

'What happens next?' An exploration of how general practitioners talk to men presenting with possible symptoms of prostate cancer.

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## TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	6
ABSTRACT.....	7
1. INTRODUCTION .....	8
1.1.Literature Review .....	8
1.1.1. Search strategy.....	8
1.2. What is Prostate Cancer?.....	9
1.2.1. Symptoms.....	9
1.2.2. Incidence .....	9
1.3. Risk Factors .....	10
1.3.1. Age .....	10
1.3.2. Ethnicity .....	11
1.3.3. Family History .....	11
1.4. Detection .....	11
1.4.1. Detection practices .....	13
1.4.1.1. No Screening programme .....	13
1.4.1.2. Different approaches .....	13
1.5. Decision aids .....	16
1.6. Treatment issues.....	17
1.7. Masculinity.....	18
1.7.1. Seeking help .....	19
1.7.2. Treatment .....	20
1.7.3. Interactions with professionals.....	20
1.8. Groups at greater risk.....	21
1.8.1. Seeking help .....	21
1.8.2. Treatment .....	22
1.8.3. Interaction with services and professionals.....	22
1.9. Psychological theories and frameworks .....	23
1.10. Reasons for the study and relevance to clinical psychology.....	28
1.11. Research aims .....	30
1.12. Research Methods Choice .....	31

2. METHODOLOGY AND METHOD.....	32
2.1. Methodology.....	32
2.1.1. Epistemological Position .....	32
2.1.2. Rationale for qualitative approach and thematic analysis .....	34
2.1.2.1. Appropriate for research aims .....	34
2.1.2.2. Greater flexibility and complexity .....	35
2.1.2.3. Thematic analysis rationale .....	35
2.1.3. Semi structured interviews .....	36
2.1.3. Reflexivity .....	36
2.2. Method .....	37
2.2.1. Ethical considerations .....	37
2.2.1. Recruitment .....	38
2.2.1.1. Participants and recruitment procedure.....	38
2.2.1.2. Interviews.....	39
2.2.1.3. Interview schedule .....	39
2.2.1.4. Interview procedure .....	40
2.3. Analysis .....	40
2.3.1. Development of themes - planning .....	40
2.3.2. Development of themes – the analysis .....	41
3. RESULTS .....	44
3.1. Demographics .....	44
3.2. Thematic Analysis .....	47
3.2.1. Dilemmas and differences .....	48
3.2.1.1. Perceptions of roles and responsibilities .....	48
3.2.1.2. Uncertainties .....	56
3.2.1.3. Awareness of risk factors but not making assumptions based upon them .....	64
3.2.2. 'Being men' .....	66
3.2.2.1. Self-concept - denial and stoicism.....	66
3.2.2.2. Feeling embarrassed.....	69
3.2.3. Awareness, action and assertiveness.....	71
3.2.3.2 Are men aware? .....	71
3.2.3.2 Influences on awareness, action and assertiveness .....	72

3.2.4. Significance of gender and age .....	76
4. DISCUSSION	
4.1. Summary of participants' experiences.....	79
4.2. Addressing the research aims .....	81
4.2.1. Research aim one – explore how GPs approach conversations with men who present with possible symptoms of PCa.....	81
4.2.1.1.Approaches to information provision .....	81
4.2.1.2.Managing the consultations and relational issues .....	84
4.2.1.3. Approaches to managing uncertainty .....	87
4.2.1.4.Approaches to managing risk.....	92
4.3. Research aim two - explore the way GPs describe issues related to masculinity and how they may influence conversations with men who present with possible symptoms of PCa. ....	94
4.3.1. Perception of services and legitimising attendance.....	94
4.3.2. Embarrassment and preserving their image.....	96
4.3.3. Influences of other factors .....	98
4.4. Implications and recommendations .....	101
4.4.1. Clinical implications.....	101
4.4.1.1. Training programmes .....	101
4.4.1.2. Consultancy .....	103
4.4.1.3. Partner involvement .....	104
4.4.2. Implications for future research.....	105
4.4.2.1.Live consultations.....	105
4.4.2.2.Groups at risk.....	105
4.5. Critical review .....	106
4.5.1. Quality.....	106
4.5.1.1. Owning own perspective .....	106
4.5.1.2.Situating the sample.....	106
4.5.1.3.Grounding in examples .....	107
4.5.1.4.Providing credibility checks .....	107
4.5.1.5.Coherence.....	107
4.5.1.6.Accomplishing general versus specific research tasks.....	107
4.5.1.7.Resonating with the reader .....	108

4.5.2. Reflexivity .....	108
4.5.2.1. Epistemological reflexivity .....	108
4.5.2.2. The researcher as a man .....	108
4.5.2.3. The researcher as a trainee clinical psychologist .....	109
4.5.2.4. Ethical issues .....	110
4.5.2.5. Strengths of the study .....	110
4.6. Critique of Methodology and Methods .....	111
4.6.1. Recruitment / sampling .....	111
4.6.1. Data collection .....	112
4.7. Summary .....	113
5. REFERENCES .....	115
6. APPENDICES.....	140
Appendix 1: Ethical approval .....	140
Appendix 2: Interviews schedule .....	141
Appendix 3: Consent form .....	143
Appendix 4: Simple transcription scheme .....	144
Appendix 5.1: Final stages of theme development - Stage 1 .....	145
Appendix 5.2: Final stages of theme development - Stage 2 .....	146
Appendix 5.3: Final stages of theme development - Stage 3 (final) .....	147
Appendix 6: Worked example.....	148
Appendix 7: Demographics of Participants.....	149
<b>Tables in Results</b>	
Table 1: Demographics of Participants .....	45
Table 2: Overarching Themes and Sub Themes .....	47

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## ABSTRACT

Prostate cancer is the most common form of cancer amongst men in the UK. It is also the second most common cause of death in the UK. The strongest risk factors for developing the condition are increased age, family history and African-Caribbean ethnicity.

Detection methods have problems with reliability, specificity and being unpleasant. Further, there are debates about the effectiveness of treatments. Treatments are also associated with a number of temporary or long term side effects, including erectile dysfunction and incontinence. Issues related to masculinity and how men are often unwilling to seek help or delay in presenting to general practitioners further complicate detection and treatment.

NICE (2008) recommend that decisions about testing are made on an individual by individual basis. It is recommended that general practitioners advise men about issues of detection in order for them to make an informed decision about testing. This study aimed to explore how general practitioners approach such conversations and issues related to the construct of masculinity. Semi structured interviews were completed with 14 general practitioners in the UK. Data were analysed using thematic analysis.

Overall, participants had a number of different approaches and strategies to managing conversations. Four overarching themes were identified, 'dilemmas and differences', 'being men', 'awareness, action and assertiveness' and 'significance of gender and age'. Participants described how issues related to masculinity might have impacted whether men sought help. However, adopting a proactive approach and coming from higher socio-economic status may have modified these. General practitioners may benefit from further training about managing uncertainties around detection and treatment given the increased emphasis on primary care involvement following treatment for cancer in secondary care. Further research involving examination of live consultations may be useful to gain another perspective on how general practitioners manage such conversations.

# 1. INTRODUCTION

This chapter will provide an introduction to prostate cancer. This will include information about the clinical features, the numbers of men affected and risk factors for the condition. The chapter will also outline the uncertainties and problems with detection methods and treatments for prostate cancer. Additionally, the chapter will also explore how issues related to detection and treatment are further complicated by the way men manage their health.

## 1.1. Literature Review

### 1.1.1. Search strategy

Two databases were searched, PsychINFO and PsycArticles. The search, “prostate cancer AND primary care OR GP OR general practitioner OR primary practitioner OR counselling”, generated 120 studies published between January 1998 and April 2013. The search, “prostate cancer AND masculinity”, generated 56 papers published between January 2001 and April 2013. The titles and abstracts of these studies were reviewed and reduced to 41 studies. Studies that were not relevant to issues relating to conversations about prostate cancer between men and general practitioners (GPs) were excluded. An examination of the 41 studies revealed a further 10 studies, which were also reviewed. An additional 10 papers were retrieved through discussions with colleagues. In total 61 papers were included.

This literature review includes studies about prostate cancer that were completed in other western countries (e.g. North America, Australia). While there are differences in provision of health care across western countries there is value in examining these studies as the recommendations around screening, testing and informed decision-making are similar to that in the UK (Ross, Coates, Breen, Uhler, Potosky, & Blackman, 2004). In North America and other countries family physicians, primary care physicians and primary care practitioners occupy a similar role to that of GPs in the UK. For ease of reading, the term GP will refer to all providers working in a similar role and will not include providers of secondary or specialist services (e.g. urologists).

## **1.2. What is Prostate Cancer?**

Prostate cancer (PCa) is a type of cancer, which develops in the prostate gland. The prostate gland is found only in men. It surrounds the urethra and is located between the penis and the bladder (The British Association of Urological Surgeons, 2011). The prostate gland often grows larger due to non-cancerous cells in men over 50 years old. This is called benign prostatic hyperplasia or hypertrophy (BPH).

### 1.2.1. Symptoms

PCa often develops slowly and men in primary care may not present with any symptoms (NICE, 2008). Due to the location of the tumours, symptoms may only appear when the prostate becomes large enough to put pressure onto the urethra (McNeal, 1969). However, PCa can also be aggressive with a rapid onset of symptoms (NICE, 2008).

It has been suggested that PCa “is not a single disease entity but more a spectrum of diseases, ranging from slow-growing tumours, which may not cause any symptoms or shorten life, to very aggressive tumours. Some tumours can change from being low risk to high risk. Many men with slow-growing tumours die with their cancer rather than of it.” (Burford, Kirby, & Austoker, 2009, p. 9).

Symptoms may include lower urinary tract symptoms (LUTS) such as an increased urgency, frequency, hesitancy, straining, weak flow when urinating and sensations that the bladder has not emptied (Burford et al., 2009). However, these symptoms overlap with that of BPH, which make it difficult to differentiate PCa from other prostate conditions (Hamilton & Sharp, 2004). Secondary symptoms of PCa may include general symptoms such as increased fatigue and loss of appetite. Signs of metastatic PCa may include pain in bones, back, hip and pelvis. Other symptoms may include weight loss and erectile dysfunction (Burford et al., 2009).

### 1.2.2. Incidence

In the UK, USA and other western countries, PCa is the most common cancer amongst men (Prior & Waxman, 2000; The American Cancer Society, 2011). In 2009, 40,841 men in the UK were diagnosed with PCa (Cancer Research UK, 2012). In 2010, 10,721 men died from the condition (Cancer Research UK, 2012). In 2010, it was the second most common cause of cancer death, after lung cancer in the UK (Cancer Research UK, 2012).

PCa predominately affects older men and is less common amongst men below the age of 50 (Burford et al., 2009). The average age of diagnosis is between 70-74 and the average age for mortality is 80-84 (Burford et al., 2009). It has been suggested that 80% of 80-year-old men will have cancerous cells in their prostate (Sakr, Grignon, Haas, Heilbrun, Pontes & Crissman, 1996).

Increasing numbers of men are diagnosed and living with PCa (Cancer Research UK, 2008). Developments in detection methods may have increased the number of men diagnosed without clinically significant features (Chamberlain, Melia, Moss & Brown, 1997). These developments include the examination of chips removed during a transurethral resection of the prostate for benign disease, the use of the PSA and ultrasound guided biopsies (Burford et al., 2009). Other possible explanations include an increase in life expectancy and an ageing population (Burford et al., 2009).

### **1.3. Risk Factors**

Age, ethnicity and family history have been associated with an increased risk of developing PCa (Burford et al., 2009).

#### **1.3.1. Age**

Age is considered the strongest risk factor for PCa (Burford et al., 2009). Most men are diagnosed after the age of 50 (Chapple & Ziebland, 2002). Haas, Delongchamps, Brawley, Wang and Roza (2008) found that 80% of 90 year olds had undiagnosed PCa in a post mortem study. Although PCa mainly affects older men it is reported to occur in approximately 20% of men under the age of 65 (NICE, 2008).

### 1.3.2. Ethnicity

Individuals from African-Caribbean backgrounds in the UK are at two to three times greater risk of developing PCa in comparison to white men (Ben-Shlomo et al., 2008; Chinegwundoh et al., 2006; Metcalfe et al., 2008). Similar findings have been reported in the USA (American Cancer Society, 2004). Men from these groups may develop PCa at an earlier age than the general population (Moul, 2000). They are also more likely to be diagnosed at more advanced stages of the condition (Bennett et al., 1998; Powell et al., 2002).

### 1.3.3. Family History

Johns and Houlston (2003) conducted a systematic review and found that men with a family history of PCa were at a significantly greater risk of developing PCa than those without. Bratt (2002) suggests that 5-10% of all diagnosed PCa had a hereditary link. Carter, Beaty, Steinberg, Childs, and Walsh (1992) found that those diagnosed before 55 years old had a 30-40% hereditary susceptibility to developing PCa. The risk increases if there is more than one relative with a history of early PCa (Carter et al., 1992). A family history of breast cancer has also been proposed as a risk factor for PCa (Edwards et al., 2003; Thompson & Easton 2002).

## **1.4. Detection**

There are different methods of detection. These include the prostate-specific antigen (PSA) test, digital rectal examination, transrectal ultra sound (TRUS), TRUS guided biopsy and histology and imaging techniques (Magnetic resonance, computerised tomography, X-ray, bone scan) (Burford et al., 2007).

The prostate specific antigen (PSA) test is a blood test and is currently the most widely accepted test used in primary care (Fowler et al., 1998; Moran et al., 2000). PSA is a protein involved in the production of semen (Balk, Ku, & Bubley, 2003). There may be increased levels of PSA in the bloodstream as a result of PCa as well as other conditions such as benign prostatic enlargement. The PSA test measures how much of the protein is in the bloodstream.

PSA levels vary between men and increases with age. Burford et al. (2002) suggest that 3 nanograms per millilitre of blood g/ml (ng/ml) or less is in the normal range for a man under 60 years old, 4 ng/ml or less is normal for a man aged 60 to 69 and 5 ng/ml or less is normal if you are aged over 70. If the PSA levels are higher than the norms for a particular age group further investigations may be required.

Although the PSA is widely accepted as the best test currently available, it has significant problems with reliability, which can lead to false negative and false positive results (Mackie, 2010; Schröder et al., 2009). The PSA also has poor specificity and is unable to distinguish between benign prostatic problems and PCa (Schröder et al., 2009).

The digital rectal examination involves a manual examination of the prostate to check for abnormalities, lumps or a hard prostate, which may indicate the presence of PCa (Burford et al., 2007). However, the digital rectal examination may not exclude the possibility of PCa and where there is cancer it may not be useful for early detection (Brawer et al., 1992; Burford et al., 2007).

TRUS is an ultra sound of the rectum to determine the size of the prostate. In the UK this is usually completed in secondary services (NICE, 2008). While it is not reliable in excluding PCa it can be useful in determining the placement of needles for a biopsy (Burford et al., 2007). The biopsy involves inserting needles through the rectum to retrieve samples of tissue from the prostate (Olliffe & Thorne, 2007). A Gleason score is calculated if a tumour is detected (1 to 5 per tumour), the lower the score the less likely it is that the cancer will progress and better the prognosis (Burford et al., 2007). TRUS with a biopsy may detect PCa before symptoms develop and identify which is tissue affected. However, it can be painful and may also fail to find tumours (Burford et al., 2007). In addition, early detection of clinically insignificant PCa may not improve outcomes and increase feelings of 'anxiety' for patients (Gomella et al., 2011).

Imaging techniques may also be used to identify spread of cancer but are not sufficient in excluding PCa (Burford et al., 2007). Although there are different

methods used to detect PCa all of them have problems and not definitive in confirming or excluding the presence of cancer (Burford et al., 2007; Ilic, Connor, Green & Wilt, 2011).

#### 1.4.1. Detection practices

##### *1.4.1.1. No Screening programme*

Screening programmes for breast, colorectal and cervical cancer have been shown to be effective and reduce mortality (Gøtzsche, 2011; He & Efron, 2011; Peto, Gilham, Fletcher, & Matthews, 2004.) However, the current international consensus advises against regular PCa screening due to inconclusive evidence about detection methods and uncertainty about whether the benefits outweigh potential harmful effects (Illic et al., 2007; Ross et al., 2004).

Firstly, there is mixed and inconclusive evidence as to whether early detection improves outcomes and survival chances (Andriole et al., 2009; Schroder et al., 2009). Secondly, not only do the tests have problems with reliability and specificity (Schröder et al., 2009), additional tests (e.g. digital rectal examination, TRUS and biopsy) which follow a positive PSA, are invasive, uncertain and can be unpleasant experiences (Burford et al., 2007). Thirdly, screening may lead to painful and unnecessary investigations or treatment for clinically insignificant cancers in older men, which leads to the possibility of harmful side effects outweighing any potential benefits (Gannon, Guerro-Blanco, Patel, & Abel, 2010; Tannock, 2000).

##### *1.4.1.2. Different approaches*

Different guidelines from different organisations (e.g. Canadian Task Force on Preventative Health Care, US Preventative Task Force, The American Urological Association) appear to offer slightly different recommendations about PCa detection (Hoag, Davidson, & Pommerville, 2008). Consequently, there has been widespread variation in testing practices and opinions on testing across western countries (Hoag et al., 2008). For example, there are differences in testing practices between the US and UK. It has been suggested that 57% of 50-year-old men in the USA had undergone PSA testing (Sirovich, Schwartz, & Woloshin, 2003) in comparison to 6% of men aged 45-84 between 1999-2002 in the UK

(Melia, Moss & Johns, 2004). Between 1994 and 2004 there was a significant decline of PCa mortality in the US in comparison to the UK (Collin et al., 2008). Collin et al. (2008) acknowledge that there may be other explanations for this, such as the way death rates were reported in the USA and UK. Schröder et al., (2009) found PSA screening may reduce mortality by 20% but there is a risk of over-diagnosis and unnecessarily treatment for PCa.

Due to the uncertainties around testing for PCa decisions about screening are made with men on an individual by individual basis in the UK (NICE, 2008). The Department of Health (Watson, Jenkins, Bukach, Brett & Austoker, 2002) introduced the PCa Risk Management Programme, which states that men should have access to the PSA test as long as they have full information about it.

NICE (2011) suggest that when a man presents to his GP with possible symptoms of PCa, he should be offered a digital rectal examination and the PSA test. NICE (2008, 2011) recommends a patient-centred care approach to suspected cancers, which involves a consideration of the individuals' needs, preferences and allows for the opportunity to make informed decisions about whether they want to be tested, treated or referred to secondary services.

NICE (2008) also recommends good communication and the tailoring of information is essential when having discussions about testing with men. This is particularly important as the complexities, uncertainties and lack of confidence about PCa has the potential to undermine communication between patients and doctors (Oliffe & Thorne, 2007). It is important that clinicians are aware that inadequate communication can leave patients and their families unsure about diagnosis, further investigations, prognosis, and treatment (Fallowfield & Jenkins, 1999). It has been suggested that the use of jargon-laden terminology is a potential barrier to communication (Deuster, Christopher, Donovan & Farrell, 2008; Roter & Hall, 1992).

Clinicians should involve the patient in decisions and discuss issues about the risks and benefits of testing (Hoffman et al., 2009; Ross et al., 2004). Studies conducted in USA suggest that men have a preference for shared decision

making rather than a doctor led approach (Frosch, Kaplan & Felitti, 2001; Woolf et al., 2005) However, McFall, Hamm and Volk (2006) found that views on shared decision making were mixed. Some participants felt comfortable about shared decision making where as others thought it was important to follow the advice of the experts.

Relatives and carers may be involved in the decision making process unless the patient specifically requests they are excluded (NICE, 2008). Volk et al., (2004) found that men perceived screening and treatment for advanced PCa worse than their wives did. McFall, Hamm and Volk (2006) found that women were less aware of issues around screening but were more in favour of it than their husbands.

NICE (2011) acknowledge the challenges of making a diagnosis of PCa and encourage GPs to review the patients' history and engage in discussions with specialists if they are uncertain about symptoms or signs.

If a man is suspected to have PCa he is referred to urology services and provided with support and information. NICE have produced a booklet about PSA which includes information about diagnosis, the role of the GP, referral to specialist services, prostate biopsy, treatment and its side effects, palliative care and follow ups (NICE, 2008).

The guidelines indicate that an urgent referral to secondary care is to be made if the man has a hard or irregular prostate or if a man with or without symptoms has a higher than expected PSA (NICE, 2011). An urgent referral may not be necessary if the prostate is enlarged or if the PSA is in the borderline range in which case it should be repeated 1 – 3 months later (NICE, 2011). NICE (2011) also highlight the importance of taking into account comorbidities. Once men are under the care of specialist urology services a diagnosis can be confirmed and a management plan developed (NICE, 2011).

NICE (2008) outline the value of continued support and information in primary care (usually the GP) while men are waiting for their urology appointment. The

patient should be given information about where they are being referred, waiting times, where to get further information about the suspected type of cancer, who they will be seen by, what to expect, types of tests they might expect, duration before results, whether they can take someone with them and other sources of support (e.g. for minority groups). Other priorities include discussing the PSA, digital rectal examination and other comorbidities alongside risk factors when thinking about a prostate biopsy (NICE, 2008). Access to specialist services for erectile dysfunction, continence and palliative care should also be made available (NICE, 2008).

In the absence of screening programmes it is important that men are aware of PCa including relevant risk factors, possible symptoms and then willing to approach their GP to request testing.

### **1.5. Decision aids**

Given the complexities surrounding PCa informed decision-making about testing is important and several aids have been developed (Watson et al., 2006). A systematic review concluded that decision aids for PCa improve knowledge, reduce decision-making conflict and promote greater involvement of men in the process (Volk et al., 2007). They also suggest that decision aids reduce interest in PSA testing amongst men seeking routine testing. Men were also more likely to prefer watchful waiting if they were found to have PCa (Volk et al., 2007).

