

Healthcare Professionals' Attitudes to Rehabilitation Programming for Male Cancer Survivors

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Abstract

Purpose: The purpose of this study is to describe and interpret the attitudes and conduct of hospital healthcare professionals (HCPs) in association with male cancer survivors and their municipal rehabilitation participation.

Design: Ethnographic fieldwork was conducted, consisting of participant observation and nine semistructured focus group interviews with 58 hospital HCPs.

Methods: Using interpretive description methodology with symbolic interaction as a theoretical framework, data were collected through fieldwork in three oncology wards in Denmark.

Findings: Attitudes about both gender and rehabilitation were identified as overarching obstructions within hospital HCP conduct toward promoting men's participation in cancer rehabilitation.

Conclusions: Gender and rehabilitation perceptions formed barriers in this context, suggesting that male cancer survivors' rehabilitation outcomes may be compromised by HCP attitudes and conduct.

Clinical Relevance: These findings provide insight into approaches to guide HCPs to take responsibility for rehabilitation and to take gender into account in their work.

Keywords: Rehabilitation; oncology; healthcare professionals; gender; cancer survivors.

Introduction

The growing proportion of cancer survivors has resulted in a rising number of people experiencing persisting side effects and residual consequences of their disease (Ganz, 2009; Harrington, Hansen, Moskowitz, Todd, & Feuerstein, 2010). In the *World Report on Disability*, rehabilitation is

defined as a “set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments” (World Health Organization [WHO], 2011). The specific aim of cancer rehabilitation is to optimize the patient's physical, psychological, vocational, and social functioning while countering the limitations imposed by the side effects of cancer treatments and/or comorbid conditions (Alfano, Ganz, Rowland, & Hahn, 2012; Armes et al., 2009).

An increasing body of evidence endorses rehabilitation as being beneficial and effective in strengthening the patient's health, improving survival chances, and preventing additional illness and side effects (Armes et al., 2009; de Leeuw & Larsson, 2013; Pearson & Twigg, 2013; Temel et al., 2010). Lack of cancer rehabilitation might lead to problems and consequences for the patients in returning to an everyday life during and/or after treatment (Ganz, 2009; La Cour, & Johannessen, 2010).

Municipal cancer rehabilitation programs are available and free of charge to all cancer patients as part of the National Health System in Denmark (Danish Health and Medicines Authority, 2012). Cancer rehabilitation in Denmark takes place either at the hospital as a specialized program prescribed by a physician or in the patients' home

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municipality in the form of a generalized rehabilitation program to which patients are referred by a hospital doctor or nurse, a general practitioner (GP), or the patients themselves. The Ministry of Health expects that the municipalities consider physical rehabilitation as a holistic and coordinated effort and as a cooperative effort if needed (Ministry of Health [Ministeriet for Sundhed og Forebyggelse], 2015). Rehabilitation is considered to begin at the time of diagnosis (usually at the hospital) and continue in the municipalities during or after hospital treatment (Danish Health and Medicines Authority, 2012, 2013; Local Government Denmark [Kommunernes Landsforening], 2012). The programs vary from municipality to municipality and typically include an array of interdisciplinary evidence-based interventions, such as physical training, stress relief, and supportive care, aimed at restoring functioning and supporting the patient to achieve independence and a meaningful life (Danish Health and Medicines Authority, 2012; The Danish Cancer Society [Kræftens Bekæmpelse], 2015).

Cancers are diagnosed more frequently in men, and unfavorable prognoses and survival rates are seen in men by comparison to women (Ganz, 2009; Peate, 2011; White et al., 2011). Although male cancer survivors have unmet rehabilitation needs, they are nevertheless significantly underrepresented in current programs (Holm et al., 2012, 2013), and only around 16%–25% of the participants in the cancer rehabilitation programs in Denmark are men (Handberg, Nielsen, & Lomborg, 2014; Holm et al., 2012; La Cour & Johannessen, 2010).

There is a tendency that the healthcare system is undergoing a feminization through at least the last decade (Bottorff, Oliffe, Robinson, & Carey, 2011; Danish Health and Medicines Authority, 2012). Those responsible for care, treatment, and rehabilitation are predominantly female healthcare professionals (HCPs), such as for instance nurses, doctors, and physiotherapists (Ministry of Employment [Beskæftigelses Ministeriet], 2014).

