Challenges having conversations about sexuality in ambulatory settings: Part II—Health care provider perspectives

by Margaret I. Fitch, Gerry Beaudoin and Beverley Johnson

Abstract
Cancer treatment can have a significant impact on an individual's quality of life. In particular, body image and sexuality can be compromised. There is increasing evidence that conversations about these specific consequences are not happening often between cancer patients and health care providers, especially in busy ambulatory settings. This study was undertaken to explore the perspectives of cancer care providers regarding the conversations about sexuality that happen following a cancer diagnosis. There was a desire to understand more about the barriers that exist with regards to having this conversation in daily practice.

Thirty-four cancer care professionals (nurses, physicians, social workers and radiation therapists) were interviewed to explore their experiences in having conversations about sexuality. Transcripts were subjected to a standard qualitative content and theme analysis.

Six themes emerged from the analysis. Overall, participants acknowledged treatment can have an impact on a patient’s sexuality. For the most part, any conversations about sexuality topics occurred during informed consent processes before treatment began or when a patient raised a question about a side effect. However, these conversations rarely covered more than the physical side effects and did not focus on the impact of those side effects on emotional and personal relationships or intimacy. Most providers waited for patients to raise any concerns and expressed their own personal discomfort and lack of training in holding these types of conversations. They perceived the conversations as difficult for themselves and for patients.

The findings support the need to clarify role expectations for cancer nurses, as well as other members of the cancer care team, about patient care regarding sexuality, and the provision of education to support the expected role.

Introduction
Cancer and its treatment can have a significant impact on an individual's quality of life (Tierney, 2008) given there are physical, emotional, psychosocial, spiritual, and practical consequences. Body changes and alterations in bodily functions can influence body image, self-esteem, fertility, and sexual functioning (Tan, Waidman, & Bostick, 2002; Reese, 2011). Sexuality is an important aspect of quality of life (Shell, 2002) and a central aspect of being human (World Health Organization, 2002). Unresolved issues regarding sexuality stemming from cancer treatment contribute to heightened emotional distress (Schover, 1999; Tierney, 2008).

Providing person-centred or whole person cancer care includes attention to sexuality (Institute of Medicine, 2007) and is cited as an important dimension of quality cancer care (Institute of Medicine, 2001). However, studies reveal sexuality needs frequently remain unmet (Harrison, Young, Price, Butow, & Solomon, 2009) and patients report their concerns about sexuality are not always addressed during their visits with physicians and nurses (Fitch, Deane, & Howell, 2003; Hughes, 2000; Lindau, Surawska, Paice, & Baron, 2011; Penso, Gallagher, Gioiella, Wallace, Borden, Duska, et al., 2000). Although health care professionals may be aware of sexual concerns experienced by cancer patients, it appears discussions about sexuality may not be happening in daily practice.

Purpose
This study was undertaken to gain an increased understanding about the dialogue between cancer care professionals and cancer patients regarding the topic of sexuality. There is limited evidence to describe the barriers that exist, which limit this dialogue, or how the barriers may be overcome in a busy ambulatory care setting. Ultimately, the work was undertaken to provide a basis for improving the care of cancer patients who have difficulties concerning sexuality related to their disease and treatment. The study gathered views from both patients and health care professionals. This article focuses on the perspectives of the health care providers while the views of cancer patients are reported in a separate article (Fitch, Beaudoin, & Johnson, 2013).

Background
In Canada, approximately 177,800 individuals are diagnosed with cancer annually (Canadian Cancer Society, 2011). This number is expected to increase 50% by the year 2020 (International Union Against Cancer, World Health Organization, 2002). The impact of cancer treatment on individuals has been well documented and presents a clear picture of physical, psychosocial, emotional, and practical consequences (Fitch, Page, & Porter, 2008; Harrison et al., 2009). Advances in screening and treatment have resulted in an ever-increasing number of individuals who survive after treatment (Sun et al., 2002) making an emphasis on the survivorship experience and rehabilitation of paramount importance (Braude, MacDonald, & Chasen, 2008).