However, Watson et al. (2006) found that the decision aids did not influence men's intentions to be tested in the next 12 months. They suggest that while knowledge of PSA testing is low, attitudes towards testing remain positive, possibly because of positive messages about early detection and treatment for cancer in the UK (Watson et al., 2006). Consequently, it may be difficult for men to consider how the negative aspects of PCa testing may outweigh the positives. Gattellari and Ward (2004) also found that while decision aids may improve knowledge they may not impact testing practices of men.

## 1.6. Treatment issues

There are a range of treatment options available which vary according to stage of diagnosis (Chapple & Ziebland, 2002; Ream et al., 2008). These include external beam radiation, brahytherapy and radical prostatectomy (Chapple & Ziebland, 2002; Ream et al., 2008). The effectiveness of treatments and curability of PCa may be related to early detection (Gwede & McDermott, 2006). However, PCa is often slow growing and, depending on age of onset, it may not be clinically significant and not require treatment. In these circumstances watchful waiting or active surveillance may be recommended (Cancer Research, 2012). Hormone therapy may be used if the cancer has spread beyond on the prostate; while this may reduce cancer growth it does not necessarily improve survival chances (Lu-Yao et al., 2002; Tannock, 2000). All of the treatments for PCa are associated with long lasting or permanent unpleasant side effects such as erectile dysfunction, urinary incontinence and bowel dysfunction which can also have an impact on men's sense of self (Gannon et al., 2010; Tannock, 2000).

Galbraith, Ramirez and Pedro (2001) looked at outcomes for five different types of treatment and identified the following side effects, erectile dysfunction (ED), urinary incontinence, reduction in the length of the penis and dry ejaculations. Kao et al. (2000) found that following radical prostatectomy 66% of men reported urinary incontinence and 88% reported impotence. Stanford et al. (2000) looked at men 18 months after they had undergone a prostatectomy and found 59.9% still reported being impotent and 8.4% incontinent.

It is important to consider the implications of treatment and their side effects for a number of reasons. Although older age is one of the strongest 'risk factors' for PCa (Albertson, 1997; Gorman, 2002) studies have found that men are living longer with PCa (Kozlowski & Grayhacl, 2002; Remzi, Waldert, Djavan, 2004) and that most will die from other health conditions (Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002)

Ellison (2000) believe that PCa will be a chronic and long-term illness. As a result informed decision making becomes even more important as current treatments

are likely to result in a number of unpleasant side effects that an increasing number of men will have to live with for a longer period of time. Clark, Wray, and Ashton (2001) found that men treated with androgen deprivation therapy expressed substantial regret over their treatment choice and the impact it had on their quality of life. Payne and Gillat (2007) propose that taking into consideration the side effects of the different treatment options would enhance patient experience and satisfaction with their care.

In summary, there are a number of issues related to PCa. Firstly, there are a number of reliability and specificity issues with current detection methods (Schröder et al., 2009). As a result there is no screening programme. This means that men who may have symptoms (if they are present at all) need to be aware of risk factors and be willing to approach their GP for help. Further there are debates about the effectiveness of treatments for PCa and a danger that they may be harmful and create more problems for men (Lu-Yao et al., 2002; Tannock, 2000). Decisions about testing, treatment and their resultant side effects may be further complicated by issues related to the construct of masculinity (Olliffe & Thorne, 2007).

### **1.7. Masculinity**

Hegemonic masculinity is a construct that refers to the socially desired characteristics of what it means to be a man within a particular society at a given time (Connell, 1997). It may be useful to view masculinity (or masculinities) as multiple, complex and constructed differently depending on the cultural and historical contexts (Connell, 1995, 1997; Courtenay, 2000).

Cheng (1999) suggests that in western societies hegemonic masculinity may include characteristics such as domination, aggression, competitive, sexual and athletic prowess and control. Connell (1987, 1995, 2000) suggests that hegemonic masculinity also represents a position of cultural authority and leadership, which is constructed in relation to other subordinate forms of masculinity and women.

Courtenay (2000) suggests that in the USA, men may use health-related behaviours as a way of demonstrating hegemonic masculinity. These include the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust thus dismissing the need for help. Courtenay (2000) argues that adopting these types of culturally informed ideals of masculinity results in men utilising more unhealthy behaviours. Further, men may “risk reproach and sometimes physical danger for failing to demonstrate gender correctly.” (p. 1397). Men do not use cancer screening as frequently as women which could be a reflection of the way men demonstrate their masculinity (Evans, Brotherstone, Miles, and Wardle, 2005).

Issues involving masculinity have the potential to impact upon communications between men and doctors (Moynihan, 1998; Oliffe & Thorne, 2007; Walsh, 2000). The potential hierarchical relationships between men with PCa and their doctors may be important to take into account (Chapple & Ziebland, 2002), particularly when considering the potential losses or challenges a man may experience as a result of treatment for PCa (e.g. erectile dysfunction, incontinence, feelings of vulnerability and dependence) (Oliffe & Thorne, 2007). Broom (2004) found that cultural ideas about masculinity had the potential to influence men before and after treatment for PCa.

#### 1.7.1. Seeking help

Men do not engage in as many health-promoting behaviours as women (Courtenay, 2000; Mahalik, Burns & Syzdek, 2007). This may be related to a combination of issues such as access to information, concepts of masculinities and service organisations (Courtenay, 2000; Oliffe & Thorne, 2007). This can have important implications for whether men seek help for their symptoms, making informed decisions about testing, treatment and any accessing ongoing support.

In a UK study of 52 men diagnosed with or suspected to have PCa Chapple and Ziebland (2002) found men were reluctant to consult their GP about prostate symptoms because they believed it was not masculine to show weakness. They acknowledged that three quarters of their participants were white middle class

men and that different issues may have been identified with another group of men (Chapple & Ziebland, 2002). Hale et al. (2007) found that men delayed seeking help from their GPs by denying or reducing the severity of their symptoms. They also suggest that men viewed prostate symptoms as a threat to their masculinity and by hiding their symptoms men were able to protect the image they presented.

Men may also legitimise their reason for attending in masculine ways, i.e. they were only there because of their wife, symptoms had become severe, or in responses to friends, family and health campaigns (Hale, Grogan, and Willott, 2010). It has been suggested that men do not engage in health promoting behaviours as frequently as women (Courtenay, 2000; Mahalik, Burns & Syzdek, 2007). However, Oliffe and Thorne (2007) found that men did not avoid doctors because they did not want to hear bad news or were afraid of showing weakness.

### 1.7.2. Treatment

Men have been shown to be concerned about the impact of treatment on work, providing for their family and leisure activities (e.g. sport) (Chapple and Ziebland, 2002). Men who had experienced hormonal therapy have reported a loss of interest in sex, which they reported reduced their sense of masculinity (Chapple and Ziebland, 2002).

### 1.7.3. Interactions with professionals

Hale et al. (2007) suggest that interactions between men and GPs may be important. Participants in their study believed that their GPs considered them “soft” or “moaning” when they presented with symptoms. It has also been suggested that GPs may disempower men by labelling their problems as trivial and this may lead to their exclusion from making decisions about their health (Hale Grogan, & Willott, 2010). This may be important in relation to informed decision making about testing and treatment for PCa. It has also been suggested that over-consulting is more acceptable for females than males and this may be due to the beliefs they had about what was acceptable for men and women (Hale Grogan, & Willott, 2010).

Oliffe and Thorne (2007) used data from two interview studies of men who had survived PCa. There were 19 men in a Canadian study and 33 men in an Australian study who received treatment from male GPs and male PCa specialists. They suggest that communications between GPs and participants resembled business transactions, which fit with ideal masculine characteristics. They found that humor was employed to manage feelings of 'anxiety'. This may be important for conversations about PCa and whether men are able to discuss psychological or emotional concerns related to their experiences (Oliffe and Thorne, 2007).

In a systematic review of 26 papers Roter and Hall (2002) examined the effects of gender in medical communications in non-cancer settings. They found that male doctors engaged in less active partnership behaviours, fewer conversations about psychosocial issues, reduced emotional talk and had shorter consultations than female doctors. Roter and Hall (2002) suggested that patients were less assertive, spoke less and disclosed less to male doctors than female ones. These dynamics are important given the recommendations from NICE (2008) for managing possible symptoms of PCa.

## **1.8. Groups at greater risk**

As highlighted earlier, men from African-Caribbean backgrounds are at greater risk of developing PCa (Ben-Shlomo et al., 2008; Chinegwundoh et al., 2006; Metcalfe et al., 2008).

### 1.8.1. Seeking help

Men from these groups are less likely to seek help than men from other backgrounds (Braithwaite, 2001). African-Caribbean men may not seek help for their symptoms for a number of reasons (Nanton & Dale, 2011). They may have limited knowledge about PCa (Wilkinson, List, Sinner, Dai, & Chodak, 2003) and not think their symptoms were serious (Nanton & Dale, 2011). Further, they may fear cancer, death, loss of sexual function and the invasive nature of investigations (i.e. digital rectal examination) (Nanton & Dale, 2011). Despite this increased risk for developing PCa, white men are more likely to undergo

screening than men from Black African and Caribbean backgrounds (Braithwaite, 2001; Steele, Miller, Maylahn, Uhler, and Baker,, 2000; Eisen et al. 1999; Weinrich, 2006).

### 1.8.2. Treatment

Nanton and Dale (2011) explored the experiences of African-Caribbean diagnosed with PCa in the UK. They found African-Caribbean reported that they received little information about the condition, treatment or side effects (Nanton & Dale, 2011). Further, they felt unprepared for the extent and duration of the side effects of treatment. They talked about feelings of stress and embarrassment about the lack of support around continence issues. Concerns around sexual functioning were also highlighted.

Nanton and Dale (2011) suggest that the men had been affected by negative attitudes. A number of assumptions and stereotypes (e.g. not wanting to have hormone therapy in order to remain “macho”) were made about the men, which had a negative affect on them.

### 1.8.3. Interaction with services and professionals

African-Caribbean men may experience the health care system as insensitive, lacking in understanding and unresponsive to their needs (Nanton & Dale, 2011). They also found that a majority of men did not question the professionals about their illness or treatment even though they later reported that they wanted more information. Nanton and Dale (2011) propose that professionals may have thought the participants were not interested and inadvertently closed down conversations regarding treatment. These issues are of concern given the recommendations for information provision and decision making in guidelines for PCa management (NICE, 2008).

Nanton and Dale (2011) suggested that there is a complex interaction between ethnicity, social class and age when looking at communications between patients and health care professionals. Cultural, historical factors (e.g. growing up in a colonial era, strong influence of the church and having limited access to medical help) as well the effects of old age and feelings of vulnerability due to illness may

have impacted on their communications with professionals (Nanton & Dale, 2011). They reflect that the authority embedded in the GP role may have been a barrier to asking questions and that participants might have been reluctant discuss issues around continence and sex as a way of maintaining their own dignity (Nanton & Dale, 2011). Although their study was completed with men from African-Caribbean backgrounds it may be possible that some of their findings are applicable to men in general.

Papadopolous (2004) suggests that culture influences patterns of communications as well as language. These are important with men who may be at a higher risk of developing PCa given the uncertainty around testing, treatment and emphasis on informed decision.

Chan, Haynes, O'Donnell, Bachino and Vernon (2003) completed four focus groups with 20 couples from African American, Hispanic and Caucasian backgrounds about how they would want information presented to them about PCa. They analyzed the data using content analysis and suggest that there were cultural differences between these groups. For example, in relation to content, African Americans wanted to highlight they were at greater risk of PCa and increased mortality rates, whereas Hispanics wanted to know more about advanced symptoms and Caucasians early symptoms. Caucasian and African-Americans wanted to know the advantages and disadvantages of the PSA, where as Hispanics favored a presentation of the facts. They conclude cultural sensitivity is important when designing and using educational interventions. This may help promote informed decision making about testing.

### **1.9. Psychological theories and frameworks**

A number of theories and models have developed for understanding health behaviours (Glanz et al., 2008). This section considers how the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974), theory of planned behaviour (Ajzen, 1991), social cognitive theory (Bandura, 1977, 1986, 1997), shared decision making model (Coulter & Collins, 2011) and patient centred principles (Mead & Bower, 2000) may influence how GP's approach conversations about PCa.

Whilst these theories focus on individuals affected by health issues, they may also be applied to understanding the behaviour of health professionals. For example, the beliefs and attitudes of GPs about PCa may influence their behaviour in relation to offering men testing. These beliefs may also influence how GPs communicate information to men about PCa and issues related to detection and treatment.

The health belief model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974) proposes that health behaviours are influenced by an individual's attitudes and beliefs. These are related to perceived susceptibility severity, benefits, barriers, cues to action and self efficacy (Glanz et al., 2008). According to this theory an individual will be likely to take action if they perceive themselves to be at risk of a condition that can have serious consequences, that beneficial action is available to them and the anticipated benefits outweigh the barriers to action (Glanz et al., 2008).

In relation to the current study it is possible that GP's beliefs about PCa and PSA testing may be influential. In the USA Voss et al. (2001) found increased rates of PSA testing between 1993 and 1998. They suggest that a number of positive beliefs about PSA test and fear of malpractice liability lead to increased testing. Philips et al. (2005) found that aggressive testing for prostate and colorectal cancer is frequent, GP-driven and is correlated to GP's beliefs about screening. They suggest that GPs need better education if testing practices are to change. In relation to the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974) it may be that GPs have the potential to have an influence on testing through providing men with cues to action or by suggesting that the benefits of testing outweigh the costs.

The theory of planned behaviour (Ajzen, 1991) focuses on motivational factors for particular behaviours. This theory proposes that the best predictor of a given behaviour is intentions. Behavioural intention is influenced by attitudes, social normative perceptions and perceived control over of the behaviour (Ajzen, 1991). Attitudes are influenced by beliefs about the outcomes / attributes of the

behaviour considered against the evaluation of those behaviours (Glanz et al. 2008). Subjective norms are influenced by normative beliefs about whether referent individuals would approve or disapprove of the behaviour considered against their willingness to comply with those referents (Glanz et al., 2008). Perceived control is influenced by control beliefs related to the presence, absence and perceived power of factors to behavioural performance (Ajzen, 1991).

In relation to the current study the way GPs talk to men may have an influence on behaviour intentions and the various weighting up processes. For example, men who may have negative beliefs about the detection methods such as the digital rectal examination (e.g. Zully and Buki, 2011) may agree to be tested if their GP (referent individual) suggests that the outcomes will be beneficial. Men may also be willing to comply with their GP and believe they have control over the outcome of PCa.

In a French study Eisinger et al. (2008) found a disparity between recommended guidelines on testing and actual clinical practice. They outline three possible explanations. Firstly, patients were influenced by their GPs, secondly, patients influenced their GPs and requested testing, and finally, both GPs and patients are influenced by what they call the “magical touch” of blood analysis for PCa screening. This suggests that attitudes or beliefs about PCa testing may be influential on men’s intentions to be tested. In relation to the theory of planned behaviour (Ajzen, 1991) this study may suggest that beliefs about the PCa testing can have an influential on whether men intend to be tested. Alternatively, it may be possible that beliefs about testing have the potential to influence whether GPs intend on suggesting it to men.

Social cognitive theory (Bandura, 1977, 1986) proposes that personal, behavioural and environmental factors have an influence on human behaviour. This theory places emphasis on the idea of reciprocal determinism, which is the idea that environments shape behaviour but that humans alter and construct their environments to their purpose (Glanz et al. 2008). For example, promotion of public health can be viewed as an example of reciprocal determinism (Bandura,

1997) as societies attempt to control or influence the environmental and social factors which in turn that can have an effect on health behaviors and outcomes (Bandura, 1997). This theory may be useful in relation to PCa because it highlights the role of social or environmental factors on testing. For example, if GPs viewed PCa testing as part of promoting public health they may offer testing more frequently. There are several other concepts in this theory outcome expectations, self efficacy, collective efficacy, observational learning, incentive motivation, facilitation, self-regulation and moral disengagement (Banduara, 1997).

Social cognitive theory (Bandura, 1977, 1986, 1997) also suggests that health behaviours are influenced by beliefs about outcomes and the ability to complete the desired action. However, social cognitive theory also includes environmental factors, which may have an influence on health behaviours. For example, the concept of observational learning suggests that new behaviours (such as learning about PCa and testing) may be learned through interpersonal interactions, the media or peer modeling (Glanz et al. 2008). Studies (e.g. Chapple et al., 2008; Hale, Grogan, & Willott, 2010) have suggested that men may be influenced to engage in health promoting behaviours by friends, family and health campaigns. The concept of facilitation (Glanz et al. 2008) may also be important as it involves providing people with resources and tools to make decisions about their health. In relation to PCa this would involve providing men with information about the condition, detection methods and treatment issues.

Overall, these theories highlight ways GPs may influence men's behaviour in relation to PCa testing. While there are several differences between the theories they all highlight the important role of beliefs. In relation to PCa beliefs about the condition, detection methods and treatment may influence the information GPs provide and whether they encourage or discourage them from taking the PSA test. Given the uncertainties surrounding PCa and NICE (2008, 2011) recommendations for men to be counselled on testing it is useful to outline the person centred approach (Mead & Bower, 2000) and the decision making model (Coulter & Collins, 2011).

Mead and Bower (2000) suggest five dimensional important to patient centred care; biopsychosocial, 'patient as a person', sharing power and responsibility, therapeutic alliance and 'doctor as a person'. The biopsychosocial involves expanding the perspective of the illness to include psychological, social as well as biological issues (Mead & Bower, 2000). In relation in PCa, GPs may place varying importance on the psychological or social impact of testing or treatment if PCa (e.g. impact on sexuality). The second dimension, 'patient as a person' involves understanding the individual's experiences of the illness (Mead & Bower, 2000). Different men may experience testing and treatment for PCa differently depending on their own personal and unique circumstances. The third dimension, sharing power and responsibility involves greater patient involvement and equality between patient and doctors (Mead & Bower, 2000). In relation to PCa, this may involve men being more involved in decisions about testing and treatment. The fourth dimension, therapeutic alliance is concerned with the quality of the relationship between the doctor and patient (Roth & Fonagy, 1996). The fifth dimension, "doctor as a person" acknowledges the influence of doctors' personal qualities and attributes (Mead & Bower, 2000). Overall, these dimensions may be influential and important to how GP's approach conversations with men about PCa.

Finally, this section will considered the shared decision making model (Coulter & Collins, 2011). They suggest that shared decision making involves clinicians and patients working together to make health decisions (e.g. about testing, treatment) through providing evidence based information about the different options, including uncertainties (Coulter & Collins, 2011). It also involves developing empathy and trust, negotiating the agenda and prioritising, information sharing, re-attribution, communicating and managing risk, supporting deliberation, summarising and making the decision and documenting the decision (Coulter & Collins, 2011)

Coulter and Collins (2011) suggest patients and clinicians bring their own expertise to the process. Clinicians have expertise on diagnosis, prognosis, treatment, support and outcomes (Coulter & Collins, 2011). In contrast, patients have expertise in understanding the impact it will have on their lives, their

attitudes to risk, values and preferences (Coulter & Collins, 2011). Shared decision making where patients are active participants rather than passive recipients may be an important factor in better health care outcomes (Coulter & Collins, 2011). Further, shared decision making has been suggested to improve patients knowledge and understanding, increase accuracy of risk perceptions, increase comfort with decisions, greater participation, better treatment adherence, improved coping and confidence, improved health behaviours and more appropriate service use (Coulter & Collins, 2011; Murray et al. 2005; O'Connor et al., 2009; Picker Institute Europe, 2010). This approach may provide a way of considering how different aspects of shared decision making may be related to how GP's approach conversations with men about PCa.

### **1.10. Reasons for the study and relevance to clinical psychology**

Clinical psychology can be a valuable resource for other professionals (Management Advisory Service, 1989; Manpower Planning Advisory Group, 1990). Clinical psychology has much to offer beyond traditional mental health settings and in physical health services in relation to PCa. Clinical psychologists may have a potential consultancy and training role in primary care. They can work with GPs and other health professions in helping promote effective communication with patients and facilitating informed / shared decision-making. This is particularly important in relation to PCa and recommendations from NICE (2008, 2011).

PCa is complex because there is an intersection between physical and psychological issues across all aspects of the illness from testing to treatment to the interaction with masculinities and groups at greater risk. Given these multiple and complex aspects of PCa it is important to understand how GPs approach conversations with men. This includes whether issues around masculinity manifest themselves and how they are managed.

Some research has been conducted in the USA about whether GPs discuss the PSA with men. Hall, Ross, Taylor, and Richardson (2011) found 80% of GPs routinely discussed PCa testing with their patients and 64.1% reported that they

would persuade men into having the PSA test done. Guerra and Jacobs (2007) interviewed 18 GPs in the United States. All reported that they would discuss the PSA with men but six acknowledged that occasionally they did not. They suggested that patient barriers to discussions included increased co-morbidities, limited education / health literacy, and assumptions that the patient would refuse the PSA. They suggested that GP barriers were forgetfulness and negative attitude about testing. Systemic barriers were when patients visited for other reasons than an annual physical check up, limited time and lack of consensus within the medical profession about practice guidelines. Discussion was more likely to occur when patients requested it, men were highly educated, from an African- American ethnicity group, presence of family history, and had a previous PSA. GP facilitators to discussions were positive attitudes towards testing. Systemic issues with associated with increased likelihood of discussions were related to having annual physical examination, greater time for consultations and reminders to discuss testing. GP assumptions and systemic pressures may have an influence on whether GP's have discussions about the PSA test with men (Guerra and Jacobs, 2007).