Gender relations between men and women can affect conduct and attitudes within the healthcare sector (Street, 2002). Gender can influence communication patterns, processes, and outcomes, and it is known that communication is led and guided by interactions and context within society and culture (Bottorff et al., 2011; Connell & Messerschmidt, 2005; Oliffe, 2009; Street, 2002). Conversely, the influence of gender within the healthcare sector is still uncertain and constitutes an issue that warrants further elaboration. The conceptualizing of gender is ongoing and relational and varies across personal, interpersonal, and institutional levels (Bottorff et al., 2011; Oliffe, 2009). The purpose of this study was to describe and interpret the attitudes and conduct of HCPs in

association with male cancer survivors and their rehabilitation participation in the primary healthcare system.

Methods

Design and Material

The study design and methodology was interpretive description, which is an applied methodology drawing upon established methodological technique directed toward the questions of practice disciplines (Thorne, 2016). The data set for this study was obtained from 58 hospital HCPs; these were nurses, radiology technicians, and social and healthcare assistants, all women except one (Table 1), representing rural and urban hospitals. The data collection strategy was theoretical sampling (Malterud, 2001), aiming for depth and variety. Data were generated through a 5-month period of ethnographic fieldwork, in one chemotherapy clinic and in two radiation therapy departments. The fieldwork was conducted by the first author from September 2012 to January 2013 at a university hospital in Denmark. The focus of the fieldwork was to understand the HCPs' conduct toward and attitudes associated with men's participation in cancer rehabilitation; specifically what the social interactions were between the HCPs and the male cancer survivors that informed and influenced meanings and choices and how they interpret these events in their daily work (Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2015b). The study was part of a larger project focused on male cancer survivors' lack of participation in cancer rehabilitation, and the findings on the men's perspectives are published elsewhere (Handberg, Lomborg, Nielsen, Oliffe, & Midtgaard, 2015a).

Table 1 Demographic data on participants

	(n = 58) (%)
Gender	
Female	57 (98)
Male	1 (2)
Age	
20–35	14 (24)
36–45	19 (33)
46–60	24 (41)
>60	0 (0)
Missing	1 (2)
Educational status	
Registered nurse	47 (81)
Registered nurse, ward sister	3 (5)
Student nurse	2 (3.5)
Radiology technician	2 (3.5)
Student radiology technician	1 (2)
Social and healthcare assistant	3 (5)
Working place	
Radiation therapy ward	36 (62)
Chemotherapy clinic	22 (38)

Data included participant observation and semi-structured, recorded focus group interviews. Field notes were made on observations, conversations, and general reflections. At the end of each day, reflective and analytical field notes were also recorded and used as a means of planning specific data collection approaches for subsequent sessions (Thorne, 2016).

After the first few months of fieldwork, the first author invited 58 HCPs (Table 1) to participate in focus group interviews, informing them about the study orally and in writing (one fell ill on the day of the interview and did not participate). Included in the nine recorded semistructured focus group interviews were the HCPs working in the three hospital departments; these individuals were therefore the HCPs best placed to potentially inform the patients about rehabilitation programs and also refer them to it. The interview and observation guides were informed by a literature review (Handberg et al., 2013) and symbolic interactionism (Blumer, 1969), with a focus on social processes and structures among the HCPs and male cancer survivors.

The study was approved by the Danish Data Protection Agency (no. 2014-41-2970). All participants were contacted in person by the first author and supplemented with a written information letter on the project. During field work, the first author always informed everyone of the reason for her presence and the purpose of the research. Written consent was conducted with all participants, and all participants were guaranteed anonymity when participating.

Data Analysis

The theoretical framework for the study was inspired by Herbert Blumer's theory of symbolic interactionism (Blumer, 1969). Symbolic interactionism has three basic premises: (1) human beings act toward things on the basis of the meanings the things have for them; (2) individually or collectively, the meaning one makes of things arises from the social interaction one has with one's fellows; and (3) meanings are handled in, and modified through, an interpretive process (Blumer, 1969; Handberg et al., 2015b).

Drawing upon this framework, we analyzed the data set in an iterative constant comparative manner by means of the interpretive description methodology (Thorne, 2016). In contrast to the more usual alignment between symbolic interactionism and grounded theory, in which a basic social process is being sought, we interpretively examined fieldwork participant observations in comparison with themes arising from the focus group interview transcripts as a means to thoughtfully consider what was said and done within the context of the research

aim. Data management was facilitated using transcribed textual data, uploaded to the qualitative software program NVivo. All data were read, and a process of discernment of particular circumstances and generalized patterns in relation to the study aim was identified (Thorne, 2016).

From this, a critical appraisal of relationships within the data was conducted and relevant thematic options were extracted. This process led to a set of primary categorizations and interpretations (Thorne, 2016). Finally, main messages arising from key insights within the data set were captured and developed into a formal interpretative structure concerning the participant's perspectives on men and cancer rehabilitation. The first and last authors worked together on the in-depth analysis and coding and were supported by discussions with the other coauthors.