According to the World Health Organization, sexuality is a central aspect of being human throughout life (WHO, 2002). Sexuality is a multidimensional issue, and involves physical, psychological, interpersonal and behavioural dimensions (Hughes, 2000). Expressed through various avenues, it concerns giving and receiving sexual pleasure and is associated with belonging and acceptance by another (Shell, 2002). Identity, self-image, and esteem are integral to sexuality (National Council on Aging, 1998).

Over the past decade, the literature describing the impact of cancer treatment on sexuality has grown (Hordern, 2008; Mercadante, Vitrano, & Catania, 2010; Reese, 2011). From early publications regarding breast (Meyerowitz, Desmond, Rowland, Wyatt, & Ganz, 1999) and gynecologic patients (Andersen, Woods, & Copeland, 1997), the literature has expanded to include other cancer groups such as...
lung (Reese, Shelby, & Abernethy, 2011), gastro-intestinal (Reese, Shelby, Keefe, Porter, & Abernethy, 2010), bladder (Fitch, Miller, Sharir, & McAndrew, 2010), hematology (Yi & Syrjala, 2009) and prostate (Latini, Hart, Coon, & Knight, 2009). Of note, much of the early literature focused on sexual dysfunction and physical changes following treatment, whereas more publications now incorporate a broader conceptualization of sexuality that embraces the whole person, including psychosocial, spiritual and inter-personal relationships (Katz, 2005).

The specific impact of cancer treatment on sexuality is closely aligned to the location of the cancer and the nature of the treatment. The impact can include loss of desire, erectile disorder, orgasmic dysfunction, and decreased sexual activity (Harrison, et al., 2009; Avis & Deimling, 2008; Lockwood-Rayerman, 2006; Eton & Lepore, 2002; Jonker-Pool, et al., 2001). There is growing recognition that all modes of treatment have the potential to influence sexuality (Mercadante, Vitrano, & Catania, 2010) and the impact may be felt at any point along the cancer journey (Brearley et al., 2011), including advanced and palliative stages (Redelman, 2008; Stausmire, 2004). Sexual concerns have been associated with higher symptom distress (Sarna, 1993; Reese, 2011) and have been reported by 10% to 90% of cancer survivors at some point during or following treatment depending upon the disease site, sex, and treatment type (Syrjala, et al., 2000; Jeffry, 2001). Given this reality, health care providers caring for patients with all types of cancer must consider issues of sexuality in their daily practice.

Unfortunately, there is evidence from both quantitative and qualitative studies that cancer patients have unmet sexuality needs. Harrison, et al. (2009), following a review of 94 articles assessing supportive care needs of cancer patients, described unmet sexuality needs for patients in treatment (49%-63%) and in the follow-up or survivor phase (33%-34%). This level of unmet need suggests that conversations about sexuality do not occur on a routine basis in daily practice. Although studies have reported similar observations about shortcomings (Fitch, Deane, & Howell, 2003; Hughes, 2000; Penson et al., 2000) investigations about the barriers to holding these conversations, especially in busy ambulatory clinic settings, have not been conducted. Thus, our work was undertaken to explore the perspectives of both patients and health care providers about holding conversations concerning sexuality in the daily practice of ambulatory cancer care. In particular, we wanted to understand the barriers that exist to having these conversations and how they might be overcome. This article will focus on the perspectives of the health care providers.

### Table 1: Selected demographics of participants

<table>
<thead>
<tr>
<th>Discipline interviewed</th>
<th>Number of participants (N=34)</th>
<th>Disease site represented in practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse (caseload all cancer patients)</td>
<td>12</td>
<td>breast, gastrointestinal, genitourinary, lung</td>
</tr>
<tr>
<td>Physician/surgeon (full time oncology practices)</td>
<td>11</td>
<td>breast, gastrointestinal, genitourinary (prostate), gynecologic, head &amp; neck, hematology, lung</td>
</tr>
<tr>
<td>Social work (caseload all cancer patients)</td>
<td>6</td>
<td>breast, central nervous system, gastrointestinal, genitourinic, head &amp; neck, lung</td>
</tr>
<tr>
<td>Radiation therapist (caseload all cancer patients)</td>
<td>5</td>
<td>treat all disease sites</td>
</tr>
</tbody>
</table>

### Methods

#### Design

The study utilized a qualitative descriptive design. Participants engaged in an in-depth semi-structured interview, on one occasion, with a skilled qualitative interviewer to discuss their perspectives about having conversations with their patients about sexuality. The study protocol was approved by the ethics committee of the hospital prior to initiation of the study.

