

Research Article

A Qualitative Investigation of Health Care Professionals' Perspectives on the Implementation of a Mindfulness Meditation Program in Cancer Care in Switzerland

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Received 6 September 2024; Accepted 21 March 2025

Academic Editor: Sowjanya Thatikonda

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Purpose: To describe health care professionals' (HCPs') perceptions of the implementation of an online mindfulness-based cancer recovery (eMBCR) program in the gyneco-oncology departments of two university hospitals in Switzerland.

Methods: The study analyzed determinants drawn from the Consolidated Framework for Implementation Research (CFIR) using a deductive, semantic, thematic approach. Five focus groups were conducted with HCPs and managers (12 nurses, 6 physicians, and 1 psycho-oncologist).

Results: Most HCPs supported integrating mindfulness meditation into cancer care, although some physicians viewed it as an alternative approach with insufficient evidence. Key facilitators included the presence of a center for integrative medicine within hospitals and the engagement of leaders and champions. Barriers related to time constraints, human resources, materials, and training were mentioned. Suggested strategies for successful implementation included hybrid program delivery (online and in person), context-specific adaptations (e.g., dosage), and securing stable funding for sustainability.

Conclusion: This study highlights multilevel factors influencing the implementation of a mindfulness meditation intervention in the context of cancer care and offers strategies to enhance its long-term integration within hospital settings.

Trial Registration: ClinicalTrials.gov identifier: NCT04564768

Keywords: cancer; health care professionals; implementation; mindfulness meditation; online; perception

1. Introduction

Health care professionals (HCPs) in the field of oncology are encouraged to identify and address supportive care needs by employing tailored and evidence-based interventions,

including meditation, music, art therapy or relaxation [1]. Nonpharmacological interventions such as evidence-based forms of stress reduction are recommended to facilitate the self-management of psychosocial cancer-related symptoms [2]. Among other integrative approaches, meditation has

been strongly recommended (grade A) as a way of reducing anxiety and stress as well as improving the moods and quality of life of patients with breast cancer [2].

Mindfulness meditation involves training in self-regulation exercises aimed at increasing the individual's deliberate control of attention with regard to a specific or unspecific target [3]. The main objective of such meditation is to foster self-reliant behavior aimed at improving one's well-being and health in general [4]. The mindfulness-based stress reduction (MBSR) program consists of 8 weekly in-group classes provided by a certified teacher. Several mindfulness-based interventions (MBIs) have been adapted to meet the needs of specific populations. The mindfulness-based cancer recovery (MBCR) program was adapted in 1996 for patients affected by cancer with the goal of supporting their self-care [5], and its effectiveness has been investigated by several clinical trials [6–9]. The MBCR involves sitting meditation, body scan meditation, gentle yoga, loving-kindness and mountain meditation, mini-breathing exercises, psychoeducation, and exercises focused on stress reactivity and sleep. Home practice of 45 min per day between classes is recommended [10].

Studies addressing questions relevant to the implementation and dissemination of MBIs as a primary goal from the HCP perspective are still rare [11]. Eyles et al. [12] reported that nurses and oncologists believed that an 8-week MBSR program was acceptable for patients with metastatic breast cancer and exhibited positive attitudes toward its implementation in the National Health Service. However, they highlighted some challenges, such as the time commitment, distance, and costs, associated with this approach. A qualitative study explored the experiences of 15 MBI teachers and 2 managers regarding the implementation of MBIs in Sweden's health care system [13]. Three themes were highlighted as important determinants of MBI implementation: (1) the training of MBI teachers and the importance of support for the implementation from local champions (persons who are particularly engaged in the implementation of an intervention), (2) patient referrals (including increased collaboration with coworkers and awareness of the benefits of MBIs), and (3) managers' and HCPs' knowledge and acceptance of MBIs as well as financial factors.

HCPs have been shown to be ideally suited to the task of introducing mindfulness meditation to patients with cancer since they have access to all relevant information, thus enabling them to identify patients who might benefit from self-care interventions [14]. However, HCPs may not feel prepared to discuss, guide, or monitor patients regarding their use of complementary medicine [15]. Access to HCPs who are trained in mindfulness meditation is one of the challenges associated with attempts to integrate MBIs into routine care [2]. In Europe, only approximately 20% of oncology departments offered complementary approaches in 2014 [16]. Although the availability of such resources might have increased in some countries, such as Switzerland, during the last decade, patients still exhibit many unmet needs in terms of integrative cancer care and self-management support in Switzerland [17].

