Healthcare Providers’ Perspectives of the Supportive Care Needs of Men With Advanced Prostate Cancer

Nancy Carter, PhD, RN, Patricia A. Miller, PhD, PT, Brittany R. Murphy, BSc(Kin), MSc(PT), Victoria J. Payne, BSc(H), MSc(PT), and Denise Bryant-Lukosius, PhD, RN

Prostate cancer is one of the most commonly diagnosed cancers among Canadian men, accounting for 24% of all new cancer cases (Canadian Cancer Society, 2014). In 2014, an estimated 23,600 men will be diagnosed with prostate cancer, and 4,000 will die from the disease (Canadian Cancer Society, 2014). Most men present with prostate cancer in the early stages; however, 10%–20% of men present with metastatic disease at diagnosis (Felici, Pino, & Carlini, 2012). In addition, despite improvements in early detection and treatment, 20%–30% of men who receive curative therapy for local disease will go on to develop advanced prostate cancer (APC), characterized by the spread of disease to surrounding soft tissue in the bladder or rectum, or metastases to lymph nodes, bones, liver, or lungs (Bahl, 2013). Metastatic disease can have a significant effect on health-related quality of life (HRQOL), and the enlarged prostate from the disease often leads to genitourinary problems (Resnick & Penson, 2012).

Men can live for long periods of time with APC, and outpatient care is often used for treatment, symptom management, and palliation. The usual first line of treatment for APC is either androgen-deprivation therapy or surgical castration, and disease burden and treatment can have negative effects on patients’ HRQOL (Resnick & Penson, 2012). Androgen-deprivation therapy may result in a number of adverse effects, including sexual side effects (e.g., decreased libido, erectile dysfunction, gynecomastia, reduced penile or testicular size), vasomotor symptoms, weight gain, osteoporosis, diabetes, and anemia (Trost et al., 2013). The eventual progression to hormone-resistant prostate cancer requires treatment with a range of other systemic and immune therapies, which cause additional treatment-related symptoms such as fatigue (Flynn, 2013). Patients with skeletal-related metastases requiring radiation suffer significant declines in HRQOL secondary to pain and decrease in functional ability (Resnick & Penson, 2012).

Purpose/Objectives: To examine healthcare providers’ (HCPs’) perceptions of the supportive care needs of men with advanced prostate cancer (APC).

Research Approach: A qualitative, descriptive study.


Participants: 19 nurses, physicians, and allied health providers who cared for men with APC in outpatient settings.

Methodologic Approach: Interviews and focus groups.

Findings: HCPs identified four themes related to men’s supportive care needs: pain and symptom management, informational needs, emotional needs, and the need for practical assistance. HCPs emphasized issues related to pain, urinary incontinence, and fatigue. They also reported that men continually ask for more information related to treatment, side effects, and prognosis. Participants identified a variety of barriers in meeting supportive care needs, including lack of management strategies, poor knowledge retention, and the “stoic and old-school” nature of men in this population.

Conclusions: Supportive care for this population can be improved through more focused implementation of interprofessional care, with clearly defined professional roles and additional specialized roles to address prostate cancer pain, urinary incontinence, and fatigue.

Interpretation: Specialized roles in the management of pain, urinary incontinence, and fatigue affecting men with APC could be integrated into interprofessional care to meet supportive care needs.

Key Words: nursing research; qualitative; prostate cancer; professional issues


Men with APC also need long-term supportive care throughout the course of the disease, from diagnosis to palliation (Scotte, 2012; Sonnek & van Muilekom, 2013). Supportive care is “the provision of the necessary services as defined by those living with or affected by cancer to meet their physical, social, emotional, informational, psychological, spiritual, and practical needs
during the prediagnostic, diagnostic, treatment, and follow-up phases of cancer care, encompassing issues of survivorship, palliation, and bereavement” (Fitch, 2000, p. 41). Supportive care delivery is complex and involves multiple health disciplines and people working in various agencies (e.g., regional cancer centers, community services). In addition, patients and families may come in contact with healthcare providers (HCPs) such as nurses, physicians, radiation therapists, research staff, social workers, nutritionists, psychologists, homecare coordinators, and physiotherapists.

