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Changes in attitudes, practices and barriers among oncology health care professionals regarding sexual health care: Outcomes from a 2-year educational intervention at a University Hospital

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ABSTRACT

Purpose: To examine the attitudes, practices and perceived barriers in relation to a sexual health care educational intervention among oncology health care professionals at the Landspítali-National University Hospital of Iceland.
Methods: The design was quasi experimental, pre - post test time series. A comprehensive educational intervention project, including two workshops, was implemented over a two year time period. A questionnaire was mailed electronically to all nurses and physicians within oncology at baseline (T1, N = 206), after 10 months (T2, N = 216) and 16 months (T3, N = 210).
Results: The response rate was 66% at T1, 45% at T2 and 38% at T3. At all time points, the majority of participants (90%) regarded communication about sexuality part of their responsibilities. Mean scores on having enough knowledge and training, and in six of eight practice issues increased significantly over time. Overall, 10–16% reported discussing sexuality-related issues with more than 50% of patients and the frequency was significantly higher among workshop attendants (31%) than non-attendants (11%). Overall, the most common barriers for discussing sexuality were "lack of training" (38%) and "difficult issue to discuss" (27%), but the former barrier decreased significantly by 22% over time.
Conclusions: The intervention was successful in improving perception of having enough knowledge and training in providing sexual health care. Still, the issue remains sensitive and difficult to address for the majority of oncology health care professionals. Specific training in sexual health care, including workshops, should be available to health care professionals within oncology.

1. Introduction

Sexual health is an important quality of life issue and is affected by cancer and its treatment (Mulhall et al., 2011; Tan et al., 2002; Saevarsdottir et al., 2010). With the increasing number of cancer survivors there has been a growing focus in health care on adding life to the years, not only years to the life (Enzlin and De Clippeleir, 2011). Studies have shown that discussions between patients and oncology health care professionals about sexuality remain infrequent (Hautamäki et al., 2007; Kotronoulas et al., 2009; Takahasi et al., 2006). Lack of knowledge and skills have been identified by oncology health care professionals as main barriers for discussing this important and sensitive issue (Hautamäki et al., 2007; Kotronoulas et al., 2009). In 2010 a group of oncology health care professionals at Landspítali – The National University Hospital of Iceland decided to develop and implement a two-year project with the goal of improving and integrating communication about sexual issues into to the daily care of cancer patients.

2. Background

Cancer diagnosis and cancer treatment affect all aspects of sexuality among both female and male cancer survivors. Not only the sexual response or sexual functioning aspects are affected, but

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also the sexual relationship and sexual identity (De Vocht, 2011; Cleary and Hegarty, 2011; Sadovsky et al., 2010). Studies have shown that between 40 and 100% of cancer patients report sexuality-related problems in different phases of cancer, both in the curative and palliative care phases (Mercadante et al., 2010; Sadovsky et al., 2010; Saevarsdottir et al., 2010).

Considering the high prevalence of sexuality-related problems among cancer patients, it is essential that oncology health care professionals address sexuality-related issues. Studies among oncology health care professionals have shown that sexual health discussions with cancer patients rarely take place (Kotronoulas et al., 2009). In one study among physicians and nurses working with cancer patients, 96% agreed that discussing sexuality-related issues with patients was a part of their responsibilities but only 2% actually discussed these issues with more than 50% of their patients (Hautamäki et al., 2007). In another study among oncology health care professionals treating women with ovarian cancer only 1 out of 4 doctors and a 1 out of 5 nurses discussed sexual issues despite acknowledging that the majority of the women could experience a sexual problem (Stead et al., 2003). In a study on the sexual consequences of prostate cancer treatment, sexual functioning or recovery was not raised at all in about half of the observed consultations (Forbat et al., 2012). Without sexual health discussions, patients' sexual health care needs, therefore, seem unmet (Olson et al., 2012, Saunamäki et al., 2010).