The implementation of an MBI in routine care should be explored in diverse cultural and economic contexts [18, 19]. The contexts of implementation should be carefully understood, and strategies should be adapted to local conditions to foster acceptance or minimize implementation costs [18]. To our knowledge, studies of in-group MBIs in oncology in Switzerland [20] as well as a systematic evaluation of the factors that may influence the implementation of MBIs in cancer care remain lacking. As part of a larger bicentric prerandomized controlled trial [21] investigating patients' and instructors' perspectives as well, the present study describes HCPs' perceptions of the determinants influencing the implementation of an online mindfulness-based cancer recovery (eMBCR) program in the hospital oncology setting.

2. Materials and Methods

2.1. Study Design and Setting. This qualitative study explored implementation determinants selected from the Consolidated Framework for Implementation Research (CFIR) [22] through focus groups with HCPs working in the gynecology departments of two university hospitals in Switzerland, using a deductive, semantic thematic approach.

2.2. Participants and Study Procedure. Participants included nurses and head nurses, attending residents and head physicians, and one psycho-oncologist working in breast and/or gynecological cancer contexts. HCPs received brief study information orally, and interested HCPs received complete study information and consent forms via email. The researchers aimed to recruit an estimated sample of 20 participants, including a minimum of 4 participants per focus group [23].

2.3. Methodological Guiding Framework. The CFIR was used to guide data collection and analysis. The CFIR involves an extensive taxonomy of 39 constructs, which are grouped into 5 domains and may influence the implementation of an intervention in routine care. These 5 domains include *intervention characteristics*, *inner setting*, *outer setting*, *characteristics of individuals*, and *process*. The CFIR is mainly used in the postimplementation stage to inform the adaptation or maintenance of an intervention [24].

2.4. Variables and Data Collection. Participants' socio-demographic and professional data were collected before the focus groups through a self-administered questionnaire. The variables included age, gender, nationality, professional qualification, practice setting as well as work experience, working percentage, awareness of mindfulness meditation, personal use of complementary approaches, and training in complementary approaches.

The following CFIR constructs were selected by the research team to be explored during the focus groups: *evidence strength and quality*, *intervention complexity (intervention characteristics)*; *patient needs and resources (outer*

setting); culture, available resources and relative priority (inner setting); knowledge of and beliefs regarding the intervention (individual characteristics); and engagement (process) [25]. The rationale for the selection of these constructs was based on the stage of the implementation process and contextual needs. Since the study was testing the eMBCR program for the first time in this specific context, this process focused mainly on the perceived need for the implementation of the program, the readiness of the stakeholders to implement the program, and the need for specific resources. The interview guide is available in the supporting file (click here).

The focus groups were conducted at each hospital during the postimplementation stage of the eMBCR, namely, between February and March 2021. Physicians (and the psycho-oncologist) and nurses participated in separate focus groups to ensure balanced participation [26]. An intersite focus group involving head nurses and physicians was also conducted. The focus groups were conducted by a trained psychologist who had no influential relationship with the participants as well as external moderators (a senior researcher in psychology and a researcher with a background in sociology).

2.5. Data Analysis. The methodology used for data analysis was based on Braun and Clarke's thematic analysis [27]. The analysis exhibited the following structure: (i) becoming familiar with the data, (ii) generating codes, (iii) seeking themes, (iv) reviewing themes, (v) defining themes, and (vi) producing an organized synthesis of the corpus. A deductive approach based on the CFIR codebook was used. Two focus groups were independently coded by two researchers, and agreement between these researchers was reached through discussion. The remaining focus groups were coded by one of the researchers, cross-checked, and discussed with the second researcher. Regular meetings with a third researcher were held to reach consensus in case of disagreements between coders.

2.6. Ethical Considerations. The SERENITY study (2019-00965) was approved by the Cantonal Commission for Ethics in Human Research (Geneva and Vaud) in July 2019 (final amendment approved in September 2021). The study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki. Informed consent was obtained from all participants included in the study.

3. Results

In total, five focus groups were conducted, each of which lasted between 53 min and 1.5 h. A total of 51 HCPs were invited, and 19 people ultimately participated in the focus groups. Due to last-minute absences, the number of participants per group ranged between 3 and 6. Three focus groups were conducted online, and two were conducted in a face-to-face format.

3.1. Participants' Characteristics. The participants' characteristics are presented in Table 1. Overall, most of the participants were women (84.2%). Nurses were predominant (63.2%), and most of them did not participate in the recruitment process of patients who joined the eMBCR program implemented in the SERENITY study. The residents who were present in the focus groups were all involved in patient recruitment.

3.2. The Determinants of the Implementation of the eMBCR Program. The results are presented according to the CFIR domains.