Findings

The analysis revealed two strongly held and relatively consistent categorical themes—perceptions of gender and rehabilitation—both of which served as overarching patterns in the hospital HCP attitudes and conduct implying an influence on men's participation in cancer rehabilitation. Together, the two categorical themes show how the conduct of the HCPs may result in a dual obstruction, forming a barrier for the male cancer patients' rehabilitation participation. These perceptions represent two categorical themes presenting themselves as further barriers produced by the HCP's attitudes and conduct, indicating an impact on the male cancer survivor's participation in cancer rehabilitation (Figure 1). As such, the findings point to gender and rehabilitation perceptions as connected and intersecting in this context.

Gender Perception

The HCPs all had perspectives on gender-specific factors associated with social interactions with the male cancer patients, the relatives, and the HCPs' colleagues. Gendered conduct and attitudes were observable in the manner in which the HCPs demonstrated and modified their perceptions, including emotional reluctance and conception of masculinity, thereby justifying their comprehensions of cancer rehabilitation as not being for men.

The informants described, and during participant observation it was also observed, ways in which the HCPs perceived the men as being especially difficult and troublesome with respect to helping with rehabilitation initiatives as compared with their female counterparts. The HCPs preferred it when the men brought their wives or female partners with them during treatment since they found it much easier to provide help and talk about

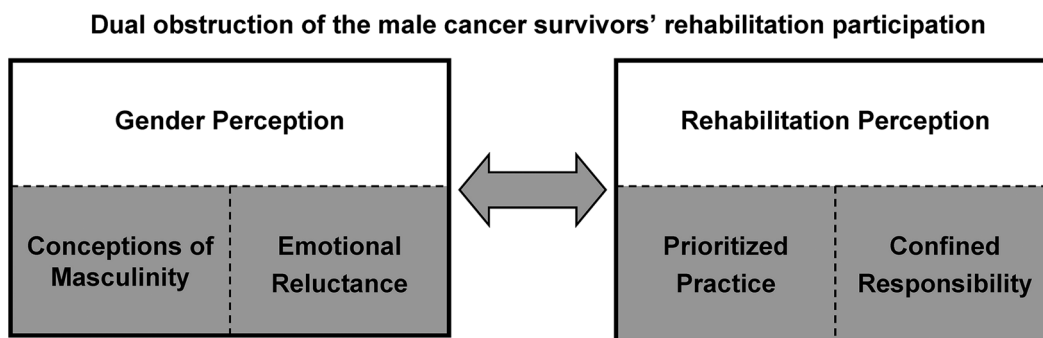


Figure 1. Healthcare professional's attitudes and conduct in association with male cancer survivors' cancer rehabilitation participation.

rehabilitation through the wives. The female HCPs used the linguistic form of “us” or “we” when referring to women, female patients, and themselves and “them” or “they” when referring to men—the male patients; “we” socialize, are emotional female patients, and are talkative whereas “they” are tough, confined, and specific.

An idea generally held among the HCPs was that the men did not worry and were less talkative and expressive than women. The HCPs explained that they would rather leave the men alone because they had a sense that their help was not wanted. They also felt that the men needed “a break” or “a timeout” following cancer treatment and did not need to be “dragged into” a rehabilitation program. Because of this, the HCPs frequently chose not to give the men general information and information leaflets on available rehabilitation programs. When the men, especially the younger men, actually did open up, showed feelings, or wanted to talk about their thoughts, anxieties, or fears, it clearly irritated the HCPs, and they found it awkward or strange that the men were being emotional and sentimental.

I know I'm generalizing now but when I think about our young Testicular Cancer Patients—there are definitely some of them that linger for a long time—dwelling in the course of their disease...and then you have to really talk to them until you almost drop dead from it! Their relatives must think it's awful to keep talking and talking. Some of the men have an almost perverted approach to all of it. (No. 2, Oncology Nurse)

Emotional Reluctance

From both the accounts and the observations, it was apparent that the HCPs functioned as emotional gatekeepers in relation to the male cancer survivors, repeatedly showing signs of reluctance in relation to discussing emotional issues with the male cancer patients. The HCPs described constantly making choices about whether to bring up sensitive subjects, such as fear, anxiety, the need for rehabilitation, or sexual problems related to treatment, and were aware that they often opted out of this with

the men. They explained that they could always “catch up” on these needs over time instead of being systematic about the time and placement of these conversations to make sure it was brought up. During participant observation, it was observed that, if the HCPs brought up sensitive subjects or spoke with the male cancer survivors, it would often be in places where there was no privacy, such as the waiting area or, in some instances, while the patients were lying (almost naked) on the gurney in front of the linear accelerator ready to get treatment. In such circumstances, it was clearly impossible to get into a longer intimate or emotional dialog. Despite this, several occasions were observed in which the men actually tried to answer a sensitive question while being rolled into the accelerator. According to the HCPs, however, men could not grasp the idea of rehabilitation while they were “being hurt, touched or in shock” due to experiencing a life-threatening disease like cancer which took up all their attention.

