Oncology nurses' views on the provision of sexual health in cancer care

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OBJECTIVE: To describe the current sexuality-related nursing practice of oncology nurses.
DESIGN: Self-report survey to examine the practice of sexual health with a purposive sample of nurses working in cancer care.
SETTING: Six nursing units within a large tertiary care centre were used to recruit study participants. The units included ambulatory care, medical oncology and surgical oncology.
PATIENTS: Surveys were delivered to 155 oncology-registered nurses working on the identified nursing units. A response rate of 48% was achieved.
RESULTS: The overall scale score (M=103.27) suggests that the oncology nurses who responded to the survey perceived sexuality to be a part of their nursing practice. While the majority of the subscale scores were above the midline, practice was slightly below.
CONCLUSIONS: The oncology nurses who participated in the study were somewhat confident, responsible and valued sexuality; however, the delivery of care did not reflect those attributes. Issues raised by the oncology nurses are not limited to this discipline but have broad implications for the delivery of health care.

Key Words: *Attitude; Nursing practice; Sexual health*

Point de vue du personnel infirmier en oncologie sur la place de la sexualité dans les soins aux personnes atteintes de cancer

OBJECTIF : Décrire la pratique actuelle des soins infirmiers en oncologie en ce qui a trait à la sexualité.
PLAN D'ÉTUDE : Questionnaire d'auto-évaluation visant à étudier la place de la sexualité auprès d'un échantillon choisi à dessein d'infirmières et infirmiers en oncologie.
LIEU : Les participants et participantes à l'étude provenaient de six services de soins infirmiers en soins ambulatoires, en oncologie médicale et en oncologie chirurgicale, organisés dans un grand centre de soins tertiaires.
PATIENTS : Le sondage a été remis à 155 membres du personnel infirmier autorisé, pratiquant en oncologie dans les services en question. On a obtenu un taux de réponse de 48 %.
RÉSULTATS : Le résultat général (M=103,27) semble indiquer que les infirmières et infirmiers en oncologie qui ont répondu au sondage considéraient la sexualité comme partie intégrante de leur pratique. La plupart des résultats partiels se situaient au-dessus de la médiane, mais celui relatif à la pratique se trouvait légèrement au-dessous.
CONCLUSION : Les répondants se sont montrés sûrs et responsables jusqu'à un certain point et accordaient de l'importance à la sexualité; toutefois, la prestation des soins ne reflétait pas leur état d'esprit. Les problèmes soulevés par le personnel infirmier en oncologie ne se limitent pas à cette discipline mais ont d'énormes conséquences pour la prestation des soins de santé.

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The diagnosis and treatment of cancer can have a devastating effect on how individuals perceive themselves as sexual beings. These perceptions may alter a patient's ability to maintain or achieve meaningful relationships with family, friends and partner(s). To competently manage the sexuality-related concerns of such individuals, nurses who work in oncology must consider sexuality to be an important aspect of cancer care. In North America, the specialty practice standards of oncology nurses state that sexuality is a nursing responsibility when providing care to individuals with cancer (1,2). Although health care providers have good intentions to address sexuality in cancer care, a decade of evidence supports the conclusion that nurses and physicians lack both the knowledge and the level of comfort that are required to communicate or initiate sexuality discussions. Nurses and physicians have had little formal or continuing education either to assist them in examining their personal attitudes regarding sexuality or in implementing sexual health care.

Sexuality, a very real and important aspect of life that is affected by cancer and its treatment, has not been legitimized in the literature or in clinical practice. Few health professionals are knowledgeable about the effects of cancer and its treatment on sexual health, and are often reluctant to talk about such issues. Most cancer patients will not initiate discussions concerning sexuality unless an opportunity is presented by a health professional with whom they interact (3-6). To provide patient-centred care, health professionals must first learn what sexual health means to an individual, explore the changes that occur over time as treatment is completed and identify strategies that will support an improved quality of life. The oncology nursing specialty requires nurses to plan nursing interventions that are related to alterations in sexuality, body image and self-concept (2). Before nurses can begin to address concerns that are related to sexual health, an atmosphere of respect and open communication must be established. This atmosphere provides the opportunity for the nurse to engage patients and their partners in pretreatment assessments, and enables the exchange of relevant information and the initiation of interventions according to mutually determined needs over time (4). To meet the above standards, it is necessary to address nurses' knowledge, comfort and practice in providing care that is related to sexual health.