Gattellari and Ward (2004) study in Australia found that of men who responded to questionnaires after their index consultations, 10.7% said their GP discussed the PSA with them, 2.7% said they received information about it, 10.0% said their GP advised them to have a PSA and 4.1% said their GP performed one. However, these studies are limited and do not provide detail about how conversations are managed between GPs and men. Further, much of the literature outlined above is taken from studies outside the UK and we cannot assume that they can be generalised to the UK. There are differences in culture and the organisation of health care systems (Collin et al., 2008) which may have an impact on how GPs and men approach conversations about PCa. For example, in North America, men may be able to access specialist services more directly than in the UK where they would need to go to the GP first. Further, the NHS is free at point of access where as there is an insurance-based system in the USA. These issues may influence approaches to PCa.

There has been limited research investigating how men interact with GPs regarding issues related to PCa (Olliffe & Thorne, 2007). It is important to gain a fuller understanding of how these interactions are approached, particularly if the doctor is also male (Olliffe & Thorne, 2007). This is because the treatment and care of PCa is more likely to become long term and will involve the development of more long-term relationships between patients and doctors (Olliffe & Thorne, 2007).

GPs occupy an important and powerful position when men present with possible symptoms of PCa. They are involved in completing initial tests, gatekeepers to specialist services and may be involved in providing on going support (NICE, 2011). Consequently, gaining their account of the ideas that inform their practice and their approach to conversations with men about PCa is valuable and may have important implications. This method would help explore such ideas.

Gaining a better understanding of GPs' accounts of conversations with men presenting with symptoms of PCa may help in the development of more acceptable, inclusive and appropriate services. Many of the studies outlined above use survey or questionnaire designs. While these are useful for examining the views of a large number of people, they do not necessarily capture the richness of GP's accounts of conversations with men about PCa. It may also be helpful to explore GPs' ideas about PCa to examine whether they are related to constructs of masculinities or culture. It may be that there are particular ideas that have implications for whether men seek help or advice about testing or treatment, which may be important when making decisions about their care. Given the lack of a reliable testing tool, treatment consensus and a high likelihood of distressing side effects (Gannon et al., 2010) it would be important that conversations with men about their options are effective and enable informed decision making.

### **1.11. Research aims**

There are two main aims of the investigation. Firstly, to explore how GPs approach conversations with men who present with possible symptoms of PCa.

Secondly, to explore the way GPs think about or describe issues related to the construct of masculinity in relation to PCa.

### **1.12. Research Methods Choice**

Qualitative research methods were considered most appropriate for exploring the approach GP's use when approaching conversations with men. Semi-structured interviews would provide a more detailed exploration of these conversations.

## 2. METHODOLOGY AND METHOD

This chapter outlines the epistemological position, methodology and methods of the study. The rationale for adopting a qualitative approach, and using thematic analysis is explained.

### 2.1. Methodology

#### 2.1.1. Epistemological Position

Research is influenced by assumptions and beliefs about ontology, epistemology, methodology and methods (Denzin & Lincoln, 2005). Ontology is concerned with 'what is the nature of reality?' and epistemology is concerned with the theory of knowledge or how it is acquired (Denzin & Lincoln, 2005; Barker, Pistrang & Elliott, 2002). These have an influence on the methodology and methods (how data is collected) (Denzin & Lincoln, 2005).

Realism is an epistemological position that assumes the existence of an objective and true reality that is measurable, independent of our perceptions of it (Bhaskar, 1975). In contrast, relativism is an epistemological position that assumes there is no absolute truth or reality but multiple truths or realities (Nightingale & Cromby, 1999). Critical realism (CR) is positioned between realism and relativism (Sullivan, 2010).

CR assumes "ontological realism by proposing that events, (observable and experienceable phenomena) are generated by underlying, relatively enduring structures such as biochemical, economic or social structures. This cannot be directly accessed but they can be detected through their effects" (Willig, 1999 p.45) Subsequently, CR assumes that there is a real world independent of people and ideas that can be represented by scientific theories (Alvesson, 2002).

However, CR ascertains that reality is not only made up of material objects, but is affected by ideas and discourses (Alvesson, 2002, p. 41). Knowledge is seen as historically and culturally specific (Sullivan, 2010). Within this approach language

is seen as both reflecting 'reality' and having the ability to shape ideas of what is real (Sullivan, 2010). CR assumes epistemological relativism in relation to knowledge, and the "impossibility of knowing objects except under particular descriptions." (Bhaskar, 1978, p. 249).

From a CR perspective the work of science is to "investigate and identify relationships and non-relationships respectively, between what we experience, what actually happens, and the underlying mechanisms that produce the events in the world" (Danermark et al., 2002. p. 21). However, they recognise that we can never be sure of these structures or relationships (Sullivan, 2010). Further, our knowledge is influenced by power and culture (Sullivan, 2010). Subsequently, CR assumes our understanding is fallible, changeable and our knowledge is always tentative (Barker, Pistrang & Elliott, 2002). From a CR position "truth claims can be evaluated against evidence. But, knowledge and truth are still recognised as being, to some extent, socially constructed" (Sullivan, 2010, p. 30).

CR was selected because it acknowledges both the existence of, and interaction between the material world (i.e. the body), language and ideas about it (for example, approach to conversations, ideas about masculinity). Williams (1999) argues that the "body in short, diseased or otherwise, is a real entity, no matter what we call it or how we observe it. It also, like all other social and natural domains, has its own mind-independent generative structures and casual mechanisms. As such it has an ontological depth independent of epistemological claims, right or wrong, as it to its existence." (p. 806.)

Through adopting a CR position to thematic analysis (TA), the researcher can stay close to participant's experiences and also consider the impact of the wider social context on those experiences.

Sims-Schouten, Riley and Willig (2007) outline how CR may be applied within discourse analysis as it, "enables an analysis that can consider why people draw upon certain discourses, by proposing that the extra-discursive provides the context from which the use of certain discourses is more or less easily enabled; second, critical realism can explore the impact of material practices on discursive

practices; and, third, this approach does not only map the ways in which participants use discourse in order to construct particular versions of reality, but it also positions their talk within the materiality they also have to negotiate.” (p 103).

Sims-Schouten, Riley and Willig (2007) approach to CR analysis is also applicable to the current study. Firstly, it acknowledges the existence of the material body and reality of how disease can impact it (i.e. experience of PCa, detection methods and treatments). Secondly, it considers the impact of participants' ideas and the language they use to describe the body and issues related to PCa (for example, issues related to masculinity and other constructs such as 'anxiety'). Thirdly, it considers how such ideas and language might be related to and influenced by non-discursive factors (Sims-Schouten, Riley & Willig, 2007). These may be related to underlying biochemical, economic or social structures (Willig, 1999). Nightgale and Cromby (1999) also highlight the importance of embodiment, the physical properties of objects in the world and institutional power.

### 2.1.2. Rationale for qualitative approach and thematic analysis

A qualitative approach was considered appropriate for a number of reasons.

#### *2.1.2.1. Appropriate for research aims*

The first aim of this study was to explore how GPs approach conversations with men who present with possible symptoms of PCa. The second aim was to explore the way GPs think about or describe issues related to the construct of masculinity. Relatively little is known about the nature of these conversations. Qualitative methods are useful when conducting discovery-orientated research and answering exploratory research questions (Barker, Pistrang & Elliott, 2002). In contrast a hypothesis-testing approach would have required careful construction of more specific research questions, which would be tested empirically. This approach would not be appropriate when there is little known about a particular area because there is a danger that hypotheses may not be meaningful and could constrain early investigations into a phenomena (Barker, Pistrang & Elliott, 2002).

### *2.1.2.2. Greater flexibility and complexity*

Qualitative methods have fewer restrictions on the data and the underlying theoretical models (Barker, Pistrang & Elliott, 2002). This allows the researcher to adopt a more open and flexible approach, which is particularly useful when developing new understandings, new meanings and unanticipated findings (Barker, Pistrang & Elliott, 2002). Quantitative methods can lead to an oversimplification of phenomena, which can reduce people and their experiences to numbers. In contrast, qualitative methods allow for a richer, deeper and more complex examination of the data and appreciation of people's experiences (Barker, Pistrang & Elliott, 2002)..

Qualitative methods allow exploration of thoughts, feelings, experiences and ways of communicating which are often difficult to quantify (Hakim, 1987). In this study it would have been difficult to capture the complexities and ambiguities of how GPs approach conversations with men through quantitative methods. Qualitative methods acknowledge and allow for there being multiple and subjective truths rather than one ultimate truth about an experience (Berger & Luckermann, 1967).

### *2.1.2.3. Thematic analysis rationale*

TA can be defined as a qualitative "method for identifying, analysing and reporting patterns (themes) within data." (Braun & Clark, 2006, p. 79). It is an approach that can be used to describe data sets and make interpretations about the research area (Boyatzis, 1998). TA is independent of theory and can be used within different epistemological positions including realist, constructionist and critical realist (Aronson, 1994; Braun & Clark, 2006; Roulston, 2001). There have been debates about what TA refers to (Boyatzis, 1998). It has been suggested that TA is a generic skill (Holloway & Todres, 2003) or tool (Boyatzis, 1998) used across different qualitative methods. However, Braun and Clark (2006) argue that it is "a method in its own right" (p. 78).

TA was appropriate for this study because it offered a flexible and adaptable approach to analysis (Braun & Clark, 2006). Grounded Theory would not have

been relevant because the study did not aim to develop a theory of the phenomena being investigated (Glaser, 1967). Interpretative Phenomenological Analysis was not used as the study did not seek to focus on participants' experiences or how they make sense of given phenomena (Smith, 2003).

### 2.1.3. Semi structured interviews

Self-report methods allow participants to give their views directly and allow access to information that may not be available through observations (Barker, Pistrang & Elliott, 2002). It was decided that semi-structured interviews would be appropriate for answering the research questions as they allow for participants to respond with greater freedom than questionnaires, which may impose researcher-determined categories on them (Weiss, 2008). This approach would allow participants to provide their own account of their approach to conversations. Semi structured interviews allow for complex, multiple perspectives and apparently contradictory information (Barker, Pistrang & Elliott, 2002), which may be valuable when exploring the complexities of conversations about PCa. Interviews can provide depth of information and also permit access to emotional as well as rational aspects of participants' experiences (Weiss, 2008).

### 2.1.3. Reflexivity

Researchers play an active role in the identification of themes in the data and "data are not encoded in an epistemological vacuum" (Braun & Clark, 2006, pg 84). Consequently, it is important to be transparent and make explicit the researcher's identities and position in relation to the research (Willig, 2001). These will be expanded and developed further in the discussion section.

The researcher identifies himself as a British Indian man aged thirty, currently employed as trainee clinical psychologist at the University of East London (UEL) / Camden and Islington NHS Foundation Trust. The training programme at UEL adopt a critical approach to clinical psychology, which has influenced the researcher's approach to this study.

The researcher became interested in the relationships between psychological issues (e.g. coping, impact on identities) and physical health conditions following

his clinical experiences. The researcher had no previous personal or professional experiences of PCa but became interested in the condition following conversations with colleagues about the challenges and complexities around it.

## **2.2. Method**

### 2.2.1. Ethical considerations

The researcher obtained ethical approval from the UEL School of Psychology Ethics Committee before proceeding with the project (Appendix 1). NHS Ethics were not required as the participants were not patients or relatives of patients (National Research Ethics Service, 2011). There were a number of potential ethical issues that the researcher considered before the study commenced. The researcher was aware that he defined the topic, which would guide the direction of the interview (Kvale, 1996). Participants might have felt under scrutiny, uncomfortable and feared poor practice being exposed. However, there may also have been some benefits to participating in the study. Given the complexities and challenges surrounding PCa participants may have felt relieved about being able to acknowledge and share their experiences (Koizumi, 1992; Seppanen et al., 1999).

Whilst it was not anticipated that the interviews would evoke strong affect, the researcher advised that if participants felt uncomfortable during the interview, they could let the researcher know and discuss whether to proceed. Participants were given the opportunity to withdraw retrospectively one month post interview. The researcher offered to meet participants at their place of work or at a neutral venue depending on what was most comfortable for them.

The researcher was transparent about the aims of the study and provided participants with information during recruitment and again prior to interviews. Consent was obtained at two points. Verbal consent was given when the interviews were arranged over the telephone. Written consent was obtained prior to the interview. All participants consented to taking part in the study and agreed to have the interview recorded on a digital recording device.

Data were collected by the researcher and stored in line with the Data Protection Act (1998) on a password protected laptop and data stick at the researcher's home. Consent forms with identifying information were separated from recordings and transcripts. Participants were assigned a pseudonym and allocated a participant number.

### 2.2.1. Recruitment

#### *2.2.1.1. Participants and recruitment procedure*

The main inclusion criterion for participants was that they were currently working as a GP in the United Kingdom. It was important that participants had a good level of spoken English because of the methodology (use of semi-structured interviews, transcription and analysis of the content). The inclusion criteria were kept as broad as possible to ensure that between 12-16 participants could be recruited.

An opportunity sampling strategy was used to recruit GPs. The researcher attempted to recruit participants from the North West London region initially. This area was selected because the GPs in this area served a culturally diverse population. This would enable exploration of the extent to which GPs take into account cultural factors during conversations with men discussing testing. Further, this may have allowed for discussion about local context. GP surgeries were identified within a 2 miles radius of the NW2 postcode using the [www.nhs.uk](http://www.nhs.uk) website. Invitation letters were sent to 267 GPs working at 56 different surgeries. This contained information about the study, why they were being asked to participate, what it would involve, potential benefits, information about confidentiality, potential ethical issues and the researcher's contact details.

Recruitment uptake was slower than anticipated. It was decided that the recruitment strategy should be expanded and not be restricted by geographical location. Snowball sampling methods were employed (Patton, 2002) and participants who had already been recruited to the study passed on information to colleagues they thought would be interested. Two participants posted information on GP forums. This yielded a further six participants. A further five participants were recruited through work colleagues and acquaintances that had connections

with GPs. In total 14 participants were recruited from 13 GP surgeries across London, Hertfordshire, Bedfordshire, Surrey and West Sussex.

#### 2.2.1.2. Interviews

GPs who were interested contacted the researcher directly through email or telephone to arrange an interview at a mutually convenient time. The researcher offered to conduct interviews at the participants' place of work because it was hoped that this would be more convenient for participants and increase the likelihood of their participation. All the interviews except one were conducted at GP surgeries. The one exception was conducted at a therapy room hired in North London, as it was more convenient for the participant.

#### 2.2.1.3. Interview schedule

An interview schedule was developed to explore how participants approached conversations with men who present with possible symptoms of PCa. It was decided that in order to increase the likelihood of participation, interviews would only last approximately 20-30 minutes.

The questions were intended to gain information about four main areas. The first focussed on factors participants thought were important to groups they considered to be at greater risk. The second was concerned with how participants managed these conversations. This included the content and style of conversations, and how they promoted informed decision-making. The third was related to how participants approached conversations about diagnostic / testing issues including the PSA test and the digital rectal examination. The fourth was about challenges related to PC and explored participants' views about the differences between different men who sought help and those that did not.

The interview schedule comprised of mainly open questions. This was to allow participants to provide a rich description of their experiences. The interview schedule underwent some changes following the first two interviews. Prompts were added to facilitate more detailed responses and aid participants if they were unsure as to how to respond. The initial and revised interview schedules are included in Appendix 2.

#### 2.2.1.4. Interview procedure

Before the interview the researcher reminded participants about the study, consent and confidentiality, their right to withdraw and use of a digital recorder. They were given the opportunity to ask questions. Written consent was obtained before proceeding with the interview (Appendix 3).

During the interview the researcher adopted a conversational style to increase engagement and reduce the likelihood of participants thinking that their knowledge or skills were under scrutiny. The average length of interviews was 21 minutes 27 seconds, the longest was 34 minutes and 13 seconds, and the shortest was 11 minutes and 3 seconds. The researcher asked participants to complete demographic forms at the end of the interview. Participants were given the opportunity to ask questions at the end of the interview.

### **2.3. Analysis**

#### 2.3.1. Development of themes - planning

The guidelines for conducting TA developed by Braun and Clark (2006) were used when planning and analysing the interview data. Braun and Clark (2006) highlight the need for researchers to make explicit their choices around analysis to ensure that it is “theoretically and methodologically sound” (Braun & Clark, 2006, p. 78).

A theme was determined by the number of times particular patterns of responses were given by different participants. A high frequency of particular responses expressed by a number of different speakers influenced what constituted a theme.

The researcher chose to provide a rich thematic description of the entire data set rather than focus on a specific aspect. This approach is “a particularly useful method when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known.” (Braun & Clark, 2006

p. 83). This would allow for a range of perspectives to be represented in the final analysis.

An inductive approach was adopted to ensure the themes were linked to the data (Patton, 1990). This would also allow for unanticipated outcomes rather than trying to fit themes into pre-existing studies or ideas. Data were analysed at the interpretative (latent) level to explore underlying ideas and assumptions. This enabled an exploration of “the underlying ideas, assumptions, and conceptualisations” which inform or shape the explicit content (Braun & Clark, 2006, p. 84).

### 2.3.2. Development of themes – the analysis

#### *2.3.2.1. Phase 1 – Familiarisation with the data*

The researcher transcribed the interviews. This process was valuable for becoming familiar with the data and was a “key phase” of analysis (Bird, 2005, p. 227). Identifying information was removed from the transcripts to maintain anonymity and confidentiality. TA does not require the same level of detail in transcription as other forms of analysis such as discourse analysis (Braun & Clark, 2006). The researcher made a number of decisions about transcription protocols. It was decided to provide a verbatim account of verbal information and to ensure that the semantic meaning of participants’ responses was retained. Non-verbal utterances such as coughs, pauses, false starts and words emphasised were not transcribed. A simple transcription scheme was adopted (Banister et al., 1994) and is presented in Appendix 4.

The researcher familiarised himself with the data through transcription and re-reading them on four occasions. Data were read actively in the search for meanings and patterns (Braun & Clark, 2006). The researcher maintained an open approach during the process and highlighted as many potential data items as possible. Initial data items included comments on the content of participants’ responses, use of language and possible ideas about underlying ideas. On the third occasion the researcher highlighted extracts and possible ideas for coding.

#### *2.3.2.2. Phase 2 – generating initial codes*

On the fourth reading of the transcripts the researcher systematically worked through each transcript and generated potential initial codes of interesting aspects of the data items. Items were un-coded, coded once or coded up to three occasions depending on whether they fitted into different initial codes. Coding was conducted manually, and the researcher made notes in margins of the transcripts and highlighted relevant sections.

The researcher copied extracts of data with their initial codes from the transcripts into an Excel database. These extracts and their initial codes were then re-organised and collated according to their initial code. For example, extracts coded for “denial” were placed together. This process generated 1000 codes and extract pairs.

#### *2.3.2.3. Phase 3 – searching for themes*

The next phase involved a move to an increased level of abstraction and grouping the codes into potential themes. The researcher used an Excel file to sort through the codes and identified how they may have clustered together or formed potential themes. For example, initial codes that were related to “denial” and “stoicism” were collated and linked together under the potential theme of “hegemonic masculinity”. Some themes were merged and others were discarded. A thematic map was developed to identify how potential themes might link together to form overarching themes or sub-themes.

#### *2.3.2.4. Phase 4 – Reviewing and naming themes*

The researcher reviewed the themes by reading through the extracts that were collated for them. This was to ensure the themes formed a coherent pattern and still linked to the data extracts. The research initially identified 11 candidate themes with three to five sub themes. The researcher then refined the thematic map to form four overarching themes each with several sub themes. The final stages of how the themes were developed is provided in Appendix 5.

#### *2.3.2.5. Phase 5 – Defining and naming themes*

During this phase, overarching and sub themes were renamed and refined. Further refinement was needed to clearly identify what each theme was about

and how it was related to other themes which had been developed. Each theme was characterised with a description and examples of quotes that captured their essence.

#### *2.3.2.6. Phase 6 – Producing the report*

The outcome of analysis is presented in the following results section.

Descriptions of themes and quotes from participants are provided for the reader.

An example of a section of worked through transcript is provided in Appendix 6.

### 3. RESULTS

This chapter outlines the findings from the TA of the 14 participants who took part in the study. Table 1 outlines demographic information of the participants. Four overarching themes and several sub themes were developed (Table 2). These themes are interrelated and should not be read as separate from each other.

#### 3.1. Demographics

There were 11 male and three female participants. The age range was between 32 and 63 years old. The mean age (excluding missing data) was 43.8 years old. There were five (36%) participants who identified their ethnicity as Asian or British Asian – Indian, seven (50%) as White British, one (7%) as White Australian and one participant who did not provide their information (7%). Participants had between two years and 39 years experience of working as a GP in the UK. The mean years of experience was 13.4 years.

Participants reported that the approximate range of men they had seen for possible symptoms of PCa in the previous year was between five – 50 men. The mean number of men seen for possible symptoms of PCa was 17.6 men in the previous year.

Overall participants reported seeing men from a range of diverse backgrounds. Eleven participants (79%) reported seeing men from at least two different ethnic groups. In total, 13 participants (93%) reported seeing White British men, 11 (79%) reported seeing Asian or British Asian – Indian men, 9 participants (64%) reported seeing Black or Black British – Caribbean men and 7 participants (50%) reporting see men from Black or Black British – African backgrounds. There were two participants who reported seeing men from White British backgrounds only. A comprehensive breakdown of the different populations participants reported seeing is available in Appendix 7.

Table 1

*Demographics of Participants*

Participant <sup>1</sup>	Age	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>2</sup>
Harjeet	44	Male	Asian or Asian British - Indian	British	13	20-25
Rina	33	Female	Asian or Asian British - Indian	British	3	6
Nisha	52	Female	Asian or Asian British - Indian	British	20	6-7
Paul <sup>3</sup>	Declined	Male	Declined	Declined	Declined	Declined
Ravi	35	Male	Asian or Asian British - Indian	British	5	24
Barry	38	Male	White British	British	3	10
Michael	50	Male	White British	British	20	5
Simran	34	Female	Asian or Asian British - Indian	British	5	5

<sup>1</sup> Pseudonyms names used to maintain confidentiality and anonymity.