Supportive care services are not always available to or accessed by people with cancer. A systematic review examining the prevalence of unmet supportive care needs of people with cancer showed individuals were more likely to express unmet needs post-treatment compared to any other time, and the most frequently reported unmet needs were related to activities of daily living, followed by psychological, informational, psychosocial, and physical domains (Harrison, Young, Price, Butow, & Solomon, 2009). A study examining the continuity of cancer care provided by regional supportive care networks identified that cancer survivors are not very aware of the supportive care services available to them. For those aware of available services, use was unexpectedly low (Whelan et al., 2003). Researchers also have emphasized the development of generalized services aimed at meeting a broad range of needs for cancer survivors and their families. However, because survivors experience unique needs specific to their cancer types, disease stage, treatment type, and prognosis, individualized care must also be available. With more men being diagnosed and living with prostate cancer, innovative services are needed to meet the supportive care needs of this patient population. HCPs play an instrumental role in identifying and understanding each patient’s supportive care needs and facilitating access to the appropriate supportive care services.

The health needs of men with various stages of prostate cancer have been investigated (Bryant-Lukosius et al., 2010; Fitch, Gray, Franssen, & Johnson, 2000; Gray et al., 2002), but very few studies have focused on the needs of men with APC. In a cross-sectional survey of men with prostate cancer, those with hormone-sensitive APC (HS-APC) and hormone-resistant APC (HR-APC) had different unmet health needs (Bryant-Lukosius et al., 2010). Men with HS-APC were most concerned about sexual function, urinary frequency, urinary incontinence, and physical activity, whereas those with HR-APC were concerned about pain, fatigue, and decreased physical activity.

Carter, Bryant-Lukosius, DiCenso, Blythe, and Neville (2011) conducted a multistakeholder needs assessment involving patients, their families, and HCPs to systematically identify and understand factors that influence HCPs’ ability to meet the reported supportive care needs of patients and families affected by APC. Data were collected separately from men with HS-APC and HR-APC and their family members. Twenty-nine men participated in interviews and focus groups. Of those, 17 men had HR-APC and 12 men had HS-APC. Patient participants consistently identified the need for APC-specific information about treatments and side effects, as well as information about the services available to them. Men were concerned with changes in their functional capacity related to advancing disease and treatment-related pain and fatigue. They also cited problems with urinary function and sexual concerns as major functional issues. They experienced emotional distress related to their diagnosis and treatment and wanted more information and assistance interpreting the information.

In the family arm of the study (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2010), data were collected from 19 family members. Ten family members of men with HR-APC participated in focus groups and nine family members of men with HS-APC participated in individual interviews. Both groups of family members had unmet supportive care needs, including lack of information and uncertainty about the future. Family members of men with HR-APC also reported caregiver burden, isolation, and a need for practical assistance. Although most participants were satisfied with the care their family member was receiving, they requested increased access to information and more time with informed HCPs that understood their family member’s condition (Carter et al., 2010). Additional research to explore the perspectives of HCPs is needed to fully understand the use of supportive care services and provide data and information to guide the development of innovative services.

**Study Purpose and Research Questions**

In the current article, the authors focused on the needs of men with APC as described by HCPs. The objectives of this study were to examine HCPs’ perceptions of the supportive care needs of men with APC, the current resources available, and the barriers to meeting these needs. Specifically, the authors addressed the following questions: What are HCPs’ perceptions of met and unmet supportive care needs experienced by men with APC and their families? What do HCPs identify as the top-priority healthcare needs of patients and their families? What do HCPs recommend to improve the delivery of healthcare services to meet the top-priority supportive care needs of patients and their families?
Methods
Design and Sample
This study is a component of a multistakeholder needs assessment of men with APC in a region of Ontario, Canada, which was approved by the Faculty of Health Sciences at McMaster University in Hamilton, Ontario, and local hospitals’ research ethics boards. The study used a qualitative, descriptive methodology, as described by Sandelowski (2000), which provides a means to summarize participants’ experiences without overinterpreting the data, allowing it to remain in its most original form (Milne & Oberle, 2005).