The purpose of the present study was to determine the extent to which sexual health was included in oncology nursing practice; nurses' perceptions of both staff and client reactions to discussions about sexual health; and whether oncology nurses believed that they have a responsibility to provide sexual health care. Existing literature does not refer to sexual health as being a component of nursing care in a Canadian context. Comparisons with reports from the United States provide a North American perspective on the implementation of this aspect of oncology nursing practice standards.

NURSING PERSPECTIVES ON SEXUAL HEALTH

Nursing aspires toward the provision of holistic care. To meet this expectation, issues that concern the sexual health of individuals must be considered for the delivery of care to all clients (7). Curricula for schools of nursing often include sexuality as it relates to obstetrical care or sexually transmitted diseases. This approach is restricted to reproduction and ignores the broader construct of sexual health (6), and may result in the inability of nurses to consider addressing sexuality as a component of holistic care or as being a part of their nursing role. Nurses' recognition of altered sexuality due to changes in health status from a variety of disease entities or illnesses may be limited (8).

The inclusion of sexual health in nursing practice is a relatively new discussion in the literature, found predominantly during the past five years. Research to explain both the support for and the barriers to nurses' sexuality-related practice is minimal. Evidence suggests that nurses perceive their clients to be too ill or anxious to discuss sexuality; that clients' sexual issues are considered minor compared with illness; and that nurses rarely have had the opportunity to observe other health care professionals address sexuality (8). Violating a patient's privacy has also been identified as a concern for nurses (9).

Practice behaviours that are specific to oncology nursing, an area in which specialty standards dictate the inclusion of sexual health in the delivery of care, have been examined. Attitudes of nurses toward their own values and beliefs about sexuality, level of knowledge and personal comfort have been identified as being key predictors for the practice of sexual health (10). More recently, Matocha and Waterhouse (11) found that regardless of clinical specialty, nurses who worked in a hospital setting in which sexuality was particularly relevant included sexual health in their practice when they believed that they were responsible for discussing sexuality, felt knowledgeable about the topic and were comfortable with such discussions.

An expectation does exist by patients that nurses will discuss sexual health in the provision of care (6). The challenge is to provide the appropriate education to assist nurses in becoming more comfortable and knowledgeable in the delivery of care so that practice behaviours will communicate respect and a sense of worth of one's sexual being (12).

METHODS

The study combined both a qualitative and a quantitative approach by using focus groups and a self-report survey to examine the practice of sexual health by nurses working in cancer care. Only the quantitative aspects of the study are reported.

Study population

All registered nurses who were employed full time in the oncology portfolio of a tertiary care hospital in Atlantic Canada were asked to complete the Survey on Sexually-Related Nursing Practice (SSRNP). The survey was based on Annon's (13) model of behavioural treatment in sexuality, specifically on permission and the limited information levels at which all nurses should be expected to intervene (11).

Instrumentation

The SSRNP (revised) provides a total score and seven subscale scores for practice, values, responsibility, confidence, discussion with others, clients' reactions and staffs' reactions. A high score indicates support for sexually-related nursing practice. Reliability using test-retest (n=99) yielded alphas greater than 0.774 for all subscales, with the exception of discussion with others (alpha = 0.696); the total questionnaire alpha was 0.906. Confirmatory factor analysis yielded the seven subscales; reportedly, all factor loadings of at least 0.59, with most loadings attaining 0.65 or higher (Waterhouse J, 1998, unpublished data).

Ethics

The study was approved by the Research Ethics Committee of the hospital where data were collected. The surveys were delivered to the identified oncology nursing units. Each registered nurse received an information letter that described the study, and explained that participation was voluntary and would not affect employment. Completed surveys were returned anonymously, and consent was assumed.

Statistical analysis

Data analyses were performed using the SAS Statistical Program (SAS Institute, USA) (14). Descriptive statistics using means, standard deviations, ranges and frequencies were compiled. The reliability of the SSRNP was determined using Cronbach's alpha.