<sup>2</sup> Average number of men seen for possible symptoms of PCa over the last 12months.

<sup>3</sup> Paul declined to provide demographic information.

Table 2 continued...

Participant <sup>4</sup>	Age	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>5</sup>
Eddy	40	Male	White British	British	2	10
Len	42	Male	White British	British	14	30
James	50	Male	White other - Australian	Australian	13.5	20
Joshua	45	Male	White British	British	15	30
Steve	51	Male	White British	British	22	50
Raymond	63	Male	White British	British	39	10

<sup>4</sup> Pseudonyms names used to maintain confidentiality and anonymity.

<sup>5</sup> Average number of men seen for possible symptoms of PCa over the last 12months.

### 3.2. Thematic Analysis

Four overarching themes were identified from the data, 'dilemmas and difference', 'being me', 'awareness, action and assertiveness' and 'significance of gender and age'.

Table 2

#### *Overarching Themes and Sub Themes*

Overarching themes	Sub themes
1. DILEMMAS AND DIFFERENCES	Perceptions of roles and responsibilities  Uncertainties  Awareness of risk factors but not making assumptions based upon them
2. 'BEING MEN'	Self-concept - denial and stoicism  Feelings of embarrassment
3. AWARENESS, ACTION AND ASSERTIVENESS	Are men aware?  Influences on awareness, action and assertiveness
4. SIGNIFICANCE OF GENDER AND AGE	

### 3.2.1. Dilemmas and differences

The first overarching theme can be defined as the different approaches and strategies participants described in several areas when managing conversations about PCa. It is important to highlight that this overarching theme is connected to all the other themes identified in this study. For example, participants expressed a number of 'dilemmas and differences' in their descriptions of issues relating to masculinity ('being men'), how aware men were about PCa and how willing they were to act on their knowledge or experience ('awareness, action and assertiveness') and the influence of relational aspects ('significance of gender and age').

There were several sub themes within this overarching theme. The first was related to different perceptions participants' described concerning their roles and responsibilities when managing conversations about PCa. This also included the different strategies or approaches they employed to meet their perceptions of these roles and responsibilities. The second sub theme was related to 'uncertainties' participants described about investigations and treatment for PCa. This also included how they managed and approached some of these uncertainties. The third sub theme related to participants having an awareness of epidemiological patterns of PCa but not making assumptions about risk based upon them.

#### *3.2.1.1. Perceptions of roles and responsibilities*

This sub theme related to the different perceptions participants had of their roles and responsibilities, and how they managed them in relation to information provision, clinical duties, managing the consultations to achieve desired outcomes and involvement following referral to secondary care.

The first aspect of this sub theme was related to information provision. Participants believed it was their role and responsibility to provide men with information about PCa. However, there were differences in how this was approached and what information was believed to be important to share with them.

Some participants believed it was important to be honest with men from the outset about the uncertainties related to investigations, diagnosis and treatment.

<sup>6</sup> I express my view that the test, as a screening test is probably worse than useless, it's actually positively harmful to do it. (Paul, 75-77.)

I tell them about the differential diagnosis. I say, it could be a recurrent UTI, it could be an infection in the prostate, or chronic or acute prostatitis; it could be something to do with his epididymitis; it could be an infection; it could be a benign prostate, or it could be something more sinister. (Nisha, 53-57.)

Barry highlighted the importance of being honest with men and giving them enough information when thinking about making a referral to secondary care.

...you need to explain to the patient why you are referring them quickly and what it might be. With a lot of people I might use the, I might say prostate cancer. I use the C word, if I think they can cope with that. It's not fair to send people off (to hospital), and they go to the clinic and they walk into the clinic and it then becomes apparent that they are being investigated for possible prostate cancer (Barry, 35-39.)

Len and Barry tailored information about the possibility of PCa according to what they believed men wanted to know or could handle.

...it's balancing out when to share information with someone that there are possibilities and when those

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<sup>6</sup> Minor amendments have been made to make quotations easier to read.

possibilities are relatively low. If I know a patient well, I may have more of an idea that this patient just wants to know everything. Even if it's a low suspicion, he wants to know I've got a low suspicion. Other people just don't want to hear that word. (Len, 24-29.)

Rina and other participants adopted a stepped approach when providing men with information about testing, diagnosis and referral to secondary care services. They believed that men preferred this approach, as too much information would be overwhelming.

I don't go into a lot. It's too much information to give them in one go (R-ok). Often they don't want to know what their options are yet. They want one step at a time. If they ask about it, then I will discuss it, but it's usually too much information overload. (Rina, 63-67.)

Len described how doubts about diagnosis and treatment would make him less likely to provide information about treatment options.

So where there is a lot of doubt, I don't tend to start talking about surgery, radiotherapy, chemotherapy, and injections. (Len, 154-155.)

Participants believed it was their role to ensure that men had enough information about the merits of testing and what the results might mean so they could make an informed decision about whether they wanted to proceed with testing.

I have had one patient refusing to go, which was fine. I think we gave him full information about the pros and cons. If he didn't have prostate cancer he's going to avoid some unnecessary tests. (Len, 180-182.)

I think most of the time men have made up their mind (to be tested) but I think there is a responsibility. If you're determined to have an investigation done, then there is a responsibility to understand what the results might mean. (Eddy, 91-94.)

Most of the participants found it beneficial to use written material when providing men with information about the PSA and PCa. They described how this helped save time during consultations. Further, it contained information about the pros and cons of testing men could refer to in case they were unable to recall information from the consultation.

.... because of the limited time in general practice, having something really nice written down is useful. So I can give out the patient information leaflets, (Barry, 154-157.)

The second aspect of this sub theme relates to perceptions of what participants' clinical tasks and duties entailed. Participants described their main roles and responsibilities to gather information, take a history, identify symptoms, complete appropriate investigations and refer on to secondary care services where necessary.

... with further tests, I would make sure that the patient comes back to me. I say, look, after you have had these tests you need to come back to me and do the PSA test. Sometimes I request an ultrasound of the prostate gland as well because an examination of the prostate's not always entirely accurate...(Simran, 115-121.)

Gathering information is one of your jobs. Also, you kind of advise the person, being an advisor, being an explainer because I don't think a lot of people understand what the prostate is ...(Eddy, 126-128.)

All the participants highlighted the importance of identifying symptoms. However, there were differences in the way symptoms were used by participants. Some used symptoms as a way of indicating the presence of PCa.

The most reliable symptoms that might relate to prostate cancer are frequency and urgency, and irritative type symptoms rather than obstructive symptoms such as nocturia and poor flow, dribbling. (Steve, 37-39.)

Other participants used symptoms as a way of indicating whether the cancer had spread to other parts of the body.

...possibility of symptoms that suggest spread beyond the prostate gland are weight loss, anorexia, bone pain, pain in the back or somewhere else. And obviously the other symptoms that are suggestive of prostatic cancer, so haematuria, difficulty passing urine. (Harjeet, 7-12.)

Some participants used symptoms to focus on more general prostate problems rather than concentrating on symptoms related to PCa or spread of cancer.

The other group would be someone who actually doesn't have prostate cancer. They only say I've got trouble with my stream or they've had a urinary infection problem or difficulty emptying their bladder and the most likely diagnosis is going to be in my mind is benign prostatic hyperplasia. Clearly the possibility of prostate cancer, I have to think of, and then it goes back to the questions, of how severe the symptoms are, how much they have changed over time. (James, 10-16.)

The third aspect of this sub theme is related to participants' perception that it was their role to manage conversations to ensure that the desired goals for the consultation were completed. These goals were determined either in

collaboration with men, requests from men or according to the participants clinical priorities. This often involved adopting a factual, rational, directive and transactional approach. However, participants described different strategies in to doing this.

Some participants described adopting a collaborative approach, which involved developing an understanding of what men were asking for and letting them set the agenda during consultations so that participants could aim to meet their needs. This may involve finding out what men already knew about PCa.

I would always elicit what the persons' understanding is. Because without talking at the level of the customer, the client, you can't really address the concerns. (Paul, 53-55.)

...it's discussing what they are concerned about, what they want to get out of the consultations, discussing their anxieties, trying to address those and then talking about how we jointly go ahead. (Michael, 125-127.)

However, just under half of the participants also described how this might not always be possible. In some circumstances participants indicated they would influence men according to what they thought was in their best interests. There were two male participants who talked about adopting a paternalistic and direct approach to ensure that investigations were conducted.

...if someone is frightened, elderly and confused, not interested, then I tend to put on my best interest cap and say I think you should probably do this...(Eddy, 116-118.)

With a trained doctor they are sometimes trying to share the decision too early on and the patient isn't in a position to make an informed decision themselves, you've got to help them, guide them along. (Joshua, 163-165.)

In such cases participants may have focussed on ensuring that clinical tasks and investigations were completed. One participant talked about the distinction between clinical and emotional thought processes that they went through during conversations with men.

I would probably think quite clinically rather than emotionally about the tests that I need to undertake, the examinations that I need to perform and the questions I need to ask in order to exclude a prostate cancer. (Joshua, 6-9.)

Participants would spread conversations over multiple sessions as a strategy for helping them complete investigations. They believed this would also give men the opportunity to think about what they want to do about their symptoms and also weigh up the pros and cons of testing.

... often after the initial consultation I might always break into two. (Len, 122.)

Some participants talked about the need for men to be being rational, mature and sensible about seeking help.

...hopefully most men, if they are getting symptoms will be mature enough, responsible enough to come and present. You know, I think it's a relatively small population who completely deny, who don't turn up, but I suspect there is delay in men turning up. (Michael, 244-247.)

Participants spoke of developing positive relationships with men as a strategy to help achieve the desired goals for the consultations. These related to how well men knew their GP, previous interactions, effectiveness of communication skills and having a generally positive relationship with the practice in a more general sense.

Most guys around here know that they are going to end up with a finger up the back passage. There's people worried about that obviously. So, if you've got a good relationship and you have friendly practice, people feel less worried about coming about those sorts of things. (Barry, 224-228.)

I suppose it's just good GP skills, sitting back and listening, opening up the agenda for them to talk about their concerns and talk anxieties....(Michael, 19-21.)

The fourth aspect of this sub theme is the way participants described their role once men were referred to secondary care. Participants said they often lost contact with men when they entered secondary care. However, they expected to have a continued role with treatment and ongoing support.

I think it depends on whether they are on treatment, you might end up giving the injections or prescribing the medication. You might end up also giving supportive treatment and eventually in some cases palliative care. (Raymond, 177-180.)

Participants also talked about providing practical support following diagnosis and referral to secondary care.

A lot of them have work on their case so you can support them by giving them medical certificates. Often support their wives and spouses, support the children. A lot of frightened young people generally, when they have cancer they are more worried, they are not worried about themselves, they are worried about their children. (Rina, 206-211.)

However, some participants believed that they would have a limited role once men entered secondary care services. This was linked to a perception that

secondary care services are better placed and qualified to manage issues related to PCa described in the following sub theme.

I think with the cancer lead specialist, they do get a lot of those, psychological aspects, information and decision-making. (Len, 202.)

### *3.2.1.2. Uncertainties*

Participants expressed a number of different views about testing and treatments for PCa. Participants described how testing and treatment were further complicated by men who requested testing due to feelings of 'anxiety' and men with co-morbidities. Participants described different ways they managed these issues. These appeared to reflect the wider uncertainties in the management of the condition. These uncertainties may be linked to variations and differences in relation to their perceptions of their roles and responsibilities outlined above.

One participant expressed a positive view about the PSA and believed this could be offered to men at regular intervals.

... it might be better if men came along at certain intervals, maybe at 50 or 55, whatever you know, you decide and just have a chat, just get it examined, get a few basic blood tests etc done. (Ravi, 187-190.)

In contrast, Paul had a very negative view about the clinical utility of the PSA.

I express my view that the test as a screening test is probably worse than useless. It's actually positively harmful to do it. (Paul, 75 – 77.)

Other participants also talked about the danger that testing may lead to unnecessary investigations and increased levels of 'anxiety' or 'worry'.

... not only do I talk to them about the test being quite sensitive and not particularly specific but I also talk about the implications of a test that is non-diagnostic and how that may lead to a series of events which may leave them worse off than when they came in here (James, 81-83.)

.... you might end up having investigations or being worried for no reason....(Raymond, 70-71.)

The majority expressed concern and doubts about the PSA test. These were related to problems with reliability, specificity, implications and potential for creating greater uncertainty.

I tend to say, it's all we've got, you know and it's not a great test, which is, it's a difficult thing right from the outset but I think you have to be fairly clear about it. (Michael, 59-61.)

Despite concerns about the uncertainty of the PSA test participants were cautious not to dissuade men from it. They highlighted occasions whether a high PSA score took them by surprise.

... a lot of men just come, just requesting the PSA, which, I always think is not going to be very productive but actually I have had a couple of people who, have had a sixth sense about wanting PSA testing, and they have been right. It's been sky high. (Michael, 10-14.)

The uncertainty around testing is highlighted through the mixed views expressed by one participant who initially expressed reservations about the PSA test but later referred to it as an essential test.

I think the PSA is probably an essential test. I really struggle to exclude prostate cancer unless the patient has mild symptoms, sorry has no systemic symptoms, has a normal

digital rectal examination, which suggests a benign disease and a PSA that is normal or near normal. (Harjeet, 73-78.)

Some participants managed the uncertainty around the PSA by incorporating it into an overall investigation package, which also involved taking a history, discussing symptoms, the digital rectal examination and repeat PSA tests. Additional investigations and repeat tests helped them feel more confident in forming their clinical impression.

If you put them all together then it can be an accurate assessment, as part of the overall. I think, if you just want a simple blood test to tell you whether you got prostate cancer there's no point going to have the blood test (PSA) because it doesn't do that...(Barry, 108-111.)

All the participants reported that they discussed issues around the PSA with men as a strategy to manage the uncertainties around testing. There were differences in how they would do this. Some participants described how they would focus on the reliability of the test itself.

...explain to them that the actual implications of doing the tests, a lot of them don't understand, they think its just a blood test, and that's it. It's not, so even if it came back positive, we'd often have to repeat it depending on their symptoms. (Rina, 25-30.)

Issues around PCa testing appeared to be further complicated when men requested the PSA test because they had positive views of it. This may have created a conflict for participants between their reservations about the value of testing and the assertive requests made by some men asking for the PSA.

...when you get men coming in for the PSA, you know, there is a natural assumption that a screening test must be good. Usually a 5-10 minute conversation, its quite difficult

to get the subtly, the complexity, that it's a difficult test, it not a great test, but it's the only one we've got....(Michael, 49-53.)

Participants described how men often requested tests because they were "worried" and wanted reassurance. Participants suggested that these "worries" might have stemmed from public health messages or having heard about PCa from a friend or family member. This is closely linked to the theme about 'awareness, action and assertiveness'.

...worried that they might have cancer or want to do something to take their concern away, so they can do something about it. Well if I have a PSA every year that means I don't need to worry about having prostate cancer because I will be under some kind of surveillance...(Barry, 253-256.)

There appeared to be a reciprocal role in the way 'anxiety' was managed in conversations. Participant's described adopting a gentle and cautious approach to manage issues around investigations, diagnosis and treatment to limit potential 'anxiety'. They described how they would provide reassurance and complete investigations to reduce feelings of 'anxiety'.

So what I tend to do as a strategy is say, ok, let's do a PSA, let's bring you back, hopefully reassure them that...(Michael, 36-38.)

...to gently introduce the concept that actually the vast majority of prostatic illness is caused by benign conditions but there are occasions when malignancy can be a factor (Harjeet, 26-29.)

Some participants talked about the additional complications of taking comorbidities into consideration when managing conversations with men.

Participants described how it might not be helpful to explore and discuss the possibility of PCa if men had other health conditions.

If they live on their own, have other diseases like diabetes and heart disease and are more frail. They may be less likely to want to talk about other things. (Steve 231-233.)

Participants expressed uncertainties about treatments for PCa. Some participants viewed all forms of treatment as problematic due to the unpleasant side effects and potential for men to be left worse off than if they had been left untreated.

I tell them that they might dribble, that they will almost certainly be impotent. I don't know many men who function sexually following prostate intervention of any sort, but obviously I'm only seeing a small sample...(Paul, 94-97.)

Participants believed that some men are have put off from treatment once they hear about the side effects. James commented on how some men would be dissuaded from investigations upon hearing about the treatment uncertainty and side effects.

...sometimes that's enough to put them off and they say, my family history is so low, I'm not really interested. (James, 84-85.)

Participants expressed uncertainties of making a diagnosis when there are no effective treatments available for PCa.

Why rush to pick up something you can't treat? And you've got the prostate ones, when I think, there's quite a muddle to how we are approaching that and PSA screening is a muddle. (Joshua, 238-240.)

In contrast, some participants talked about improvements in the effectiveness of treatment and believed that early detection increased the curability and outcomes. Participants said that the majority of men did not refuse treatment for PCa and appeared to take this as evidence that men wanted treatment and were positive about it.

...are faced with the prospect of a patient who may have prostate cancer who say doesn't want to act on it you might bring up the concept then, that if you treat the cancer early you could be potentially curative. If you leave it long time then it might, you might die from it...(Barry, 147-150.)

Overall, all participants believed that secondary care services take the lead in the management of PCa. Participants viewed secondary care specialists as the most qualified professionals to have complex conversations and provide information about diagnosis, treatment and potential side effects.

I don't tend to get into a lot of depth but I think it should be the surgeon who does that because he knows, what his risk data is and I do not know who is going to see the patient at the end of the day. (Eddy, 108-111.)

Participants believed that as GPs they were not fully aware of all the treatment issues and did not feel comfortable providing such information during early conversations.

I don't really (talk about treatment), I have to say because also, treatment for prostate cancer is complicated and you really need to be an oncologist to have a better grasp of it as it ranges from surgery to radiotherapy, laser treatments, chemotherapy; there's lots of different modalities. (Barry, 134-137.)

Those participants who did discuss treatments issues discussed them following diagnosis or if the diagnosis appeared likely. They did not discuss them prior to testing. Some participants would only discuss issues if the man initiated such conversations.

...just bring it back, just step by step. And then absolutely later on (after diagnosis) I'm happy to share with them any decisions that they are having difficulty with. (Joshua, 134-135.)

...no, I would only really get involved with that at the point of diagnosis. So no, I tend not to, I think it's a complex enough discussion about the potential that they may or may not have before we start talking about treatment. (Michael, 115-117.)

Participants described perceptions of wider uncertainties and complexities around PCa diagnosis and testing. They reflected that PCa was often mismanaged; there were problems with the industry aspect of PCa and with wider governmental policies.

Prostate cancer is an enigma because of the fact that it doesn't kill a lot of people. There's a whole industry out there, just as there is with breast cancer, there's a whole industry that has been created around the idea that you must diagnose it. (James, 334-337.)

...there are challenges in the screening process, there are challenges in the diagnostic, there are challenges in the around the treatment of prostatic cancer. All of them are significant and grey, there are very few clear-cut guidelines that can support clinical practice so it is pretty murky area. (Harjeet, 200-205.)

However, three participants felt comfortable managing PCa and were supported well by secondary care services. One talked about the benefits of having a specialist PCa nurse visit the practice on a monthly basis.

I quite enjoy dealing with prostate cancer, because most people don't have it. If they do have it, there are all sorts of treatments for it and you can often set people's minds at rest. It's not something people walk through the door and you think, oh God, I can't deal with this. If it's there I can probably diagnose it, if it's not I can usually reassure people, so it's actually quite a satisfying thing to be involved with as a GP. (Barry, 270-275.)

Participants made several comparisons between 'older' and younger' men in relation to testing and treatment. There was a sense that PCa was an 'older man's condition' and that they were not as concerned about issues related to testing and getting treatment.

In an 85 year old, they are all going to have a bit of prostate cancer, pretty much. 35 year old, they are very unlikely, if they did, those are the catastrophic aggressive ones. (Joshua, 194-196.)

Some participants commented on how men themselves tended to normalise possible symptoms of PCa and put it down to normal ageing.

...people just take it for guaranteed that, oh yeah it's probably just old age just creeping in, its just a simple prostate problem. At least if they come over discuss it and get it examined, probably we may find out prostate cancers much earlier in the stage rather than later...(Ravi, 17-21.)

PCa in younger men appeared to be a source of greater concern both in terms of side effects of treatment and chances of survival.

It's usually young people, they usually need really aggressive treatment and it poses problems not just for them but for what they are leaving behind. Because young people usually have aggressive tumours, and they don't, they often they don't survive it. It's about dealings with the families that are left behind. (Rina, 136 – 140.)

In contrast six participants considered older men to be less “worried” and less embarrassed.

I think because it tends to affect older men. It's men usually above 50 who are coming to see you, they don't tend to feel particularly embarrassed. But not all of them are keen to have a rectal examination done by a female so I would say it's probably 30% of men might decline that only really, so not huge amounts. (Simran, 84-87.)

### *3.2.1.3. Awareness of risk factors but not making assumptions based upon them*

This theme can be defined as the different approaches participants had to groups that they considered at greater risk of developing PCa. To different degrees, participants identified ethnicity, age, family history and generic lifestyle issues as factors that would influence their approach, practice or risk assessment. These factors may have influenced their doubts or reservations about testing and treatment. Overall, participants emphasised the importance and preference for taking an individual by individual approach rather than making assumptions about men according to their epidemiological information about risk.

Participants commented on ethnicity as a risk factor for PCa. They described how it would be something they would hold in mind during conversations with men.

I hold it in my mind, part of it, part of it is linked to the fact that the younger patients and the Afro-Caribbean have a lower threshold to be worried... (James, 242 – 243.)

... people with family history, in terms of racial groups, Asian and Black African groups, I might ask a bit more closely. As I say, as an individual practitioner I don't see bit racial difference, I see prostate cancer across all groups. I think I would have to do a population analysis to sort of decide if in my area there was difference. (Eddy, 200-204.)