During the fieldwork, it was also observed that humor was widely used as a form of communication, especially with male cancer patients. This form of engagement seemed to add to the difficulty for the men to talk about serious issues with the HCPs. The HCPs described that while humor played a helpful role in engagement with patients, it also created the potential for leaving out something important.

But with humor...you can easily be funny 39 times right? I think we should be careful sometimes you know...and not to let us get totally caught up by humor...it can overshadow everything you know. I sometimes grab hold of myself thinking this is going so well...right...but you really have to be careful...what if something important stays hidden without being touched upon. (No. 42, Radiation Oncology Nurse)

Thus, paradoxically, the humor that was used to facilitate connection between HCPs and their male rehabilitation patients also seemed to play an unintended role in preventing men from being comfortable with expressing a possible need for that rehabilitation.

Conceptions of Masculinity

The HCP accounts also demonstrated shared perspectives on the importance of gender as well as specific conceptions of masculinity, shown in both attitudes and conduct, indicating that they did not consider that the men might need rehabilitation. Specifically, there was evidence that they expected men to be and act in a certain way. The HCPs generally thought it was important to the male patients that they were able to act like a man and be strong instead of showing signs of weakness and requiring the kind of help that rehabilitation implies. The HCPs described the way in which they experienced the importance that a sense of control seemed to have for their male patients and explained how these men showed signs of trying to stay in control, such as avoiding being confronted with thoughts of illness and death. The HCPs clearly understood these as barriers related to male concern for potential loss of control and found it difficult to address them.

If I ask them...just like that...if it's difficult to deal with everything right now or how they are—then I'd get a rejection! I don't think they can handle to...to lose control. I think it's all about the fact that "I can stay in control if I only relate to the technical things" or "I can't stay in control when I have to pass across to my feelings." (No. 39, Radiation Oncology Nurse)

The HCPs had a clear sense that the men's priority was to get back to a normal everyday life. According to the HCPs, the men sought normality through staying in the role they had before falling ill and trying to distract themselves by doing different activities that made them forget about their current situation. These perspectives resulted in the men being left alone more frequently in the wards than women and often not getting introduced to or offered rehabilitation programs.

Rehabilitation Perception

In addition to the shared ideas about gender, from both the interviews and the observations it was apparent that the HCPs also held shared perspectives on rehabilitation. These perspectives about rehabilitation were observable throughout their social interactions within the group of colleagues and also in their engagement with the male patients. Specifically, they concentrated on technical practice and maintained an interpretation of a confined responsibility area in relation to rehabilitation. The way they dealt with and modified these perceptions about rehabilitation was apparent in both attitudes and conduct, and it contributed to obstructing the men's participation in rehabilitation as a meaningful choice.

The HCPs described themselves as intentionally or unintentionally screening the patients for rehabilitation needs, and such conduct was also observed in the fieldwork. As a result of this screening, the male patients frequently fell short of being identified as requiring rehabilitation. According to the interpretations of the HCPs, this screening conduct was designed as a decisive mechanism to resolve when it would be relevant to begin discussing and providing rehabilitation information with the patients. However, several of the HCPs were also aware of what they considered something of a prejudice in relation to rehabilitation that may have affected their attitudes toward the male cancer patients. For instance, one HCP suggested that she thought the men's idea of rehabilitation was that it was "something like in the seventies where you sit on a blue pillow in a circle."

Because of this perception of what rehabilitation programs were like, the HCPs considered the municipality rehabilitation programs as gendered in the sense that they were much more appealing to women than men. The HCPs' comprehension of and attitudes toward rehabilitation therefore indicated their perceptions on rehabilitation, which often resulted in them not informing their male patients on rehabilitation programs available. The HCPs justified this by explaining that the men were not ready for rehabilitation when they left the hospital or during treatment. Many were quite emphatic in their repeated explanations of why they thought men did not need or want rehabilitation and how they themselves found it inadequate for the men.

It might be like this with the men; we'll have to accept that we cannot help them with our professional advice. We have to sit back and accept that rehabilitation is not something they need...the men. If they don't use it (rehabilitation) then it's because they don't need it. (No. 30, Radiation Oncology Nurse)

Surprisingly, however, on the few occasions that HCPs actually prioritized their activities to sit down with the men at time of discharge and discuss the possibility of rehabilitation, some of them did discover that their male patients actually had rehabilitation needs. Nevertheless, despite this observation, the attitude that rehabilitation was not well suited to the needs of men created a strong tendency for the HCPs to screen out the male cancer patients in the sense of falling short of identifying meaningful rehabilitation needs worthy of referral.