Individuals eligible to participate in this study consisted of HCPs currently working with men with APC in healthcare facilities in a region of south-central Ontario, including a urology clinic located in a tertiary care facility, an ambulatory healthcare center, urologists’ offices, and the regional cancer center.

Data Collection and Analysis
With the help of nurses, physicians, and other members of the interdisciplinary team, the principal investigator contacted HCPs at institutions caring for men with APC. Data collection occurred through semistructured, in-person interviews and focus groups. Individual interviews were held in the participant’s office (i.e., the urology clinic, the physician’s office, and the ambulatory healthcare center). Two focus groups were held at the regional cancer center—one with nurses only and another during a meeting of a genitourinary cancer team.

All participants completed a short demographic questionnaire prior to data collection and signed an informed consent form. Data collection was led by the principal investigator of this study, who is not a cancer specialist and had no previous relationships with participants or their respective agencies. Interviews and focus groups ranged from 40–90 minutes in length. The demographic questionnaire and interview guide (see Figure 1) were developed by the research team, which included a medical oncologist and clinical nurse specialist who worked with men with APC. The demographic questionnaire included questions about the amount of time spent working with men with APC and the care and services the HCPs gave to these men.

The interviews and focus groups were audio recorded and transcribed. The large number of participants in the interdisciplinary focus group prevented accurate identification of the participants (and their respective disciplines) when transcribing the data. At the conclusion of interviews and focus groups, a summary of the collected data was shared with the participants to validate and clarify the information. Data were collected until saturation occurred (Morse, 1994). To promote the auditability of this study, a journal was kept by the principal investigator to document the research process, including the rationale for decisions made throughout the data collection and analysis processes.

These data were analyzed by a team that included the principal investigator, a rehabilitation science faculty member, and two students in a master’s entry-level physiotherapy program. All team members read the transcripts independently and developed a coding scheme collaboratively. Thematic content analysis, as described by Burnard (1991), was implemented to develop core categories, which then were used to organize the coded transcripts and identify significant themes. To improve the study’s rigor, triangulation was applied by comparing the results of the current study with those of the previous two arms of the parent study (Carter et al., 2010, 2011). In addition, the data analysis process purposefully included researchers from multiple disciplines to ensure unbiased data interpretation (Morse, 1994).

Findings
Participants
Nineteen HCPs participated in this study. Fourteen HCPs participated in one of two focus groups at a regional cancer center. One focus group included five primary nurses, and one included nine HCPs from primary nursing (n = 3), clinical trials nursing (n = 2), medical oncology (n = 1), radiation oncology (n = 1), social work (n = 1), and radiation therapy (n = 1). In
addition, five HCPs participated in one-on-one interviews. Two HCPs (a urologist and a nurse coordinator) were interviewed at a community urology resource center, and two HCPs (a urologist and a researcher coordinator) were interviewed at a urology clinic located in a teaching hospital. A nurse practitioner specializing in continence care was interviewed at an ambulatory healthcare center.

On average, participants reported working five hours per week with men with APC (range = 0.5–20 hours). Participants were asked to describe the services they provided to men with APC, and the most frequent responses were emotional support (n = 16), information (n = 16), coordination of care (n = 14), and pain and symptom management (n = 14). The least frequently reported services included provision of practical support and assistance (n = 3) and rehabilitation therapy (n = 1) (see Table 1). Analysis of the interview and focus group data revealed four themes related to the supportive care needs of men with APC (i.e., pain and symptom management, informational needs, emotional and psychosocial needs, and practical assistance).

