A diagnosis of localized prostate cancer propels patients and their partners into the complex realm of decision making. The decision-making process and final choice of treatment affect quality of life (QOL). Physical, social, psychological, and spiritual aspects of QOL all can be impacted. Making a choice regarding cancer treatment is a high-risk decision. The decision-making process for localized prostate cancer is complicated further by a lack of scientific evidence that supports one treatment rather than another.

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initiation, a time when significant decisions must be made. The research literature is replete with examples of the emotional work that occurs in the immediate response period. Although changes too numerous to count have taken place in oncology care in the past 20 years, one of the most striking has been the increased involvement of patients and family members in making decisions. Active involvement in the decision-making process now is expected of patients. Some patients embrace this new participatory role and others find it overwhelming (Frosch & Kaplan, 1999; Woolf, Krist, Johnson, & Stenborg, 2005).

This article will address QOL as it relates to the decision-making process regarding prostate cancer treatment. How men with early-stage prostate cancer make treatment decisions and the effects of those choices on QOL will be discussed.

Quality of Life

QOL dimensions have been well described in the literature, expanding on the seminal work of Betty R. Ferrell, RN, PhD, FAAN, and colleagues (Ferrell, Dow, Leigh, Ly, & Gulasekaram, 1995; Ferrell et al., 1992). Although several models exist, the most frequently identified dimensions of QOL are psychological, physical, social, and spiritual well-being. Each dimension is explicated further; for instance, psychological well-being considers changed priorities, anxiety, the idea of a second chance, and fear of recurrence. Similarly, social well-being focuses on financial burden, role relationships, work, family relationships, and aspects of sexuality. The four dimensions are affected by the diagnosis of prostate cancer, the treatment decision-making experience, and the treatment.

Prostate Cancer Screening and Treatment Option Controversies

Each year, approximately 20,000 men and their physicians struggle with the decision of which treatment, if any, is best for newly diagnosed prostate cancer. No other disease with such compelling incidence levels has so many available treatment options yet so few certainties regarding outcome (Montie, 1994). Treatment options have expanded rather than narrowed in recent years and now include watchful waiting or observation, radical prostatectomy, brachytherapy, external beam radiation therapy (XRT), hormonal therapy, cryotherapy, or a combination. Although healthcare providers have solid evidence of treatment outcomes, evidence of treatment benefits is lacking (Bermejo et al., 2004). The National Comprehensive Cancer Network ([NCCN], 2007) guidelines for the treatment of localized prostate cancer defined low risk of recurrence as men with T1 or T2 disease confined to the prostate, a Gleason score from 2–6, and a prostate-specific antigen (PSA) value of 10 ng/ml or less. For men with a low risk of recurrence and life expectancy of 10 years or more, radical prostatectomy with or without lymph node dissection, three dimensional conformal XRT, brachytherapy, and watchful waiting are recommended treatment options. For men with localized disease, a low risk of recurrence, and an estimated lifespan of less than 10 years, radical prostatectomy is not a recommended treatment option. The guidelines are based on NCCN category 2A evidence, which is defined as a uniform

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NCCN consensus derived from low-level evidence that includes clinical experience.

Prostate cancer screening and treatment controversy exists because current screening with PSA testing identifies a significant number of tumors that, if left untreated, may not cause disability or death. Until recently, prostate cancer was largely a disease of older men, who died from other causes (i.e., dying with prostate cancer rather than because of it). Men who have regular PSA testing effectively double the risk of being diagnosed with prostate cancer (Barry, 2006). The relatively poor specificity of PSA testing results in high rates of false positives, which necessitate numerous biopsies that cause men to feel anxious and uncertain even when conditions are benign. Data from the Prostate Cancer Prevention Trial revealed that 15% of men with a PSA level of less than 4 ng/ml, which is considered a normal PSA, had prostate cancer, of which 15% had high-grade disease (Thompson et al., 2004). Of men screened, 92% have a PSA level of 4.0 ng/ml or less (Thompson et al.). Clearly, although considered normal, a PSA level of 4.0 ng/ml or less is an indicator of the majority of prostate cancer cases. Healthcare providers are unprepared to assist men with prostate cancer in making treatment-related decisions. The current state of the science does not allow healthcare providers to make predictions as to whether low-grade tumors detected in men with low PSA levels pose a true health risk (Bermejo et al., 2004).