Prioritized Practice

Within the study sample, it was apparent that there was a clear intention of a holistic approach by the HCPs in their conduct toward the male cancer survivors. They described ways in which they sought to achieve coverage

of every aspect of the men's needs, including rehabilitation. However, the HCPs also described many aspects of their daily practice that made it difficult to fulfill this aim of a holistic approach. For instance, they explained how their routine was shaped by the extensive influence of a biomedical, scientific, and technical approach in their practice setting. This approach took up a significant extent of the HCP's time and was highly prioritized.

To illustrate, in both the chemotherapy clinic and the radiation therapy ward, therapy technique using a biomedical approach was paramount and therefore drew a lot of attention from both the HCPs and also from the male cancer patients. This focus was observed when the staff would explain how they had to prioritize primary physical parameters such as blood samples, the patient's weight, and medical treatment. It was also observed how the HCPs constantly had to make shifts from technical tasks to the patients as human beings and not as a part of the technique. Consequently, the lack of available time influenced the HCPs conduct and thwarted their intention of getting around to all aspects of patient experience, especially with the male patients, since they did not express needs and concerns to the same extent as did the women.

When I have a new patient then I never know how long time I've got and when...when the right day is to bring up rehabilitation because I don't know if I see this man again the next time or the next time. (No. 10, Oncology Nurse)

Thus, the care of the men often ended up being focused on physical and technical areas. It was apparent in this context that technique often seemed to catch the interest of both the male cancer patients and the HCPs. This appeared to add to the difficulty for the male patients to bring up sensitive subjects. Rather, they seemed to choose the "easy talk" about technical equipment that was otherwise dominating attention. If the patients and the HCPs did succeed in getting a conversation started on matters associated with psychosocial needs and rehabilitation, both parties tended to be quickly drawn back into the technical equipment, especially if the subjects were sensitive or when there were "difficult" breaks in the conversation.

Confined Responsibility

The HCPs at the hospital did not perceive rehabilitation as being a part of their responsibility area and constantly referred to their responsibility as being confined to the work required in the hospital setting alone. They had a clear comprehension that the patient's rehabilitation needs should be dealt with elsewhere, such as in the municipality programs, with the GP, in the outpatient clinic, at the

Cancer Society, by the patients themselves, or by the patient's relatives. As the HCPs did not think of rehabilitation as a cross-sectorial or interdisciplinary task, they held the attitude that they needed to "sell" the municipal programs to the men. From their perspective, the GPs and the municipalities were responsible for a majority of rehabilitation initiatives. However, it was also apparent that the hospital HCPs were uncertain about and, in some instances, actually mistrusted the GPs and the municipality programs with respect to their capacity to address the needs of male cancer survivors.

I was looking at the programs in the municipalities—they have a pink folder! Honestly I'm going to puke! There's so much focus on not being able to recruit men and then they go and make a pink folder—come on! That's just the way I feel. What kind of people plan rehabilitation programs like this? What man would want to enter a pink door?... (several are laughing)...with flowers on it—almost. Come on! That's just the way I feel. That's not good enough. No way! (No. 6, Oncology Nurse)

In this context, they also emphasized that the discharge interview was not regularly offered to all patients due to financial resources. As a result of this, the offer of rehabilitation was of lower priority for male patients since, according to the HCPs, men were less likely to express a need for it. Simultaneously, the HCPs acknowledged that they themselves lacked competence and knowledge with respect to informing the male patients at a useful level. Thus, according to the HCPs, the men neither needed nor wanted the interview that might have led to a rehabilitation referral at the time they were leaving the hospital and concluding active treatment.

Discussion

The findings of this study provide important insight into the attitudes and conduct of the hospital-situated HCPs toward men's participation in municipality-based rehabilitation. According to these findings, HCP perceptions around both gender and rehabilitation served to constitute a dual obstruction that led to a reduced proportion of men participating in cancer rehabilitation. The HCPs' actions toward the patients were therefore based not on the patients' personal preferences, wants, or needs but rather on their own socialized norms and conceptions.

Understanding the diversity of gender perceptions that influence conduct and health behaviors is at a nascent stage. The literature suggests that, although gender relations vary across situations and contexts, men and women

have different communication styles and needs (Bottorff et al., 2011; Street, 2002; Thorne & Oliffe, 2007). Because patients have an expectation that the HCPs will take an active and controlling part in the interaction, the style that HCPs use in their communications matters. Focusing on gender over other personal and situational attributes can lead to a misinterpretation of conduct and to a manner of support that may perpetuate gender inequity in health (Bottorff et al., 2011; Street, 2002).