Participants felt that family history of PCa was very important and would take this into account when managing conversations about PCa

And strong family history, I think with any type of cancer, if you've got lots of cancer in family. Otherwise there aren't that many major risk factors for prostate cancer. (Barry, 179-181.)

Similarly, age was as important a risk factor, with participants commenting on how it would influence their thinking during conversations with men about PCa.

Age is probably the single most important factor. (Joshua, 186.)

Participants shared that they would be reluctant about making risk assessments based on men's cultural, ethnic or age groups alone.

...if I think someone has symptoms suggestive of prostate cancer I need to investigate them as I would with anyone. I am not going to look at them and say you're not likely to have it because you're from this particular group. So it doesn't really have much bearing on my decision-making I have to say. (Simran, 175-179.)

Even where participants identified different risk factors they would not necessarily adapt their approach. Instead there was a greater emphasis for participants to adopt an individual by individual approach to conversations about PCa.

Well again, I guess it might do, it's not something that I would have specifically thought about in terms of groupings. I think I tend to be seeing individuals and think of them as individuals really...(Steve, 194 –196.)

### 3.2.2. 'Being men'

The second overarching is related to the significance participants placed on the influence of issues related to hegemonic masculinity and gender had for interactions with men about PCa. There were two sub themes, 'self concept – denial and stoicism' and 'feeling embarrassed'. This theme is related to the overarching theme, 'awareness, action and assertiveness'.

#### *3.2.2.1. Self-concept - denial and stoicism*

There are two aspects to this sub theme. The first relates to whether men seek help in the first place and factors which may facilitate or prevent this. The second is related to the physical examination of the prostate.

Some participants described the perception of general practice as being more accessible for women. They described how men have become excluded from general practice and may not see it as appropriate for them. Participants discussed how women were more likely to contact their GP and seek help for possible symptoms of breast cancer and other health conditions.

I think there is still a thing about general practices being around women. I think a lot of men feel physically uncomfortable about coming to see their GP. Between 15-50 men disappear. It's not actually until they start to develop stuff that we often start to see them again. (Michael, 186-192.)

Participants described how they believed men were concerned about the negative effect of seeing their GP would have on their self-concept.

.... it's full of stigma, it's about masculinity, genitals, rectal examinations, you know, all those things most people, most men are just embarrassed and find difficult to talk about. So just getting them, allowing them to talk about it and feel free to discuss their concerns, and then being able to address those concerns when they raise them. (Michael, 21-25.)

Participants talked about how men may seek to maintain a "macho" image by denying possible symptoms and not seeing their GPs about them.

There's maybe a macho type image about not consulting doctors. (Steve, 241-242.)

Men don't talk about symptoms, it's often a macho thing, I'm fine, I'm fine they don't talk about it. (Rina, 218-219.)

Participants commented on the uncertainty men might experience about what may happen to them and the transformative effect it may have on their lives or sense of self.

... they don't want to come and turn from ordinary people to becoming patients, they don't like the sick role and they are apprehensive about what might happen to them and all that stuff. (Raymond, 201-204.)

Participants described how men would frequently deny experiencing difficulties, avoid seeking help or not report symptoms.

P5 – I think it's just being men

R – What do you mean by that?

P5 –sort of, being everything is alright, everything will get right and that I am a man and that I don't need any help or support. The psychological, make up of men. That needs to change, yes, you might want to seek help, at least for a consultation if not for anything else and make sure everything is alright, just like women do. (Ravi, 158 – 168.)

...they just kind approach to health is that it will all go away, and eventually they realise it hasn't gone away, perhaps the doctor can do something. (Len, 227-230)

Participants described how they believed men would frequently present late.

...a few might be late presenters. Some have been suffering from symptoms for years and hadn't said anything, you'd be a bit more concerned about them. (Len, 222-224.)

Participants described how men were more concerned about issues related to work and not having time to give attention their health.

...they might be busy at work, you know they tend to put things on the back burners, they'll tend to, generally ignore health issues until they've got something they cant ignore. (Steve, 239-241.)

Participants also commented on how men may be less likely to complete investigations once they had started the process.

...getting men to first of all recognise there is a problem. Getting them diagnosed with benign or suspicious disease and I think following up as well. Typical, health accessing habits, men aren't so good as women. There can be

problems coming back getting things completed, getting the follow ups done. (Eddy, 208-211.)

### *3.2.2.2. Feeling embarrassed*

The second sub theme relates to participants' descriptions about how embarrassment might make men reluctant to seek help for their experiences or report symptoms. This theme is linked to the overarching theme 'significance of gender and age' as issues related to masculinity and gender may interact with feelings of embarrassment. Participants described how they might manage issues of embarrassment by offering men the chance to see a male GP.

...if it was an old fashioned gentleman of a particular type then yes I can imagine he might be a bit embarrassed. There's generally not a problem seeing a male doctor and we are around. (Eddy, 152-155.)

Participants also talked about managing potential feelings of embarrassment by not putting pressure on men to complete investigations and giving them time to prepare for the digital rectal examination.

... I tend to advise that it will happen next time and that works a lot better than what I used to do which is I try and do everything in one consultation, that is actually quite uncomfortable for people. Because they may not feel they are physically prepared, people quite often like to have had a shower or bath if they are going to have that examination. So when I have put pressure on people in the past, it's not been a very kind thing to do, its made them a bit embarrassed. (Joshua, 66-72.)

Participants indicated that men would often attend the actual consultation on their own. However, they added that partners may have played a significant role in them making an appointment and coming to see their GP.

...sometimes that can be a way for a man, a bit of an excuse to come in. Say oh yeah, my wife told me to come in, so it gives them permission to come in, so that can be helpful for them. (Joshua, 83-85.)

I think if often people have got supportive relationships they are more likely, you know encouraged to come along by partners, partners who are noticing problems. (Steve, 229-231.)

Although, participants described the potential impact of embarrassment and men may refuse the digital rectal examination.

...when I have put pressure on people in the past, it's not been a very kind thing to do, it's made them a bit embarrassed. (Joshua, 71-72.)

However, the majority of participants believed that men did not appear to have issues with the digital rectal examination and that it was rare for men to refuse it.

I've never come across somebody who says they don't want to have it. So, we are obviously supposed to discuss it with them but generally most men think that if they need the test they'll rather just have the test, if it helps, it helps. (Simran, 60-63.)

... there are very few patients that come here that object to it once the symptoms have been discussed. There are a few, I usually ask them if they've had the examination before and some of them say yes and some of them say no and some of them say they heard it's unpleasant. But actually, I don't think I have had anybody refuse to have one. (Raymond, 102-106.)

Participants described how they might manage the digital rectal examination by giving men time to adjust to the idea.

...in relation to the rectal exam, erm no, I never had resistance from a man having that done, I've occasionally deferred it to the next visit if we have already discussed quite a lot, not because of any resistance but because of time management really. (Eddy, 52-53.)

### 3.2.3. Awareness, action and assertiveness

The third overarching theme is related to the different views participants had about men's awareness of PCa. These related to awareness about symptoms, testing, and treatment. It also captures participants' ideas about what may make it more or less likely for men to take action and be assertive about what they want from consultations. Participants described a range of ideas about what may have an influence on this, such as education, class, social isolation, geographical locations and external resources (e.g. media, Internet). This theme can be seen as a contrast to the 'being men' theme which highlights participants views about why men do not seek help.

#### *3.2.3.2 Are men aware?*

Some participants described how much more aware men are of PCa including issues around treatment.

I think that men are nowadays quite aware of the prostate, of prostate cancer because of all the press and everything, so I would probably ask him, do you have any anxieties, or try to find out what he wants me to do or to find out if he has any thoughts about what he has got, his perspective of his symptoms. (Nisha, 32-36.)

...they might be concerned they've got cancer and might be that kind of person that would rather not know about it. They may think there is nothing that can be done for prostate

cancer. They may, someone said, quite rightly, that they may out live a prostate cancer, so why, they may be as well informed about the condition as that, they might think if they are 85 and they've got other health issues, do I really want to be bothered by something that the papers tell me I might die with rather than from. (Len, 84-90.)

In contrast, others like Paul, Simran and Raymond felt men had limited or no awareness about PCa. Participants talked about public issues and raising awareness about PCa.

Men have been slightly left out of the equation I think and certainly prostate awareness is much lower than breast awareness. (Paul, 83-85.)

... some are reluctant because they are scared, because they are ignorant or for some other reason (Raymond, 200-201).

This sub theme can be linked to the sub theme about 'perceptions of roles and responsibilities'. Within the theme of 'perceptions of roles and responsibilities' participants described how one of the responsibilities was to provide men with information about PCa, testing and to a lesser degree treatment. The provision of information may be linked to how much knowledge and awareness men had about PCa.

### *3.2.3.2 Influences on awareness, action and assertiveness*

Participants described how the media and the Internet had a significant influence on raising mens' awareness about PCa and on whether they sought help for prostate related symptoms. Participants perceived that men who had greater access to these sources of information were more likely to be informed about issues related to PCa and those who did not have access were less likely to be informed.

The media have a large part to play so if there is a lot of press attention that might encourage people to come in.  
(Joshua, 268-9.)

Steve also highlighted the value of the Internet for providing information following consultations.

...of the PSA test and that leaflet is quite useful in that, there's also quite good information on patient.co.uk as well.  
(Steve, 53-55.)

Some participants believed that access to information around PCa was unpredictable.

I think it's a random event, although, a small number of people, I ask them why did you come now is a good question, and one of the reasons can be, my friend died of prostate cancer or as I said earlier my dad had it when he was 60, I want to have a check. There was something on the television, something on Eastenders (British soap opera) about prostate cancer. It came to their mind that way. I'm having problems with erections, could it be my prostate? There's no pattern...(Steve, 280-285.)

Len highlighted potential problems associated with media attention. Although it can be helpful for increasing men's knowledge and awareness of PCa it can also lead to increased feelings of 'anxiety'. Media representations of new treatments may also be premature but can have a significant impact on men asking for these treatments.

... the media, can be friend or foe. It can raise, raises up this issue from time to time you know during certain weeks of the year, it might raise it, that's quite good, it raises public awareness but it can also sometimes be too alarming, alarm

headlines about some small study about prostate cancer shows this and they get. (Len, 253-258.)

Participants described the influence of socio-economic factors, culture and language barriers on whether men sought help, their awareness of PCa and the ease of conversations during consultations.

Some participants perceived that men from more affluent and educated backgrounds had greater awareness of health issues and PCa. Subsequently, they were more likely to make an appointment about symptoms and request a test. Other participants described how increased affluence may have made men more demanding and feel entitled to good health. This could have increased their desire for active treatment rather than more conservative approaches like watchful waiting or active surveillance.

Yeah that demographic area, it's an affluent area, very rich retired people who have been abroad come here to settle down in their, for their retirement, they have been abroad in Africa and then they come back and settle down here.... yeah, very health conscientious, well educated population. (Nisha, 183-18.)

...how demanding people are of themselves and others you know. I think that people in this area are what I call the entitled affluent. They think they should feel better than they do. They have a right, so they'll come and bang on the door of the doctor...(Paul, 171-174.)

In contrast, participants described how men who were experiencing financial or housing difficulties were less likely to see the GP about any symptoms they had.

So if you are a media, if you're a Guardian journalist just up the road from here that's going to be fine but if you're living over there in a council flat with 5 people and loads of debt

problems, there might be more than one, so those people need extra support (Barry, 196-199.)

Participants also commented on the role of class. They described how individuals from higher classes were more likely to seek help and consult with them about PCa. Participants described how men from working class backgrounds either did not attend or would attend much later, once their symptoms had become worse.

...social economic class plays a factor, it's real, people from lower social classes tend not to come in, where as high social classes will. I don't know if that because of lack of education...(Rina, 215-217.)

However, other participants such as Raymond were unsure about whether it was possible to make assumptions about men from different backgrounds.

...we've some affluent people, but the majority of it's an agricultural area. We get quite a lot of patients who are manual workers and they are not necessarily highly educated but nonetheless they are reasonably clued up (about prostate cancer). (Raymond, 230-233.)

I couldn't say that necessarily, the more educated, the more likely to come. I have a feeling that might be. And, that the working class, less educated man may not. But I don't know and that's the sort of thing that needs to be looked at (Joshua, 269-272.)

Some participants commented on how men who were socially isolated or not in relationships may be at greater risk and seek help for their symptoms than those who had family or a partner to support them,

There's reclusive men possibly, those who live on their own and their wives haven't noticed or no ones has noticed they

are going to the toilet a lot, or are in pain. Whatever, and they can hide it. So possibly, that group is more vulnerable, but again that's very anecdotal I'm saying, I'm not even sure I can think of someone who fits that group. (Len, 282-287.)

Participants described potential difficulties if the patient's first language was not English. They believed this could have an effect on conversations and on how aware men were of issues related to PCa.

If you're from different ethnic groups. For example, like our area here, they don't speak English, they are not aware all what all these symptoms could mean and put up with it. (Rina, 219-222.)

#### 3.2.4. Significance of gender and age

The fourth overarching theme can be defined as the value participants placed upon the influence of gender and age on how they managed and approached conversations about PCa. This theme is linked to the sub theme of 'perceptions of roles and responsibilities', in particular a perception of their role in developing a positive relationship and a collaborative approach. This theme is also related to 'being men' as relational dynamics influences whether men seek help and discuss their symptoms or concerns.

Participants believed that the nature of prostate issues meant that men were more at ease, comfortable and less embarrassed talking to another man. Participants suggested that being a male GP helped to increase empathy and feelings of connectedness with men.

...there will be patients that I don't normally see that might be a regular of a female doctor but will come and see me for a prostate... (Len, 108-110.)

Eddy described how being a male GP enabled more open and frank conversations with men.

...they feel more at ease and I can talk to them, possibly more frankly about urination, erectile dysfunction and sort of the things that go around this issue as well, so I think it helps. (Eddy, 68-70.)

Michael, Barry, Joshua and James placed this view within a wider gendered context. They commented on how both men and women may have a preference for consulting a GP of their own gender for health issues related to intimate parts of their body.

...it would be a bit unusual for the women to see me about prolepses and gynaecological issues and the same way men tend to come and see a male doctor about prostate problems. (Joshua, 108-111.)

...well there's empathy, and I guess it's the same for women, the women prefer going to a lady doctor for some of the intimate stuff because they perceive that a lady understands better. And for the male folk, ditto. (James, 113-119.)

Some participants described how conversations might be related to their own age as well as gender.

I think age comes into it. When I was very fresh faced then I was probably a little bit more intimidating for an older male patient to come in. But, I am probably the right age now, right age and right gender to, for people to be relatively comfortable. (Joshua, 118-122.)

However, Raymond highlighted the variations between men on their GP preferences. He suggested that they were influenced by the meaning they ascribed to consulting GPs from the same or different gender for prostate issues.

There are also a substantial tail on that group though, that want to go to the opposite sex. Somehow it makes it less, something about socially acceptable stuff, maybe these people are truly heterosexual and they can't face the idea of the genitals being waved at the same sex. It might be at some very subconscious level that that's being displayed. Because a bulk of people are, as you know, not only are they heterosexual but they are, they're not too bothered about the changing room stuff. (James, 119-123.)

## 4. DISCUSSION

This chapter will outline the main findings of the study, discuss how they address the research aims, consider how this fits in with existing research and the clinical implications of the study. The chapter will conclude with a critical review and critique of the methodology.

The overarching themes identified in this study were 'dilemmas and differences', 'being men', 'awareness, action and assertiveness' and 'significance of gender and age'. These themes are related to the different ways participants managed and approached conversations with men about issues around PCa. The themes are interconnected and the following summary provides a broad overview of the research findings rather than describing each theme in isolation.

### 4.1. Summary of participants' experiences

Participants appeared to have a number of dilemmas about managing conversations with men about PCa. They used different approaches and strategies to manage these. Participants believed it was important that they provided men with enough information about the pros and cons of testing for PCa to enable them to make a decision about whether they wanted to proceed. They often used written information to help them achieve this aim. However, there were differences in the amount and timing of the information they provided to men. Some participants believed it was important to share all the problems with testing and treatment from the outset. Others believed it was important to take a stepped approach and provide information at an appropriate time (for example, information about treatment provided after a diagnosis was confirmed).

Participants viewed it as their responsibility to gather information, identify symptoms, and complete investigations. However, there were uncertainties about testing and treatment which were further complicated when men requested PCa testing. Consequently, participants appeared to manage these issues by referring to secondary care specialists. There was a perception that secondary

care specialists were the most qualified professionals to have more complex conversations about diagnosis, treatments and side effects.

There were differences between participants about perceptions of their role, post referral to secondary care services. Some participants believed they had a significant role in supporting men (providing medication, injections, practical support or palliative support). In contrast, other participants believed that secondary care services provided the majority of support.

Participants described it as their role to manage the consultations to achieve the desired outcomes (such as completion of tests). They approached this in different ways. Some described how they would develop an understanding about what men wanted and what they already knew. Others took a directive approach and focussed on the completion of clinical tasks (for example, taking a history, ordering tests). Some participants focussed on developing a positive relationship with men.

All the participants acknowledged and considered epidemiological data in relation to age, ethnicity, family history and general lifestyle factors important. However, participants believed it was important to take an individual by individual approach rather than make assumptions or adopt additional strategies based on epidemiological information.

In summary, participants described differences in the provision of information, management of uncertainties about testing and treatment. They also described differences in the perceptions of their responsibility and what they viewed as secondary care responsibility, and how managed epidemiological information was. Further, these were complicated by issues related to masculinity.

Participants believed that men were stoic and denied their symptoms to preserve their self-concept or image. Participants believed that men might have perceptions of general practice as more appropriate for women and may therefore be reluctant to seek help. There appeared to be uncertainty and mixed views about the impact of feelings of embarrassment. On the one-hand

participants suggested that men felt embarrassed due to the nature of the symptoms and digital rectal examination. They managed this by giving men time between consultations to prepare for the test. However, on the other hand some other participants believed that embarrassment did not hinder investigations or the use of the digital rectal examination.

The results suggest that issues around masculinity were in part modified by other factors. These included partner involvement, proactive attitude amongst men about their health and an increased awareness of PCa, which was associated with socio-economic status. Participants indicated that men often attended alone, but their partners may have encouraged them to make an appointment.

Participants suggested that age and gender were influential during conversations with men. There was a perception that being a male GP would be more likely to put men at ease and help them feel comfortable and less embarrassed during consultations. There was a view that people from either gender preferred seeing someone from the same gender about intimate health issues. There was a perception that being an older GP would help men feel more relaxed and comfortable.

The results of this study will now be discussed, in relation to the research aims and existing research.

## **4.2. Addressing the research aims**

### **4.2.1. Research aim one – explore how GPs approach conversations with men who present with possible symptoms of PCa.**

This research question will be addressed across approaches to, information provision, managing the consultations and relational issues, uncertainty and managing risk.

#### *4.2.1.1. Approaches to information provision*

Participants described different approaches to the provision of information. Some believed it was important to be transparent and share the issues and

uncertainties related to investigations and treatments with men from the outset. In contrast, other participants tailored information according to what they believed men wanted to know or were able to handle. Finally, some participants provided information in a stepped way to avoid overwhelming men. With the latter two approaches, participants described how they would share uncertainties around testing for PCa but would not discuss treatment until the diagnostic / testing phase was completed. Further, participants in the current study described how men often had positive views of PCa testing and would request it during the first meeting.

Previous research has shown that increased knowledge about the PSA test and PCa is associated with men having an active role in decision-making (Sinfield, et al., 2009) and reduced likelihood of taking the PSA (Volk et al., 2007). However, studies have also shown that by the time men decide to see their GP they may have already made up their decision about testing and may not view information provision as important (Rai et al., 2007; Woolf et al., 2005). Woolf et al. (2005) found in a sample of 161 men that 58% had already decided to be tested before any discussions with their GP took place. In addition, Rai et al. (2007) found that the majority of men did not place much importance on information about the limitations and benefits of PSA testing. Instead, men had already made their decision to 'do' something and be tested before seeing the GP. Provision of information at the point of testing was considered irrelevant and premature with only a small number of men reported that information was relevant to their decision-making (Rai et al., 2007).

Consequently, the current study suggests that GPs may be faced with the challenge of discussing different options and providing information about PCa and testing which is complicated, as men may have already made a decision about proceeding with testing. Participants in the current study appeared to manage this by ensuring that men were aware of the issues with the PSA test before they proceeded to arrange it for them.

It is important to consider whether current practice guidelines and recommendations (for example, NICE, 2008) are an effective way of

communicating information about PCa to men. Men prefer hearing information about health issues from informal sources rather than professionals (McEachreon et al., 2000; Rai et al., 2007). Rai et al. (2007) suggest that community based information provision may be more effective in promoting informed decision-making.

The development of 'decision making aids' for PCa testing may be useful in providing men with information and supporting them to make decisions about testing (Volk et al., 2007). For example, Costanza et al. (2011) provided men with an education booklet followed up by a computerised telephone call. They found an increase in men's knowledge about PCa, there was greater satisfaction about decisions, decreased decisional conflict, and decisions were consistent with men's values. They conclude that such aids have the potential to replace face-to-face discussions about PSA testing. There are a number of other studies that have demonstrated the benefits of decision aids for PCa (see Miller et al., 2012; Myers et al., 2011).

Similarly in the current study, participants also found it useful to provide men with written information about the PSA to help consolidate conversations, save time and help them make decisions. However, Hale et al. (2010) suggests that written information can lead to misunderstanding and be a source of 'anxiety'.

As highlighted in the introduction it may be important to consider the way information is presented to different cultural groups (Chan et al., 2003). Participants in the current study did not describe how they might tailor information for different cultural groups or emphasise different aspects of PCa to them. It may have been that they believed that it was not necessary and more effective to provide everyone with the same information. This may be important as different cultures may have difficult ideas and explanations in relation to cancer (Wong-Kim, Sun & DeMattos, 2003). Consequently, having an awareness of this may be important when GPs provide men with information about PCa.