### Pain and Symptom Management

The most common response from HCPs was the importance of effective pain and symptom management. Participants focused on the need for better pain control to optimize the patient’s quality of life. Most participants reported that men experienced ongoing pain throughout the disease progression. Better pain management was a priority need across disciplines and HCPs said that, despite best efforts, the pain was difficult to manage. One participant said, “I think a lot of them are still in pain and a lot of them don’t get pain free” (allied health).

Although participants agreed on the importance of pain management, perspectives differed on the overall effectiveness of pain management for men with APC, with one participant saying, “But it’s hard to manage their pain. . . . There’s just not great drugs out there” (allied health) and another commenting, “I think, nowadays, the pain is well managed in most cases” (nurse).

Participants elaborated on strategies used to meet these needs, such as referring patients to specialized teams to ensure pain was optimally managed. Several noted that many men appeared to be uncomfortable expressing the severity of their pain, limiting HCPs’ ability to recognize and manage pain effectively.

A lot of time you’ll go in and ask how they’re doing and they’ll say, “Fine.” And then the wife will say, “Oh, he’s had pain for a week, and he hasn’t slept.” (allied health)

Only one participant elaborated on management strategies for urinary incontinence, but many indicated it was a common issue for men in this population.

### Informational Needs

Participants reported that men repeatedly expressed a need for information about treatments, side effects,
and alternative therapies. In addition, they said men had difficulty understanding the abundance of information provided to them when HCPs attempted to address their concerns. Consequently, men often reported feeling ill-informed and unprepared for the negative side effects of treatment.

They spent the last five years of their lives completely incontinent, and it was devastating, and they both said to me, “Had I ever known this was how it would be, I would never have had surgery.” (nurse)

Participants reported that the men were continually asking questions and seeking information regarding disease progression, prognosis, and end-of-life expectations. Participants suggested that men wanted to know specifics about how their respective cancer would progress and how their selected treatments contributed to disease management. Because of the complex nature of prostate cancer, the diversity of treatment options available, and the routine use of medical terminology, participants perceived that patients experienced difficulty understanding and interpreting the diseasespecific information provided by HCPs. One physician elaborated on this observation.

You keep getting asked the same questions over and over again. . . . I think I am communicating simple concepts . . . but to patients, they’re not simple.

Participants stated many prostate cancer resources were available for patients and their families. They encouraged patients to ask questions and to seek support through peer groups. Despite these recommended opportunities, they said patients continued to demonstrate difficulty understanding health information. One physician suggested that emotions were interfering with information retention, commenting, “When I talk to them, their mind is blank. All they are thinking is, ‘I have cancer and I’m going to die.”’ The informational needs of men and HCPs’ lack of success in meeting them were noteworthy.

**Emotional Support**

Participants noted that the men required emotional support to address their fears related to the diagnosis and disease prognosis; however, the limited time available to discuss the issues with patients and their family members was identified as a barrier. HCPs observed that the men’s anxiety led them seeking prognostic information, such as up-to-date PSA, likely in an effort to help them determine the effectiveness of treatment on their disease progression. One nurse explained, “There is the anxiety of living from PSA to PSA. They really live from blood work to blood work.”

Participants noted that men and their families struggle with the uncertainty of their disease course, as well as with end-of-life planning. As a result, they seek HCPs’ guidance in dealing with these issues and in making difficult decisions. They also hesitate to make any treatment decisions autonomously, often saying they are fine with whatever their doctor decides.

Participants said men did not often discuss emotional needs, instead choosing to “bear it alone.” They suggested the “stoic and old-school” nature of this patient population was likely a barrier to emotional support. Along with this apparent hesitancy to discuss emotional issues, HCPs noted that many men appeared reluctant to seek counseling. One participant suggested this reluctance was a gender-related issue, stating, “It’s interesting that men naturally are afraid of coming, and talking, and sitting down, and having counseling” (allied health).