#### Sample accrual and procedures

Accrual for this study utilized a purposive, convenience approach. We wanted to ensure there were health care providers who cared for patients with various types of cancers. A list was drawn up of the oncologists, nurses, social workers, and radiation therapists who cared for patients in each disease site group (i.e., breast, gastrointestinal, head and neck, etc.). Using the list, the research assistant contacted individuals from each of the disease site groups and informed them about the study. Invitations were extended until the sample contained individuals from each disease site group at the ambulatory cancer centre. Those who consented to participate engaged in one interview conducted in person by a skilled qualitative interviewer. The interviews were audiotaped and lasted between 30 and 45 minutes.

#### Interview guide

The interview guide was developed by the authors for the purposes of this study to elicit perspectives of health care providers about having conversations with patients regarding sexuality. The same guide was used for all participants. Initially questions were posed to determine the proportion of patients who raised issues of sexuality with the participant during routine clinical practice and the frequency with which the participant initiated the topic. Each participant was then asked to describe a clinical scenario where the patient raised an issue related to sexuality and one where the participant raised the issue. This provided an opportunity to explore the nature of the interactions and the specific types of issues considered as sexuality ones. The concept of sexuality was not defined ahead of time for the participants. Following the discussion about the clinical scenarios, the participants were asked to talk about the obstacles they thought prevented patients from raising the topic of sexuality and the obstacles they thought existed for health care providers. Finally, the participants were asked to reflect upon their professional role related to issues of sexuality in cancer care and what could facilitate the conversations between patients and their health care providers.

#### Analysis

The interviews were transcribed verbatim and subjected to a standard content and thematic analysis (Denzin & Lincoln, 2000). The authors read through the transcripts independently making marginal notes about the content. Following a discussion about their impressions of the interview data, they created content category codes and definitions. The entire set of transcripts was coded according to the content categories by one individual. Subsequently, review of the coded data by the authors allowed comparison across participants’ responses and identification of common perspectives. These common perspectives are reported as themes in the findings section below.

### Findings

#### Sample characteristics

Thirty-four cancer care providers participated in the study. The sample consisted of medical (n=3), surgical (n=4) and radiation (n=4) oncologists; nurses (n=12) and social workers (n=6) who are assigned to specific patient populations, and radiation therapists (n=5) who work across all disease types. Table 1 presents selected demographics of the sample.
Themes

Six themes emerged from the analysis of the interview transcripts. Each theme will be highlighted below with illustrative quotes from the participants. Following the themes, the recommendations made by these participants will be shared.

Theme 1: The extent of the impact cancer and cancer treatment can have on a person’s sexuality varies by the site of cancer.

Without exception, the participants described sexuality as an important aspect of a person’s life and acknowledged it was part of whole person care. Each provided examples of how cancer treatment could result in changes in sexual functioning and appearance and, in turn, how these changes might influence body image, self-esteem, and relationships. The extent of any change was described as a function of the tumor location and the nature of the required treatment. For example, gynecologic surgery was described as bringing about different changes than breast cancer surgery; radiation for a brain tumor will bring about different changes than radiation for prostate cancer. Because of anticipated types of changes, participants expected conversations about sexuality to be different across the various disease site practices. In the words of one physician who treats prostate patients: “If they don’t bring it up, then I do because the treatment can affect sexuality in all of the patients. I mention it before treatment decisions are made and ask how much they want to know.” (MD-P3) In another interview, a nurse caring for individuals with CNS cancer indicated, “I never raise it with them, as they are so impaired. I just don’t.” (RN-P4) While another nurse indicated, “I raise the topic of sexual functioning with all my patients with cervical cancer, but never with my breast cancer patients because they only get radiation.” (RN-2)

Theme 2: Sexuality is not perceived as a priority for cancer patients, especially during diagnostic and treatment.