RESULTS

Reliability testing was conducted for this study by using Cronbach's alpha measure for internal consistency. Results supported the subscales' reliability for practice (alpha = 0.91), values (alpha = 0.72), response (alpha = 86), confidence (alpha = 0.86), discussion with others (alpha = 0.85), clients' reactions (alpha = 0.87), staff reactions (alpha = 0.80) and total (alpha = 0.89).

The survey was distributed to 155 registered nurses who worked in oncology. Seventy-four nurses responded to the questionnaire; 45% worked in surgical oncology, 35% worked in medical oncology and 20% worked in ambulatory care. Most nurses had 13 years of experience and had worked in their present oncology setting for the past six years. The overall scale score (M=103.27) suggests that the oncology nurses who responded to the survey perceive sexuality to be a part of their nursing practice. While the majority of the subscale scores were above the midline, practice was slightly below (Table 1). This finding suggests that the oncology nurses were somewhat confident, responsible and valued sexuality; however, the delivery of care did not reflect those attributes.

The oncology nurses indicated that their practice occasionally included the following activities: assessing a client's sexual health, teaching modifications of sexual practices, lis-

TABLE 1
Results of Sexuality-Related Nursing Practice Survey (n=74)

Variable	Range of scale scores	Mean (±SD)	Range of scores obtained
Practice	0 to 32	13.89 (6.0)	1 to 27
Values	6 to 30	18.54 (3.0)	8 to 26
Responsibility	4 to 20	15.91 (2.2)	11 to 20
Confidence	5 to 25	17.01 (2.9)	11 to 25
Discussion	4 to 20	12.45 (3.4)	4 to 20
Clients	4 to 20	12.57 (1.6)	7 to 16
Staff	4 to 20	12.91 (2.4)	5 to 17
Total	26 to 182	103.27 (13.5)	72 to 141

TABLE 2
Sexual health practice of oncology nurses (n=74)

Current practice	Never n (%)	Rarely n (%)	Occasionally n (%)	Frequently n (%)
Assessment of client's sexual health	2 (2.7)	19 (25.7)	40 (54.1)	13 (17.6)
Teaching modifications of sexual practices	12 (16.2)	13 (17.6)	34 (45.9)	15 (20.3)
Answering clients' questions about sexuality	3 (4.1)	13 (17.6)	45 (60.8)	13 (17.6)
Listening to clients' concerns about sexuality	3 (4.1)	15 (20.3)	45 (60.8)	11 (14.9)

TABLE 3
Sexual health practice of oncology nurses in 1999 (n=74)

	None	1% to 20%	21% to 40%	41% to 60%	61% to 80%	81% to 100%
Assessment of sexual health	6 (8.1)	29 (39.2)	19 (25.7)	10 (13.5)	6 (8.1)	4 (5.4)
Offered discussion of sexual concerns	6 (8.1)	30 (40.5)	18 (24.3)	11 (14.9)	4 (5.4)	5 (6.8)
Provided information and/or education on sexuality or sexual practices	11 (14.9)	25 (33.8)	20 (27)	8 (10.8)	5 (6.8)	5 (6.8)
Referred for sexuality-related questions and/or counselling	29 (39.2)	29 (39.2)	10 (13.5)	5 (6.8)	–	1 (1.4)

tening to sexual concerns and responding to questions about sexuality (Table 2).

When asked to describe the extent to which these practices occurred in the past year, nurses revealed that approximately 73% (n=54) assessed sexual health in only 40% or less of their clients (Table 3). Only 65% of respondents offered to discuss sexual health with the same percentage of patients. The provision of education and/or information to patients concerning sexual health was rare. Fifteen per cent of the nurses reported that they never provided education and/or information on sexual health. Thirty-four per cent of the nurses did provide this service but to only 20% or less of their patients. Many of the nurses (n=29, 39%) indicated that they did not refer clients to another health professional to provide sexual counselling or answer sexuality-related questions.