A number of participants noted that family members were the first to identify emotional challenges in this population, as indicated by the following statement:

The wives or the daughters or the sons are saying, “You know, he’s not really doing very well at all.” So the complaint comes from the family members’ perspective as opposed to the patients themselves most of the time. (physician)

Participants were clear about the importance of taking time to address emotional issues, but consistently reported they did not have the time necessary to meet this need. Participants frequently recommended peer support groups to patients to meet their emotional needs. One nurse indicated that prostate support groups were the main support system for men. Conversely, some participants suggested that these groups address informational needs rather than emotional needs, as one participant explained, “If men go there, it’s just to get information. They don’t want to go there and start talking about how they feel and their experience” (allied health).

**Practical Assistance**

Men’s needs for practical assistance included support and resources for dealing with incontinence. Participants suggested that men receive no education on pad and catheter use, and they do not have easy access to supportive care resources to address ongoing practical issues. One nurse elaborated on the complex issues men face living with incontinence by saying,

They want to use the little tiny pads. One guy might be using 40 of these tiny pads a day, and 40 is too much in one day. But psychologically, the smaller pad is what works for him.

Participants described the community resources available to assist men with practical needs in the home, such as in-home nursing care, housekeeping, and support groups. Despite the availability of services,
some men are reluctant to take advantage of them. One participant said one of the reasons men may not access home care could be that, “Men are especially reluctant about having people in their home” (allied health).

Participants recognized the financial burden some men experienced as a result of long-term disability, unemployment, and the expensive medical costs associated with disease progression as another source of concern. One participant described a patient’s experience by saying, “He was scared. He had a family with teenagers who would be going to school, and he saw the financial impact of him losing his management part of the business” (allied health).

**Discussion**

To the best of the authors’ knowledge, this is one of the first explorations of the needs of men with APC from the perspective of HCPs. Although the findings validate those of previous studies indicating that men with APC have many unmet supportive care needs, they also provide insight on the reasons behind this finding. In particular, the current study’s findings provide a greater understanding of three topics: (a) the similarity of priority needs reported by HCPs to those identified in previous studies of men with APC and their families, (b) the lack of expertise and resources some HCPs have to address the men’s unmet needs, and (c) the possibility that HCPs’ perceptions may influence the way they interpret men’s words and actions.

Similar to the findings of previous studies of men with APC and their families (Boberg et al., 2003; Carter et al., 2010, 2011; Ream et al., 2008; Steginga et al., 2001), the HCPs in the current study identified pain and symptom management, information, emotional support, and practical assistance as the main supportive care needs of men with APC. Pain, urinary incontinence, and fatigue were recognized by HCPs and men with APC as significant symptoms. These findings indicate that HCPs hold differing perspectives on the effectiveness of pain management for the population, which has been reported in earlier studies. Akin and Durna (2013) suggested that pain may not be well managed by nurses, as they showed poor-to-fair agreement with patients with cancer in evaluating pain intensity. Snowden et al. (2011) reported that HCPs have difficulty detecting even severe levels of distress in patients with cancer. A study by Seow, Sussman, Martelli-Reid, Pond, and Bainbridge (2012), conducted in a Canadian regional cancer center, found little evidence of HCP action when the patients admitted to suffering significant pain through an online survey. Although that finding may be related to the lack of documentation to indicate the pain interventions, it may suggest that some HCPs do not attend to the pain if patients fail to clearly articulate their symptoms directly to the HCP.

The need for management strategies to address fatigue and urinary incontinence was stressed by the current study’s participants, and it was a key finding in the companion patient study (Carter et al., 2011). The HCPs in this study did not discuss strategies to reduce fatigue, and only one participant described specific strategies to manage urinary incontinence—a continence clinic nurse described exercises to strengthen pelvic floor muscles. Based on a systematic review, high-quality evidence supports pelvic floor muscle exercises in the treatment of urinary incontinence after a radical prostatectomy (Nahon, Dorey, Waddington, & Adams, 2006). In addition, in a preoperative, prospective, randomized, controlled trial, men who did such exercises demonstrated improved quality of life (Centemero et al., 2010). The Canadian Continence Foundation (2009) suggested physiotherapy as a conservative treatment that is effective and less invasive than other treatments, and it should be promoted in men with prostate cancer. However, physiotherapy management may not be effective for patients with advanced cancer who are suffering from urinary frequency and incontinence aggravated by a growing localized tumor and associated urinary obstruction (Bahl, 2013); therefore, other strategies are needed specific to men with APC.