Despite acknowledging sexuality as an important aspect of whole person care, participants indicated they thought it was not a priority for cancer patients in light of the life-threatening nature of cancer. Especially during the diagnostic and treatment phase, they perceived the priority for cancer patients as getting treatment underway and curing the disease. In the words of one physician, “I think patients want to treat the cancer first and foremost.” (MD-3) Additionally, few participants thought sexuality would be a concern at the end of life. “I never raise the issue with palliative patients. It just seems to be the least of their problems then.” (MD-P3)

Participants associated the treatment interval with the presence of side effects and patients being too ill to focus on sexual matters. In the words of one provider, “I would not bring up anything associated with sexuality with head and neck cancer patients. They are just too miserable to even think of sex. If you can’t eat, you can’t swallow, you barely breathe, sex is the last thing on your mind.” (RT-28)

Theme 3: If sexuality is going to be a concern for cancer patients, it will occur after treatment is finished.

The majority of participants expressed the view that if sexuality was going to be an issue for patients it would emerge later in the course of the cancer journey. In the words of one nurse, “Not with patients on treatment, it is more an issue before and after treatment.” (RN-1) Participants found that, following treatment, as patients started living with the changes in their bodies, a few patients raised concerns related to sexuality with them. During the treatment interval, the topic of sexuality was not raised. Following treatment, loss of a breast, treatment-induced menopause, stomas, fatigue, and erectile dysfunction were cited as examples of changes patients raise that could affect sexuality. Even so, these participants generally did not find that patients raised sexuality issues very often. They perceived this observation as indicating not many patients experienced concerns about sexuality.

Theme 4: Conversations about sexuality occur most frequently in the context of informed consent discussions prior to surgery or treatment or if the patient asked a specific question.

Overall, participants reported that patients themselves rarely raised the topic of sexuality. Depending on the type of cancer, participants estimated the proportion of patients who initiated the conversation varied. For example, a large number of men with prostate cancer asked questions about erections and potency in contrast to patients with lung cancer. Often, when issues were raised, they were focused on symptoms or side effects and did not focus initially on intimacy or personal relationships.

In terms of the health care provider initiating conversations related to sexuality, this occurred most frequently during the discussion of treatment plans and the potential physical side effects of the particular treatment. For example, one nurse shared the following: “I speak to the young men with testes cancer about sperm banking and fertility, but rarely initiate any conversations about the patient’s situation otherwise.” (RN-18) Participants acknowledged that the impact side effects can subsequently have on emotions, intimacy, and relationships was not necessarily specified during these discussions. The process of informed consent most frequently provided the context for the conversation. During this conversation, a patient might ask a specific question about the treatment effects, particularly in the case of surgical or radiation treatment to a specific body part (i.e., pelvis, prostate, vagina, breast, etc.). Otherwise, the majority of these health care providers did not raise the topic again. They waited for the patient to introduce it.

Theme 5: If cancer patients have difficulties or concerns about sexuality, they will ask questions or tell the health care professional.

For the most part, the participants shared the viewpoint that patients experiencing difficulties related to sexuality, because of the cancer treatment, would raise these concerns during clinic appointments. They frequently waited until the patient voiced any concerns about sexuality rather than inquire about them.

Concerns related to physical side effects were described as the most likely route for raising topics of sexuality. For example, vaginal dryness, the inability to achieve an erection, and pain were examples of side effects that might be raised and could interfere with intimacy. However, it was noted that these topics could be raised by the patient and discussed together without in-depth conversation about intimacy or personal relationships.

Theme 6: Having conversations about sexuality is difficult for a variety of reasons.