Numerous well-designed studies have provided strong evidence regarding the short- and long-term morbidity of prostate cancer treatment and its harmful effects on QOL. Men are being diagnosed at younger ages, increasing the number of years they will live with distressing side effects of treatment, which include erectile and bowel dysfunction and urinary incontinence. The incidence of the treatment-related side effects is difficult to ascertain from the literature. For example, incontinence rates following prostatectomy range from 2%–87% (Palmer, 2000). The wide variance can be attributed to measurement methods and differing incontinence definitions. Urinary incontinence rates also vary by age, with younger men experiencing less incontinence than men older than age 65 (Catalona, Carvalhal, Mager, & Smith, 1999).

Erectile dysfunction is a particularly distressing treatment side effect for men and their partners. The exact incidence of erectile dysfunction as a treatment-related side effect is difficult to determine because of the absence of a uniform definition and because older men experience erectile function as a result of concomitant medical conditions (e.g., diabetes, hypertension) and commonly prescribed pharmacologic agents (e.g., beta-blockers). Conflicting data have been reported. Lim et al. (1995) found significantly higher rates of impotence following radical prostatectomy compared with XRT, whereas
Walsh, Marsche, Ricker, and Burnett (2000) reported potency rates of 38%, 54%, 73%, and 86% at 3, 6, 12, and 18 months postradical prostatectomy, respectively. In a retrospective review of 142 men undergoing brachytherapy, Davis, Kuban, Lynch, and Schellhammer (2001) reported that prostatectomy was associated with significantly worse sexual function than brachytherapy. Although the studies provide evidence that treatment for early-stage prostate cancer is associated with significant impacts on QOL, what remains unclear is to what extent and how consideration of potential side effects influences patients’ decision for treatment.

Why Men Choose One Treatment Option Rather Than Another

Choosing a treatment option for early-stage prostate cancer involves many factors. The decision-making process is collaborative in nature, involving patients, their partners, and the healthcare team. The decision is affected by medical considerations and a patient’s general health status, life expectancy, comorbidities, and unique preferences. Other key factors include disease stage and Gleason score. In addition, patient factors, such as personal preferences and biases toward and against specific treatment modalities, can influence which treatment patients choose. Patients also report that prior cancer experiences and those of influential others affect their decisions, as well as concerns about potential side effects of therapy, costs of treatment, lost time from work, and tolerance of uncertainty (Berry et al., 2003; O’Rourke, 1999, 2001; O’Rourke & Germino, 1998).

A recent meta-analysis of 69 studies exploring treatment decision making among men with early-stage prostate cancer examined common themes that influenced patients to choose one treatment option rather than another (Zeliadt et al., 2006). Eradication of cancer was a universal concern and the primary factor in the treatment decision for most men. In a study involving 1,000 patients (Crawford et al., 1997), 42% of men defined an effective treatment as one that extended survival and/or delayed disease progression; however, 45% of men indicated that effective treatment meant preserving their QOL.

Treatment options can take on special significance. Patients in a focus group study and a larger longitudinal study (O’Rourke, 1999; O’Rourke & Germino, 1998) frequently identified surgery as the only way to eradicate cancer. “The only chance of cure is removal. Prostate cancer is like a bad spot in an apple. If you don’t get rid of the bad spot, pretty soon the whole apple will be brown,” a patient said (O’Rourke, 1999, p. 355).

The theme has been echoed in numerous other explorations. Maliski, Heilemann, and McCorkle (2002) reported that men expressed a strong desire to “get the cancer out” and believed that the only certain option to remove the cancer was surgery. Berry et al. (2003) cited a man who said, “Maybe I can cure it with surgery, then that took precedence. So, getting all the cancer cells is important—more important to me than... preserving sex life (p. 96).”