DISCUSSION

The study sample of less than one-half of the practising oncology nurses in a tertiary care centre limits the generalizability of the findings. The decision to include only nurses who worked in a tertiary care centre may also be limiting given the trend toward community-based cancer care. The nurses who completed the survey believed that their values concerning sexuality were either average or less conservative than those of the general public. The nurses believed that their opinions about sexual practices and standards of sexual behaviours were liberal. Recent literature suggesting that nurses value sexuality as being a part of their practice supports the opinions expressed by the oncology nurses (11). Interestingly, in 1983, Fisher and Levin (15) found that oncology nurses had more conservative attitudes toward sexuality that influenced their practice. It appears that there has been a shift in how nurses value the inclusion of sexuality in nursing care, which may contribute to more positive outcomes concerning the sexual well-being of cancer patients. This shift in values is supported by patients who believe that nurses should discuss sexual concerns as an aspect of holistic care and not limit such discussions to select groups of patients (5).

When asked about their own knowledge of sexuality, most of the oncology nurses believed that they were either somewhat or very knowledgeable. The fact that nurses indicated minimal sexuality content in their basic curriculums and had rarely participated in continuing education related to sexuality suggests that their knowledge is experiential. This perceived knowledge enabled the nurses to feel confident about engaging in discussions about sexual concerns. Matocha and Waterhouse (11) similarly reported that nurses were predominantly comfortable discussing sexual concerns with clients. Further examination of nurses' interactions with clients about sexuality revealed that nurses were more comfortable discussing sexuality if the client initiated the discussion (8,10). Oncology nurses in this survey, while confident in their knowledge, overwhelmingly reported that they believed it was appropriate to respond to sexual concerns when the client initiated the discussion. They felt it was less appropriate for nurses to initiate these discussions.

While a shift may have occurred in the extent to which sexual health is valued in cancer care, the knowledge and confidence of the oncology nurses, and their behaviours did not indicate that a transition had occurred in their practice. This has been a consistent pattern in oncology nursing practice in North America (6,10).

RECOMMENDATIONS

To deliver quality patient care, oncology nurses must include sexual health in their plan of care. At present, the burden of responsibility seems to be on patients to initiate discussions because nurses have been reluctant to address sexual health needs in their assessments. To achieve the level of care described by oncology nursing standards, practice must reflect what nurses say that they value.

Consistently, health professionals have been criticized for not attending to the sexual needs of patients with cancer. The lack of attention to this aspect of quality patient care has been pervasive in health education, practice and institutional policies. Nurses have indicated that they value sexual health but need ongoing education and mentors to help them practice. Practice standards dictate that oncology nurses assume responsibility for leadership, education and advocacy for the sexual well-being of cancer patients.

To influence cancer care, oncology nurses need to ensure that sexual health is included in the plan of care as patients move from diagnosis to preoperative assessment, treatment and follow-up. The restrictions imposed by the health care system, such as shorter lengths of hospitalization, varying treatment settings and multiple care providers, emphasize the importance of nurses taking responsibility for the management of the ongoing effects of cancer and its treatment on an individual's sexual well-being. Nurses can achieve this standard of care by open communication with patients, consulting with other members of the health care team or initiating referrals to specialists for specific sexual health needs.

This study investigated the views of only one discipline that is involved in the provision of cancer care. The lack of research to support evidence-based care that is consistent with standards of practice is a concern for all health care disciplines. The need for further research from multidisciplinary, multisite prospective clinical trials is critical. The extent to which the issues raised by this study apply to other chronic illnesses is, essentially, unknown. Further investigation to identify and develop a conceptual approach to examine this aspect of quality of life is needed.

CONCLUSION

The issues raised by the oncology nurses who participated in the study are not limited to this discipline but have broad implications for the delivery of health care. Very little is known about the long term effect of treatment on the sexual health of individuals. Previous data have focused on physiological changes, sexual functioning and body image. Individuals' interpretations of the effect that these changes

may have on their quality of life as a sexual person are lacking. Open discussions and the exploration of methods other than intercourse to foster sexual expression, intimacy and communication (16-18) are critical components for inclusion in curricula for health professions. Continuing educational programs should provide the information to enable practitioners to include sexual health in their practice.

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Note from the Editor-in-chief

Physicians who treat cancer patients often deal with sexual issues during the initial stages. Concern regarding erectile or ejaculatory function may seem secondary to survival and is often not discussed again. Support staff have more time (as perceived by the patient) to provide education, and support to individuals and couples. All health care professionals should have knowledge of the sexual implications of the disease that they deal with and be proactive when it comes to assisting their patients in this area.