Physical therapy may be an option to address other physical symptoms experienced by men with APC, such as pain, fatigue, and weakness. The current sample did not include a physiotherapist and, to the best of the authors’ knowledge at the time this study was undertaken, no designated physiotherapists who worked with men with APC were associated with the regional program studied. Some evidence exists that physiotherapy services can play a positive role in fatigue management, but most studies have looked at patients with early disease. Galvão, Taaffe, Spry, Joseph, and Newton (2010) reported that a supervised exercise program significantly improved levels of fatigue in patients with early-stage prostate cancer. However, in another controlled trial, a physiotherapist-led physical training intervention did not help depression and anxiety in a sample of men (of which 20% had metastatic disease), but the authors suggested small sample sizes were a limitation (Berglund et al., 2007). The role of the physiotherapist as an integral member of the oncology healthcare team is developing and will become clearer with more research (Massa, 2011).

Men’s need for more information about treatments, medications, side effects, disease progression, and available supportive care resources have been identified previously (Carter et al., 2010, 2011). Participants in the current study confirmed the diverse and incessant informational needs of men with APC. HCPs reported delivering information to patients and being open to answering questions, but they thought the men were unable to retain the information provided. The participants suggested this
may be related to the use of medical terminology and ineffectual timing. Echlin and Rees (2002) suggested that men typically seek information related to prognosis at the time of diagnosis, and then seek information related to side effects after the delivery of treatment. In contrast, the current sample reported that men repeatedly sought both types of information following diagnosis.

The participants reported they did not have time to meet the emotional needs of patients and families, confirming the concerns raised by patients and family members in the companion studies (Carter et al., 2010, 2011). Unfortunately, the increasing workloads resulting from a stressed healthcare system cause HCPs to carefully set priorities, and the less concrete task of providing emotional support may become a lower priority. The study findings do not clearly determine whether nurses and other HCPs have the skills to provide this type of support or are able to refer to more appropriate providers (i.e., social workers or clinical psychologists may not be available). That lack of support is particularly troublesome for men with APC who do not want to bother overburdened HCPs by asking for more support (Carter et al., 2010). A number of participants in the current study referred men to local prostate cancer support groups with the expectation that they might access the emotional support they require in that environment. Unfortunately, men with APC reported that prostate cancer support groups were not helpful to them because group discussions were monopolized by the many questions of men who were newly diagnosed (Carter et al., 2011). The results of other studies also indicated that support groups are often a source of information and not emotional support (Fitch et al., 2000; Steginga et al., 2001; Weber, Roberts, & McDougall, 2000).

Men are less likely to seek help than women, which was noted by several of the participants (Mansfield, Addis, & Mahalik, 2003). Some HCPs suggested that gender-related issues barred men from seeking supportive care for their needs (e.g., emotional support, practical support related to continence issues, home care), but no specific strategies address this issue. Although fully investigating that finding is beyond the scope of the current research, the authors made a few observations. Some HCPs may not be skilled enough to provide emotional support in a well-received way for men with prostate cancer, and what patients and HCPs mean by “emotional support” may be different. Strategies for helping men address their existential concerns are likely to be different than for women. For example, the results of an exploration of gender differences in cancer communication suggested that, although women with cancer search for emotional and social support, men turn to the Internet for information (Seale, Ziebland, & Charteris-Black, 2006).

Emotional support for patients with advanced disease should be a priority regardless of the patient’s gender. Earlier research has indicated that family members often bear the burden when men with APC do not share their disease-related concerns (Carter et al., 2010). If individual members of the healthcare team do not have the time to provide emotional support, identifying another HCP on the team with the necessary expertise and resources is imperative. One valuable strategy may be to introduce palliative care earlier in the disease trajectory for men with APC because those teams include HCPs whose role is to address emotional needs. In addition, including formal assessments of patients’ symptoms and HRQOL using validated tools can lead to interventions that measure improvements in quality of life and, therefore, should be routine (Debono, 2011).

