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DETERMINING WHAT PATIENTS SHOULD KNOW ABOUT TRANSURETHRAL PROSTATECTOMY

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ABSTRACT

Many hospitals have developed patient education materials for individuals about to undergo surgery. Information in these educational packages varies in quality and is generally based on 'common sense' beliefs concerning what patients wish and need to know. Since such interventions vary greatly in their effectiveness, the present investigation was undertaken to assess empirically the concerns and needs of patients undergoing a specific procedure, transurethral prostatectomy. Data from 73 men who had undergone transurethral prostatectomy for benign enlargement of the prostate and 32 of their wives indicate that patients would have wanted more information concerning the consequences of surgery, both medical and sexual. In addition, written information, clear instructions concerning the do's and don'ts during the recovery period, and reassurance about what is 'normal' and to be expected contributed to feeling positive about the prostatectomy experience. Results concerning helpful and distressing aspects of the surgery experience and patients' recommendations for improvement are presented. The necessary components of patient education materials are discussed and a synthesis of information needed for patient education related to prostatectomy is provided.

Key words: Surgery — Needs assessment — Instructional materials — Sexuality

INTRODUCTION

The study of response to traumatic life events has generated considerable research interest and an increasing volume of literature on coping with

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stress during the last 20 years. Many of these investigations have focused on evaluating the effects of various types of cognitive-behavioral and educational interventions on patient distress related to aversive medical and surgical procedures [e.g. 1,2].

The most common form of intervention utilized by medical personnel is patient education delivered via informal discussion and written informational materials. It is difficult to evaluate the effectiveness of this 'standard medical practice' because of a variety of confounds and inconsistencies in information-delivery techniques. Even the effectiveness of information delivered in written format is difficult to assess for a variety of reasons. These include variations in the timing of information delivery [3] and the dispositional characteristics of patients to either avoid or to seek out medical information [4–6]. In addition, a diversity of stressful medical procedures, measurement approaches, and indicators of effectiveness have been used. In 'standard medical practice' the behavioral characteristics of the health professional who engages in dialogue with the patient (e.g. rapport, patience, amount of reassurance, amount of information) can also influence the patient's response. The type of information contained in written informational materials may also vary tremendously (e.g. amount and type of information provided, the use of medical terminology, inclusion of a graphic description of the procedure). Indeed, the information contained in educational materials itself may constitute a stressful stimulus.

Most patient education materials have been based on 'common sense' beliefs about what patients should know concerning their surgical procedure. Materials developed on this basis risk repeating the demonstrated shortcomings in doctor-patient communication [7]; these can result in a high incidence of patient misunderstanding of the nature of the physical disorder (leading to poor therapy compliance) and in lack of recognition of patients' psychosocial concerns by physicians and medical personnel (leading to patients' psychological concerns never being addressed at all). The incorporation of information concerning what patients wish to know is likely to enhance the effectiveness of educational materials.

Given the diversity of information delivery approaches, it is not surprising that no straightforward relation has been found between the receipt of information about impending surgery and patients' reactions to that event. For example, a recent meta analysis of the literature dealing with the effect of preoperative instruction on postoperative outcomes indicates that, overall, 67% of patients receiving preoperative instruction have more favorable outcomes than those not receiving such instruction [8]. Nevertheless, large variances were noted in these data which appeared attributable to differing patient characteristics such as level of fear or anxiety, unique situational variables, differences in the nature of the outcome measures used (e.g. physical, psychological or some combination of both) and the differing aims of the interventions themselves (e.g. providing facts about the procedure, providing information about what physical sensations the patient could expect, exploring patient's attitudes and feeling).

Roth and Cohen [9] have advocated evaluating the process of coping in the context of one stressor at a time. It seems clear that in order to draw meaningful conclusions the role of information in modifying distress reactions related to surgery must also be examined in one particular surgical context at a time.

The purpose of the present investigation was to obtain, in an empirical manner, data on the type of information desired by patients undergoing transurethral prostatectomy. Prostatectomy in common with other surgical procedures, involves two types of stressors — the procedure itself and its aftermath. Prostatectomy, specifically, also has potential sexual and marital implications. First, the procedure has been associated with a definite sexual casualty rate [cf. 10]. Second, the population of individuals undergoing this procedure is already at risk due to the aging process, medication side effects and North American attitudes regarding sexuality, specifically cultural censure and the opinion held by society in general that sexual activity in older individuals is not desirable [11]. Third, because this is surgery involving the genitals, numerous myths and misconceptions about its effects abound. Therefore, positive and negative commentary with respect to both these stressors was collected from patients who themselves have undergone the transurethral prostatectomy procedure. Such an empirical determination of patients' needs and concerns can provide the basis for the development of patient education materials for individuals about to undergo transurethral prostatectomy.