3.2.1. The Strength and Quality of the Evidence Regarding Mindfulness Meditation (Intervention Characteristics). HCPs agreed that mindfulness meditation may be helpful for some patients, e.g., patients with breast cancer who are in the early stage of disease or in the post-treatment phase, when patients may feel anxious and receive less follow-up. The group effect of such programs was emphasized. Nurses mentioned that they felt that there was a difference between patients who meditated and, consequently, seemed to be more peaceful during their treatment and distressed patients, who seemed to need more support. Meditating patients were perceived as being more likely to express their needs and adhere to care requirements. Thus, mindfulness meditation was perceived as a self-care intervention that can facilitate self-awareness and active participation in one's treatment, potentially helping the patient recenter and prioritize personal values during the course of cancer.

"Meditation allows them (patients) to receive a therapy of their choosing [...], they have much better adherence to the treatment. They adhere and are actors of their treatment, more than people who don't have those personal resources."

HCPs' knowledge about mindfulness meditation varied. Attending physicians, head nurses, nurses, and some residents were convinced that mindfulness meditation represented an evidence-based approach that cancer centers either could or should propose. They highlighted the gap between the evidence supporting mindfulness meditation and its lack of implementation in practice as well as the need to train HCPs. Nevertheless, a lack of awareness regarding the evidence supporting mindfulness meditation was specifically observed among some residents who considered mindfulness meditation to be an alternative approach thus not to be implemented in hospitals. They recognized that their motivation with regard to discussing complementary and alternative medicine (CAM) was primarily to maintain their relationship with the patient.

"Since the beginning of our doctor studies, we have been accustomed to doing evidence-based medicine. [...] When I say evidence, I am talking about good quality studies, phase III studies, with a large scale, which show us a clinically and statistically significant benefit."

TABLE 1: HCP's sociodemographic and professional data.

Characteristic		Number (%)
Gender	Female	16 (84.2)
	Male	3 (15.8)
Age category	20–30	3 (15.8)
	31–40	6 (31.6)
	41–50	2 (10.5)
	51–60	7 (36.8)
	> 60	1 (5.3)
Nationality	Swiss	11 (57.9)
	Non-Swiss	7 (36.8)
	Mixed	1 (5.3)
Professional role	Physician	6 (31.6)
	Nurse	12 (63.2)
	Psycho-oncologist	1 (5.3)
Setting of practice	Onco-senology	1 (5.3)
	Onco-gynecology	5 (26.3)
	Onco-senology and onco-gynecology	4 (21.1)
	Oncology more broadly	9 (47.4)
Work experience in the setting	< 5 years	3 (15.8)
	5–10 years	8 (42.1)
	> 10 years	8 (42.1)
Work percentage	< 50%	0
	50%–80%	10 (52.6)
	> 80%	9 (47.4)
Work experience in the profession	< 5 years	0
	5–10 years	5 (26.3)
	> 10 years	14 (73.7)
Awareness of mindfulness	Personal interest	10 (45.5)
	As part of training	1 (4.6)
	In the context of professional activity	9 (40.9)
	As part of the serenity study	2 (9)
Personal use of complementary approaches		12 (63.2)
	Homeopathy	4 (25.0)
	Hypnosis	3 (18.8)
	Acupuncture	2 (12.5)
	Meditation	2 (12.5)
	Yoga	2 (12.5)
	Herbal medicine	1 (6.3)
	Kinesitherapy	1 (6.3)
	Aromatherapy	1 (6.3)
Training in complementary approaches		3 (15.8)
	Hypnosis	3 (15.8)

Complementary medicines struggle to have this kind of evidence, and coming from us [physicians], it's tricky to propose evidence-based and nonevidence-based medicine."

Nevertheless, some of these participants noted that if they were convinced by solid evidence, they would be more open to such interventions due to their core interest in their patients' well-being.

3.2.2. Relative Advantage of the Implementation of Mindfulness Meditation Instead of Another Approach (Intervention Characteristics). All participants shared the belief that mindfulness meditation should be offered *among other*

approaches; patients in general have various preferences and needs, and there is no "one-size-fits-all" approach.

"I think that one shouldn't say "oh, but mindfulness is the solution to everything, all your troubles and for everybody," no. Because as we observe in oncology with our treatments, ultimately, we don't have a unique solution, "one size fits all," this is not true. And I think [mindfulness meditation] should be one of many proposals [...]."

Some participants questioned the choice to implement mindfulness meditation instead of another integrative approach, such as acupuncture. The perceived advantage of mindfulness meditation mainly included its support of patients' autonomy. Once the patient has learned to

meditate, he or she is able to use this resource without the support of a professional, which is not the case with acupuncture, for example.

3.2.3. The Adaptability and Complexity of the eMBCR Program (Intervention Characteristics). In general, HCPs perceived the eMBCR program as being excessively long and restrictive in terms of schedules, while some participants mentioned that even though the program seemed to be demanding, motivated patients would find the time to meditate. Suggestions to increase patients' access and acceptability of the intervention were proposed (see Algorithm 1).