Our findings show that the men in this cancer rehabilitation context were often left out and received lower levels of health information than did women. This finding is consistent with literature showing that men are more reluctant in help-seeking in relation to their own health (Moller-Leimkuhler, 2002; Sher, 2016). Moreover, it has been shown that women have a tendency to express their concerns, feelings, and questions more openly, resulting in HCPs often thinking women have more needs than do men (Street, 2002), such that men receive less support, help, and information. These factors pose a significant challenge in supporting men with the right amount of help and information so that they can choose for themselves and benefit from rehabilitation to the same extent as women.

The HCPs in this study demonstrated gendered attitudes in expecting their male patients to demonstrate a certain masculine role that is understood as influenced by hegemonic approaches (Connell & Messerschmidt, 2005; O'Brien, Hunt, & Hart, 2005). This resulted in the male cancer patients (intentionally or unintentionally) trying to fulfill the HCPs' expectations by being independent and not needing help or rehabilitation (Connell & Messerschmidt, 2005; Galdas, Cheater, & Marshall, 2005; O'Brien et al., 2005). The HCPs' attitudes toward these male patients appeared to be based not on the male cancer patients' personal preferences or needs but rather on socialized norms and their own gender conceptions.

Some of these patterns continue to be observed in Danish society even though Denmark has a well-established culture around equal rights for men and women. However, especially in the older generation, there remains a tendency to have expectations that men are strong, able to provide for their family, and refrain from showing any signs of weakness. Therefore, although men are not necessarily fundamentally opposed to help-seeking, because of cultural norms and socialization, including expectations from the families and HCPs around them, they may choose to fulfill the expected hegemonic role of being strong and masculine rather than requiring rehabilitation assistance.

The conceptualization of masculinity demonstrated by the HCPs in this study showed that rehabilitation was inconsistent with an expected component of masculine conduct. This is unfortunate since it is known that

recommendations and incentives from HCPs in relation to matters such as exercise can have a positive effect on patient compliance (Jones, Courneya, Fairey, & Mackey, 2004; Missel, Schönauf, Pedersen, & Pedersen, 2015; Street, 2002). Men are not necessarily fundamentally opposed to help-seeking. However, because of cultural norms and socialization, including expectations from their surroundings including HCPs, men may choose to fulfill the expected hegemonic role of the strong masculine man who does not need help (Connell & Messerschmidt, 2005; Handberg et al., 2015a; O'Brien et al., 2005). Some studies have shown that men do not hesitate to express needs for help and support if they are addressed with an approach and attitude that departs from this hegemonic masculinity (Ahlsen, Mengshoel, & Solbraekke, 2012; O'Brien et al., 2005). This interpretation of the findings lends emphasis to the importance of the HCPs, giving the male patients the same amount of information and motivation as the women (Handberg et al., 2015a; O'Brien et al., 2005).

Because research in other contexts has made it apparent that gender disparities in health service delivery roles may add to the tensions associated with gender differences in care received (Bottorff et al., 2011), it seems reasonable to consider the possibility that reduced male involvement in rehabilitation may be a product of perpetuating masculinity expectations. It is known that around 70% of HCPs in Denmark are women (Ministry of Employment [*Beskæftigelses Ministeriet*], 2014), and the proportion was almost 100% in this study. The HCPs in this study appeared to serve as emotional gatekeepers on behalf of the men, letting emotional reluctance prevail to make rehabilitation less likely. When they are liberated from the traditional hegemonic view, men naturally have needs and do express psychosocial concerns (Ahlsen et al., 2012; O'Brien et al., 2005). Thus, it is important that HCPs become aware of the damage that can arise from a fixed gendered bias in their approach.

Should the HCP's approach change to one that involves listening to men as they express their needs without being prejudiced, it might well have the effect of reinforcing the men's likelihood to confide their needs (Ahlsen, Bondevik, Mengshoel, & Solbraekke, 2014). A challenge for the HCPs is, for example, to recognize when humor is facilitative or restrictive for the male cancer patients (Oliffe, Ogrodniczuk, Bottorff, Hislop, & Halpin, 2009). If humor is recognized as restrictive, HCPs can then learn how to confront or challenge men's resistance in a way that is helpful and does not deter the use of humor entirely (Oliffe et al., 2009). In some studies, it has been shown that shared attitudes and beliefs that may control and guide HCPs' actions and communications into a pattern of behavior may be further reinforced by

being in groups that share gender or other sociodemographic characteristics (Street, 2002). The HCPs in this study were a quite homogenous group (female, with the vast majority having been in clinical practice for several years; Table 1), which might explain some of the shared conduct toward the male patients.