The results of this study suggest that the beliefs participants held about providing information (for example, about testing or treatment) had the potential to

influence their behaviour (i.e. what information they would provide men about PCa). Drawing on aspects of the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974) it may be possible that participants weighted up the perceived the benefits of providing information against positive negatives (e.g. overwhelming men). In relation to the shared decision-making model (Coutler & Collins, 2011) it appears there was differences in how much information participants provided men. This may have impacted the extent to which decisions were shared. Further, it may be that decisions to share information were influenced by 'doctor as person' factors (e.g. not wanting to overwhelm patients) or 'patients as person' factors (e.g. what men wanted to know) (Mead & Bower, 2000).

#### *4.2.1.2. Managing the consultations and relational issues*

In general participants viewed their role as to manage the consultations to achieve the desired outcomes and approached this in different ways. This appeared consistent with the shared decision making approach (Coulter & Collins, 2011) as participants appeared to take different approaches to negotiating the agenda and prioritising things in consultations. Some participants believed it was important to gain understanding about what men wanted from the consultations so they could develop a plan to meet their expectations. For example, whether they wanted to be tested for PCa or what information they wanted to know. Participants also suggested that it was important to gain an understanding of what men already knew, as this would help them know how to approach the conversation. Some participants described how they would influence men according to what they believed was in their best interests. In contrast, other participants were more direct and focussed on completing clinical tasks, rather than thinking about emotional issues (i.e. what their goals were as GPs and how they could achieve them). All three approaches could be characterised as a business like or transaction approach.

Social cognitive theory (Bandura 1977, 1986) may provide a theoretical framework for understanding these different approaches. Through a process of reciprocal determinism (Bandura 1977, 1986) participants may have had an influence on men's behaviour but also have been influenced by them, which in

turn had an effect on the way they approached conversations about PCa. The concept of collective efficacy (Bandura 1977, 1986) may be useful in understanding how participants may have sought to join men in making decisions about their health. It also appears that participants were influenced by their own attitudes and beliefs about how to approach conversations which is consistent with the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974).

Previous research has also found that communications between men and their GPs were businesslike and resembled that of the work place (Gray et al., 2002; Oliffe & Thorne, 2007). Studies also found that men appeared to value decisiveness and skilfulness, characteristics associated with hegemonic masculine traits (Oliffe & Thorne, 2007). It may be that participants in this study adopted such an approach because of a perception that men preferred this way of communicating. In relation to the person centred approach (Mead & Bower, 2000) the results may support the idea of participants developing a theoretical alliance with men if that is indeed the style they preferred. An alternative explanation could be that the pressures placed on health services require clinicians to take a more businesslike approach to health and that perhaps men adapted their approach to fit with that of professionals (Oliffe & Thorne, 2007). It may be that these pressures made it difficult for participants to engage in a person centred approach (Mead & Bower, 2000). Coulter and Collins (2011) acknowledge the tensions clinicians have in managing relationships with patients, time and risk.

Participants in the current study described how they may influence men according to what they believed would be in the man's best interests. In an USA study Hoffman et al. (2009) found that of the GPs who discussed issues around the PSA with men, 73% would encourage them to be tested. Hall et al. (2011) found that 80% of GPs would have conversations with men about testing. Of those having such conversations 64.1%, reported that they would usually encourage the man to be tested. Oliffe and Thorne (2007) reported that many participants trusted their GPs judgment about testing and asymptomatic men who were recommended to be tested did so based on the GP's advice. They note,

that while participants trusted the GP and were satisfied with their actions, GPs may not have been explicit about the limitations of the PSA or digital rectal examination. This may be important because it demonstrates the powerful and influential role GPs have when discussing testing with men. The theory of planned behaviour (Ajzen, 1991) highlights the way individuals may be influenced by the beliefs of others and their willingness to comply (Glanz et al. 2008). In relation to the current study men may be influenced by the position GPs take in relation to testing for PCa. Further, this may influence the extent to which decisions are shared or person centered (Coulter & Collins, 2011; Mead & Bower, 2000).

Participants described the importance of considering the relational aspects of consultations. This would be consistent with the emphasis on developing empathic and trust relationships in the shared decision making approach (Coulter & Collins, 2011). Participants indicated that they managed this by ensuring that they (and their general practice) appeared open and available. This may have been developed through long-term associations and previous interactions with other members of the man's family. Similarly, Oliffe and Thorne (2007) found that participants had established rapport with their GPs through long-term associations. Fenton et al. (2008) study suggested that PCa testing may be related to continuity of care. They looked at 50-78 year olds enrolled on a Washington State health plan who visited their GP on two or more occasions between 2002-2003. They defined continuity of care as seeing the same GP more than 50% of the time. A greater percentage of men were more likely to be tested with high continuity of care than those who were defined as having lower continuity of care (39.4% vs 37.4%).

In addition, participants in the current study believed it was important to take a gentle approach and not pressurise men to complete investigations and other goals of the consultations. This approach is advocated in the decision making model (Coulter & Collins, 2011) and also is in line with taking a person centred approach (Mead & Bower, 2000). Other studies have found that men valued GPs who were genuine, active listeners, investigated symptoms, solved problems and referred on to specialists when things were more complex (Oliffe & Thorne,

2007). In another study, Woods, Montgomery, Herring, Gardner, and Stokols (2006) found GP skill as an engaging communicator, encouragement to go for testing and sharing information about PCa, understanding severity of risk, culture and positive interactions with health providers as predictors of men engaging with the digital rectal examination. The results of the current study suggest that the participants were using strategies that men have reported to find helpful in previous studies (for example, Woods et al., 2006).

Participants in the current study suggested that their own gender and perhaps age were influential during conversations with men. Taking into consideration the impact of their personal attributes is consistent with a person centred approach (Mead & Bower, 2000). There was a perception that being a male GP would be more likely to put men at ease, feel comfortable and less embarrassed during consultations. Participants described how they would manage any potential embarrassment by discussing the option of seeing a male GP. Previous studies have shown mixed results as to whether men prefer seeing a male GP. Tudiver and Talbot (1999) suggest that men do have a preference to see a male GP. In contrast other studies have suggested men are more likely to have conversations about sensitive issues with women (Henderson & Weisman, 2001) and that men may feel pressured to present a masculine image to male GPs (Hale et al., 2007).

Although participants acknowledged that issues of gender might have been an issue for men, they did not talk about whether they would discuss possible concerns. GPs are under significant time pressures and it can be challenging to discuss such issues. Consequently, they may have focussed on establishing whether men had a gender preference and meeting their needs, rather than exploring the meaning of their preferences.

#### *4.2.1.3. Approaches to managing uncertainty*

All the participants in the study described the uncertainties with detection for PCa. They managed these by making men aware of these issues. However, there were differences in whether they focused on issues with the test itself (i.e. reliability, specificity) or went further to discuss the potential for additional

investigations or treatment, which may be unpleasant. This suggests mixed evidence as to whether participants adopted a shared decision making and person centred approach (Coulter & Collins, 2011; Mead & Bower, 2000).

This variability and the extent to which men feel they were informed about the problems with the PSA have been highlighted in other studies (Brett, 2001). The results of this study suggest that the variability may in part be explained by the differences in information GPs said they provided men during consultations. This is important given the effect it can have on whether men decide to be tested (Volk et al., 2007).

Despite concerns about the PSA test, participants in the current study also viewed it as an important test to complete when detecting PCa. Chan, Gann and Giovannucci (2005) found that out of a sample of 178 doctors aged 50 and over, 87% reported having taken the PSA test. In addition, 21% out of 150 doctors under the age of 50 reported having taken the test. The authors suggest that despite the uncertainty around the PSA test, GPs may believe testing could be beneficial.

In addition, participants in the current study reported that men requested testing because they believed it was beneficial, had a proactive approach to their health or wanted reassurance. These accounts suggest that beliefs were influential which would be consistent with aspects of theory of planned behaviour (Ajzen, 1991) and the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974). Previous studies have also found increased PSA testing amongst men who had a positive view of it (Rai et al., 2007) and that men who also experienced anxiety about their health sought help for prostate related problems (Hale et al., 2007). Further, perceptions about risk of developing PCa may be related to increased worry about PCa (Bratt et al., 2000; Cohen et al., 2003). Cohen et al. (2003) found in a sample of men with a family history of PCa, that increased perception of risk was related to increased likelihood of cancer worry impacting their everyday life. However, the causal direction of these relationships have not yet been identified. Increased worry may increase PCa risk perception or PCa risk perception may increase worry, (Schnur et al., 2006).

In summary, GPs may be faced with the dilemma of recognising the limitations and problems of PSA testing but may view it as the only option they have available to them. GPs may have viewed the PSA test as a relatively low cost procedure (Labrie et al., 1992), which does not involve complex or invasive testing. As a result these GPs may be more likely to comply with men's requests for the test, despite the uncertainties and possible consequences.

Participants described how they would use a gentle approach in order not to overwhelm men and make them feel 'anxious' about testing. This may have influenced the information they provided them about testing and PCa. Further, participants indicated that sometimes they might not want to 'worry' men about PCa if they had other co-morbidities. This was in an effort to reassure them and not increase feelings of 'anxiety'. This may be important because previous research has suggested that men may not seek help from GPs, particularly from male GPs, due to perceptions that male GPs held negative attitudes towards them (Hale et al., 2007). Limiting these perceptions may be important in ensuring men feel comfortable about sharing their concerns, adopting a person centred approach and facilitating shared decision making (Coulter & Collins, 2011; Hale et al., 2007; Mead & Bower, 2000). Participants in the current study appeared to make efforts to make men feel more comfortable which may have helped manage the potential concerns men had about seeking help.

There was uncertainty in how participants approached issues around treatment. Some participants were prepared to have conversations about treatment before testing, following diagnosis or if men raised the issue. However, the general consensus was that secondary care specialists were best qualified for further conversations about further investigations, diagnosis, treatments and their side effects. Many participants in the current study did not see it as their role to discuss treatment issues. This is consistent with previous research, which has also found that GPs are unlikely to have conversations about treatment with men (Chapple et al., 2008; Nanton & Dale, 2010). Previous research has also found that men view GPs more favourably when they refer on to specialists who have greater knowledge and experience (Olliffe & Thorne, 2007). In summary, GPs

may be uncertain about issues related to treatment and refer to secondary care services. This approach may also be favourable to men seeking more specialist advice.

Participants in the current study had mixed views about their involvement post secondary care treatment. Participants recognised that men may have ongoing needs once they have been discharged from secondary care services. Some believed they continue to have a role and appeared willing to provide support to men once they had started treatment or had been discharged from secondary care. This may involve prescribing medication, giving injections, practical support (for example, providing sick notes) or palliative support. This increased willingness to be involved in follow-up was consistent with the findings of a study by Watson et al., (2011).

However, some participants believed that secondary care services took the lead and provided men with support. Previous research has also found variation in the involvement of primary care services in follow-up for PCa (McIntosh et al., 2009; Watson et al., 2011). Some services were involved in regular hormone treatment and managing side effects (Watson et al., 2011). However, they found that it was uncommon for GPs to be involved in interpreting PSA tests or communicating results to patients (Watson et al., 2011). Follow up appointments were routine and did not involve conversations about how men were experiencing treatment or other psychological issues (Watson et al., 2011).

Watson et al. (2011) found that barriers to primary care involvement were lack of knowledge, time, and willingness of some GPs to take a greater role, financial issues. In addition, Watson et al. (2011) suggest that secondary care specialists were concerned that the late effects of treatment may be missed and men would get lost in the system. The results from this study are consistent with some of these issues, particularly around the lack of knowledge and belief that secondary care specialists are better placed and qualified to discuss more complex issues such as late effects of treatment. McIntosh et al. (2009) concluded that the differences in service provisions reflected the limited evidence for managing PCa and recommended further research into evidence based models of follow up.

Watson et al. (2011) proposed that greater education of primary health care professionals is needed and follow-ups are required to be robust and of high quality.

There is an increasing emphasis for primary care services to be involved in follow up care (Watson et al., 2011). Studies suggest that men have a number of unmet physical and emotional needs following treatment (Llorente et al., 2005; Ream et al., 2008). Consequently, GPs may be facing a number of complex and challenging issues following secondary care involvement including physical and psychological issues. It may be important for GPs to be supported and prepared adequately to manage such complex issues.

Participants viewed 'older' and 'younger' men differently, as a strategy for having conversations and making decisions about testing, and also encouraging treatment. There was a sense that PCa was an 'older man condition' and participants would be worried about younger men both in terms of aggressiveness of PCa and the side effects. Participants were more prepared to take rapid action and refer on quickly if necessary with younger men. Participants also appeared more likely to advocate that younger men have treatment for PCa. This approach is consistent with research suggesting that younger men are at greater risk of dying of PCa, rather than dying with it (Frydenberg, 1998). Lyrtzopoulous, Neal, Barbieri, Rubin, and Abel, (2012) found that young patients suspected of cancer were more likely to be seen by their GP on 3-4 occasions before a referral to secondary care services in comparison to older ones.

In summary, GPs face a number of challenges in relation to uncertainties about treatment for PCa. They may not believe they are sufficiently knowledgeable or qualified to discuss issues related to treatment for PCa. They may manage these by deferring such conversations and decisions to secondary care specialists. GPs also face challenges when men return to them following further testing or treatment from secondary care. Men may be seeking clarification about treatments or may have struggled to understand what the specialist had told them. Previous research has found that men diagnosed with prostate disease believed GP's were poor diagnosticians and did not have enough information

about treatments (Hale et al., 2007). It may be that GPs may feel uncertain about issues about PCa and that uncertainty is reflected in conversations with men about testing and treatment.

#### *4.2.1.4. Approaches to managing risk*

Participants in the current study outlined the importance of being aware of age, ethnicity, family history and general lifestyle risk factors in developing PCa. However, epidemiological data did not appear to influence their approach to managing individuals who may be at greater risk of developing PCa. This approach does not appear to be consistent with the shared decision making approach (Coulter & Collins, 2011) which advocates active communication and management of risk.

Participants were aware of the increased risk of PCa in men from African-Caribbean backgrounds. However, this view did not appear to influence whether they would encourage these men to be tested and preferred to take an individual by individual approach. In contrast, Stroud, Ross and Rose (2006) found that GPs in the USA were more likely to test men from Black African-Caribbean background earlier because they believed the benefits outweighed the costs of side effects.

Previous research has suggested that individuals from these backgrounds may not be aware of this increased risk and that they may have negative perceptions of health services, which influence whether they seek help. For example, Pedersen, Armes and Ream (2012) examined perceptions of PCa amongst African-Caribbean men. They found mixed results about whether men from these groups were aware of being at greater risk for PCa. They found that there was misunderstanding about diagnosis and treatment. There was a perception that testing and treatment for PCa posed a threat to their masculinity. Finally, they suggested that there was mistrust of health care systems and limited number of trust relationships with professionals. They suggested it was important for health professionals to take these factors into considerations when having discussions with men about PCa.

In the UK, Nanton and Dale, (2011) suggested that the needs of African-Caribbean are not being met. Their study found that African-Caribbean men with PCa found services insensitive, lacked understanding and were unresponsive to their needs. In relation to communication and information, they also found a majority of men did not question professionals about their illness or treatment, even though they later reported that they wanted more information. Professionals may have thought that the participants were not interested and inadvertently closed down conversations regarding treatment.

Participants in the current study did not appear to take a pre-emptive approach in terms of actively seeking out or encouraging patients who were at a greater risk to be tested. Drawing on social cognitive theory (Bandura 1977, 1986, 1997) a possible explanation could be at participants did not believe they could facilitate increased testing for men at greater risk of developing PCa. Instead, they waited for men to seek help or ask for advice. This may be because of the general uncertainty around testing and treatment for PCa made GPs reluctant about taking a proactive approach based on epidemiological data. However, given the increased risk in this population, it may be important for GPs to consider how they take a more active approach to detection for men at greater risk. This may be further complicated as men from these groups are less likely to seek help than men from other backgrounds (Braithwaite, 2001).

Participants in the study highlighted how family history was a risk factor for PCa. However, similarly to their approach to men from African-Caribbean backgrounds, they did not appear to have an active approach in addressing this through additional testing. Studies in The USA have found that African-American men with a family history of PCa may not see themselves at being at a greater risk of developing PCa (Bloom et al., 2006; Weinrich et al., 2006). This has important implications, as current guidelines require men to seek help or ask for a PSA. However, men may not be aware of all the risk issues. It may be that GPs are in a position to provide men with information about testing if they are at a greater risk of developing PCa.

In summary participants in the current study used a number of strategies and approaches with men presenting with possible symptoms of PCa. It appeared that these approaches were influenced by how confident they felt about the uncertainties related to testing and treating PCa. Further, the limited time and resources available to them make it difficult to have complex and in depth conversations about all the uncertainties. In addition, these uncertainties may make it difficult for them to feel confident about taking a pre-emptive approach to PCa in men who may be a greater risk of developing the condition.

#### 4.3. Research aim two - explore the way GPs describe issues related to masculinity and how they may influence conversations with men who present with possible symptoms of PCa.

Participants in this study described a number of issues related to masculinities and the impact this had on their conversations about PCa. Colon or bowel cancer, affects approximately the same number of men and women (Cancer Research, 2013). In contrast, PCa is a male cancer, this carries with it assumptions about men (Wall & Krisjanson, 2004). This may influence the way conversations are approached. Participants in this study suggested that men did not seek help for possible symptoms of PCa because of perceptions about general practice and feelings of embarrassment. However, participants also described ways in these perceptions were modified and managed.

##### *4.3.1. Perception of services and legitimising attendance*

Some participants held a perception that men do not seek help for their symptoms and that men viewed general practice as being more appropriate for women. Participants in the current study reflected that although men attended the actual consultations independently, they formed the impression men were encouraged to attend by their partners.

Tudiver and Talbot (1999) explored why men do not access health care services in the USA. They found a perception amongst GPs that men tended to seek help more indirectly and through other sources and female partners. This view is consistent with a number of studies, which found that partners were influential in men seeking help (Gascoigne, Mason & Robert, 1999; George & Fleming, 2004;

McFall, Hamm & Volk, 2006). Hale et al. (2010) propose that this allowed men to legitimise their reasons for seeking help in a way that allowed them to maintain their masculinity and sense of self.

Although participants described how partners were probably involved in the decision to see their GP they did not discuss other ways partners may be important. Studies have shown that partners are more likely to be in favour testing for PCa than men (Volk et al., 1997). In the USA, Volk et al. (2004) examined the views of 168 couples where the man was eligible for PSA testing using a 'utility assessment procedure'. They found that the views of men and their partners differed. For example, wives would not trade off the length of their husband's lives for a better quality of life in relation to side effects such as impotence and incontinence. In contrast, husbands were more prepared to favour quality over quantity of life. O'Rourke (1999) used a grounded theory design to examine treatment decision-making process in 18 newly diagnosed PCa patients and their wives in the USA. They found that men were less willing to accept treatment "at any cost" in comparison to their wives.

Whilst participants in the current study acknowledged the role of partners only two of them talked about how they might try and include them in consultations. One of the participants said they would involve partners if a man experienced memory difficulties and another said they would when discussing treatment options. Given the pressures, demands and other challenges related to PCa GPs may find it challenging to involve partners or discuss relational issues with men during consultations. There may be an assumption that men tend to make decisions about their health on their own. Person centred approaches (Mead & Bower, 2000) advocate and outline the importance of social factors. This may also be applicable to increasing the involvement of partners in decisions around PCa.

Sinfield et al. (2009) highlighted the importance of ensuring patients and their carers were involved throughout the process from investigations, diagnosis, treatment and follow-up care to ensure that they understand the diagnosis, treatment options, and support that is available. However, NICE (2008) suggest that it is important to respect a man's preference if he wishes to be seen alone.

#### *4.3.2. Embarrassment and preserving their image*

In the current study participants suggested that men did not seek help in order to preserve their self-concept and maintain their sense of themselves as men. Participants suggested that men preferred not to think about or downplayed difficulties they were experiencing. Participants suggested that men wanted to maintain a “macho” image and they often denied or played down their symptoms. Similar results were found in other studies (George & Fleming, 2004). Chapple and Ziebland (2002) interviewed 52 men in the UK and found that they were reluctant to consult their doctors. Maintaining a “macho” image and a view that symptoms of PCa were “embarrassing” made them reluctant to seek medical help. Hale et al. (2007) found that men in their study acknowledged the social pressure of living up to a macho image and viewed it as having a detrimental effect on men’s health.

Participants in the current study appeared to manage these issues by increasing their empathy, awareness and having a sensitive approach to what it might be like for men who may be presenting with possible symptoms of PCa. Another way participants managed these issues was offer to them the chance to see a male GP (see section 4.2.1.2.).

Although participants believed men might have been embarrassed they said they experienced little resistance from men about the use of the digital rectal examination. This is in contrast to previous studies have found that men had negative experiences of transrectal procedures, such as the digital rectal examination, and often felt embarrassed (Broom, 2004; Ollife, 2004). It may be that the men described by participants in the current did not have any issues with the digital rectal examination. This may have been related to the small sample size. It may also be that GPs may not aware of some of the negative experiences men are exposed to because they may not have time to explore the meaning of them with men or because men are reluctant to share how they feel.