"What I think was a limiting factor was that the group sessions took place at a fixed time, on a fixed day. I had a patient who had to quit because she began working again. So, [...] if [sessions] were recorded, if patients could have a sort of "replay" function, or if they could still participate later [...]"

3.2.4. Patient Needs and Resources (Outer Setting). All HCPs mentioned the topic of discussing CAM with patients. Attending physicians and head nurses highlighted the importance of orienting patients with regard to evidence-based approaches. They also acknowledged the interest of some patients in mindfulness meditation.

"It's one of the supportive care modalities that patients in general (at least some of them) wish to benefit from."

Nurses emphasized the fact that some patients rely on CAM, although they do not systematically discuss it with HCPs. Other patients, in contrast, actively seek support from HCPs; an attending physician highlighted the fact that some patients want to choose a form of self-care and to be active in that approach but nevertheless seek validation from HCPs.

The fact that some patients would not want to return to the hospital after the treatment was highlighted; therefore, offering both internal and external access to CAM was suggested. Residents and nurses also referred some patients to a center dedicated to offering complementary approaches to patients with cancer who were located near the hospital.

"[...] when I was saying to patients "you may be in a study to do meditation in 6 months," they were looking at me a bit like "But what should I do?", and so I happened to send them to [the center] because it already offers mindfulness meditation, and so they would go there and thought it was great."

3.2.5. External Policies and Incentives (Outer Setting). An attending physician and the head nurses highlighted the lack of reimbursement by basic health insurance as a barrier to access to CAM in general.

"We also have to remember that the center [the center of integrative medicine, which is located within the hospital]

was created then by the management's will, but there was also strong pressure from the population because the people voted on the federal level and did many interpellations on the canton level in favor of the development of these types of complementary medicine in hospitals. [...] It's worth mentioning again the question of reimbursement for those services. We will really be ready - and this will be at the federal level because it goes through LAMal (basic insurance) - when those approaches will be reimbursed."

In Switzerland, reimbursement for MBIs still primarily depends on supplementary insurance policies taken out by individuals. However, not everyone is eligible to take out such a policy (e.g., some insurance reject individuals depending on their health status), nor can everyone afford to do so. To ensure sustained accessibility to CAM within hospitals, the need for stable funding rather than merely initial support was emphasized.

"Anyway, one of the blocking points would be that the patients must pay for this program. It can also be a selection of the patients by their wealth; there are some patients who can financially allow themselves to search for approaches that fulfil their needs because they have complementary insurance or revenues that allow it. And then there is a whole group of patients who won't go toward this type of approaches, and if they must pay for it, it will be an obstacle to wider implementation."

3.2.6. Culture (Inner Setting). Some residents observed a lack of a medical organizational culture that includes integrative medicine. Indeed, some participants believed that it was not their responsibility to guide patients in their use of CAM.

"I'm making a big generalization again, but we doctors are often a little less interested in complementary therapies, and whether it's on a personal level or on a level. . . well, of reading studies, we don't know much about it, if at all, and we don't necessarily feel the mission of having to talk about it."

"In French-speaking Switzerland, there is a dichotomy between, let's say, "western medicine" and these complementary medicines, and personally I am not against this dichotomy. For complementary therapies, we have the [center,] which has just been created and which is located next to [the hospital], and I find it quite practical to be able to say to interested patients, "we have something for you, to guide you in your choice of complementary therapies, but ultimately it will not come from us." We can somehow get rid of this topic. If I can get rid of complementary therapies, that's fine."

One nurse shared her uncertainty regarding the openness of the medical culture with regard to the inclusion of integrative approaches. In contrast, other residents and nurses perceived integrative medicine as

Strategies suggested by HCPs

- To decrease the level of expectations regarding dosage
- To encourage flexibility by allowing a patient who must cease participating in the program after class 4, for example, to join a future group in class 5 (this suggestion was opposed by another participant, who claimed that being part of a stable group is important)
- To propose online and face-to-face formats to satisfy patients' preferences and needs
- To offer the possibility of joining the group while hospitalized or participating through an online format
- To offer reminder classes once per year for advanced participants
- To offer guided meditation apps that patients can use during their treatment
- To facilitate the translation of the program into different languages (multicultural context)

ALGORITHM 1: Strategies suggested by HCPs to increase access and acceptability of the intervention.

compatible with their institutional values and culture. Nurses clearly highlighted the need for CAM to be integrated into the organizational culture in the context of cancer care. The attending physicians and head nurses expressed support for openness toward the integration of CAM on the part of cancer centers and hospitals in general; they also highlighted the need for a clear structure for such integration. One example of such openness is the delivery of mindfulness meditation to professionals within hospitals. A center for integrative medicine within hospitals was perceived as an implementation facilitator.