Although this study took place in one national context, which may have certain distinctive features, some of the patterns in conduct and attitudes described in relation to the HCPs in this study can be observed in society in general. There are, for instance, still high expectations that men are strong and able to handle all kinds of challenges within such domains as family, job, and leisure time. Research shows similar patterns in illustrating, for instance, how smoking behavior among men is shaped by ideals of masculinity and social contexts (Kwon, Oliffe, Bottorff, & Kelly, 2014). Social conceptions of how men should be or act may contribute to their opting out of rehabilitation while trying to fulfill an expected role. Some of these hegemonic trends in relation to gender were observed within the social and cultural comprehensions of female HCPs in this study, such that they seemed to create unintended barriers to male cancer patients' participation in cancer rehabilitation. Theories of masculinity and gender are helping us understand that attitudes around sex and gender are far more complex than simply the perceptions most often displayed and comprehensions about them are not as stereotypically defined as has been previously assumed. Clearly, the gender idea has changed and developed together with society (Bottorff et al., 2011; Connell & Messerschmidt, 2005; Street, 2002), signifying the ongoing need for a gender analysis in understanding health and health equity issues.

Conceptions of rehabilitation, according to the HCPs in this study, suggest that rehabilitation is primarily for women; indeed, even the name "rehabilitation" itself may be somewhat gendered. Traditionally, many HCPs claim to take a holistic approach in their care and treatment of patients, as did the participants in this study. However, HCPs in our study found that it was often hard to live up to their aim of holistic care and treatment due to many competing tasks and lack of time.

The emphasis on technique and biomedical priorities that we noted in our study often ended up as an unintentional (or perhaps also intentional) reason for the HCPs to omit certain tasks. It is known from the literature that workload and complexity of the work in cancer wards can result in the HCPs giving low priority to communicating and interacting with the patients and seeing to their support and needs (Camicia et al., 2014; Zamanzadeh et al., 2014). Such a circumstance calls for expressive patients who do not hesitate to put across their needs—a

condition that may not always, as shown in this study, appeal to men.

The influence of contextual parameters, such as the extensive amount of technique or the behavioral environment, can become important when considering the effect of an intervention (Hansen, Tjornhoj-Thomsen, & Johansen, 2011; Oliffe, 2009). The alluring influence that technique and the biomedical approach seemed to have played in the care of the male patients in this study apparently resulted in neglect with respect to the HCP's intentions for a holistic approach to their care. These two polar tensions—the holistic approach and the actuality of the technical biomedical focus—create a contrasting reality for the HCPs in this study, resulting in the men less often having their rehabilitation needs covered.

The assumption by these HCPs that rehabilitation was outside their responsibility area also seemed to result in men not getting referred to or being informed about rehabilitation programs in the municipalities. The rehabilitation literature shows significant problems with transitions to supportive care, including rehabilitation after hospital treatment, leading to multiple problems with fragmentation of care and disorganization between sector limits (Camicia et al., 2014; Lundstrom, Johnsen, Ross, Petersen, & Groenvold, 2011; Thorne & Stajduhar, 2012). Although the HCPs claim to have an active responsibility around rehabilitation, our findings revealed various obstructions resulting in many of the men not being rehabilitated.

Patterns of conduct such as these are suggestive of worrisome trends in the cancer survivorship field, since the role of care tasks outside the hospital setting is growing due to hospitals being developed and equipped for acute primary treatment (Kelly & White, 2011; Wiener, Anderson, & Gage, 2009). The traditional and continuing purpose of the hospital is primarily at the level of symptoms and needs associated with acute treatment, and these are obviously essential areas requiring immediate attention and prioritization. As we have demonstrated, this may affect male cancer patients especially, since declining to attend to their rehabilitation needs would appear to initially reduce the overall costs of care. Thus, as hospital cost containment initiatives expand, we may find increasing instances of rehabilitation and supportive care inequities.

Study Limitations

The recruitment and data collection strategy for this study was theoretical sampling, since the aim was depth and variety in the data and findings. The study informants represented rural and urban areas and hospitals, with some variety in age. Although we did aim for a

broader variety of gender and educational background, our sample was more homogenous than originally intended, and this may have influenced our findings. Thus, the commonality of perspective found in this study population may constitute a social condition that would not be found with a more heterogeneous staff mix.