The emotional distress associated with treatment complications and poor prognosis for metastatic disease is common, and reassuring men and their family members about that may help to normalize assessment and treatment (Rabow & Lee, 2012). A review of prostate cancer literature suggested that men who are highly distressed are likely to benefit from social support intervention (Paterson, Jones, Rattray & Lauder, 2013). Men with APC deserve consistent and professional care to meet their emotional support needs, and those findings suggest that including additional HCPs who can address the unmet needs of men with APC (e.g., pain, incontinence, emotional distress) would be beneficial.

Limitations and Strengths

The authors presented the collection and analysis of region-specific data, which may not be representative of other urban areas in Canada. However, with the increasing focus on implementing evidence-based practice guidelines throughout the country, the provision of care in this region is most likely representative of care elsewhere. Collecting data from busy HCPs during their work hours was difficult, and despite the authors’ intentions to explore the supportive care needs of men and obstacles to providing care, time did not permit in-depth exploration, particularly in focus groups. Not all health disciplines caring for men with APC were represented in the study, which may have resulted in unequal emphasis on the perspectives of certain providers. Despite that limitation, incorporating interviews and focus groups contributed to the trustworthiness of the data through the data triangulation (Creswell, 1998). Although diverse disciplines were represented, demographics showed a greater representation by nurses and physicians, which may bias the results toward their experiences. However, these HCPs may be more involved in prostate cancer care, which would accurately represent the HCPs routinely interacting with this population. No physiotherapists or occupational therapists participated in the study, but the interdisciplinary nature of the research team facilitated...
the inclusion of evidence regarding the management of men with APC by rehabilitation professionals.

Implications for Supportive Care

Because the Canadian healthcare system expects to see an increase in the number of people living with cancer, understanding and addressing survivorship issues and facilitating a better quality of life for patients living with advanced disease becomes more crucial (Ward, 2010). Carter et al. (2011) identified the opportunity to develop nursing roles focused on prostate cancer at various stages of the cancer care continuum and proposed an advanced practice nurse role focused on APC. Advanced knowledge, educational preparation, and clinical expertise are needed to care for older men with metastatic disease.

An opportunity may also exist to create specialized roles in other health disciplines. The current study’s findings suggest that an advanced practice role in physiotherapy would be beneficial to address the treatment-related urinary incontinence and fatigue experienced by men with APC. The Canadian Physiotherapy Association (2013) introduced a national program through which physiotherapists can achieve designation as a clinical specialist, and one of the practice domains is oncology. An interdisciplinary care approach is important for the development of strategies to meet the supportive care needs of men with APC. In Ontario, Canada, efforts are underway to implement a framework to improve interdisciplinary care throughout the province (Health Force Ontario, 2007). The framework focuses on several actions, such as clarifying professional roles and responsibilities and ensuring that patients and their caregivers have sufficient resources to participate fully in their care. A synthesis of evidence of the characteristics of effective teams found that members of effective teams can determine areas of improvement for patient care and what resources should be reallocated to make improvements (Clements, Dault, & Priest, 2007). San Martin-Rodriguez, D’Amour, and Leduc (2008) demonstrated significant improvements in pain management among patients with cancer who were treated by an interdisciplinary care team with highly integrated collaboration when compared to patients treated by a minimally collaborative interdisciplinary care team. However, the HCPs in that study appeared to be unaware of the diverse HCP roles that could be involved in meeting the supportive care needs of this population. That further demonstrates the potential of implementing an interdisciplinary framework in cancer care and ensuring that the diversity and complexity of the entire spectrum of supportive care needs is adequately addressed by skilled HCPs as part of a comprehensive interdisciplinary care team.