Although participants believed that some men did not seek help for their symptoms they did not describe any additional steps to encourage men to seek

help or of any initiatives that may help reduce issues around embarrassment. Participants in this study did not describe how they managed cultural differences or constructions of masculinity during conversations with men about PCa. Instead they tended to think about men and the way masculinity was constructed in a more general and stereotypical manner (Galdas, 2009) rather than as affecting particular cultural groups. For example, participants in the current study held the perception that whilst men may not like the digital rectal examination there was no active resistance towards it. Some participant reflected that they did not see many men from different cultural groups and did not have a sense of any cultural differences. This is in contrast to previous research, which has suggested that social and cultural constructions of masculinity may have influenced conversations with men about PCa. For example, Zully and Buki (2011) explored the views of Latino men in the USA about their views on PCa testing. They found that what it meant to be a man within this cultural group influenced their understanding of PCa testing (for example, not wanting to be tested and a negative perception of the digital rectal examination). Other studies found similar results (Addis & Mahalik 2003; Courtenay, 2000). This highlights the potential impact of cultural factors, masculinities and testing.

Participants in the study appeared to suggest that men were not willing to seek help because of their own views / beliefs about what it meant to be a man. This would be consistent with the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974) and theory of planned behaviour (Ajzen, 1991). Broom (2004) interviewed 33 Australian men with PCa and found that men talked about the wider cultural pressures they were placed under to appear 'well' and 'strong' which reduced their ability to seek help for their symptoms. The authors suggested that structures in society, both formal (for example, education) and informal, bring about and reinforce stereotypes about masculinity.

Broom et al. (2004) suggested that the complex interactions of men's ideas of masculinity and of institutional support networks had an influence on men not seeking help. The results from the current study may be consistent with this as there appears to recognition that men may not seek help because of their beliefs

around masculinity. Although, there is some recognition that systemic factors may also have an influence there appears to be no attempts to bridge the gap. Broom (2004) recommended that clinicians should be aware of the potential influence of masculinity on men when making decisions about treatment and the effects it can have on their feelings of 'anxiety' before (i.e. during investigations) and after treatment. In addition, Broom (2004) recommended creating safety and a non pressurising environment so men can share their values and priorities. Broom (2004) believed that it is important to increase clinicians' awareness of how masculinity may have interacted with testing for PCa.

There is mixed evidence as to whether participants adopted a person centred approach (Mead & Bower, 2000) and shared decision making approach (Coulter & Collins, 2011). On one hand they acknowledge that it is important to be empathic, sensitive, consider their own attributes and developing a therapeutic alliance. However, participants did not talk about how they may seek to help or support men who may not be willing to seek help.

#### *4.3.3. Influence of other factors*

Participants in the current study suggested a range of additional factors that may have influenced the way men approach their health and issues around PCa. The first was related to men having a proactive attitude towards their health. The second was related to an increased awareness associated with coming from a higher socio-economic background.

Participants in the current described these men as being conscientious about their health and taking a proactive approach. This view is reflected in research conducted by Rai et al. (2007) who explored factors that influenced men to have a PSA test. One of findings was that men believed having the PSA test meant they were being proactive and taking control of their health. They also found that men's awareness of the PSA was linked to the media and accounts from friends, rather than GP consultation.

In the UK, Chapple et al. (2008) interviewed 30 men who had the PSA test or were considering taking it. They found a perception that men and clinicians

believed that the PSA was “just another blood test” because it was “simple” and its use was similar to that of other preventative medical procedures such as checking for high cholesterol. In addition, Chapple et al. (2008) found that men viewed testing as responsible behaviour which was related to moral obligations of what they “should” do based on what people in the wider community or friends had told them. It has been suggested that wider perceptions of blood tests as of being of little importance or significance (Pferffer & Laws, 2006). These views may have influenced their approach to the PSA.

Crawford (1986) argued that there has been over emphasis on individual responsibility for health and that social structures have been given little attention. This would be consistent with the current study as participants described how men believed it was their responsibly to seek help to be tested for PCa.

Participants in the current study believed that men who were more aware of PCa were more likely to seek help for their symptoms. They held several ideas about what was likely to increase men’s awareness. These included greater access to the Internet / media, increased socio-economic status which is comprised of a higher level of education, financial security and being from a middle class background.

Participants associated higher socio-economic status with men adopting a proactive and assertive approach to men’s health, where as those with wider socio-economic difficulties may not have sought help. Lyratzopoulous et al. (2012) found no consistent interactions between the number of consultations before referral to secondary care and socio-economic differences amongst people referred to secondary care for suspected cancer. They acknowledged that their findings may have over or underestimated differences. Further, their survey did not include a question about education level. However, Berglund (2009) suggest that socio-economic factors are influential in relation to the management and mortality rates in men at high risk of PCa. Rapiti et al. (2009) found that individuals from a lower socio-economic background were at greater risk of dying from PCa due to delays in diagnosis, poor investigations and use of less invasive treatment options.

The current study suggests that participants made assumptions about risk based on socio-economic status. These assumptions may be useful in approaching conversations about PCa. However, it would be important to consider whether other factors may also be important.

In addition, participants in the current study described how it might be easier to have conversations about PCa with men who were more educated and whose first language was English. This view was consistent with Guerra et al. (2007) who found that discussions with men were more likely to occur when men requested it and if men were highly educated. They also identified limited education / health literacy as potential barriers to conversations about PSA testing.

In summary, participants in the current study held a number of assumptions about the role of hegemonic masculinity (Cheng, 1999). While these may explain some of differences between men seeking help it has been suggested that the construction of hegemonic masculinity can be problematic and limits the understanding we have of how masculinity may be related to PCa (Wall and Krisjanson, 2004). Wall and Krisjanson (2004) argue that the experiences of men with PCa have been presented in a less complex form which propagates dominant ideas about masculinity and as a result the more complex aspects of their experiences have been missed.

Participants in this study appeared to describe a stereotypical view of men as being unwilling to seek help (Cheng, 1990; Galdas, 2009). However, Courtenay (2000) suggests that it is only recently that the issue of men seeking or not seeking help has become an issue. Galdas (2009) argues that perhaps the dominant perception of men not seeking help is related to political and professional research interests. It is argued that the picture is much more complex and cannot be explained by stereotypes alone. For example, Hewitt et al., (2004) found that women delay seeking help for suspected myocardial infarctions longer than men do. Smith, Pope, Botha, and Malterud (2005) found a similar pattern in relation to seeking help for possible cancer patients. Broom

(2004) highlights the complexity of differences, variability and complexities of masculinity in relation to PCa. Some men in their study had a negative view of men who adopt a macho approach to their health and while masculinity was important, it may not necessarily stop men from getting information or help.

It has been argued that people are expected to have control over their bodies (Scott & Morgan, 1993). In western cultures men are expected to exercise greater control over their body than women (Morgan, 1993). These wider societal expectations may make it difficult for men experiencing symptoms of PCa to seek help for them (Chapple & Ziebland, 2002). In addition, previous research has suggested that men use health behaviours as a way of demonstrating their masculinity (Courtenay, 2000). Courtenay, (2000) also suggested that men deny weakness or vulnerability, have a desire to remain emotionally and physically in control and dismiss the need for help. Tudiver and Talbot (1999) also found a similar perception of men as being reluctant to seek help due to a sense of immunity and immortality; difficulty relinquishing control; a belief that seeking help is unacceptable; and believing men are not interested in prevention.

In the current study participants appeared to consider issues related to masculinity but not the complex interaction it has with other factors. Consequently, GPs may hold simplistic assumptions about the influence of masculinity in relation to PCa rather than consider the complex interactions it has with other issues such as historical, social and cultural context as well as identity, ethnicity, sexuality, age and occupational role (Galdas, 2009).

#### **4.4. Implications and recommendations**

##### 4.4.1. Clinical implications

###### *4.4.1.1. Training programmes*

The findings from the study highlight the different strategies and approaches GPs may use to manage conversations with men about PCa. The strategies were influenced by how confident and qualified GPs felt in having these conversations. Some participants appeared confident in explaining the PSA and outlining the

uncertainties related to it. However, they appeared less confident and did not see it as their role to have discussions about treatments issues.

Participants in the study appeared to use stereotypical assumptions about men based on western notions of hegemonic masculinity which include denial of weakness, appearing strong and being in control (Cheng, 1999). While these assumptions may explain the why some men approach issues related to PCa it may be that they limit or close down ideas about other reasons men may not be seeking help about possible symptoms of PCa and how they have conversations.

One recommendation is that it might be beneficial to develop a communications skills training programme for GPs. The programme could help GPs feel more confident in discussing a range of issues from the uncertainty around investigations and treatments. This could also include psychological issues such as managing 'anxiety' and exploring beliefs about masculinity may influence men's approach to testing, treatment and follow-up care.

Communication skills training programmes can help clinicians feel more confident and have greater self-efficacy when communicating with patients (Bylund et al., 2011). Such approaches have been found to be acceptable to clinicians working with cancer patients (Bylund et al., 2011).

Other studies have shown the benefits of such programmes in relation to PCa. For example, Gattellari et al. (2005) found that "peer coaching" helps increase GPs knowledge about PSA and increase patient involvement in decision making. It may be possible that clinical psychologists could deliver an adapted version of the Gattellari et al. (2005) programme which provides GPs with information about PCa, resources (videos, patient information, clinical guidelines), feedback on current practice using questionnaires and applying motivational interviewing techniques (Rollnick, Miller & Butler, 2008) to encourage informed decision making. In addition, they could provide information about psychological issues (e.g. 'anxiety', gender"). In another study, Weller et al., (2003) used educational outreach visits targeted at individual GPs and concluded that it may be possible to influence GPs practice and increase knowledge about PSA use.

Coulter & Collins (2011) highlight how shared decision making involves more than information provision. It involves counselling by trained health coaches and includes listening, asking open and closed questioning, providing support for deliberation and non-directive guidance (Coulter & Collins, 2011). Coulter & Collins, (2011) highlight how most health professionals are not taught these skills as part of their training and they may require additional training. Psychologists may be able to provide such training to support GPs ensure that the expertise of patients is also brought forth and valued during consultations. Psychologists may use ideas such as motivational interviewing (Rollnick, Miller & Butler, 2008).

Using Coulter and Collins (2011) ideas on shared decision making as a framework psychologists may provide training to GPs on topics such as empathy and trust, negotiating the agenda and prioritising, information sharing, re-attribution, communicating and managing risk, supporting deliberation, summarising and making the decision and documenting the decision (Coulter & Collins, 2011). Psychologist may also have a role in teaching skills related to person-centred approaches which involve attention to biopsychosocial, 'patient as a person', sharing power and responsibility, therapeutic alliance and 'doctor as a person' (Mead & Bower, 2000).

#### *4.4.1.2. Consultancy*

Clinical psychologist could offer GPs psychological consultation (Lavender & Allcock, 2006) to think with them about how they are managing the various issues related to PCa. Consultations could explore issues in putting clinical guidelines into practice. They may also be used to provide GPs with greater awareness and knowledge about psychological theories and models, which may have an influence on patient's health behaviours. These theories and models may include the health beliefs model (Becker, 1974; Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974), theory of planned behaviour (Ajzen, 1991), social cognitive theory (Bandura, 1977, 1986, 1997), shared decision making model (Coulter & Collins, 2011) and patient centred principles (Mead & Bower, 2000).

Consultations could also explore how GPs manage and approach conversations with men who experience 'anxiety' and maybe requesting the PSA as a reassurance strategy. Bion's (1962) ideas of containment may be useful to support GP's contain men's anxieties about PCa. The results of the current study suggest that GPs experience uncertainties about managing PCa. This is understandable given the various difficulties surrounding the condition and diversity of ideas to approaching it. Consultations may also be an opportunity for GPs to think about how they manage their 'anxieties' associated with PCa such as issues around the PSA or discussion of the treatments. Further, it may be possible for psychologists to contain (Bion, 1962) GP's 'anxieties' about PCa in order to make them more manageable and tolerable for them.

Consultations may also focus on management of men at greater risk of developing PCa and men who may not seek help for their symptoms. Finally, consultations may be an opportunity for GPs to share ideas with each other and benefit from each other's knowledge, skills and experiences (Fredman & Rapaport, 2010).

#### *4.4.1.3. Partner involvement*

This study found that men appeared to be expected to make decisions about testing on their own. This may reflect stereotypes about hegemonic masculinity and men taking control (Cheng, 1999). Another recommendation from this study is to develop ways to include partners in conversations about testing for PCa. A view shared by other researchers (Volk et al., 2004). This may include giving men the option of inviting their partner to a joint consultation. However, if men do prefer to come on their own perhaps GP's could develop ways of exploring issues systemically and keep the partner in mind (Dallos & Stedmon, 2006).

Oliffe and Thorne (2007) suggest that men found it beneficial to have partner attend appointments as they helped to recall information, interpret results and provide emotional support. Volk et al. (2004) propose that whilst the involvement of partners in decisions about treatment are more common (Butler, Downe-Wamboldt, Marsh, Bell & Jarvi, 2000; Davison et al., 2002) decisions about testing is not a widespread practice. They suggest that because PCa testing does

not need to happen immediately there is scope to involve partners in the process as they are also invested in the outcomes (Volk et al., 2004).

#### 4.4.2. Implications for future research

##### *4.4.2.1. Live consultations*

A limitation of this study is that it is based on GP's accounts of how they managed conversations with men about PCa. Future research could focus on live interactions between GP's and men. Recording and analysing data from 'live' conversations would allow access to information about what happens in actual consultations rather than participants' accounts of them. A conversational analysis (Sacks, 1995) of data may enable a detailed elaboration of conversational sequences and strategies (Schegloff, 1998) used by GPs and men to achieve their aims during consultations. It may also be useful to interview men and GPs to explore their experiences of the conversations. This would allow for a more comprehensive account, which explores conversations about PCa at different levels, the actual interaction, the GP's perspective and the man's perspective.

Participants in the current study indicated that they would inform men of the issues of detection and that they tailored information depending on the man. However, it was not possible to know the extent to which men understood these issues and what they thought about the information they were given. Previous studies have suggested that there can be lack of communication about the uncertainties of treatment and testing (Chapple et al., 2008; Dube, Fuller, Rosen, Fagan, & O'Donnell, 2005). It would be useful to explore what men thought of the information they had been given, whether they understood it and what might be changed to make it easier or more helpful.

##### *4.4.2.2. Groups at risk*

This study had a general focus on how GP manage conversations with men. It may be beneficial for future research to explore how GPs approach conversations with men at higher risk of developing PCa such as individuals from African-Caribbean backgrounds or men with first-degree relatives who have been

diagnosed with PCa. This would be important, as the needs of these groups may be different (Nanton & Dale, 2010). Men in these groups may have particular views and ideas about what it means to be a man, which could influence whether they seek help and view of investigations or treatment (Zully & Buki 2011). Although the current study found participants did not change their approach based on epidemiological data it would be useful to learn more about this issue. It may also be useful to consider using a questionnaire design with a larger sample to determine how they approach people at greater risk of PCa.

#### 4.4.2.3. Managing post-treatment care

The results of this study suggest that GP's may not feel confident about discussing issues related to treatment for PCa. There is an increasing emphasis on primary care management of PCa following secondary care treatment. It may be important to explore GP perceptions of their roles and responsibilities with men post-treatment, once they are discharged back into their care. It may also be useful to explore what GPs would require to feel confident in supporting men who are discharged back to their care.

### 4.5. Critical review

#### 4.5.1. Quality

The following section outlines how the researcher ensured good practice in using qualitative methods, drawing on guidelines outlined by (Eliot et al., 1999).

##### *4.5.1.1. Owning own perspective*

The researcher was transparent and declared the epistemological position adopted in conducting this study (section 2.1.1.). The researcher was reflexive about the role and potential influence they may have had during the interviews. The researcher acknowledged their role in the identification of themes and that different themes may have been identified by another researcher.

##### *4.5.1.2. Situating the sample*

The researcher was transparent about the characteristics and recruitment of participants which can allow the reader to judge the applications of the findings.

#### *4.5.1.3. Grounding in examples*

The researcher was transparent about their analysis procedure (section 2.3.2.) and there is a clear audit trail (Lincoln & Guba, 1985), which can be used to trace themes back to how they were originally developed. The researcher has provided the final stages of theme development in Appendix 5. The researcher provided a sample of coded transcription in Appendix 6. The researcher included examples of their raw data in the results section to illustrate how they developed overarching and sub themes. The researcher attempted to remain close to the responses of participants and outlined where they were adopting a more analytical position.

#### *4.5.1.4. Providing credibility checks*

The researcher consulted their supervisor, who has extensive experience of men's health and PCa to review the analysis and supporting examples. In addition, used peer review (Creswell & Miller, 2000) and asked an independent colleague to also review the analysis and supporting examples.

#### *4.5.1.5. Coherence*

The researcher presented their results in a table, which clearly outlined the overarching themes and the sub themes that were connected to them. The researcher provided a rich verbal narrative of the results and explicitly stated themes that were interconnected to each other. Where there were differences the researcher attempted to be transparent about them in the results and discussion sections.

#### *4.5.1.6. Accomplishing general versus specific research tasks*

The researcher used opportunity and snowball sampling to recruit 14 participants in the study in an effort to obtain a range of different perspectives. They did not seek to make claims about the representativeness of their sample or generalisability of their findings. The researcher acknowledges that geographical, cultural and gender issues may have influenced the findings. They acknowledge that the findings are only a reflection of the group of participants that took part in

the study. However, the study may provide knowledge about possible ways that GPs manage conversations with men about PCa.

#### *4.5.1.7. Resonating with the reader*

The researcher attempted to ensure resonance with the reader by bringing the participants experience alive through examples they have used. The researcher attempted to bring together varied, complex and multifaceted ideas.

#### 4.5.2. Reflexivity

Issues of reflexivity are now considered in relation to epistemological reflexivity and personal reflexivity (Willig, 2001).

##### *4.5.2.1. Epistemological reflexivity*

This study adopted a critical realist approach for reasons outlined earlier (section 2.1.1). Adopting such an approach may not have enabled a greater exploration of the construction of concepts such as “masculinities” and “help seeking” in greater detail.

The constructions of concepts of masculinity in relation to PCa have been shown to be important. For example, Oliffe and Thorne (2007) suggest that using a social constructionist gender framework allows an understanding of the plurality of masculinities and gender performances. They argue, “men’s communications and relationships with other men vary but are constructed in relation to culturally informed masculine ideals” (p.150). Oliffe (2006) comments on the plurality of hegemonic masculinity and how men at different ages may construct it in different ways.

##### *4.5.2.2. The researcher as a man*

The researcher acknowledged their gender might have influenced the study. PCa is a male cancer and issues related to gender are perhaps more salient than other cancers which affect men and women equally (Wall & Krisjanson, 2004). Subsequently, it may have been possible that issues related to gender and masculinity may also have influenced the study in different ways.

By virtue of the researcher's gender participants, may have adopted a particular approach or position during the interviews. For example, during one interview one of the participants enquired about the researcher's age and suggested they may want to consider testing for PCa in the future.

Male GP's in particular talked about the benefits of being a man when talking about PCa. This may have enabled them to have a more open discussion with the researcher about their experiences. It may also have been possible that participants adopted a frank and pragmatic approach to interviews, which may have influenced the extent to which they spoke about the emotional and psychological aspects of their experiences.

Secondly, the researcher acknowledged their epistemological stance that during the analysis phase of the study they may have been drawn to particular ideas and assumptions made about men and masculinity. However, the researcher took a number of steps to ensure quality in the study (section 4.5.1).

#### *4.5.2.3. The researcher as a trainee clinical psychologist*

The researcher acknowledges that their professional role as a trainee clinical psychologist may have influenced the study. At the start of three of the interviews participants were interested in knowing more about the researcher's job and interests in PCa. The participants may have focussed on what they considered "psychological" issues because they assumed that is what the researcher wanted to know about. This may have meant that other aspects of their conversations with men were not discussed, considered important or gave what they thought was the "right answer".

During the study the researcher gained an increased appreciation of the challenges faced by GPs. The researcher became aware of the complexities of providing support in primary care for complex conditions such as PCa. The research anticipates that these experiences will be invaluable to them as a clinical psychologist in the future. The researcher gained an understanding of how GPs have to know a lot of information about a range of health issues. The

researcher learnt about the importance of establishing good links with GPs and being in a position to support them where appropriate.

#### *4.5.2.4. Ethical issues*

During two interviews participants enquired as to whether their responses were similar to other participants and if what they said fitted in with what they should be doing. The researcher wondered whether they felt under scrutiny or uncomfortable and reassured participants that the study was not a test of their knowledge but to gain an understanding of the different ways conversations about PCa were managed. They were also reminded that they could retrospectively withdraw if they wished. Both participants indicated that they were just curious about other responses and were happy for the researcher to include their data.

#### *4.5.2.5. Strengths of the study*

The strengths of this study are that participants in the study were GPs working in the UK. Much of the existing research has been conducted in the USA. While those studies do have some relevance to UK because of the consensus around PCa management (Illic et al., 2007; Ross et al., 2004) there are differences in the organisation and provision of health. These can have an influence on the types of conversations GPs have with men about testing for PCa.

Another strength of this study is the qualitative research methods. Much of the existing literature with GPs has been questionnaire or survey based. While these are useful they do not provide an account of the ways GPs manage the challenges and dilemmas related to conversations about PCa.

There were several features that were novel about the study. Firstly, the idea to explore GP's accounts of conversations with men about PCa was unique. Previous studies have not examined accounts of GPs and other health professionals about PCa management. It is important to consider the accounts of both patients and professionals to ensure that we provide the best services possible. This is particularly important as given the increasing prevalence, general uncertainty related to PCa and increased emphasis on shared decision

making (Coulter & Collins, 2011). Further, GPs are gatekeepers to secondary care services and have a growing influence on the commissioning of services. Subsequently, their views and perspectives may have an influence on service provision.

Another novel finding of the study was that despite guidelines about the management of PCa, GPs experience a number of uncertainties, challenges and dilemmas. It is important to acknowledge these and consider ways we can better support GPs enhance their consultations and improve service provision.