We acknowledge that the imbalance in gender among the HCPs may have created a “same gendered perspective” that influenced the findings in this study. However, although the field work was conducted in an iterative analytical process in which we constantly sought to challenge data, looking for variation and outliers, the attitudinal findings appeared as rather consistent. Although we detected some contrary cases and outliers, these were relatively few and, often, these were inconsistent. For example, an HCP might acknowledge that hospital-situated staff ought to better inform men about rehabilitation and subsequently explain why that aspect of care was not really within the hospital-situated HCP’s responsibility or in alignment with the patient’s expressed needs.

Using data obtained in various ways, including observations, informal conversations, semistructured focus group interviews, and field notes, proved helpful to a comprehensive exploration and analysis in relation to answering the research question. The informants were all interested, engaged, and motivated to share their perspectives and experiences. The first author executing the field work was a nurse who, as a benefit to the study, had prior knowledge of cancer experience, treatment, and rehabilitation, which allowed for an effective in-depth interaction with the informants.

However, the female gender of the fieldworker/interviewer may have influenced the findings due to a sense of community among the primarily female informants. The findings could, in that sense, represent categorical biases about gender, and the questions that were asked may have inadvertently prompted for that. Furthermore, there may be a risk that the gender focus of the study—reflecting on male patients rather than all patients—may have caused these patterns to stand out distinctly where they might have been less apparent had another study lens been employed. However, the research group as a whole represented different professional backgrounds and genders, which helped to prevent the personal or disciplinary biases of a single researcher from excessively influencing the findings. Nevertheless, the results from this study can be considered potentially transferable and practicable to other similar cancer rehabilitation contexts, in that they are reflected in general gender theories that have been represented in the literature by other authors in other clinical contexts (Bottorff et al., 2011; Connell & Messerschmidt, 2005; Street, 2002).

Implications of the Study

To counterbalance the gender inequity in cancer rehabilitation that we found in this study, these findings allow for a number of implications of concern to HCPs. In that they have access to patients nearing the conclusion of active treatment, it seems reasonable to expect that nurses and others in the hospital setting ought to engage in cross-sectorial cooperation with respect to responsibility for rehabilitation information as a mandatory component of care for both male and female cancer patients. Where such information is discretionary and especially where cost containment is an influencing factor, male patients may be disadvantaged. Thus, rehabilitation needs assessments, referral practice, and information should be provided to all cancer patients prior to or at the conclusion of treatment. A systematic practice around the hospital discharge may provide consistency in information content for all patients, thereby ensuring that all patients are well informed on rehabilitation, its known effects relative to their condition, and the avenues by which they can obtain access. Furthermore, it seems necessary to take gender into account in the development and planning of rehabilitation interventions. There is a need for HCPs, a dominant percentage of which are female in the Danish context, to examine their attitudes or possible biases toward male patients and rehabilitation. To reduce stereotypic programming that may be tailored more to women than men, it may be helpful to embed a gender understanding in information materials and communications surrounding them. The message that seeking help or rehabilitation is no sign of weakness or reduced manliness, but rather an active deliberative choice, may help prevent or reduce stigmatization.

Conclusion

The findings of this study indicate an interaction between gender and rehabilitation attitudes that, in this context, affected the health behaviors of male cancer survivors’ participation in cancer rehabilitation and perhaps their outcomes. The comprehensions of gender held by nurses and other HCPs, comprising emotional reluctance and a manifest conception of masculinity, appear to justify their idea that cancer rehabilitation is not well suited to men. Their attitudes and conduct associated with concentrating their practice on technical and physical issues and interpreting their responsibility area in relation to rehabilitation as demarcated and confined also seemed to create barriers to men’s cancer rehabilitation participation.

Clearly, further research is needed to explore the importance of gender in healthcare, health and gender inequity, the impacts of a growing proportion of women

Key Practice Points

- Gendered assumptions can influence patient experience of cancer rehabilitation.
- Rehabilitation attitudes may differentially affect male and female cancer rehabilitation patients.
- More gender-sensitive rehabilitation programs may be needed to ensure effective outcomes.
- Active recruitment into rehabilitation programs may be needed to overcome perceptions that seeking help is a sign of weakness for male cancer survivors.

in the healthcare sector, and the cross-sectorial gap between hospitals and municipalities. These findings provide insight into approaches that might be explored to guide practice in developing more gender-specific rehabilitation programming for male cancer survivors, thereby contributing to an evolving understanding of the role of embedded attitudes in disadvantaging certain population sectors with respect to survivorship support. Although further research is required to understand these dynamics more fully, there is much that can be done using the intersectional lens of attitudes about rehabilitation and gender to ensure that cancer rehabilitation for men is articulated and developed in a manner that is accessible to men and aimed at supporting them in their survivorship continuum of care and rehabilitation toward a meaningful everyday life during treatment and in the ensuing phases of the cancer trajectory.

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