The participants described conversations about sexuality as difficult ones for themselves and for patients. Various reasons contributed to this difficulty (see Tables 2A and 2B). Participants stated the topic is a private, personal one and individual comfort levels with talking about it vary widely. In particular, age, culture, and religion can influence whether or not patients are comfortable with conversations about sexuality. In many respects, sexuality is still seen as a taboo topic.

For these provider participants, time, clinical priorities, and training were described as key influences regarding whether or not conversations were initiated. As one physician described, “The big issues are time and lack of knowledge; not many of us are trained for this.” (MD-3) Participants thought most of their health care colleagues would not be very comfortable with the topic and would have difficulty engaging in conversations about it. These conversations were seen as complex and needing to be handled sensitively and in privacy. Few had received any training in the topic area and most did not feel adequately equipped to have the conversation. “I think most of us try to stay away from the topic because we don’t know how to handle it.” (MD-4)

The majority felt they had a role in letting the patient know it was appropriate to talk about the topic and, if issues were raised, to help the person obtain appropriate help whether it be information,
advice or counselling. However, in light of the many disease-related issues and the heavy caseloads in the ambulatory setting, taking the time for these types of conversations was not seen as a priority. The view that disease-oriented care was the priority was expressed most clearly by the physician and radiation therapy participants. For example, one physician stated, “We focus on cancer and treatment, we don’t want to miss a recurrence. With the limited time we have, that has to be the priority.” (MD-16) In comparison, nurse and social work participants more readily described their roles as including concerns about sexuality as part of their practices. In the words of one nurse, “It’s important that patients know you are open to any and all discussion, and we need to tell them that.” (RN-23)

### Suggestions from participants to facilitate conversations about sexuality

Participants shared three key ideas about what would facilitate the conversations with cancer patients about sexuality. In the first instance, they felt specific training in how to have the conversations with patients about sexuality would be important. The focus of the training would need to be on how to identify the specific issue, what was concerning to the patient, and the best route for referral and intervention. Part of the conversation would be to work through with the patient what route was acceptable to the individual. Participants thought educational sessions that included role playing for the health care professionals and focused on practical aspects of care related to sexual issues would be most helpful to them.

| Table 2(A): Health care provider perspectives: Why conversations about sexuality are difficult for cancer patients |
| --- | --- |
| **Reason for difficulty** | **Examples of comments** |
| Age | Younger patients are more apt to bring it up. They seem more open and comfortable with the topic. Most elderly are not as comfortable with it. (MD-15) |
| Culture | It is not appropriate in some cultures to talk about this topic… and beliefs can be hard to overcome… it is a taboo topic for many. (SW-17) |
| Private, personal topic | Both partners may not want to talk about it with others. It’s very personal. They may not be interested or perceive that cancer patients should not have sexual needs… or feel it is not related to the cancer. (RN-P4) Depending on who is in the room makes a difference… and comfort with us as providers. (RN-27) |
| Embarrassment/ comfort talking about topic | Guilt, fear can be an obstacle, I think. (RT-29) Some patients may think it is a bit shallow to be thinking about sex or have concerns like that… I have cancer, should I be worrying about sex? They are embarrassed to bring it up or don’t know how to raise it. (RN-1) It can be embarrassing to talk in front of family members, for example, a man talking about potency in front of his daughter. (MD-P3) |
| Gender | I think it can be hard for a woman to talk with a male about sexuality. Female to female or man to man would be better. (RN-21) It would likely be difficult for a woman to raise the issue with a male doctor and, perhaps, vice versa, a male with a female doctor. (MD-4) |
| Language | We can get into difficulties because of language and needing a translator… say, having a son translate for a mother and talk about using a dilator. (RN-2) |
| Overwhelmed with the situation of having cancer | Patients are overwhelmed with everything and they don’t hear. They really do not understand the implications of what they hear or are in denial about it. (RN-1) In light of having a life-threatening illness, how does one raise the issue of sexuality? (MD-4) There is just such an overwhelming emphasis on the disease, on the cancer. Sexuality is not promoted as an issue or even generally acknowledged. (SW-6) It is the last thing on patients’ minds at the beginning; they are just focused on the diagnosis and treatment; it comes up more later, in the long term. (SW-8) |
| Trust and rapport with health care provider | Patients need to have a personal comfort with me, as a health care professional. It is a tough issue to talk about and they need to trust me. (SW-P1) I think it depends to a large extent on the relationship between the patient and the doctor and how comfortable they are… how good the rapport is and how much they want to confide and trust. (MD-P3) |
| Perceived time with health care provider | I think patients prioritize what they will talk about. They know they only have so much time with you. I think they have their mind set on the disease. (MD-19) |
| Sexual orientation | Patients in same-sex relationships can have difficulty raising the topic. (RN-1) If an individual is a homosexual, it is hard. (SW-7) |
| Relationship between partners | If there is any issue with sexual abuse, that is hard to talk about. (RN-2) |
| Perspective on role of cancer centre and providers | I wonder if patients even think about asking us or see it as our role; do they look to this place to deal with this type of issue? (SW-6) Patients are focused on the disease and the oncologist is not who they expect would deal with this issue. (SW-9) I can see how they might not think it would be my area, to discuss it with me. I don’t think they see that it is my role. (MD-15) I wonder if the patients even think it is our role? (RT-29) |
Secondly, participants thought having a list of available services and knowing what was offered by those agencies in terms of sexuality information and counselling would be helpful to them in talking with the patient and making the best referral. In particular, having an individual on staff with specialized knowledge in sexuality was also flagged as beneficial. This individual could be consulted for ideas about how to work with specific patients or actually be a referral source for more complex situations.