3.2.7. Implementation Climate (Inner Setting). Most HCPs indicated that the implementation climate is favorable to the implementation of approaches such as mindfulness meditation. Some participants had already tried this approach and experienced its benefits. Nevertheless, some residents were less open to integrating mindfulness meditation into the hospital setting and feared change.

"We have had bad experiences with the ease of setting up new things. And consequently, we are afraid that adding something on top of something else that works well will make things more complicated for us."

3.2.8. Tensions Related to Change and the Relative Priority of the Implementation of Mindfulness Meditation (Inner Setting). Tensions related to change were perceived by the attending physicians and head nurses regarding the reimbursement of CAM-related expenses and the integration of this approach into the hospital setting. They highlighted their desire to guide patients and ensure that a broad variety of valid and safe approaches (e.g., through a center of integrative oncology) were available to everyone through public funds or health insurance reimbursement.

"It comes from the patients, it comes from the population < XX: yeah, that's right >, it's a request, and I think that when there is a vote, I don't remember which one, and that finally this complementary medicine, which has been acclaimed by the people, is still not reimbursed, it is inadmissible! We do not respect a decision of the people. That's all!"

These participants also highlighted the need to disseminate information that emphasizes the importance of integrating CAM into cancer care. The piloting of this eMBCR program was a way in which such information could be made visible. The importance of the hospital's role in guiding the patients through accessible approaches was highlighted, although as mentioned previously, some residents did not see the need to change, since patients were already referred to the external center for complementary medicines on occasion.

"If we want to be attractive, in my opinion, we should respond more and more to these solicitations. People have access to information. We should propose those things instead of them going to gurus and absorbing plants or whatever [laughs], which are maybe completely contraindicated."

3.2.9. Leadership Engagement (Inner Setting, Readiness for Implementation). One implementation facilitator that was mentioned was leaders' convictions, decision, and engagement. Nevertheless, some last-minute absences from the focus groups were perceived as a barrier by the other participants.

"I can promise you that if we discussed the last checkpoint inhibitor or whatever, they [physicians] would all be here. [...] One has the impression that there is a medicine, and then there is a kind of submedicine, and it is not true. [...] and I think [physician] mindfulness is as important as their last checkpoint inhibitor."

Some participants noted that if the decision to implement mindfulness meditation was made by the leaders, if they were motivated, and if a sufficient budget was available, the implementation of mindfulness meditation within the hospital should not encounter any major barriers. Interdisciplinary leadership engagement (e.g., nurses, physicians, and psycho-oncologists) was also perceived as an implementation facilitator.

"One of the elements that would be beneficial - whether at the level of a service, a department, or an institution - is that the interdisciplinary executives carry the project together. Not whether it's the care management or the

medical management or the general management, but whether it's together. And that is one of the success factors, in my opinion."

3.2.10. Available Resources (Inner Setting, Readiness for Implementation). Practical barriers that were emphasized included the lack of time, human factors, materials (including budgets), and training resources as well as a dedicated location to offer CAM approaches (e.g., a place that was not located nearby treatment rooms to avoid disease-specific memories). Fear of increasing costs related to the management of hospitals was mentioned as a potential barrier.

HCPs also highlighted the need for tools to identify patients' needs in CAM contexts as well as the value of the presence of such tools.

"[...] if we are convinced [by one approach], we will say "you have to do it," and then it may not really correspond to the patient's needs. I really like this idea of an integrative anamnesis or of finding tools [...] that can be generalized, which would make it possible to identify the patient's requests and needs. And finally, to try to find something that matches the patient's needs exactly."

Residents indicated that they lacked the time necessary to discuss CAM with patients during their consultations, which usually last 30 min. They suggested that nurses could be better suited to the task of guiding patients since they spent more time with them.

"[...] we don't really have time during the consultation to do that. We usually have 30 minutes to talk to the patients. In general, they have so many different topics to discuss that adding this point, which is often the source of a lot of questions and discussions, is difficult. I mentioned that it might be proposed by someone other than a doctor... and in particular by nurses, for example."

In terms of intervention delivery, nurses suggested that mindfulness meditation should be delivered by a dedicated person. Indeed, the head nurse emphasized the fact that there are not enough nurses for them to take on an additional role in the delivery of complementary medicines during care. Thus, the presence of a structure such as a center for integrative medicine within the hospital, including dedicated and trained staff, was perceived as a facilitator.

3.2.11. Access to Knowledge and Information (Inner Setting, Readiness for Implementation). Because of the frequent turnover faced by oncology teams, dissemination activities were suggested as a means of maintaining information and knowledge about mindfulness meditation, as was the provision of written support to patients. Flyers were viewed as an option for providing initial information and as a way to tell interested patients to call a specific person to obtain additional information. Playing a video on screens in waiting rooms was suggested as a way to promote information on the

available CAM offers. Overall, the implementation of a dedicated center for integrative medicine was considered as a way to increase access to credible knowledge and information regarding CAM in general.