Implications for Nursing

As many as 80% of men with prostate cancer have unmet needs, and supportive care and contact from nurses have significant impact on men’s outcomes (Cockle-Hearne et al., 2013). Opportunities exist to create nurse-led models of care to identify and address the unmet supportive care needs of men with APC. McGlynn et al. (2004) reported on the implementation of a nurse-led clinic for newly diagnosed men undergoing radical prostatectomy, which consisted of a specialist urology oncology nurse, an incontinence nurse, and a physiotherapist. The findings suggested patients cared for in the new model had improved urinary control, continence, and quality of life compared to men cared for in the traditional model. In a randomized, controlled trial, Faithfull, Corner, Meyer, Huddart, & Dearnaley (2001) compared the nurse-led care of patients receiving radiation therapy for prostate and bladder cancer to standard care. The specialist nurse focused on coping with symptoms by providing information on treatment and symptoms and assessing men’s understanding of their cancer and treatment. Men receiving nurse-led care were significantly more satisfied with care at 12 weeks, and the study found significant cost benefits as well (Faithfull et al., 2001). A practice pattern study of clinical nurse specialists caring for men in all stages of prostate cancer found that the focus of the role was coordination of care and emotional support for men at the point of diagnosis (Ream et al., 2009). Nurses working with men with metastatic disease need training and resources to properly address the supportive care needs of men and their family members. Pain and symptom management guidelines that include evidence-based strategies—such as those created by Cancer Care Ontario (2014)—are a valuable resource for nurses and other clinicians.

Future Research

Including patients, family members, and HCPs in additional health services research aimed at meeting the needs of men with APC is important. The types of unmet needs men, family members, and HCPs reported were consistent (Carter et al., 2010, 2011). All three groups described similar reasons why HCPs could not meet men’s needs, including lack of time. The role interdisciplinary care may play in meeting the needs of men with APC is unclear. Although a number of studies have focused on the effectiveness of multidisciplinary teams on the medical management of prostate cancer (Kovner et al., 1999; Sternberg et al., 2007), a paucity of research explores the effectiveness of interdisciplinary care on supportive care needs. In addition, the challenges of designing experimental studies to compare ways of providing care has led mainly to observational or retrospective studies.
which are prone to bias (Fleissig, Jenkins, Catt, & Fallowfield, 2006). No studies were found that explored the roles or effectiveness of various non-medical team members such as social workers, physiotherapists, and psychologists. The emergence of nurse-led care for patients with prostate cancer may present future opportunities to test their effectiveness in providing care to men with APC.

Conclusion

This study identified HCPs’ perceptions of the unmet needs of men with APC in four key areas: pain and symptom management, informational needs, emotional support, and practical assistance. The study completes the comprehensive review of the supportive care needs of men with APC by adding the experiences of HCPs to the earlier findings of the men (Carter et al., 2011) and their families (Carter et al., 2010). Recurrent themes indicate that patients experience unmet supportive care needs that negatively affect health and quality of life. To improve care for patients with specific needs and facilitate the transition to cancer survivorship, an interdisciplinary team of HCPs that includes specialized and advanced roles is recommended. Previous research has demonstrated the potential for nurse-led care for men with APC. Additional research is needed to explore how nurses and other clinicians who are part of an interdisciplinary healthcare team can use their discipline-specific skills and work collaboratively to provide comprehensive supportive care, as well as whether such efforts are successful in meeting the supportive care needs of men with APC.

Nancy Carter, PhD, RN, is an assistant professor in the School of Nursing; Patricia A. Miller, PhD, PT, is an associate clinical professor, Brittany R. Murphy, BSc(Kin), MSc(PT), is a physiotherapist, and Victoria J. Payne, BSc(H), MSc(PT), is a resident physiotherapist, all in the School of Rehabilitation Science; and Denise Bryant-Lukosius, PhD, RN, is an associate professor and clinician scientist in the School of Nursing, all at McMaster University in Hamilton, Ontario, Canada. No financial relationships to disclose. Carter can be reached at carternm@mcmaster.ca, with copy to editor at ONFEditor@ons.org. (Submitted October 2013. Accepted for publication February 28, 2014.)

References