Finally, participants recommended the creation of appropriate educational materials for patients as important. The materials ought to be in a written format and focus on what issues to expect for particular disease sites and treatment, what interventions are available, and what resources can be accessed. These materials could be used in the conversation, as well as given to patients or posted on the clinic website. The idea that patients ought to have access to information about the impact of cancer and treatment on sexuality was supported by the health care professional participants.

**Discussion**
This study was undertaken to identify the perspectives of cancer care providers about holding conversations regarding sexuality. Participants reflected a cross-section of the health care professionals working in an ambulatory cancer centre. Both males and females were included, as well as individuals caring for cancer patients with different types of cancer. Given the study was conducted within a single cancer centre and would benefit from replication with

### Table 2(B): Health care provider perspectives: Why conversations about sexuality are difficult for professionals

<table>
<thead>
<tr>
<th>Reason for difficulty</th>
<th>Examples of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time (patient load and clinic flow)</strong></td>
<td>I don’t think the doctors and the nurses have the time for these conversations. Me, I have more time. Besides, their priority is on the disease. (SW-P1) You really don’t have the time to sit down and talk to a patient for half an hour on a one-to-one basis. There are so many things happening at the same time. There are pressures to finish on time and patients are waiting so long. (RN-25) If they started a conversation of that magnitude it could take a lot of time and time is a very precious commodity around here. (RT-26)</td>
</tr>
<tr>
<td><strong>Priority of clinical care on disease</strong></td>
<td>You need to have a conversation before surgery about what will happen and what will happen afterward. It has to be part of every pre-op conversation. But it is pretty much focused on the physical structures and the surgical changes. (MD-12) When we look at the list of priorities, disease control is one thing that’s important... sexuality wouldn’t rank at the top of the list. (RN-23) We are here to get rid of the disease and that's the number one priority... nine times out of ten staff don’t even think of the other stuff unless the patient brings it up. (RT-28)</td>
</tr>
<tr>
<td><strong>Personal comfort with topic</strong></td>
<td>I think our own personal comfort with the topic is one of the reasons [it is difficult to talk about it], our upbringing and experience with it. (RN-2) Providers need experience, personal comfort with the topic, tools to help talk about this. It's a difficult topic and we need to be comfortable ourselves. (RN-10)</td>
</tr>
<tr>
<td><strong>Lack of training (experience and knowledge)</strong></td>
<td>I really think health care professionals are uncomfortable with the topic. They have not had much training in it and lack the knowledge about what to do to help. (RN-P2) In general, there is a lack of skill in having the conversations. It is a difficult topic and professionals need to be trained properly. (SW-7) You need to have knowledge about what is available and what can be done. (MD-12) I think it’s about being somewhat anxious that you might not have the answers. It’s difficult to strike up a conversation if you don’t know what the answer might be. (RN-13) I really don’t feel equipped to do it, not only because we do not have enough time, but I don’t feel fully qualified or knowledgeable to deal with it. (RT-30)</td>
</tr>
<tr>
<td><strong>Privacy</strong></td>
<td>You need a private space to talk about this. The clinic is not always the best setting. (SW-8) This is a topic that requires uninterrupted time to talk about it and privacy. (RN-18)</td>
</tr>
<tr>
<td><strong>Perspective on own role</strong></td>