3.2.12. Knowledge of and Beliefs Regarding Mindfulness Meditation and CAM in General (Characteristics of Individuals). Although some residents felt that it was not their responsibility to discuss CAM with patients, mindfulness meditation was perceived as a way of giving a voice to patients, thus increasing their choices and self-determination. The participants noted that CAM may represent an added value, particularly for patients with breast cancer (since CAM was perceived as less well suited to older patients or men, for example). Compared with other approaches (e.g., acupuncture), mindfulness meditation was perceived as requiring commitment, emotional maturity, and the courage to expose oneself.

In addition, the attending physician and head nurses emphasized the risk that some HCPs would be "too motivated" and thus encourage the use of CAM without being sufficiently knowledgeable of this approach; on the other hand, concern was also expressed with the possibility that some HCPs would be "unconvinced" by CAM and would thus avoid discussing this approach with patients.

"I think that medical studies will have to integrate this integrative medicine because we need to explain it [to patients] like we can explain diabetes and insulin. [...] we will need to be able to make our physicians aware of it so that they can be a partner for the patient. Because if you don't know something, you cannot be a partner [...], hence the importance of also teaching our physicians."

"The risk, depending on which [caregiver] takes care of the patient, of the information that he [the patient] will receive, is that [the caregiver] doesn't explain it well, is maybe not even convinced, and won't present the offer well to the patient."

The need for interprofessional education regarding CAM was emphasized. Residents and nurses demanded further education related to CAM to ensure that HCPs would be able to inform patients correctly.

"There really should be training for the nurses, the people in the field, so that we have a minimum of knowledge on the topic."

In most focus groups, practical questions were raised, such as "Who should benefit from the program? Is it all patients, or should it be specific to needs? Who should discuss mindfulness meditation with the patients? When should these discussions take place?"

3.2.13. Self-Efficacy With Regard to Guiding Patients Through CAM and Mindfulness Meditation (Characteristics of Individuals). According to the attending physician and head

nurses, the lack of knowledge regarding the evidence supporting mindfulness meditation resulted in a lack of self-efficacy on the part of HCPs with regard to discussing meditation with patients. Indeed, during the patients' recruitment process, some residents mentioned that they did not have the expertise necessary to discuss CAM and would not feel comfortable doing so without receiving additional education.

"It is wrong to think that it is necessary to have lived something to be able to explain it well. In contrast, the fact that one is informed of what it is and what it is not either still allows one to be an interlocutor with the patient. Otherwise, [the doctor] is not [an interlocutor]; very quickly he or she closes the door, [...] [the lack of knowledge] puts him or her in a very uncomfortable position, and so he or she closes the door. [...] And hence the importance of informing and training our doctors."

3.2.14. Champions (Process). From the residents' perspective, a motivated person who regularly reminds colleagues of the importance of approaches such as mindfulness meditation can help create habits and facilitate patient referrals. Other participants suggested that establishing a dialog with patients regarding integrative medicine should be an interprofessional mission that is not merely the task of a specific person.

"[...] To see someone who is convinced of the thing and who speaks to us about it in a completely open way, who is there, who is motivated, who does even more work than us, and then who says to me "ah, we have to include the patient", well, that's how it works, our bosses do that every day [...]."

"It's not just the nurses who can give [information]. Doctors, I think it's going to be difficult because of their consultations; they have more and more things to go through in a minimal amount of time. On the other hand, there are all the caregivers, from the nursing assistant to the nurse, including the physio who intervenes with the patients, all the caregivers, not just the nurses."

4. Discussion

This study identified some facilitators and barriers that must be accounted for in attempts to increase the readiness of HCPs and organizations to successfully implement mindfulness meditation programs such as the eMBCR and even, more broadly, validated complementary approaches in the context of cancer care in Switzerland.

Despite the available evidence and current clinical guidelines encouraging the use of mindfulness meditation in oncology, this study highlighted the contrasting views of HCPs regarding its integration into a hospital oncology setting. The negative attitudes of some HCPs are a concern, as many patients will use this type of approaches during their cancer journey, and seek to engage in dialog with HCPs [15]. Indeed, patients affected by

cancer from Australia, Canada, New Zealand, the United States, and Europe have increasingly (40%) been using complementary and alternative medicines (CAMs) in the last 20 years [28]. A European study highlighted the fact that patients with breast cancer in Switzerland exhibited one of the highest rates (52.6%) of CAM use in 2004 [29]. In French-speaking areas of Switzerland, some patients affected by cancer have reported using alternative medicines to deal with some side effects of treatment due to a lack of support from medical staff [30]. Other reported motivations are to address unmet needs, to reduce cancer symptoms, and to improve their quality of life [2]. Therefore, it appears reasonable for the hospital to be, at a minimum, a place where patients can engage in open discussions with their HCPs regarding these complementary approaches. Furthermore, although the literature reported mixed results regarding HCPs' perceived usefulness of practicing integrative medicine [15], the hospital should probably also be a place where a certain number of validated interventions are offered, so that they can be carried out in a safe context and by trained HCPs.