In order to improve sexual health care it is important to understand the factors that influence whether oncology health care professionals will provide sexual health care or not. Two recent reviews addressed this issue. Authors of a systematic review of qualitative studies from the U.K. investigated the perceived barriers and facilitators among healthcare professionals to talking about sexuality with service users (Dyer and das Nair, 2013). They found that in order to facilitate addressing sexuality issues three major factors needed to be considered; structural, organizational, and personal. All three factors were reported to be intricately linked and have a combined effect on health care professional's decision whether to initiate sexuality discussion with patients or not. The second review reports on evidence regarding knowledge, attitudes and practices of oncology nurses and what key factors determine whether sexual health care is provided or not (Kotronoulas et al., 2009). In line with the results of Dyer and das Nair, various structural, organizational and personal factors were found that either help or hinder oncology nurses in providing sexual health care. Nine influential key factors were identified: patient-and nurse related issues, incorrect assumptions toward sexual issues, sexual knowledge, comfort, professional nursing role, work environment-related issues, continuing education activities, and society-related factors. The authors concluded that myths about sexual health in cancer care needed to be dispelled and continuing education activities may assist in addressing sexual concerns while caring for patients with cancer. There is limited knowledge about educational efforts to help addressing sexual health within oncology.

To address this important issue an educational intervention was developed and a study was designed to assess and compare changes in attitudes, practices, and perceived barriers among oncology health care professionals. This paper describes the intervention and reports on the results of the study.

3. Method

A comprehensive long-term educational intervention project was developed and implemented over a two year period to facilitate that nurses and physicians participating in the project would discuss sexual issues with their patients in relation to cancer and its treatment. The aim was that they would do so with more than 50% of their patients.

3.1. Purpose of study

The purpose of this study was to evaluate the outcomes of a sexual health care educational intervention by comparing the attitudes, practices, and perceived barriers of health care professionals before and after implementing the intervention.

3.2. Description of the educational intervention project

First, a project team from medical (including radiation and palliative care), surgical and gynecological oncology wards at Landspítali –The National University Hospital of Iceland were formed. The team developed a two-year plan designed to integrate sexual health into oncology (Table 1). The plan consisted of several components that included organizational and personal factors such as hospital policy, sexual counselling services and staff training. The following were the major components of the intervention:

1) Change agents identified: twenty-five interested staff members, primarily nurses from a total of 8 wards were identified and offered to participate in the project and act as role models on their ward.
2) Sexuality counselling service was established: a nurse; also a sexuality educator and a specialist in clinical sexology, was hired part-time (20%) as an employee of the project and to provide sexuality counselling services for cancer patients. This new referral possibility was advertised within and outside the hospital, among staff, in patient support groups and in the media.
3) Education and training of staff.
   a. Workshops: 40 staff members from 10 different units within medical, surgical, and gynecological oncology at the hospital, including the 25 change agents among staff attended two workshops with Woet Gianotten, a gynaecologist and psychotherapist, as the main instructor. The first was a 5 h workshop held in January 2011 that focused on oncology and sexual health care, addressing attitudes and practices. Various teaching methods were utilized such as short lectures, group discussions and case-studies in pairs where participants practiced starting discussions about sexuality and taking short sexual history. The second workshop, with the same participants, was held a year later. It too was a 5 h workshop, focusing on building upon the contents of the baseline workshop, by including more role play exercises designed to practice communication about sexuality-related issues.
   b. Educational meetings among staff and change agents on wards: short staff meetings (max. 20–30 min in duration) were held on each unit following the workshops. These meetings were intended to follow-up on the training and highlight the various steps in the project. Different issues were discussed such as specific communication strategies, practical issues in providing sexual health care and screening possibilities. It was recommended to use the Distress Thermometer and Problem List (Gunnarsdottir et al., 2012) to screen for sexual issues in general, since that tool was already in use on some wards. Further guidelines were provided on sexual assessment.
   c. A staff pocket-guide was developed for nurses and physicians as an aid to initiate communication with patients about sexual-related issues and to do a basic assessment. The front side of the pocket guide was based on translation of the BETTER model (Mick et al., 2004). The back side of the pocket