<td>I see my role as one of the time and creating a way to open the topic and explain things to the patient. It is a medically necessary discussion. (MD-P3) It is probably more relevant for medical oncology practice than for a radiation oncology practice. (MD-4) I really do not see my role as one of dealing with sexuality issues. You need time, confidence and knowledge to do it. And you haven't got that when you are trying to manage the disease... and that is the priority for me. (MD-11) I think there are some physicians who see their role as treatment, their priority is attending to the disease. (SW-6) I see that it is important for patients to know about the side effects and to talk about the potential complications. I see that as part of the care I give... I refer also to psychology, as needed. (RN-1) I see my role as focusing on the side effects, but keeping the door open for other conversations. (RN-10) I don’t think we should be asking them unless the surgery caused the issue. Or if they are having problems in the area. If they ask, okay, but we shouldn’t push them. (RN-14) I see my role as counselling based on what the patient requires. The nurse deals with the physical side effects and I deal more with the emotional and relationships issues. (SW-7) I think it is our responsibility to bring it up if it relates to treatment. (RT-27)</td>
</tr>
<tr>
<td><strong>Incentive</strong></td>
<td>There needs to be incentives to talk about this. Paying for the time would help. (MD-20)</td>
</tr>
</tbody>
</table>
participants from another setting, the cross-sectional nature of the sample provided insight into the varying perspectives health care professionals hold regarding conversations about sexuality across disease site groupings.

Despite the different professional/disciplines represented in the sample, there was a surprising amount of similarity in the perspectives held by the individuals. All acknowledged sexuality was an important dimension of being human and were aware of the potential for cancer treatment to have an impact upon sexuality. All shared the perspective that having a conversation about sexuality was difficult for both health care professionals and for patients. However, it was clear that individual practices concerning conversations about sexuality varied considerably and were closely linked with individuals' personal comfort, philosophy of care, perception of role, and preparation concerning the topic area (including education, skill training, and confidence). No one described policy or explicitly stated expectations about how this topic was to be handled in the clinical setting.

The only consistency in practice regarding conversations about sexuality occurred within the informed consent processes for cancer treatment. Health care professionals stated that they mentioned topics that could be linked to subsequent changes in sexuality. However, the focus of the informed consent conversation was upon the side effects that might be experienced and not necessarily upon the impact those effects could have upon emotions, body image, self-esteem, or personal relationships. For example, treatment-induced menopause would be mentioned as a potential side effect, but the specifics of a dry vagina or the emotional grief associated with infertility was not discussed during the informed consent conversation.

Similarly, health care professionals described that the focus of routine monitoring, during and after treatment, was on the presence of side effects and not on the deeper topic of the subsequent impact the side effects had upon the person. Pain on intercourse might be mentioned and documented by the health care professional, but the impact on the individual patient's personal relationship or sense of loss related to lack of intimacy would not be discussed. The majority of clinicians in this study practised the approach of waiting until the patient raised any concerns about sexuality of a personal or deeper nature; they rarely, if ever, raised the topic themselves. Of note, in the companion study investigating patient perspectives concerning conversations about sexuality (Fitch, Beaudoin, & Johnson, 2013), patients described waiting for the health care professional to raise the topic and signal that it is appropriate to ask questions about it or share their concerns.