The unknown effects of some complementary approaches [2] and the risk of patients' misuse further highlight the need to provide better information to patients [31]. Integrating efficient approaches alongside conventional care may increase patients' participation and improve their quality of life [32]. The choice of interventions should be based on patients' distress and needs as well as on existing evidence and available resources, starting with the most natural, effective, and least invasive interventions [33]. Attention should be paid to determinants influencing patients' participation and adherence to MBIs. Barriers to adherence to MBIs can be categorized into four domains: (1) practical barriers; (2) person-related barriers, (3) health-related barriers, and (4) meditation-specific barriers [34, 35]. HCPs identified several strategies to enhance accessibility and adherence, including flexible delivery formats (e.g. online MBIs) and adjustments in session frequency and duration.

This study highlighted the need for training on ways of guiding patients through the safe use of CAM. Currently, a lack of knowledge among HCPs remains a barrier to the future implementation of MBIs in cancer care [15, 36, 37]. Many HCPs at hospitals do not feel prepared to discuss integrative medicine or to guide or monitor patients in this context [15]. The inability to provide recommendations and guidance or a tendency to avoid the topic may lead to negative impacts on the patient-provider relationship and patients' outcomes [38]. Poor patient-provider relationships can increase rates of nonadherence to cancer treatments, which may in turn increase the risk of disease progression or even mortality [39]. Thus, training HCPs is essential to meet patients' needs more effectively [40], and such training may improve CAM referral as well as dialog between professionals and patients [41]. In this sense, the KOKON-KTO framework encompassing a 20-min consultation to inform patients about complementary and integrative medicine in a structured way during routine

consultations has been shown to be feasible among oncology physicians in a German-speaking context [42]. The physicians were trained through a hybrid learning method based on e-learning and a 2-day onsite workshop [40]. However, the acceptability and feasibility of such a consultation in the oncological departments of academic hospitals in French-speaking areas of Switzerland remain unclear. The KOKON-KTO framework [42] could be tested among oncology physicians in these contexts and if feasible, this framework would allow the systematic guidance of patients with cancer on complementary and integrative medicine [43]. Such a framework could be extended to nurses as well [42]. It could be adapted and integrated into their teaching plan, as well as being part of a continuing education program for nurse managers and advanced practice nurses. Registered nurses and advanced practice nurses are in a key position to refer patients to MBIs or to train themselves to deliver MBIs [14]. Translation of the learning and manual in French would be a first step if considering testing and adapting this method to local contexts. Training could be made dynamic, and delivery methods varied to cater to different learning styles [44].

The study, supported by the literature, suggests national implementation strategies that may be tested for effectiveness in a future trial (Algorithm 2). The referral of patients to MBIs and integrative medicine in general may depend on the personal interest and understanding of the relevant HCPs [13]. In a worst-case scenario, these factors may have consequences for patient safety if HCPs are not able to guide patients regarding the safe use of complementary medicine [15]. The establishment of collaborations and relationships among colleagues with the goal of increasing their awareness of MBIs may be a way to overcome this barrier [13]. Positive experiences expressed by the patients themselves may, for example, increase their awareness [13]. Future implementation strategies may focus on HCP attitudes toward mindfulness meditation [45]. The theory of planned behavior, for example, posits that both motivation (intention) and ability (opportunities and resources, e.g., time, skills, and money) are necessary to trigger a behavior [46]. The determinants of intentions and attitudes toward the behavior (a favorable or unfavorable evaluation of the intervention: beliefs), the subjective norm (the perceived pressure to engage in the behavior), and the perceived behavior control (facilitators of or barriers to the behavior) could be explored [46]. Teaching integrative medicine may lead to increased referrals, improved patient–health care provider communication, and enhanced positive attitudes regarding complementary approaches on the part of HCPs [15]. Educating service managers is also important for increasing effective referrals [47]. Finally, most HCPs acknowledged the need for and value of the presence of a center for integrative medicine within the hospital, including HCPs with specific knowledge and dedicated time for integrative consultations. However, the evidence shows that even when a meditation and yoga center is located within a hospital, HCPs are not necessarily aware of this fact [48]. Therefore, actively informing HCPs and patients

regarding existing resources via a website, for example, may increase the visibility of such resources [49].