In a study of 119 men with localized prostate cancer, Gwede et al. (2005) reported that 44% of men chose radical prostatectomy and 56% chose brachytherapy. Men who chose surgery were significantly more likely to identify surgery as curative, which was the primary reason they chose it. Men who chose brachytherapy wanted to avoid surgery and preserve QOL. Of 20 men participating in a qualitative study, 40% chose surgery because it was the quickest option and had the most certain outcome, which offered a sense of finality (Denberg, Melhado, & Steiner, 2006). Denberg et al. concluded from in-depth interviews that many men made early and rapid decisions because of flawed reasoning or incomplete knowledge. In previous studies (O’Rourke, 1999; O’Rourke & Germino, 1998), men and their partners cited inaccurate information regarding treatment modalities and associated side effects. For example, XRT was not considered to be a curative treatment; one patient used the metaphor of a re-igniting fire to describe the superiority of surgery over XRT.

You know, it’s like a fire. You put it out, you go about your business. Couple days later, you see smoke again. There comes the fire back. But I’ve never heard of anyone growing back a new set of prostates [sic] after they’re gone. Never heard of that (O’Rourke, 1999, p. 356).

Many factors influence the bias toward surgery. Radical prostatectomy has been the mainstay of treatment in the United States. Although men may have PSA testing done by their primary care physicians, they are referred to a urologist and a surgeon for definitive diagnosis by biopsy. Surgeons are the primary source of information regarding treatment options for localized prostate cancer, and men are not always referred to a radiation oncologist for first-hand information on XRT or brachytherapy. Urologists almost universally identify surgery as the optimal treatment option, and radiation oncologists, similarly, identify radiation therapy as the best option (Fowler et al., 2000).

Surgery may be chosen to avoid radiation therapy. Studies (O’Rourke, 1999; O’Rourke & Germino, 1998) have shown that men inaccurately believed that XRT was not a curative treatment and that if the cancer returned following XRT, surgery would no longer be an option. Patients viewed XRT as a fallback treatment that would be available in the future if needed (O’Rourke, 1999; O’Rourke & Germino). The lack of a multidisciplinary approach to care by urologists and radiation oncologists may compromise patients’ access to critical information in the decision-making process.

Few studies have reported men seeking second opinions. O’Rourke (1999) found that couples determined the value of a second opinion based on whether they expected it to confirm or refute the diagnosis. Couples erroneously failed to consider a second opinion based on whether they expected it to confirm or refute the diagnosis. Couples erroneously failed to consider a second opinion to discuss various treatment options. Some couples believed a urologist’s assessment was a second opinion, having received an initial opinion from a primary care provider. Couples noted that second opinions were costly, could result in more testing and pain, and could waste precious time. The main reason couples did not seek a second opinion was because they trusted a urologist (Denberg et al., 2006). Concordance between a primary care provider and a urologist greatly influences treatment choice. Only one man sought a second opinion, which caused considerable anxiety for him. The man received primary information from a local urologist and sought a second opinion from another urologist. He hoped the second urologist would recommend surgery and was highly disappointed when brachytherapy was recommended. The divergent opinions only added to his stress. Ultimately, he chose brachytherapy but ex-
experienced considerable anxiety and worked hard to convince himself that it was the best option (O’Rourke, 1999). Second opinions offer opportunities to validate the recommendations of the original urologist, thereby minimizing uncertainty; however, if the second opinion diverges from the first, it can be the cause of increased uncertainty.

Although watchful waiting is a viable option for early-stage disease, particularly among older men with a lifespan of 10 years or less, studies in the United States consistently find that the concept lacks acceptability (O’Rourke, 1999; O’Rourke & Gemino, 1998). The central idea of watchful waiting is to first do no harm. In addition, research has shown that prostate cancer incidence rates exceed death rates (American Cancer Society, 2007). NCCN (2007) guidelines suggest that men who choose watchful waiting be monitored with digital rectal examinations and PSA levels at least every six months, which is not “doing nothing” as some patients believe. Watchful waiting involves vigilant follow-up with the option to initiate treatment if any clinical indicators indicate disease progression.