## **4.6. Critique of Methodology and Methods**

### 4.6.1. Recruitment / sampling

Participants were recruited using opportunity sampling as it was anticipated that GPs would be difficult to recruit because of the demands on their time. However, this was expanded to include snowball sampling following a slow uptake in recruitment. While this approach was successful, one of the drawbacks of this approach is that participants may have directed the researcher towards other like-minded people (Barker, Pistrang & Elliott, 2002). Consequently, the views of the participants may have been similar and bias the results. However, GPs are a difficult group to recruit given the demands of their job and pressures on their time. It was important to be realistic and adopt a pragmatic approach to research.

Further, two participants were recruited from the sample general practice and the way PCa was managed by the practice overall may have influenced responses. However, upon examination their responses it did not appear that there was any particular ethos or approach that was being advocated.

Another drawback is that participants contacted the researcher following invitation letters and may have participated because of a special interest in PCa or were keen to share their experiences. It may be possible that the sample may represent the views of people interested in the management of PCa rather than general practice. Subsequently, it may be difficult to generalise the findings to general practice without further research.

In this study participants were from White British and British Indian backgrounds. Further research may seek to explore whether the cultural background of GPs has an influence on conversations about PCa. It may be beneficial to explore how Black Caribbean-African GPs manage conversations about PCa with groups at higher risk.

Finally, as there were 11 men and three female participants in the study. It was decided that all data would be analysed together. However, it is possible that accounts of conversations with men about PCa may have differed between male and female participants. On reflection, it may have been useful to have separated out these accounts and explored whether any potential differences.

It would be useful if future studies with a more diverse sample explored the accounts between male and female GPs in greater depth. This may enable a greater understanding of the way the gender of GPs may play a role in conversations about PCa. Some participants from the current study suggested that being a male GP might have made it easier for men to feel comfortable about discussing issues related to PCa. From a clinical practice perspective, it would be useful to know more about whether the gender of the GP has the potential to influence the conversations they have with men about PCa. The patient centred approach (Mead & Bower, 2000) considers how the personal attributes and qualities of the doctor may have an influence on interactions with patients.

#### 4.6.1. Data collection

A limitation of the study is that the data is based on participants' personal accounts of how they managed conversations with men about PCa. The data may not accurately represent actual conversations. It may be participants provided responses of how they think they should approach conversations with men rather than how they actually approach them. Further, participants may have reviewed guidelines on PCa before the interview and so their response may reflect they think they should be doing rather than actual clinical practice.

Another limitation in the data is the possibility of the actor-observer effect (Fiske & Taylor, 1991). Participants may have viewed men who did not seek help as avoiding or denying their problems. In contrast men may believe that it is difficult to access their GP.

Another approach to collecting data would have been to use focus groups. This may have allowed GPs to discuss the issues around PCa and comment on each other's experiences, perspectives and ideas.

Another limitation of the study is that although there appeared to be a number of questions related to gender in the interview schedule these were not reflected in participant's responses and the analysis. This may be because participants were not asked explicitly to comment on men in comparison to women. Some participants did comment on this spontaneously but many did not. It might have been useful to have had included specific questions asking participants to reflect on possible differences in how they would approach conversations with men about PCa and conversation with women about cervical or breast cancer. These may have allowed for comparisons between gender specific cancers.

#### **4.7. Summary**

Participants in this study described a number of challenges and uncertainties in managing conversations with men presenting with possible symptoms of PCa. These uncertainties appeared to be related to the general uncertainties surrounding the management of PCa in relation to detection methods and treatments. Further, participants described the way hegemonic masculinity may have an influence on whether men sought help for their symptoms and the conversations themselves. However, participants also noted that socio-economic status may have a modifying effect on issues related to masculinity. This may suggest that issues of masculinity are more complex than stereotypical notions.

Participants were aware of groups at greater risk of developing PCa and managed them by adopting an individual-by-individual approach rather than assessing risk based on epidemiological information. GPs may benefit from

training about managing uncertainties related to detection and treatment. They may also benefit from training to explore more complex dimensions of masculinity. Further research involving examination of live consultations may be useful in gaining another perspective on conversations about PCa.

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## 6. APPENDICES

### Appendix 1: Ethical approval

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

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To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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## Appendix 2: Interviews schedule

1. What factors do you consider when a man presents with possible symptoms of PCa?
2. What conversations do you think would need to happen?
3. How do you have these conversations with men?
4. Given the uncertainty around the PSA test, how do you discuss and approach this?
5. How do you talk about the side effects of treatment? If so, how do you do this?
6. How do you promote informed decision-making?
7. Are there any particular issues you think would put men at greater risk? How would you approach this?
8. Do you think that there are particular groups for whom treatment may raise particular issues? How would you approach this?
9. What do you think are main challenges to engaging men in testing? Treatment? Accessing support?
10. What do you think is different about men who seek help for their symptoms and those that do not?

Are there any questions or comments that you have?

### Revised Interviews schedule

1. What factors do you consider when a man presents with possible symptoms of PCa?
2. What conversations do you think would need to happen? How do you provide information? Do you tailor it?
3. How do you have these conversations with men? Prompts – how do people feel about testing? / is there any resistance to the digital rectal examination? How do you approach this? Do you have these conversations with men on their own or do their partners (if they have any) come along too? Do you think your gender has an impact on these conversations? – in what why? – how do you manage this?

4. Do you discuss the option of having a PSA test with men? Prompts - Given the uncertainty around the PSA test, how do you discuss and approach this? How you talk about the PSA test / counsel men about it? How do you discuss the pros and cons of testing?
5. How do you talk about the side effects of treatment? If so, how do you do this?
6. How do you promote informed decision-making? What kind of role do you play or expect to play when a man presents with possible symptoms of PCa?
7. Are there any particular issues you think would put men at greater risk? How would you approach this?
8. Do you think that there are particular groups for whom treatment may raise particular issues? How would you approach this? Do you think that certain groups are at great risk of being diagnosed with PCa? How do you communicate this risk?
9. What do you think are main challenges to engaging men in testing? Treatment? Accessing support?
10. What do you think is different about men who seek help for their symptoms and those that do not?

Were there any questions or comments that you had?

**Appendix 3: Consent form**

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

**“WHAT HAPPENS NEXT?” AN EXPLORATION OF HOW GENERAL PRACTITIONERS TALK  
TO MEN PRESENTING WITH POSSIBLE SYMPTOMS OF PCA.**

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant’s Name (BLOCK CAPITALS)

.....

Participant’s Signature

.....

Researcher’s Name (BLOCK CAPITALS)

.....

Researcher’s Signature

.....

**Date:**

.....

**Appendix 4: Simple transcription scheme adapted from Banister et al. (1994)**

R Indicators where researcher has spoken

PX Indicate where participant has spoken. X signifies the participants' identification number.

(inaudible) Researcher was unable to determine what was spoken.

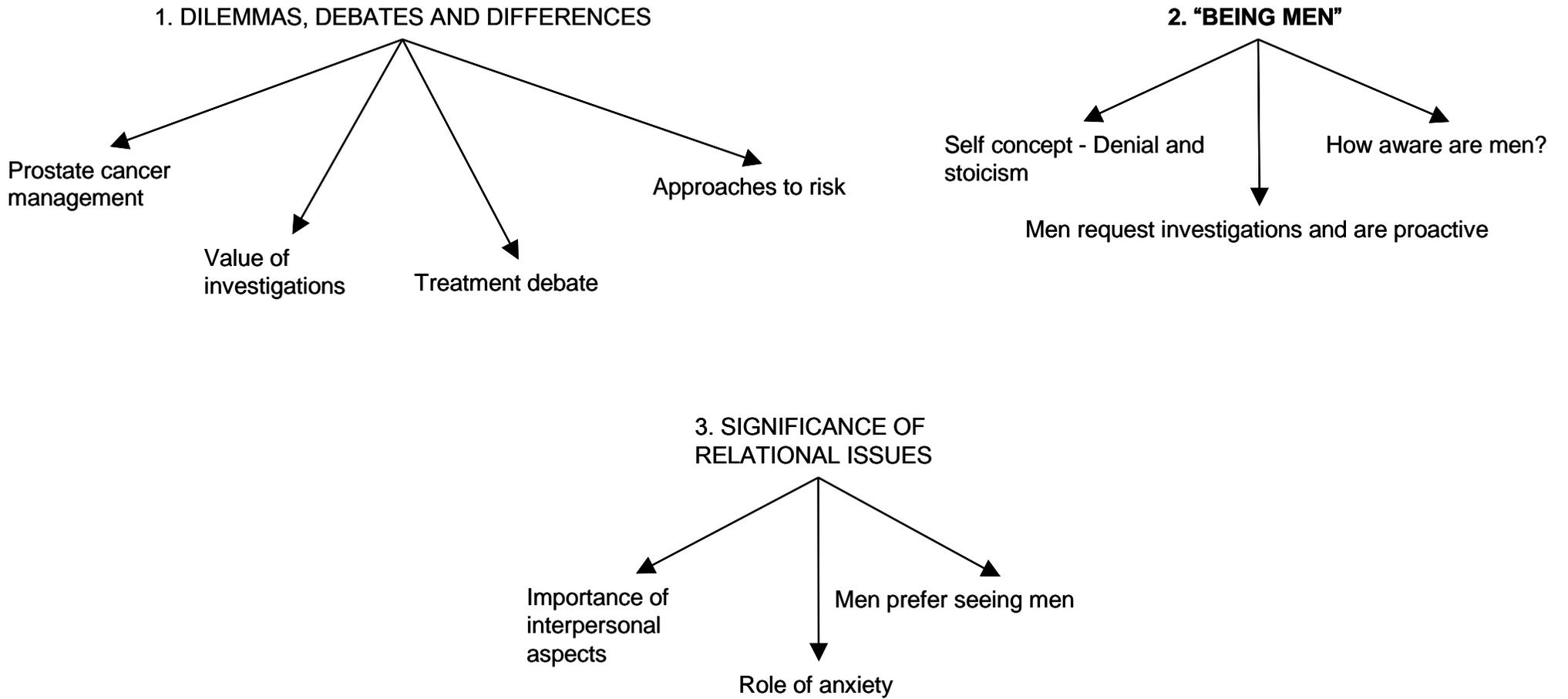
(...) Where there is an interruption made by a speaker, it is placed in brackets.

(Action) Where a participant has passed the researcher something. For example, a leaflet about the PSA Test.

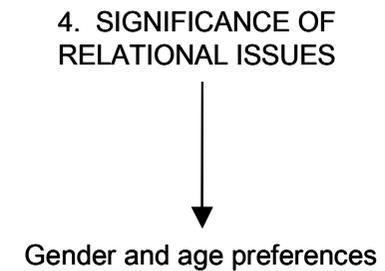
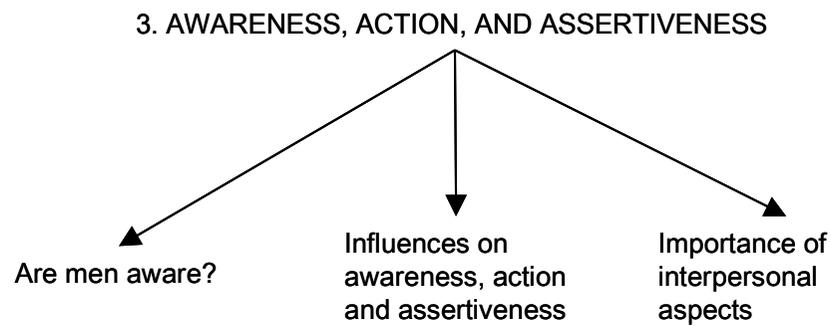
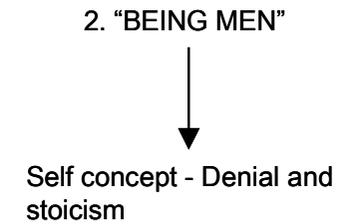
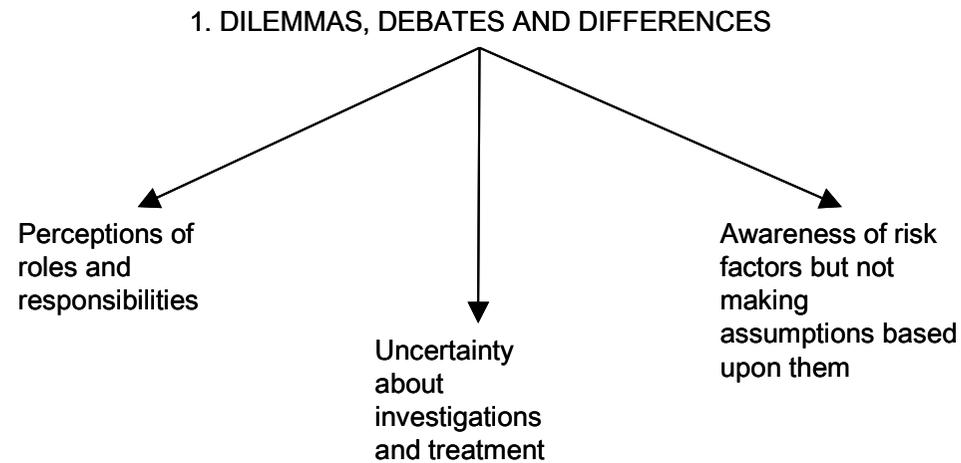
Minor amendments will be made to final quotations to improve readability. The semantic meaning of participants' responses will be retained.

Non-verbal utterances such as coughs, pauses, false starts and word emphasises were not transcribed.

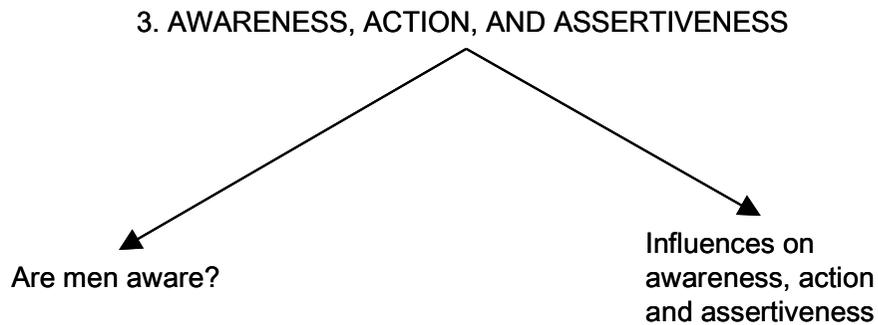
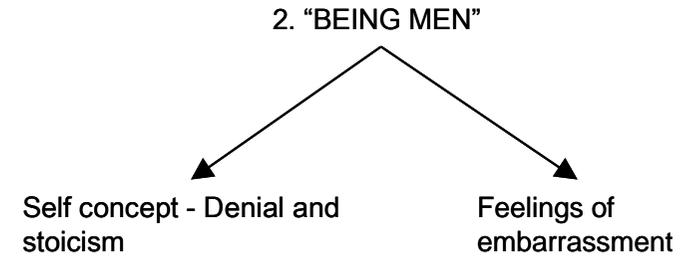
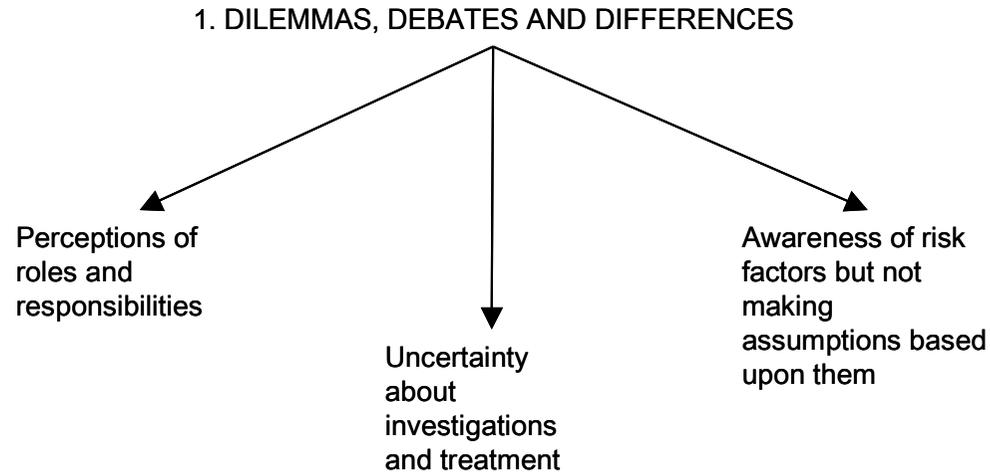
**Appendix 5.1: Final stages of theme development - Stage 1**



## Appendix 5.2: Final stages of theme development - Stage 2



**Appendix 5.3: Final stages of theme development - Stage 3 (final)**



**4. SIGNIFICANCE OF GENDER AND AGE**

## Appendix 6: Worked example

Participant 4

1 R – so kind of the first question that I wanted to ask you was  
2 what factors do you consider when a man presents with  
3 possible symptoms of prostate cancer, what kinds of things do  
4 you take into account.

5 P4 – well, this is a very complicated subject I've had this  
6 conversation already today with a man who has symptoms of  
7 benign prostatic enlargement like most of us are going to get in  
8 our lifetime and the worry of course behind all of this is a  
9 malignancy, of course benign prostatic enlargement is not a risk  
10 factor for malignancy, malignancy is quite independent of  
11 prostatism and its one of those difficult areas where the longer  
12 you live the more likely you are to have malignancy so if you  
13 live to be 100 you will have a malignant prostate and the  
14 difficulty in the discussion is trying to help people understand  
15 the inevitability of having abnormal prostate pre-malignant or  
16 malignant cells and the feasibility of doing something that is in  
17 the benefit of the patient because what is certain is that the  
18 treatment is devastating and ghastly for the man. Erm there are  
19 various attempts to minimise the trauma through different kinds  
20 of treatment but in the main men are devastated by the  
21 treatment for prostate cancer and the idea that you might be  
22 doing this and not prolonging their life in any meaningful way is  
23 quite distressing for clinicians and patients alike. Im very careful  
24 about whether to diagnose it in the first place so I need to know  
25 the age of the person, I need to know what their attitude to risk

- complicated issue of factors.  
- most of us we have Pros symbs.  
- benign not R x of malign.  
- Age factor increase malignancy  
- Challenge explaining to me - inevitable of prostate.  
- Treatment is devastating.  
- All meant it.  
- Treatment may not prolong life.  
- Not for clinicians + patient careful.  
- Age.

## Appendix 7: Demographics of Participants

Participant <sup>7</sup>	Age	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>8</sup>	Ethnic groups GPs served
Harjeet	44	Male	Asian or Asian British - Indian	British	13	20-25	White British White other Mixed white and black Caribbean Mixed white and black African Mixed White and Asian Mixed any other mixed background Asian or Asian British – Indian Asian or Asian British – Pakistani Asian or Asian British – Bangladesh Black or Black British – Caribbean Black or Black British – African Any other Black background

<sup>7</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>8</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>9</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>10</sup>	Ethnic groups GPs served
Rina	33	Female	Asian or Asian British - Indian	British	3	6	White British Asian or Asian British – Indian Asian or Asian British – Pakistani Black or Black British – Caribbean Black or Black British – African Chinese
Nisha	52	Female	Asian or Asian British - Indian	British	20	6-7	White British Mixed white and black Caribbean Mixed white and black African Asian or Asian British – Indian Black or Black British – Caribbean Chinese
Paul	Declined	Male	Declined	Declined	Declined	Declined	Declined
Ravi	35	Male	Asian or Asian British - Indian	British	5	24	White British

<sup>9</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>10</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>11</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>12</sup>	Ethnic groups GPs served
Barry	38	Male	White British	British	3	10	White British Irish White other Mixed white and black Caribbean Mixed white and black African Mixed any other mixed background Asian or Asian British – Indian Asian or Asian British – Pakistani Black or Black British – Caribbean Black or Black British – African Any other Black background Chinese

<sup>11</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>12</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>13</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>14</sup>	Ethnic groups GPs served
Michael	50	Male	White British	British	20	5	White British Irish White other Mixed white and black Caribbean Mixed white and black African Mixed any other mixed background Asian or Asian British – Indian Asian or Asian British – Bangladesh Black or Black British – Caribbean Black or Black British – African Chinese Any other ethnic group – Eastern European

<sup>13</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>14</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>15</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>16</sup>	Ethnic groups GPs served
Simran	34	Female	Asian or Asian British - Indian	British	5	5	White British Asian or Asian British – Indian Asian or Asian British – Pakistani Any other ethnic group – Polish White British Irish Mixed white and black Caribbean Mixed white and black African
Eddy	40	Male	White British	British	2	10	Mixed White and Asian Asian or Asian British – Indian Asian or Asian British – Pakistani Asian or Asian British – Bangladesh Black or Black British – Caribbean Black or Black British – African

<sup>15</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>16</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>17</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>18</sup>	Ethnic groups GPs served
Len	42	Male	White British	British	14	30	White British Irish White other Mixed any other mixed background Asian or Asian British – Indian Asian or Asian British – Bangladesh Black or Black British – Caribbean Black or Black British – African Chinese

<sup>17</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>18</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>19</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>20</sup>	Ethnic groups GPs served
James	50	Male	White other - Australian	Australian	13.5	20	White British Irish White other Asian or Asian British – Indian Asian or Asian British – Pakistani Any other Asian background Black or Black British – Caribbean Black or Black British – African Chinese
Joshua	45	Male	White British	British	15	30	White British Irish Asian or Asian British – Indian Asian or Asian British – Pakistani

<sup>19</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>20</sup> Average number of men seen for possible symptoms of PCa over the last 12months

Participant <sup>21</sup>	D.O.B	Gender	Ethnicity	Nationality	Years as GP	Average number of men seen <sup>22</sup>	Ethnic groups GPs served
Steve	51	Male	White British	British	22	50	White British Asian or Asian British – Indian Asian or Asian British – Pakistani Asian or Asian British – Bangladesh Black or Black British - Caribbean
Raymond	66	Male	White British	British	39	10	White British White other

<sup>21</sup> Pseudonyms names used to maintain confidentiality and anonymity

<sup>22</sup> Average number of men seen for possible symptoms of PCa over the last 12months