Implementation strategies may be tested for effectiveness in a future trial. Indeed, knowing that mindfulness meditation research has been mainly focused on early-stage designs (e.g. adapting and testing MBIs), implementation and dissemination studies should be further developed [11]. More pragmatic trials and hybrid designs are needed to understand the effectiveness of implementation strategies [50]. This would help in the development of a national implementation toolkit for MBCR, as it was done in the United Kingdom for the implementation of MBCT [51]. National specific guidelines for MBIs (e.g. national training requirements) may ensure patient safety and outcomes by avoiding inconsistencies in the delivery of such programs.

4.1. Strengths and Limitations of the Study. To our knowledge, this study is the first to explore the perceptions of HCPs regarding the implementation of an MBI in oncological settings in a systematic way based on an implementation framework such as the CFIR. The study included participants from a variety of professional backgrounds, including physicians, nurses, a psycho-oncologist, and leaders drawn from two academic hospitals, thus increasing the richness of the study results. However, the impossibility of maintaining anonymity among professionals during the focus groups while simultaneously ensuring confidentiality with regard to what can be said outside the group may have discouraged some HCPs from participating in the focus groups. To mitigate this risk, we separated physicians (and the psycho-oncologist), nurses, and managers into different groups and ensured that both the animator and the moderator were neutral to avoid at least a strong social desirability bias. Some participants clearly expressed their discomfort with regard to participating in the focus group, which was likely due to a misunderstanding of the goal of the focus group. Adding the possibility of individual interviews may have been a way to increase participation rates, as would integrating quantitative measures to decrease social desirability bias. In addition, while the separation of groups allowed for focused discussions relevant to each professional role, it may have also limited the opportunity to explore interprofessional dynamics and collaboration. Combining separated focus groups with mixed-group sessions could provide a more global understanding of the shared and divergent views across roles.

Finally, the results of this study should be interpreted with caution due to the specific context in which the research was conducted and the small sample size. The results may not be directly transferable to other populations or settings (i.e. nonacademic hospitals or other countries). This is particularly relevant when examining complementary medicine practices, which are highly variable and influenced by cultural, regional, and individual factors. Further research is needed to explore how the findings of this study may apply in broader or alternative contexts. Qualitative research, by its nature, prioritizes depth and contextual understanding over generalizability. Adding quantitative methods alongside

- Developing and testing a strategic plan based on the identified barriers and facilitators [52].
- Engaging a steering group of interprofessional stakeholders to increase implementation efforts [44, 52].
- Seeking a local champion who exhibits leadership and plays a potentially influential role within the setting [51].
- Seeking leadership support [53].
- Including MBI experts and project leaders within the setting [18].
- Targeting HCPs' attitudes toward intervention [45].
- Identifying and training already motivated staff [51].
- Teaching integrative medicine to HCPs [15].
- Educating service managers to increase effective referrals [47].
- Reducing resistance by offering mindfulness training to staff in the form of experimental sessions [18].
- Establishing collaborations and relationships with HCPs to increase their awareness of MBIs [13].
- Establishing a center for integrative medicine within the hospital to coordinate, organize, and control CAM delivery [49].
- Increasing collaborations with early adopters at the local, national, and international levels who can share relevant experiences [44].

ALGORITHM 2: Potential national MBI implementation strategies.

qualitative approaches may be a way to identify similarities and differences across contexts and populations.

5. Conclusion

This qualitative study improved our understanding of the multilevel components that may positively or negatively affect the implementation of a complex intervention such as an MBI in the context of cancer care. The results from the focus groups conducted with HCPs suggest some specific barriers, e.g., the lack of reimbursement, the need for education regarding mindfulness meditation and CAM in general, the lack of time dedicated to CAM during patients' consultations and care activities, and negative attitudes toward mindfulness meditation and its integration within hospitals. Strategies for increasing access to MBIs within hospitals, among other evidence-based approaches, could be adjusted to accommodate those barriers. The establishment of a multidisciplinary implementation group, including leaders, that can target professionals' attitudes and skills and overcome some barriers in terms of resources could be a first step toward addressing the contextual needs thus identified.

Data Availability Statement

The data are not available due to privacy and ethical concerns.

Conflicts of Interest

The authors declare no conflicts of interest.

Funding

This study was supported by the Leenaards Foundation, the Swiss Cancer Research Foundation, and the Universities of Geneva and Lausanne.

Acknowledgments

The authors would like to thank all the participants and the healthcare professionals who coordinated and facilitated their recruitment. They also thank Benny Maboso and

Magali Londono for the transcription of the focus groups as well as Stellio Giacomini for his support in the transcription and analysis of the data. The authors finally thank Dr. Kim LeVan and Dr. Karin Ribbi for moderating the focus groups.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. (*Supporting Information*)

Interview guide for the focus groups, based on relevant CFIR domains.

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