Radical prostatectomy has been the mainstay of treatment in the United States and remains the dominant choice among men with localized prostate cancer.

The lay press has publicized the diagnosis and treatment of several celebrities with prostate cancer, of which most have chosen surgery. The watchful-waiting option has not received the same positive attention in the press. For men who struggle with uncertainty and need a definitive course of action, watchful waiting is not optimal. Several studies reported that men and their spouses described this option as “doing nothing” and were generally uncomfortable with the idea of not taking some action (O’Rourke, 1999; O’Rourke, & Gemino, 1998). The response may be related to how physicians technically described the option or may be culturally influenced. Of 90 men with localized prostate cancer who responded to a mailed survey in the United Kingdom, only 29% recalled watchful waiting being discussed by their physicians as an option, and none of the 90 men chose watchful waiting (Sri-rangam et al., 2003). Whether physicians actually discussed the option cannot be determined, but what is apparent is that men did not hear the option or perceived it as being de-emphasized.

In a European study, men who chose watchful waiting experienced considerable pressure from family members, doctors, and support group contacts to seek active treatment (Chapple et al., 2002). One man’s comment illustrates how strong the pressure can be to accept treatment, in his case surgery: “He [the doctor] said I can do nothing and die before long” or “have radiation and die a little later” (O’Rourke, 1999, p. 354).

Prostatectomy remains the dominant choice among men with localized prostate cancer. The treatment decision is influenced heavily by significant others and the desire for a cure. Choosing surgery over XRT, brachytherapy, or watchful waiting occasion-ally is based on inaccurate information about treatment side effects and efficacy.

How Men Choose One Treatment Option Rather Than Another

The process of treatment decision making among men with localized prostate cancer has been the object of inquiry only recently. Men with prostate cancer who have had regular PSA testing should be made aware that it may lead to a subsequent diagnosis of malignancy. Primary care providers also should inform patients that potentially life-threatening, early-stage tumors are not fully discernible from benign tumors. Discussions and true informed consent to PSA testing might cause men to consider in advance how they want to be treated if a malignancy is diagnosed. Prior consideration was noted by men in the literature (Berry et al., 2003; O’Rourke, 1999). Some men knew and were able to articulate their treatment preferences at the time of diagnosis and occasionally before urologists had an opportunity to identify available options. Immediate decisions also were noted by Denberg et al. (2006) and could be based on faulty information. Immediate decisions without the benefit of counseling regarding the risks and benefits of treatment options could result in regret if end results are disappointing.

Men and their partners put themselves through a “crash course” upon learning the diagnosis. The process entails a serious fact-finding mission, during which they seek information from books, Internet sites, journals, and articles in the lay press (Maliski et al., 2002). When researching, patients and their partners are influenced by the choices of others, including high-profile celebrities (Berry et al., 2003; Maliski et al., 2002; O’Rourke, 1999).

Managing information about prostate cancer and treatment options is difficult for men and their spouses. Although some men want their physicians or significant others to tell them only what they need to know, others actively collect and digest as much information as possible (Denberg et al., 2006). Men and their partners often feel overwhelmed by the information they gather, and couples can experience confusion when confronted with an abundance of conflicting information (Gray, Fitch, Phillips, Labreque, & Kloz, 1999). Some men choose to defer their decisions to a doctor, and others want to be actively involved in the process. Studies have found that men ask physicians directly “What would you do if you were in my shoes?” (Maliski et al., 2002; O’Rourke, 1999).

A recent review (Zeliadt et al., 2006) suggested that men are becoming more active in the decision-making process; however, some men view choosing a treatment as a technical decision that is best left to the expertise of physicians. Unfortunately, men did not report systematic attempts to learn about urologists’ backgrounds, training, or experience. Instead, they relied on recommendations from friends, family members, and primary care providers. Urologists were judged on relationship factors: the ability to instill a sense of trust, congeniality, and willingness to spend as much time as necessary to respond to questions (O’Rourke, 1999). Maliski et al. (2002) reported a more concerted effort by men to seek the best surgeon and hospital, information that is more readily available with widespread use of the Internet.