METHOD

Subjects

Subjects consisted of 73 married men, aged 55—79, who had undergone prostatectomy 3—18 months prior to testing. Thirty-two of their wives also participated; all subjects were involved in a larger investigation of the effects of transurethral prostatectomy on sexual functioning. Subjects were in good physical and psychological health. Mean educational level was 12 years of schooling and average family income was $35,000.

Procedure

A structured interview format was used to elicit information about the subjects' experiences related to prostate surgery. The following questions were asked in the context of patients' experiences prior to, during and after hospitalization:

- Was anything said or done that made you feel more comfortable or particularly good?
- Was anything said or done that made you feel more tense or particularly bad?
- What kind of information would you have liked to have?
- What did your doctor tell you about sexual functioning and prostatectomy?

- When did the doctor tell you you could resume sexual activity?
- Prior to prostatectomy, what had you heard (from friends, etc.) or read (newspaper articles, etc.) could happen to one's sex life after prostate surgery?
- How and when, in your opinion, should information on prostatectomy (the nature of the experience, its effects and implications) be given?

RESULTS

The responses elicited from subjects about their experience of the male having undergone transurethral prostatectomy were examined within the following 7 categories: positive experiences, aversive experiences, medical information wanted, sexual information wanted, sexual information received (two categories), presurgery beliefs about the sexual consequences of prostatectomy and effective modes of information delivery.

Participants' responses were classified within each category; overall inter-rater agreement [12] for these classification groupings ranged from 43% to 95%, with an overall average of 75%. The findings with the exception of the last category are illustrated in Tables I, II and III.

The data indicate that the most important variables which made participants feel positive about their surgery were a reassuring doctor, an efficient hospital staff and being given information about the experience. Inefficient hospital staff and lack of information or misinformation about medical and sexual matters contributed to discomfort. Patients stated that they would have wanted more information concerning the consequences of surgery, both medical and sexual. The most frequently desired information about sexuality concerned retrograde ejaculation. Participants also indicated that information is most helpful when provided prior to entering the hospital, in the presence of both spouses and in written form.

TABLE I

EXPERIENCES REPORTED

Positive	%	Aversive	%
Reassuring doctor	38	Inefficient staff	31
Efficient staff	29	No medical information given	23
Information regarding surgery	27	Pain	15
Having friends around	3	Inaccurate or no sexual information given	9
Others	3	Other comments by health professionals	14
		Other patient's remarks	4
		Complications	4

TABLE II

INFORMATION WANTED AND RECEIVED

		%
Medical	*Wanted*	
	Consequences of surgery	38
	None	27
	What to expect in general	16
	Specific details and instructions	11
	Why surgery was necessary	4
	Other information	4
Sexual	*Wanted*	
	Retrograde ejaculation	63
	Sexual effects of prostatectomy	21
	When to resume sexual activity	11
	Other	5
	Received	
	Re: consequences	
	Retrograde ejaculation	56
	Nothing	24
	Other	10
	Infertility	7
	Different orgasmic sensation	3
	Re: when to resume sex	
	Not told	30
	Whenever comfortable	5
	1—2 weeks	4
	3 weeks	5
	4 weeks	12
	5 weeks	5
	6 weeks	26
	7 weeks	5
	8 weeks	5
	2—3 months	3

TABLE III

PRESURGERY BELIEFS ABOUT SEXUAL CONSEQUENCES

	%
No change	60
Worse	19
Did not think about it	12
Did not know	7
Better	2

While 60% of respondents believed prior to surgery that prostatectomy would not affect sexuality, 19% believed that their sex life would deteriorate, 2% believed it would improve and the rest did not know. With respect to receiving sexual information from their doctors, 56% of subjects reported that they were informed about retrograde ejaculation, 24% indicated they were told nothing about the sexual consequences of surgery and 30% reported they were not told when to resume sexual activity.

DISCUSSION

The results indicate that prostatectomy patients wish to have information concerning the procedure itself, the events of the hospital stay and the types of experiences to expect during the recovery period. In addition, the data indicate that patients also need information about the sexual consequences of surgery, most notably concerning the implications of retrograde ejaculation, the potential consequences of the procedure for other dimensions of the sexual experience and when sexual activity may safely be resumed.

