limitations on year of publication.

Study selection

Following the systematic search, all citations identified will be collated and uploaded into Mendeley v2.98-dev3 (Mendeley Ltd., Elsevier, Netherlands) and duplicates will be removed. The Rayyan web-tool (Qatar Computing Research Institute, Doha, Qatar) will be used during the screening phase. To ensure consistency and reliability in the screening process, a pilot test will be conducted prior to the full review. This pilot test will involve screening data from a sample of 10% of the total citations identified in the initial search. Two independent reviewers will participate in the pilot test, screening the titles and abstracts to assess eligibility based on the predefined inclusion criteria. The pilot test results will be compared to assess the agreement level between reviewers. If a high similarity level (at least 80%) is observed between the reviewers' decisions, the process will proceed. However, if similarity is lower than expected, additional training will be provided to the reviewers to ensure better understanding of the inclusion criteria tool. This may include discussions to clarify ambiguities, reevaluation, and adjustments of the inclusion criteria tool, if necessary. Throughout the entire review process, any disagreements between reviewers will be resolved through discussion or by consulting a third reviewer if consensus cannot be reached. The potentially relevant papers will be obtained and the finalized citations will be entered into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI Adelaide, Australia).[32] Where the full text of a potential source is not available, the authors will be contacted up to 3 times in an attempt to obtain them. The full texts of the citations selected will be assessed in detail against the inclusion criteria by 2 independent reviewers. The reasons for excluding full-text evidence sources that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any disagreements that arise between the reviewers at each stage of the selection process will be resolved through discussion or in consultation with an additional reviewer. The results of the search and the study inclusion process will be reported in full in the final scoping review and presented in a PRISMA flow diagram.[33]

Data extraction

A pilot test will be performed for the data extraction phase. Two reviewers will independently extract data from 10% of the eligible full-text articles. The data extracted will then be compared to assess the agreement level between the reviewers. In cases where similarity of the data extracted is below the 80% threshold, further training will be provided to the reviewers to ensure uniform understanding of the data extraction tool and the specific information being sought. Any disagreements during extraction will be resolved through discussion or by involving a third reviewer, if necessary.

The data extracted will include specific details about participants, concept, context, study methods, and key findings relevant to the review question. The table was discussed among the authors and will include elements such as year, author, study design, and breakdown of the attitude or behavior that meets the review goals (see Appendix II). The extraction table will be tested before initiating data extraction. The draft data extraction tool will be modified and revised as necessary during the process of extracting data from each included paper. The modifications

will be detailed in the full scoping review. During the study selection stage, any disagreements between the reviewers will be resolved with the third author. When required, the authors of the papers will be contacted to request missing or additional data. The draft extraction form is provided in Appendix II. Critical appraisal will not be conducted as this is not required for a scoping review.

Data analysis and presentation

The scoping review findings will be illustrated using tables and figures. The attitudes and behaviors will be categorized according to the framework selected, regardless of the corresponding health professional. The results will be presented using a descriptive approach and summarized and presented in table formats accompanied by a narrative summary.

Author contributions

Conception and design of the article: ASL, ALR, BL, DS, DF; drafting the article: ASL, ALR, BL, DS, DF; critical revision of the article: RS, PM; final approval of the version to be published: RS, PM.

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Appendix I: Search strategy

MEDLINE Complete (EBSCOhost)

Date searched: December 23, 2024

Search	Query	Records retrieved
S1	TI "health personnel" OR AB "health personnel" OR MH "Health personnel"	75,312
S2	TI ("health care team" OR "Healthcare team interdisciplinar" OR "multidisciplinary care team" OR "health team") OR AB ("health care team" OR "Healthcare team interdisciplinar" OR "multidisciplinary care team" OR "health team")	7220
S3	S1 OR S2	88,803
S4	MH "professional-patient relations" OR TI "professional-patient relations" OR AB "professional-patient relations"	28,949
S5	MH "attitude of health personnel" OR TI "attitude of health personnel" OR AB "attitude of health personnel"	136,388
S6	TI "staff attitudes" OR AB "staff attitudes"	1190
S7	TI "behavior" OR AB "behavior" OR MH "bahavior"	862,498
S8	MH Humanism* OR TI Humanism* OR AB Humanism*	4613
S9	S4 OR S5 OR S6 OR S7 OR S8	1,023,201
S10	MH "Neoplasms" OR TI "Neoplasms" OR AB "Neoplasms"	633,943
S11	MH "oncology service, hospital" OR TI "oncology service, hospital" OR AB "oncology service, hospital"	1531
S12	TI ("cancer care units" OR "hospital oncology service") OR AB ("cancer care units" OR "hospital oncology service")	25
S13	MH "home care services" OR TI "home care services" OR AB "home care services"	38,322
S14	TI ("domiciliary care" OR "home care" OR "home health care") OR AB ("domiciliary care" OR "home care" OR "home health care")	25,551
S15	S10 OR S11 OR S12 OR S13 OR S14	683,638
S16	S3 AND S9 AND S15	428

Appendix II: Draft data extraction instrument

Author, year, country	Study description	Subjects/ population characteristics	Attributes of humanization Attitudes Behaviors	Integrity	Excellence	Collaboration and compassion	Altruism	Respect and resilience	Empathy	Service	Care context
	Study design Objective Study population Sample size	Demographics (age/others) Setting									