Once patients and their partners become educated, they begin their quest for the best treatment (Maliski et al., 2002). The main
goal of the decision-making process for localized prostate cancer has been described as “making the best choice for me” (Berry et al., 2003, p. 97). To make the best decision for them, patients must put the diagnosis and treatment decision in the context of their lives (Berry et al., 2003). The search for meaning and putting the experience in context seemed to be a crucial element in the decision-making process in several studies (Berry et al.; Maliski et al., 2002; O’Rourke, 1999; Zeliadt et al., 2006).

Among the studies that examined the influence of spouses on choosing a treatment (Berry et al., 2003; Davison et al., 2002; Maliski et al., 2002; O’Rourke, 1999; O’Rourke & Germino, 1998; Srirangam et al., 2003; Volk et al., 2004), no spouses were willing to accept responsibility for the ultimate decision; partners mainly supported patients and helped gather information. Two studies (Maliski et al., 2002; O’Rourke, 1999) reported that wives believed the decision belonged to their husbands and emphasized that “it’s his body.” Partners across studies were noted as being especially diligent about attending appointments and taking notes. Although 88% of partners in one study were involved actively in the decision-making process, their self-assessed involvement was less (Srirangam et al.). The apparent de-emphasis on their role may be psychologically protective; partners may not want to feel as involved if treatment does not go as planned or causes harmful side effects. Regardless of the magnitude of partners’ influence on the ultimate decision, clearly partners are involved in the process and should be a part of patient counseling sessions.

Decisions are made deliberately and by default. Default decisions occur when age or health conditions limit available options. In addition, default decisions occur when other treatments are adamantly rejected, such as XRT or watchful waiting, which leave surgery as the only other option. Some men and their partners described the prolonged uncertainty associated with XRT to be intolerable, so they chose surgery only because it was a more expedient treatment (O’Rourke, 1999).

Deliberate choices are not precipitous, but rather involve serious consideration by patients, their partners, and urologists of each option and its related side effects, as well as its effect on QOL. Five cognitive factors, aside from age and Gleason score, were identified by men who chose brachytherapy: pain, invasiveness of treatment, side effects, convenience, and the desire to avoid surgery (Gwede et al., 2005). Men who opted for surgery identified a cure as the most salient factor. Men and their partners face challenges during the decision-making process that include weighing disparate side effects and personal values. For example, in at least one study, retired men were more likely to choose XRT than employed men. Older patients and their spouses worried more than younger couples about the risks of surgical treatment (Srirangam et al., 2003). Taken together, the data suggest specific areas of focus for patient education during the decision process and that healthcare providers must allow patients and their partners to express personal values and concerns instead of offering purely factual information.

Case Study

S.J. is a 66-year-old Caucasian man diagnosed with localized clinical stage T2 prostate cancer by biopsy, following the finding of an elevated PSA of 8 ng/ml on a routine annual screening. His Gleason score was 5. While relating his history, he shared that he had annual PSA testings done for a number of years but, in retrospect, could not recall having discussed implications of the test with his primary care provider. The diagnosis came as a shock because he believed that he was in otherwise good health, had no family history of the disease, and had experienced no symptoms indicative of a prostate-related problem.

The patient and his wife met with a urologist for consultation and discussion of treatment options. The urologist discussed three main treatment options: XRT, surgery, or a watch-and-wait approach. The patient and his wife agreed with the surgeon’s primary recommendation of a radical prostatectomy. The patient repeatedly stated that the option was “superior for cure,” and he wanted to avoid radiation because he knew people who had experienced “bad skin burns.” In addition, he believed that radiation was not a curative treatment. The option of watchful waiting was dismissed immediately. The patient, a veteran, spoke of high-profile celebrities, such as retired U.S. Army General Norman Schwarzkopf and his decision to undergo surgery “as a factor that reinforced his own choice. S.J. described himself as a “take-charge kind of guy” and expressed that he was unwilling to “do nothing.”