The majority of the participants in this study saw a role for themselves (or their professional group) regarding sexuality and believed that patients ought to have information about the impact of cancer treatment on sexuality and available resources. However, most thought their colleagues would be uncomfortable engaging in conversations about sexuality and identified significant barriers to holding these conversations in busy ambulatory settings. The barriers they identified raise the question about what the best approach would be in this setting. In all fairness, the complexity of the topic and the need for privacy and sensitivity, coupled with the pressures of time, increasing daily caseloads, and the expressed lack of preparation and comfort on the part of cancer care providers present challenges in responding to patient concerns regarding sexuality. Clearly there is a need to clarify roles and responsibilities for holding conversations with patients about this topic and for health care organizations to think about the processes and locations for care.

The solutions for responding to patient concerns regarding sexuality may lie beyond the actual clinical appointment. The actual clinical appointment exchange may be best focused on signaling to the patient that it is alright to raise the topic and conducting a brief exploratory conversation about the issue when it is raised. Providing basic information about sexuality impact, as well as checking regularly with the patient if bodily changes are having an impact, is also doable for health care providers in a busy clinic environment. Making patient education materials is also feasible and beneficial. However, the actual in-depth and personal conversation for those patients or survivors with concerns about sexuality may need to be purposefully scheduled at another time and in another setting outside the routine clinic appointment. The practitioners holding these in-depth conversations ought to be individuals who are comfortable and well prepared for these exchanges.

**Implications for practice**

This work emphasizes the need for cancer centres to develop strategies that ensure attention to patient concerns about sexuality are integral to routine clinical practice. The standard of care should be established that all patients are informed about the potential impact of cancer treatment on sexuality. This information exchange ought to occur early in the patient's cancer journey. This information needs to be about more than side effects alone. Descriptions about how side effects could alter self-esteem, personal relationships and physical intercourse need to be clear. This information ought to be easily available to patients across all cancer disease types and include a list of available resources to help with concerns the patient is experiencing.

Health care professionals need to have clearly stated role expectations about having conversations regarding sexuality, established by managers in the setting, and appropriate preparation to perform to those expectations. In particular, the oncology nurse ought to be able to provide basic education about the impact of cancer treatment on sexuality and conduct a basic assessment to identify patient concerns (Katz, 2005). Furthermore, basic assessment should include the determination of whether the individual wants assistance with the concern. This approach is what patients themselves have described as desirable (Fitch, Beaudoin, & Johnson, 2013) and should acknowledge that not all patients want help with supportive care issues at a specific point in time (Steele & Fitch, 2008). The key practice approach is being able to open a conversation about the topic and tailor the subsequent assessment and follow-up actions to the individual context (Katz, 2005).

Given the personal discomfort with the topic that health professional participants expressed in this study, there is a need for education (knowledge and skill development) of staff. Education could focus on how to hold the basic conversation about sexuality, when it is appropriate to refer the patient to another provider or service, and when it is appropriate for an oncology nurse to offer intervention. Recently, an online course about sexuality in cancer has been made available through the Inter-professional Psychosocial Oncology Distance Education (IPODE) Project at [http://www.ipode.ca/english/announcements.html](http://www.ipode.ca/english/announcements.html). The Canadian Cancer Society also has an excellent booklet on sexuality that can be helpful to nurses and to patients alike.

Cancer programs also need to consider developing focused sexuality educational programs, clinics or services for patients and have clearly articulated referral pathways to community based services. Group-based educational programs can be helpful and recent online group interventions have been introduced successfully (e.g., [http://www.cancerchatcanada.ca/page.php?p=support/online_support](http://www.cancerchatcanada.ca/page.php?p=support/online_support)). Nurse-led sexuality clinics that offer in-depth education, counseling and evidence-based interventions have also provided successful approaches (Barbera et al., 2011). For those individuals with identified sexuality problems, referral to a qualified practitioner may be the most useful approach. Ensuring these referrals are timely and easily navigated by the patient is important in order to avoid added distress.

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