Written patient education interventions

Information delivered in written form, in conjunction with a verbal explanation, may be an optimal means of providing patients with needed information. Because of individual differences in coping style, some individuals (those usually described as 'vigilant') will attempt to seek out information from all available sources. Discrepancies in information received and memory distortion may generate anxiety in such individuals; this anxiety will be exacerbated by inability to obtain sufficient and accurate information. On the other hand, other individuals ('avoiders') will wish little information about the surgery and its consequences; instead, for such individuals information itself may constitute a substantial source of stress. Thus, anxiety apprehension and distress may be increased if these patients are provided with unwanted or too much information.

Written information can serve the needs of both types of individuals; 'vigilant' patients will have the reassurance of the written word which can be consulted as and when needed. Patients whose coping style is best characterized by avoidance and repression can easily avoid the information contained in pamphlets*. In addition, spouses, who are typically excluded from the verbal information sessions about the disorder the surgical experience and its sequelae, have the opportunity to be informed without having to rely on the patient's comprehension of the issues involved, his willingness to share information and his possible discomfort in discussing the information received.

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*'Vigilant' and 'avoider' patients can most easily be identified by administering the Miller Behavioural Style Scale [15] which takes less than 10 min to complete.

A major factor influencing distress reactions to a stressful medical or surgical procedure is the amount of actual and perceived control available to the patient over such an aversive event. The control involved in reducing the perceived aversiveness of an event consists of varying amounts and combinations of behavioral, cognitive, informational, and attributional components; these interact with the meaning the individual has assigned to the event. The meaning of the event, ultimately, is an important key to understanding an individual's reaction to stress [13]. To evaluate how effectively individuals cope with a stressful event, one must specify: (a) the point in time at which effectiveness is evaluated, (b) the controllability aspects of the stressor, and (c) the fit between the individual's coping style and the particular demands of the stressful situation [9].

Both the literature as well as the results of the present investigation suggest that the design of patient education interventions intended to increase coping effectiveness and reduce stress reactions must recognize and incorporate the multidimensional function of information. Such interventions must provide an objective description of the procedure and must address potential discrepancies between expected and actual experience. Interventions should also provide reassurance as well as behavioral and cognitive control features; these latter should take into account that both approach and avoidance coping strategies may be of benefit at different times during the sequence of the total experience.

Information for transurethral prostatectomy patients

In the case of information concerning transurethral prostatectomy, the coping strategies available to patients at various times will differ. Prior to the procedure, patients will want to have some information about the prostate, about how an enlarged prostate causes problems with urine flow, and about how the surgery will correct the problem (i.e. an objective and accurate version of the meaning of their symptoms and the means by which the problem will be solved). In addition, patients need information concerning the hospital stay, what to expect before, during and after the procedure and what they themselves can do to make the experience more comfortable at each stage.

Patients also need to know what to do after leaving the hospital. Here, patients need to be provided with copious amounts of reassurance concerning what is normal and to be expected as well as with effective active and passive coping strategies. A list of do's and dont's, within a specific time framework should be provided.

In addition, patients' actual and potential concerns about sexuality must be addressed. This should consist not only of facts, such as the consequences of retrograde ejaculation or when sexual activity may be safely resumed but also of reassurance and concrete suggestion for how to resume sexual activity in order to enhance comfort and prevent potential sexual difficulties. For many men and their partners, the first sexual encounter

after prostatectomy is fraught with anxiety. Will it work or won't it? What is the future to be? Since such performance expectations and the associated anxiety can by themselves contribute to sexual difficulty postprostatectomy [14], suggestions concerning the best means of resuming sexual activity should be provided*.

CONCLUSIONS

Written patient education materials can be a major asset in the reduction of anxiety and distress associated with stressful medical and surgical procedures. Information materials which are based on patients' actual needs and follow the recommendations listed above can be utilized to address patients' questions and concerns in an accurate and meaningful manner. Furthermore, an information intervention constructed on this basis is likely to be maximally effective in alleviating psychosocial distress related to the experience of surgery.

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*We have designed two information booklets for prostatectomy patients based on our findings (Libman, E. & Fichten, C.S. in collaboration with The Sexual Dysfunction Service of the Sir Mortimer B. Davis Jewish General Hospital (1985) [16,17]. One of these is intended to be given to patients prior to their surgery while the other is intended for distribution after the first 2 to 3 weeks post-surgery. At present, we are engaged in the empirical evaluation of the effectiveness of these information booklets.

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