During the course of his preoperative workup, S.J. was noted to have significant cardiac disease, initially suspected from a routine electrocardiogram and confirmed by a cardiac catheterization. The new clinical finding prompted the urologist to suggest that surgery would no longer be the best option and that the patient and his wife should meet with the radiation oncologist to discuss alternatives. The patient was admittedly angry and confused about the change in plans and delayed his appointment with the radiation oncologist for several weeks. His wife reported that they had many sleepless nights while S.J. struggled with his decision. His wife gathered information about brachytherapy and XRT and tried to encourage her husband to read articles and view Internet sites. S.J. chose XRT rather than brachytherapy and cited his fears of radioactivity and living with permanent seed implants as the main factors in making the decision.

The patient did well following his course of XRT and was seen three months later. He still was experiencing some urinary dysfunction and stated that it was a major deterrent to his desire to resume sexual activity. He continued to have urinary and bowel urgency and burning on defecation that required the use of topical analgesics. S.J. and his wife expressed uncertainty about how to manage the side effects and were worried they would be permanent.

In discussing his choice of XRT, S.J. emphasized that he “always knew that radiation was the way to go.” He expressed no regret regarding his ineligibility for surgery, even when questioned directly on the topic. At six months post-treatment, S.J. continued to express satisfaction with his choice of XRT; however, he reported significant changes in his lifestyle. He had resigned from his position as manager of a large parking deck because of his bowel and bladder urgency. In a private interview, his wife reported that they always had looked forward to traveling after his retirement, but he was no longer willing because of his fears of incontinence.

At 12 months post-treatment, the patient reported that he hoped his disease was cured but expressed fears that it might...
return. He felt uncertain about his future. His PSA was 1.4 ng/ml. He reported some resolution of bowel and bladder urgency, but he continued to wear an incontinence pad for protection. He also reported that he was unable to achieve an erection sustainable for sexual intercourse. Both he and his wife shared frustration about their efforts to resolve the problem using a vacuum-assisted device and sildenafil. They expressed feeling somewhat guilty about their concerns because he was alive and “this is what matters most.” They believed they should be thanking God for his second chance at life.

Discussion

The NCCN guidelines (2007) for prostate cancer treatment classified S.J. as having localized disease with a low risk of recurrence. He typifies many men who undergo annual PSA testing but have not considered the ramifications seriously. Although the information his primary care doctor gave him at the time of PSA testing cannot be validated, he did not recall having a discussion about the implications of PSA testing. Consequently, S.J. was shocked by the prostate cancer diagnosis. Like many men, he decided early that surgery would offer the best possibility for a cure and rejected radiation treatment before speaking to a radiation oncologist. The decision was based solely on a discussion with the urologist. He did not seek a second opinion. Watchful waiting was dismissed immediately, without any serious consideration. When S.J.’s preferred option was no longer available because of compromised cardiac function, he was angry and forced to consider a treatment that he had labeled as suboptimal and not curative. The dissonance added to his anxiety. Despite speaking with a radiation oncologist, S.J. rejected brachytherapy because he feared being radioactive. His understanding of the treatment was inaccurate. Nursing interventions at that time would have included assisting the patient and his spouse in seeking accurate information about the treatment options. The provision of written materials and access to informative videos would have enhanced the couple’s decision-making process.

Several weeks passed from when S.J. was told that radiation was a better option for him until he took action, which would have been an ideal time for a telephone intervention by a nurse. Allowing the patient and his wife an opportunity to vent their frustration and discuss concerns about the newly recommended treatment may have helped to allay their anxiety. The wife admitted that their sleep was compromised during that time period. A nurse contact may have recognized that the couple was losing sleep and acted to obtain a prescription anxiolytic or sleep medication. Lack of sleep contributes to heightened anxiety and can be a barrier to effective decision making. Following XRT, S.J. experienced urinary dysfunction that persisted six months later. Bowel and bladder urgency caused him to resign from his job and interfered with leisure activities, such as travel. The changes were difficult for the patient and his wife, and their QOL was diminished. Post-treatment home visits or nursing telephone interventions may have been beneficial in assisting S.J. with a selection of incontinence devices and providing information about how long the side effect typically persisted. A review of 10 clinical trials conducted among men who had surgery for prostate cancer showed mixed results in terms of efficacy; however, Kegel pelvic floor muscle strengthening exercises may be of benefit in giving men a sense of control over incontinence (Hunter, Moore, Cody, & Glazener, 2004). Given that many men were averse to “doing nothing” with respect to their treatment decisions, “doing nothing” about incontinence may be a source of frustration as well.

For the couple, expectations about retirement were unmet. Physiologically S.J. was better at 12 months, but he continued to wear incontinence pads for fear that he would experience urgency and suffer embarrassment. Taking action helped to minimize some uncertainty. He and his wife shared their frustrations regarding his erectile dysfunction and their inability to resolve the problem, despite trying several methods. The side effect impacted yet another dimension of their QOL. The couple felt guilty about the concern because it conflicted with their gratitude that he is alive.

Although S.J. expressed hope that he was cured, his helpfulness was dulled by his fear of recurrence. The uncertainty may be related to his initial belief that the only curative treatment is surgery. How does a person who has so much invested in surgery accept XRT and convince himself that it is the best treatment for him? S.J. did so by comparing himself with other patients who had surgery and experienced worse conditions. Social comparisons can be an effective way of dealing with dissonance. Nursing intervention in S.J.’s case might focus on XRT as the best treatment for him and guiding him away from the more global question that cannot be resolved currently: What is the best treatment? Considering that even scientists cannot answer that question, personalizing it may allay some anxiety about whether he made the right choice.

Only one intervention aimed at minimizing uncertainty among men with localized prostate cancer has been described in the literature (Mishel et al., 2002). A nurse-delivered intervention, which included strategies for cognitive reframing and problem-solving assistance relative to treatment-related side effects, was conducted via telephone weekly for eight weeks. Men receiving the intervention had significant improvement in uncertainty management and control of urinary incontinence. Bailey, Mishel, Belyea, Stewart, and Mohler (2004) tested the intervention with men who chose watchful waiting and found that men receiving the intervention experienced a decrease in confusion and reported significantly greater improvement in QOL (Bailey et al.).

One strategy that S.J. used was cognitive reframing. He decided that XRT was the best choice with no acknowledgment that surgery was his original preference. S.J. and his wife were able to de-emphasize erectile dysfunction when they focused on cure and survival. The couple would have benefited from nursing intervention that encouraged problem solving and active management of treatment-related side effects. Maliski, Heilemann, and McCorkle (2001) demonstrated that a weekly homecare intervention over a period of eight weeks focusing on assisting couples with immediate postoperative care, intimacy, communication, and psychosocial support helped couples to obtain, evaluate, and manage information, leading them to regain mastery over their lives. For S.J., early retirement coupled with a decreased desire to travel affected him and his spouse. Her QOL was compromised by changes in their physical intimacy and social functioning. Just as spouses are involved in the treatment decision process, their QOL is affected by the ultimate decision, further supporting pretreatment counseling that includes partners.
For S.J. and his wife, each dimension of QOL was affected: psychological, physical, social, and spiritual. The need for nurses to move beyond describing disruptions in QOL to designing and testing theory-driven interventions has never been more acute. Nurses are the vanguard in the struggle to keep QOL at the forefront of cancer research and treatment. In an era of cost containment, nurses must demonstrate that nursing interventions not only improve patients’ QOL but are cost effective. Two interventions have been tested and found to be effective in minimizing uncertainty and enhancing QOL among patients with prostate cancer (Maliski et al., 2001; Mishel et al., 2002). The challenge is to demonstrate cost effectiveness in real dollars and cents and to work toward acceptance and implementation of interventions as standard of care.

Choosing wisely involves a full knowledge of the available options and the potential side effects associated with them. Nurses must assure patients and their partners that choosing wisely is less about making the right choice than making the best choice for them.

The author dedicates this article to her aunt, Marian Mastronardi, RN.

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